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Management Accounting Change in the Saudi Public Health Sector: A Neo-Institutional Perspective

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"In the name of Allah the Most Beneficent, the Most Merciful"

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Abstract

This research has investigated and analysed why and how Management Accounting (MA) has contributed, at the institutional level, to improving Health Care Quality (HCQ) within the Saudi Arabian Public Health Sector (SAPHS). Analysing these developments as a form of change consistent with the dynamics found in the emergence of New Public Management (NPM), this study draws on Neo-Institutional Sociology (NIS). The research studies how MA change operated across institutional contexts within an NPM-based approach to improving health care and public health in the Kingdom of Saudi Arabia (KSA). It focuses on how, in this context, the roles and practices of MA have been defined, designed and implemented to promote 'quality outcomes' in health care. Methodologically this has involved two extensive case studies of MA change in two carefully selected hospitals, including semi-structured interviews with accountants, management, consultants and clinicians along with the collection and analysis of key documentary information used in managing the human and financial resources within the hospitals.

The findings show how and how far new management accounting practices (MAPs) have promoted the ability and 'right' of management to coordinate control and monitor the human and financial resources, but in a way that specifies HCQ outcomes for patients, thus meeting both economic and social/political objectives. It is argued that MAPs had significant success because the allocation of budgetary resources by the Ministry of Health (MOH) was based on hitting non-financial quality and productivity targets. In both hospitals MAPs came to operate within a 'non-accounting budgetary style' (Hopwood, 1973) de-emphasising cost control, and managers and staff focussed just on effectiveness and efficiency measures. However, this initiative can also be seen as a response to significant institutional pressures and concerns at both government and professional levels, responding to 'public voice' concerns over HCQ. The response drew on world-leading medical research and practitioners to introduce best-practice HCQ solutions allied to internationally accredited quality standards into the KSA hospital sector. The study found that *coercive, mimetic and normative isomorphism* all contributed to the successful implementation of the HCQ agenda, and the new MAPs here contributed to strengthening the internal and external legitimacy of certain key KSA institutions. There was some institutionally significant resistance from clinicians who saw these MAPs as compromising their professionally-defined focus on quality outcomes for patients. But over time, the mix of 'soft' quality and 'hard' MA derived targets was increasingly accepted and internalised as integral to delivering HCQ.

Table of Contents

Chapter 1 : Introduction 1

1.1 Introduction 1
1.2 Background and motivations 2
1.3 Context of the study 6
1.4 Research questions 8
1.5 Research objectives 9
1.6 Research process 10
1.7 Structure of the thesis 11

Chapter 2 : Literature Review 12

2.1 Introduction 12
2.2 Institutions, accounting and the emergence of NPM: a historical frame 13
2.3 The role of MA in NPM 17
2.3.1 Economic imperatives 18
2.3.2 NPM and MA: a scene of power 20
2.4 MA change in public health from the past to the present 24
2.4.1 An early start 24
2.4.2 After WWII and beyond 26
2.4.3 MA change in health care sector 29
2.4.4 A recent focus: quality 35
2.4.5 Implementation initiatives of health care reforms 38
2.4.6 HCQ as a problem in KSA 40
2.5 Discussion and analysis 45
2.6 Conclusion 49

Chapter 3 : Conceptual Framework 50

3.1 Introduction 50
3.2 Institutional theoretical approaches 52
3.3 Neo-Institutional sociology 58
3.3.1 Competitive isomorphism 61
3.3.2 Institutional isomorphism 62
3.3.2.1 Coercive 62
3.3.2.2 Mimetic 63
3.3.2.3 Normative 64

3.3.3 Power and resistance 65
3.3.4 Limitations of NIS 66
3.4 NIS as a framework of interpretation 68
3.5 Conclusion 72
Chapter 4 : Methodology and Method 73
4.1 Introduction 73
4.2 Research approach and design 73
4.3 Case study selection criteria 76
4.4 Choosing research methods 78
4.4.1 Interviews 79
4.4.2 Interview themes 81
4.4.3 Pilot study 83
4.4.4 Document and archival material 84
4.5 Research process 84
4.5.1 Collecting material: out in the field 85
4.5.1.1 Access 85
4.5.1.2 Interviews 85
4.5.1.3 Documents and archival records 88
4.5.2 Analysis and theorising material collected: at the desk 89
4.5.3 Writing up an argument 91
4.6 Ethical considerations 92
4.7 Conclusion 94
Chapter 5 : The First Case Study: KKH 95
5.1 Introduction 95
5.2 From old to new MA: an overview 95
5.2.1 Power of the political and economic: regulation and resources 100
5.2.2 Informal non-governmental discourses and patients 104
5.2.3 International and national state interfaces: JCI and IT 107
5.2.3.1 Joint Commission International 107
5.2.3.2 The improvement of IT 110
5.2.4 Professional development and involvement 115
5.3 The emerging and changing roles of MA in managing quality 120
5.3.1 The role of the budget 121

5.3.2 Turning the MA role into total quality management 125

5.3.3 Interplays of MA and TQM around ‘quality benchmarks’: new visibility for all 134

5.4 Conclusion 138

Chapter 6 : The Second Case Study: KFH 140

6.1 Introduction 140

6.2 From old to new MA: an overview 140

6.2.1 Power of political and economic: regulation and resources 145

6.2.2 Informal non-governmental discourses and patients 150

6.2.3 International and national state interfaces: JCI and IT 153

6.2.3.1 Joint Commission International 154

6.2.3.2 The improvement of IT 157

6.2.4 Professional development and involvement 160

6.3 The emerging and changing roles of MA in managing quality 164

6.3.1 The role of budget 164

6.3.2 Turning the MA role to total quality management 168

6.3.3 Interplays of MA and TQM around ‘quality benchmarks’: new visibility for all 173

6.4 Conclusion 178

Chapter 7 : MA as ‘Solution’ to HCQ Problems 180

7.1 Introduction 180

7.2 Institutional roles of MA change in enabling and delivering HCQ 182

7.2.1 Key institutional roles of MA at KKH 185

7.2.2 Key institutional roles of MA at KFH 187

7.2.3 A critical comparison between the two cases 191

7.3 New agenda: developing HCQ in the context of promised social innovations 194

7.3.1 Public voice 194

7.3.2 Non-accounting budgetary dynamics 198

7.4 Beyond the MA focus: other aspects in the institutionalisation of HCQ 201

7.4.1 Centralisation and decentralisation interplays in the reformed institutional setting 201

7.4.2 Institutional interactions between MAPs and elite medical knowledge and expertise 203

7.4.3 Clinicians’ resistance to PMs and KPIs 209

7.4.4 The roles of IT and management accountants 211

7.5 Conclusion 213

Chapter 8 : Conclusion 215

8.1 Introduction 215
8.2 Summary of the study 216
8.3 Research questions revisited 228
8.4 Contributions 231
8.5 Limitations 233
8.6 Future research possibilities 234

References 236

Appendices 254

Appendix A: Interviews Questions 254
Appendix B: List of documents 262
Appendix C: Health care Systems around the world 263
Appendix D: Kingdom of Saudi Arabia 269
Appendix E: Management structures 282

Table of Tables

3-1: Differences between OIE and NIE 56
4-1: Case study research: design and methods 76
4-2: First and second collection of material 87
4-3: Summary of the research design 94
5-1: Ministry of Health’s development budget 109
5-2: Total number of employees at KKH 116
5-3: Summary of the changes in the KKH 139
6-1: Summary of the changes in the KFH 179
7-1: Summary of the changes in the two SEP hospitals studied 193
7-2: Numbers of Medical Staff 213

Table of Figures

2-1: Country budget allocation in KSA 43
2-2: Growth rate of GDP and its major components 44
3-1: Gorwth of Saudi Students in the World 70
3-2: The main institutional focus 71
3-3: Conceptual Framwork: NIS and the theorising of MA change 71
4-1: Design for Case Study Research 75
5-1: Framework of the electronic systems 110

Abbreviations

BSC	Balanced Scorecard
CM	Contracting Management
DRG	Diagnosis Related Group
ERP	Enterprise Resource Planning
FFH	King Faisal Hospital
GCC	Gulf Cooperation Council Countries
GDHAR	General Directorate of Health Affairs in the Riyadh
GDP	Gross Domestic Product
HCQ	Health Care Quality
IT	Information Technology
JCI	Joint Commission International
JHH	Johns Hopkins Hospital
KAFSP	King Abdullah Foreign Scholarship Program
KFH	King Fahad Hospital
KKH	King Khaled Hospital
KPI	Key Performance Indicators
KSA	Kingdom of Saudi Arabia
MA	Management Accounting
MAPs	Management Accounting Practices
MBE	Modern Business Enterprise
MOF	Ministry of Finance
MOH	Ministry of Health
MOHE	Ministry of Higher Education
NACC	National Anti-Corruption Commission
NIE	New Institutional Economics
NIS	Neo-Institutional Sociology
NPM	New Public Management
OIE	Old Institutional Economics
PA	Public Administration
PMs	Performance Measurements
QPD	Quality and Performance Department
SAPHS	Saudi Arabia Public Health Sector
SEP	Self-Operation Programme
TQM	Total Quality Management
WB	World Bank
WHO	World Health Organisation

Chapter 1 : Introduction

1.1 Introduction

This study investigates and analyses Management Accounting (MA) changes within the Saudi Arabia Public Health Sector (SAPHS) under the self-operating programme[1] (SEP) reform to improve the Health Care Quality (HCQ), defined as New Public Management (NPM) (Hood, 1995, 1991). Over the past few decades, MA has increasingly moved to become made up of a range of practices beyond simple cost management, budgeting and decision-making, including such practices as tracking, monitoring and evaluating quality as well as financial performances and enhancing worker skill, education and autonomy, thus promoting ‘human capital’. This change has come about for many reasons, but these include institutional development such as the greater emphasis put on knowledge development and management and the recognition of the external and strategic importance of effective internal delivery of quality work and motivated workforces (e.g. Weber, 1922/2013; Abdel-Kader, 2011; Hopper *et al.,* 2004; Luther and Longden, 2001; Hopper, 2000).

This thesis aims to study and analyse how management accounting practices (MAPs) have contributed to the success of a HCQ agenda, pursued over the past decade within the Kingdom of Saudi Arabia (KSA), which has transformed the SAPHS in some significant ways. The KSA is an interesting context for this research since this is a high-income state which is a major global power, but it is also a state which has a major commitment to developing social provision in a range of key ways, ranging from enhanced educational opportunities from pre-school to university for its citizens, to enhanced provision of services such as housing and health care. Thus it has aspects of both a ‘developed’ and a ‘developing’ state. This study has been able to observe how a major government initiative for promoting HCQ has been implemented in two

[1] A word by word translation from Arabic would be ‘Self-Employment-Programme’. However, a better translation of the meaning would be ‘Self-Operating-programme’. For more information about the SEP reform see appendix D.

hospitals, one of which was in the first wave of hospitals rolling out the new HCQ agenda beginning from 2007, and the other of which was in the second wave of the roll out, from 2010. It has been able to follow, through being granted access to undertake detailed fieldwork in both hospitals, how and how far new MAPs were developed and accepted by accountants, consultants, managers and clinicians in these two hospitals. It has also been able to track the range of institutional pressures at work as this new HCQ agenda was rolled out, and how these have shaped and contributed to the ways in which MAPs have been put to work and internalised in the hospitals. As will be seen the research has indicated that *coercive, mimetic* and *normative isomorphism* have all played a part in shaping what has taken place.

1.2 Background and motivations

MA is used extensively in organisations across the world (Liguori and Steccolini, 2012). Traditionally, MA concentrated largely on the costing of goods and services, setting organizational and departmental budgets, and enabling decision-making by top and departmental management. By the 1920s early cost and management roles were being extended with the development of innovations such as responsibility accounting and the use of measures such as Return on Investment as targets for divisional CEOs in multidivisional or M-form entities (Chandler, 1977). Further management control innovations developed by the 1950s, in relation to issues such as transfer pricing and more fine-grained forms of performance measurement (PM) (e.g. Hopper *et al*., 2007; Hoskin and Macve, 2005). Then a further wave of MA innovations is widely seen as developing from the 1980s through such developments as the focus on the cost of indirect labour (as found in Activity-based costing) and a more explicit concern with measuring and monitoring customer concerns and employee quality and its enhancement (as found in the Balanced Scorecard (BSC) or the Performance Pyramid).

Chandler's analysis in *The Visible Hand* (1977) of the development of the Modern Business Enterprise (MBE), and of the roles played by accounting and statistical information in

developing a first form of 'administrative coordination', arguably raised scholarly awareness of the constructive roles played by MA in making possible the modern economic and also political world (e.g. Johnson and Kaplan, 1987; Miller and O'Leary, 1987; Hoskin and Macve, 1986).

At the same time, MA began to penetrate into the public sector as a possible solution to the perceived weaknesses of traditional bureaucracy, enabling both greater budgetary and cost control and then promoting the use of non-financial as well as financial targets in public-sector settings. As one aspect of this, MA in the public health sector has changed significantly during the last few decades, reflecting what has emerged as a new management philosophy, now known as NPM, to be implemented in the health care sector (McSweeney, 2006; Hood, 1995, 1991). Here, in an updated version of Chandler's (1977) MBE, public sector organisations become conceived in many respects as businesses which have to use accounting information to set budgets and budget targets, evaluate employee performance, and meet both quality and cost or profit targets (McSweeney, 2006).

Over the past few decades, NPM has been adopted in the health sector in many countries and regions around the world to improve health sectors and to meet the expectations of the public and the government alike in terms of financial accountability, effectiveness and efficiency (Osborn and Anderson, 2015; Morales *et al,* 2014; Cutler, 2011; European Union 2010; Lane, 2000). NPM has become an international phenomenon, and arguably the majority of hospitals worldwide have adopted it (Christensen and Laegreid, 2007). Kurunmäki *et al.* (2003) argues that MA played a different role in each country during NPM implementation. Thus, we can see that MA changes in the health sector are not solely influenced by the adoption of NPM. Other factors also influence the role of MA. However, the implementation of NPM through the changes in MA has been unsuccessful in several countries due to conflicts between the objectives of the reform and those of public health care (Malee, 2003). The reasons NPM

implementation is not always successful relates to the characteristics of the reform, the organisation and the environment. This deserves further research to gain a clear understanding of the necessary changes to management strategies in the context of developing countries.

In this respect, Hoskisson *et al.* (2000) have argued that developing countries are undergoing continuous institutional change in a bid to adapt to free-market ideologies, that in turn require consistent development in terms of accounting and MA suited to those evolving institutions. For example, Barrage *et al.* (2007) note increasing health care needs in the KSA market and the expected future growth of the health sector. The provision of health care services is largely handled by the KSA government due to the significant size of the public sector in the kingdom. Health care capital and operating expenditures are funded directly by the government, and hospital policies are largely controlled by the government because of its role in the provision of health care services. However, Hassan (2008), Lukka (2007), Modell (2007) and Scapens (2006), have argued that there is a lack in the research about the role institutional factors play in the context of developing countries, and how these factors interact in the changes of MA.

Researchers observed that the use of MA developed in the private sector and in the public sector in different national contexts has resulted in different outcomes (Cinquini and Campanale, 2010; Hampson, 2009; Hassan, 2008; Agrizzi, 2008; Kurunmäki, 2004; Lapsley, 2001). Each country has its own characteristics and environment, and this has allowed us to see the application of NPM from different perspectives (Osborn and Anderson, 2015; Morales *et al,* 2014; European Union 2010). For example, Hampson (2009) investigated the implementation of MA initiatives to achieve the target outcomes for the public sector in terms of performance management in the state of Queensland and in Australia generally. The results show that there remains a significant gap between the desired objectives of the implementation of MA and the actual outcomes, implying that creating an enabling environment is essential to ensure MA initiatives are fully

implemented in public sector organisations. The weakness of such initiatives includes the inability of management accountants to gain substantial control over the resource allocation process and the possibility that existing power structures might marginalise the importance of management accountants (Al-Nafjan and Al-Mudimigh, 2011). Although the importance of MA to the success of firms has been widely established and has become an important determinant of the future success and competitiveness of firms operating in liberal economies (Hassan, 2008; El-Ebaishi *et al.,* 2003), few studies however have studied recent MA trends in the KSA context. Most studies of MA are in the form of theses undertaken by researchers in the US and the UK (Naser, 2002; Elkharouf, 1994; Alnamri, 1993). There is a lack of research into MA within the SAPHS and into the way MA is perceived by accountants, consultants, managers and professionals. In addition, there is little research in the context of KSA as a developing country, especially after the emergence of NPM within the public sector. Thus, the existing gap in the research literature warrants a comprehensive study analysing MA in KSA hospitals.

Furthermore, criticism has been raised about the lack of research and understanding outside Western countries (Uddin *et al.,* 2011; Jayasinghe and Thomas, 2009; Hopper *et al.,* 2009; Van Triest and Elshahat, 2007; Waweru *et al.*, 2004; Uddin and Hopper, 2001). Abernethy *et al.* (2001) point out that developing countries have different government systems than Western countries, and external powers such as the World Health Organisation (WHO) and the World Bank (WB) have the power to regulate health care at a global level. These aspects make the context of developing countries more interesting as a subject for research, especially when the government and external factors have significant impacts on MA within the public health sector. Furthermore, the role of accountants, consultants, managers and professionals has changed in line with changing MA in modern organisations (Burns and Baldvinsdottir, 2007). However, there is a lack of research focusing on the way these changes are perceived by accountants, consultants, managers and clinicians in the public sector in developing countries.

Regarding MA and public health care in developing countries there remains a lack of research, particularly about the characteristics of developing countries (Scapens, 2006; Hassan, 2005). For example, Henriksen *et al.* (2012) state that culture in developing countries is seen as a significant factor that influences the use of NPM in the health sector. Pillay (2008) observes that the successful implementation of NPM in developing countries cannot occur without paying attention to the governance systems and the level of change in the country when applying new reforms originating in developed countries. Moreover, the changing environment, such as the introduction of new IT, new strategic systems and a greater focus on quality and customer service has led to changes in practices within organisations (Hopper and Bui, 2016). MAPs are one of the practices that have been strongly influenced by these changes in the KSA environment. In addition, external factors, such as politics, economics, IT, demographics and education, are seen as variables that have influenced the development of MA within organisations (Stamatiadis, 2009; Hassan 2008). A substantial portion of the research concerning MA changes has been conducted in different sectors and different countries.

1.3 Context of the study

Like other countries (Campanale et al., 2011; Cutler, 2011; Cinquini and Campanale, 2010; Hassan, 2008; Jacobs et al., 2004; Nyland and Pettersen, 2004; Kurunmäki et al., 2003; Lawrence et al., 1997; Pettersen, 1995), the SAPHS has been influenced over the last decade by the way in which public hospitals are managed under NPM, and this led the KSA Ministry of Health (MOH) to create a new reform for public hospitals. Given the different political, economic, professional, social, cultural, and educational context in KSA to other countries, it is expected that the adoption of NPM by hospitals in KSA would be different at the outset, giving rise to interesting opportunities to investigate and analyse the implementation and possible outcomes of changes to MA.

In context of the study, the SAPHS has been strongly criticised in terms of how public hospitals are operated. This criticism is manifested in the centralisation of human and financial resources management in hospitals and the HCQ that the public hospitals provide, particularly after the KSA government sharply increased the SAPHS budget without improving the HCQ. Therefore, in 2007, the MOH designed the SEP reform, which aims to improve hospitals by helping them achieve optimal efficiency and correct the previously mentioned issues, particularly the HCQ. Thus, it is interesting to gain a deeper understanding of how the new MA has been changed within the context of KSA to cope with the innovations of NPM, and of the benefits and consequences the sector has experienced over the past few years. This is especially interesting considering that the KSA government has previously given great attention to social services, including medical services for Saudis, as this matter had become a serious issue. The government has focused on improving the public sector to ensure that it meets the needs of society and also so that it would become aligned with the requirements of the WHO and other international quality standards organisations (Ministry of Finance (MOF), 2013). Therefore, the health sector budget has increased during the last few years, to become the second highest government expenditure. In 2013, government spending in the health sector was nearly 16% of the total government budget, or nearly $26.7 billion, which shows that there is an increase in the demands on the health sector which should it continues, could present serious problems in the near future (MOF, 2013).

It is from this context and background that we can look at KSA (see appendix D). KSA is neither a developed nor a developing country. According to the World Bank definition in categorising the world's countries, KSA is a high-income country (Nielsen 2011). KSA is now in a transition phase in the health care sector with the availability of resources for health care sector, with a free health care and no taxation, a population of 57% under 30, and where major illnesses such as cancer, diabetes, cardiovascular illness and obesity problems (WHO 2014) have put a lot of

pressure on the government. Most of the population, 82.3% (ibid), is located in urban areas and the two holy cities, putting the health care system under huge pressure when millions of people from all over the world visit in a short period of time. The gap in the existing literature warrants a comprehensive study that analyses MA changes in KSA hospitals. This study seeks to encourage research activity in this area by initiating an enquiry into a topic that has been under-researched.

1.4 Research questions

This thesis aims to clarify and enhance understanding of several recent MA changes: changes in SAPHS under SEP reform, the recent institutional emergences and changes that affect MA, and the way in which new MA is perceived by accountants, consultants, managers and clinicians on the ground. It is anticipated that the adoption of NPM by Saudi hospitals will be different to that in Western countries, due to factors including governmental regulation and resources, informal non-governmental discourses, international/national state interfaces, and professional development and involvement. These differences in adoption will give rise to opportunities to investigate the implementation and possible outcomes of accounting change. One of the fundamental issues to consider when studying NPM is around how MA has developed or changed to cope with the innovations of NPM to improve HCQ. Therefore, to better understand the recent changes of MA in the KSA context, two questions should be asked:

- Why, at institutional level, was new MA introduced to enhance HCQ outcomes in KSA?
- How has new MA been (re)defined, introduced and implemented in the context of HCQ delivery?

The issue of HCQ has become key for KSA, as is the case with other governments globally. This research is not trying to pre-empt the answer to the question of ‘why’ this might be, but rather has a broad institutional focus; a ‘why’ question contains many layers, especially when different forces are at play. As noted in the research background, the range of experiences for a change

like this must be sensitive to the unexpected (Hood and Peters, 2004), especially when the study is focussed on a country that is less researched within this context of MA change. The 'how' questions perhaps are even more interesting and complex. The last 5-year budget plan in KSA (see appendix D) is however a strong signal and component of 'how' quality has occurred, with the government's commitment to quality demonstrated not least through financial resources and projects either completed or under way. But between the government's ambitions and actual practices in everyday work, there are at hospital level (as a key institutional player) issues and battles of an on-going 'translation' and redefining of problems that need to be better understood in order to explain how quality as an issue is significant.

1.5 Research objectives

The focus of the study is on investigating and analysing MA changes within the SAPHS. The thesis pays particular attention to the challenges faced by hospitals in adapting to the changes, and to whether MA can support in management of these changes in order to achieve better HCQ. The aim of the study is to shed light on and develop a theorising about accounting changes based on evidence from countries where little research has previously been carried out. This study seeks to encourage research activity in this area by initiating an enquiry into a topic that is under-researched, and which would then contribute to both academic and management practitioner literature. Moreover, it provides managers in the public sector with a comprehensive understanding of current trends and recent changes in management in the context of MA changes, and of the causes and results of those changes. Furthermore, the research contributes to a better understanding of recent trends in MA, the recent institutional emergences and changes that affect the implementation of MA and the evolution and future direction of modern MA in SAPHS. This research also considers the way public health sector accountants, consultants, managers and clinicians perceive MA systems. The research objectives are:

- ❖ Understanding of MA changes in SAPHS and to what extent the new MA role, through NPM reform, has improved HCQ.
- ❖ Understanding the recent institutional emergences and changes that influence MA changes.
- ❖ Understanding the perceptions of accountants, consultants, clinicians and management teams of the changes in MA that occur under SEP reform.

1.6 Research process

The main objectives of this study are to examine MA changes within the SAPHS to improve the HCQ, defined as NPM, and the recent institutional emergences and changes that affect MA changes. The theoretical framework selected for this research is Neo-Institutional Sociology (NIS) as this provides substantial room for the understanding of institutions in the context of their existing forms and behaviour, through the process of decoupling and resistance and power by focusing on a social constructionist perspective.

A number of steps were required to meet the objectives of this study. The first step was to review the NPM and MA literature to identify current key discursive areas, and to classify appropriate factors for consideration in this study. The next step was to design the research questions based on the gap in the existing research literature. The third step was to choose the research methodology that could clearly answer the research questions. As part of this, a pilot study was conducted to ensure that the research instruments were appropriate and suitable to achieve the stated objectives (Baker, 1994). The next step was to conduct the actual study by interviewing accountants, consultants, clinicians and management teams, at which stage a number of documents were collected. The data was collected during two periods, with the first set collected over three months starting in July 2013 and the second set over two months starting in August 2014. The final step was to analyse the data by putting them in a format that allowed interpretation of the information in order to answer the research questions.

1.7 Structure of the thesis

This rest of this thesis will be divided into seven further chapters, as described below:

Chapter 2 presents a review of MA research literature and the changes that have taken place in the field over the past few decades within the public sector. The chapter starts with the historical significance of management, the emergence of NPM and the role of institutions, followed by a critical discussion on the discourse found in the literature about MA changes in the public sector.

Chapter 3 discusses the theories behind changes in MA with a special focus on the NIS perspective, which forms the conceptual framework of interpretation for this study. The NIS helps to demonstrate the beliefs of the researchers about the area, the best strategy to follow in conducting the research and the most appropriate way of collecting the relevant data.

Chapter 4 presents the research methodology and methods, and includes a discussion about the paper's research strategy, research methods, research design, data collection, analysis and theorising of the collected data and ethical points.

Chapters 5 and 6 present more detail about the two hospitals selected for this study with analysing and theorising of the MA change within each of these hospitals, as well as the interplay of recent institutional emergences and changes with the hospitals.

Chapter 7 consists of a discussion of the main results of the two case studies and links them to the research in the areas of MA changes and NPM.

Chapter 8 provides a summary of the study, including a brief background of MA change in order to highlight the importance of the thesis and proposed research questions and objectives in the context of the contribution it makes to research knowledge and suggestions for future research.

Chapter 2 : Literature Review

2.1 Introduction

MA change is a large research topic (Youssef, 2013; Fraser, 2012; Abdel-Kader, 2011; Ferreira *et al.,* 2010; Hassan, 2008). Not only are there various theories and methodologies highlighting a range of issues to sensitise MA, but there are also different theories regarding the role of MA in organisations and MA history (e.g. Hoskin and Macve, 1988; Chandler, 1977). In fact, Chandler (1977) explained that the modern business practices that come from MA include using accounting for administrative coordination. Chandler described how administrative coordination led to the emergence of the MBE and changed how the market worked on an aggregate level, because each entity was superior. However, with the emergence of the welfare state, so public sector institutions necessarily formed, for example in health care, education and pensions, with accounting practices also being central to their success (Miller, 1990).

Modern bureaucracies, governments and professionals have evolved and promoted their own interests; this has resulted in operating and interacting institutionally, similar to Chandler's (1977) description (Waters and Waters, 2015; Weber, 1922/2013). Therefore, NPM (Hood, 1995, 1991) has emerged as a remaking of existing bureaucracy aspiring to be a more efficient and coordinated managerial practice and structure as solution, and moving from professional bureaucracy to managerial professional bureaucracy; the bureaucracy does not disappear, but it changes form. This remaking also includes a dissemination of MA; managers have to go beyond what typical managers did before and include other professionals in their practice, such as nurses and doctors in the case of health care (McSweeney, 2006). Therefore, MA has emerged as integral to public sector entities. This is theorised, particularly by Hood, as NPM. NPM practices are largely considered as bottom-up MA (Anessi-Pessina *et al.*, 2012). The emergence of forms of NPM is now a feature of health care delivery in KSA.

This chapter will be divided into several sections, beginning with the historical significance of management, the emergence of NPM and the role of institutions. This is then followed by a critical discussion on the discourse found in the literature about MA changes in the public sector. The next section reviews the literature focussing on MA change in the public health sector, redefined as NPM, followed by a discussion of issues around implementation of reforms in the health sector and the diversity of experiences within different developed countries. The review progresses with a discussion regarding MA changes in the context of developing countries, even if this is not wholly relevant to the case of KSA. The chapter then gives special attention to the HCQ discourse. The chapter ends with a brief summary of the main points relevant for the research question in this thesis.

2.2 Institutions, accounting and the emergence of NPM: a historical frame

Since the nineteenth century, organisations have implemented MA to cope with managing organisations in the modern economy (Johnson and Kaplan, 1987; Chandler, 1977). Chandler (1977) argued that a new kind of 'administrative coordination' was invented with the introduction of hierarchical structures of management, combined with a 'staff office' function attached to each departmental unit. Through this structure, accounting and statistical information was gathered in each unit and relayed up to a central head office, where activity was reviewed and where necessary improvements, planning and decision-making took place. This new form of management enabled the development of the MBE with multiple departments and divisions, so that managers manage other managers. This form of operation increased the efficiency, income and profit of the organisations that adopted it, leading to the emergence of cartels and oligopolies where a few large corporations dominated whole business sectors, and leading to the 'visible hand' of management replacing the 'invisible hand' of the market as the major way of organising economic activity. In Chandler's view, this remains the way in which markets operate, leading to outcomes of 'imperfect competition and misallocation of resources' (1977:6). At the same time,

the process of administrative coordination fostered such distinct advantages through the harnessing of the ‘three E’s ‘economy, efficiency and effectiveness’ that it was able to present itself as a possible ‘norm’ for running public sector entities as well.

McSweeney (2006) argues that initiatives for bringing business practice into the public sector began to take off in the 1960s, and by the 1980s were well established in both the US and the UK, to the point where the trend could be named as ‘NPM’ (e.g. Hood, 1995, 1991). This trend has since then been much studied and debated within the field of accounting (e.g. Broadbent and Guthrie, 2008; Olson *et al.*, 1998). One particularly interesting outcome for this study is how the use of accounting practices and statistical information in the public health sector has become intensified, in the sense that they have expanded and become an integral aspect of everyday life of medical professionals; such professionals have shown different degrees of acceptance of such changes, but the integral presence of these practices is now clearly visible (e.g. Frandsen, 2010, 2009; Kurunmäki, 2004).

Accounting has such a large role in NPM because, as Chandler (1977) showed, accounting and statistical information are central to managerial forms of administrative coordination. From this perspective, NPM emerged as a remaking of the existing bureaucracy to produce more efficient and coordinated managerial practices and structures. Thus leading to ‘professional bureaucracy’ becoming a form of ‘managerial professional bureaucracy’ (McSweeney, 2006; Du Gay, 2000). This remaking also included a dissemination of MA and managing beyond traditional managers, to include other professionals, such as nurses and doctors. The recent evolution of organisations, including changes in education, economy, professional and political situations and other recent institutional emergences and changes, has included an expanded role for MA. For example, major institutional emergences and changes at the global level are:

1. Governments with departments delivering social services, including health care, for populations with a range of illnesses and ages, run by trained professional bureaucrats (Weber, 1922/2013).
2. Health care sectors delivering primary care, networks of doctors and acute health care in emerging and growing hospitals, occupied with medical specialists who analyse and develop treatments, from birth to all stages of life.
3. Universities and research cultures where three areas of research are emerging and interplaying:
   A. Political science and governmental research in different forms of government.
   B. Research in business, management, accounting and finance.
   C. Specialists and medical researchers for a population.

Because of these major institutional emergences and changes, the NIS is helpful because it isolates these domains as a focus for analysis; NIS also considers how different kinds of professionals evolve, change, promote their own interests and interact (DiMaggio and Powell 1983). NIS focuses on institutions within professionally populated fields particularly at the level of institutional action, as well as on institutional interactions. In general, it sees health workers as becoming professionals who 'own' health care delivery. Professional bureaucrats now seek to manage the health care sector through delivering budgets given scarce resources (McSweeney, 2006).

Public sector research institutions, such as the Kennedy School of Government at Harvard, have begun to focus on the roles of accounting, finance and management within the public sector and government. They look at how the new 'managerial professional bureaucrats' increasingly operate with management and financial accounting in various ways, as governments start pushing through budget control and efficiency initiatives, often drawing on techniques and ideas

developed by MA researchers. At the same time, health care professionals have realised they must play this management and accounting game, as it challenges their dominance in the institutional field. Hood (1995, 1991) theorised these battles and the form of new knowledge solutions as NPM. McSweeney (2006), however, pointed out that in NPM discourses, the professional bureaucrats never went away; they were redefined in light of the new theories. It is clear that there are three institutional fields in tension with each other:

A. The government and professional bureaucrats
B. Management and financial accounting research taking a public sector direction
C. Health care professionals playing the managerial game

In sharing ideas with other countries, both developed and developing, the setup of these three fields is key in understanding this mosaic of experiences (Merchant and Van der Stede, 2012). This is especially important in looking at developing countries, where international actors have played a significant role, such as the World Bank which does so in normative ways (Burns and Baldvinsdottir, 2007; Abernethy *et al.*, 2001). However, it is also clear that what could be seen as imitations of ideas have been travelling through other international networks via medical professional associations and higher education, whereby young scholars educated in the US and the UK then bring back new methods of doing things.

These three institutional fields and their professionals have given rise to institutional battles and a mosaic of initiatives, rather than a coherent field of experiences and initiatives. There are regularities, and MA change is part of this story. This historical review frames the understanding that, even if NPM is one label, there are many experiences and a patchwork of different ideas and discourses (e.g. Ashraf and Uddin, 2015; Malmmose, 2012; Broadbent and Guthrie 2008; Mimba *et al.,* 2007; Dunleavy *et al.,* 2005; Llewellyn and Northcott, 2005; Olson *et al.,* 1998). This literature review's themes are institutional battles in the name of change, and diversity of

experiences as a mosaic of experiences and initiatives. NIS theory has argued that organisations in the same context have the same characteristics (Scapens, 2006); this has meant that, in order to understand differences and change, attention has been given to external pressures, e.g. from governments, professionals and experts including academics, bureaucrats, accountants and health care experts and the roles of international influential agencies such as the World Bank and International Monetary Fund. Hanan and Freeman (1977), who argued that firms in the same sector were isomorphic to the environments in which they worked, developed this argument. According to Hawley (1968, cited by DiMaggio and Bowel, 1983), isomorphism refers to the way a group of people behave compared to other groups of people under the same environmental conditions.

2.3 The role of MA in NPM

Over recent decades, many studies have been carried out looking at how NPM has reshaped the public sector, and how it is organised, managed and funded. These studies generally review NPM in the context of commercialisation such as in social care (Bracci and Llewellyn, 2012), social housing (Lowe *et al.,* 2012) cultural organisations (Nikos *et al.*, 2016) and education (Möller and Skedsmo, 2013; Ezzamel *et al.,* 2012) and health care, where the professions, governments, professional bureaucrats and citizens (the social context) have faced new challenges (Broadbent and Guthrie, 2008; Olson *et al.*, 1998). Olson *et al.* point out that a key component and problem has been the issue of limited financial resources, with the public sector mainly being financed through taxes yet with efficiency and delivery issues within the sector. Another issue in the debate has been improved democracy and active participation by citizens who also clearly define what they want in terms of services and where ‘transparency’ of information and performance has played a key role. MA or more informative accounting has played a key role in delivering, understanding, talking about and therefore reshaping the landscape of the public sector.

The researchers in the field of NPM can be divided into four general groups. The first group, such as Broadbent and Guthrie (2008), discuss and evaluate how the use of NPM has improved (or not) the public sector. The second group focuses on how NPM, once being implemented takes on a new shape as reforms (Christensen and Laegreid, 2007). A third group argues that NPM is 'passé' and other reform solutions are therefore adopted, not least because, as Dunleavy *et al.*, (2005) argue, NPM has resulted in more negative consequences than advantages. As this is realised by those involved, it becomes time to 'move on'. The last group are those researchers who focus on investigating MA from the perspective of PMs and accountability which are seen as the main vehicles for change, intensifying the use of MA as more staff are 'forced' to actively use PMs, with major consequences for professionals (Van Helden, 2005; Lapsley and Wright, 2004; Brookfield, 2001). Jacobs (2012) argues that there is still a lack of research within the public sector that focuses on how MA is actually used in practice and the many different roles MA might play. This is a theme that both Miller *et al.*, (2008) and Kurunmäki (2008) have investigated. They focussed on how different professions have translated MA for different needs and purposes and have given new roles. They see that often, current balances of power and knowledge shift to different professionals and experts, such as to accountants from the medical professions. This suggests that, as new practices get 'hold' of each profession; they also re-shape what it means to be an accountant, a bureaucrat, a teacher, a doctor or a nurse. The next section discusses such studies and how they address the issue of economic imperatives over social goals, as well as the enhancement and influence of the (medical) profession.

2.3.1 Economic imperatives

One main criticism that has been raised towards the use of MA in practice with its focus on managing via accounting, PMs and linked forms of targets for accountability is that it has been geared towards meeting economic imperatives. The impacts of accounting on social relations have been ignored; too often management has had a lack of understanding of social relations and

of the range of unintended consequences within but also beyond the boundary of the organisation itself (Campanale *et al.,* 2010; Agrizzi, 2008; Hassan, 2008; Osmond and Loffler, 2006; Østergren, 2006; Lawrence *et al.,* 1997; Hopwood 1992). The idea that what gets measured will get managed and lead to economic improvement has been dominant. However, with too much 'trust' in numbers and the idea that measurements will work according to plan, unintended consequences are seen as something abnormal which will be eradicated with more of the same more and 'better' measurements. But often, underlying issues are unsolved. Also what is left outside measurements is ignored and considered less important, e.g. issues of trust and feelings of alienation. What is generally not picked up by managers is what Hoskin (1996) discusses as a 'fear of failure', following from being constantly measured as part of general applied accountability in all managerially run organisations, private or public. Such a lack of broader understanding of the social consequences that PMs may cause has often resulted in serious issues developing within organisations, including a lack of motivation among employees. The conflict between the objectives of the sector, which is to create societal conditions that ensure good health, and the use of private sector accounting practices, has been studied carefully (Lapsley 2009, 2008). It is clear that these practices can result in negative consequences in and for the public sector.

For example, Linneberg *et al.*, (2009) studied NPM within the health sector and found that health institution employees had been trained to work in the context of social goals rather than economic ones, and so became confused about the organisation's vision once private sector practices were implemented. Other researchers, such as Pettersen (2004), mention that a using private sector practices within the public sector results in a change in the work environment, which often increases administrative work and creates a time pressure obstacle for workers within the sector. In the case of New Zealand, Boston *et al.*, (1996) looked at how NPM resulted in both greater centralisation and decentralisation by combining control and flexibility

mechanisms, allocating staff with more responsibility but within a given economic frame which was set centrally, hence combining diversity (within a set frame) and uniformity (at the national level). The move toward centralisation and decentralisation is not uncommon as part of the NPM solution (Olson *et al.,* 1998).

Chang (2006) mentions how NPM has created a conflict between national goals and local needs. In many cases, the purpose has been to achieve economic national goals, whilst local needs have either been ignored or had low priority, leaving perhaps an overall and aggregated picture of success at a national level but underneath showing a range of different outcomes (here with hospitals), some not very desired. This suggests that governments have been perhaps more interested in legitimising certain solutions that benefit them politically, rather than having a detailed understanding of different needs from one region to another (Weber, 1922/2013; Merchant and Van der Stede, 2012). Furthermore, Jacobs *et al.*, (2004) discuss how economic perspectives have supported the commercialisation of the public sector today. The focal point has shifted towards budgets, targets and cost analysis where historically, it has been on citizens' wellbeing, the improvement of the areas in which they live and their communities. However, with a move from the 'physical to the fiscal' such as in health care (Samuel *et al.*, 2005), there has also been a shift in attitude and thinking towards what it means to be a patient or citizen, and ethical issues will become prevalent within the sector (Cordery *et al.*, 2010).

2.3.2 NPM and MA: a scene of power

Power struggles between governments and professional bureaucrats running the administration of the state, and professionals and academics have been constant factors in the dynamics of forming and transforming the public services of the state. The health care profession has played a significant role not only due to its status in society as a profession with expertise (Cardinaels and Soderstrom, 2013) but also because of the relatively large proportion of national budgets spent

on health care, even if this varies hugely between countries (Osborn and Anderson, 2015; Morales *et al,* 2014, see also Appendix C). A good example is the USA where physicians have a strong position, perhaps the strongest of any country, even if that has not always been the case (Daniels, 1984); for example, the American Hospital Association, the American Medical Association and the insurance industry have succeeded in keeping compulsory national health insurance at bay (Preston, 1992), even following "Obamacare".

There are always a range of professionals and actors in play, such as expert accountants and professional bureaucrats, and also politicians themselves who have strong positions as well which are both difficult to challenge and change. For instance, Du Gay (2000) discusses how those in government can identify and define problems such as what the state is for, and so have a power of influence that cannot be ignored. In such ways, 'public' services can be redefined and delivery can be transferred to the private sector, at least in part. The shift to NPM as a discourse and its redefining of problems has meant that traditional professional bureaucrats have had to become managerial professional bureaucrats. But it has not meant that they went away, but instead medical professions, politicians and academics have become part of a different 'power dance', as argued by McSweeny (2006). Another illustration of how powerful ideas play key roles is in work by Nordgren (2010), where he points out how political economists have influenced decision makers and reshaped health care. Giddens (2013) (who acted as an advisor to New Labour in the UK) played such a role. But we also find specific tools and concepts that are developed and sold by academics or consultants such Kaplan and Norton (1992) with their BSC, now hugely used in the public sector not least in health care (Aidemark and Funck, 2009; Aidemark, 2001; Baker and Pink, 1995). The consultant's role in transforming the public sector is now relatively well established (Aidemark, 2001; Lapsley and Oldfield, 2001; Bloomfield and Best, 1992). Ideas come from other sources as well, not least from organisations such as OECD and the World Health Organisation (WHO) (Cardinaels and Soderstrom, 2013). These dynamics

and power struggles are important to understand in explaining the changes seen in the public sector, not least with health care.

In health care, clinicians are key actors in achieving the objectives of the health sector, both through their research and practically through their treatment of patients. The dynamics and change in power is similar in other areas such as education, as reported by Demirag and Khadaroo (2008) and Adolfsson and Wikström (2007). Studies on MA change imposed by governments within health care often show that clinicians have used their power and refused to go along with the changes, not least as their power to define how care should be organised has been threatened (Kirkpatrick and Jespersen, 2011). As a response politicians, with the support of professional bureaucrats' expertise, have to either force or redefine what is to be implemented. However, the power struggles and outcomes are more complex and diverse with no single outcome over time. Kurunmäki (1999) examines the relationship between professionals and what she denotes as 'financial capital' as economic reasoning set up within a competing environment, and suggests that clinicians are uncomfortable with recent changes in PM because their own power is diminished. PMs have often been a major vehicle for change and challenges to the professional. As shown in recent decades, they often focus on the numbers and *how much* clinicians have done rather than on *what they do*. However, such reforms have often not reduced the level of financial resources for health care. But they have often changed the discourse and how the game was played; as the profession has been forced take the new rules on board, while trying to defend their own position whenever possible.

Some studies have noted how the medical profession is listened to, and how PMs for quality purposes are modified to become *relative* PM, as noted by Blomgren and Sahlin (2007). The new measures are still in their infancy and more development needs to be done to achieve better quality overall in the context of limited resources. Quality is on the agenda however, even if it

has not as yet been separated out from a focus on economic outcomes. Medical professionals are still in a power position to play the game of good health. But the game and the dynamic of the game have changed.

Remuneration is often awarded relative to knowledge rather than performance as in the private sector (Pizzini 2010). Translating targets and standard practices in order to drive profit and market share as applied in the private sector is not always successful when applied in the public sector. However in different institutions, power struggles between professionals have more than one outcome. Brorstrøm and Nilsson (2008) interviewed clinicians at a hospital in Sweden, interested in how clinicians reflected and responded to the many organisational changes, often with NPM as its frame. It is interesting to note how answers pointed towards the importance of more collaboration and adopting a flexible approach. Clinicians had strong views on how health care should be organised, to serve patients' medical needs with as little administration as possible, which seems to support the traditional medical professional hierarchy. However, they also had a more positive and open attitude to the need for management and structural changes. In fact, with a deeper understanding of the complex issues facing the health care sector, many recognised that it requires collaboration rather than conflict. They requested more change, but that changes should aim to be in line with professional ideals. However, the power dynamics are complex. Sometimes, as Chang (2006) claims, it is the legitimisation that something will be done about quality that matters. Leaders seek to show tough decisions being made politically. As a result, governments translate solutions as found in the private sector with promises of hope. But often the objective is to achieve legitimacy rather than providing good quality. However, medical professionals can also create their own, competing, measures, using a bottom up approach, to show improvements and legitimise their existence and work. This was found in Sweden where specialist nurses treating severe heart failure put their own measures in play to manage time with

each patient, because they knew how important measures are in visualising work done (Frandsen 2010; Frandsen and Mouritsen, 2008).

Lee (2008) looked at PMs reporting within Australia's health care and issues of accountability. It was clear that accountability relied heavily on quantitative methods for reporting and sharing of information while the qualitative aspect was still very basic, indicating one of the many experiences of PM but also shared regularities. The promise of 'what can be measured can be managed' is strong, but so also are unintended consequences.

2.4 MA change in public health from the past to the present

It needs to be remembered that MA is not an isolated event but that a complex set of practices, institutions and social relations is in play. However, it is still of value to review some of the literature of MA or accounting changes in health care over the last years, and at the same time give a brief but broader historical context with examples of the emergence of the welfare state.

2.4.1 An early start

With growing populations and modernization, especially in Western countries, a greater need to control and measure the 'population' was emphasised. This also occurred historically in Sweden, which had one of the world's first statistical offices (1686), which was utilised by the medical profession as a way to control the health and mortality rates of the population (Skold, 2004). But with industrialisation and the emergence of the state (Weber, 1922/2013), hospitals became the primary channel to manage illnesses and health. Accounting was used by the state for cost calculation, overall budget planning and governance. Miller and O'Leary (1987) looked at the early part of the last century to how standard costing and budgeting emerged, and how it could be used to engineer social relations and health for a whole population where each individual could be managed. Statistical norms and standards linked to cost benefit analysis for best

utilisation and optimisation of resources were common both in the USA and the UK. This is a key point made by Miller (1992); that accounting and the emergence of the state go hand in hand.

Given the background of the emergence of MBE in the USA as described by Chandler (1977), and the practice of managing via accounting and statistical information a model which was disseminated across the state and Higher Education in the form of writing, examining and grading (Hoskin and Macve, 1986) it is perhaps no surprise that governing and administration via accounting is a key theme for any state, not the least within health care. It also appeared at Harvard in the Business Administration Masters programme, supplying the state with people trained in governance and professional bureaucracy. But it had different outcomes than it did in Europe. For instance, controlling cost on health care at a national level has been difficult not least as the medical profession and the insurance industry in the US take the position to stop such ambitions (Daniels, 1984). One outcome of this is that USA has the highest spending of health care in the world (Osborn and Anderson, 2015). Preston (1992) took a closer look the birth of the clinic in the USA and new cost practices such as Diagnosis Related Groups (DRGs). In 1873 there were only 121 hospitals and by 1920 there were 6,000 (Preston 1991, p. 67, cited Vogel 1980). The main cost control method at hospitals at the beginning of the 1900s was cost reimbursement, which dominated for 70 years.

In the UK, Digby and Bosanquet (1988) looked at the period 1913-1938, giving an extensive background to National Insurance which was introduced in the UK in 1913; within this, accounting is shown to play a crucial role as part of cost benefit analysis in providing health care service to the population, and to the rise of doctors and patients included in the scheme. The ‘old’ style cost focus in the UK was, as Chua and Preston (1994) put it, concerned with treasury and reporting roles. A similar role for accounting was also found in Sweden. Here it was the county council who had the main financial responsibility for health care from around 1862. Between

1862 and 1965, the system was mainly organised as hospital care, or what is known as the acute care model a merger of medical and administrative hierarchies of professionals (Gustafsson, 1989) led by the leading physicians as chief executive officer, while every day running of the hospital was delegated to the head physicians and administration led by an economic manager, and where an accountant and clerks took care of the technical service and maintenance of the buildings (Axelsson, 2000, p. 48).

2.4.2 After WWII and beyond

As Malmmose (2012) argues, the role for (management) accounting played a more systematic role after WWII. It is then we find the development of DRG as discussed above. In the USA from the 1960s onwards things changed and a focus on cost control via retrospective reimbursing began to emerge and develop (Preston, 1992; Miller and O'Leary, 1987). Samuels *et al.*, (2005) show a more detailed account of how DRG (a form of retrospective reimbursing) developed; starting with how the insurance industry needed a way to price their products. But it was also an outcome of a battle between accountants, engineers, economists and physicians that set the final DRG form. In 1983 DRG was mandated by the US federal law, which made it the base on which prospective payments for medical care should be based. This changed how clinicians defined patients and their relation to them, with many unintended consequences (Preston *et al.*, 1997). Today we find DRG as the way of combining diagnoses and resources consumed to manage health care worldwide, often in a so-called quasi market (Forgione *et al.*, 2005).

But DRG as a pairing of medical diagnosis with pre-defined economic value is not a fixed way of calculating but in constant change, for instance it is now used in fabricating budgets (Chua, 1995; Preston *et al.*, 1992). Llewellyn and Northcott, (2005) followed the spread of this, adopted by the Labour government in the UK in 1998, as they tried to standardise financial and non-financial indicators for similar treatments and diagnosis, now named as Health care Resource

Groups. This was an extension of DRG combined with benchmarking to improve both quality and cost control at the same time, all linked to government funding and imposed on all NHS Trusts. Given that the latest report on the NHS financial situation in 2015 is a deficit of £930m (BBC[2]) it is doubtful this was the ‘outcome’ they hoped for. It will be interesting so see what will be the next invention. In Sweden we see another kind of extension, or perhaps an offspring, in pricing and budget planning named BESIS, a form of application of DRG to open day care. DRG has incentivised hospitals to reduce beds, and replace beds with open day care, all still part of secondary health care. However, as open day care spreads and beds are less needed a new pricing and budget system has become required to calculate costs for pre-set diagnosis and care activities for open day care (Frandsen and Mouritsen, 2008).

From around the 1980s we see the entrance of NPM and MA change in the developed world (Olson *et al.*, 1998). For instance, Swedish hospitals introduced MA changes such as responsibility accounting, internal markets and the use of DRG. However, it is interesting to note that the county council under study abandoned the internal market in 1995, as it was thought by clinicians to have lost integrity, and by professional bureaucrats to be a threat; not least as it enhanced the financial problems they faced, making it even more difficult to cost savings and shifting costs to primary care instead (Aidemark, 2001). However other new roles of MA took its place.

With the introduction NPM the PMs made an entrance as part of MA in HC, and are now a key component along with a general application of accountability. Strandberg-Larsen *et al.*, (2007) conducted research in the Danish health sector in order to determine the impact of PM on the medical profession. The study shows a different outcome to where the introduction of PMs resulted in lower quality. One factor seems to have been the feeling of a loss of influence in defending traditional views. A similar experience was reported by a study in Norway by

[2] http://www.bbc.co.uk/news/health-34353408 2015-10-15

Østergren (2006), who notes that with the transformation of the private sector practices as regards time and money, time *as* money became a way of thinking within the public sector and that seems to have lowered HCQ, as staff motivation decreases. Finding indicators for (quality) targets is difficult, and even more so to work in practice; and as Goodhart's law points out, 'when a measure become the target it become a bad measure' (Hoskin, 1996), as unintended consequences are always lurking. What is clear however is how the PMs are a vehicle for change and conflict.

As mentioned earlier, a 'balanced' view on activities performed in health care has been given special attention, not least to deal with the critique of unintended consequences of MA and PMs. The BSC (Kaplan and Norton, 1992) is now an obvious choice for many countries and local governments. It is now not uncommon to find different benchmark aspects of key performance made publicly available to patients. Internally BSC is now part of many medical professionals' everyday practices (Aidemark and Funck, 2009; Aidemark, 2001; Baker and Pink, 1995). TQM (Mosadeghrad, 2013; Kaluarachchi, 2009) is another type of solution being introduced in health care where MA is a key. We also see the development of patient-centred care as part of how MA plays a significant role (Frandsen 2010), and new support systems that will rationalise medical work (Berg, 1997) as solutions seem to emerge from the 'cracks' of previous (accounting) solutions. At the same time accounting keeps repeating the same mistakes: feeding its own failure and solutions at the same time in an endless loop (Power, 2003).

However, what is also interesting to note is that several MA solutions seems to be 'active' at the same time. For example, there are BSC, DRG and patient clinical complexity and other decision-making support systems in place at the same time in the same hospitals. The range of experiences are not only an outcome of power struggles, but also an outcome of a range of solutions present in hospitals, creating a complexity of medical everyday work.

2.4.3 MA change in health care sector

It is within such recent MA change in Health care context as described above that we have witnessed research in different countries (Cardinaels and Soderstrom, 2013; Campanale *et al*., 2011; Cinquini and Campanale, 2010; Hampson, 2009; Agrizzi, 2008; Kurunmäki, 2004; Lapsley, 2001). Lawrence *et al*., (1997) conducted a study in New Zealand. The aim of the study was to determine how accounting has changed the public health sector and what the impact on the sector has been when hospitals are run as a business. The results of the study indicate that clinicians within New Zealand's public sector have become subject to accounting methods and are accountable for such aspects as revenue. Revenue has been used to evaluate the performance of clinicians, as well as to control spending on the treatment of patients; for example, the length of time a patient is treated in a hospital and how much money was spent in their treatment. As a result, spending control within the sector has now been limited to the budget assigned to the hospital by the government. Using such methods has transferred responsibility for the budget from the authorities that fund the sector to the clinicians, and this has led them to behave in ways that consider economic rather than social impacts. Such transferral is consistent with Weber's argument (1922/2013) that governments with departments delivering social services are run by trained professional bureaucracy.

Jacobs *et al*., (2004) studied the cost and performance information for clinicians within the public health sector of two countries, Italy and Germany, and compared the practices between them. The results of the study show that in both countries, the integration of costs into decision-making took place within the public health sector. The first consideration by decision-makers is low pricing of medicines. However, in Germany, implementation of DRGs, which can assist in the reduction of the costs of the production of services related to the health care sector, led to changing the practices of decision-makers within public health. The clinicians in this context become more responsible for economic outcomes and as a result increasingly controlled by

accounting policies and numbers. Use of the DRG system makes clinicians more worried about their organisation, especially if the costs of their activities are not subject to control. In some cases, public health professionals find it difficult to understand techniques such as DRG, but responsibility to their hospital and issues that they may face in the future encourage them to do what it takes to understand the DRG system more quickly.

In Italy, the allocation of costs within the public health sector is different than in Germany. In 1995, the Italian government implemented reforms within the public health sector. They integrated cost as an important part of any decision by associating costs with PM. The head of each department became responsible for all activities within their department, including the outcome and cost of activities, which influenced clinicians to become more aware of the costs involved in all of their decisions. Furthermore, self-interest was a consideration and the performance of clinicians is connected to their salaries, which is seen as a critical point: clinicians must meet targets established by PM and achievement of the targets impacts their salaries (Jacobs *et al*., 2004). However, such practices or methods of measurement have led clinicians to behave in ways that protects their interests rather than the main objective of the sector, i.e., to provide a good service to the public, which has resulted in clinicians having to work under the pressure of these PMs. In addition, clinicians have turned to manipulation in order to meet targets, no matter what the consequences.

Using the institutional theory, Pettersen (1995) studied budgetary control of hospitals in Norway. The aim of the study was to determine what role the budget played in operations, and the difference between what happened in practice compared to the plan set by the council for health. The results of the study indicate that using such practices within the public sector does not establish power over the sector and its professionals, because the main focus of using such methods by the government is to formalise practices in the sector. Therefore, clinicians are free

to do their work without the pressure that comes from implementing MA. The researcher supported her argument by citing the hospital manager, who stated, ‘The Budget does not really matter. The hospital will always get what it needs, because the County Council has to pay the bill’. From this study, it can be seen that adopting private sector practices for use within the public sector does not mean that the same procedures will be used. In some cases, such as in Norway, adoption of private sector practices is seen as more of a formality than the establishment of control and power over the sector. It is worth noting that the drivers for adopting the practices within this context have not changed to economic goals, they remain the same as before. Such changes appear to be an attempt to modernise practices while remaining in line with the practices followed in a different context.

Cinquini and Campanale (2010) conducted a study in Italy to determine how accounting and control systems have influenced the public health sector. The results of the study show that development of constraints has led to a change in the MA and control at national and local levels. The main focus of the study was to ascertain how setting a budget limit within hospitals influences and affects accounting and control practices. The authors note that using a budget to drive accounting and control systems led to strong pressure on the sector. Hospitals are now required to control their spending within the limits of the budget, which is set at the beginning of the year. They are also required to achieve the established objectives under given financial constraints. Hospitals in Italy have a clear target and budget set every year at a national level and must meet them by the end of the year. However, the power of such practices has filtered down throughout the entire sector, including to the clinicians. Campanale *et al*., (2011) argue that using such techniques influences clinician behaviour, and will lead to such negative consequences as clinicians behaving in a way that ensures they personally achieve their target to come in under the set budget and will decrease their focus on other, more social aspects.

Developing countries have been slower to adopt the changes in MA due to relatively limited resources and Information Technology (IT) expertise availability (Mat 2010). Moreover, organisational hierarchies and large corporate governance frameworks in developing countries have also contributed to the inability to meet the pace set by developed markets in the use of MA for organisational changes and benefits (Kholeif *et al*., 2007). Furthermore, improvement in education levels, poor leadership, inappropriate organisational cultures, uninvolved employees, unsupportive top-tier managers, and inadequate training and resources in developed countries are other factors affecting the adoption of reformed MA within the public sector of developed countries compared to that in developing countries (Mosadeghrad, 2013). However, even within developing countries, there are differences in adoption of the changes in MA according to the characteristic and the institutional power of each country. For example, in the context of KSA, the WB (2014) has identified KSA as a high-income country, putting it in a better position to change in comparison with other developing countries.

In recent years, the hospital business has been globalised to the same extent as other industries. Hospitals in the developed world have entered partnerships with hospitals in developing countries to enable the implementation of MA, and to provide expertise in managing the hospital as a business. Moreover, developed countries have begun outsourcing operations across international borders to reduce costs faced by patients who do not enjoy complete insurance coverage and cannot afford the cost of surgery in a developed country. This creates an opportunity to transfer MA from developed countries to developing countries (Hassan, 2008).

Most pro-NPM reformers claim that their changes would be effective in reducing costs. This is one of the main reasons that make the change of MA through NPM important in order to keep cost-reduction in the framework. Increasing efficiency or improving effectiveness is slightly easier than economising given the current fiscal undersupply. The challenges of fiscal austerity

are a well-known problem among politicians and public servants (Hassan, 2005). Pettersen, (2000) mentions that several reforms have been introduced in public sector hospitals over the past decade in order to emphasise the role of MA in organisational learning. The changes in hospital management and growth of hospitals have resulted in the need to use MA as an aid in decision-making processes at managerial level. The reforms in the public sector are viewed as signals for organisational change over the long-term, and an institution's response to the reform process highlights their ability or inability to adapt to the changing environment. Other researchers link the MA changes to the broader social context of accounting change and institutionalism (Naslund, 2008). For example, Stamatiadis, (2009) states that the education level of accountancy teams was a significant factor that influenced the level of change in Greek public hospitals. However, some researchers disagree and argue that changes to MA depends on firm-specific factors, such as the size of the organisation, resource capability, foreign partners and the level of employee accounting knowledge (Wu and Boateng, 2010).

Hassan (2005) analysed MA changes in Egypt's hospitals. The objective was to link hospital management changes to shifts in the broader social context of accounting and institutionalism. The results show that changes in an institution and MA at hospitals are related to managers' entrepreneurial behaviour. The hospitals demonstrated substantial resistance to change initially, and MA is seen to benefit institutional development through its ability to challenge the bureaucratic power held by physicians in hospitals, which has enabled a change in the power structure and efficiency of hospitals across the country.

Other studies have been conducted to determine the factors that have led developing countries to apply NPM within the health sector. Amagoh and Bhuiyan (2010) observe that in the cases of Kazakhstan and Tajikistan, the main objective that led to the application of NPM was to decrease the level of corruption within the sector. However, Timoshenko (2010) views changes as a result

of pressure created by recent institutional emergences and changes, and the culture of developing countries. His comparison of public health in Nepal and Russia found that global organisations such as the WHO exerted strong pressure on them, but found great variance between the health systems of both countries.

In developing countries, political, cultural, education and economic factors also play a significant role in changing MA (Adhikari *et al.*, 2013; Luther and Longden, 2001; Hopper, 2000). Hopper, (2000) claims that to better understand the recent changes in MA in the context of developing countries, recent institutional emergences and changes need to be considered because those countries are less homogeneous cultures, with weaker capital markets and less effective bureaucracies and regulations. This is also supported by Luther and Longden, (2001) who argue that much of modern MA might be resistant to this context, because developing countries have different social, legal, cultural, and educational characteristics to those of developed countries. For example, in Gulf Cooperation Countries[3] (GCC), Joshi *et al*., (2011) argue that external factors, such as politics and religion, have influenced the adoption of MA more than internal factors in the private sector have.

The role of external consultants has gained significance in certain industries due to the fact that MA capabilities are not inherent to some businesses. External consultants tend to aid their service-dominant clients in the adoption of suitable MAPs and software and to implement these processes (Groene and Garcia-Barbero, 2005). The role of management accountants as external consultants has grown and is expected to gain increased significance in the future. Therefore, researchers such as Paulsson, (2012) and Lapsley and Oldfield, (2001) argue that there is a lack of research into the role of consultants regarding changes within the public sectors of developing countries. Abdel-Kader, (2011) and O’Mahony and Doran, (2008) mention that changes in the information provided by organisations, as well as improved technology, have guided changes in

3 Gulf Cooperation Countries are Saudi Arabia, Kuwait, the United Arab Emirates, Qatar, Bahrain, and Oman.

the roles of MA and management accountants, who have become active and strategic. Indeed, they have become more active in management departments because they now play a significant role in the efficient management of organisational operations (Burns and Baldvinsdottir 2007). Scapens and Jazayeri (2003) refer to how the use of IT has improved accounting in the public sector by improving accrual accounting. However, Lawson (2005) observes that public sector reforms are expensive for hospitals in terms of the introduction of new information systems and staff training. Therefore, most public sector managers attempt to defer implementation of any new MA or technology that affects the hospital budget.

Most research into the use of MA reform within the public sector has been conducted in developed countries (Cinquini and Campanale, 2010). Each country has its own characteristics and environment, which has resulted in the application of MA reform under NPM from different perspectives. However, there remains a lack of research in developing countries, despite good reasons for conducting additional research. This is supported by Hopper *et al.*, (2009) and Uddin and Hopper, (2001) who argue that there is a lack of research and understanding outside of Western countries. For example, Henriksen *et al.*, (2012) state that the culture in developing countries is seen as a significant factor that influences the use of NPM in the health sector. Pillay (2008) observes that successful implementation of NPM within developing countries cannot exist without attention to governance systems.

2.4.4 A recent focus: quality

Lately quality has yet again become a key concern. However, this is within a different context, where MA is central to its application. Llewellyn (1993) in an early paper discusses how economic incentives (particularly in the sense of a focus on cost reduction or profit maximising through cost cutting) have created unintended consequences such as poor quality, and the question has been raised as to how this may be managed through MA. Here it is interesting to

note Ezzamel's (1994) contribution to answering this question, where he responds to Thomas Johnson's argument (Johnson, 1994) that MA with its typical cost control focus should be replaced with TQM metrics so that organizations can deliver quality outcomes.

He notes that this is a move beyond the argument made by Johnson along with Robert Kaplan in *Relevance Lost* (Johnson and Kaplan, 1987), where the claim was that MA had a potential relevance so long as it abandoned traditional forms of cost-focused management. However he argues that Johnson's emphasis on having TQM metrics *replace* MA ones misinterprets or narrows the roles that MA plays in Chandler's (1977) 'administrative coordination' within any given organization. Ezzamel's point is that TQM as a system typically works when its 'quality' metrics are backed up by MA ones. He argues that typical TQM metrics are 'soft' in the sense of promoting 'good outcomes' without having a way of ensuring that failures to hit the 'good outcome' targets are managed and corrected. So TQM systems in fact also have 'hard' metrics dealing with the problem of inadequate performance, and these metrics are typically MA ones.

So in effect, Johnson's (1994) claim that TQM should *replace* MA misinterprets how TQM succeeds, which is dependent on constructing a TQM system that has a well-designed mix of 'soft' quality and 'hard' MA measures. So MA is in practice already an integrated part of TQM. This is an insight which will be returned to later in this study. For the approach to delivering a HCQ agenda in KSA hospitals was very much focussed on developing HCQ targets and measuring hospital performance in terms of the effectiveness in delivering quality as measured in terms of these targets. But in practice MA measures became an integral part of delivering quality, not least because it was recognised that workforce efficiency in terms of productivity was an important aspect of quality delivery. Thus this study has found Ezzamel's insights as particularly valuable in seeking to understand the roles played by MAPs in the delivery of a HCQ agenda in KSA hospitals.

At the same time, it is important to recognise that this is not the only way of analysing or understanding the delivery of quality in public sector settings. Ostergren (2006) discusses quality in the public sector as an outcome of the institutional construct of consumerism. For Llewellyn and Northcott (2005), a similar benchmark theme is how (management) accounting and quality are linked to hospitals' funding. Vikkelsø (2007) gives another study where MA is a PM quality tool initiating structural change. Quality is also an issue raised by the WHO (Cardinaels and Soderstrom, 2013). A common theme noted in this review is how PMs, with the 'awful idea of accountability', are a key vehicle for change whether of quality or throughput of services (Hoskin, 1996). It is clear that PM raise issues for concern not least when HCQ may be worse rather than better.

As Cardinaels and Soderstrom (2013) highlight, there is a complex dynamic of institutional forces that are necessary to take into account when looking at 'quality' and the role of MA, which perhaps at first looks straightforward. And as Hood and Peters (2004) point out, translating MA ideas into different local contexts will always provide a range of experiences, where there is more to discover than meets the eye. It is within the institutional health care research context on MA change that this thesis contribution will be located.

From the noted studies, it can be observed that the use of MA in different national public sector contexts has led to different outcomes. Therefore, it would be interesting to gain a deeper understanding of how MA has been implemented within the KSA context, as a developing country under NPM reform, especially following the improvement of the country's major institutions such as education, economic, political system, professions and IT. It will also look at the benefits and consequences the sector has faced over the past few years, especially when the KSA government has previously given much attention to social services, including medical services for Saudis, as this matter has become a serious problem.

2.4.5 Implementation initiatives of health care reforms

Experiencing implementation of reforms in health care also shows a range of diversity in terms of outcomes. While Cinquini and Campanale (2010), Kurunmäki (2004) and Kurunmäki *et al*., (2003), argue that there are mainly two ways of implementing reforms in the public sector, there are a range of different outcomes with regard to the acceptance or resistance of workers within the sector. The first, which they see as more suitable given the complexity of the health sector, is gradual reform, which has been the most common way that the public sector and its professionals have tended to accept reforms. In contrast, the radical reform method, which has the approval of researchers, creates the most resistance in health care staff when applying reforms in the public health sector. Examples from existing studies demonstrate the two ways in which reforms can be implemented, and some strengths and limitations of each.

Kurunmäki *et al*., (2003) conducted a comparative study to shed light on NPM reforms in health care and its impact of using accounting, focusing on the medical professions in Finland and the UK. This was a reform implemented gradually which left room for participation of the professionals who were able to become involved and any issues that arose in a progressive way. The study also showed that after the reform, medical professionals were much more positive and started to acquire accounting practices and knowledge. In terms of implementation strategy, it suggests that the reform was successful. At the same time and perhaps as an unintended outcome, the medical professionals were also able to strengthen their position as they now had the knowledge to apply accounting to their own work, and hence challenge the professional accountants and mangers.

In contrast to Finland, in the UK the health sector seems to have preferred a more radical implementation strategy method to achieve the needs of the government (Kurunmäki *et al.,* 2003). And perhaps as expected, conflicts and resistance has arisen from the medical professionals; in fact, they had little to do with the practices of accounting and hence followed a

different path to that of Finland. Two ways of implementing in two countries led to two different ways in which the medical profession strengthened, and changed the relative power relations between the profession and the Government and its bureaucrats. Reforms followed by force led to opposition from professionals within public health, who hence kept their traditional professional role. Agrizzi (2008) gives another example of the preferred radical strategy in the UK when following implementation on PMs. The implementation of new policies was set by an exact date and without prior staff engagement, resulting in poor HCQ. He also notes that sometimes poor reforms may also be related to being unprepared, with insufficient equipment to properly implement the accounting reforms such as internal tools and IT.

Jones and Dewing (1997) have shed light on the breakdown of communication between clinicians and financial staff. Clinicians agreed to the implementation of new accounting tools and methods as it was said they were accurate and appropriate for their work. However, they later discovered that the real objective was to bring their behaviour under control. This suggests that trust might become a key factor next time reforms are to be implemented.

Whatever the strategic choice in implementing health care changes, the research shows that the outcome can deviate from the original objective. That is not to say that a plan should not be set up or a strategy carried out according to a plan. Every reform needs to be working in practice and as such adjustments are always needed. Berg (1997) makes this point when studying how a decision-making support system was implemented in health care and why the plan as to how it *should* work was never going to happen. Life is more complex and in constant flux. But the point he is making is that it worked in *some* ways, and in fact staff *made* it work despite the system in place. The outcomes and experiences of implementation are therefore many.

However, implementation is also, at the same time, part of a power game both as a planned strategy and as an applied implementation. A reform may have the purpose to shift key actors'

influence. In fact, part of the reforms implemented have been about shifting power within the health care sector from clinicians to new PMs and structures; recently in the name of improving the HCQ to achieve public demands (Agrizzi 2008; Hassan, 2008; Lapsley 2001; Kurunmäki 1999; Jones and Dewing 1997; Laughlin *et al*., 1994; Lapsley 1994). However, it is perhaps doubtful that the clinicians have actually lost autonomy due to MA reforms. Some suggest that it is a myth to be kept alive in order to keep the power intact (e.g. Ezzamel *et al*., 2012; Daniels, 1984). Either way, it suggests that research into such a complex area of institutional power is subject to a range of factors and interpretations. For instance, Meyer and Rowan (1977), now a classic work in NIS, studied the concepts of autonomy myth in relation to accounting practices. Accounting is more about formalising activity rather than being used for decision-making. However, accounting helps to rationalise decisions made afterwards and hence legitimatise actions *as* a competent actor.

2.4.6 HCQ as a problem in KSA

Quality is a key factor of concern that frequently features in policy and academic debates today. In 2006, WHO is launched *The World Health Report*. Given the context of health care issues many countries face such as an aging population and wealth-related illness such as heart problems, diabetes, obesity and cancer, health and HCQ becomes problematic.

At the same time, quality as a heading can cover any aspect of public services, including the views of service producers and experts, or the opinions of service users. However, the public health system worldwide has changed, especially with regards to funding where countries either apply one source or where a combination of tax, insurance, fees are used to secure services (Osborn and Anderson, 2015; Morales *et al,* 2014; see also Appendix C); where a new and intensified debate on quality, and value for money, are now part of reforms. In the past, the primary focus for governments within public health was to control costs, performance and budgets to improve efficiency and transparency, whereas this has always been a focus for the

medical profession. With a new intensified focus on quality, not least because of how past reforms have failed, especially in relation to quality, most health care reforms today have aspects of quality included (La Forgia *et al.*, 2004). As in the private sector, and as problematized by Kaplan and Norton (1992), quality issues have been solved by introducing the BSC. The public sector has been keen to adopt a tool that seems to solve the issues in NPM. Today it is a widely used tool in the public sector, including *health* care, with different success (Aidemark and Funck, 2009; Aidemark, 2001; Baker and Pink, 1995).

According to Library (2009), the system of public health in New Zealand has changed to complement economic goals, with quality targets as the main points for improving practices within the sector. A similar argument is seen in Denmark, where quality was the main reason for the reforms implemented in 2003, rather than gaining more control over costs and the profession (Strandberg-Larsen *et al.*, 2007). Total quality management (TQM) represents a strategic approach to address the quality issue (Mosadeghrad, 2013; Kaluarachchi, 2009). It mainly relies on the opinions of patients (as consumers) to define quality (Green and Janmaat, 2011), which are then incorporated into medical processes.

Not surprisingly, and despite the range of experiences of MA and NPM as reviewed here, one of the constant regularities seen in the literature is PM as the vehicle for quality change (Otley, 2001). Information is important for achieving the objectives in health care. Therefore, without accounting as a visualising device for what has been done, but also could possibly be done, it is difficult to get a sense of direction; of knowing what to coordinate and how, or of objectives. Health care is of huge concern for many countries today, hence why WHO published *The World Health Report* in 2006. The governments of most countries have reviewed these aspects in the context of operations in their own country health care facilities in order to improve the HCQ and meet the demands of the public. As a vehicle for change, PMs have now moved from the role of controlling professionals to quality measures. Therefore, the question should be raised as to how

far PMs have changed from focusing on costs and controlling professionals within the public health sector, to dealing with recent demand for quality. Furthermore, Hopwood (1973) has shed light on how budgetary information was used to evaluate the mangers' performance. He found that there were three 'management styles' relating to different ways of putting budgetary information to work: the 'budget constrained' style, where managers had to hit budgetary cost targets, the 'profit conscious' style, where the focus was on profit targets, and the one of interest here, the 'non-accounting' style where the focus was on how managers performed on non-accounting performance criteria such as quality.

In the KSA context of this study[4], SAPHS has faced a backlog due to the relatively limited resources and scarce IT expertise available to local hospitals. The objective of public health sector reform, under the title of SEP, was to improve the HCQ. However it is important to keep in mind that HCQ is a complex problem and has many layers, notwithstanding power games among professionals. However, the MOH designed the SEP reform with the aim of improving the hospitals in this sector by helping them to achieve high efficiency and to solve issues, especially relating to HCQ. It gave the management teams within the hospitals the right to employ and attract highly qualified employees, which contributes to improving the services offered to patients. Also, this helps to make good on the MOH's slogan, Patient First. Therefore, the responsibility of managing the financial and human resources of the hospitals has shifted from the MOH to the management teams within the hospitals over the last few years, which has changed most management practices. Under this reform, hospitals are able to choose the best management methods to improve efficiency and effectiveness. The MOH now supervises hospitals within a given frame instead of directing and administrating them. In 2013, eight hospitals implemented this method of management. In total, nearly 99 out of the 259 of public hospitals, which represent around 60% of the health services in the country, have implemented

[4] For more information about the context of the study see appendix D.

this SEP. However, under the SEP reform MA has changed, to reflect a different management philosophy that can be successfully implemented within the health care sector and which has become known as NPM. The vision, mission and objectives of the SEP were stated as follows (MOH, 2015):

Vision: To turn the MOH's self-operation programs into distinctive role models, to be followed in all of the Kingdom's health sectors through the provision of high HCQ by national, qualified calibres and cadres.

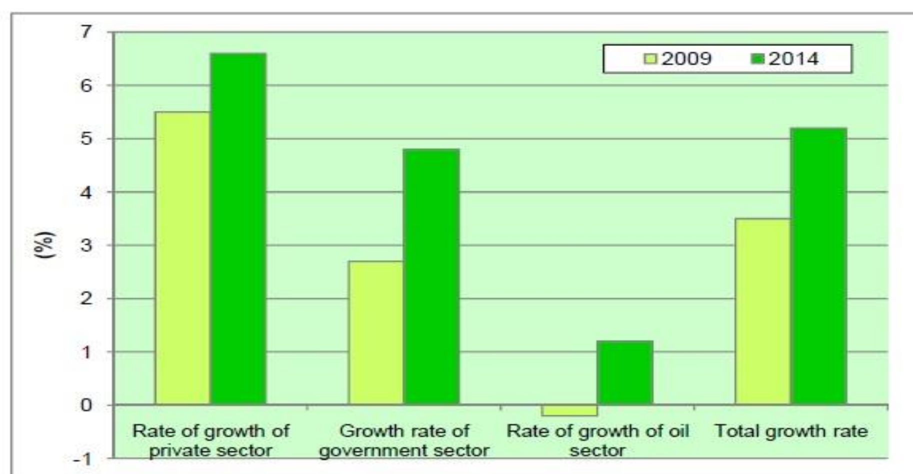
Mission: The Self-Operation Programs General Department seeks to enhance and improve the level of employment programs through the optimal exploitation of human and financial resources in order to contribute to providing a high HCQ to patients.

Objective: To supervise the employment of hospitals and the MOH's self-operated programs and follow up on their implementation (according to systems distinguished with resiliency) and to avail the optimal use of human and financial resources in order to provide high HCQ.

2-1: Country budget allocation in KSA: Source: Ministry of Health, 2014

To support the implementation of the reform in 2014, the KSA government increased the budget of the SAPHS by nearly 8% over the last year, which equates to SR108 billion. The plan for this budget is to operate the health sector and construct eleven new hospitals, eleven medical centres, and two medical complexes. However, during the last few years, the MOH has already started 123 projects, including hospitals and medical centres (Al Arabiya News, 23 December 2013). However, in 2015, the KSA government increased the budget of the SAPHS and the new sector budget is SR160 billion.

It is from this context and background that we can look at KSA (see Appendix D). However, KSA is neither a developed nor a developing country with a great availability of resources for health care sector. While categories such as NPM are not fixed, they do have an implication for the agenda of governments when dealing with other countries and influential actors such as the WHO. According to the World Bank definition in categorising the world's countries, KSA is a high-income country (Nielsen 2011). KSA is now in a transition phase in the health care sector, with a free health care and no taxation, a population of 57% under 30, and where major illnesses such as cancer, diabetes, cardiovascular illness and obesity problems (WHO 2014) have put a lot of pressure on the government. Most of the population, 82.3% (ibid), is located in urban areas and the two holy cities, putting the health care system under huge pressure when millions of people from all over the world visit in a short period of time.



2-2: Growth rate of GDP and its major components: Source: Ministry of Finance, 2015

However, since 1970, KSA has created five-year plans in order to improve the economy by taking it from an oil-based economy to a modern industrial state. During the ninth plan[5] in 2010, the main focus of the government was social services, including medical services for Saudis because they were becoming serious issues. Therefore, the government began emphasising the

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[5] For more information about the ninth plan see the link: http://www.mep.gov.sa/inetforms/themes/clasic/file/download.jsp;jsessionid=82F54B1915D71A4482B7C82AF3F6899A.alfa?FileAttribute=DownloadTranslation.Content&TableName=DownloadTranslation&DownloadTranslation.ObjectID=602.

SAPHS in order to improve this sector and meet the requirements of the public (MOF, 2013). Reforms were applied to public sectors, such as the SAPHS, which implemented SEP to improve the HCQ in KSA hospitals. According to the report published by the ministry of economy and planning:

> The financial requirements for public health sector in the Ninth Development Plan are estimated to be about SR273.9 billion, i.e. 19% of the total amounts allotted for all development sectors; an increase over comparable expenditure under the Eighth Development Plan by 75.7%. This allocation is consistent with the increased demand for services due to population growth and the target improvement in the standards of living and quality of life of citizens.

2.5 Discussion and analysis

As noted, the remit of this study is to investigate and analyse how, and how far, MA changes are consistent with an NPM approach to delivering HCQ within the SAPHS in contributing to improve HCQ in KSA. With that in view, chapter 2 has reviewed how key issues of relevance to this study have been discussed and analysed in relevant research literatures.

First, it was important to give this study a longer diachronic background to the current MA and institutional changes and not solely have a contemporary aspect in mind. With this in mind it particularly looked at the 19th century genesis and development of management and first forms of modern MA were reviewed, in order to set a context for understanding MA and its roles in constructing as well as delivering forms of management in organizational settings; also reviewed were the subsequent emergence in the 20th century of forms of public sector 'reform' incorporating private-sector management and MAPs and concerns. These often supplemented or replaced old-style bureaucratic practices with those focussing on promoting economy, efficiency and effectiveness through accounting-based forms of 'administrative coordination'. This kind of shift became so widespread in developed countries by the 1980s that it became designated as the new phenomenon of NPM.

A focus was then put upon how, within varying forms of NPM 'culture' in different developed states, research traced the trajectories and effects of introducing MAPs into public sector institutional settings, including central and local government settings and more specific types of institution that are publically funded or supported, such as educational, social services and health care institutions. As the literature shows, there are many variations in how MAPs are implemented, and in forms of support and resistance for these. There is evidence at the institutional level of the isomorphism of 'pioneer' institutions seen as successful in implementing MA based innovations, which then become replicable models within a sector. The rich range of differences within and between states in the developed world was noted, in terms of implementing MA based innovations in public sector settings. Also highlighted were the range of approaches to research, analysis and critique of NPM and MA change, including the roles played by critical accounting and critical management research in how 'change initiatives' are not unidirectional, and do not necessarily promote positive changes in delivering outcomes, either for staff or customers/patients. The importance of recognising how political and economic special interests may be in play and how these interests may conflict with those of the majority of citizens and workforces is one outcome of research in these traditions.

The chapter proceeded to consider how 'quality' in terms of performance and outcomes has emerged as a significant objective for MA-based forms of delivering public services, including health care; therefore focusing on this objective has become a serious issue for public health organisations. Whereas the first approaches to introducing MA into health care had a primary focus on improving, at the institutional level, efficiency and transparency of performance through setting budgetary and performance targets and controlling costs, research has tracked the emergence of an increasingly widespread institutional concern to measure and improve quality of performance and outcomes, which has required the specification of MA-based measures to quantify and evaluate 'quality outcomes'. The chapter then reviewed how MA research has

investigated the ways in which quality has become an object of MA measurement and reviewed the issues and unintended consequences that can follow from this new form of MA-based management. Again there are various outcomes in specific developed countries, but it is apparent that over recent decades a concern with measuring quality via MA-based techniques (such as the BSC) has been taken up across many different developed states and has become an integral feature of public sector institutions and their approach to delivering social and political benefits, particularly in health care settings. Governments in most of the countries researched have moved towards incorporating a commitment to quality, and to measuring the delivery of 'quality outcomes' across their respective health care facilities in order to improve HCQ as a form of meeting public expectations and demands.

Research into the introduction and dissemination of MA changes is less advanced in the context of developing countries, but such MA changes, along with research into these changes undertaken from a range of theoretical perspectives, are now on the increase, as this literature review has indicated. There are various reasons for this, including the increased focus on globalisation, which has affected not just the patterns of international trade but the dissemination of developed-world practices and solutions into developing world settings; there is also the fact that the growth of higher education institutions and global participation rates in higher education has led to the emergence of significant numbers of graduates from non-First-World states undertaking research for higher degrees in the West and in their home states. This has provided a stimulus for the dissemination of knowledge of Western business and accounting techniques and solutions among future elites, and for research into the potential benefits and drawbacks of such systems by researchers and academics from non-Western and developing world backgrounds.

Research conducted into the adoption of MA in non-Western settings is therefore now undertaken by significant numbers not just of Western researchers but also of non-Western

(though often Western-trained) ones. Such work has built on research in Western settings to establish, as noted here, how far MA-based solutions are, as in the West, introduced initially to improve the economy, efficiency and effectiveness of organisations; thus exporting to non-Western states gives a focus on managing scarce financial resources via MA-based practices. In the case of health care systems, a major focus has therefore emerged of seeking to reduce health expenditures.

As noted earlier in this section, KSA is not a developing country in terms of its political and economic significance; and given its natural and financial asset base, it does not necessarily confront resource constraints in a significant way in seeking to address health care provision and quality issues. At the same time, it does share similarities with other non-Western countries in drawing on Western research-based knowledge and expertise, and this increasingly applies in the fields of management and accounting. It also now builds on research in Western settings, and has the benefit of research being undertaken not just by Western scholars but also by KSA researchers with Western training. In these respects, the opportunity to undertake research into changing ways of using MA-based practices in the delivery of health care provision and quality within KSA is timely. It can draw on research findings on this issue from both developed and developing world settings to approach the distinctive situation of health care delivery in KSA, since aspects of findings in both types of setting may be of value in seeking to understand the dynamics of change in the institutional settings of health care in KSA.

Therefore, drawing on the research reviewed in this chapter, this study now seeks to take into account the findings from studies into MA change undertaken in both developed and developing world settings to consider the distinctive case of health care change in KSA. KSA's high levels of state revenues mean that it can largely avoid issues with financial resources that are common in developing countries; at the same time it is drawing on Western knowledge and expertise in

seeking to deliver its new objectives of improving HCQ. Thus, the case of health care in KSA constitutes a gap in the existing literature which warrants a comprehensive study analysing MA in the SAPHS. This study seeks to take a first step towards closing that gap and hopefully will stimulate future research activity in this area, taking into account our understanding of the roles currently and potentially played by MAPs in health care, both in the specific KSA context and in wider international and transnational contexts as well.

2.6 Conclusion

The literature review focused on the history and development of MA changes over the past few decades and the reasons for their increasing popularity in the business community. MA has gained significance in recent decades, and critical analysis of the literature suggests that MA is a dynamic field that is continuously undergoing substantial changes in developed and developing countries. The changes are less pronounced in the context of the developing world, but an increased focus on globalisation and international trade has provided a stimulus for the adoption of MAPs to improve the efficiency of organisations around the globe. The public sector has experimented with implementing NPM in the administrative context and the failure of such initiatives to generate substantial improvements in organisational efficiency implies that MAPs need to be actively implemented to bring about effective organisational change (Cutler 2011). Furthermore, the public sector, including public hospitals, faces increasing pressures in terms of the budgets available to the sector and the increasing healthcare requirements of individuals due to an aging population. There has been a lack of studies that cover MA changes within the SAPHS and the perceptions of accountants, managers and professionals in the context of developing countries, especially after the emergence of NPM within the sector. Thus, the existing literature gap warrants a comprehensive study analysing MAPs in SAPHS. This study seeks to encourage research activity in this area by initiating an enquiry into a topic that is under-researched.

Chapter 3 : Conceptual Framework

3.1 Introduction

The above discussion has sought to set out the grounds for adopting an approach based on NIS principles that will add to the literature which has studied the developing roles of MAPs and systems in public sector settings. The particular focus of the discussion and the above literature review has been on the deployment of MA to promote health care delivery and reform within states where NPM solutions are increasingly advocated; the analysis has suggested that 'quality' has emerged as a key concern, and that MAPs and systems have emerged as a major channel for the delivery of 'quality' outcomes.

This chapter proposes to go further into the reasons for adopting a theoretical approach which draws principally upon NIS. The strengths of NIS are its focus on a mid-range level where so much thought and action plays out in the modern world, which has become widely populated by institutions as sites where experts and expertise are deployed to coordinate institutional activity and set goals for institutional action, while also enrolling institutional members in the 'way of doing things' and motivating them to commit to institutional projects. Thus NIS as a theoretical framework potentially lends itself to a study of health care delivery where a new concern with 'quality' is being articulated. For health care is a field where different types of institutions are involved e.g. medical, political, professional, educational and commercial, each of which has its own interests as well as a commitment to delivering health care, and where the members of a given institution, such as a hospital, will have connections to other relevant institutions. For instance all medical professionals will have qualified via training under a professional institute in an educational institution, e.g. a university or training hospital, and through their professional socialisation will have levels of commitment to a professional identity as well as to the particular medical entity or organisation where they work.

Therefore one benefit of NIS is the way in which it recognises and traces the effects of participation, not just in the particular institution where people work, but of other institutions which are significant to constructing and carrying on the work experience; these will include professional and educational institutions as well as political and commercial ones, insofar as health care activity is shaped and changed in significant ways by the decisions and actions undertaken in those organisations as well. Thus NIS can be of significant benefit in theorizing and developing insights concerning interactions and power struggles both within a particular institutional setting and across a range of such settings (e.g. Cardinaels and Soderstom, 2013; Campanale, 2010; Jarvinen, 2006; Hassan, 2005). NIS therefore offers valuable ways of analysing both the positive aspects of new initiatives and the complex actions and reactions that such initiatives then provoke among key participants in a given institutional setting. It also recognises how dynamics at an institutional level may shape and affect both the success of particular initiatives and the forms of acceptance or resistance that emerge, through such conceptual terms as *institutional isomorphism* and the subsequent analysis of the mechanisms and predictors of isomorphic change (DiMaggio and Powell, 1983).

Given the richness of the NIS framework as developed since the 1980s, it is adopted here as a potentially fruitful way of seeking to analyse MA changes and practices in the SAPHS (Liguori and Steccolini, 2012; Selto and Widener, 2004). The approach is seen as useful at each of the philosophical, conceptual and operational levels that Burrell and Morgan (1979) argue research should seek to appropriate. First, it is argued here that NIS is appropriate at a philosophical level, i.e. in terms of its basic assumptions about the world and the human subject (including therefore the researcher); second, it is appropriate at the level of the conceptual specifications that follow from its philosophical stance, which is important since the translation of the initial stance into conceptual specifications guides the overall design of the study; finally, it is appropriate at the level of operationalising the conceptual specifications into practical procedures for undertaking

the research agenda, e.g. in selecting and determining what data to collect and how to collect it, and how to carry out the analysis of the data obtained and to structure the outcome of the thesis. Therefore, this chapter seeks to explain how an NIS approach informs this project, and how it forms an appropriate conceptual framework for the study that follows into the roles of MAPs in implementing a HCQ agenda in the KSA health care system.

3.2 Institutional theoretical approaches

NIS has significant theoretical value in considering health care change given the evolution over recent decades of institutional structures and processes in both developed and developing world states. Old bureaucratic modes of government give way to managerial bureaucratic modes, old-style bureaucrats increasingly take on managerial roles and discourses, and as that happens there is a greater presence and significance in public sector settings for forms of financial and MA. Therefore, the old Weberian form of 'rational' government (Weber, 1933/2013) is extended into a new form where MAPs become increasingly central, since all forms of management since the 19th century have operated through the constant collection and analysis of 'accounting and statistical information'; and so, it is argued, have been forms of 'managing it all by numbers' (see Ezzamel 1994; Ezzamel *et al.,* 1990; Chandler, 1977).

Thus, 'management via accounting' has become increasingly integral to public sector management (McSweeney, 2006), and as this has happened MA innovations in the public sector can be seen to occur not purely within a broad social context of accounting change but largely at an institutional level (e.g. Naslund 2008). Furthermore, the 'institutional' level of analysis needs to take into account both intra-institutional and trans-institutional dynamics in explaining accounting change (and also continuities where change is resisted). For example, Stamatiadis (2009) states that the educational background of accountancy teams was a significant factor in understanding different levels of change in Greek public hospitals, drawing attention to the

importance of inputs from the realm of educational institutions. Meanwhile Moll *et al*., (2006) see the degree of government power and influence over the public health sector as the main factor that explains how effective changes in MAPs prove to be, flagging up the significance of political institutions.

Thus institutional theory has a general applicability to the kind of study undertaken here. However, there are different forms of institutional theory, among them Old Institutional Economics (OIE) (Scapens, 1994) New Institutional Economics (NIE) (Walker, 1998), and NIS (Carruthers, 1995; DiMaggio and Powell, 1991). All have the same basic orientation: the decisions and actions of key participants in organisations cannot be understood without consideration of the middle range context of the institution, even while larger social and narrower individual factors will also be relevant. Therefore, all of these theories focus on institutions and institutional change.

However, as Burns and Scapens (2000) note, in their study of the growth of social scientific forms of analysis of MAPs, institutional theory has become increasingly drawn upon, because of the way it can specify aspects of 'social construction' which get constructed largely at the organisational level. Therefore, one reason behind scholars' increased interest in the approach is that it offers a more in-depth way of understanding organisation-specific features such as local schemas, rules, norms and routines that shape both individual and social regularities in behaviour (Scott, 2004). Given the range of approaches developed, there is understandably no one definition of what an 'institution' is. While as described above it can be in a general way mapped on to 'the organisation', 'organisation' itself refers not just to particular entities but ways of setting up and then doing things. In a similar way, where researchers have begun to focus on aspects of organisational reality such as rules and routines, this has led to defining 'institution'

more in terms of ‘a way of thought or action of some prevalence and permanence, which is embedded in the habits of a group or the customs of a people’, as Scapens has put it (1994: 310).

More generally, DiMaggio and Powell (1991) have argued that definitional ‘uniformity’ may be unhelpful, as different forms of institutional theory have different elements and features, which lead them to use a different approach. With these considerations in view, the next section covers the three perspectives of institutional theory outlined above, OIE, NIE and NIS, as well as their potential applicability to understanding changes in MAPs within institutional settings.

OIE arguably goes back to the work of Veblen (e.g. 1898), whose main unit of analysis was the ‘social group’ and who recognised the potential significance of ‘institutions’ for understanding the economic actions of different ‘social groups’. Thus Veblen defined ‘institution’ as ‘a habit of thought common to the generality of men’ (Veblen, 1898: 374 cited in, Burns and Scapens, 2000). In a similar way, Hamilton (1932) defined it as ‘a way of thought or action of some prevalence and permanence, which is embedded in the habits of a group or the customs of a people’ (Hamilton, 1932: 84, cited in, Burns and Scapens, 2000). This definition therefore considers that cultural and social elements are important in shaping middle-level institutional factors, which then shape the actions of individuals and within-institution groups. Barley and Tolbert (1997) have more recently followed this form of analysis but updated the definition to be ‘presuppositions that are shared and taken for granted, which identify categories of human agents and their appropriate activities and relations’ (Barley and Tolbert, 1997 cited in Burns and Scapens, 2000). According to all these definitions it can be seen that ‘the institutional’ is not located in ‘organizations’, but more at the level of ‘organizing’ human activities and routines through the way in which modes of thinking (common either to Veblen’s ‘generality of men’ or to more specific human groups) get taken on or internalised at a number of levels which may include states, firms, social norms and individuals.

Thus, one way in which the relationship between human actions and institutions takes effect is at the level of organisations, and the main outcome of this relationship is the structure of the activity within an organisation. Studying the role of 'institutional factors' in this way is raises an issue which has been widely discussed in the literature as that of the relation of 'agency' to 'structure' (e.g. Archer, 1995). This is an issue which comes up in various forms for all types of institutional theorising; with this particular type of institutional analysis the issue takes shape as the status given to the individual agent, and the individual's agency, given that there is a construction of reality which takes place at the 'institutional level' where ways of thinking, norms and routines develop. How far is the 'agency' of the individual compromised, as the individual becomes an 'object' of institutional forms of construction?

Within the frame of reference developed first by Veblen and then elaborated as noted above, OIE tended initially to focus on how markets cannot be analysed in isolation; instead analysis must take into account the interactions between activity in a range of settings, with the active role of 'ways of thinking' and so of evolving possibilities and regularities in human action. This kind of approach may have relevance in a study such as this insofar as new MAPs are outcomes of shifts in ways of thinking and the emergence of new regularities in ways of managing entities such as hospitals or other public sector entities wherein new roles for MAPs emerge, as for instance with reference to delivering 'quality'.

'Norms' have since become known as 'microeconomic' issues, i.e. how agents operate in different social or organizational settings, particularly, in the economics field, at the level of 'the firm'. At the same time, the ways in which the 'institutional' may be understood as an integral feature of economic activity diversified into what became known as NIE. Here it is widely held that NIE gained its focus as economists began to consider the implications of Ronald Coase's observations on 'The Nature of the Firm' (Coase, 1937), which meant that factors that have

influence at the level of the 'firm' as organization began to be seen as significant in shaping economic choices and activities. The 'institutions' focussed on initially were often legal rules or norms, such as those defining the boundary of 'the firm', but other factors relevant to the firm began to come under consideration. These included its forms of organization, its definitions of 'property rights' (e.g. the rights of owners or shareholders, managers and workers), the issue of the workforce as human asset, and the issue of 'transaction costs' (and so whether it was more costly to conduct activity in the firm or in the market).

3-1: Differences between OIE and NIE

	Old	New
Conflicts of interest	Central	Peripheral
Sources of inertia	Vested interests	Legitimacy imperative
Structural emphasis	Informal structure	Symbolic role of formal structure
Organisation embedded in	Local community	Field, sector, or society
Nature of embedded in	Co-optation	Constitutive
Locus of institutionalisation	Organisation	Field of society
Organisation dynamics	Change	Persistence
Basis of critique of utilitarianism	Theory of interest aggregation	Theory of action
Evidence of critique of utilitarianism	Unanticipated consequences	Unreflective activity
Key forms of cognition	Values, norms, attitudes	Classifications, routines, scripts, schema
Social psychology	Socialisation theory	Attribution theory
Cognitive basis of order	Commitment	Habit, practical action
Goals	Displaced	Ambiguous
Agenda	Policy relevance	Disciplinary

Source: DiMaggio and Powell, 1991

Here institutions might be defined as 'the rules of the game' but it was a game that was largely played at the level of a given organisation (the firm), or of markets made up of networks of firms. As Burns and Scapens note (2000), one outcome was the definition of the field of interest as 'microeconomics', in the sense that NIE came to pay particular attention to the microeconomic level of the functioning of organisations. In this respect, NIE is also potentially helpful for

gaining a research understanding of MAPs and their changes (Busco *et al*., 2006). For, as Hodgson (1999) has observed, 'it is a defining characteristic of NIE that institutions act primarily as constraints upon the behaviour of given individuals'. Each approach therefore has potential benefits; at the same time each approach is critical of how the features it emphasises are overlooked in the other approach. The differences have been summarised in the following chart, which is helpful so long as it is recognised how each approach has evolved over time, and how different the understandings of 'institutions' are in each, as observed above. With those provisos, the chart does show some key differences in the two approaches, and perhaps is helpful insofar as it highlights some key aspects of how each side tends to view the other.

3-2: Features of the three streams of institutional theory

	New Institutional Economics (TCE-variant)	New Institutional Sociology	Old Institutional Economics and the works inspired by OIE
Unit of Analysis	Transaction	Organisation	Social (sub) group
Assumptions on individual	Bounded rational	Institutional determinism	Individual constructs social realities
Process view?	No	No	Yes
Changes addressed	Governance structure	Institutionalised formal practices (budgeting; Activity-Based Costing)	Behavioural regularities
Institutional focus	Efficiency	External legitimacy	Behavioural regularities

Institutional studies have focused on case studies and comparisons of several hospitals over different time periods, analyses of policy initiatives based on the case studies, interviews, observations, reviews of the MA that has been implemented at the hospitals, multi-country case studies, analyses of the history of firms and questionnaires (Campanale, 2010). Yet Modell (2007, p. 352) suggests 'we still know very little about how economic, technical and institutional factors interact in the change process'. This thesis applies the interpretive research paradigm described by Covaleski (1996), based on institutional theory. Whereas researchers have traditionally seen MA as a technical rational tool, this thesis departs from this to consider MA

within a social context. Furthermore, this thesis supports the epistemological position of 'alternative MA research', which assumes that it 'socially constricted the reality' (Baxter and Chua, 2003). However, scholars such as Berger and Luckmann (1966) have criticised this epistemological position by arguing that an actor is the main factor constructing reality and social context. In other words, reality consists entirely of subjective meaning that leads to objective facts.

3.3 Neo-Institutional sociology

Brinton and Nee (1998) evaluated the evolution of NIS as an emerging paradigm that is advanced through research aimed at explaining institutional development. Institutional economics has influenced social interactions between individuals and institutions by stimulating research and economic action. The field of sociology has been closely linked to the study of social institutions and the analysis of institutional change. The main unit of analysis of this new sociology stream of institutional theory is organisations. So, NIS assumes incomplete information, inaccurate mental frameworks and expensive transactions that are obtained when merely studying the behaviour of individuals in the context of institutions' social development. Furthermore, NIS provides an interesting insight into the functioning of economic institutions such as health centres and hospitals (Selto and Widener, 2004). For example, Hassan (2005) analysed MA changes in Egypt's hospital sector using institutional theory of organisational change to link hospital management changes to the changes in the broader social context of accounting change and institutionalism (Naslund, 2008). The results show that MA changes at the hospitals are related to entrepreneurial behaviour by the management of the organisation.

However, according to Moll *et al*. (2006) the main reason for the appearance of NIS is shortage in the OIE. So, the main focus of NIS is external legitimacy. Researchers from various institutional perspectives have argued that legitimacy for obtaining resources in organisations

cannot exist without acknowledging institutional rules (Schmid, 2001). Scapens (2006) mentioned that NIS gave a clear understanding of the similarity between organisations that work in the same sector. DiMaggio and Powell (1991:8) explained characteristics of NIS as:

> a rejection of rational-actor models, an interest in institutions as independent variables, a turn toward cognitive and cultural explanations, and an interest in properties of supra individual units of analysis that cannot be reduced to aggregations of direct consequences of individuals' attributes or motives.

Therefore, it can be seen that NIS started from the old version of institutional economics; however, it has features and characteristics that make it different from the tradition of the OIE. The main focus of both theories is the relationship between the firms and their environments; however they view this relationship from different perspectives. However, NIS proponents have argued that the external environment is the main element that affects and causes changes in MAPs and the formal structure and practices in firms (Scott and Meryer, 1991). Another aspect that makes NIS different is how it defines an institution.

The concepts that have been raised by scholars using NIS are decoupling, resistance and power (Orton and Weick, 1990). In the case of decoupling the main argument is that, along with the formal structures and actual operations, there are contradicting forces (Nor-Aziah and Scapens, 2007). Therefore, accounting within an organisation is seen as a decoupling because it offers a harmony between the technical and the institutional demands (Collier, 2001). On the other hand, if accounting has just been introduced within an organisation to justify the legitimacy of decisions, the role of accounting will be decoupled from its main role, which is rationalizing decisions (Carruthers, 1995). For that reason, the role of decoupling in this case seems to play an important role in solving the clash between institutional pressures. According to research in the public sector, some have used decoupling as a common strategy to study conflicting institutional pressures (Brignall and Modell, 2000). However, when they have used this common strategy

they have ignored the critical role of the local actors (Modell, 2003). In the case of resistance and power, the first criticism supporters of institutional theory have faced is that it did not give any attention to the relative power of institutional actors and the issues that have been raised in the conflicts of such power relations (Collier, 2001). The basic definition of power can be seen from the work of Giddens (1996). He defined power as the 'ability of individuals, or the members of a group, to achieve aims or further the interests they hold' (1996, p.744). According to Dillard *et al*, (2004) there are three main levels to the factors that influenced organisations. These levels are: societal norms, organisational field and organisational level. Each one of these levels refers to different factors. For example, societal norms refer to economic, political and social factors; organisational field refers to industrial groups, professional bodies, and consultants; and organisational level refers to the organisation itself.

3-3: Drives of MA change

	Drivers of management accounting practices			
	Economic pressures	Coercive pressures	Normative pressures	Mimetic pressures
Factors driving convergence	Global economic fluctuations/ recessions, deregulation of markets Increased competition (the globalization of markets) Advanced production technology Advanced information technology	Transactional legislation Transactional trade agreement Harmonisation of the financial accounting legislation Transactional ('especially global firms') influence on their subsidiaries Headquarters influence in general	Management accounting professionalisation University research and teaching	Limitation of leading companies' practice International/ global consultancy industry
Factors driving divergence		National legislation National institutions/ regulation (labour unions, financial institutions, etc)	National cultures Corporate cultures	

Source: Granlund and Lukka, 1998

Yazdifar and Tsamenyi (2005), as new institutional scholars, have argued that during the processes of isomorphism firms maintain the same structure and practices. Therefore, in their view (and similar to DiMaggio and Powell's (1991:66) definition), isomorphism is 'the concept that best captures the process of homogenization'. According to Granlund and Lukka (1998), *institutional isomorphism* has two different dimensions: convergence and divergence, each of which presents the factors that led to MA changes (see table 3.3).

3.3.1 Competitive isomorphism

According to Mizruchi and Fein (1999), *competitive isomorphism* is similar, under the same conditions. Hannan and Freeman (1977) have claimed that '*competitive isomorphism* concerns efficiency. When there is one best, cheapest or most efficient way to do things, then the forces of competition will eventually impose upon organizations that one best way' (Carruthers, 1995, p.317). From this argument we can see that the main concern of these researchers is the pressure of competition. According to them, organisational rationality and environmental rationality are not as prevalent under the condition of competitive markets. They support this argument by stating 'the optimal behaviour of each company is to maximise profit and the rule used by the environment' (Hannan and Freeman, 1977, p.938). It is quite clear that competition plays an important role, but this role cannot be the only thing guiding organisations to be smaller in the same context (Abdel-Kader and Luther, 2008; Kholeif *et al*., 2007).

DiMaggio and Powell (1983) have a different position to Hannan and Freeman (1977). They argue that, in the case of the modern enterprise, the best way to understand the politics and pressures that make organisations act similarly is through *institutional isomorphism*.

3.3.2 Institutional isomorphism

Most organisations seek to be isomorphic with their environments. Meyer and Rowan (1991) have argued that all firms, regardless of their context, work to be in line with their environments because it provides them with structure. There are two ways in which organisations seek to be isomorphic under the same environment; one is related to how formal organisations adapt to be in line with their environments, and the other is related to the assumption that reality is socially constructed. The argument in this case is that the structure of organisations is influenced by society, which leads these organisations to be in line with their environments. According to Mizruchi and Fein (1999), *institutional isomorphism* creates a number of formations of how behaviour disseminates. However, according to DiMaggio and Bowel (1991) there are three classifications for *institutional isomorphism*: *coercive, mimetic* and *normative isomorphism*. They argued that these classifications play an important role in institutional isomorphic change, but that each classification has different antecedents.

3.3.2.1 Coercive

In a different context, governments play a significant role in *coercive isomorphism* (Weber, 1922/2013; Ezzamel *et al*., 2012). This can be seen from the pressure of government departments on all organisations (Abernethy and Chua, 1996). As DiMaggio and Powell have mentioned, '*Coercive isomorphism* results from both formal and informal pressures exerted on organizations by other organizations upon which they are dependent and by cultural expectations in the society within which organizations function' (1983, p.150). Also, Mizruchi and Fein (1999, p.657) have supported DiMaggio and Powell's argument by stating:

> *Coercive isomorphism* is driven by two forces: pressures from other organizations on which a focal organization is dependent and an organization's pressure to conform to the cultural expectations of the larger society.

Thus, as mentioned before, external governmental pressure demonstrates how formal changes and informal pressures can lead to changes in organisations (Weber, 1922/2013). In the case of KSA, the recent liberalisation of the KSA market and its aspiration to achieve global financial integration through economic reform and membership in the World Trade Organisation has exposed domestic firms to foreign competition. Therefore, the KSA government put pressure on these organisations to achieve a high quality of financial integration through best practice to achieve the membership targets.

As noted previously, in any context the reality of the environment has a powerful influence on the behaviour and structure of an organisation. Moll *et al*. (2006) mentioned that external pressures such as governmental rules, which are central to *coercive isomorphism*, have led organisations to change their structures and processes to fulfil such requirements. However, DiMaggio and Powell (1983) have argued that the phenomenon of change in this case could be largely ceremonial, but at the same time it is important to consider these factors as significant and leading to change. With regard to NIS supporters' perspective on *coercive isomorphism*, changes in organisations' MA occurs depending on the force of external pressures such as national institutions and regulations, which have a strong effect on MA within organisations.

3.3.2.2 Mimetic

DiMaggio and Powell (1991, 1983) have argued that *coercive isomorphism* is not the only form of *institutional isomorphism*; other forms include *mimetic isomorphism*. In the literature, the researchers have argued that there are three main factors that lead to *mimetic isomorphism* in organisations. Firstly, DiMaggio and Powell (1991) have argued that *mimetic isomorphism* is a result of the strong power that coercive authorities place on organisations. As Haveman (1993) argued, *mimetic isomorphism* not only comes from the power of coercive authorities but that 'obligatory action', or the type of social structure, also causes organisations to imitate each other.

The last factor that guides organisations to imitate others is uncertainty (DiMaggio and Powell, 1983). With regard to institutional theory, efficiency considerations play a significant role in the reorganisation of structure within organisations, especially when they reorganise or establish a new structure (Palmer, *et al*., 1993).

When organisations face any problems or uncertainty, it is best to follow what others have done in the same position; thus, we can often see an increase in the mimetic actions in the economy (Abernethy and Chua, 1996). For example, when firms implement new MA such as Activity-based costing or BSC, these practices are not understood by those who work within organisations (Cooper, 1990; Johnson, and Kaplan, 1987). Therefore, the best solution is to adopt MA that has been successfully implemented within other organisations in the same sector (Yazdifar, *et al*., 2008). However, *mimetic isomorphism* in most cases takes place in organisations without consideration of whether adopting these practices or structures will support the efficiency of the firms (Palmer, *et al*., 1993). In addition, as Abernethy and Chua (1996) highlighted, organisations often preferred to implement practices and structures that have been successfully implemented by others because the external factors are the same; this will then offer them greater advantages such as regarding time and expense. Within KSA, organisational structures such as NPMs are starting to be implemented in hospitals because this organisational structure has been successfully adopted by different countries similar to KSA (Hassan, 2005).

3.3.2.3 Normative

The third kind of *institutional isomorphism* is *normative isomorphism*. The main focus of this kind of isomorphism is professionalization. DiMaggio and Powell (1983, p.152) have defined professionalization as 'the collective struggle of members of an occupation to define the conditions and methods of their work, to control the production of producer'. In the case of isomorphism, there are two main sources of professionalization: formal education and

professional training. Formal education is the knowledge and scientific skills that employees have gained during their university studies, and continued professional development training. Professional training entails the designing of new practices to use within organisations. If these two sources of professionalization both exist within organisations, it guarantees highly qualified managers and employees, and thus improves organisational efficiency.

Abernethy and Chua (1996, p.574) have supported the influence of formal education and professional training as a *normative isomorphism* on organisations as 'when professionals operating in organisations are subject to pressures to conform to a set of norms and rules developed by occupational/professional groups'. Furthermore, according to the literature, formal education and professional training have a strong influence on how professionals act inside firms (Carruthers, 1995). Most universities offer master's degrees for accountants and non-accountants. Moreover, the King Abdullah Foreign Scholarship Program[6] (KAFSP) offers Saudi students an opportunity to obtain their bachelor's, master's and doctoral degrees in accounting and management in the world's best universities. All of these graduates from both national and international universities are prepared to apply new practices of management and accounting within KSA organisations. The table below shows the features of the three streams of institutional theory.

3.3.3 Power and resistance

According to Dugger and Sherman (1994), the relationship between power and organisations should be considered when conducting research in the area of organisational change. So, it can be argued that under institutional theory the power to change comes as a result of the conflict between factors of institutional change and factors of institutional stability (Oliveira, 2010; Tsamenyi et al., 2010). Therefore, all streams of institutional theory emphasise power. The OIE

[6] For more information about KAFSP see the link: http://he.moe.gov.sa/en/studyaboard/King-Abdulla-hstages/Pages/default.aspx

theory has shed light on power within organisations whereas NIS has considered the external environment as the power that leads to change. Therefore, before discussing power under institutional theory we need to understand what power means.

There are many definitions of power, but the simplest definition is also the most helpful in understanding its influence. Dugger and Sherman (1994, p.103) defined power as ‘the ability to get others to do what you want them to do’. Burnes (2004) argued that the distinction between power, politics and authority cannot be easily understood and that each has its own characteristics; authority means the right to act to achieve organisational goals (ibid), whereas politics is the exercise of power (Pfeffer, 1981), and power is the capacity to affect decisions (Burnes, 2004).

NIS has given clear attention to the influence that the external environment can have on institutional change, yet it has overlooked a source of power that comes from the micro level of organisations (Yazdifar, *et al*., 2008). DiMaggio and Powell (1991) mentioned that power is significant in NIS because it plays a fundamental role in organisational change. *Coercive isomorphism* can be seen as the best example representing power. Hensmans (2003, p.356) argued, ‘the focus of NIS is now shifting from the study of fields as relatively static and predictable units of analysis to the study of fields as arenas of power dependencies and strategic interactions’.

3.3.4 Limitations of NIS

Different scholars have criticized institutional theory and its suitability for the study of MA changes. DiMaggio and Powell (1991) claim that *institutional isomorphism* does not fully address the difficulty of applying practices from one organisation to another, and the need to attend to unique features or characteristics, focusing too much on external environment factors. Furthermore, the representation of organisations is too passive and therefore unreliable, whilst

other internal factors such as the role of human actors in shaping institutions are unaccounted for (Meyer, 2010). Yazdifar *et al*. (2008) have highlighted three main points in their critique of NIS. First, NIS solely emphasises the macro level of organisations without attention being given to the practices or operating systems that take place at micro level. Second, the main focus of NIS is the pressure that comes from active agencies, power and interest instead of other factors such as the activity within the organisations. The third criticism is that it assumes all practices within organisations come about as a result of the pressure to have external legitimacy, without mention of the internal workings of organisations such as their operation systems (Modell, 2001). Furthermore, Ribeiro and Scapens, (2006) have argued that the main approach that NIS used is static, and using such an approach does not give a clear understanding of the process of change.

Furthermore, researchers have argued that the users of institutional theory have ignored the important role that individuals play in recent developments within their institutions (Suárez, 2008). For Meyer (2010), global culture, changes in education and rules of external agents such as the WB have become important factors shaping the behaviour of actors within organisations. Thus, NIS solely emphasises the role of organisations as the unit of analysis without giving any attention to individuals. According to Meyer, individuals are important factors that change over time, which can play a significant role in organisational changes, e.g. the promotion of science (Drori, *et al*., 2003), the power of educational systems (Baker and LeTendre, 2005) and environmental protection (Frank, *et al*., 2007). Meyer (2010) argued that ‘actor agency is made real through the highly expanded educational systems now found everywhere. These meld the principles of scientist knowledge into the selves of entitled persons, constructing empowered individual actors capable of building society through their choices. Much social structure, then, turns into modern formal organization, assembling individual actors into structures of mobilized participation’ (2010, p.15).

3.4 NIS as a framework of interpretation

This study investigated and analysed the MA changes in SAPHS. Therefore, the theoretical framework selected for this research is that of NIS, as this provides substantial room for the evaluation of institutions in the context of their existing forms and behaviour through the process of decoupling resistance and power. The main argument for NIS and its *institutional isomorphism* is that using such a theory gives the researcher a clear understanding of the institutions in the context of their existing forms and behaviour, continual change and the political factors and social elements that affect institutionalisation. According to the context of the study, there are various factors that have changed. Those factors have previously influenced the Saudi public sector, and they can be argued as the main agents of change in the public organisations of most developed economies. For example, social, political, economic, education and professional factors and globalisation have further shaped MA and systems within public organisations (Miller and O'Leary 1990). Chang (2006) mentioned that the legitimisation of practices within the public sector has become the main focus of governments, overshadowing the needs of the public from one region or another, as the implementation of NPM and the MA is for the purpose of achieving national goals. In this context, changes have occurred over the last few years that concern the development of the country and the westernisation of the most of the management philosophies and practices (Al-falih, 2008). Those changes can be seen in the political system, social, e-government, economics, education and professional sectors and knowledge-based management.

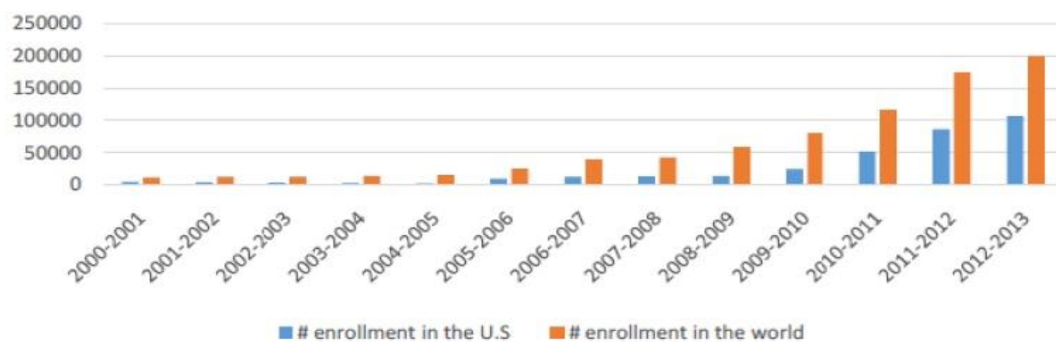
According to the political system, the country has implemented a number of five-year plans since 1970 (this is discussed more in appendix D) in order to improve the economy and the infrastructure of the country by taking it from an oil-based economy to a modern industrial state; as well as to improve the social services, including medical services and residential housing for Saudis. The main driver of each plan was that the country needed to be improved. Therefore, in

plan nine, when social media become more prevalent giving the public new freedoms to discuss and criticise the governmental systems in the Arab world, the KSA government focused on the social feedback and applied various reforms to satisfy the public. Also, the implementation of e-government in most public organisations during the last few years has enhanced the efficiency and effectiveness of service delivery in the public sector. That implementation has enhanced most of the public health organisations, changing their practices from traditional methods that were based on paperwork to ones built on information and telecommunications technologies.

Other changes can be seen in the improvement of the economy during the last few decades, during which KSA has become one of the strongest economies in the Middle East (G20, 2014). The oil industry has developed, which has led the country to become the world's largest oil producer. Therefore, oil revenues are the main source of income for the country (Exports of KSA, 2010). In the last few years especially, oil prices have increased to all-time highs, and this has led to a great increase in the income for the country. Therefore, the government began emphasising the SAPHS in order to improve this sector, have it more in line with the improved economy, and meet the requirements of the public (MOF, 2013). Reforms were applied to public sectors, such as the SAPHS, which implemented SEP to improve the HCQ in KSA hospitals. Therefore, the adoption of the NIS for this study provided a more in-depth understanding of the changes that have taken place within SAPHS, after having implemented the new reform that has been driven from the recent institutional emergences and changes.

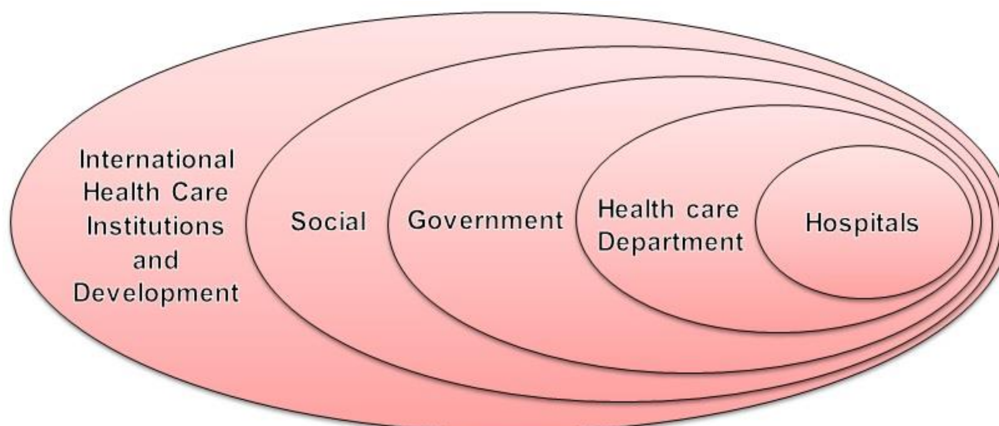
Furthermore, the shifting of the national strategy and action plan to consider knowledge-based management also played a role and shaped most public organisations' practices (Al-falih, 2008). KSA has, over the last decade, given a special focus to improving the level of education through three actions: the first was to attract qualified employees from developed economies to work in public organisations; the second was to improve the education level of the public by improving

the education system, for example, the number of universities has increased from 7 to 25 during the last 10 years; and the third was the KAFSP, which sends hundreds of thousands of students to obtain their studies in developed economies such as the US, UK and Australia. The aim of the KAFSP is to improve the prospects of Saudi employees and make them more qualified and specialised. Also, the programme aims to import modern scientific and business methods from the world's best institutions and implement them in the KSA context in order to improve the country in different areas and to build the Saudi society upon a knowledge-based economy (Innovative Government, 2014).



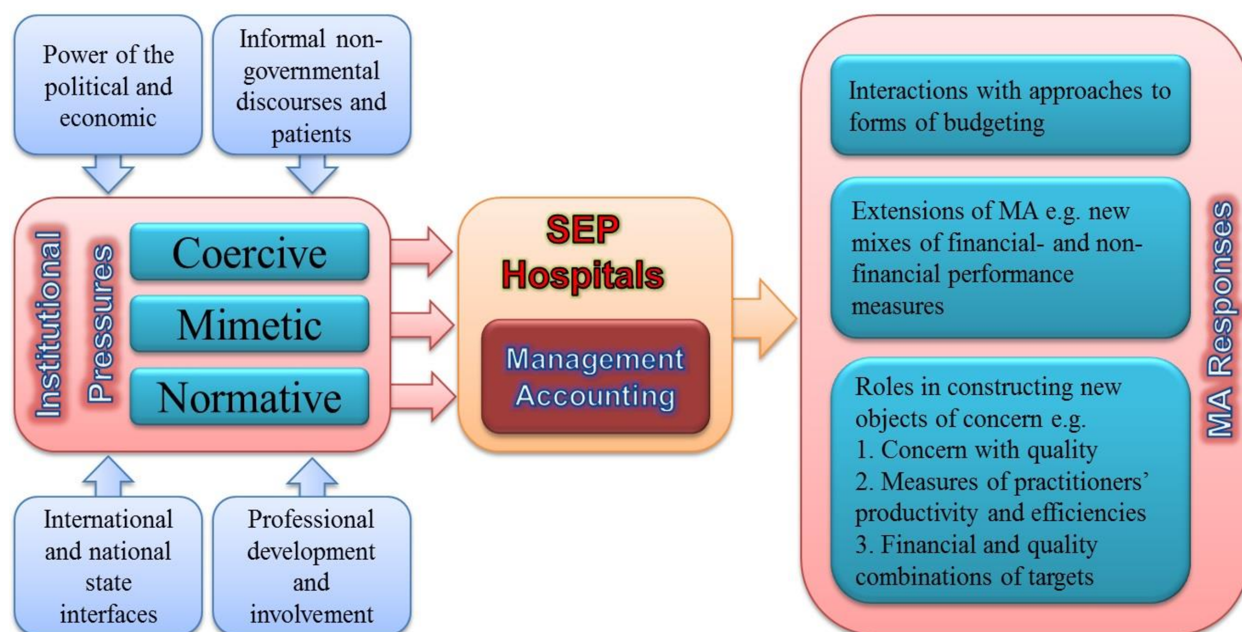
3-1: Gorwth of Saudi Students in the World: Source: Innovative Government, 2014

According to these changes in the political system, e-government, economics, education and knowledge-based management can be seen as *coercive, mimetic and normative isomorphism* and the NIS external environment argument is one of the main elements that affects and causes change in the formal structure and practices of firms (Scott and Meryer, 1991). Therefore, this research adopted NIS to get an in-depth understanding of the MA changes in the SAPHS and the factors that lead to MA changes. NIS helped in the achievement of the objectives of the study and differs from other theories, such as contingency and agency, that are based on the assumption of the neoclassical economic theory and that do not give weight to impact of the institution on MA organisational change (Rutherford, 1995); as Richardson (1987, p.348) stated, 'the way in which accounting is used to constitute reality and the effect on individuals of the legitimating of a particular version of reality'.



3-2: The main institutional focus

The figure below constitutes a conceptual framework, (in reading from left to right) starting from NIS categories, and its dynamics that frames MA practices (old and new) into new Management and MA regimes with new MA outcomes.



3-3: Conceptual Framwork: NIS and the theorising of MA change

Another reason that led to the adoption of NIS for this study is that this theory provides a more in-depth understanding of the changes that take place within organisations, and it addresses the limitations of other theories such as structuration theory (Scapens, 2006). Furthermore, Boland (1993, p.126) argued that structuration theory 'does not really allow us to see the knowledgeable,

purposive human actor who is producing and reproducing social structure through MAPs'. Thus, NIS is suitable to address all the issues that have been raised from other theories. According to Scapens (2006) and Burns and Scapens (2000), the use of the NIS theory can help guide research to be more focused on MA change. Moreover, they emphasise that researchers should conduct case studies to obtain a clear and in-depth understanding of MA change within organisations.

3.5 Conclusion

NIS theory is used as the framework for this work due to its relevance to explaining how change operates at the mid-range level between 'the social' as understood in conventional sociology and 'the individual' as studied in conventional psychology. The approach is therefore very useful for highlighting the interactions that take place at organizational and inter-organizational levels, and in this instance for investigating and analysing changes in the forms of MAPs and the use made of them within public-sector institutions such as hospitals. Also, NIS provides a range of useful ways of explaining the forces behind the emergence and change in MA through ensuring that middle level forces are taken properly into account. This approach has therefore been adopted here is the most useful approach for generating an in-depth understanding of the MA changes in the SAPHS and the institutional factors leading to MA change. In general terms the approach here has a form of 'social constructionist' perspective, while seeking to recognise the 'agency' problem by acknowledging the significant roles played by individuals, and the ways in which individuals may differ in their views on MA change and their commitment to it. With that proviso, a social constructionist perspective may offer a helpful and constructive understanding of the influence of external factors such as the government's power over the sector, while enabling the research to track how such government power plays out in differing ways at institutional and inter-institutional levels, in the form, for instance, of varying degrees of *institutional isomorphism*.

Chapter 4 : Methodology and Method

4.1 Introduction

This chapter will specify how NIS has been applied in guiding the overall approach and design of the research and how it has been operationalised in practice, through the collection, analysing and theorizing of material (Kvale and Brinkmann, 2009). The first discussion will cover NIS, its main concepts in relation to the approach, and the case study approach. Two distinct case studies were selected to represent the changes in SAPHS in MA in KSA hospitals. This is followed by a discussion of how the cases were chosen, the analytical themes for interview and how the analysis was developed, also guided by a pilot study. The next section gives an overview of the more practical side in collecting material and how any issues were dealt with in how the interviews were conducted and archival documents were collated, followed by how the analysis and the theorising was carried out, along with the choice of how to present the material. Finally, the chapter gives an overview of the ethical aspects that were involved in this study. The chapter ends with some concluding remarks.

4.2 Research approach and design

As discussed in chapter 3, NIS as a form of interpretive research targets phenomena at an institutional level that rest on an ontology assuming that humans construct their reality through an understanding of social structures, as well as from an individual perspective (Meyer, 2010; Scapens, 2006; Crotty, 2005; Miles and Huberman, 1999). Institutions are a ‘given’ social phenomenon in the modern world, and it becomes necessary to understand the differences and similarities between organisations as actors; a model of ‘actor hood’, so to speak (Meyer, 2010). Within this context, the professionals such as clinicians, accountants, consultants and managers are both part of and constrained by organisational differences and similarities. In this study, the focus is on how hospitals who are implementing MA with the aim of improved HCQ in KSA are influenced by and are influencing new ‘actor hood’ models. It is between external factors and

everyday practices, between 'the social' as understood by conventional sociology and 'the individual' as studied in conventional psychology, that the focus is directed here; and where 'why' and 'how' questions become vehicles to arrange and design the research.

It is from such an approach that the research focus and case study approach has been chosen; in this instance, the case studies will be two hospitals in KSA adopting new MAPs for HCQ. Case studies give an opportunity for institutions to be studied in the game of change, within the specific cultural context to which they 'belong' (Gummesson, 2000; Westgren and Zering, 1998). Observation of and dialogue with participants gives researchers the opportunity to gain a deeper understanding. Case studies direct the collection of material, and allow a focus on the role of key professionals in the change of MAPs in organisations. They must also take place at a time where change can be studied. For instance, since the decision by KSA government to implement SEP as part of increasing HCQ in 2007, much has happened. However, this is an ongoing major change which locates the study in the centre of (i) the current situation based on the changes in place so far, (ii) a position to reflect and understand the forces in play before and after SEP was implemented, (iii) possible futures. The material was collected during periods in 2013 and 2014.

In the analysis, the concepts of different forms of isomorphism (as discussed in chapter 3) are useful in gaining further insights into what happens within a KSA hospital. However, concepts of NIS applied to such case studies should not be, and have not been used as a strait jacket but as a guiding principle for the overall design, collection and analysis, of the case studies brought in. This thesis is then much in line with Eisenhardt (1989) who explains how case studies are a fruitful way of providing further explanatory categories, and hence give originality and 'testability' to what is under investigation.

The major decision was to decide how many case studies to bring in. As Flyvbjerg (2006) points out, one in-depth and detailed case study is often used to provide historical insight and can

provide all that is necessary in terms of material for analysis and in development of knowledge around the subject. This is in contrast to large surveys where breadth is of importance and part of a positivist approach. In this thesis the focus is instead on a detailed understanding at hospital level of the change itself, its dynamics over time, key actors involved and possible driving forces. Even so this is not a straightforward matter as it is also a balance between time and resources vs. relevance in answering the questions set.

	Single-case design	**Multiple-case design**
Single unit of analysis	Type-1	Type-3
Multiple unit of analysis	Type-2	Type-4

4-1: Design for Case Study Research: Source: Yin, 2013

Westgren and Zering (1998) have argued that the number of cases and units of analysis are of importance, and provide a two by two box as a guide (see Figure 4-1). One interpretation is to see this study as under Type 3 of the problem (MA change at the hospital level), as a single unit of analysis. Romano (1989) has suggested that the number of cases to be conducted should be based on the needs of the researchers and the availability of, and access to, material that can shed light on the issue in focus. With this is mind this thesis has chosen two case studies, which gives scope for comparison, a key component in developing understanding of MA change. However, carefully selected case studies are crucial. The cases chosen must represent key aspects of the issues under scrutiny that will inform the analysis and the validity of the results (Glaser and Strauss, 2009; Flyvbjerg 2006; Yan and Gray, 1994). At the same time it is also a matter of finding and being given access to material within the time frame. Still, this overall research

design, which in many ways corresponds as described in figure 4-2 below (Yin, 2013), gives an overall guide to the research focus, the material to be collected and to ways to answer the questions set (Gill and Johnson, 2002; Atkinson and Shaffir, 1998; Hoepfl, 1997).

4-1: Case study research: design and methods

Tests	Case study tactic	Stage of research
Construct validity	Use multiple sources of evidence Establish chain of evidence	Data collection Data collection
Internal validity	Do pattern-matching Do explanation-building Address rival explanations Use logic models	Data analysis Data analysis Data analysis Data analysis
External validity	Use theory in single-case studies Use replication logic in multiple-case studies	Research design Research design
Reliability	Use case study protocol Develop case study database	Data collection Data collection

Source: Yin, 2013

4.3 Case study selection criteria

Based on the discussion above, I selected King Khaled Hospital (KKH) and King Fahad Hospital (KFH) as the two case studies. Those two cases represent (i) similarities in being hospitals having to adopt SEP (NPM), forcing them to become the same in certain aspects, and (ii) differences in terms of how many years of experience they have of 'modern' MA, of public vs. privately organised management systems, of experience in implementing the SEP reform, and of quality. Below I will give further detail to these aspects.

Both hospitals are considered by the MOH to be the ultimate referral hospital, thus having a national responsibility to improve the care provided to patients. The employees are highly qualified and dedicated health professionals of many nationalities (KFH, 2014). The question arises at this point: What were the reasons for choosing these hospitals over others? The first reason was that both have implemented the SEP that gives their management teams the right to manage and control their human and financial resources. In 2007, the Council of Ministers

approved a new programme, called the SEP, to resolve those issues. This reform programme gives managers more flexibility in whom to recruit and employ, which contributes to the improvement of specialised services offered to patients.

A second reason was that that both had experienced other management systems before implementing the SEP. KKH was managed by AMI Ltd., which is currently managing a group of 21 private hospitals and surgical centres throughout the Middle East. Therefore, it can be argued that the management's connection with this hospital is interesting in terms of how and why MA was implemented to support the HCQ, when the hospital was in the private sector under the CM reforms that were introduced in 1984 to improve the operating capabilities of hospitals in the country. Furthermore, the first step that KKH took upon becoming self-operating was to collaborate with Johns Hopkins Hospital (JHH) in the US, which assisted in improving its medical and management practices through transferral of relevant practices. Therefore, this hospital also provides material for understanding the role that Western hospitals have had in changing MA in the context of KSA hospitals.

The second case illustrates a different management style. KFH was managed by the MOH's branches as a form of PA. Therefore, the hospital centralised the human and financial resource management, which limited the hospital's flexibility concerning those resources. Decisions about human and financial resources are made at high levels in those divisions. Therefore, the role of hospital management teams was to lead or direct hospital activities without any ability to plan financially or recruit staff. Also, this hospital's first objective was built on the MOH's goals, which focused on providing health care to all citizens, as defined in Article 31 of Saudi law. However, in the period during which this was the hospital's main objective other issues surfaced, which caused the hospital to come under public and governmental criticism.

Furthermore, employees at both hospitals have different nationalities, with staff members including Saudi, Philippine, Indian and American employees, among others. Therefore, this also provides an opportunity to understand the role that those employees of various nationalities and educational backgrounds have in changing the MA in KSA under the NPM reform.

Another reason for choosing them was that both have been influenced by recent institutional emergences and changes such as within the political system, social, e-government, economics, education and knowledge-based management as well as the development of the country and the Westernisation of the most of the management philosophies and practices; practices which enhanced those two hospitals and changed their practices from traditional management based on PA and CM, to ones built on MA under the SEP reform, defined as NPM.

4.4 Choosing research methods

The next step in answering the issues given NIS and the case study approach was to consider practical methods for the collection of relevant material from the case studies. There are several relevant methods for the research as regards answering the research question, supporting the unit of analysis, fitting within theoretical approach chosen, and the overall research design (Yin, 2013; Reige, 2003; Lee, 1999). In addition, as already discussed in length, professionals are key in understanding the dynamic of change at hospitals. So the first issue was to identify who exactly were the key people at hospital level. After investigation, also confirmed via a pilot study, four kinds of professional emerged as key to include, and these were: (i) accounting and financial managers, (ii) managers of hospitals and head of departments, (iii) clinicians and nurses, and (iv) consultants who were involved in the MA change.

The next issue was selecting which method to use to ‘collect’ their range of experiences of MA. Interviews were chosen as the first method and the reasons for this were several. It was important to set aside enough uninterrupted time where key professionals could share their experiences,

and shadowing them at work (Carniawska (2007) would have been more intrusive. But more importantly the unit of analysis here is at the level of institution as understood by NIS. If interviews are well-planned and carried out they are a good source of material. In relation to this choice it was decided to carry out a pilot study to see how well interviews would work including a test of the questions designed (see 'Pilot Study' in this chapter for further details). The pilot study supported the choice of interviews.

The second major source was archival and documents collection. We live in a culture of writing and reading, of which MA and FA are part. Policies, guidelines and discourses on quality are all published. Change of policies and rules are stated in written documents and hence are of great importance here. To complement the interviews, cross check the analysis and give time perspectives on MA change, extensive use was made of both 'live' and archival documents.

4.4.1 Interviews

The interview method is widely used in social sciences, including in the area of management and accounting studies. This method is appropriate for research that aims for an in-depth understanding of the phenomena, as it highlights the relevance of contextual factors. However, as with other methods, there are some disadvantages. For example, the interviewer requires a high level of interviewing skill to make sure the material collected in this way will answer the research questions. In addition, interviewees may misunderstand a question or the terminology used in a question, which can influence the validity of the research method as well as material collection. Other disadvantages relate to time and money; the researcher might be required to travel to meet the interviewees (Saunders *et al.*, 2009).

Advantages and disadvantages aside, the interview method can be divided into three categories: structured, unstructured, and semi-structured. The structured interview has pre-defined questions in a specific order, which means that all the participants' answers can be measured using the

same rating scale. However, using structured interviews was not considered to be appropriate for this research as it is quite inflexible. It does not allow for participants to expand where they see necessary to do so and possible new insights can therefore be excluded. It is easy to forget that the researcher is the ‘learner’, that the interviewees are the experts of their own working environment and that questions created by the researchers are never ‘perfect’. Structured interviews disregard much of the learning aspect of the researchers, and the interviewees are treated more as objects rather than humans creating their reality which the interview setting is part of too. Finally, this approach gives the researchers fewer opportunities to ask follow-up questions that could help to gain a deeper understanding (Smith, 2014).

The second category is the unstructured interview. This kind of interview does not include any prepared questions; rather it is a direct conversation or discussion which allows the researcher to probe particular issues. However unstructured interviews have different challenges for the researcher. ‘Directing’ interviewees to the topic being investigated can be difficult as there are no themes or questions to guide the interview process. Even in terms of analysis, the unstructured interview offers difficulties because different questions will be asked depending on the context of the interview, making systematic analysis of material collected problematical (Patton, 2002). It is also time-consuming to analyse the material. Hence this method was not suitable for this study.

The third category is the semi-structured interview which combines elements of both; some defined questions and also some supplementary questions which give the researcher more freedom to explore in-depth. In addition, this method allows the researcher to obtain material about a participant’s feelings, opinions, experiences and reasons for adopting MA. However, this method also needs a high level of interview skill in order to follow-up significant points. In

comparison with the use of questionnaires, this method is costly and time-consuming (Smith, 2014).

Accordingly, four different question formats were designed for different key professional roles; accounting and financial managers, managers and heads of departments, clinicians (and nurses, and consultants (which were a combination of all three). The sets of interview questions were based on the assumption that these professionals were playing key roles in their official roles in MA change at the hospitals and as such they also represent a range of experiences as professions.

4.4.2 Interview themes

Thematising refers to the topics that need to be investigated before designing the interview questions. The themes discussed with the interviewees in this study were: general questions, the clinicians' work, MA, the SEP, the HCQ, official factors that have led to influence or change, and the use and influence of MA and key performance indicators (KPI).

The first topic included general questions focusing on the background and the experiences of participants within the public sector. The aim of this section was to give the participants the chance to introduce themselves and to talk about their work, position and responsibilities. In addition, this section included a general discussion about the current health care situation, improvements in the sector compared with the previous year, and how these changes and improvements had influenced the participant's job.

The second section was more important as this focused on the clinicians' work and the HCQ. It included a discussion of what the typical working day looked like for the clinician, the amount of time that clinicians spent on medical, management and administration tasks, and also the changes in the work of clinicians over the last few years. The sections concluded by considering how the HCQ had changed over time and the reasons behind this change. The aim of this section was to

investigate and analyse the changes in medical practices and management tasks that clinicians carry out, as well as quality improvements in recent years.

The third section was about MAPs and the changes within these practices that the participants had experienced during the last few years. It included questions about the key changes in MAPs, the importance of these changes, the implementation of MAPs, the role of accountants and others in MAPs, and the most challenging factors that have influenced MAP implementation. The section ended with a discussion about the benefits of these MAPs in directing, controlling and managing operational activities.

The fourth section shed light on the SEP and how such management reforms have influenced the MAPs that are used to assist managers and clinicians in achieving the objectives of the self-operating program. This section included different questions such as why the programme was introduced in KSA hospitals, the objectives of the programme and the changes needed in existing MA in order to support the objectives of the programme.

The fifth section was a key because this provided the material needed to investigate and analyse the HCQ after the changes in management at the hospital as well as the changes in the MAPs. The section started with questions on how HCQ changed in this hospital, how MAPs (new or old) support HCQ change, how specific MAPs have been implemented to support the HCQ, and how these MAPs have supported the HCQ. The section concluded by examining the role of costing systems, performance evaluation, budgeting and strategy in supporting the HCQ. There were other questions about the factors that have led to influence or change. This part of the interview included a discussion of the participant’s reactions to factors such as regulations, economics, number of employees in the hospitals, IT, hospital structure/decentralisation, competitors and bench mark organisations, the needs of the public, training of staff, consultants and any other factors the participant might think had influenced the HCQ. However, during the interview,

different themes were generated such as the role of budgetary and other financial information, IT and its influence, performance monitoring, continuing education and training programmes.

4.4.3 Pilot study

A pilot study refers to an examination of methods that researchers carry out before beginning their research proper, to ensure that the research instruments are appropriate and suitable to achieve the objectives of their studies (Baker, 1994). As De Vaus (1993: 54) stated, 'Do not take the risk; take the pilot test first.' Conducting a pilot study can protect researchers from the risk of failing in the actual research. Such advantages can be seen in developing the questions further to meet the objectives of the study better, in examining the suitability of the population that the researcher has chosen, in making the researcher aware of any issues that may arise during the actual research, and in providing the researchers with good training in the best way to carry out the research before it actually takes place (Holloway, 1997).

On March 2013, a pilot study was carried out in order to test whether interview as the method would work, along with the questions developed. The pilot interviews were conducted with the Head of the Accounting Department and the medical director at the KFH. These interviews were conducting using Skype due to the distance between the field of the study and the researched university. Results of the pilot study highlighted some significant issues relating mainly to accounting terminologies. Consequently, some questions were modified to reflect these issues and to make them more easily understood by interviewees, as not all Saudi clinicians are familiar with certain terms in English. In addition, the results of the pilot study showed that the interviews would take more than an hour, which was beyond the arrangement. As a result, interviews were redesigned to make some of the questions more specific and direct. However there was no major issue around the interview as a method as such.

4.4.4 Document and archival material

The study makes use of a range of documents that were collected during the fieldwork, information from hospital websites and other research in the same field as the study. Documents are widely used in social sciences research (Yin, 2013; Sarantakos, 1998). Creswell (2013) suggests that the main advantages of documents as a way of collecting data and evidence are that the researcher has more opportunity to understand the language of members of the study, and that most documents are easy to access which can therefore be more time-efficient than other methods. The disadvantages are that some of the documents are sensitive and can be difficult to access, that sometimes they may only be available in hard copy which then requires transcribing or scanning, and that if they are sourced via press or the internet they may contain inaccuracies or bias. That said, each form of document must be contextualised to be relevant for the specific purpose. For instance, news articles may not report events and stories truthfully but they may be relevant to illustrate a public discourse such as debates on HCQ or power plays between professionals.

However, writing is part of our modern world today. Policies and decisions are made in writing. Accounting is about writing records, KPIs are a form of writing, tracking and monitoring of quality is a form of writing that professionals, mangers and bureaucrats at all levels need to relate to. In other words it would be very difficult to conduct a study like this without support from documents. In fact they are a key source to inform the analysis.

4.5 Research process

This section presents an overview of the main part of the research process and how it was executed in practice. For instance while collecting material the researcher kept a log with theoretical comments to develop an understanding of what was going on. However, the three distinct phases were more flexible than presented here and illustrate the main focus of work at each stage.

4.5.1 Collecting material: out in the field

In July 2013 the practical work of the research started. This was the first of two long periods where most of the material was collected in KSA. The first lasted 3 months (ending in September 2013) and the second the year after, for 2 months (August- September 2014). These two long periods were valuable not only to collect material but also to follow the change as it happened. Collecting material is however never a straight forward matter and is also a learning process for the researcher. This study was no exception. Having fairly limited knowledge about the health care sector and its professions in particular, this was a period of gaining new knowledge and understanding. Having good access was the key to the success of the work.

4.5.1.1 Access

Fortunately, access was not an issue as it can sometimes be in empirical research. The Saudi Cultural Bureau in London and King Saud University provided official letters to send to the SEP General Department asking for support to conduct the study. The SEP General Department at the MOH, Dr Khaled Kidder, gave support within both hospitals to provide access to conduct the research. Furthermore, access was kept open until completion of the thesis. Also, at both hospitals, the managers were supportive in assisting with the organisation and conduction of the interviews and in collecting the documents required.

4.5.1.2 Interviews

In conducting social research interviews there are three main steps that a researcher should consider: recording, taking notes and processing (Patton, 2002). During the first stage of these interviews, the researcher used advanced technology such as a digital recorder, iPhone or iPad to record. Patton, (2002) has argued that the technology used in interviews does not play a significant role even in the way questions are asked. The most important thing is to focus attention on the conversion and what is being said during the interview.

However, Saunders *et al*. (2007) have explained the benefits and difficulties of using technology in the interview. The benefits can be seen in the time that the researchers have during the interview to concentrate on the interview itself and on generating questions. Afterwards they are available to listen back which helps to develop an understanding that moves beyond first impression, gives the ability to make direct quotes, and can provide a resource for future papers. However, disadvantages include the length of time spent in transcribing and translating recorded interviews, as in this study, and also in the reliability of the information that the researchers record. In some cases interviewees may feel that recordings could be used against them and therefore they do not tell the truth, which is why trust and anonymity is central to minimise such issues.

The second step is taking notes during interviews. Patton, (2002) has argued that writing notes during the interview helps the researcher in two ways. First, when the interviewee sees the interviewer writing down what he has said, the interviewee will feel the importance of what they are saying and will keep talking, and raise other points that could be important. Second, taking notes during interviews can help the researchers generate different questions that could improve the level of the discussion as well as reporting confidential information that interviewees do not want to have on record. In this research, as mentioned before, both these methods have been used. The mix helped the researcher generate different questions during the interview as well as to obtain some confidential information that helped achieve the objectives of the research.

Regarding the interview process itself, the researcher planned to conduct 50 face-to-face interviews in the hospital during working hours, with 25 interviews in the KKH, 24 interviews in KFH and one with the SEP General Department at the MOH. The materials were collected across two different times; the first was starting from July 2013 for three months and the second was starting from August 2014 for two months. However, different issues were raised during the

collection of material. The first issue was during the first period where the researcher became ill during the collection process and this led him to conduct six interviews with staff from KFH at his home after the participants kindly agreed to this. The second issue related to the language used to conduct the interviews. After designing the interview questions, all the questions were translated into the Arabic language by a professional translator. The main language of the context of the study is Arabic and the researcher obtained approval from the Essex Business School Research Director to do this. As a result, most of the interviews were conducted in the Arabic language and were transcribed in Arabic. The Arabic transcripts were then translated into English. However, some of the transcribing process was conducted without the help of a professional translator as some of the interviews contained confidential information that the researcher wished to protect. The selection of the participants was designed to cover Accountants, Consultants, Managers and Head of departments and Clinicians. These four levels of participants helped the researcher to have a clear understanding to the changes of the MA and how these practices are used to support the HCQ in the context of the study.

4-2: First and second collection of material

First data collection: July 2013 to September 2013								
	Doctor	Nurse	Medical Director	Accountant	Executive Manager	Head of department	Consultant	Total interviews
First case	3	2	1	3	4	3	0	16
Second case	2	1	1	3	4	2	0	13
Second data collection: August 2014 to September 2014								
First case	2	1	0	1	1	2	2	9
Second case	3	2	0	1	1	2	2	11

The interview material was collected as two sets: over three months starting from July 2013, and over two months starting from August 2014. In the first data collection, the interviews were conducted as follows. In the first case study, 16 interviews were conducted at this hospital, involving three doctors, two nurses, a medical director, three accountants, four executive directors and the heads of three departments. The total length of the interviews was nearly 16.41 hours. In the second case study 13 interviews were conducted at KFH, involving two doctors, a

nurse, four executive directors, a medical director, two heads of department and three accountants. The total length of the interviews was just under 14.5 hours. Also, the general manager of the SEP General Department at the MOH, Khaled Kidder, was interviewed and the length of the interviews was an hour and a half.

The second time material was collected for the first case study, 9 interviews were conducted involving two doctors, a nurse, two consultants, two heads of department, an executive director, and an accountant. The total length of the interviews was nearly 7.48 hours. In the second case study 11 interviews were conducted at KFH, involving three doctors, two nurses, two consultants, an executive director, two heads of department and an accountant. The total length of the interviews was just under 9.25 hours.

4.5.1.3 Documents and archival records

A range of documents from different sources and periods were included that were directly or indirectly linked to MA change and HCQ. Some of these documents could be defined as 'formal' and strongly linked to the management system in place or in change, especially where the professionals were producing these as part of their responsibilities and as part of the power game. Documents were collected which were directly suggested by the interviewees as important (see appendix B). Below is given in detail the method of interviews chosen, the themes developed and the documents collected.

In relation to hospitals this included: copies (soft or hard copy) of organisation charts of both hospitals and their relation to MOH, monthly hospital statistics reports, hospital annual financial reports, old and new performance appraisals, monthly reports, pricing reports, employee contracts, job descriptions, training and education plans and the material used during training, and other reports published by the hospitals. A set of pictures was also taken, with permission, to document and illustrate specific events and settings. External documents included: the MOH

structure and its relation to the government and hospitals, the national expenditure budget and 5 year plans, new essential standards such as the JCI standards, and quality reports published by the WHO. These were selected as they framed the rules based context of the hospitals. Also included were reports on social media as HCQ became a public issue for debate and this illustrates one of the other external forces in play. The documents were either collected because they were publicly available such as on the Internet, or participants when asked during interview provided them.

4.5.2 Analysis and theorising material collected: at the desk

With the relevant unit of analysis in focus (Patton (1987:51), interviews with clinicians, management team, consultants and accountants were conducted in two hospitals in KSA. The analysis has very much a general principle found in social studies research, that is reduction and (re)organising of material, display of the material, and conclusions. The main part of the analysis took place once most of the material was collected (Miles and Huberman, 1994); however analysis has been a constant part of the process. Guided by NIS, isomorphism concepts and the themes developed, this research was looking for both regularities of pattern and a range of experiences at the same time. In principle the process was characterised by a focus on the themes as found in the literature, and then questions were asked of the material that would challenge the picture at hand, which resulted in a revision. During this process there was a constant interplay between different types of material to check and cross-check. This process continued until the possible explanations had a maturity that held for further critical questions.

More precisely, all interviews were transcribed and translated from Arabic into English (see ‘Interviews’ above). However, any translation issues were noted as open for cultural significance, and original tapes were listened to several times as the theorising developed. The analysis also included the researcher’s former diaries, notes and questions raised at the time. Theorising is a

matter of organising the material so that the reading raises questions, and then re-organising it in order to find answers and develop a pattern of 'what is going on' and 'what can explain it'.

The interview material was great in quantity, and so after several careful readings and listening back to recordings, summaries were created and then the material prepared in order to use NVivo software for analysis. This is helpful when many of the questions are similar for a range of interviews as this study shows (Scapens 2004:270). It is also helpful to make data more readable and understandable which is important for the analysis (Berg, 2004; Miles and Huberman, 1994). However, it was not only interviews that were prepared for NVivo. In fact the analysis of *all* the material collected including interviews, pictures, webpages, organisational charts, monthly reports etc. (see 'Archival and documents') was entered into NVivo as an open coding based on the main themes, paragraphs and sentences. This helped the reading of the material as a first stage in the analysis (Yin, 2013). The NVivo programme has great advantages as it helps manage and organise large amounts of data and therefore decreases the analysis time. However, Bazeley, (2013) has argued that while this kind of computer program is very helpful in data analysis it includes a huge risk as a small mistake could result in the analysis missing very important components of data. This was particularly helpful at the start after the initial collection of material in 2013. NVivo helped me to create an overview of how the material was linked in terms of themes.

A traditional factor influencing change (as seen in the literature) is the link to different forms of isomorphism. As mentioned in the previous chapter, the main argument to the NIS is its *institutional isomorphism*, and using such theory is helpful in investigating and analysing the institutions in the context of their existing forms and behaviour. According to the context of the study, there are different factors that have influenced the Saudi public sector during previous years such as economic and political systems, education and IT. The main focus of the NIS is the

relationship between the institutions and their environments, and furthermore, it provides interesting insights into the functioning of public institutions such as health care centres and hospitals (Selto and Widener, 2004).

The material was analysed and then questioned as to how the theme corresponded with either of the concepts described in chapter 3. Sometimes it was in one way, sometimes two, or it varied depending on the context and how MA changed over time. In other words the concepts worked as a guide and an outcome of analysis. It was important to let the material 'lead' the way. For instance education was often linked with *normative isomorphism* and IT and computer systems developed in different contexts and countries could be *mimetic isomorphism*. Applying the concepts to the material provided a way to theorise MA change and explanatory categories.

After the first collection of material, some re-organisation allowed development of and challenges to ideas, and then the first preliminary outcome was reported. The writing of the report helped clarify areas which needed further investigation, and in the 2014 interview phase follow-up questions were then asked previous interviewees on specific issues. At this point NVivo was no longer used as it had given an overview of links within the material and made it workable, but was less useful in identifying nuance. Again a phase of constant interplay between documents and interviews took place, checking sources and asking hospitals for clarification. Notes were also included as part of theory development. Additionally, during the research process it was important to be open to surprise, and one such surprise was the significant multi-cultural influence of the MA change process. Finally, the theory was developed to give answers to the research questions.

4.5.3 Writing up an argument

The organisation of the argument of the thesis follows in many ways a traditional structure, in terms of type of chapters and their order. The argument is constructed from the discussion and

material presented around the ‘bigger’ picture and the ‘smaller’ picture. The first focuses on key factors as an overview of influences on MA change, starting with (i) what was there before the old and the initiatives and the problematizing of the new, (ii) how the institutionalisation of MA change was made to happen (or not), and what factors were in play. These factors are characterising into for main group which are:

- Governmental regulations and recourses (including: financial resources, regulation, management and decision making and structure).
- Informal non-governmental discourses (newspaper and social media).
- International-national state interfaces (medical standards and MAPs).
- Professional development and involvement (education and western employees).

(III) The next level of argument presenting and discussing how HCQ was adopted (or not) and the main vehicles to make that happen as part of the power game played within the hospital. Each chapter ends with a discussion on the significance of MA as a solution for HCQ. Each empirical chapter is part of the overall story and argument, and each case study is linked to the other and is analysed in a similar way, with the second case building on the first. Chapter 7 is where the main argument and discussion come together, critically discussing the weight given to factors under investigation and forming the main theorising. The chapter ends with the main conclusion.

4.6 Ethical considerations

There are many ethical points the researcher has given attention to while conducting this study, including obtaining informed consent and maintaining confidentiality and anonymity, to make sure the study meets the standards of academic research. Regarding consent, before each interview the researcher gave the interviewed participant a formal consent form explaining the participant’s rights during and after the interview. This document included some information about the researcher, the project and the research objectives. By signing it, each participant

attested that he or she was informed of and understood the purpose of the study, and understood that he or she could withdraw from the study at any time without prejudice, even after the data had been collected. Each participant was given the opportunity to ask questions about the study procedures before signing the consent form. After all interviews were transcribed, the researcher returned the transcript of the interview to each participant, giving them the opportunity to comment or amend, or withdraw from the study. Furthermore, after the researcher analysed the data, he went back to KSA and presented the results and findings to 17 of the participants and Saudi academic staff in the Accounting department, King Saud University in order to receive feedback from a qualified audience on the results and findings.

In terms of confidentiality, participants were informed that all information collected during the interviews was kept secure and was only accessible by the researcher and his supervisor. Specifically, the collected data was stored in the researcher’s password-protected PC, including written material (field notes and documents), pictures, and tape recordings. No one else had access to the computer. Also, hard copies of the material were stored in a locked cabinet, and the researcher personally transported all material back to the UK, where it was kept in another locked cabinet at Essex University. To protect their anonymity, participants were informed that any individual statements would be cited using a participant number or a pseudonym, and all identifying details would be removed. Even after the collection of material, confidentiality and anonymity of the thesis was maintained in order to avoid any ethical issues. The ethics boards of two organisations have approved this research; the University of Essex, where the researcher is studying, and the department of SEP at the MOH in KSA, which manages access to the SEP hospitals in the context of the study.

4.7 Conclusion

This chapter discussed the methodology and methods for studying the MA changes in the SAPHS, using NIS and its concepts (DiMaggio and Powell, 1983) for interpreting, describing, and analysing the material. The two main methods were semi-structured interviews and document analysis and discussed at length. The chapter also discussed the case study as a research design, as a way to gain an in-depth understanding of a specific phenomenon of MA change and HCQ. However, to be able to draw further insights and develop explanatory power, two case studies were strategically chosen representing similar drivers in having to adopt HCQ and MA change but with very different experiences and backgrounds. The chapter then presented the key issue of access, and an extensive discussion on how the collection of material and the analysis and theorising was carried out. The two Saudi Hospital case studies included face-to-face interviews with management accountants, consultants, management staff and clinicians. The research also analysed the documents used in managing human and financial resources within SEP hospitals. This was then followed by a discussion of presenting the argument as a text, and finally key issues regarding ethical considerations. Chapters 5 and 6 present the results, followed by final theorising in chapter 7.

4-3: Summary of the research design

Level of decision	Choice
Epistemological and ontological assumptions	Interpretive
Research strategy	Multiple case studies
Research Techniques	Semi-structured interviews Document analysis
Hospitals selected	KKH KFH
Sub-units of Analysis	Hospital
Timeline	July to September 2013 August to September 2014
Subject	Changes of MA to support HCQ
Theoretical Framework	NIS

Chapter 5 : The First Case Study: KKH

5.1 Introduction

This chapter will discuss and present KKH as the first case study, using the following analytical categories: (i) governmental regulation and resources, (ii) informal non-governmental discourses, (iii) international / national state interfaces, and (iv) professional development and involvement in the hospital. The discussion is divided into three main sections. The first includes a brief presentation of KKH, the wider institutional context, changes in the hospital's structure and objectives, and emerging SEP and SEP reforms. This is followed by a detailed view of three periods of key MA change, and finally a conclusion of the main argument so far.

5.2 From old to new MA: an overview

KKH was established in 1984 as an eye specialist hospital in Riyadh with a capacity of 220 beds to provide high-quality ophthalmic care. Today it is a 250-bed hospital and is the largest ophthalmic tertiary referral center in KSA, as well as providing health care education and conducting research. There are more than 1,200 full-time employees, including over 300 nurses and 101 doctors. Initially, despite being a state owned hospital, its medical operations and management were delivered by AMI Saudi Arabia, Ltd. Formally this arrangement took shape as a contract (CM) between MOH and AMI where MOH managed the contract based on the specification by AMI to deliver what was needed. The reason for such an arrangement was to quickly solve the urgent need of good health care in KSA through the establishment of 5 state-owned hospitals (of which KKH was one). AMI was established in 1981 as a result of a joint venture between American Medical International of the US and XENEL Industries to ensure that qualified expertise could deliver what was needed. For KKH this meant that management, accounting and medical staff were chosen and sanctioned by AMI, except for top management where AMI was represented. In practice this meant that the structure and the processes in place much reflected AMI's way of working. For instance it meant that the accounting practices in use

had mostly a financial reporting focus and internal managerial had a clear costs focus, to run and track the performance of each hospital, to support AMI's overall business ambitions. In 1988, AMI became 100% Saudi owned and still part of the XENEL Group but could now also provide contract-based management and health care services for big insurance companies as clients, which KKH also started to do.

From 1988 and in particular the period leading up to 2007, there was increased pressure building within the media and social media for radical change regarding HCQ. Health care statistics, including those for KKH, showed that the quality was not up to standard. For instance 25,000 patients were waiting for treatment. One reason for this cited lack of quality was that the SAPHS was too centralised and hence lacked the understanding and flexibility to be responsive to the actual requirements of human and financial resources within its hospitals; it became an inflexible and ineffective system in meeting the needs of the population. One other reason given was that some public hospitals which were managed by the CM, as implemented in various hospitals in 1984 such as KKH, failed to achieve satisfactory status (Alfalih, 2008).

> The CM has resulted in huge corruption in health care services. Basically, these hospitals have become to treat just for basic diseases such as cold and flu. (Consultant 1)

In 2007, the Council of Ministers approved a new programme, the SEP, to find a resolution. SEP transferred the authority of managing human and financial resources from the private companies (who then managed the hospital) to the new hospital management team. KKH was one of the first hospitals to be included is this major reform. One of the first things that happened was that MOH discharged the contract with AMI that was in place since 1981. For KKH this meant becoming part (in practice) of a new (MOH) management structure for decision-making and delivery of health care (more on this below). The responsibilities of managing the hospital were now those of the hospital's board of directors, given the SEP frame (see appendix D).

Following the criticisms from the MOH, KKH was chosen to be the start of major improvements in SAPHS, addressing such issues as the economic position being prioritised without any improvement in health care services, and a lack of control over clinicians and operations. Those issues led to high numbers of medical errors and accidents, low standards of patient safety, few qualified medical employees, and low standards of medical quality. In 2007 when MOH broke the contract with AMI they gave the responsibilities of managing the hospital to the hospital's board of directors. Regulation and resources as defined by SEP played a dominant role for KKH especially at the time of the implementation in 2007. This initial phase included a new structure, administration and management, and as the AMI management team was replaced by MOH staff, so new processes were introduced using a local bottom-up-built budget under approval from MOH. Thus was created a new role for MA to enter the scene, combined with accountability involving and linking staff and their responsibilities at different levels. The earlier finance reporting perspective was deprioritised and the internal perspective, which was previously absent, took priority. However the MAP setup, its tracking, and monitoring performance evaluation were separated in reports and discursively from HCQ issues at least for the time being. For instance HCQ was carried out as patient satisfaction feedback sheets, which were then put together and analysed.

However, at the same time KKH SEP initiated collaboration with JHH. This helped the hospital improve its medical and management practices by transferring relevant practices and qualified employees from JHH. This (international) professional development also led to an interface between international states to exchange ideas and best practice. As mentioned above KKH now has more than 1,200 diverse full-time employees; however at the time of SEP in 2007 this staff was less diverse with medical staff principally coming from Egypt, India and Philippines and accounting staff from India. Once the MOH took over the management in 2007 the hospital started to employ people both from KSA and the US, MOH staff withdrew and the diversity

increased as skilled staff was sought. JHH provided a significant number of clinicians, many from the US, and the MA accountants were a combination of people from KSA and India. When the executive manager of medical services, who came from the US, was asked about the number of staff and their qualifications in relation to achieving hospital objectives, he answered:

> The movement from past to present requires huge efforts in terms of both employees and budget; therefore, we have employed a great number of medical staff from different countries, educated the most recently hired employees and implemented advanced IT and management practices to ensure that the people who work at the hospital and the technology we use are helping to meet the international medical standards, as well as the expectations of the patients.

The executive manager in his response showed that the hospital was keen to change, and at the same time it also suggests how professional development and international interfaces were on the agenda for KKH. As Chang (2006) suggests, this form of NPM could be seen as a way to embrace local needs across KSA. Therefore, the new objective for KKH and all SEP hospitals was to link management changes to the changes in the broader context of public accountability and better HCQ for the KSA population.

While the regulation and financial resources were key issues, they remained in the background through the study period, making way for dynamic interplay between professional and international interfaces regarding medical and MAPs. JHH hospital with its expertise became a key ally, with their accountants being trained in the latest models abroad. New staff and education became a vehicle for change for how to become a new medical or management accountant professional. At the same time, new staff also carried new ideas about medical quality standards through the Joint Commission International (JCI) and as such brought in international interfaces. JCI was accepted by the SEP and in 2007 KKH started major work to implement these HCQ standards, and then in 2009 they were accredited. However, this was not enough. The standards were also to be linked with MA explicitly as a form of a joint

accountability using KPIs as the main vehicle. Building on the monitoring and performance structures and processes already in place a new role of MA emerged, where every aspect of HCQ had a cost/benefit, target and accountability aspect. This was also the reason for the resistance among clinicians in 2010 where KKH became a battleground for influence (more on this below). However, the medical standard and MA duo were here to stay. In fact, by 2013 the solution expanded to create a benchmark, which all (SEP) hospitals had to be measured against and make visible to the public. It was also at this time that non-governmental discourses started to shift. First of all it was clear that KKH's HCQ had improved but why stop there? Was it not possible to ask for more?

In addition to implementing the SEP, again the financial aspects took priority as the government increased the budget of the hospital in order to meet the programme's objectives. For example, in 2014, the KSA government increased the budget of the SAPHS by nearly 8%, which equates to USD$29 billion, and in 2015 by USD$42.7 billion.

> Achieving high HCQ and low prices at the same time is not currently possible; therefore, the recent evolution of the methods of management within the health sector focuses on the first part [which is quality]. (Head of the financial department)

According to the interview with the general manager of the SEP, its implementation was thus far moving in the right direction. Everything being done was based on the plans and strategies. Follow up studies have been conducted to ensure that the programme responds to non-governmental discourses and demands for a high HCQ that is equal to those of other good hospitals around the world. However, Kidder mentioned that the programme still faces some difficulties in implementation, such as finding qualified employees and developing a strong work environment. Still, the programme needs time to be implemented in all of the hospitals around the country and to meet its objectives effectively.

> Difficulties, such as employees, equipment and work environment, need huge funding to be solved, and this is the reason the budget for the sector is always increased. (Consultant 2)

It is clear that since 2007 the role of MA at KKH changed several times towards quality integration. That said, there are on-going adjustment issues in play, not least how more hospitals are included under SEP every year. But what is clear is that MA has taken a central role as part of a new structuring and processing, as such transforming HCQ. The following analysis will explore further areas in this dramatic change.

5.2.1 Power of the political and economic: regulation and resources

The political power in any country plays the principal role in changing its public organisations, and such changes in most cases are intended to resolve issues that the organisations face. Unintended consequences, however, sometimes occur with such changes. Such is the case in the context of KSA; the health sector in general and this hospital in particular had faced various issues that placed the MOH under pressure to change its methods of operating public hospitals. The new methods were to ensure that the sector was meeting the demands of the public and that it remained in line with the country's overall development ambitions.

The first issue was patient satisfaction and their acceptance of hospital services. According to social media and public reports, under the old style bureaucratic method of management KSA hospitals could be seen as health centres that did not meet the demands of the public. That public perception showed the failure of CM to manage hospitals. The public reports also mentioned that, over the last few decades, the government had spent billions to improve public health care, but in reality there had been no improvement in the health sector within the Kingdom.

> The MOH implemented the CM because it believed that this system has created great advantages in different countries and that it should be the same within our context.

> However, after 20 years, the MOH realised the failure of this method of management, which resulted in public dissatisfaction. (Consultant 2)

From this it can be seen that the government was under pressure to change, especially after the failure of the CM to operate hospitals, and that it used its power to change the sector by implementing the new reforms that would meet the public's demands and reduce strong criticism. Furthermore, according to the objectives of KSA's national plan nine which addressed social service issues, including health care, the government implemented a number of reforms and measures. Such reforms, like SEP, can be seen as a form of collective *coercive isomorphism* for those hospitals that were selected in 2007. The reform ambition was to enable the public hospitals to deliver high HCQ with increased patient satisfaction; in short a population cared for.

> Most of the changes that have taken place at the public hospitals are actually driven by the government to improve access to health and social care services for all citizens. (Head of the financial department)

The second issue that received extensive attention was the fact that while the economic position of the country has improved, the public sector has not witnessed the same improvement. KSA has a very good economic position; for example, the MOHE has improved its universities in line with KSA's growth and during the last decade the number of major public universities has grown from 8 to nearly 25. However, despite all of these improvements to the economy, until 2007 public hospitals such as KKH were still struggling to match the country's progression and an interview with one of the managers illustrates one of the reasons.

> The major issue with the public hospital is how to manage the budget and to use it as a way to guarantee the improvement of the hospital. The company that was operating the hospital is focusing on their interests, and the role of the MOH in supervising these companies was really poor. (Management 4)

However, it did not take long after the implementation of the SEP for the hospital to experience significant improvements due to the support they were given.

> This hospital has very advanced medical equipment and technology compared to those of other countries. Basically, the current hospital management tries to support us with everything we need to do our work, and this is because of the strong support from the government. (Executive director)

Also, an American nurse who just started at the hospital mentioned:

> What I find here I did not find in the US. The hospital does not have any financial problems, and anything we need to improve our work, we get. We have, at the hospital, very, very, very expensive equipment, and this equipment is much better than the equipment in US hospitals.

It is clear that the economic improvement of KSA has had a great influence on the SEP hospitals; however, this influence varied from hospital to hospital, depending on the methods of management.

> The hospital strategy is focusing on quality rather than the financial aspects. Therefore, the hospital has implemented different accountability practices to use the financial and human resources in the way that help to meet the strategy's objective. (Head of human resources)

The third issue facing KKH before SEP was the lack of control over operations.

> In the past, the role of the MOH in controlling and supervising the hospital was very limited, and this led these companies to focus on their interests, rather than the MOH's interests. (Head of medical department 3)

Before 2007, the MOH focused on simply providing health care to different regions of the Kingdom, without any focus on the HCQ. Perhaps this was not surprising given the urgent need for health care in the early 1980s. The MOH put trust in companies with international reputations and track records with other health care institutions. However, after the MOH acknowledged the

un-intended consequences of the CM and the conflict between their objectives and those of these companies, it implemented a new reform. The director of the hospital identified the changes in the hospital's objectives as follows:

> In the past [before 2007], the main objectives were providing health care at a very low cost. However, this has changed; at the moment, the objective is providing high HCQ to ensure the satisfaction of the patients and to meet the international standards of health care, such as the Joint Commission International (JCI).

Accountant 2 also discussed the issue that led to change when the hospital became self-operating:

> After the management shifted to SEP, most of our practices changed, especially when the decisions became decentralised. At the moment, we are working under a great supervision environment to ensure that the social objectives are met.

There is no doubt that the Government's ambition and its strong economic position has had a strong influence on KKH's MA change. The structure allowed for a budget to be locally created yet discussed and approved at the top, and this alongside with integrated general accountability and constant reporting on targets was a form of *coercive isomorphism*. The Government's 5-year budget objectives were to be fulfilled with a special focus on social reforms. However, while hospitals which were to be regulated by SEP were applying the new frame of structure and processes which combined and respected the medical and administrative hierarchies (Aidemark, 2001), it also provided opportunities for staff to engage in new ways, to develop their skills and ambitions, and to provide health care in new ways as there were financial resources as long as the targets were met. New equipment, new IT, new staff, new training, new concepts and discourses started flourishing. This meant that over time what was first a *coercive isomorphism* in its form changed and became more accepted as a way of how things should be done, to a form of *normative isomorphism*. There was now more of a consensus in terms of the ambition for quality. For instance, when the new JCI standards were implemented in 2009, the exchange

between professionals at KKH and MOH as the international interface was to a large extent similar. It was also clear that the old style of bureaucracy at MOH and KKH had started to change. With the new structure and process in place new skills were required at both ends. If a budget were to be set locally and be reviewed and monitored at the top, it had to rely on new forms of bureaucracy which were more professional than before.

5.2.2 Informal non-governmental discourses and patients

Informal non-governmental voices also played a role in designing and selected the accounting system and putting that system into practice. After SEP was implemented in 2007, views coming through from social media and from patients themselves helped external and internal users of the accounting information to measure and control the performance of the hospital. Therefore, the focus on the needs of patients became the main guideline for all practices, processes and activities at the hospital. The hospital's management started to collect relevant information regarding patient satisfaction, including patient comments and complaints about the services provided. It was a start.

> The most important thing we work to achieve is the satisfaction of the patients, which we do by providing them with the best standards of health care services. The MOH has put strong attention on patients and their needs through the slogan that has arisen "Patient First" and all of us at the hospital use this as our main objective. (Head of patient relations)

In managing the work of the medical staff, the executive manager of medical services also gives patients first priority, stating:

> We are here for treating patients, so the patients' needs and their feedback are the main things that I focus on when I make any decision. I know that the financial aspect is also important, but what the hospital is aiming to do is to improve the HCQ, not the financial aspects.

The main problem facing KKH was the satisfaction of patients regarding services. As a result, the power of the patients and the public discourses in the media and social media became the driving force behind every demand for new management practices; discourses being heard not only at KKH but perhaps more importantly at SAPHS and MOH. The issues, according to a financial analyst who works in the MOF and specialises in governmental budgets, included:

> SAPHS does not have any issue with funding, and the recent budget is at a level that can help create the best health care in the world; however, the problem is actually with the method of managing the public hospitals.

In order to improve its services, the hospital opened new departments, one of which being patient relations. The aim of this department is to resolve patient and visitor issues such as medical, technical and administrative problems. The department is also responsible for collecting relevant data from patients and visitors about the services provided by the hospital, analysing this information and providing its analysis to top management on a monthly basis.

> The main duty for us is that we are the voice of the patients in the hospital, and their issues and comments are the main input to our work. (Head of patient relations)

The quality and performance department (QPD) was created to address the quality of the services patients receive, as well as making sure that these services are up to the medical standards implemented worldwide. This was where the Management Accountant worked.

> New departments, such as QPD and the patient relations have been opened. These departments measure patients' satisfaction with the procedures of the medical work, the performance, the relationships between departments and the quality of medical services…This is done through the implementation of different accountability practices. (Head of QPD)

The duties of QPD can be broken down into two main areas. The first is to set quality standards for all levels of the hospital. These standards may include hospital standards, quality standards

set by the MOH, international quality standards or a mix of all three. The second is to supervise, control and measure the activities of departments and employees to ensure that the standards are fully followed and provide the top management with the information that will help them with decision-making.

> The role of QPD can be seen in all of the levels of the hospital, and they do a great job of creating the best HCQ in comparison with that of the hospital in the past or with that of any other hospital. At the moment, the managers and the committees are able to direct, control and manage operational activities easily by using the information that the department periodically provides. (Doctor 2)

The Chief Executive Officer also stated:

> The movement from economic objectives to social objectives has improved our quality. The QPD and their measurement practices for medical services guide us in building a solid foundation for creating the best HCQ in comparison with other hospitals.

As mentioned earlier, the public discourse on HCQ was affected by how HCQ was visualised and reported. Even if KKH did not explicitly talk to media, they did have direct communication with patients. By the time a benchmark was created which all SEP hospitals were to be measured against by 2013, the strongest critiques were addressed as it was clear from the publicity they put out that the HCQ had improved and had also created ideas for other possible demands. While this analytical field (informal non-governmental discourses) is perhaps not a main stream category with NIS, and is perhaps even less common in defining forms of isomorphism aspects, it has however been very clear in this study that the discourses in the public domain were a powerful influence. It was of such strength and consistency that it could not be ignored and as such *coercive isomorphism* is the best description.

5.2.3 International and national state interfaces: JCI and IT

One of the most important elements to achieve the objective of the new reform was the acceptance of new ideas. Under this analytical category there are two significant ideas that emerged from the material in the area of HCQ JCI and IT which was adopted by KSA as part of their overall plan, and which also significantly affected KKH. While it could be argued that MA is also part of this story due to how it relies on IT via systems such as ERP, instead a close up revisit of MA change will be presented in figure 5-1; this will provide a tight analysis of the dynamics in the role of MA change during the period 2007-2014.

5.2.3.1 Joint Commission International

JCI was accepted by the SEP to become the standard for HCQ. JCI is a global accreditor for international medical quality standards, who analyse current best medical practices worldwide and turn them into ‘Gold Standards’. These are then published, and used to direct quality work when adapted to local care. The organisation is staffed with medical experts from five world regions[7] and it works mostly with national health care agencies dedicated to improving HCQ. While medical organisations in the US are not accredited by these standards, they directly influence the standards through their expertise and sitting on panels. Major work was being done at KKH to implement these HCQ standards right from the start in 2007, as staff from JHH were already familiar with these standards and also given SEP’s decision to adopt the ‘best’ international standards and give accreditation for all SEP hospitals. In 2009 KKH was awarded their ‘Gold Standard’ accreditation. It was clear that the best practice was to lead the hospital’s HCQ sufficiently to meet its customers’ needs and the MOH requirements.

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[7] These are Latin America and the Caribbean, Asia and the Pacific Rim, the Middle East, Europe, and the United States http://www.jointcommissioninternational.org/about-jci/standards-advisory-panel/

> The implementation of the JCI standards gives the hospital more control over the quality aspects, and helps to compare the outcomes of the hospital to those of other hospitals, as well as to enhance patient satisfaction. (Head of QPD)

It is clear from the previous point that the hospital benefitted from its implementation of the JCI standards, as it affected the hospital's internal and external stakeholders. Concerning internal stakeholders, the standards helped hospital management and medical staff to achieve and enhance patient satisfaction by following medical practices that have been adopted worldwide. Concerning external stakeholders, the standards gave patients and the public in general more trust in the hospital's medical practices. But as the JCI standards are always being updated they had to make sure they were doing the same. This was a major improvement from the days of collecting feedback sheets from patients after treatments at the hospital. JCI was concerned with preventing quality issues before they happened, measuring the outcome against standards including feedback from patients, and thereby ensuring further improvements. JCI was also very much a device for the public to see.

> When the JCI standards have been implemented, the majority of the patients will have more trust in the services we are providing to them, as they believe that those standards reflect high HCQ. (Head of medical department 2)

However, the road towards JCI was not easy. It is one thing to achieve an accreditation, and as seen with KKH this takes a lot of effort, training, discussion and paperwork. During the period 2007-2009 this was a major issue for KKH not least as they were one of the first to adopt SEP and hence served as a raw model. But perhaps more importantly once accredited it is important to maintain standards and therefore accreditation examiners re-evaluate every three years. This meant that after 2009, all medical staff was required to adhere to the infrastructure in terms of training, practice and handbooks. Hence SEP's support and MOH budget was essential to give support with the financial resources required. The executive manager 2 noted:

> The objective of the hospital is providing HCQ accomplishing this requires, at the least in the beginning, a massive expense.

Moreover, accountant 2 stated:

> Financial resources are one of the main aspects necessary to improve. However, in the hospital, financial resources are not one of the important factors, as long as the hospital is 100% funded by the KSA government and, honestly, the government fund meets the needs of the hospital and its strategy.

Financial resources to this end were no problem. In fact the budget for the health sector in KSA has increased over the last few years, with health care becoming the second-largest government expenditure. HCQ rested on the adoption of JCI standards.

5-1: Ministry of Health's development budget

Ministry of Health's development budget										
2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
27.1	31	39.5	44.4	52.3	61.2	68.5	86.5	100	108	160
1= Billion Saudi Riyal						1 US dollar = 3.75 Riyals				

The last and most important advantage of the implementation of the JCI standards is that it helped the government to compare and control the HCQ at the SEP hospitals and make sure they were on target for the nation as a whole. It also helped the government monitor (via SEP) the requirements for HCQ at hospitals so that they could be comparable to worldwide hospitals. This once again meant that it required the SEP bureaucrats to have the required knowledge and to become more professional. JCI was and is a major influence on all involved, from patients, to possible patients, to every staff member in SEP hospital and SEP itself; new knowledge, new practices, more training and new resources. With a new IT system in place in 2010 it was easier to collect the information needed, and disseminate and visualise their ambitions, effort and outcomes.

SEP urged the need for adoption of JCI which could be seen as a *coercive isomorphism*. However, with the decentralised frame and new and better-qualified and motivated staff in place, HCQ became part of their normal way of working. These concepts can be seen as *normative isomorphism* at the KKH level. It may be argued that at a national level it is better characterised as a *mimetic isomorphism*. JCI was clearly linked to professionalism and became a key idea for various hospital activities such as training and educating current employees and collaboration across professions. But it would also be attracting more highly qualified employees from developed economies and attracting Saudi employees who graduated from universities in Western countries who have valuable experience in HCQ.

5.2.3.2 The improvement of IT

In 2005, the KSA government undertook IT improvements in an effort to move towards a more modern way of working. This improvement led public ministries and organisations to implement the electronic systems that they required and to link these systems with users. Alongside this change there was also a change of old-style bureaucracy at all levels, not least because the IT changes also rested on new ideas of administration and the skills that required.

5-1: Framework of the electronic systems

The MOH implemented IT systems both internally and in most of its hospitals in 2010, including KKH, as a part of a new strategy for the next 10 years under the “Patient First” slogan. However, the head of the IT department mentioned that the success of the implementation of the IT system

comes from qualified employees who are sufficiently educated to use the new system. He also mentioned that, as part of the system's implementation, training courses were critical to achieving the system's objectives. Therefore, various courses were designed to train employees at different levels about the use of the system and how to use the outcomes. There were also those who were resistant to change. The reason behind this is that, as the head of the department 4 noted,

> Using advanced systems forces corruption to be controlled and this is not acceptable to most of these people.

Moreover, some of the more 'traditional' employees who had worked in the hospital for more than 20 years rejected the new system because they believed that they were too old to learn new things. They also believed that the implementation of such technology could influence their careers and that they could be forced to retire.

> The IT system being unacceptable to the oldest employees, since most of these employees do not wish to change their work patterns after several years of doing the same things. (Head of the IT department)

It was necessary to improve systems however in order to generate the information needed to manage the hospital. Or as expressed by staff from within the system:

> All the practices are based on IT; therefore, the results become more accurate and available to use for the decision-making process and control. There is an important thing I have to say: to be fair, there are some top managers who help us a lot in implementing new systems and modern practices, and their help can be seen in their support for our budget every year. (Head of IT)

> Implementing new IT and new MA Enterprise Resource Planning (ERP) systems also influenced the practices and roles of the accountants, who were required to take more advanced training courses to do their jobs using the new technology. (Head of the financial department)

> The improvements to IT and to the programmes we use have required employing new accountants, who are familiar with recent technology, and training existing accountants to give them the skills they need to operate the new system accurately. (Head of the financial department)

> The improvements to IT also influenced the roles of management at different levels, starting with top management and continuing with the heads of various departments. With the recent improvements, decision-makers were able to obtain high-quality information at the right time, helping them make effective decisions and control performance. (Executive manager 3)

> With the recent IT we have, the roles of managers have become easier than before, since we can get the information we need so quickly and in forms that are easy to understand. Also, the heads of the departments can measure their productivity and evaluate their departments and employees using these programs. (Executive manager 3)

However, various issues, such as the languages used within the electronic programmes and communication, affected the performance of Saudi managers who did not speak English. Most IT programs are implemented by contracting international companies that use English as the main language for software and programming. Executive director 2 stated:

> Some of the top management teams and employees are graduated from Saudi universities, and they find it difficult to use the information systems, as well as to communicate with the international medical staff, because they did not learn English. This issue has influenced the efficacy and effectiveness of management.

However, the new IT in place intensified the link between MA and HCQ via KPIs. It linked the internal perspectives of each hospital via MOH to an outward-facing coherence and perspective on HCQ on a massive scale. This new system aimed to help users through different services, such as the voice of the citizen, electronic medical services, management systems, employment systems and medical staff services. It allowed internal and external users such as patients, MOH

and MOF to control and organize hospital activities. From a patient perspective and according to the MOH (2014), the new IT strategy supported the MOH goals in the following ways:

- To Care For Patients.
- To Connect Providers at all levels of care.
- To Measure the Performance of health care delivery.
- To Transform Health care Delivery to a consistent, world-class standard.

Their website gives an illustration, as below, of how the new IT system is claimed to have contributed to different levels of management in the public hospitals. The public are now informed that all SEP hospitals can manage their areas of responsibility effectively because they now have all the information available in a dashboard of up-to-date performance indicators, automatically captured at the point of service, with no delays or manual processes to acquire the information.

- Drill down into the source details of data appearing on dashboard (e.g. by facility, region, provider, etc.) to explore problem areas.
- Compare their area's performance against similar business areas.
- Access comparative data from other countries.
- Be alerted to emerging trends in service delivery, patient conditions, etc.
- Electronically communicate and collaborate with their co-workers within the MOH, other KSA health organizations, and other international health organizations.
- Control costs and demand for services, by preventing unnecessary or duplicate services being delivered at the front line through IT system controls.
- Communicate policies (electronically) to all those affected by the policies, and either enforce those policies or report on when they are not being followed.
- Perform advanced data analytics, including the ability to do "what if" planning.
- Share information with other health delivery organizations in KSA, regarding the delivery of services to patients that we mutually serve

It is clear that in 2014 (with the new IT technology, building on the SEP frame) the intensification of accountability for all involved in SEP in all areas reached new levels. Key measures on quality and targets across hospitals were now available to anyone at any time. Moreover, the new system also provided such services as registration, scheduling, summaries of

patient medical information, laboratory tests and results, results of x-rays, results from the pharmacology unit, and results from ambulatory care clinics.

> During the last few years, we have had a great improvement in IT, which has led to changes in most of our practices and has made our work more effective and the same as any hospital in western world. (Head of IT)

The head of the medical department 2 noted:

> Hospitals, at the moment, are using highly advanced IT that is implemented worldwide and this has changed our practices and made the procedures of doing our work different, compared with the past.

Doctor 1 said:

> Each patient has an electronic file number, which helps a great deal in the process of our work (rather than paper files, which caused many medical mistakes). Also, the IT helps us improve our practices, from meeting the patients in the main reception area to giving them prescriptions. Honestly, the main reason for the reduction in the number of people on the waiting list this year to the year before is the use of this technology.

There are several ways to define this analytical field in terms of isomorphism. Given that the new IT was considered later in the reform process (2010) when the structure and processes were more or less in place and progressive ideas on quality were being accepted, it was not a challenge to put in place; staff at both KKH and MOH were actively seeking best practice as a way to improve performance. Seeking the best in IT practice is an international issue but in this case it is also a *mimetic isomorphism*. It was clear that enough staff had analysed how IT best practice had succeeded in different organisations worldwide, and therefore, it can be argued that the hospital, without influence from MOH, had imitated international IT management. However, all IT and ERP implementations require change of practice if they are to support the role of

management and financial accounting in becoming more effective and efficient. As they were built on the SEP framework, they merged and intensified with MA and HCQ.

5.2.4 Professional development and involvement

One of the first decisions that the SEP had handed over to managers was that of employment. Currently, the hospital has the ability to contract any employee who can benefit the hospital in meeting its objectives. One key aspect in improving quality was the employment of highly qualified human resources and their involvement as employees. This point has been seen as focal in improving the HCQ in the eyes of the MOH and the hospital management.

> The SEP seeks to enhance and improve the levels of employment programs through the optimal exploitation of human and financial resources, in order to contribute to providing high HCQ to patients. (SEP's general department)

> The employment system is one of the main issues that the hospital faced in the past. However, the SEP is solving this issue by helping to fill the deficit with which the hospitals were faced, especially in rare medical specialties. (Executive manager 2)

> The qualifications and experiences of the medical staff and employees are central to achieving a high HCQ, for example, the executive manager of medical services, who comes from JHH and the financial manager, who comes from the banking sector. (Head of human resources)

This meant that from 2007, KKH could start improving the quality of its workforce by choosing who to employ and their education level requirements. This meant a shift from a strong focus on costs, including little attention to competence and knowledge among the workforce, to a requirement policy of staff focussed on (medical) quality. The link however between level of salary (costs) and level of competence when coming from different countries is not a straightforward matter and is highly debatable. However, from the interviews and other documentation it is clear that KKH experienced a high level of serious medical issues that were claimed to be linked to their workforce's knowledge-base. They had a significant number of staff

with less experience and knowledge regarding medical quality issues before 2007 and SEP. In short KKH had a shortage in qualified employees. Hence this was one top priority after SEP which gave KKH 'the ability to employ specialized certificates and efficient and high-quality employees who could contribute to the hospital objectives', as the Executive manager 2 expressed it. This triggered a range of activities to close the knowledge gap, the as Head of human resources department indicates:

> During the last few years, we worked hard to contract the best medical staff in the world, whatever the cost. Therefore, you can see that most of the doctors and nurses are from Western countries and have worked in the biggest hospitals around the world.

If more qualified medical staff meant higher costs, this did not create an issue for MOH, in fact they embraced it. With the new recruitment policy in place during 2007 and 2014, this meant that the workforce knowledge-based changed significantly, but it also changed the diversity of people. Currently, the hospital has highly-qualified employees from several countries around the world, including principally the US.

> The hospital management has contracts with highly qualified medical staff from different countries. Honestly, working with such people gives the hospital and the Saudi medical staff great advantages. (Doctor 2)

The changes can be noted from the figures in the table below:

5-2: Total number of employees at KKH

	2006		2013	
Saudi Arabia	41%	287	35%	446
United States	4%	28	28%	356
European countries	0%	0	10%	127
Asian and Arabic countries	46%	322	18%	229
Other countries	9%	63	9%	114
Total	100%	700	100%	1272

The changes in the employment system encompassed administrative roles, including those of managers and accountants.

> What we have tried to do during these years is to employ the right people, who can drive the hospital in the right direction. For example, we try to contract employees who are highly qualified, whatever the cost, as long as the hospital needs them. (Head of human resources)

For instance most of the accountants who worked in the hospital prior to the implementation of the SEP were highly qualified accountants (mainly from India), not least because they had worked for long periods in the private sector. However there were ambitions to hire more Saudis for this type of work, not least because since the KSA has sent nearly 150,000 students to more than 30 countries under the KAFSP reform (MOHE, 2014). However it also often meant that new Western accounting graduates had in fact less experience, which sometimes resulted in inaccurate financial information. One of the accountants, who has been working there for more than ten years, said:

> There were accountants working in the hospital from the West of Asia, and they had very good knowledge in the subject, which helped them to implement a very good costing system. However, what we have at the moment is quite different: most of the accountants are Saudis and new graduates. This makes it difficult to implement a good costing system.

To achieve the new hospital objectives, it was also important to support staff with the latest IT technologies (See section 5.2.3.2) where needed but also provide training to improve and keep up with recent developments in accounting knowledge and techniques. This was also important not least because the National Anti-Corruption Commission (NACC) monitors and visits hospitals to ensure there is no corruption[8]. Training and incentives were therefore important to

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[8] Before the SEP was implemented and during the beginning of its implementation, the KKH had faced corruption in most of its financial practices, For instance, in 2011, one of the national newspapers published an article mentioning that The NACC found various indicators of corruption at the hospital. One such example of corruption was that the person in charge of the employees' salaries embezzled nearly USD$2,909,392 during the first year of the programme's implementation.

not only attract new staff but also to keep the motivation high among the current workforce. Hence a range of different management practices that could achieve this was implemented.

> Changes in salaries, motivations and accountability practices have given the hospital a great chance to attract a highly qualified medical staff, as well as to improve the communications among medical staff. For example, the medical director, Professor Ashley Behrens has given strong powers to the doctors in the decision-making process. (Doctor 3)

It is clear that the SEP framework in place with its decentralised decision-making process was a motivational factor in itself. This was a critical point. Without the medical staff's involvement and engagement, highly qualified or not, the reform adopted at KKH would not be successful. The power of the medical professionals, especially clinicians, was crucial to the reform. With KKH's (medical) decision-making taking place locally, they were now part of the controlling and planning. Their knowledge and influence as medical experts were cornerstones on which HCQ was built. The new structure as discussed in appendix D made room for both the (updated medicine based evidence model) medical expert hierarchy and the new administrative (line staff administrative coordination model) hierarchy. One of the advantages mentioned by doctor 3 was the decentralisation of the decision-making, which gave doctors more encouragement, motivation and creativity in contributing to the main objective of the hospital. Doctor 2 stated:

> When decisions become decentralized, we all work together to sort out any issues, since we all share the same responsibilities. For example, last year, we were working on opening a new department, and our voices were central because we are closer to the patients and we understand their needs more than the top management or the MOH.

It motivated the top management team to achieve more.

> The SEP is a great health care movement, and not just for improving health care and sorting out the issues that arose from the previous operator; this programme has also

> improved Saudi health care managers by giving them the power that they need to manage the hospital effectively. (The Chief Executive Officer)

It also meant that the structure embracing both medical and administrative hierarchy was now occupied with new and trained staff who were stabilizing and developing the processes in place. For instance, despite having MA and HCQ seen initially as two different areas, it was clear that both MA and medical staff started to work together on how they could do more. What needs to be remembered is that with new staff trained in the latest techniques abroad (mainly USA and UK), and current staff being trained in new techniques in MA and medical quality, staff were infused with new ideas for KKH both whilst working together and through conflicts. Perhaps it was then of no surprise to discover hospital management using advanced accountability practices in managing employees as the focal point for improving the HCQ; 'normal' practice elsewhere in the world.

> Using the MAPs supported by IT has helped us a lot in making the right decisions at the right time and controlling the activities of the clinicians, which has led to improvements in the level of health care and in achieving the objectives of the hospital. (Head of nursing)

So while the controlling function of accountability was an essential part of the SEP frame it was complemented with a more 'positive' side too of a new, expert workforce having the opportunity to carry out 'best' medical practice with little financial restriction. It was also an acknowledgement of their experience. This meant that the SEP slogan "Patient First" became part of the staff's everyday discourse, with doctor 1 mentioning that:

> The patients are essential; they are number one in any situation. The first thing we were taught is how to respect the patients and how to offer them very high HCQ.

The executive director also mentioned:

> 'Patient First' means: the patient should get health care that meets very high standards, to ensure that the patient gets what he/she needs. To do this, we should, as directors, control activities and implement everything needed to achieve this objective. Paying attention to the HCQ to achieve patient satisfaction has become a focal point linked to daily activities.

Also, doctor 2 mentioned:

> In the past, providing health care was the one of the objectives, and there was no focus on the HCQ. However, these days, the situation is different, since the needs of the patients and patient satisfaction play a role in our work.

While the framework for decentralised decision-making was coercive in its form, the content regarding employment and how it developed was more normative. This illustrates *normative isomorphism*, not least because of how the recruitment policy allowed for staff with similar experience and knowledge about HCQ and MA to occupy the (updated medicine based evidence model) medical expert hierarchy and the new administrative (line staff administrative coordination model) hierarchy. This kind of institutional pressure in adopting new ideas and practices has appeared in various hospital activities, such as training and educating current employees, attracting highly qualified employees from developed economies and attracting Saudi employees who graduated from universities in Western countries who have valuable experience in HCQ.

5.3 The emerging and changing roles of MA in managing quality

Given the analysis in 6.2 the focus will now shift and revisit MA change in more detail, to better understand how far MAPs was promoted to manage, coordinate and monitor human and financial recourses that also include HCQ. From the analysis, five important shifts between 2007 and 2014 regarding the role of MA emerged. The section below will begin with the first starting

in 2007 and the new role of the budget. MA then follows this as it is given a role as TQM in conjunction with JCI in 2009 and IT in 2010. The last section pays attention to a new emerging role of MA with a much wider emphasis on SEP hospitals making their performance visible, and as such an intensifying of accountability and pressure for more HCQ.

5.3.1 The role of the budget

With SEP in 2007 the role of budget changed as part of the frame imposed on KKH. Pre SEP, MOH allowed the hospitals to monitor and plan their own financial resources, which in practice however meant that, via CM, it was AMI who set the agenda and role of the budget at KKH giving them a clear cost focus.

> In the past, the management used the economic information to measure the performance of the departments, based on their expenses. (Head of medical department 2)

For MOH this meant less control and oversight leading to a lack of accurate and reliable performance information, and to public dissatisfaction regarding hospital services. Following the implementation of the SEP frame, this all changed. The budget was given a new role, and was forced upon by MOH, which simultaneously meant a change of the budget for KKH as well (and the other SEP hospitals). MOH and the MOF were now clearly in charge of the financial resources as national level health care budget. It was this budget that became a key tool for MOH to control the nation's health. It used the budget information to evaluate hospital objectives, and KPIs were met at frequent intervals, making sure MOH's overall long term objectives were fulfilled. KKH was a cog in this budget wheel, in the sense that the new budget role was the outcome *of coercive isomorphism* and so the control over finances shifted.

However, the budget represented something else as well as an incentive. While KKH was asked to set its budget locally, it had to be an outcome of HCQ. With this in mind KKH had to

demonstrate to MOH that the budget was indeed an outcome of such work. At the end of the day the KKH budget had to be approved by MOH. But there were few financial resources restrictions, which is 'normal' when implementing NPM reforms (see e.g. Olson et al. 1998), as long as quality can be ensured. However, what is interesting given this new set up is that the budget at KKH was seen to have less importance and significance than before.

> The role of the budgetary system was more significant than what we have at the moment. We were run as a private hospital, and each single activity needed to be accounted and measured. This situation is no longer the same. At the moment, the budgetary system is less important than before, as we have become self-operating. (Doctor 3)

Also Accountant 2 mentioned:

> The role of the budget is to give the government the power to control…It is not that important at the level of the department because the focus is on improving department activities and achieving social acceptance, whatever the cost, as long as the hospital has sufficient funds every year.
>
> Still, cost control is not a real problem for the hospital, and implementing practices such as Activity-based costing will not be, in the near future, as important as other practices that relate to the HCQ. (Accountant 2)

The hospital's budget was used only to control the department expenditure and the hospital as a whole, rather than being a management control technique to measure performance. The budget-related indicators and accountability were hence about showing the spending of money, rather than controls for activities.

> The daily objective has moved from how much is spent to how many patients we have served, and neither of these helps our objectives as doctors. I believe that we are here to treat patients, not to touch numbers. (Doctor 1)
>
> The roles of the financial indicators in the SEP are less important than before, as our objectives are different than they were in the past. (Head of the financial department)

Another example of how the indicators shifted was from the pre SEP cost focus, meaning less expensive medicines which were often of lower quality, and from 2007 less top end medical equipment and technology. With today's budget KKH has the best available materials on the market not least because of how the use of quality indicators helps identify quality of supplier.

> One of the important things that we need to claim that we have a highly good HCQ is a high quality of medicines, medical equipment and medical technology. (Doctor 4)

> We have, at the hospital, very, very, very expensive equipment, and this equipment is much better than the equipment in US hospitals. (American nurse who just started at the hospital)

Moreover, the doctors are happy with the tools they have because they believe that such materials allow them to learn about the most advanced health care technology in the world.

> The courses given by the manufacturers of medical devices allow us to be well educated about the latest trends in medical improvements. (Doctor 2)

As such the budget served as a symbol for what was important: quality. This was also supported by the structure which separated the financial and budget department from QDP. QDP and their work served as a bridge between medical expert hierarchy and the new administrative (line staff administrative coordination model) hierarchy. However the separation served as an important symbol for quality as well. The purpose of using the costing system in the hospital was 'just' to monitor the costs and measure the activities of the patients in each department. KKH did not have to be worried about costs as long as quality according to target was achieved, which directed staff attention to quality in everyday work supported by QDP. The budget was in that sense not a cost cutting device; it was a sort of (non) budget similar to what Hopwood (1973) discussed as non-accounting budget. The accounts and the budget could be seen as an account of future potential and possible quality, within reach. It was a budget that encouraged and

incentivised collaboration among staff so that every budget was fully supported from a quality perspective.

One other reason for this shift was the quality of the KKH budget itself and its relation to quality work, which was an imperative to convince MOH of. It was a power game in which KKH could not afford to show a lack of understanding. This meant that competence in both MA and medical quality was required at both ends, while they had to be developed over time. As mentioned in 6.2.4 KKH did have an issue of un-experienced accountants and lack of competence. So while at the start in 2007 there were still things to improve in the budget work at both MOH and KKH, it would strengthen over time not least because of training, recruitment policy and the new IT system. However, the new role of the budget still had an impact right from the start with a range of outcomes. For instance the departments began to consider their performance and the quality of their services rather than costs and expenses. The head of the anaesthetics department argued that the change in role of the budget resulted in changes to daily practices.

> The most important thing at the moment is the satisfaction of the patients, whatever it costs the hospital.

Similar but slightly different reflections can be seen from managers actually involved in these practices.

> The management of financial resources is one of the main points they have to pay attention to in order to achieve stability. However, I noticed that the government is working to improve its public sector, paying less attention to the financial aspects. (Financial manager)

> The costing system used in the hospital was very good and accurate, according to the employees and the interests of the hospital at that time. At the moment, the shift in focus to the HCQ has resulted in less care about the information related to economic decisions (Head of the financial department)

> We calculate the cost using the common average price for each activity in each department... But, as I told you, this information is just for management purposes to control the budget of the hospital and to measure the budget for the next year. (Head of the IT department)

So, while the budget made space for 'unconstrained' financial resources on quality, it did not mean KKH could relax. On the contrary with all the attention toward quality it meant that the KPIs and accountability really started shifting towards quality productivity indicators, including the number of patients, medical incident reports, waiting lists, waiting times and patient satisfaction. However this was just the beginning and more was to come.

It is quite clear that the new budget role was the outcome of *coercive isomorphism* and that control over finances shifted. The change in the budget system allowed MOH to have more control over the hospital through a focus on planning, coordination and evaluating financial and non-performance. However, the new budget role was formed based on its *normative isomorphism* in its development of the content, in the sense of the framework in which KKH was allowed to act. They filled the new budget with quality content and were financially supported, and included training that nourished innovation and collaboration in quality. Given how the MOH budget has increased every year, this role of the budget intensified. However, the past is not a guide to the future. As will be discussed below, quality was to be linked to MA in a very specific way. Further development of quality work and discourse that the (non) budget made possible would once again transform MA into new roles.

5.3.2 Turning the MA role into total quality management

With a specific budget role and a structure promoting quality, KKH could now give all its attention to developing the best practices in health care. It is during this time that MA came to play a complementary and extended role to the budget. Part of the MA function and structure was related to the department of QDP which was responsible for tracking, measuring and

monitoring quality, and was still in its infancy although this would soon change. Ambitious quality work was discussed and established where accountants, mangers and medical staff collaborated. A different phase started to take shape turning MA into TQM. However, it was a change that would be dramatic and filled with ups and downs over a period of two years.

The medical staff and managers were working explicitly with medical quality, mainly with people from JHH to benefit from their experiences and knowledge about medical standards and research and management. JHH is one of the leading hospitals in the US affiliated with the Johns Hopkins University School of Medicine with ties to 36 Nobel Prize winners. The hospital's top management focused on improving the HCQ, through a patient focus, continuous improvement, support from management and leadership, employee education and training. At the same time international accreditation of JCI as a form of HCQ standardizing was also progressing. JHH became the international benchmark for the successful implementation of those standards.

> Obtaining international accreditation, such as JCI, is one of the main elements that the hospital management is paying attention to. Obtaining such accreditation is important for improving the hospital's performance up to high quality standards. (Head of QPD)

Thus, in KKH, there is a committee named the JCI Committee. The role of this committee is to review the performance of the various departments based on JCI standards. According to the head of the nursing department:

> This committee has various roles at the hospital, including examining departments' implementation of JCI standards[9] to make sure that we are in line with international

[9] For instance, one of these standards is Quality Management and Patient Safety, which addresses the daily work of individual health care professionals and other staff, such as physicians and nurses, who assess patient needs and provide care. This done in the hospital by: 1) Planning and implementing the quality management and patient safety program, 2) Designing new and effective clinical and managerial processes, 3) Collecting data to measure how well the new processes work, 4) Analysing the data, 5) Implementing and sustaining the changes that result in improvement.

> hospitals and that the quality of the services we provide is meeting the expectations of the public.

On the other hand, QPD worked on a more general quality aspect and designed various surveys to collect information about the services people received using tools such as the hospital website, computer points in different places around the hospital and hardcopy surveys.

> The main role of the department is collecting, reporting, summarizing and analysing the information from different resources, such as the evaluation reports, patients' satisfaction, morbidity and mortality reports, risk management surveys, accident reports, infection control reports and information systems, to help the managers and directors of departments make the right decisions at the right times. (Head of QPD)

The data collected from these surveys were analysed by QPD and then distributed to the different management levels along with their recommendations of actions points. The focus on patients helped the hospital develop a clear picture of the issues that were important to the patients, as well as of their views regarding the HCQ. According to the medical director:

> The patient is the starting point to achieve a high HCQ; therefore, we consider their opinions as one of the main resources to improve our quality.

However, at the same time managers, accountants and key medical staff were constantly sharing ideas, ideas that new staff brought in either because they had already worked with them or because they brought the latest from universities studies abroad. It was a discussion that brought not only the two areas of medical and administrative quality closer together in terms of their input, throughput and output. With expertise in accounting and management it was possible to explore other possibilities of what and how MA could be used given this new situation for KKH. What was clear was that MA had more to offer when it came to quality. It offered a range of possibilities in making things visible in terms of where more quality work needed attention; in other words what to track and monitor, and how. MA did not only offer the possibility to help

track JCI-guided medical performance but also anything beyond it. It was perceived that JCI standards had to be part of a quality approach in everything they did, not least as it was their overall aim. It was a logical extension and step. MA was hence in a transition to be reshaped as a TQM frame for all quality work at KKH, as a homogenous effort towards quality. This was also supported by KKH's key ally of JHH, which not only had expertise in medical standards but also in management and consultancy in TQM.

> The implementation of TQM is the focal point to achieve the objectives of the hospital and meet the demands of users. Therefore, special focus on the main elements of quality has been the main concern for the last few years, and this has been accomplished with the help of the consultants and medical staff from JHH, as well as from universities in KSA. (Executive manager 2)

> MA is not a real issue for clinicians because most of them have experience with private sector practices from previous years, and others come from different countries that already have strong accountability systems. (Accountant 3)

Whilst some critiques were being raised, generally these were going unnoticed.

> The improvement of health care during the last few years is just a transfer of the methods of management control and monitoring of JHH to the KSA context, and, to some extent, I disagree with such a system, as it does not pay attention to the differences between the countries. (Head of the surgery department)

Early on in the discussion it became clear to the management that something else was needed. To further 'incentivise' this new kind of TQM productivity, the hospital started looking for solutions. One was related to an employment contract that could specifically be linked to each individual's quality performance at KKH, creating a direct line between MOH's ambitions for the nation to each individual at KKH. Therefore staff were set quality targets against their responsibilities for each budget year and evaluated quarterly, and for department heads and some administrators meeting these targets was compulsory for renewed contracts. It was a continuous appraisal

contract for each individual employed, giving the hospital more power and accountability over both medical and non-medical employees. In that sense it corresponded to and strengthened the medical and administrative structure and processes now in place.

> The contracting system gave the management team more accountability over employees and made them more responsible for their work and actions…The employees' contracts renew every year, and this renewal is based on their performance…The aim of this system is to make the employees work hard, which, at the end of the day, improves the level of the quality at the hospital. (Management team 3)

However, the 'coercive' side of the contract in motivating staff was also 'balanced' with other incentives such as money, vacations and training courses. The department heads' roles were to set the targets and evaluate employees, and decide whether to renew the contracts based on these targets. If an employee did not meet all of the targets or if there was a problem with some of the criteria, the employee had to attend certain courses related to the criteria to improve his or her skills in order to renew the contract. Moreover, these training courses served as an important indicator for the head of the department to consider in the next evaluation report.

> We have a performance appraisal for each job. These performance appraisals come from different hospitals inside and outside the country. These performance appraisals give the heads of the departments some flexibility to change their targets and objectives based on work conditions and, based on these targets and objectives, we renew the contracts. (Head of human resources)

The overall frame of TQM started to take shape. The head of medical department 3 stated:

> The improvement in quality at the employee level can be seen from the improvement of various elements: first, the motivation of the employees, the improvement of the equipment we use and the training courses focused on quality.

Through such training courses, the hospital was focusing on the development of its employees and clinicians by educating them on modern practices related to their work. What is interesting is that the training courses have had a great influence on the heads of departments, since most of them ‘speak the accounting language’ in a very interesting way. According to the head of the medical departments 2:

> Accounting and accountability become central points in our lives. We use accounting in our work, at home and in daily activities; therefore, being aware of accounting terminology and practices gives us more opportunity to improve our careers.

But TQM also meant that KKH itself was monitored via the KPI of education and training of employees by MOH. Hence following KKH’s accreditation in 2009, this was a not only a moment when JCI standards were implemented after 2 years of hard work, but it was also a moment when JCI standards were part of an overall TQM framework of productivity in its input, throughput and output. This resulted in improvements to the productivity and quality of the clinicians, while also making their work more measureable and placing it under the power of numbers. Incentives and remuneration play a significant role in clinicians’ productivity.

> At the moment, clinicians are working to achieve their performance targets, which build on the quality standards, not just to feel safe in renewing their contracts, but also to get the incentives and remunerations. (Medical director)

Also the medical director mentioned:

> We had a huge waiting list when I came here, with more than 25,000 patients. At the moment, the waiting list is down to 200 patients, which is a huge success in just a few years. What we are trying to do is to make health care services available to all, and the patient does not need to wait to get treatment. Therefore, the number of patients is one of the important matrices we highlight to improve quality.

There was no need to question the MA new role as overall TQM as such. It was a role with a convincing title and with content that was producing a range of reports of improved quality. The

extended and complementary role of the budget was working and it was hard to argue against. Still, it was early days and the role was fragile in form. Unintended consequences were often linked to measures and appraisals and could not be ignored. But things would get worse before they got better. In 2010 a new IT system was implemented (see 5.2.3.2) to support an increase in paperwork, a result of the quality measures, and also to assist inexperienced accountants. But the IT also intensified the link between MA and quality, TQM, and made them inseparable, including KPIs of employees and their appraisals. All forms and documentations entered in the ERP and JCI system were now based on the TQM frame. With databases filled with different quantified categories, not only could the IT system produce and visualise a range of quality and productivity reports it could also do it faster and more frequently and also disseminate the reports to a wider network of people. The improvement in IT at the hospital did lead to the improvement of the quality productivity.

> This information is highly important for managing the hospital accurately, and it needs to be in the right form at the right time. This cannot be done without it. At the moment, nearly 95% of our work uses IT, and this has helped us a lot in implementing correct accountability practices. (Head of IT)

However critical voices could no longer be ignored. Employees were disappointed about being evaluated by KPIs because they believed that each patient requires a unique amount of time and effort, which may differ to the amount of time and effort needed by another patient. There were several reasons for these critical voices. One major issue was about how the KPIs became the main focus and not the patients. It was in a sense like Goodhart's law where 'every measure that becomes a target becomes a bad measure' (Hoskin, 1996).

> Following this way of improving the HCQ has improved the quality, but it also leads to real consequences, as the doctors become focused on activities that are beyond what the patient needs. (Doctor 3)

> Before SEP, performance was measured based on the objectives of the departments whereas, at the moment, the situation is different. There is a strong focus on the KPI and on the targets that need to be achieved for each doctor. Honestly, it is very difficult for us to consider time and numbers over the treatment of patients. (Doctor 1)

> The main role of the current KPI is just to control the clinicians' activities and to bring their work under control. We have to follow what the numbers say. (Doctor 4)

> We do not see any problems with accountability, but the problem can be seen from the strong pressure that these practices place on us. (Nurse 3)

> The PMs we use may not help the doctors feel that they have freedom in doing their work, but it helps the patients get the medical services they need at the right time and up to international health care standards. (Medical director)

> Recent strategy has aimed to document the activities of clinicians in the form of numbers in order to make these activities more measurable. Therefore, everything I do as a doctor must be recorded in the system using the form of a number. Basically, the time we spend recording this information is more than we spend with the patients. (Doctor 2)

Another source of criticism was that clinicians struggled to use the information system following the IT improvements and the implementation of a range of accountability practices. The IT system was complicated and difficult to use, misunderstanding resulted in a number of accidents, which in turn led to the termination of certain clinicians' contracts.

> The main issue for the clinicians is the usage of the system. For example, one of the doctors entered a medical examination report for the wrong patient, and this resulted in performing the wrong surgery on the wrong person. (Head of IT)

> The technology we use at the moment is really very complicated, and any mistake could cause real consequences. (Doctor 5)

> Every year, we face several issues in allocating the hospital's budget; the heads of the departments, from time to time, enter incorrect data, which requires visiting them

> and re-entering the data from zero to make sure that everything is OK. This action delays the work and keeps it from being on time. (Accountant 2)

It was important that KKH responded not least because at the other end of the budget MOH was monitoring and appraising their performance.

> The MOH always stands behind the patients, as well as what the public needs…Therefore, the focus for the MOH has become the HCQ and the satisfaction of the patients...The MOH evaluates our performance based on the information we provide from the internal reports, as well as on the accreditation from external organisations, such as JCI. (Executive manager 2)

KKH responded to the critique by offering more advanced training courses, some of which were abroad. It particularly focussed on JCI courses for the medical staff in helping them refocus on the patient. In one sense it was about a lack of experience in applying these new set of standards, as such a transition requires extensive time and effort. A great deal of work is involved in moving from the traditional method to a method involving the kind of comprehensive health information that is helpful in managing hospitals using new technology. It was also about dealing with an accountability system that measured every aspect of their medical work. The training kept its focus on quality as the (non) budget encouraged.

> In my country, financial information is highly important at the level of the department because it helps to control the budget, expenses and assets, which help the hospital and its departments achieve sustainability. In the KSA, I have not seen any consideration of this point. (US doctor)

The difference to earlier courses offered was how they now were offered in various places, both inside and outside the hospital, and abroad. According to the head of the training department:

> We have had a great number of training courses concentrating on different aspects of quality. These courses are aimed at improving the understanding of HCQ among medical and non-medical staff. However, these training courses also have a great

> influence on the employees with regard to improving their skills and keeping up-to-date with modern medical and management practices.
>
> One of the main reasons for the improvement in the HCQ is the education and training programmes that the hospital designed, both in- and out-of-house. I believe that, as long as employees are well educated, this contributes somehow to improving the HCQ. (Executive manager of nursing)

After a lot of work in updating and training staff, and despite the strong criticisms, the role of MA as TQM was never questioned as such but was now strengthened and reinforced. Different *isomorphism* was in play during this period of adoption. *Coercive* in the sense of the (non) budget as a background set up, but also via the new employment contract. *Normative* in the sense that sufficient new and trained staff were now in place to embrace JCI standards in an international medical professional way of working, on which JHH had been a major influence. TQM more as *mimetic isomorphism* and an idea influenced by accountants and consultants not least as the head of QDP was a graduate from University of Leeds, UK, with a Master's degree in hospital management bringing back the latest in MA but also via JHH expertise. What was now clear was how TQM as the overall frame became part of how KKH carried out their work and discourses.

5.3.3 Interplays of MA and TQM around 'quality benchmarks': new visibility for all

During the study a third MA role emerged around 2012 and was established by 2014 as an extension of and a complement to what was now in place. This role made possible and supported KKHs vision "To be the best hospital in the Middle East" and the MOHs overall ambitions of quality health for KSA's population. It would support a robust response to the persistent non-governmental discourses. It would allow a linking of internal facing activities with an external facing one. In fact, supported by MOH it would combine all SEP hospitals in a joint external facing benchmark visible to all. On central stage were JCI's 'golden' standards. The MOHs role and national aims became explicit once more. The budget was in place, encouraging KKH and

other SEP hospitals to give all their attention to quality. KKH was now in a position for MOH to take the next step.

KKH could now communicate to the general population about their JCI standards and accreditation to monitor medical improvements. MA made it possible and offered new visibility by linking KKHs internal activities of TQM work to the outside world and to any potential patient. JCI, within the TQM frame, made visible their improvements in patient satisfaction, medical practice, education and training. Top management believed that international accreditation was one of the best ways to help the hospital show quality improvement, since such accreditation examines the HCQ in areas with which patients are unfamiliar. It was therefore also a way to educate the population in terms of what to expect as regards HCQ. Patient feedback was transformed and was returning in a format which could be compared to a standard. In that way the internal frame of accountability (with new employment contracts and KPIs) extended beyond the hospital but also into the future of possible care for the population. It was clear that the HCQ had improved that which was visible to all. But by being able to compare with standards they could now raise expectations.

> The country has improved in the last few years, and this improvement has positively influenced the citizens of the country. Most of the patients are well educated and can help the hospital in collecting real information about health care services and issues with which we are faced. (Head of the patient relations department)

However, the new role of MA offered more than that. The MOH used international accreditation to evaluate the hospital's performance and to make comparisons with other accredited SEP hospitals, and so they forced all hospitals into the same frame.

> Different international accreditations have been the focus of the hospital because such accreditations help the hospital meet the acceptance of the MOH. (Consultant 2)

KKH was fully aware of how the MOH used the JCI standards as a way of measuring and controlling the performance of the hospital. Their internal focus was now linked reciprocally with an external facing focus to all SEP hospitals. MA as framing TQM was in this sense about creating a benchmark. As such it was now possible also to rank each hospital, and a ranking list appeared.

> The implementation of the JCI standards increased the level of the competition between the SEP hospitals, as it allowed the MOH to compare hospitals. (Head of medical department 1)

But comparisons towards a benchmark, such as for KKH, were now not only possible with other accredited hospitals in the country, they could also be compared to all 600 accredited hospitals (2015) in 57 countries across the world. At the same time the pressure increased at KKH to achieve more, not least as the (non) budget was still financially supportive as long as the quality was met, and notwithstanding how since 2007 the quality discourse and practices had intensified.

Critical voices are hence still being heard such as clinicians see them only as a form of power or control, which shifts the focus from treating patients to achieving targets and objectives. At the same time with the benchmarks new KPIs can be developed yet again, giving management the ability to evaluate and measure most of the activities within the departments, as well as to allocate the hospital budget. MA’s new role in making benchmarks internally and externally visible has been extended to that which was introduced in 2007 with the (non) budget. And for each critical voice the frame has been re-enforced and never really questioned. In that sense it has been successful as all attention had been towards quality and a supportive role for MA. And as such it has not only evolved but also played many roles at the same time. This MA benefit was reinforced by the executive director for nursing services, who noted:

> The current management practices, such as evaluation methods, give us, as heads of departments, all the information we need to control and manage the daily activities, staff and budget.

However, now, improving the knowledge of clinicians and employees is considered one of the main points that the hospital uses to improve HCQ and the level of competition internally and externally. Once again:

> The hospital, these days, is conducting different training courses that help us, as medical staff, improve our practices to meet international health care standards. In the past, we were working based on what we had learned at universities and from our experiences, whereas, at the moment, we can ask for any training course that can help us improve our practices, even if the course is outside the country. (Doctor 4)

According to the head of QPD:

> The relationships among patients, clinicians and the management team are one of the main points in improving quality. Therefore, the evaluations of patients regarding the services we provide help us, as a management team, to know where our strengths and weaknesses are and work on them.

This last analysis of the MA change also concluded this study. While the other two periods of MA change were strongly influenced (*coercively*) by non-governmental discourse via media and social media, it is during this time that a qualified response and a form of dialogue was established. At the same time, it also increased expectations and pressure on KKH in terms of what can be done and what would be expected. In that sense, it allowed the public to play a role in the management of the hospital and to support the improvement of the hospital's HCQ. A *coercive isomorphism* that changed the role of MA was also coming from MOH. With the benchmark in place they could communicate and respond to expectations for health care. Finally, the MA change within KKH was characterised by *normative isomorphism* in the sense that it was yet again appealing to staff professionalism and development. Productively from such a

perspective it is difficult to argue against this, especially when financial resources were not an issue. Even when productivity was visible to all, it was a matter of increased professionalism and its development. The (non) budget was clearly an intelligent move, as it made way to unquestioningly accept what MA had to offer.

5.4 Conclusion

This chapter presented the first case study of KKH, a hospital situated in Riyadh, the capital city of KSA, to analyse MA changes within the SAPHS given the new reform of SEP. Between 1984-2006 the hospital was part of a contracting system between AMI and MOH but in practice it was managed and influenced by AMI's private sector based way of working. From 2007 onwards, things changed dramatically. SEP enforced a structure of hospital medical expertise hierarchy with an administrative hierarchy to produce HCQ with efficient and effective aspects. However, financial resources were never really an issue as long as HCQ targets were met at the level of KKH but also at the individual level. During this period the role of MA at KKH changed several times, from a cost (cutting) role; to a (non) budget role, to framing TQM as a solution for HCQ (and more); and finally to a role making quality completely visible to all. This occurred as a continuous dynamic flow of ideas coming from many directors that would strengthen through training, new staff, IT and KPIs. However, the introduction of the (non) budget was important in initiating these changes. MAPs were not only an outcome of ideas coming from many different directions but MA also influenced and shaped ideas such as the perception of HCQ amongst the general population. It also influenced how medical professions were analysing their work via KPIs and accountability 'persuading' them to include other perspectives, especially those who had not used MA in this way before. MA became both a frame for TQM while being inseparable from it, tightly bundled together with accountability. This is perhaps for some a debatable issue (Ezzamel 1994; Ezzamel *et al.,* 1990). But the point being made here is how MAPs were making collaboration possible among staff, directing all attention to quality due to its (non) budget frame.

The budget had to be an outcome of quality work. However, such an approach was not adopted without critique. The response did little to change the new structuring and processing now in place. In fact, as the response was about more and better training, this also meant more of the 'same' and the role of MA as framing TQM became established. With this in mind the question of how far MAPs was promoted to manage, coordinate and monitor human and financial recourses provides evidence for an extensive promotion of making MAPs central to their work. Key in doing so was the making of the budget role into a (non) budget. By making it non-important it became important as it directed everyone's attention towards quality and professionalism, which MA would also support and offer new possibilities in doing so.

5-3: Summary of the changes in the KKH

	KKH	
Main features	Before	After
Management system	Private Sector	New Public Management
The main objective	Maximise profits	Improve Quality
The main focus	Market needs	Social needs
Strategic focus	Central planning in private company	Central planning with coordination with MOH
Services concept	Providing health care with available resources	Providing health care with high quality for all citizens
Accounting system	Business type with focus on financial control	Business type with focus on non-financial control
Budgeting use	Internal	External
TQM	Not implemented	Fully implemented
Costing system	Very advanced	Benchmark
Performance measurements	Based on financial targets	Based on quality targets (non-financial)
Resistance	Exists	Exists
The role of MA	Partially	Strong
Relation to MOH	Independent	Mix autonomy and dependant

Chapter 6 : The Second Case Study: KFH

6.1 Introduction

The first case was a hospital managed by CM implemented in KSA in 1984, which involved in many ways a private sector based way of working and managing the organisation. This chapter presents and analyses the second case study King Fahd Hospital (KFH) in a similar structure to the first. There are some important similarities with KKH such as both hospitals were part of SEP early on, and both were prominent referral hospitals. However one key difference is KFH's experience in being managed before the SEP reform, and the use of accounting in so doing; from 1988 to 2009 the KFH was administered and managed by MOH as a central branch. This case will hence bring into light an analysis from a 'contrasting' case and the dynamic of management changes made in MA under SEP reforms. It will also shed light on any relations between KKH and KFH. This chapter is divided into the same headings as in the previous chapter using the same analytical categories to analyse MA change in this setting.

6.2 From old to new MA: an overview

KFH was built and opened in 1988 as a state-owned hospital. The hospital's construction cost nearly 1 billion Riyals (nearly US$260 million), and as such gave an important signal of improving health care in KSA. There were five hospitals built with the same name because they all opened during the reign of King Fahd, however, this case study concerns only one. According to the latest statistics, KFH has 509 beds (2013), and treats nearly 1 million patients yearly. In addition, it has 15 fully-equipped operation rooms, as well as a large number of intensive care beds.

Being owned by and part of MOH meant to be part of a style of management, or rather a 'traditional' bureaucratic style of public administration (PA), where it was of key importance to follow specific procedures. That also meant that between 1988-2009 KFH was expected to build its operations based on the MOH's goals, as defined in Article 31 of the 1992 law on Saudi

health care, i.e. 'The state is responsible for public health care and provides health care to every citizen.' It is from these rules that the MOH is regulated and is required to operate in order to comply with the health care law. In hospitals managed by the MOH, decision-making about human and financial resources was made centrally at a higher level in these divisions. Therefore, the role of hospital management and administration teams was to lead or direct hospital activities without any ability to plan for, organise or recruit staff.

Perhaps more importantly all decisions regarding financial resources were centralised. That meant that the hospital management should only execute and supervise decisions already being made. They had also little influence on the decisions before they were made. The experience of accounting was limited and was very much based on producing a budget role to serve and support MOH in identifying the resources needed, and basic bookkeeping. As such the budget did not really have any managing role at KFH as such as it was the procedures that were more important than outcomes. KPIs and a general and systematic accountability were hence a practice with which they were not familiar.

To make sure KFH and other hospitals were carrying out orders according to instructions from MOH under this model there was also a monitoring function and process coming from the local office of MOH, the General Directorate of Health Affairs in the Riyadh (GDHAR). So while this governing structure and process meant a less active hospital management role in KFH as well as within other similar public hospitals, they were not alone in terms of communication channels. In fact, it was a governing model and therefore the same for all public sector organisations. The executive manager for financial and administrative affairs and operations at KFH described this as:

> The role of the administration team was quite basic, and we could not do more than what we were allowed by the General Directorate of Health Affairs in the Riyadh region (GDHAR). Even in human resources management and practices, the GDHAR

> was the only entity responsible for employing and monitoring activities involving human and financial resources, and our role was just to be supervisors.
>
> In the past, the hospital was run the same as any public organisation, paying attention to administrative elements and the government's regulations rather than public needs. (Doctor 2)

As decisions regarding human and financial resources were centralised, it also meant that KFH was managed by the GDHAR in practice. This management approach did not support the hospital's needs and demands from a medical point of view, not least as GDHAR managers were not familiar with the hospital's situation. Instead, they made decisions based on a top down approach, an approach they were experienced in but that did not necessarily consider the hospital's best interests:

> The previous structure was centralised in the GDHAR; therefore, most of their decisions did not adequately cope with the public's and hospital's needs, as what was suitable for hospital A could not be the same for hospital B. (Executive manager of medical services)
>
> The bureaucratic management hierarchy in the past was unsuited to making public organisations effective. Different levels of management took up time without providing any real benefits. (Executive Manager 3)
>
> The role of the management was less than what it should have been: they even could not make any decisions without authorisation from the GDHAR. (Head of medical department 3)

During this period different issues surfaced which caused the hospital to come under criticism from the public and the government regarding HCQ. In that sense the HCQ discourse was very much similar to that which was described in chapter 5. With the introduction of SEP in 2007 and the ensuing improved HCQ within those hospitals, it was perhaps not unexpected to find such critiques for KFH. It was hence now time to shift the focus for the hospital and listen to the public, by putting 'patients first' as the slogan suggests.

Since 2007, eight new hospitals were included each year under the SEP frame. In 2010 the MOH chose KFH hospital to be integrated under this, a centralise-decentralised decision-making process with focus on output, and with a structure that combined hospital medical expertise hierarchy with a managerial administrative hierarchy to promote HCQ. When the hospital moved under the SEP frame in 2010 the financial resources that were hence made available for HCQ purposes improved the overall human resources, as well as improved facilities to attain the same standards as other hospitals worldwide. The SEP frame allowed decisions regarding financial resources to be delegated to hospital management and gave them the ability to manage these. KFH had a full agenda where new medical and management staff, standards, departments, practices and technology were considered in how they could better meet the new HCQ issues at hand. The head of human resources pointed out that the recent improvements in management processes transformed the hospital, so that it worked in line with the public's requirements.

> These days we have become more responsible, as clinicians and managers, for meeting the public's demands, by offering services that meet their expectations rather than other expectations [i.e. the expectations of top managers at GDHAR]. (Doctor 4)

> However, what we have now is different. At least, the management can provide us with the equipment we need without waiting a long time. (Head of medical department 3)

It also meant that the GDHAR's role changed from monitoring procedures to supervising targets and outcomes. This new situation gave the management team the ability to improve the hospital and to contribute to the main SEP objectives.

> The move from PA of financial resources to SEP is the main cause of improvement in HCQ. In the past, the GDHAR was not aware of work environments and demands made of the hospital, which made the hospital management's efforts to improve operations more difficult. (Executive manager 2)

With a new management structure imposed by MOH, public hospital management teams faced different issues, one of which was the lack of qualified management personnel who would understand and implement the new strategies successfully.

> Moving to the SEP is one of the most significant steps that the MOH has taken, but handing over management to people who are not familiar with this form of management could lead to worse consequences than those we experienced before. (Head of human resources)

With the new structure in place KFH's hospital's management could now make their own decisions regarding recruitment and managing human resources. So whilst they were lacking in sufficient qualified staff, they could now address the issue differently and with greater speed. One of the first things they focussed on was to enhance the number of qualified staff across medical, accounting and management areas. In order to incentivise HCQ and establish relevant processes they initiated a similar contracting system to that at KKH, with targets and job descriptions. KFH combined extensive training for existing staff along with a recruitment strategy attracting qualified employees from Western countries, like KKH. However there was one major difference in that KFH quickly established a network and collaboration with hospitals experienced in SEP.

It is interesting to note that the institutional context into which KFH was introduced in 2010 was a time when the SEP had already been active for three years, and the first eight hospitals already had three years' experience. It also meant that the KSA population was well aware of these significant changes in HC, and especially that HCQ was improved, as illustrated in chapter 5. Also, as eight new hospitals were added each year, it meant that by 2009 there were 24 hospitals already part of the SEP frame, and eight more by 2010. In other words a whole network of hospitals, with new expertise and new HCQ practices were in place or underway. KKH was

hence in a position where they could build on, collaborate and imitate practices in terms of medical, management and accounting practices.

More hospitals with experience of SEP were now in place, producing higher HCQ than ever before and closing the gap of local difference in HCQ across KSA, and this together with MOH managing two different HC models, meant that the pressure on KFH to adopt quickly increased. KKH was one of the first adopters of SEP and as such a lot was at stake, even with much experience of KPIs and modern management. However, the situation for KFH, joining further along the process, was not as simple; the discourse about improved HCQ (and perhaps about resistance too) was already circulating in social media, among hospitals and their staff and within MOH. KFH had little experience of such a model, whereas MOH were becoming experienced and established in managing it. MOH also had experience of how to manage problems that hospitals faced when adopting the new model. In fact, they now had knowledge about two models whilst also managing them; a traditional bureaucratic public administration version, together with a more modern management model, where decentralisation and accountability were operating within a given frame. KFH was in a situation where not only SEP and a new kind of budget and accountability to support HCQ were to be implemented, but so were IT and JCI simultaneously. Within 15 months they were also to be accredited with JCI. Perhaps it was of no surprise that the roles of MA changed several times in a short period of time. Perhaps even less surprising was how the overall changes became much more dramatic, and resistance became more strong.

6.2.1 Power of political and economic: regulation and resources

As demonstrated before, prior to 2007 the KSA government was under huge pressure to improve HCQ, and criticism had built around the health service’s failure to maintain medical practices that did not meet the public’s needs at best and had medical consequences at worst, which in turn led to the shift from MOH to SEP at public hospitals. These negative consequences gained

extensive momentum in national media and social media, partly as a direct result of increased freedom within media particularly after the Arabic spring. It is therefore interesting to see the figures around medical incidents within KSA hospitals from 2001-2010. Official medical committees in KSA confirm that, from 2001-2006, the number of medical incidents in KSA hospitals was 25,900, 85% of which were directly linked to hospital employees and implemented procedures (Al Riyadh, 2012); whereas in 2010 alone, 1,758 medical incidents occurred (all of which were fatal however).

These medical incidents correspond with the public's dissatisfaction with services, particularly as the numbers of complaints increased over time. In addition, these findings are supported by the study conducted by Alboardy and Almegreen (2012) on patient satisfaction with services provided by MOH hospitals. The study's results reveal that 70.6% of the study population, which covered 167 public hospitals managed by MOH, were dissatisfied with hospital services. The study's authors found four main aspects about which patients were dissatisfied. The first was difficulties in obtaining basic services including appointment times, beds in internal wards and emergency departments and a lack of medications, which forces patients to go to private sector hospitals. The second aspect was poor quality buildings, maintenance and cleaning, which were inferior in public hospitals as compared to other hospitals. The third was poor response to patients' complaints and needs, with no departments matching their requirements. The last aspect was long waiting periods and delayed services, which in most cases led to significant consequences for patients (Alboardy and Almegreen, 2012).

With the implementation of the SEP frame in 2007 (see appendix D), HCQ started to show good results from the hospitals included, which put further pressure on the government to change not only hospitals but most of its public organisations. Within this input a new five-year plan was set, the Ninth National Development Plan (i.e. the five-year plan 2010-2015, see also appendix D), with the aim of improving social and medical services. The SEP reform became the vehicle and

solution for this change for all PA-run MOH hospitals. In the same way as KKH, KFH was given a decision-making responsibility within a given frame along with a generous budget as an outcome of HCQ to manage human and financial resources to improve HCQ. The SEP model with a new structure and processes that simultaneously combined and respected the medical and administrates hierarchy (Aidemark, 2001) was now to be imitated to all PA-run hospitals, as experience showed it worked. In this sense the isomorphism was *coercive*.

With the SEP and financial resources in place it was time for optimism. Still, the issues that MOH imposed on them to quickly solve were significant given what needed to change. The main issues in filling the SEP frame with HCQ content were lack of competence and the right qualifications across all areas from medical to management to accounting. For instance, hospitals did not have sufficient qualified staff who could manage the hospitals effectively. According to the head of human resources:

> Most of the employees who worked in management did not have enough education, and they did not have the abilities needed to push the hospital to meet its objectives. I see this as the main issue that put pressure on the MOH to change.

All management-level employees in Saudi public hospitals were from Saudi Arabia and graduates from Saudi Arabia universities that had previously enforced the old style of PA, and hence were lacking experience and knowledge about this new form of public sector management. Another issue was the control over financial resources, since KFH, as confirmed by the head of the financial department, was unable to manage its resources in ways that would help the hospital improve. This was perhaps surprising as the role of the hospital's accountants was just basic bookkeeping. In addition, the department only had three employees because the MOH was the main authority with the right to manage hospitals, including accounting and accountability. This type of PA centralisation had substantive consequences within KFH. One of these issues was the pharmacists' accounting and accountability records of their inventory. Pharmacist 1 gave

a good example of the lack of previous accountability in the hospital’s financial resource management:

> Before 2010 [when] the SEP was implemented, we lacked control of storage areas, and we could not know exactly what we had and what we did not have, which put us in really bad situations when patients or doctors asked for medications that were available on paper but not in the pharmacies.

When implementing a new style of management however a clash of new and old practices was an immediate and caused difficulty in managing as intended. This finding is supported by Alshamari’s (2010) study evaluating the education levels and qualifications of Saudi managers in SAPHS. In particular, the cited study showed, most significantly, that nearly 90% of Saudi managers at hospitals did not have any educational qualifications in health care management, which explains difficulties in managing the hospitals effectively within this frame. In addition, Alshamari’s (2010) study showed that 34% of Saudi managers did not have a bachelor’s degree and that 89% of these managers believed that managing a hospital well depends on experience more than educational qualifications or training courses.

> MOH has opened a large number of new hospitals and medical centres, but they have difficulty finding qualified Saudi employees who can work at, and manage, these hospitals and medical centres. Therefore, cooperation with local (private hospitals) and international hospitals is the only way to operate the public hospitals in a way that can help achieve the hospitals’ objectives. (Consultant)

Furthermore, this shortage included qualified medical staff and was an outcome of the previous policy of hiring staff from developing economies with fewer qualifications as the salary demand would therefore be less; MOH’s budget for PA-run hospitals up to 2010 did not support a wider spending on staffing. This all changed with SEP when the MOH budget increased and more competent staff could be hired, although this was a laborious task. Additionally, in 2012, the KSA government discovered that a large number of the medical employees who come from

these countries had falsified certifications from fake universities. These employees totalled 663, including 383 in nursing and more than 150 in sterilisation, anaesthesia and laboratory facilities (Alriyadh, 2012). All of these factors resulted in pressure on the government, and KFH itself, to adopt new practices quickly. This point is corroborated by the executive manager of medical services, who reported that:

> There was a lack of qualified employees at both the administrative and medical levels. Therefore, the move to the SEP is one of the main steps that the government has taken to solve this issue, as the programme allows us to hire employees that can help us do our jobs in the right way.

However as the patient relations department KFH said:

> Currently, since the SEP implementation, the number of complaints has decreased, which reflects improvement in regard to the services we provide patients, and this can be seen quite clearly in our statistics.

The executive manager of medical services also reported that:

> The number of medical incidents is always used as a KPI to measure the hospital's performance. Comparing the present with the past, we have decreased the number of incidents, and we have reached a level accepted by hospital managers and external organisations, such as JCI.

In 2011 they also had a JCI accreditation in place and with MOH's extended vision they were also included in the national JCI benchmark in 2013. From the above it can be seen that the change to a SEP frame with HCQ was very much driven by the government, but well supported financially via a locally-set budget. In that sense the problem was now both a matter for the centre and at hospital level, as they were now explicitly linked together via accountability on HCQ as expressed in the budget. The King Abdullah stated in a speech that "KSA cannot achieve global competitiveness unless quality becomes the basic standard for all it provides to the world, with a level of excellence derived from the teachings of Islam" (King, 2009).

However, the journey has not been straightforward or easy, not least because of how KFH were forced to implement SEP, IT, and JCI at the same time to make way for HCQ. Therefore, it can be argued that the government has influence in changing the management system from PA to SEP as a form of NPM. This institutional field is very much characterised as the *coercive isomorphism* that reflects the influence of external organisations, including the government, to change public organisations. At the same time for KFH during this period of 2010-2014 there were also signs of *normative isomorphism,* but it was much more mixed and fragmented than what has been seen at KKH, due to KFHs previous experiences anchored in staff with a different knowledgebase regarding management, medical and accounting practices.

6.2.2 Informal non-governmental discourses and patients

Since the Arabic spring and the popular adoption of social networking sites, the voice of the public in Arabic countries has become stronger and exerted more influence for change in most governmental organisations, including hospitals. This has been noticed in KSA during the last few years, during which the government and its organisations have increasingly acted in ways that have met the expectation of the public; the government has taken the criticisms of the public under consideration, and reformed most of its public organisations to meet the demands of the public.

> During the last decade, the public has influenced the hospital....what we do these days is driven by the needs of the public and their evaluations of the public hospitals…. if the demands of the public are to be achieved, it will be as a result of the hospital achieving its objectives that were driven by the implementation of the SEP. (Head of patient relations)

This public non-governmental discourse was, as described in chapter 5, a strong force that demanded attention. It was also clear that it affected the government, MOH and staff at each hospital. For instance, the new management structure was an explicit solution as a response to the critique and allowed for the creation of SEP hospitals. Departments focused on quality and

public satisfaction, including patients, and these departments are directly linked to the highest management levels. With reports demonstrating the progress of HCQ since 2007, this could be used to influence the future and hence 2010 saw KFH included. KFH now had departments for patient relations and QPD. Their main objective was patient satisfaction by following different methods such as assessing patients' views over a wide range of specific issues, and working with employees at different levels to improve the quality of their work and satisfy patients' needs; progress was evidenced by patient satisfaction reports evaluating the hospital's performance. Therefore, huge changes can be seen in the level of services, as well as in the way these services were provided to meet the public's demands.

The patient relations department and QPD implemented different practices to measure and evaluate patients' needs, getting patients' opinions and feedback on a wide range of issues, such as timing, processes and materials. The role of this department was setting quality standards for all levels of procedure. The second part of this role was to supervise, monitor and measure the activities of departments and employees to ensure that standards are fully met.

> The starting point of improving HCQ is the patients, because nobody can know what the patients' needs are better than the patients themselves. (Doctor 2)

This opinion is also shared by the head of department 5, who reported that KFH's improvement started with the shift from merely providing health care to providing health care that meets the public's expectations and the standards of health care in Western countries. He stated that:

> The government has spent much money on improving public health care by implementing different strategies, standards, practices and technologies used in Western hospitals, in order to meet patients' expectations and provide them with the same HCQ that patients travel abroad to receive.

The public discourse affected what the MOH slogan 'Patient First' meant for staff at KFH (and other hospitals). From following procedures, to listening to and caring for patients, addressing

the issue of quality changed how a whole sector worked. When asked what the hospital management meant by this slogan, the interviewees' answers shed light on the public's needs, and ways to use the public's evolving role as one of the main resources to improve hospital practices. As mentioned earlier, the hospital in the past had focused on meeting government objectives, putting less of a focus on social objectives. Therefore, the public's role was not that important in decision-making. However, after the hospital joined the SEP, this role became central, as objectives changed into social goals:

> In the past, no reports or departments were responsible for collecting, reporting, summarising and analysing patients' perspectives on our work, whereas, at this time, patients' perspectives have become extremely important in managing and improving hospital activities. (Head of patient relations)

KFH implemented a number of new practices, including collecting data from patients and their visiting relations, direct contact with patients, online or manual surveys, website discussions and patients' complaints and suggestions.

> The system has changed because patients' requirements have become quite important, and this has forced us to implement new rules and practices that help to meet these requirements. Therefore, during the last few years, patients have become the hospital's managers, and most decisions are based on the patients' needs, as they are the most important members of the health care system. (Executive manager 3)

The role of patients' voices also influenced and transformed expectations of how HCQ can be visualised and how it can increase the competition between hospitals to show proof of their success using JCI benchmarks. However, with less experience and coming from a different set-up, KFH had to learn fast. However, it did mean that staff among different hospitals starting sharing their experiences on HCQ. In this sense the voice from the public created a sense of collaboration of what was needed, as it was not only about competing among each other, it was to achieve the common aim of HCQ. In the past, most of the public hospitals were managed by

the GDHAR, so no competition existed between hospitals because hospital A was the same as hospital B:

> There was not any kind of competition between the hospitals because the public hospitals were managed and evaluated by GDHAR; however, these days we have strong KPIs, medical standards and patients' evaluation that [we] use to compare the results between hospitals. (Doctor 3)

This form of informal non-governmental discourse can be characterised as *coercive isomorphism*, as a power that results from both formal and informal pressures exerted on organizations by other organizations upon which they are dependent, and by cultural expectations in the society within which an organization functions. But it is also quite clear that KFH was in a different position in 2010 to that of KKH, and among a network of experienced SEP hospitals; since 2007 the public voice and expectations re quality were increasing. Additionally, staff were coming to terms with the new requirements and in that sense it can be argued to represent a *normative isomorphism*. Therefore, it can be argued that in KSA, public opinion regarding change required in public hospital services has indirectly influenced the KSA government and its public organisations.

6.2.3 International and national state interfaces: JCI and IT

The new IT system and JCI standards imposed by MOH created both opportunities and problems at the same time for KFH. The opportunities included improved medical practices standards, and tools to process information. However, one key issue was how to handle three significant changes as the same time. Given that in 2010 there was a lack of qualified employees who could use the system and standards effectively, and the heavy expense of changing the hospital's traditional methods to the new management system based on IT and international quality standards, it meant that these ideas had to be dealt with based on collaboration nationally and internationally and through education. The hospital contracted various IT organisations from

inside and outside the country to design and implement the new system and standards, and exchanged some of their employees with other SEP hospitals to implement the new practices. The timescale and therefore pressure was tight however. What was not really questioned was whether this was the right way to proceed and whether there was sufficient time planned in:

> Implementing the IT systems and JCI standards has raised issues because most of the staff has difficulty using the system. These problems have made the process more complicated. Therefore, we work with other SEP hospitals and different training courses have been designed, to improve the employees' skills and ability to use the system and standards correctly. (Head of medical department 1)

6.2.3.1 Joint Commission International

After becoming SEP, KFH contacted several international organisations who already had a JCI accreditation, as well as JCI (see section 5.2.3.1) to get the expertise they needed to progress as quickly as possible, whilst maintaining the quality objective. Such collaboration was also important as they also symbolised organisations with tangible evidence of commitment to ensuring a safe environment, improving the HCQ and working continuously to minimise any risks to staff or patients. MOH had now set JCI as their overall HCQ standard because as an international accreditation it was recognised as an effective tool for evaluating and managing HCQ. While time was pressured for KFH, they could utilise the network of hospitals they could work with and get valuable assistance. Medical and administrative practices were shared and discussed:

> The implementation of JCI standards at the hospital has contributed to HCQ. It also gives us more advantages in comparison with other public hospitals. (Doctor 2)

In addition, the executive director of finance, administrative affairs and operations stated that:

> The move to the SEP has given the hospital management the ability to implement JCI standards that help with management tasks and control the medical, clinical and administrative work.

With JCI, KFH started to fill HCQ with specific 'golden' practices and standards and following hard work they were accredited 15 months later. JCI can be seen to be a *coercive* form of isomorphism. While the new JCI standards gave KFH great advantages by improving the HCQ and management practices, employees resisted changing their activities.

> Most employees always reject change and keep repeating a famous saying in Saudi culture ('God does not change our lives'). In other words, these people do not accept anything new, even if this helps them. (Head of human resources)

In addition, the head of nursing reported that, with the new JCI standards, controlling daily operations has become easier than before because JCI gives the management team the ability to monitor activities and enhance employee performance, which contributes to patients' satisfaction levels. The SEP implementation has at the same time increased the resistance of the medical staff and competition between public hospitals and turned their focus on seeking proof of their achievements based on patient satisfaction. It was a sort of competition seeking international accreditation, to prove to the public and government that the hospitals meet international standards of HCQ.

> The role of international accreditations within the hospital has influenced most of our practices and has made the hospital management and employees more focused on achieving these international accreditations, to prove our success. (Executive manager 3)

> However, we have faced some issues in implementing these standards, such as employees' resistance to the new accountability system we use. (Doctor 2)

> The implementation of JCI standards is seen as just a new way of showing international organisations' acceptance and satisfaction, rather than patient and employee satisfaction. (Doctor 4)

Again, motivation and education became central. It was important to demonstrate the best way of using JCI in practice in trying to overcome the resistance at KFH; resistance that was in many

ways stronger and more persistent than at KKH. It was assumed that with more training and knowledge about HCQ via JCI in this way, they would overcome difficulties. Financial resources were never an issue under SEP to improve HCQ. According to nurse 3, who worked in the hospital for three years and comes from India:

> I have attended so many courses during the last few years in different subjects, which helps me improve my work, as well as my CV. These courses educate me on how to use recent international quality standards in my work and keep me up-to-date with health care advances.

Even if there were other hospitals in KSA already accredited with JCI, they were different from hospitals which were previously MOH PA-managed ones such as KFH. If KFH worked hard on the implementation of JCI quality standards in providing higher quality levels it could also gain a 'competitive advantage' over other KSA hospitals. It could become a role model for the type of hospitals now being included. This would also satisfy and fit with MOH not least as they had already monitored JCI work since 2007 and experienced some of the benefits from a national HCQ perspective. KSA's work was also recognised internationally. According to the executive manager of medical services, JCI standards helped the hospital on several points, including continuous improvement, a safer environment and reduced risk, higher HCQ, increased patient safety, better hospital outcomes and patient satisfaction. With the support from national and international employees KFH could imitate established practises that strengthen the two different hierarchies of medical and administrative expertise, and at the same time respond to queries. It was a network to nourish and to build upon. This was supported by the head of the medical department 3 who mentioned that:

> The medical and non-medical employees who are come from FFH have given the hospital great advantages especially in implementing the JCI standards and accountability practises.

Also Doctor 2 argued that:

> The implementation of the JCI has been driven from the medical employees who come from Western countries with great experience with these standards.

JCI was adopted and used to fill the new HCQ frame. However, KFH came from a different background and the change caused much more resistance and required more effort to overcome these issues. Whilst both *normative* and even *mimetic isomorphism* were part of how ideas and practices were picked up at KFH, especially near the end of this study, still, with time such a factor it is doubtful whether JCI would have been implemented so soon if it had not been forced upon them by MOH; and therefore *coercive isomorphism* better characterises how these ideas were adopted.

6.2.3.2 The improvement of IT

As a part of the SEP implementation in 2010, the hospital was required by MOH to implement an IT system which fell under their new 10 year strategy plan 'Patient First' (MOH, 2010). As shown before, the new system was said to support and serve all users through different services, such as management and employment systems, as well as medical staff. Moreover, the system was also meant to support management teams in planning, organising, staffing, directing, monitoring and evaluating public hospitals' activities.

> The implemented IT system has resulted in an impressive improvement in the hospital and in the HCQ provided. In the past, most health and management practices were carried out manually, which meant a much greater possibility of mistakes, whereas now, these practices are computerised and the margin for errors has become quite limited. (Head of IT department)

This represented a great shift; until 2010, KFH and the network of PA-managed hospitals had very basic IT support. With JCI and HCQ, budgets and targets become more complex. IT could then serve as a stabiliser of the new practices and ways of reproducing them. Therefore, it can be argued that the upgrading of its IT system was an influential improvement for KFH, through the

ways in which it helped users through different services, such as management and employment systems, medical staff and electronic medical services. According to the head of IT:

> The implementation of up-to-date IT at the hospital has improved most of our practices. For example, the management team can now quickly get a clear picture of departments and individuals' performance.

In addition, he reported that:

> ERP, for example, gives us the ability to set up managerial dashboards, create budgets based on current reviews, approve requisitions and process payments, offer self-service human capital functions for managers and employees, use par-level management, do physical inventory cycle counts and monitor costs.

Nurse 2 also said:

> The new IT implementation has made great improvements in all hospital practices. Moving from using paper to computers and great software designed for the best hospitals in the world is making our practices more accurate and timely.

But it was also a device to link the overall management system with quality at hospital level whilst allowing MOH to constantly monitor its own progress. In that sense it also promoted a sort of 'e-governing', a constant tracking and monitoring system so that national objectives were met. According to MOH's (2010) strategy (see section 5.2.3.2), one of the goals behind implementing IT systems in public hospitals is to improve accounting and accountability information systems, which will result in greater effectiveness and efficacy. According to consultant 1:

> The main criticism of all public hospitals, including this one, was the lack of IT systems. The hospital used a paper system for internal and external communication, which led to unprofessional ways of managing medical information. For example, when the patient goes from one hospital to another, there is no clear information

about his or her medical history, which causes a lack of integration, a high degree of repetition and a pervasive loss of medical data.

The improved IT system not only influenced management practices but also enhanced medical practices to help increase HCQ and raise patient satisfaction levels. Previously, most medical practices, including scheduling, registration, summaries of patient medical information and laboratory tests and results as well as x-ray, pharmacology unit and ambulatory care clinics results, were carried out manually, which negatively influenced the hospital's HCQ.

According to all previous points described by interviewees and MOH documents and reports, the hospital used the IT system and JCI standards that were developed in international health organizations in order to increase HCQ and raise patient satisfaction levels. As a part of this transformation, new practices that used the new IT system, such as tracking and monitoring KPIs, have been implemented to improve public hospitals. Further detail on those practices is presented in the coming sections. Such change has been described in the NIS as *mimetic isomorphism*, which may be seen as a growing similarity between the effectiveness and efficiency of Saudi public hospitals and those of international health organizations that have successfully implemented both the IT system and the management practices that depend on the new IT system.

However as a result, a 'spirit' of competition between hospitals and other health care providers started to emerge within the country, as previously mentioned. In the past, competition was not particularly important to hospital management because it was managed by the GDHAR, with no or little monitoring and reporting of differences between the hospitals in the region and kingdom. The IT system was seen as a guarantor for bridging the gap between locals. So while again the new IT was hard work to implement and was met with resistance, KFH had an ambition to be a successful hospital as compared to others, now that it had the right to manage its operations in

ways that generate better services. Therefore, the hospital also focused on other hospitals' improvements and tried to take advantage of links with other SEP hospitals.

> The SEP implementation has increased the level of competition between hospitals. Therefore, to prove our hospital management is successful, we have to improve the HCQ greatly. (Executive manager for financial, administrative affairs and operations)

The character of how IT was implemented follows similar patterns of isomorphism as with JCI in that is *coercive*. This is perhaps of no surprise, as after all JCI and IT were implemented at the same time following influence from MOH who needed a way to monitor. In a model like SEP, decentralising of certain decisions meant that they were only decentralised in a frame, a frame that was set centrally. One key to keeping the model running and working was that MOH needed to monitor action at a distance, and IT and its programmes provided the solution.

6.2.4 Professional development and involvement

Before 2010, hospital employees (medical and management) were employed and administered by the MOH. This mean that there was a non-written agreement between MOH and employees that their working hours were set to six hours per day for five days a week, that salaries would increase at a fixed annual rate, and that employees would have 45 days of holiday per year. As they did not have to sign a contract, this meant that MOH could not fire employees as long as they came to work every day. At this time KFH had around 850 employees and most of them were Saudis or from other Arabic countries such as India.

The SEP implementation changed this as KFH could now employ and manage human resources. With new financial resources as well, KFH started to change their overall knowledge base employing more qualified medical and management staff from Western hospitals. This had a major effect on the HCQ and how they worked. It also changed the composition of nationalities. By 2014, the number of the employees increased to more than 1300 employees with more

diversity especially from Western countries (28% US, Austria, Germany and the UK; 23% Philippines, India and Arab countries; 6% other countries; 43% KSA).

A key decision KFH made in 2010 was to change the condition for employment. First it introduced a written contract that had to be signed by the hospital and the employee. With that it could also define the content much more specifically including targets and job descriptions. They also specified working hours per week, which now increased from six hours to eight hours, and the fixed annual increase in salaries was linked to employees' targets. In addition, the yearly quota of holidays decreased from 45 days to 30 days, and gave the hospital management the ability to terminate employees if they were not doing their work as outlined in their contracts. On the other hand, and to better motivate staff they offered more education programmes and training courses to help in career development. But overall it was a dramatic change and resistance among employees emerged:

> The movement to the contracting system has given us the power we need to improve employee productivity based on the new accountability system and targets, which helps us meet SEP objectives. However, we still face some issues with old employees, and this will be resolved with time. (Head of human resources)

With a new employment system in place, KFH was in a different position in terms of pursuing their agenda regarding SEP, IT, and JCI. With increased training, new staff, and a network of supportive hospitals, new ways of working in every area - medical management and accounting - began to take shape. According to the executive manager for financial and operations, health care in KFH could be improved by upgrading different aspects, not just quality standards. He suggested that, to get better HCQ, the hospital needed to improve in three main areas. The first is the workplace and equipment used to treat patients, including information and communication technology. The second is to employ very qualified medical staff from Western hospitals, and improving existing hospital employees' qualifications by educating them in the latest models of

medical and management practices. Finally, the hospital needs to have precise KPIs that ensure employees fully experience the power of evaluations. This opinion is shared by the head of human resources, who said:

> One of the main issues that the hospital faces in improving HCQ is that most of the employees do not care about their progress reports since they are government employees.

However, according to the hospital's executive managers, the hospital must develop across six aspects in order to achieve high HCQ: to be safe, timely, effective, efficient, equitable, and dedicated to putting patients first. According to the head of QPD, HCQ in the hospital is measured based on these dimensions. Therefore, different kinds of PMs have been implemented to ensure greater quality.

> SEP's focus is to solve the issues that arose from the lack of the supervision over employees. In the past, the hospital was run as a government organisation, without considering elements of quality such as safety, effectiveness, patients first, timeliness, efficiency and equity which led at the end of the day to deficiencies in the quality of services provided to patients. (Nurse 3)

The job descriptions and requirements for top management positions and medical employees are basically built on consultants' ideas and benchmark hospitals in the kingdom, such as FFH in Riyadh (the first hospital to implement the SEP). However, most of the directors at KFH do not meet these requirements and are unaware of their job descriptions. They are doing their work by using their experience as their main guidelines.

> The hospital was based on government employment regulations, and it's not easy to change the staff's way of thinking and doing their work with a short time. (Executive director 1)

It is important to mention, however, that the hospitals that implemented the SEP started establishing good relationships and coordinating with each other, as they were sharing the same goals. What was successful for one of the hospitals often was successful for others.

> We are currently trying to see what other hospitals do to achieve their objectives, and then to follow their steps. (Head of medical department 2)

In addition, the head of QPD reported that:

> The SEP helps us to implement new management practices to meet SEP objectives, but the current management team are from the old school and to convince them to try contemporary practices sometimes is not easy, as these practices will reveal their own weaknesses.

Since this competition started between hospitals that were previously PA-managed, KFH has begun to improve its practices to achieve good HCQ, sending its employees to institutions inside and outside the country to improve their skills so they can deal with new practices. One of these institutions is the Institute of Public Administration. This institute is a government organisation that offers different courses throughout the year aimed at improving the qualifications of public health employees. Most of these courses focus on aspects of quality. Furthermore, MOH has designed a scholarship programme for public hospital employees to develop medical and managerial skills. This is also used as a way of motivating the employees and to decrease their resistance to the new ways of management and work methods.

> The hospital, in the last few years (2010- to 2013), has tried to invest in its human capital through training courses and a scholarship programme, because qualified employees is the main factor that helps us to achieve the hospital's objectives. (Head of human resources)

The change of employment contract was indeed a *coercive* form of isomorphism, as the new written employment contract made way for other writing and specifications, convincing and directing staff as to what to do. There was also *normative isomorphism* in

play, coming from medical staff, accountants and management, stabilising the coercive form and forming its content. With more working days per year and hours per day, more could be done. Given that much had to be achieved in a short period of time, this was a solution that fitted well. But it was also important in keeping motivation high given these dramatic changes, and as such it was very much linked to their profession through training and education as a form of *normative isomorphism*.

6.3 The emerging and changing roles of MA in managing quality

The following section will revisit MA change in more detail in order to better understand how far MAPs were promoted to manage, to coordinate and monitor human and financial recourses that also include HCQ. From the analysis, important shifts regarding the role of MA emerged between 2010 and 2014. This section is hence divided into the same points as in the previous chapter, using the same analytical categories to understand three important shifts.

6.3.1 The role of budget

Before 2010, the hospital's budget was based on a traditional bureaucratic PA, and following procedures was the key to control activities as a way to ensure political objectives were achieved. In practice this meant that KFH estimated its yearly budget for the next year based on hospital objectives (according to the law) and the previous year's expenses starting in October (Muharram, First month of the Islamic calendar). It was not so much about KFH having their own budget and being responsible for it, it was a matter of serving and helping MOH with financial detail so that they could apply for funding from the government. The GDHAR prepared the budget for all the region's public hospitals and then sent this to the MOH, which allocated funds for all Saudi public hospitals' budgets. While KPIs were used, performance evaluation was from a traditional approach which caused most of the issues in HCQ. Head of department 2 reported that:

> Traditional performance appraisals cannot achieve the hospital's new objectives as they are unprofessional and do not reflect employees' productivity and actual performance. I have never seen any performance evaluation fall under 95% because these appraisals are subjective, which means they are strongly influenced by the personal relationships between the department heads and their employees.

After the SEP implementation these processes changed as hospital management became more responsible for managing financial resources and using these for internal purposes, such as monitoring department level activities. The role of the budget from MOH and MO perspectives was to use it as a commitment for future HCQ monitoring and therefore of outcomes and performances. For KFH this meant changes in the use of the budgetary system, which led to improvements in the hospital's budget practices so that these are now consistent with MOH contracting hospitals.

> In the past, we allocated our budget just to show the MOH our strategy for the next year and to help them estimate the sector's budget and link our strategies to theirs. However, this changed after the SEP. Now, we plan our budget not just to get MOH funding but also to use financial resources in the best way to improve the hospital, as we are now in charge. (Accountant 3)

Three of the department heads said KFH's budget has become more important than before, as top management uses the budget to monitor and control department level operations. This was a big change for them. The SEP frame gave them a financial situation within which they could act on HCQ. Furthermore, they asserted that using a new set of budgeting practices helped them to visualise and think about departmental strategy for the coming year, since their performance would be measured against targets at all levels.

> Budgeting involves us somehow. We participate in putting together hospital objectives and getting a clear understanding of the hospital's direction. However, we still have to face some issues since employees are not familiar with these new practices. (Head of the medical department 3)

In this way the budget was perceived differently from the (non) budget at KKH, at least initially. In addition, the new way of allocating the budget had increased the coordination between departments as, in some cases, departments shared objectives. For example, the executive manager of nursing services reported that, in the past, the nursing and other medical departments were not connected. Therefore, when these medical departments expanded their capacity or decided to open new sections, they put the nursing department under pressure to cope with these situations, as these were not included in their budget plan. It also meant that more staff were participating in the budget process. For instance the nursing department takes part in allocating the budget of each medical department, to include their goals within the nursing department's objectives. However, with these improved budget practices of planning, monitoring and controlling medical and administrative operations within departments, several issues have arisen. The first issue concerns employees and their experience in executing the department budgets.

> Employees have faced important issues in dealing with the all improvements that have happened in the hospital during the last few years; therefore, they need more time to do their work as it should be done. (Medical department head 2)

Another issue concerned the mistakes that emerged from external factors such as the changing prices of medical products.

> We plan our budget every year, but we always run out of funds because the price of medical equipment, for example, is something we cannot control. (Medical department head 1)

Considering that MOH was well-informed of KFH's budgetary performance which did not take into account external price changes, KFH felt that they were evaluated on issues they could not control.

> Our general performance is assessed according to a particular procedure based on the extent to which the goals defined in our plan are met. In actuality, the hospital's real

> performance can be evaluated in relation to other hospitals operating in same area. However, unfortunately, this assessment is not possible in our case because self-operating hospitals are new in KSA and this information is unavailable. (Executive director for medical services)

This problem was also mentioned by doctor 5, who argued that KSA faced special medical issues from time to time, which directly influenced previous PA-managed hospitals' finances and made costs run over budget. The example that this doctor gave in support of his argument was regarding diseases that come into the country every year during Ramadan and when Muslim pilgrims fulfil their Haj obligation:

> During Ramadan and Hajj periods, nearly five million Muslims from around the world come to fulfil their religious obligations in holy places, and they bring with them different diseases that we need to deal with, which makes budget projections difficult.

Another difficulty in allocating the budget was reported by doctor 2:

> Saudis showed a high level of diabetes, as compared to figures worldwide, in 2013, which could result in different medical issues, such as damage to eyes, kidneys, feet and hearts. These things are one of the major issues for hospital budgets, especially when patients do not follow diets and other medical recommendations.

Despite these issues around the budget, an interesting point that all of the department heads mentioned was that the budget allocation was seen as a way to develop a future plan for the departments rather than to exercise financial control. In other words, the budget was seen as a helpful tool not least as how top management could use it to strategies future improvements.

> The role of the hospital's financial department in controlling our department's budget for the next year can be seen in the basic questions they ask us. For instance, can the cost of activities be cut next year? If our department members reply, 'No, we cannot', we have to include this in the budget. The [financial department's] decisions most of the time are not opposed to what we need. (Head of the medical department 4)

The role of MA as a new kind of budget developed both as a *coercive isomorphism* but also as *normative*. *Coercive* in the sense is that it was a forced framework via SEP. However, it was quite clear that it was received as a positive tool and quickly became a vehicle for collaboration among staff at all levels and professions, leading to positive change. The frame was a generous financial frame with carrots and sticks. The down-side in terms of targets could and did enhance development of professionalism and expert knowledge, not least so that HCQ could be argued for internally and especially in convincing MOH, and in it that sense was *normative*. The budget was more visible at the start of SEP. The budget practices started to become normalised and as a (non) budget the focus became HCQ.

6.3.2 Turning the MA role to total quality management

New budget practice allowed for collaboration and innovation amongst staff and also amongst other hospitals regarding HCQ. It was also now time to readdress TQM as an earlier reform attempt, because the context had shifted so that MA with TQM made better sense.

In 1990, the MOH introduced TQM to achieve higher HCQ. However, this implementation was unsuccessful to some extent because the MOH treated PA-managed hospitals as separate units in applying TQM (Albejaidi, 2010; Hamidi and Zamanparvar, 2008). Therefore, the TQM implementation in KSA hospitals was only partially carried out. The people involved in the TQM initiative were all top management, and as such were the ones who had the knowledge of how TQM could improve HCQ. Following their TQM training, these people were expected to monitor medical departments extensively and to make sure that what they had learned was translated into practice. However, this was done with little success.

> TQM was just on paper and in the occasional MOH training courses for the top management team, but, in reality, we did not experience TQM before SEP was

> implemented and the QPD was introduced and put it to work in the hospital. (Medical department head 1)

Al-Qahtani and Al-Methheb (1999) conducted a study to investigate TQM implementation in Saudi public hospitals. They found that this implementation faced several issues in the KSA context, including, among others, poor IT and financial systems, a management structure centralised on the MOH, a lack of KPIs and a shortage of qualified people to manage public hospitals. In 2010 after the SEP implementation the situation was very different. The (non) budget, linked closely with KPIs and decentralised decision-making to fill its frame with HCQ, was now the responsibility of hospital management rather than MOH. With MA in place it could now explicitly be integrated with TQM.

According to the interviewees, since the SEP implementation KFH has changed its practices to keep pace with the country's advances, especially after KSA became a member of the World Trade Organisation and G20. The implementation of TQM at the hospital appears on different levels. The first is the increasing number of qualified employees in medical and management positions as compared with the past. The second is the public's strong demand for high HCQ, which has required the hospital to initiate management practices that can help to achieve this high quality. The third level is improved IT and KPIs that help the hospital in administrative and strategic decision-making. The last element is international accreditation measuring the hospital's performance against external standards.

> The improvements in the hospital have resulted in a great environment to introduce successful quality practices that help to achieve the hospital's objectives. For example, the implementation of TQM has reduced the number of patient problems and complaints. (Executive director of medical assistance)

KFH could now focus on the seven principles to implement TQM[10]. One principle referred to leadership, which after the SEP implementation meant internal leadership roles that became stronger than ever before. One of the executive mangers 3 stated that:

> The movement to SEP gave the management team the necessary ability to implement any management practices and strategic planning.

Changes in hospital leadership roles have contributed to the improvement in HCQ, as managers have become more responsible for planning, monitoring employees and measuring their performance for quality achievements, as well as to improvement of quality in the hospital as a whole.

Regarding the employment system, they had already changed how employment was organised by a written and signed employment contract specifying roles and targets. The employment contract linked the HCQ to the TQM idea while using financial resources to keep staff motivated, and working with the management team to achieve hospital objectives. Therefore, the clinicians' role became more important than before as they participated in efforts to improve quality and resolve issues related to quality. There was in that sense no reason for clinicians to resist what seemed to acknowledge their medical expertise and experience. MA role towards TQM was hence reproduced and internalised.

> Now, we work as a team to improve our work and achieve our own and the department's targets. When we nurses work together to coordinate our efforts to solve any issue we face, this results in an improved HCQ and patient safety. (Nurse 4)

After QPD was established in KFH, it became responsible for providing the management with information regarding quality performance at individual and department level. The interesting

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[10] These are leadership, patients first, employee training, employee management, information analysis, continuous improvement, supplier management and international accreditation.

point is that this department fills the role of a MA department in monitoring the hospital's HCQ. The department contains 12 employees, seven of whom have obtained accounting degrees from international universities and four of whom have earned master's degrees from the US and UK.

> The improved HCQ has come from the substantive measurements that QPD has created, which help us to get a clearer picture by providing us with statistical quality reports for all levels of the hospital. (Financial manager)

Upgrading the hospital staff's education level was key to keep the TQM implementation and other innovations ongoing. As a result, KFH's management designed different courses with national and international institutions to offer training that would contribute to quality improvement concepts and practices. From this point, it can be seen that there is *normative isomorphism* that comes in the form of an increasing professionalization.

> Training courses that doctors and nurses attend regarding quality and hospital practices to improve quality lead to a clear understanding of quality concepts and to the successful achievement of the hospital's objectives. (Executive director of medical services)

TQM and quality was also enhanced by the new department of patient relations, focussing on collecting information on patient complaints and satisfaction with hospital services. The head of the patient relations department reported that the link between the quality of hospital services and patients' expectations and satisfaction levels has helped hospital management at different levels to redesign the hospital's services, to ensure the entire hospital is working in ways that are acceptable to patients.

The work on quality was also promoted by a new supplies department responsible for overseeing logistics, developing services and obtaining equipment and medical materials, as well as managing the information systems needed to coordinate these activities.

> Under the SEP, we have the budget to supply medical employees with the latest medical devices and materials, to ensure the HCQ improves. And, with updated technology, the process of placing orders has become extremely easy and quick for all employees, which helps us to get things on time. (Head of the supplies department)

MA's budget role was increasingly integrated with activities that KFH was filling the SEP frame with. TQM was a wider way of looking at quality where international standards such as JCI were of course key. Guided by the HCQ budget, a discourse of TQM and quality KPIs, MA's role shifted more permanently. It also meant much more accountability and more control over human and financial resources, as well as 'empowering' clinicians to participate in improving HCQ.

The downside of all this and especially from the clinicians' point of view was how the extended TQM quality frame put strong pressure on employees to meet targets, not least as the employment contract allowed the hospital's top management to change performance targets and measurements. Offering another, less positive perspective, the head of the medical department 3 stated:

> The implemented PMs and international standards of health care do deliver the best possible care to patients. However, most of these PMs are unacceptable to clinicians, as they feel that using this evaluation method shifts their focus from patients to measurements and targets.

Still it did not change fundamentally how the practices supported a new role for MA.

> Two departments offer us the information needed for decision-making on a monthly basis. These departments are financial and QPD. This information helps us to know where our strengths and weakness are and to address weaknesses, which has led to increased patient satisfaction at the end of the day. (Medical department head 1)

This changing role for MA was based on placing greater significance on financial and non-financial accounting information, especially as it was linked to productivity and quality as a linked coupling, creating a need for more information so that more could be seen.

> Improvements in PMs during the last few years have helped us to increase the HCQ, as well as employee productivity. Comparing the past with the present, each job has a clear focus, and expectations for each employee are well known, which contributes to achieving the hospital's objectives. (Medical department head 3)

For each written statement and account, more could be analysed and scrutinised and better quality could be achieved. MA showed its potential in visualising whatever could be named and counted, and became the main resource for decision-making and improving HCQ. In many ways the change rested on the (non) budget now working in the background, which directed staff's attention towards quality. However, given that it was very much a mix of *normative* and *mimetic* isomorphism in play as it appealed to a range of professions' status and development, at the same time it was *mimetic* in the sense that it was practices that offered status nationally and internationally.

6.3.3 Interplays of MA and TQM around 'quality benchmarks': new visibility for all

While the period 2010-2014 is quite short, a third role started to emerge when MOH made JCI the national benchmark in 2013. KPIs linking productivity with quality was now a fact, despite some considering it to be questionable. Most interviewees in management reported that the new PMs had produced more reliable information for decision-makers, as well as helping with communicating and implementing hospital strategy. New and different performance indicators were implemented to measure the processes and outcomes of HCQ such as being safe, timely, effective, efficient, patient-centred and equitable (as per WHO standards). Therefore, to meet this objective, the hospital divided its health indicators into financial and nonfinancial (qualitative).

> We did not witness any real changes in PMs, but with time, new practices and indicators have been implemented, which have fostered a strong focus on the patient services we provide. (Doctor 2)

What MA had previously offered was not sufficient; KFH and MOH had to compare productivity to set realistic targets.

> We are still facing problems in setting the targets and performance indicators that we have to use; therefore, the data provided by these PMs still need to evolve. (Executive manager for financial, administrative affairs)

This was a key concern for MOH (in terms of benefits for the population), who worked to find KPIs with commonality for patients linking indicators to their requirements. For example, the indictor that measures the time that patients spend waiting in each department from registration in the main reception to the end of their stay counted as one productivity measure of the hospital's performance, and is used to set targets for reducing patients' waiting time.

> Nowadays, most of our quantitative performance indicators focus on social aspects such as the waiting list, time that patients need to receive treatment, patients' satisfaction levels and other aspects that help us to improve the level of services provided to patients. (Executive manager of medical services)

Another KPI that received much attention from hospital management is patients' satisfaction with hospital services. Previously, considering patients' opinions regarding these services was not that important. Now they were in a position where the patients and their views on services was one of the hospital's main KPIs. MA yet again offered new visibility. With new common JCI KPIs linking all SEP hospitals, KFH was now to be included in the overall national benchmark of JCI, with a ranking list visible to all.

The head of human resources reported that most of the additional monthly allowances that doctors and nurses receive depend on patient satisfaction with hospital services. Therefore, clinicians paid close attention to this indictor to protect their personal interests and meet the hospital's objectives.

As with KFF in terms of KPI development, strong resistance was building up amongst staff, as it put pressure on clinicians' and employees' work performance.

> The new PMs have changed our job to considering numbers that reflect our work. We have become machines rather than doctors. (Doctor 2)

Although most interviewees asserted that new KPIs based on the international quality standards have influenced HCQ in positive ways, they also received criticism as they were seen as a way to control them. Three out of five doctors and four out of five nurses believed that new accountability and KPIs had given top management the power to control their activities, more so than to improve HCQ. PMs and KPIs were understood as managers' descriptions of doctors and nurses' performance more than measurements of productivity and HCQ. Comparing KKH with KFH, the resistance to new accountability and KPIs in the second case study was much stronger than in the first hospital. One reason for this difference between the two was that KKH was managed differently and the role of both financial and nonfinancial PMs was to gain economic interest. However, in KFH, the PMs and management practices were quite basic, and they did not have any actual influence on the doctors and nurses, which is the case today.

> PMs are designed without any consideration of our main roles. We are doctors, and we have to do what we see is the best to save patients' lives, not what targets or measurements want us to do. Linking the decision to renew our contracts with PMs put us under pressure to prepare good explanations for monthly meetings with the QPD. (Doctor 1)

> In most cases, I have to follow what the department needs me to do to help patients, without any thought to PMs. Honestly, I cannot focus on any performance aspect more important than human life. (Doctor 2)

> PMs have become more important than patients' lives. Therefore, most clinicians meet their targets first and then, only afterwards, see if they can do something that really improves HCQ. (Doctor 4)

The role of KPIs constantly triggers discussion between clinicians and QPD. The KPIs cover all the clinicians' activities, including waiting lists, waiting times, JCI standards, patient satisfaction, the number of patients and medical incident reports. In this context, the explanations given by department heads and the QPD are not given the same weight as clinicians' arguments. This is because clinicians have strong reasons in some cases, revealing an extremely pressing need to ignore performance indicators and focus on patients' lives.

> Doctors do what they feel is good for their patients without any attention to PMs, with the result that I have faced strong criticism from top management of how I manage my department and clinicians. (Medical department head 2)

In addition, the head of QPD reported that:

> The doctors have many reasons to give for why they do things in certain ways; therefore, if they do not change their orientation and beliefs, nobody can force them to value PMs.

A further influence that new accountability and KPIs have had on clinicians is the IT technology, which has helped to transform MA yet again but which is seen as complicated and difficult to use. In the past, most management tasks were done manually, and most clinicians used to do their paperwork by hand as well. However, the new MAPs based on IT systems were a struggle for clinicians, as they needed to develop the skills to use the new technology and comply with new practices. Most employees, including clinicians, feel that, with the implementation of up-to-date practices, they may have lost most of their rights and power.

> PMs and budgeting systems make our work more complicated and, to cope with this, we occasionally attend different courses to improve our skills to use these practices in the right way. And, if we do not do that, we will lose our administrative position. (Medical department head 2)

In addition, Saudi nurse 1, who has been working in the hospital for more than 20 years, said:

> I have been working in the hospital for a long time, but what has been done during the last few years has changed our role. We have become like students at a business administration college, which means we have to learn business and private sector practices in order to keep our job.

There was support among managers. According to the executive director for medical and clinical services, the implementation of the new MAPs helped the hospital management to examine HCQ from different perspectives, such as that of patients, clinicians and international health organisations. In addition, he reported that the new MAPs also empower clinicians and patients to participate in improving HCQ. Previously, for example, the clinicians' role was restricted to medical practices, whereas now, they can act on different levels of the hospital management structure, helping to improve HCQ and the hospital's accountability system.

> Clinicians have become more aware of their performance and the accountability systems. Therefore, meetings are conducted with clinicians from time to time to discuss their performance and determine the best method of measuring their performance to improve the hospital's level of quality, as they are one of the main factors in quality improvements. (Medical department head 2)

The next period when MA role yet again changed (2013-2014) was very much driven by the potential of KPIs and MA to offer new visibility and incentives to keep the focus on HCQ. The benchmark of JCI made key KPIs available to all and as such interacted in the overall discourse about HCQ at MOH, within social media and most importantly for hospital management. While the resistance at KFH was palpable it did not really change the overall direction or the practices now in place. The clinicians were invited to participate in developing KPIs and decision-making processes, so there was to a certain extent scope for change, albeit a shift in the same direction. At KFH, the role of MA as (non) budget, integrating TQM and in creating visibility for all was driven by *coercive isomorphism*. Much occurred in the final year of study, and more *normative isomorphism*-driven change could be identified. At the same time KFH had a much more

fragmented style of adoption where there was some support but also much resistance. It should be noted that when KFH adopted SEP it did so with much less experience of this type of management, and it did so with much to achieve in a short space of time. So while there is a similar pattern of MA change as at KKH, it was very much more fragmented, less focussed, and more *coercive* in its style of adoption. However this may change over time, as the (non) budget is still operating in the background to support and motivate for further HCQ.

6.4 Conclusion

This chapter presented the second case study selected to analyse MA changes within the SAPHS given the new reform of SEP. Between 1988 and 2010, the hospital was managed by MOH central branch, formerly based on PA. However, from 2010 and up to when this study ended things changed dramatically. SEP enforced a structure of hospital medical expertise hierarchy with an administrative hierarchy to produce HCQ with efficient and effective aspects, as mentioned in the previous chapter. However, financial resources were never really an issue as long as HCQ targets were met, both at the level of KFH but also at the individual level. From 2010, the role of MA at KFH changed several times and continued to change. It was a time when there was already a network of SEP hospitals in play reporting success in HCQ and it was difficult to perform otherwise as a newcomer. Previously there was a distinct role for the budget, however the (non) budget role came to influence the basic frame for MA change from 2010 and onwards. TQM also rose again, becoming integrated with MA as a solution for HCQ, and central to for the experiences for KFH as well as other SEP hospitals. There were new ways of connecting performance and productivity to a benchmark of JCI, from each individual employee contract, to each level of the organisation, to MOH, for everyone to see anytime and anywhere. The new reform strongly influenced the management and medical professions which had a strong resistance to the new KPIs and accountability system. Overall, it was in many ways an MA change of *coercive isomorphism* given the analytical categories used, with strands of

normative and few mimetic influences. That said this may change in the future as the process will continue. There is still a major job to be done until all of KSA's hospitals are under a SEP frame. The next chapter discusses and explains the case studies' main results in order to answer the research questions.

6-1: Summary of the changes in the KFH

	KFH	
Main features	Before	After
Management system	Administrative	New Public Management
The main objective	Political acceptance	Improve Quality
The main focus	Political needs	Medical needs
Strategic focus	Central planning in the MOH	Central planning with coordination with MOH
Services concept	Providing health care for all citizens	Providing health care with high quality for all citizens
Accounting system	Governmental type	Business type with focus on non-financial control
Budgeting use	External	External
TQM	Partly implemented	Fully implemented
Costing system	Benchmark	Benchmark
Performance measurements	Poor performance measurements	Based on quality targets (non-financial)
Resistance	Not existing	Exists
The role of MA	None	Strong
Relation to MOH	Dependant	Mix between autonomy and dependant

Chapter 7 : MA as 'Solution' to HCQ Problems

7.1 Introduction

The preceding chapters have shown how MAPs and forms of management via accounting, initially developed in MBE settings from the 19th century and greatly diversified across the 20th (Ezzamel *et al.,* 1990; Johnson and Kaplan, 1987; Chandler, 1977), were adopted and implemented in the context of a new initiative for HCQ in KSA hospitals, which began in 2007. They have also shown some intriguing differences in the form of implementation of health care improvements from conventional contemporary forms of management deploying MAPs, so that it is possible that the events studied in this research project may offer some new perspectives or even challenges to conventional understandings of how MA operates, specifically in health care settings and perhaps more generally. In particular, this study has noted how the approach to budgeting to promote health care improvements differed from most contemporary settings, given that the approach did not begin from an assumption of having to make improvements under a condition of 'scarce resources' either in the sense of inbuilt 'absolute' cost constraints or of having to justify proposals in cost-benefit terms. Therefore in a central way, the organizational set-up within which the MOH proposals were to be implemented differed from most settings within which MA change has been studied. Furthermore the situation can be argued to have been different in a significant way from what has often been presented in textbook or research settings as what managing via accounting necessarily requires, insofar as this can be interpreted as a 'non-accounting budget' approach in Hopwood's (1973) terms. For even while this approach has continued to be mentioned in textbooks as one of three possible approaches to budgeting, the focus of research studies (and of textbook cases) has been on cost-focussed or profit-conscious budgetary forms, on the basis that these are the two approaches most commonly found. One of the significant features of this study is precisely that what is commonly the case is not always so, and in the KSA context, state finances were such during the period of this research that it was

possible to attack a perceived priority problem; in this case the quality of health care as measured against international standards utilising Hopwood's non-budget accounting approach.

At the same time, as discussed in the methodology chapter, the approach to theorising this particular initiative, with its non-budget accounting dimension, was guided by NIS, drawing particularly on how new ideas can generate forms of isomorphic behaviour in different organizational settings. Drawing on NIS concepts, this research was looking for both regularities in patterns of action or behaviour across such settings, but was also seeking to be sensitive to the range of different experiences encountered within particular organizational micro-settings. In this way it was hoped to develop insights into the relations between 'how' HCQ initiatives were implemented, drawing on MAPs within a non-budget accounting frame (the 'how' questions developed in the methodology discussion) and what the outcomes were in terms of improving healthcare quality, and what could be said about the regularities and differences observed (the 'why' questions from the methodology discussion). The respective patterns of experiences in the two research sites have been reviewed and summarised in chapters 5 and 6, therefore giving an initial insight into how the initiatives unfolded in terms of regularities and differences. Therefore in this chapter the focus is on seeking to go more deeply into what has been found, and so to answer some of the relevant 'why' questions, and thus to give a deeper understanding of how MAPs developed and contributed to HCA change at SAPHS.

This specific analysis needs to be framed in terms of how and how far HCQ change has progressed more generally across the period studied. The current situation in KSA is that the MOH has now moved 99 of the hospitals in the country (out of a total of 264) into the SEP system, and has in that process seen significant improvements in HCQ ratings, as measured against international standards. At the same time the rich detail assembled in the field studies undertaken here indicates that, at a more 'granular' level, there have been different types of

outcome and different emergent challenges, as could perhaps be expected when the SEP system was rolled out in different kinds of hospitals; such as the two case study hospitals here, which had different prior experiences of delivering health care solutions. As the HCQ initiative is rolled out within the diverse range of hospitals already undertaking it and also within the 160+ other hospitals within KSA, the findings here may prove helpful. The following section will hence discuss these diverse outcomes from a MA change perspective.

7.2 Institutional roles of MA change in enabling and delivering HCQ

There were aspects in which the first two phases of roll-out of the HCQ initiative were different, and these will be discussed further below. At the same time, the way the initiative was set up, with the commitment to a SEP principle, ensured that there were variations in local structures and processes but some underlying similarities. In particular, once the pioneer institutions had developed their SEP solutions, there was the structural similarity that all came to operate with non-accounting budgetary systems in which MAPs were focussed on delivering effectiveness and efficiency, but without a focus on the first of the 'E's', 'economy'.

Perhaps the second significant similarity relates to the way that the use of MA enabled the general concern with HCQ to be operationalised along two complementary lines: first, at the effectiveness level it had major roles to play in helping to define and then to track and evaluate quality performance metrics; at the same time at the efficiency level it could produce the kind of measures that could again define, and then track and evaluate, staff productivity. This, it is argued here, was particularly feasible because of the 'non-accounting' budgetary context where the budgetary system allocated increased financial resources so long as the 'Quality Vision' was translated into an acceptable form of local implementation (including acceptable benchmarks for quality outcomes), and so long as the metrics on health care outcomes were acceptable.

But this indicates how integral the MA and actual MAPs were to making the non-budget financial framework work, in terms of inputs to tracking and evaluating the relevant effectiveness and efficiency metrics, and perhaps to some extent through inputs to the development and refinement of specific benchmarks, particularly as the JCI system was introduced. For JCI, even as a 'gold' standard system of benchmarking, has to take into account cost-benefit considerations in the decisions it makes about HCQ *priorities*; to this extent accounting metrics were already embedded in the gold standard system.

Beyond this, MA was also, it may be suggested, able to develop increasingly central and significant institutional roles as the HCQ regime was rolled out. For instance, it arguably had a significant 'mediating' role in the translation and embedding of the high-status institutional knowledge and expertise which largely came from the US into the KSA hospital settings studied. For while elite the medical professionals might accept its importance straightforwardly, this was not necessarily going to be the case across the workforce more generally. But as the high-status institutional knowledge and expertise was translated into quality and productivity targets and measures, it then took a form where the workforce understood the importance of acting in line with what high-status knowledge and expertise required.

One further feature of MA was the continuous operation of its measures and evaluations of quality and productivity across the workforce. The feature arguably played a significant and ongoing role in the management of change towards a new working system, since individual staff and units could track the contributions made by themselves and their units to quality outcomes. Comparisons were also possible between units, enabling real-time identification of problems and the sharing of best practice, as well as timely intervention by unit-level and higher-level management. Here MA could promote what may perhaps be interpreted as a mix of *coercive* and *normative isomorphism*, as similar structures and processes for managing change were imposed across the organization, but decisions about what change to adopt were knowledge-based.

In this respect, of course, a major ‘add-on’ to the management process was the adoption of the new IT system which enabled the far more detailed and speedy delivery of information and analysis for monitoring and feeding back on performance and enhancing quality outcomes. MA arguably contributed to the institutional implanting of IT systems since it provided so much of the content they were required to process, and this content was already internalised into the daily activity of the workforce as integral to achieving quality outcomes.

Finally, there was also arguably a ‘human capital’ role for MA, given how productivity measures were a key means of identifying ‘good’ or ‘promising’ workers within each hospital, and given how good work performance was a key criterion for fast-track selection for training and professional development opportunities. Both hospitals sought to improve their employees’ skill and knowledge bases by conducting different training courses and offering scholarship programmes to increase the number of employees who understood MA and could change their internal cultures, assisting in the process of achieving greater service quality and reducing resistance to new policies. Thus not only did MA contribute to selecting staff for training to enhance the hospital’s human capital, it was also an object of study in itself. In this respect MA arguably had more than one institutionally valuable role at the level of ‘learning enhancement’ and developing ‘human capital’ as the workforce came to understand the importance of doing well in MA metric terms; in this role it could help implant and improve the HCQ system as it was extended to more and more hospitals in a process that has continued since the fieldwork for this study was completed.

The next part of this section reviews how, in NIS terms, MA contributed to the management of change in the two hospitals studied. Within this general analytical framework, Chapter 5 attempted to show how MA contributed to and also shaped new institutional dynamics in KKH, as one of the first-wave hospitals that pioneered the HCQ initiative from 2007 up to 2014.

7.2.1 Key institutional roles of MA at KKH

In NIS terms the analysis saw this hospital as something of a role model for hospitals that were to develop their approaches to HCQ later; in this regard it sought to specify the institutional dynamics at play as the hospital, in line with the Quality vision, developed its particular form of HCQ initiative, and also to locate this particular hospital within the set of other hospitals involved in the early stages of rolling out the initiative, clarifying how far it was typical of them. So for instance KKH, like most of the other first-wave hospitals, was run and managed by private companies working with the Saudi Arabian state. Also the staffs in general was used to operating in managerial settings where performance measurement systems and targets were in place along with regular accountability procedures, even though the existing PM systems had a significant focus on cost control and 'economy', in line with the general practice of privately owned and run health care facilities.

As the new HCQ system (under the SEP frame: see appendix D) was rolled out therefore, there was, in NIS terms, an aspect of *coercive isomorphism*, which was arguably for two reasons. First, the government required a total commitment to implementing the system in these pioneer hospitals as a prelude to rolling it out across all hospitals later; and second, the new system entailed the move away from the familiar focus on all of the '3 E's' towards the focus just on efficiency and effectiveness.

At the same time, there was in this hospital context a strong aspect of *normative isomorphism* since the focus on HCQ coincided with traditional medical professional concerns and on specific types of 'best practice' approach to health care which were developed through medical research in elite institutional settings, particularly in the US and other leading economies: the development from 2007 of strong institutional links to John Hopkins Medical School was perhaps a key specific factor here. Arguably this type of *normative isomorphism* had particular influence because of the way the traditional cost focus of MA was de-emphasised, insofar as this

enabled management concerns to be aligned more easily with those of high-status medical knowledge since both managers and professionals were focussed on delivering effectiveness through hitting quality targets, and the managerial concern with productivity on the whole reinforced the commitment to this objective and gave a greater strategic and managerial significance to professional medical expertise and concerns.

There was also a strong role for *mimetic isomorphism*, both within KKH and across the other hospitals involved in the initial roll-out phase. For all, as privately run entities, had internal cultures where working under management targets was well embedded and also where the additional highly qualified and trained medical professionals brought in from the US were familiar with such targets; additionally such professionals, along with existing medical staff, were keen to promote the international 'golden' medical standards which from 2009 became the key benchmarks through which quality was defined and measured.

Finally, there was the issue of how human capital was enhanced at KKH. As a high status and private hospital which already had an institutional commitment to Western elite medical practice and Western-trained practitioners, *normative isomorphism* came into play as it sought to attract an increased number of qualified medical personnel from Western countries along with Saudis who had graduated from Western universities, while also establishing a close collaboration with the US's Johns Hopkins Hospital. But the same principle also operated in terms of building up the performance management and evaluations systems, as Western management and accounting knowledge and training were the norm that the hospital adopted.

Here a policy shift that had actually taken place before SEP implementation arguably played a role, namely towards a '*Saudization*' of increasing numbers of skilled jobs as a means of building the nation's human capital. This had already, as noted, affected hospital administrative jobs where non-Saudi accountants were being replaced with Saudi accountants.

This arguably intensified as the SEP regime came in with its move away from a focus on cost control. Many accountants previously working in hospitals, including both KKH and KFH, were from western Asia and were expert in traditional MA knowledge which had been useful in implementing cost-cutting initiatives. A shift to Saudi accountants therefore coincided with the new focuses on measuring and managing efficiency and effectiveness.

Normative isomorphism arguably again played a role, as a number of senior posts went to Saudis who had been trained and qualified in Western university settings; their employment also coincided with the introduction of the separate departments dedicated to that kind of measuring and managing, the QPDs. One QPD head, for example, had graduated with a Masters in Hospital Management from Leeds University (UK); additionally out of a total of 12 employees, the QPD had seven who had obtained undergraduate accounting degrees from international universities and four with master's degrees from the US and UK. This kind of trend was in one respect unsurprising considering that the Kingdom has in recent years sent nearly 150,000 students to more than 30 countries under the KAFSP (MOHE, 2014). But it signals the extent and depth of the Saudi human capital available for these new roles.

7.2.2 Key institutional roles of MA at KFH

Chapter 6 then turned to KFH, and described how the change process was introduced and implemented within a hospital which exemplified the second type of hospital where the HCQ was introduced, the PA hospitals. The same commitment to a 'non-budget' approach remained underpinning the HCQ strategy, so here too cost control was not the focus. Again KFH and other second-wave hospitals gained significant budgetary increases where they devised an acceptable framework for delivering quality care improvements and succeeded in delivering improved quality outcomes.

Once more there was, in NIS terms, a level of *coercive isomorphism*, given that there was an absolute requirement for the second wave of hospitals to follow the first wave in adopting the new approach, and with the same incentives being offered for succeeding; so the hospitals had to develop their own versions of the same focuses on efficiency and effectiveness.

However one significant difference for these hospitals, where they were unlike the private hospitals, was that they did not have a longstanding familiarity with managing and working via MA targets and outcomes stressing all the '3 E's'. Instead the workforce in these hospitals had little or no familiarity with MAPs at all. For as noted, these hospitals received their budgets from the MOH and their internal accounting department then allocated funds in line with Ministry or top management priorities, arguably leading to a form of 'budget constrained' management, but one where the managers of specific departments or functions had no real input to the budget setting process, but were effectively 'passive' receivers of budgets set elsewhere.

In this respect the change process in the second hospital studied still involved significant *coercive isomorphism* but the experience was one of having to move from a context where accounting was remote from everyday work and MAPs were unfamiliar, to one where work became subject to this distinctive form of MA focussed just on efficiency and effectiveness.

As regards *normative isomorphism*, this appeared to have a less significant role at first. For there was at the outset a relative lack of familiarity with high status professional medical knowledge and expertise, compared with the private hospitals where highly qualified medical personnel from abroad (particularly the US) were a prominent long-term feature. Therefore there was not the same initial 'fertile ground' in which normative isomorphism could play a significant role. However as PA hospitals gained familiarity with high status medical knowledge and began to employ medical professionals with high-status training and qualifications personnel, arguably

this dynamic increased in significance, and contributed to developing a work culture where people became committed to working towards quality benchmarks and outcomes.

Finally a form of *mimetic isomorphism* arguably was significant from the outset. But in this instance, the initial lack of familiarity with MA meant that staff were having to copy MAPs developed in pioneer hospitals without the level of internal institutional understanding of what they were copying that was possible in hospitals where MAPs were already familiar. So the *mimetic function* was likely at least at first to be much less robust.

Beyond that, one more global difference in the change process in the second wave of hospitals was also arguably very significant. The first wave hospitals, as pioneers of the new approach, had three years in which major changes came consecutively, with the SEP approach being developed first, then the JCI system of benchmarks being adopted, and then the new IT system being integrated. In contrast, the second wave hospitals found themselves having to adopt all these changes over a much shorter time-scale, with increased opportunities for unintended consequences arising from pursuing multiple but potentially conflicting priorities at once.

The *coercive isomorphism* dynamic was strong here, since the SEP model had already been reported as having delivered improved HCQ in the pioneer hospitals by 2010. But the context was one where, as just suggested, *normative isomorphism* was likely to be relatively weak, and *mimetic isomorphism* was often a matter of copying procedures without staff having a well-internalised understanding of them. Thus in many respects the challenges facing second-wave hospitals like that studied in Chapter 6 were significantly greater and more complex.

So for instance, the process of IT adoption had to be managed while staff were still getting used to working under contracts with KPIs. So while again MA arguably facilitated the adoption and acceptance of the new IT system since it provided so much of the content that the system processed, it did so in a context where the workforce had not had much time to become familiar

with working under a system of targets and evaluations. Therefore in a certain respect two new and very different systems had to be internalised, which produced a level or intensity of change management much greater than that typically experienced in KKH and other first-wave hospitals.

As concerned the development of 'human capital' and the promotion of staff expertise and professionalization, MA again played a significant role, but within a context where there was not, as noted above, the same initial level of understanding of or engagement with elite medical or management knowledge and expertise among existing KFH staff, given the different backgrounds that many had, and their often lower qualification levels. Therefore the role of normative isomorphism was less significant in developing human capital in KFH, at first at least. Instead, at KFH a scholarship programme offered study opportunities to promising employees along with internally and externally provided courses designed to improve performance and ensure that current employees could keep up with the new innovations introduced. Externally considerable use was made of Public Administration Institute courses. These promoted better understanding of how to achieve quality targets and also of the potential constructive roles that evaluation and management practices can play; course titles ranged from 'TQM', 'Improving Health Services' and 'Motivating Staff to Provide Higher HCQ' to 'Health Programme and Service Evaluations' and 'Evaluating Job Performance'.

But again over time *normative isomorphism* became a significant factor in embedding the new MAPs and focuses at KFH too. It also moved towards attracting qualified employees from hospitals in the West, whose high qualifications and status were important in the drive to change the ideologies, interests and beliefs of existing employees, thereby aiding in the establishment of higher-quality health care. For as both Carruthers (1995) and Adhikari *et al.*, (2013) have argued, formal education has a strong influence on how professionals act inside firms and makes them more qualified in terms of recent developments in the organisations' structure and techniques.

Arguably this was a form of *mimetic isomorphism*, in which KFH followed the model of the pioneer hospitals as a means of changing its internal work culture in the same direction, and in the process improving employee education levels, which as Kaynak and Hartley (2008) argue, can be key to lessening resistance to new MA and to improving service overall. But there was also the same focus on improving education and skills at the specific level of MA knowledge and expertise which arguably had two institutional effects. First as Scapens (2000) argues, in a context where forms of accounting knowledge are integral to achieving organizational targets as here, the ground is fertile for an institutional dissemination or 'decentring' of MA knowledge, and "in part, decentring of accounting knowledge is the result of accountants educating other people in the organisation" (Scapens, 2000, p. 21). Second, there is the fact that improving such MA knowledge largely took place at the institutional level of constructing new accounting *teams*, which Stamatiadis' research (2009) identifies as particularly important institutionally, making the case that accounting-team education levels are one of the most important factors in changing in public hospitals.

7.2.3 A critical comparison between the two cases

The two cases, it may be argued, show some important similarities but also some important differences in how the change management process unfolded. One particular more recent development shows how there tends still to be a mix of similarities and differences, with the development in question being the incorporation of a 'customer focus' into the performance evaluation system, so that since 2013 hospital quality performance statistics have become more widely available to the general public.

The incorporation of such a customer focus was arguably in part a response to the 'public voice' concerns raised over the previous decade. At the same time it became more feasible once the new IT system was operating alongside the new MAPs. There could then be a similar commitment in each hospital to this focus, as the IT system in each made it possible to generate

statistics and measurements using the JCI benchmark system. This could be done at the level of individual units or specialisms up to the level of sets of specialisms to that of the hospital as a whole, and that of the whole population of hospitals. The MOH could then analyse and publish sets of outcomes in patient friendly formats which could also construct the possibility of 'customer choice'. Across all hospitals, it was MA alongside IT that made this possibility real through its role in visualising and measuring quality and productivity for dissemination to wider audiences. In consequence the public could become used to being provided with quantitative comparisons and so becoming more knowledgeable about what to expect as quality care within the nation and internationally.

At the same time, this kind of discourse of 'customer choice' was more familiar within the institutional world of KKH than that of KFH. For the earlier private-sector focus at KKH had already meant that patients were also paying customers, so that while there was a profit-conscious budgetary system, patient satisfaction and hospital reputation were key aspects of performance, since it was crucial to maximise revenues while managing costs. In the budget-constrained context of KFH, however, there was not the same level of 'customer focus' and there was no tradition of seeking to measure satisfaction or quality, e.g. through patient surveys.

So in this respect there was as suggested a mix of similarities and differences. But as the new focus was rolled out, there was arguably increasing convergence towards acceptance of the new approach, for a number of reasons. By way of both types of hospital benefited from a higher number of international staff with high status medical knowledge and qualifications, and a growing number of KSA professionals with similar qualifications and/or experience, the institutional acceptance and familiarity of this now-widely-used form of customer focus increased in both settings.

Thus in another way, MA played a central institutional role in supporting and in creating opportunities for quality solutions not just at hospital level but also that of the nation. In this context the hospital medical directors at both KKH and KFH argue that the movement to the SEP and the implementation of the new quality practices and PM systems have increased the levels of HCQ at the hospitals, clearly shown by increasing patient satisfaction rates and the decrease of medical incidents. The overall set-ups and starting-points of the two hospitals in relation to the HCQ change process, as well as patterns of similarities and differences in their experiences, is therefore summarised in Table 7.1.

7-1: Summary of the changes in the two SEP hospitals studied

	KKH	KFH	KFH	KKH
Main features	Before		After	
Management system	Private Sector	Administrative	New Public Management	
The main objective	Maximise profits	Political acceptance	Improve Quality	
The main focus	Market needs	Political needs	Medical and Social needs	
Strategic focus	Central planning in private company	Central planning in the MOH	Central planning with coordination with MOH	
Services concept	Providing health care with available resources	Providing health care for all citizens	Providing health care with high quality for all citizens	
Accounting system	Business type with focus on financial control	Traditional Bureaucratic PA Governmental type	Business administrative co-ordination with focus on non-financial control	
Budgeting use	Internal	External	External	
TQM	Not implemented	Partly implemented	Fully implemented	
Costing system	Very advanced	Benchmark	Benchmark	
Performance measurements	Based on financial targets	Few not HCQ relevant performance measurements	Based on quality targets (non-financial)	
Resistance	Exists	Not existing	Exists	
The role of MA	Partially	Basic	Strong	
Relation to MOH	Independent	Dependant	Mix between autonomy and dependant	

With its summary of key features in the change process, this Table arguably forms a suitable conclusion to this NIS-based analysis of MA's contributions to rolling out the first phases of HCQ change in KSA hospitals. However, it should be noted that there are still many hospitals that are 'waiting' to be included under SEP, many of which may well pose distinct problems of their own, particularly as increasing numbers will not be in urban areas and cities which has generally been the case up to now. It is quite possible that MAPs will discover new roles and

also challenges in these new institutional contexts, particularly if in these new locations there is still less familiarity with the high-status medical knowledge and expertise and the forms of MAPs that have established themselves as integral to rolling out the HCQ programme so far. At the same time, it is likely that the non-accounting budgetary framework will still form the basis for implementing the HCQ agenda, so a fundamental structural similarity will still be in place. Arguably the same kind of incremental acceptance of the new ways of thinking and acting will then develop in these new hospital settings, in the way that has taken place in the PA hospital setting represented by KFH.

However, after a comparison of what happened in the two cases studied here, it is important to review the context within which change took place, and the way in which government policy shifted to focus on health care in the early 2000's, so that the MOH was able to propose a form of HCQ which could be rolled out in phases; with the hospital discussed in Chapter 5 as one of the pioneers of the new decentralised SEP approach developed, and the hospital discussed in Chapter 6 as one of the PA hospitals which formed part of the second phase roll-out.

7.3 New agenda: developing HCQ in the context of promised social innovations

7.3.1 Public voice

Chapters 5 and 6 showed how a fundamental change in health care policy and practice occurred after an ongoing public debate about health care in the KSA. This change was incorporated into the five-year national budget plans[11] which were implemented first in 2005 and then in 2010. As noted, the public discourse was intense, both in the media and in the sphere of government, and also in hospitals, revolving around a widespread concern that there was something 'wrong' with the KSA's health care system, despite the KSA's having introduced a commitment to TQM in the 1990s (Al-Qahtani and Al-Methheb, 1999; Al-Abdul Gader, 1999). In retrospect, it appeared

[11] Explained in appendix D this public discourse began as early as 2007.

that this commitment was more an aspiration than something implemented in the form of successful practical solutions.

Therefore as the debate developed in the period leading up to 2007, it began to crystallise around three questions as follows. First, why should the public-health sector's budget be increased if HCQ had not improved? Second, to what extent had the centralisation of human and financial resources led to HC providers inadequately serving the public's needs? And third, to what extent were instances of medical failure and patient dissatisfaction higher in the KSA than in other countries?

This debate was extremely prolonged, thus providing a context for introducing new ideas on health care at every level. At the same time, as the debate became 'problematized' around these three questions there emerged quite well-defined boundaries around what the key issues were; and at the same time, there was an increasingly general agreement that *something* had to be done. In that sense, what can be called the 'public voice' helped to create a general consensus for health care change, even if that 'public voice' did not articulate what specific things needed to be done and how problems identified were to be solved.

The development of what we might call a 'Quality Vision' was therefore informed by the public voices. However it took on its specific form only (i) through engagement with the understandings of HCQ developed in the high status world of professional medical knowledge and research, along with (ii) the translation of these understandings and insights into a managed quality delivery system.

Here key roles in developing understandings of what quality was and how to deliver it were played by high-status medical professionals, ranging from researchers in the West, particularly in the US, to Western-trained medical experts working within the KSA health care system, particularly in the private hospital sector. Thus, it is reasonable to characterise this stage as one

where there was a strong dynamic initially of *normative isomorphism* in the engagement with this elite professional knowledge world. At the same time, it was the stage where the powerful form of *coercive isomorphism* that later came into play was initially developed, as the government, having listened to public reaction, decided on implementing the ‘Quality Vision’ through a system where individual hospitals would propose locally appropriate delivery systems, but based on using some system of quality targets and performance measurement.

Thus the situation that developed proved very different from that in the 1990s, in which the government had developed a commitment to TQM for PA-run hospitals (on this earlier initiative, see for instance Al-Qahtani and Al-Methheb, 1999; Al-Abdul Gader, 1999). From 2007 the delivery of what Ezzamel (1994), as noted above, describes as ‘soft’ quality outcomes was directly tied to the use of ‘hard’ measures, where MA was put in place to measure and evaluate the effectiveness of achieving desired outcomes while tracking the efficiency of work done in the form of productivity.

Furthermore, in the earlier attempt at implementing TQM, the PA hospitals were still operating under the ‘budget constrained’ style of management described above. So there were no MA based ‘hard’ measures in operation in the management system; and there was no institutional dynamic, as there was after 2007, to promote putting such measures in place so as to complement the new ‘soft’ quality measures being developed under the HCQ approach.

Thus the new ‘public voice’ gave the KSA government an opportunity to provide a new solution that reinforced and reinstated the commitment to HCQ, and the MOH then devised a system that was better structured to deliver HCQ outcomes. The government also provided the resources to enable a non-accounting budgetary system to be implemented by MOH, through the policy commitments made in the successive five year plans (the eighth and ninth plans see appendix D.) for 2005-10 and 2010-15; for the primary focus in both plans was on enhancing social services,

with a particular focus on improving medical services and residential housing for Saudis (MOF, 2013).

With these resources, MOH could transform the thinking in the public-health sector towards a commitment to HCQ, through the framework they then developed effectively with its combination of both soft and hard measures, as Ezzamel describes. But additionally the SEP frame they proposed enabled a mix of central oversight by the MOH with a decentralising to individual hospitals of decision-making, and the implementation of performance and accountability systems. So hospitals, particularly in the first wave, had to devise a system that was appropriate to their local circumstances and where MAPs would track, monitor and evaluate performance and outcomes in ways that would promote continuous improvement in the local HCQ regime. It was a solution that would provide an answer to question one above as increases in medical budgets were directly tied to HCQ improvements and to question three, as treatment success rates and patient satisfaction ratings began to follow from the new quality regime.

Additionally the NIS type of analysis suggests that the way in which the reform process was rolled out step by step played a role in its success. In the initial stage, as noted, private operating hospitals led the way in implementing the SEP solution; and since they had previous experience of working with MAPs, this meant that they were not working in a wholly unfamiliar work management context as they developed their versions of the SEP approach. This arguably made them more able to operate as a role model for other hospitals in subsequent stages of the roll-out. It also was helpful to MOH, which could monitor how successful different local HCQ solutions were, and then, on the basis of their evaluations, make best-practice recommendations to shape and enhance the rolling out of the programme as a whole.

In such ways the SEP approach was successful. HCQ did improve, and MAPs, including KPIs and forms of accountability, functioned as a key institutional influence in the improvement

process. Therefore by the time the second roll-out phase was initiated, as in the second hospital studied, a clear type of management system was in place, with a non-accounting budgetary focus, and with accounting as the means of measuring and monitoring effectiveness and efficiency targets. At the same time, the SEP approach ensured that there were local variations in how the system was set up and run, hopefully promoting local 'ownership' of it in line with the SEP principle.

Thus second-wave hospitals had to buy into this structure, which was made easier since they had already established examples of successful local ownership to follow. So this was an exercise in *coercive isomorphism*, but with clear guidelines to follow. One further significant change that followed at the level of individual workers in the PA hospital was the establishment for the first time of written contracts, which included a new requirement to meet KPIs as specified for the particular work role involved. Thus the institutional dynamics of work shifted to a regime where workers were aware that an accounting-based measurement of performance and accountability was in place, and that hitting KPI targets for performance and productivity was essential.

Thus in both hospitals the workforce as a whole formed a new kind of population, where across every department all workers had contracts and were subject to accountability for meeting quality and/or productivity targets. Thus HCQ became visible to all, while each worker became visible in terms of targets set and how well they were met.

7.3.2 Non-accounting budgetary dynamics

In any event, it may be said that, as the proposals for developing a new regime of HCQ in KSA were designed and then implemented as local proposals for HCQ systems, there were not the normal types of inbuilt cost constraints on either strategic planning proposals or specific hospital budgets. In this respect the budgetary context within which MAPs operated was, to use the term first developed by Anthony Hopwood (1973), a kind of 'non-accounting' budgetary context. In

Hopwood's own study, which drew on interviews and observations with production managers in a US steelworks setting, the focus was mainly on the managers and how budgetary information was used to evaluate their performance. With this focus, his findings were that there were three 'management styles' relating to different ways of putting budgetary information to work: the 'budget constrained' style, where managers had to hit budgetary cost targets, the 'profit conscious' style, where the focus was on profit targets, and the one of interest here, the 'non-accounting' style where the focus was on how managers performed on non-accounting performance criteria such as quality.

Here the focus is not on managers as such but on how accounting acted as an institutional force enabling the implementation of the Quality Vision. That is arguably an important shift in perspective, since it means that the roles of MAPs are considered in terms of broader effects, not just those that accounting has at the level of individual managers. The NIS approach considers its effects also at the higher level where the MOH's quality strategy was translated into practice at the level of a hospital, and hospitals, as a whole; it also considers the lower level where MA targets and evaluations have effects on the workforce, for instance through measuring worker productivity and teeing performance to salary.

The other point perhaps worth making is that the analysis here shows how accounting still has significant roles even in a 'non-accounting' budget framework. For what is removed is a primary focus on controlling costs which is always present in both budget-constrained and profit conscious styles in the first case since managers are sanctioned if they exceed budgeted cost limits, in the second because the profit focus requires managerial attention to *both* revenues *and* costs in the search for the optimal profit outcome. Instead, in the 'non-accounting' approach that developed in the hospitals studied here, accounting was still central but its action was directed

only to hitting targets associated with the second and third of the '3 E's', efficiency and effectiveness, not 'economy'.

Accounting therefore operates in this context in the way that Ezzamel (1994) suggests in his critique of H. Thomas Johnson's argument (Johnson, 1994) for replacing MA systems with Total Quality ones. Ezzamel argues that TQM is not in practice an alternative to MA, on the basis that there are two types of measure that are essential to TQM success. On one side there are the 'soft' quality-enhancing measures and targets which Johnson recommends in order to gain workforce commitment to quality; but TQM systems also have to have 'hard' measures in order to track the quality performance against target, and to enable swift and focussed intervention to correct poor performance and promote incremental improvement. These measures are typically MA type measures, e.g. of time taken on task, quality of outcome within time allowed, perhaps also of actual cost incurred against target (whether at the level of a specific service or product or a department or work unit).

The 'non-accounting' budget set-up in the hospitals, it is argued here, was a key factor in enabling a quality strategy to succeed, by removing a focus on cost control and management and putting the focus instead on effectiveness and efficiency. At the same time, that new focus still required a systematic and extensive use of MAPs and measures to deliver the HCQ agenda.

More specifically, MAPs could focus on constructing performance targets and measures that would operate at the levels of 'efficiency' and 'effectiveness': 'economy' was, for once, not the constant companion of these two. Furthermore this applied in both the hospital settings studied here, so that MA played crucial roles in the successful implementation of the HCQ agenda in both, even though there were differences in how implementation took place and different problems encountered in the two different settings. MAPs therefore play a central role in the form of NIS-based analysis developed here which seeks to evaluate the similarities and

differences in what took place in the two research sites, and to understand how efficiency and effectiveness agendas played out in each.

7.4 Beyond the MA focus: other aspects in the institutionalisation of HCQ

In terms of institutionalising HCQ, the role of the non-accounting budgetary framework, as discussed by Hopwood in his 1973 PhD, cannot be overemphasised as a central plank in the institutionalisation of HCQ across the range of previously different institutional settings and set ups discussed here. The non-accounting budget, it has been argued, operated as a relatively non-threatening device for implementing a quality regime that 'respected' professional expertise but which also promoted collaboration and which did so nevertheless with central roles for MA beyond the traditional 'cost' focus assumed to be central to MAPs. This analysis therefore reinforces earlier studies which have indicated how MA can play crucial roles in management change settings (including in NPM contexts) which go beyond traditional cost-focused functions and reforms (see e.g. Cordery *et al.*, 2010; Olson *et al.,* 1998; Lawrence *et al*., 1997).

7.4.1 Centralisation and decentralisation interplays in the reformed institutional setting

It was able in this instance to give an effective form to the commitment to decentralisation via the new SEP approach; the commitment to an evidence-based medicine approach, backed up by the institutional links to Johns Hopkins Hospital, could be linked to an appropriately updated form of line and staff structure of the kind first developed in the nineteenth century (Chandler, 1977) which enabled 'administrative coordination' to operate across an entity made up of many different functions and knowledge specialisations, such as a modern hospital. Responsibility and decision-making could be devolved to appropriate levels in line with preserving the commitment to following evidence-based medical best practice, in the kind of way that Aidemark and Funck (2009) and Aidemark (2001) discuss. At the same time, an effective response could be mounted to the concerns raised by critical 'public voices', particularly through the flexibility offered by the adoption of a non-accounting form of budgeting. Not just high-status medical professionals

but the hospital workforce in general were working within a budgetary frame where a focus on delivering HCQ targets could be maintained without a concern about cost constraints; instead all could recognise that the budget would increase year on year so long as the opportunities provided by the non-accounting budget were successfully taken, in terms of delivering on quality and productivity targets.

Within this context the focus on delivering 'top of the range' quality outcomes could then be pursued, and it is here that the strategic significance lay in forming such strong institutional connections between Johns Hopkins in terms of knowledge transfer and elite medical personnel recruitment, particularly in the first roll-out phase in hospitals such as KKH. Staff from JHH brought the latest medical practices and routines, and could direct the attention of new and existing staff in KKH towards a constant commitment to adopting new and updated quality medical practices. They could also contribute from their managerial expertise in working in leading US hospital to the process of developing a HCQ-focussed management style in KKH in line with the SEP vision. This was achieved by tasking JHH clinicians with applying the hospital's new management structure. Most targets for the hospitals' various departments and employees were therefore based on JHH's practices.

In this respect, the non-accounting budget with its lack of resource constraints could provide the hospital with high-quality, and often state-of-the-art medical equipment, materials and other related resources, at a level that was often better, so US-trained medical staff observed, than those available in many American hospitals. Using such equipment and tools allowed clinicians to learn about the most advanced health care practices and to treat patients according to their expectations. In addition, training and education in using such equipment and tools grew the knowledge bases of doctors and other medical staff. Frequently the vendors of such equipment and tools gave further training courses, and this also contributed to hospitals' improved human

capital. Given that contemporary health care is an intensively knowledge-based industry, this was clearly an excellent and far-sighted way to improve HCQ through improving the knowledge and skills of all health care professionals and disseminating best-practice approaches to staff at all levels in the hospital.

7.4.2 Institutional interactions between MAPs and elite medical knowledge and expertise

In that respect the institutional interaction of MAPs and elite medical knowledge and expertise was in itself a major success and a key to understand the institutionalising of HCQ in KSA. Thus this study bears out in a significant way what Ezzamel (1994) was arguing for, by showing how MAPs can, given an appropriate institutional interaction with relevant knowledge and expertise, promote a cooperative and mutually supportive form of working which can "promote less asymmetric and more open modes of interaction between organizational participants" (Ezzamel, 1994: 279).

That being said, the research findings suggest that, given the non-accounting budgetary framework, there were perhaps five elements which played particularly key roles in motivating staff and building a culture of commitment to top quality HCQ outcomes. These were: 1) the 'Patients first' initiative, which put the patient and patient interests at the heart of health care delivery, 2) the implementation of the international quality standards, represented by the JCI standards system, as developed in western medicine, 3) the focus on increasing the number of highly-trained and qualified medical and management personnel, including a good mix of those educated and trained in high-status institutions in countries other than KSA, 4) the focus on improving the hospital's information systems in ways that would improve not only health care but accounting and accountability practices as well, and 5) the implanting of a management approach delivering constant and real-time accounting and accountability information, allied to the rolling out of KPIs based on the JCI standards and helping to shape relevant measures of productivity applicable to managing both medical and non-medical employee activities.

This having been said, it is possible to offer reflections on a number of other institutional factors that came into play as the HCQ agenda was rolled out. The first concerns the interaction between changes in structure and in MA process.

Scapens *et al.* (2003) argue that changing hospitals' management structures strongly influenced the management process, while Cassia *et al.* (2005) have argued that, in most cases, changes in organisational configurations do not equate to changes in MA processes. Yet, the present case study arguably yields results that differ from both these views. For the hospitals' new management structures with their decentralised decision-making aided managers and accountants in meeting their new objectives. That this would occur was originally suggested by Alkizza (2006), who posits that changes to the management structure of any organisation will lead to greater MAP-implementation opportunities. But it has been argued here that a key aspect of the new structure, which greatly helped to make the decentralisation work, was not a management but a budget structure change: the non-accounting budget format.

The second concerns the interaction between policy and the 'public voice'. As argued above (in section 7.3.1) the 'public voice' was a significant 'attention-directing' factor promoting recognition at government level of the importance of improving HCQ. But the translation of policy into a successful HCQ system was a separate issue. The non-accounting budget framework helped, and the interaction between institutionalising the required elite medical knowledge and expertise and constructing MAPs to deliver the quality outcomes identified as priorities by that expertise was also crucial. But beyond this was the institutionalisation of other necessary 'support systems' to ensure successful delivery over the short and longer term of these health care reforms.

The third concerns the institutional connection to wider recent developments in MAPs and discourse. Here it is interesting to note that the hospitals investigated and analysed in this study

focused on four main elements in their performance evaluations: education and training courses, medical services, medical and non-medical professionals and finance. Interestingly, these areas map onto the core elements of systems for using MAPs to 'grow' the quality and human capital of an organisation, such as the BSC developed by Kaplan and Norton from the early 1990s on (Kaplan and Norton, 1992).

It is impossible to say whether there was any direct influence on the HCQ agenda from the BSC. However its discursive commitment to developing a broader-spectrum way of managing via accounting is in line with what was accomplished via the non-accounting budget framework. This may also contribute to explaining how the findings here differ from those of Jacobs *et al.* (2004), who found that the implementation of private sector practices in hospital settings shifted the focal point to budgets, cost analyses, etc. and that this influenced HCQ, leading to negative consequences for patients. [See also Strandberg-Larsen *et al.* (2007) and Dikolli and Sedatole (2007) who similarly argue that PMs focused on financial outcomes affect HCQ negatively and lead to adverse consequences for the health sector in both the short and long terms.]

Instead as noted at length above, the approach here is avoided a counterproductive kind of cost focus. More generally this may also help explain why in this instance there was not the kind of disparity between formal policies or strategies and MAPs which NIS based studies have often found (e.g. Cardinaels and Soderstrom, 2013; Meyer and Rowan, 1977). Such studies have pointed to the ability of external institutional factors to change policies, rules of procedure and strategies without having any direct responsibility for changing practices which is clearly often the case. But in this study the changes in policy and rules of procedure (as in the move to decentralisation for implementing HCQ) resulted in a strategic plan where MAPS *did* change in both KKH and KFH (although in different ways in each), and where they changed in ways that could align directly with the policy vision and strategic plan.

Other external institutional factors were no doubt significant, e.g. governmental regulation and resources, informal non-governmental discourses, international and national state interfaces and professional development and involvement in the hospital: but the non-accounting budget framework enabled policy, strategy and practice to align and deliver the desired HCQ outcomes along with new and relevant forms of productivity.

A fourth institutional factor concerns the role of accreditation. Accreditation is widely recognised as an institutionally important way of establishing the validity and status of forms of elite knowledge and expertise, and this clearly played a significant institutional role in delivering the HCQ outcomes in these case studies, as the two hospitals were highly influenced by external monitoring organisations, such as the JCI and other international accreditors.

This can arguably be viewed as a form of *coercive isomorphism*. Both hospitals in this study had to implement a TQM system to obtain JCI certification, and this could then become one of the KPIs that the MOH used to evaluate HCQ improvements, to achieve external legitimacy. We may note that Martinez-Costa *et al.* (2009) argue that the implementation of international accreditations does not guarantee HCQ improvements or better hospital performance. Indeed, international-accreditation standards do not cover all aspects of quality within hospitals. Therefore, it can be argued, successful TQM implementation cannot be wholly predicated upon the implementation of international quality standards because these standards only provide policies and guidelines for the implementation process.

Yet while this may well be the case, again in this instance the accreditation system was able to yield KPIs which could then be linked to MAPs promoting relevant forms of productivity. So the weaknesses of accreditation noted in other studies did not necessarily occur in this setting. This appears to be further borne out since in both hospitals there were teams focused on international accreditation programmes reviewing various departments' performances based on international

quality standards, particularly JCI standards. [It is perhaps important to note that Hesham (2005) found that in other KSA organisations there was a strong commitment to this process, and that the implementation of international accreditations strongly influenced quality awareness. Also the MOH pressured hospitals to obtain international accreditation because national quality standards were lacking.]

In both hospitals the main role of these teams was to examine each department's implementation of the relevant international standards to ensure it was meeting both public expectations and international guidelines. It was in this context that the elements mentioned above were put into place to deliver quality in line with the standards specified, i.e. the 'patients first' focus, continuous improvement, managerial support and leadership, improving employee education and training, and using high-quality education and training suppliers. Thus this study adds to those which have claimed that accreditation processes, particularly those of international bodies, can have a positive impact on HCQ (e.g. Mansi *et al*., 2010; Pardini-Kiely *et al*., 2010). It also adds to those studies of TQM which argue that successful implementation depends on achieving the highest possible quality in every aspect of a hospital's operations, and that this occurs when hospitals seek to meet international accreditation standards (Kakkar and Narag, 2007; Venkatraman, 2007).

One further possible impact of accreditation is that, in both cases, it appears that the mix of accreditation and MAPs not only improved employees' skills and knowledge; it also arguably strengthened the cooperation of KKH and KFH with other hospitals as well as with international accreditors, while putting both hospitals in a position where they could take in their stride the move by the MOH to promoting a 'customer focus' through publishing information on the quality performance of each hospital. In this regard, it was noted how under the new reforms hospitals cooperate with national and international hospitals, as well as with international-

accreditation agencies. At the national level, another hospital, the FFH, played a significant role in harmonising the MA that various hospitals implement; this is because, as one of the largest hospitals in the country, it was the first to implement the SEP.

Of particular interest here is that both hospitals in the present study were strongly influenced by the FFH after they became self-operating and had decentralised decision-making. Therefore there would appear to be an interesting type of isomorphism (perhaps normative, perhaps mimetic) at play here, in the creation in both hospitals of the new QPD departments discussed above. So both, as noted, recruited new, Western-trained and qualified Saudi employees for these departments, while there was the wider knowledge of accounting and NPM disseminated by elite medical professionals and employees with experience and knowledge of NPM regimes, plus consultants from international consulting and professional service firms.

Two final points of interest concerning institutional change are worth making. The first concerns the language issue in a situation where both English and Arabic were and are relevant to delivering the HCQ agenda. Here the large-scale importation of medical knowledge and expertise from US settings, and in particular from JHH, led to a shift in language usage and dynamics within the hospital environment. Although the national language is Arabic and this continues to be the dominant language in hospital interactions with patients, with the implementation of SEP the language used in medical and clinical settings, and also in many management settings, increasingly moved towards English, particularly as or where so many senior medical personnel were English-speaking, and also given that benchmark systems like JCI had been developed in English.

This led to various coping mechanisms in what was increasingly a bilingual workplace setting. Much of the key written documentation was translated into Arabic from English, e.g. policy documents and regulations, handbooks, benchmark statements, forms for medical consultations,

etc. At the oral level, there were necessarily difficulties where interactions involved English-speaking international employees, and Saudi employees and policymakers whose English was limited, and this could often lead to misunderstandings. Up to a point, problems could be resolved through employing translators fluent in both English and Arabic, and insofar as many Saudi employees are fluent in English. However, while the language issue has been a constraint in certain ways, it has not held back the rolling out of the HCQ agenda in a setting where both languages continue to be important and relevant. The second issue concerns the connectivity beyond the hospital setting and the medical world more generally made possible by the introduction of the new IT system for HCQ. These connections included those to other IT systems and government departments, which had some significant impacts on the functioning of MA within the HCQ system. For instance, the new IT system was soon linked to wider IT infrastructures developed in response to the KSA's implementation of e-government services, including an ERP system. This enabled a form of government oversight outside the field of HCQ as such, and was arguably one way in which the roles played by MA to promote HCQ were potentially constrained, a possibility pointed out by Kantola (2014), who has argued that the role of MA within the public health sector is strongly influenced by the IT used to collect organisational information.

7.4.3 Clinicians' resistance to PMs and KPIs

Having reviewed all these above interactions involving MA in institutional change in these hospitals, and also having noted the roles of other institutional factors in such change, there are a couple of final observations to be made. One concerns the issue of resistance. Researchers have noted how forms of resistance are found in all change management programmes, whether in developed or developing countries (e.g. Nikos *et al,* 2016; Bell and Hoque, 2012; Hassan, 2008). Employee resistance to the new and unfamiliar is understandable in this context too, and it did occur. So even though within KSA hospitals managed under the SEP there were different

challenges that clinicians and managers faced with the implementation of the new accountability and KPIs, there were still issues of resistance to confront. These were not so much overt resistance as finding ways of evading or gaming the performance measurement system.

This could be seen particularly once forms of customer focus were introduced, so that for instance clinicians could earn additional monthly allowances for high quality outcomes as measured by patient satisfaction ratings. Therefore, clinicians began to pay attention to patient satisfaction ratings to protect their personal interests as well as meeting the hospital's objectives.

A form of 'Goodhart's Law' that 'every measure that becomes a target becomes a bad measure' began to take effect, in line with the observation by Jacobs et al. (2004) linking PM based rewards to the outcomes of individual clinicians' work tends to lead clinicians to manipulate PMs in order to meet targets. There was also arguably a threat to their professional ethos of serving the patient first (Pizzini, 2010). For some clinicians began to explain lower quality outcomes by providing the medical director with reasons linked to the situations of specific patients and thus were able up to a point to avoid negative outcomes for themselves. However, as this became apparent, the management commitment to quality outcomes began to predominate and so clinicians had to accept that ratings will not always be excellent and to work under the PM regime as well.

There were other forms of resistance, e.g. those resulting from unfamiliarity with the new practices and technologies, particularly those relating to the use of advanced IT systems. These were addressed by the hospital management extending the range and scope of training courses to develop the skills required to use the new technology and comply with new practices. One form of resistance to this was to see such training as not relevant to patient care, but a form of making doctors into business managers being subjected to what Kurunmäki et al. (2003) describe as 'accountingization', where professionals have to internalise professional work as integrally

involving accounting and accountability aspects. In this respect the findings of Brorstrøm and Nilsson (2008) are relevant, as they discovered how far the implementation of new MAPs could negatively influence clinicians because doctors in general prefer to work in a stable environment with low administration work and closer contact with patients and colleagues. Those points having been made, it remains the case that MA, as this chapter has attempted to show, became highly significant institutionally, so that even where there were forms of resistance like those just discussed, the outcome was that a system to promote quality via the use of MAPs to measure and evaluate both quality and productivity was rolled out and accepted as the way health care would be delivered going forward.

7.4.4 The roles of IT and management accountants

For both hospitals, the purpose of their new IT systems was to collect reliable data on budget use and department performance to help effectively manage their staff and deliver on the quality and productivity targets, as required under decentralisation. This did gradually take effect, despite concerns and resistance from some existing employees who perceived the systems as a possible threat to their jobs. So gradually the role of the management accountant grew as it was relevant to both the quality and productivity concerns which encompassed the entirety of the hospitals' workforce. This is in line with the argument of Burns and Baldvinsdottir (2007), namely that, with organisations' implementations of new IT systems, accountants' roles become all the more enlarged, making them less record keepers and more consultants (see also Abdel-Kader (2011) and O'Mahony and Doran (2008)). It might be argued in these case studies that accountants already had this kind of strategically central role, and that IT merely enhanced their ability to handle and automatically organise sizeable chunks of accounting data. But in either case, IT had an enabling function in ensuring that accountants would play important roles, due to their active participation in the decision-making process (Paulsson, 2012; Clark *et al.*, 2001). As IT integration in the KSA and the development of accounting software simplified the process of

recording information, management accountants were more able to concentrate on core activities that ensured that the information they collected is useful in managing a hospital. They stated that changes in the information provided by organisations, as well as improved technology, have guided the changes in MA and management accountants' roles. One extra factor of relevance that emerges from the last section is the difference between the roles of MA in delivering HCQ generally and the roles of management accountants in coordinating and developing MAPs.

The role of management accountants clearly became more prominent with the development of the QPD, which opened after the implementation of the reform to help management meet the hospital's objectives including high HCQ. QPD performed essentially the same role as the typical MA department by collecting, reporting, summarising and communicating data to give the management team the needed information to plan, control and evaluate hospital objectives. The management accountants compared actual performance levels with international standards of health care and provided decision-makers with the information needed to discover why standards were met or not; they also assisted with measuring risk, minimizing it or avoiding it. This kind of work is in line with the findings of Collier *et al*. (2006), namely that the decision-makers in most organisations build their decisions based on the information that management accountants provide, e.g. through identifying and analysing risk, and providing information for use in decision-making.

Another role that management accountants had to develop for MA within the SEP hospitals was ensuring that most of their work and accounting information focused on the patients. This required them to design policies, procedures and practices which were in tandem with the goal of patient satisfaction, i.e., providing high HCQ. Doing this helped hospital management at different levels to redesign the hospital's services and ensure the entire hospital was working in ways that were acceptable to patients. Then as ERP information systems were adopted, this put

them in a position to be the 'translators' between the IT systems and policy-relevant decisions; this helped them develop into analysts who were actively involved in strategic planning. In such ways these accountants have arguably made themselves more indispensable within the SEP quality regime, as those who hold significant expert knowledge at the local level. This is in line with the findings of O'Mahony and Doran (2008), who argued that the implementation of modern information systems within organisations has shifted the role of management accountants and their practices to become more involved in the corporate strategy.

7-2: Numbers of Medical Staff

The Numbers of Saudi and Non-Saudi Medical Staff							
Non-SEP Hospitals							
	Saudi M	Non-Saudi M	Saudi F	Non-Saudi F	Total	Saudi	Non-Saudi
Doctors	17%	57%	9%	18%	35841	25%	75%
Nurses	23%	2%	32%	43%	82948	55%	45%
Pharmacists	56%	8%	28%	8%	2154	84%	16%
Others	74%	3%	15%	7%	45698	90%	10%
Total	36%	14%	22%	27%	**166641**	**59%**	**41%**
SEP Hospitals							
	Saudi M	Non-Saudi M	Saudi F	Non-Saudi F	Total	Saudi	Non-Saudi
Doctors	33%	38%	17%	12%	13195	50%	50%
Nurses	7%	9%	9%	75%	29178	16%	84%
Pharmacists	36%	20%	24%	19%	1853	60%	40%
Others	46%	15%	15%	25%	20996	60%	40%
Total	26%	17%	13%	45%	**65222**	**38%**	**62%**

Source: Ministry of Health, 2014

7.5 Conclusion

This chapter has sought to review and analyse key ways in which MA change has contributed to the rolling out of HCQ initiatives in different organizational settings, and to see how NIS dynamics have been at play, shaping how MAPs have been adopted, and also resisted, across organizational settings as well as within them. One particular focus has been on how one or more forms of isomorphism can be seen to have been at work within and across these settings. In some respect, isomorphism has shown up for reasons that lie beyond the direct sphere of influence of MAPs. For instance, isomorphism can be seen to have followed from the fact that hospitals

generally, within KSA and beyond, draw their forms of medical treatment and intervention from existing elite knowledge systems (both medical and managerial), and have increasingly across the period studied drawn upon medical experts and expertise imported from abroad (and particularly from the USA) with experience in both of these knowledge systems. Similarities and differences in the rolling out of the new HCQ system at KKH and KFH have therefore had isomorphic tendencies, in part because of this shared 'knowledge framework'. But additionally, other isomorphic developments have involved MAPs or occurred because similar forms of MAP have been introduced into these different hospital settings, in a financial setting where non-budget accounting has been implemented as the basis for delivering improvements in HCQ. So here it has been possible to focus on the roles of MA in promoting or enabling key developments such as Human Capital development and the acceptance of accreditation systems. This chapter has also shed light on the interaction between new MAPs and forms of resistance to new accountability systems focussed on HCQ types of KPIs, especially among those the key actors, the hospital clinicians. The next chapter will summarise the main issues arising given the experience of MA implementation in the research sites studied, and so perhaps will indicate issues for consideration in the ongoing roll-out of the commitment to HCQ improvement in KSA, and perhaps also in wider settings where other forms of cost-focussed or profit-conscious budgeting are implemented, possibly as a contribution to what is often called 'thinking outside the box'.

Chapter 8 : Conclusion

8.1 Introduction

Chapter 7 has theorized the main findings from two case studies in the KSA concerning how and how far the adoption of a new form of MA has contributed to improving HCQ. It attempted to provide answers to how MA as social and institutional practice had positive effects on hospital care in KSA during a period of dramatic change. In doing so, a rich empirical context emerged where many institutional factors could be seen to have been in play in different ways. As such the study made visible and brought out what can be understood as a non-accounting form of budgetary style made it possible to put accounting to work to promote effectiveness and efficiency outcomes, rather than having a primary focus on cost control. Clearly this was because there was not a resource-constrained financial framework once the KSA made the commitment to promoting health quality as a primary objective under the five-year plans for 2005-10 and 2010-15. The study was therefore able to follow and analyse a way of using MA which does not occur frequently, but which could make visible ways of putting accounting to use which may be worth considering at both practical and theoretical levels going forward. This may therefore prove to have been an important context of study to bear in mind for future research. In the meantime, it is worth observing that the changes in health care delivery to which MA was able to contribute are now helping to transform the way in which HCQ is seen and practiced with implications for a nation as a whole.

Through the analysis and investigation of two hospitals, representing two different kind of management and experiences, the study attempted to analyse the wider (changing) institutional context and its dynamic within the hospitals studied. In this sense the impact and of the political and the local were brought in for theorizing. The analysis also drew on historical material to give a better sense of this specific MA change. In this way the thesis was able to provide a form of ‘rich description’ as a basis for better understanding MA change in the context of Saudi public

hospitals under the commitment to HCQ, in particular through using a NIS form of analysis to identify key influencing factors on change, including MAPs, particularly through identifying how forms of isomorphism (*coercive, mimetic and normative*) produced many of the changes observed.

Additionally, given that the HCQ initiative is still being rolled out, this study provides important insights about reforms 'in process', which may be of value to those participating in this and similar reform initiatives (e.g. government ministers, senior civil servants and bureaucrats, senior managers and management accountants in the organisations involved, plus, in the medical context, consultants and clinicians and other medical professionals in the public health sector). Looking beyond KSA, the findings from this study may be of relevance to similar groups in both developed and developing, high income or low income countries, through opening up wider understandings of the possible roles that MA can play in providing HCQ, particularly if a non-accounting budgetary style can be put to use. This chapter therefore presents an overview of the study and summarises its key findings, and seeks to lay out the implications of the contributions from this study to the wider MA and NPM fields. The final sections briefly consider possible recommendations for practice and research, and the study's limitations.

8.2 Summary of the study

In recent years the academic literature on NPM and MA change has focused both on developed and developing countries when studying reforms and especially health care reforms. At the same time, while there is now a range of interesting theoretical and empirical studies, utilising a range of theoretical approaches, including NIS, considering both contemporary and historical factors in current practice, and looking at issues impacting on the dissemination of MAPs and reform models including the interaction between globalisation processes and local cultures, KSA offers an important context of study. For this is a high income country with a major world role and strong connections to other world-leading states, including the US, which at the same time has

been confronting the challenges of introducing reforms in areas of social provision, such as housing and health care, to provide the level of facilities of a developed state. Therefore at the outset of the research KSA was seen as providing an interesting and potentially significant context within which to study MA change. Hence the objective of this research was then to investigate how and how far MA changes were consistent with the kinds of 'NPM' approaches to delivering HCQ found in many Western countries, and to see how these changes played out within the SAPHS; and in particular to discover how and how far MAPs contributed to improving HCQ in KSA, particularly as the HCQ agenda was pursued under the decentralised form of the SEP approach.

It was noted that there had been a major 'public voice' discussion concerning the need to improve HCQ in KSA, resulting in the first commitment to major reform in the 2005-10 five-year plan, with major new budgetary resources being allocated to improve both public health care and housing. In this context, two hospitals were identified as potential research sites, and permission was given to undertake fieldwork research in both. Each hospital had distinctive characteristics.

The first was a hospital run on behalf of the state by a private company, with a significant number of highly-qualified senior medical personnel coming from abroad and often from the US, and also with a management system where MA played a major role under a profit-conscious budgetary style. The second was a public sector hospital where there was little contact with Western-trained medical personnel or familiarity with the use of MA to run the hospital. There was a cost-focussed budgetary style where funds were allocated from central government and medical staff delivered care within the cost constraints of their particular budget allocation. There were therefore significant differences between the hospitals. Additionally the first hospital

(KKH) was one of the first wave of hospitals in the roll out of the HCQ programme initiated under the five-year plans; meanwhile the second hospital (KFH) was in the second wave.

However these differences meant that it was possible to study how the role of MAPs in delivering HCQ differed in the different contexts but also how they remained similar across the contexts. The fact that both types of hospital had to shift from their existing budgetary style to Hopwood's 'non-accounting' style, as budgetary resources were allocated purely on the basis of success in hitting quality and productivity targets, was significant here. For in the event, despite their initial differences, both hospitals had to deploy MAPs in similar ways to deliver these targets. This was also significant in that the hospitals were representative of a change taking place more widely across the KSA medical field. For both the first wave of hospitals, coming from a private-sector management background, and the second wave, coming from a public health sector one, all moved towards this budgetary style since it was only through hitting the quality and productivity targets specified that increased budgetary resources were released to them.

Therefore the study coincided with a significant change for the KSA medical sector as a whole. Saudi public hospitals were a key site for delivering the government response to the 'public voice' pressure. What took place was a set of major changes to health care in which changes in MA played a key role. The outcome was to enable the sector to meet the demands of the public for improved health care in line with the country's plan of development. Effective responses were developed to meet a number of key concerns. The first concern related to the satisfaction of patients regarding the HCQ, particular once the public voice increased in intensity after the Arabic Spring. The second concern related to the fact that HCQ in public hospitals was not seen as improving in line with improvements in the economic position of the country. A third concern related to the lack of control at public hospital level over financial resources and lack of local

management by clinicians over medical decisions and priorities, which was seen as failing to deliver high quality medical outcomes in the public interest. The fourth concern was over the relative lack of highly qualified medical and management staff and clinicians who could manage the hospitals efficiently and effectively and deliver high-quality medical outcomes, ideally ‘evidence-based’ and in line with the latest research.

The two case studies were studied during the period the reform started to roll out, beginning in 2007. However, the study also brought in material before the time of the reform beginning from the early 1980s to give a diachronic context to the change being implemented and the experiences that unfolded during the reform. The study focussed on analysing changes in MA defined through four analytical categories that emerged from the material: (i) governmental regulation and resources, (ii) informal non-governmental discourses, (iii) international/ national state interfaces, and (iv) professional development and involvement. It focussed on how the interaction of developments in these categories promoted the ability and ‘right’ of management to coordinate control and monitor the human and financial resources, but in a way that could deliver HCQ outcomes for patients, thus promoting both economic and social/political objectives.

Both case studies show that the changes in management practice followed on from the pressure put on the government by the ‘public voice’, and led to the introduction of a new set of MAPs across all hospitals as part of delivering high HCQ. At the same time, the form the new system took was not determined by the ‘public voice’ but by the decisions made initially by the government and more specifically, the MOH, leading to a mix of central oversight with decentralised local management, in the form of the SEP in September 2007. So the hospitals that implemented the reform changed their organisational structures and ways of managing to accord with the SEP, which was designed by the MOH to achieve their new objectives. At the same time, the design of the MOH’s budgetary allocation system gave MA a significant set of new

roles since additional resources followed only where non-financial types of quality and productivity targets were met. In line with the analysis of budgetary styles first developed by Hopwood (1973), this meant that hospitals were rewarded where they adopted his 'non-accounting' budgetary style. This did not in the least mean that accounting played *no* role. On the contrary, removing the requirement to focus on cost control meant that MA's other two strengths, devising measures that can manage efficiency (here productivity) and effectiveness (here quality) outcomes, were set free to be the exclusive focus of both medical and management staff in each hospital. Under SEP, each hospital was free to devise its own way of delivering these targets, but in each case the narrower 'cost focus' that most MA systems have was not relevant.

The new hospital structure could then define its own form of organisational structure, defining levels and responsibilities as seen appropriate locally, in order to enable decentralised decision-making at the level of hospital managers and accountants and so to meet the new HCQ objectives by improving the quality and focus of decision-making and coordination of activities. This transfer of power and the new hospital structure helped hospital managers and accountants to enhance the changes to the MA and thus to support HCQ.

The change in focus for hospital objectives meant in practice that MA could work in a number of ways to support HCQ by managing medical and non-medical employee operations and performance, and in the process could become more centrally integrated into the everyday work of both medical and non-medical employees. One example is the implementation of a TQM ethos, where what took place integrated MA and other 'hard' performance measures into the delivery of 'soft' quality outcomes. 'Hard' and 'soft' measures together, as argued by Ezzamel (1994), were necessary to deliver the TQM agenda in each hospital. This meant that the hospitals could also deliver outcomes that met the requirements of a range of external organisations that

became involved in monitoring the delivery and outcomes of the HCQ agenda, such as the government, international accreditation organisations (especially in due course the JCI), and finally the public who with the publishing of comparative quality performance numbers for different hospitals could become defined as potential 'consumers' of HCQ.

In this context, even with a commitment to the SEP approach, there were key institutional factors promoting a range of 'isomorphic' responses from the hospitals studied. The commitment to quality required the adoption of a mix of hard and soft measures in order to meet the quality and productivity targets set by the MOH, along with the adoption of a non-accounting budgetary style.

Thus in order to meet the MOH requirements and deliver required outcomes on a continuous basis across the whole of a given hospital, there was a strong pressure towards *coercive isomorphism*. There was also a strong role for *normative isomorphism* particularly as a commitment was made to delivering quality through introducing best-practice medical research and highly-qualified medical staff trained in elite Western institutions, so that Western, and particularly US, medical norms became internalised increasingly in all hospitals as they adopted the HCQ agenda. This was of major importance in delivering improved employee education and training, and attracting well-educated Saudi and non-Saudi employees trained at international universities and institutions. Finally, there was a considerable degree of *mimetic isomorphism* as hospitals compared and contrasted their SEP solutions in order to secure optimal budgetary resources from the MOH. This was particularly significant in the second wave of rolling out the HCQ agenda as hospitals such as KFH drew on the experience of first-wave hospitals.

Therefore as hospitals responded to these institutional pressures, they all across time managed to change and improve their MA in ways that coincided with the improvement of financial resources, decentralisation of their management structures, enhancing employees' skills and

knowledge, working in cooperation with other hospitals and international accreditation bodies, improving their IT systems, and changing public perceptions of and levels of satisfaction with HCQ.

In this general transformation, the four factors mentioned above all played key roles, which can be summed up as follows. First, governmental regulation and resources played key political and economic roles. The strong economy of KSA enabled the government to give the SAPHS the resources to change its ways of management in ways that would give MAPs a more significant role across the hospital sector, without this role having to be the conventional one referred to in NPM reform contexts, that of reducing costs (e.g. Hassan, 2008; 2005). This underlines the importance of economic strength for being able to set up a change management process that did improve HCQ in line with public demands, while enabling MA to function effectively at the level of practice without (as is often found in NPM research) the outcome of a decoupling between practice and policy.

Second, informal non-governmental discourses from both patient groups and citizens (the 'public voice') were significant, particularly as noted after the Arab Spring and with the availability of social media. Public criticism put the management teams of hospitals as well as the government under a social microscope where they increasingly needed to take into account, but also to be seen as taking into account, the needs of the public in planning, organising, staffing, directing, monitoring and delivering public hospitals' activities. Therefore, it can be argued that the MA in the two hospitals was affected by social pressure to meet public expectations and to reflect the MOH slogan 'Patients First'.

Third, international and national state interfaces were clearly important: the commitment to delivering best-practice world-leading evidence-based medicine and hiring and working with leading medical institutions (such as Johns Hopkins Hospital) was crucial, as was the

commitment to working in line with international accreditation standards and bodies (e.g. JCI), as also were the national level interfaces with government, MOH and between hospitals. In the KSA context, the interfaces with international-level hospitals and accreditation bodies helped the hospitals to embed and extend the use of MA to deliver quality and productivity targets, and to integrate high-quality IT systems into the management and delivery of outcomes. The implementation of IT developed in Western countries proved crucial in improving services across the board, such as electronic medical services, management systems, employment systems and medical staff services. The power of international-national interfaces also helped in a mimetic way to increase commitment to the new uses of MA in hospitals since this type of MA use was in line with developments in the management style at international hospitals.

So both hospitals studied here implemented TQM as a requirement to obtain JCI certification, which was one of the key KPIs the MOH used to evaluate the improvement of health services in public hospitals to reflect their slogan 'Patients First' and to compare the level of quality between the SEP hospitals. In order to successfully implement TQM, the hospitals focused on seven principles derived from international interfaces: leadership, patient focus, employee training and management, information analysis, continuous improvement, supplier management and international accreditation. In such ways the MOH could use the JCI standards as an ongoing and evolving way of measuring and controlling the performance of each SEP hospital and to compare the population of hospitals in KSA as a whole.

Finally, professional development and involvement was key in order to improve the level of education in hospitals across the country, and this strongly influenced the way medical and non-medical employees at the hospitals had to remake their ways of working, and internalise MAPs as an integral part of delivering HCQ. Here the role of the KSA government has not been restricted to improvements at the medical education level. During the last decade in particular,

the KSA government has improved the level of education in the country generally by following a range of strategies, such as increasing the number of free public universities as well as introducing a free scholarship programme offered by the MOHE and the MOH, and attracting highly qualified employees from Western countries who are well educated and trained in order to improve social services, including medical services.

Based on these findings, it can be noted that the roles of the three types of isomorphism *coercive, mimetic and normative* have clearly been at work in significant ways as the HCQ agenda has been rolled out, and these have included promoting the use of MAPs to deliver on quality and productivity outcomes in each hospital studied and across the hospital sector more generally (DiMaggio and Powell, 1991, 1983). Looking at this more closely, it is possible to discern this as happening in the following ways.

Coercive isomorphism was found to exist in governmental regulations to implement the SEP reform, in e-government and in budgetary and costing systems that allowed external organisations, such as the MOH, the MOF and the NACC, to have more control over hospitals by focusing on planning, coordination and performance reviews. *Coercive isomorphism* can also be seen in the power of global organisations, such as the international accreditation bodies in applying specific forms of control over clinicians to achieve high levels of HCQ to obtain patient satisfaction, and in the social power of the community in putting strong pressure on public organisations to perform in ways that meet their expectations.

Mimetic isomorphism was found to exist in implementing the IT, computer systems and MA developed in different contexts and countries. These transfers of technology and computer systems shifted most hospital practices away from manual processes. As a result, MA could play a more integral role in everyday activity as using computer technology became standard across the hospitals. Another example is copying the NPM structure applied in other KSA hospitals

than those studied, and learning from the ways in which MA change was implemented in hospitals such as JHH and FFH.

Normative isomorphism was found to exist in improving employee education and training as well as attracting Saudi and non-Saudi staff educated and trained at international universities and institutions. In addition, both hospitals introduced a scholarship programme for their Saudi employees working in the medical and management departments to improve their levels of education and skills, and to help manage the hospital more effectively in order to meet hospital objectives.

To sum up, it can be argued that the legitimisation of MA changes within the public sector to support high HCQ in KSA (via the implementation of the SEP reform) has derived from the power of recent institutional developments and changes that have affected and effected change, including political and economic developments, the growth of patient pressure, and improved training and education, along with the adoption of IT solutions. But also the new MA implemented in the SEP hospitals has itself influenced and supported the HCQ agenda in significant ways. One of the main advantages of the MA was the improvement of the accountability system. The new accountability system put pressure on clinicians to increase their productivity to meet their targets, now based on international quality standards of health care as developed in Western countries. The new accountability system also helped hospital managements to plan and control medical activities to ensure high HCQ. This was done based on the performance reports of individuals and departments, outcomes and budgets. Another way MA significantly influenced improvements in the HCQ was by increasing patient focus and employee education and training through the TQM to reflect their ‘Patients First’ slogan.

Based on these points, it can be argued that MA has significantly contributed to delivering the quality and productivity outcomes of the SEP hospitals. The move to the SEP and the

implementation of new PMs and other quality practices have together increased the level of HCQ, clearly shown by annually increasing patient satisfaction rates, the reduction of medical incidents and the acceptance of quality certification standards.

Furthermore, the results of the research also show that there are different challenges clinicians faced as a consequence of implementing the new accountability and KPIs. These challenges included dealing with and in general accepting the power exercised over them by the new accountability system, although there were aspects of struggle and resistance in the transfer to using and coping with new practices (as when failure to achieve targets was explained in terms of exceptional patient situations). For example, once salary allowances and contract renewals were linked to the targets established, some clinicians began to act in suboptimal ways (in line with 'Goodhart's Law'), sometimes acting in their own best interests. Over time, these issues were addressed and these interests could become better aligned with the main objective of the hospitals to provide high HCQ to meet the public demand.

Another challenge that clinicians faced was using and coping with new practices and technology. Some therefore argued that the new IT technology, with the multiple information record on activities, PMs and budgeting practices, were complicated and difficult to use and against the traditional method of clinical work focussing on medical rather than administration activities. Again this kind of concern has begun to reduce, and can be expected to continue to do so (as the international employees have argued), as the SEP hospitals further improve their health care information and management systems and so catch up with Western hospitals where this kind of change to clinician work has become the norm. This may take time because of late implementation and lack of experience, but the commitment from the government and MOH to delivering this change is clear.

Finally one more way in which MA has made itself more central to HCQ delivery was noted, in terms of the way in which the roles of management accountants were enhanced. Concerning the role of management accountants, this increased in significance and visibility with the establishment in hospitals of a site for coordinating quality performance measures and evaluations, the QPD. This meant that management accountants have become involved in strategic and risk management as well as performance evaluations, and in high-level decision-making where they may act on occasion as consultants for executive managers, thus influencing the hospitals' direction, especially in terms of contributing to the strategic and planning aspects of delivering quality and productivity outcomes.

This change in role has been accompanied by improvements in the quality of accountants, in terms of their institutional background, e.g. their education and professional training, and in the focus of their work away from cost control towards efficiency and effectiveness objectives. In this respect, it can be argued that the improvement in the education of the accountants in SEP hospitals has helped promote the acceptance of more strategic forms of MAP not just with the hospital world but more widely within the public sector. Insofar as this is so, this would be another example of *normative isomorphism*.

With this approach, the major field study chapters sought to discuss similarities and differences between hospitals as the reform was rolled out step by step, and to note specific organisational outcomes in each of the cases studied. It was argued that it was possible to distinguish between how previous experiences mattered and played out in terms of how each hospital adopted the new self-operating reform, what problems each then faced and how such problems were solved. This was an important aspect of study dynamics of how MA change operated to promote HCQ outcomes.

At the same time, despite some significant differences in their previous experience and institutional set up both cases showed convergence towards similar ways of using MAPs under the SEP approach, which led to MA having three major central roles in delivering HCQ, as summed up in Table 7-1. At the same time, it was argued in Chapter 7 and above here, that this was possible because, under the budgetary allocation system devised by MOH, all hospitals had a major incentive to move towards the non-accounting budgetary style identified by Anthony Hopwood (1973), where the focus was on non-financial targets. This enabled accounting to act as an institutional force enabling the implementation of the Quality Vision and the support of quality as the main vehicle, as discussed by Ezzamel (1994), of the 'hard' measures complementing the 'soft' quality measures in delivering HCQ. In this respect an accounting change has played a strategic change role not only for each of the hospitals under this new reform but for a nation as a whole. One other outcome of this has been the enhancement that has followed of 'human capital' within the hospital sector. This should no doubt be seen as part of the wider Saudi drive to enhance education, skills and qualifications more widely. However, within the scope of this study, there is evidence of a move towards an improved and more diversified human capital, as summarised in Table 7-2.

8.3 Research questions revisited

At this stage of the thesis it is appropriate to revisit the two research questions as set out in the Introduction. Overall, the questions have worked as a pair of inquiries which have clarified and enhanced the understanding of the recent MA changes in SAPHS under the SEP reform to improve the HCQ, defined as NPM (Hood, 1995, 1991). The questions worked to reveal the institutional pressures that affected the MAPs, and the way the new MA was experienced and adopted within this institutional frame by key professionals such as accountants, consultants, managers and clinicians at the two hospitals. Further discussion is given below to the nature of the issues that each research question addressed, and the 'answers' to them.

The first research question proposed in this study was: why, at the institutional level, was new MA introduced to enhance HCQ outcomes in KSA? Based on the findings, the changes in MA in these hospitals were strongly influenced by the power of the governmental response to those pressures arising from the public, as well as other institutional factors. These factors were categorised into: (i) governmental regulation and resources, (ii) informal non-governmental discourses, (iii) international/national state interfaces, and (iv) professional development and involvement in hospitals. The interaction of developments in these factors promoted the ability and 'right' of management to coordinate control and monitor human and financial resources, but in a way that could deliver HCQ outcomes for patients, thus promoting both economic and social/political objectives. Furthermore, the study found that *coercive, mimetic and normative isomorphism* played different roles for each of these institutional factors, but also found that the type of isomorphism for each factor shifted during the period of study, as a sort of constant interplay of isomorphic types. For instance, the decentralised budget with a quality focus could first be understood from a perspective of *coercive isomorphism*, but this shifted into *mimetic and normative isomorphism* later in the process. These shifts signalled the successful implementation of the HCQ agenda, and the new MAPs here contributed to a strengthening of the internal and external legitimacy of certain key KSA institutions.

The second research question proposed was: how has the new MA been (re)defined, introduced and implemented in the context of HCQ delivery? The analysis of the detailed findings showed MA change and how far MAPs were promoted to manage, coordinate and monitor human and financial recourses that also included HCQ. From the findings, three significant shifts regarding the role of MA emerged after the implementation of SEP.

The first shift was the introduction of the 'non-accounting' budget style which was important in initiating these changes. This budget style removed a primary focus on controlling costs which is

always present in both budget-constrained and profit-conscious styles in part because managers are sanctioned if they exceed budgeted cost limits, but also because the profit focuses requires managerial attention to both revenues and costs in the search for optimal profit outcome. Instead, in the ‘non-accounting’ approach that was seen to develop in the hospitals studied here, accounting was still central but its primary function was focused on targets associated with the second and third of the ‘3 E’s’ – efficiency and effectiveness – and not ‘economy’.

The second shift was turning the MA role to TQM, which meant an integration of MA and other ‘hard’ performance measures into the delivery of ‘soft’ quality outcomes. ‘Hard’ and ‘soft’ measures together were necessary to deliver the TQM agenda in each hospital. This meant that the hospitals could also deliver outcomes that met the requirements of a range of external organisations that became involved in monitoring the delivery and outcomes of the HCQ agenda.

The third shift was the interplay of MA and TQM around ‘quality benchmarks’, meaning a new visibility for all. In this shift there were new ways of connecting performance and productivity to a benchmark of JCI, from each individual employee contract, to each level of the organisation, to MOH, for everyone to see anytime and anywhere. However, clinicians faced different challenges as unintended consequences of these shifts, including in terms of how the interaction between new MAPs formed a resistance to new accountability systems focussed on KPIs, especially among those key employees, the hospital clinicians.

8.4 Contributions

This study has contributed to our understanding of MA change in an NPM context, in a state, KSA, that does not fit automatically the label of either developed or developing country. Hence one of the key contributions of this study is therefore the accumulation of richly detailed empirical evidence on MA change in this distinctive context, and its role in improving HCQ in the public sector of KSA. The three fieldwork chapters seek to provide a comprehensive map of change in this specific institutional context.

The study also has contributed through demonstrating the potential significance of the non-accounting budgetary style in a financial context where scarce resources are not a constraint so that accounting does not have to operate with a primary cost control focus. While the research reported in Hopwood (1973) was in a private-sector setting, and while there were then no forms of NPM drawing on MAP to deliver public sector solutions, this study has hopefully shown how this budgetary style can operate in a public sector context, and can also deliver efficiency and effectiveness outcomes where practice does not necessarily clash with policy. It is hoped that this study may therefore help to expand the rich literature on MA in NPM settings, adding to the extensive work in settings where accounting has a cost-control focus, as in such studies as Broadbent and Guthrie (2008), Lee (2008), Strandberg-Larsen *et al.* (2007), Østergren (2006), and Chang (2006); to name just a few.

While not all countries can afford a financial support like this, it has been an opportunity to visualise another side of the powers that accounting has. This study therefore contribute to the theorising and understanding of the power of accounting, insofar as it indicates how new management strategies can play a significant role in improving HCQ through MA changes, particularly when their implementation shifts the focus from controlling costs to promoting performance in line with effectiveness and efficiency targets to promote quality. This way of

putting MA to use arguably promoted not just quality but also professionalism, as well as an intensified role for MA as an integral feature of good management and medical practice.

Another contribution is how the study highlighted a non-traditional NIS insulation factor: that of the public voice and discourse. While the public voice never defined the content nor its forms in shaping better HCQ it did initiate the change, and was a factor in shaping change in the roll-out phase, particularly once ‘patients’ became redefined as ‘consumers’ of HCQ are. This power of the public voice also raises the issue of the complexity of such reforms as noted by Cardinaels and Soderstrom (2013) and Kurunmäki *et al*. (2003) among others, emphasising how other institutional factors influence the role and practices of MA. In this respect the public voice and its importance complements and perhaps reframes what has been previously been argued regarding changes within the public sector as being driven in most cases by the government rather than the needs of the public (e.g. Lee, 2008; Strandberg-Larsen *et al.,* 2007), by raising the issue of what may drive the government to drive change. This is an issue which could possibly be relevant to analysing change management in both developing and developed countries: see for instance Henriksen *et al.* (2012), Lukka, (2007), Modell (2007) and Hassan (2005),

More generally, the study contribute to the literature on complexity of the institutional dynamics involved in reform insofar as its set of four relevant factors is helpful. The set of (i) governmental regulation and resources, (ii) informal non-governmental discourses, (iii) international / national state interfaces, and (iv) professional development and involvement was shown to have significant contributions in the KSA context. Arguably this kind of analysis could be applied to the wider field of studying MA change in developing countries such as Hopper *et al*. (2009), Jayasinghe and Thomas, (2009), Van-Triest and Elshahat, (2007), Waweru *et al.* (2004) and Uddin and Hopper, (2001).

Finally, this study has made a contribution to the relations between MAPs and policy-making, insofar as its evidence indicates the value of a staged roll-out process focussing on quality and enabling MA to avoid having to implement a cost-control focus. There are of course various legitimate ways to implement reform, from the revolutionary approach which Agrizzi studied (2008), to the pilot study followed by general roll-out or more piecemeal approaches (see for instance Cinquini and Campanale, 2010; Kurunmäki, 2004; Kurunmäki *et al*., 2003). But this form of phased roll-out, combined with decentralisation of solutions and the value of adopting a non-accounting budgetary style, may certainly be one for policymakers in similar settings but in other countries to consider.

8.5 Limitations

This research provided a comprehensive understanding of how MA has changed in SAPHS under SEP reform to improve the HCQ, and of the institutional factors that influenced this change. However, there are several limitations to the study that should be acknowledged and that stress the need for further research in the context of KSA.

The theoretical framework selected for the research drew on principles of NIS, as this provides substantial room for the evaluation of institutions in the context of their existing forms and behaviour, continual change and the political factors and social elements that affect institutionalisation. However, the theoretical framework has two limitations, which are an inability to recognise the relative power of and conflicts between different institutional actors and the role that individuals play in recent developments within hospitals, and an inability to analyse at hospital level how these competing interests can be accommodated or reconciled.

The second limitation of this research is limited interview access to both Saudi citizens and patients, which would be instrumental to a comprehensive understanding of the power of the public voice, and the development of what we might call a ‘Quality Vision’ from the public

perspective. Documents collected during the fieldwork enabled the researcher to understand the fundamental issues; however much was taking place that could not be accessed. Despite these limitations, the results and findings of this research have not been impacted.

8.6 Future research possibilities

From the contributions and limitations discussed above, it is clear that this study also creates new possibilities for future research. The first would be to continue where this study ended and to follow the ongoing roll-out of the HCQ agenda, and undertake fieldwork in one or more hospitals involved in future phases. In particular, both hospitals studied to date were located in urban settings, and it would be valuable to see how far roll-out in hospitals in non-urban or rural settings might differ. We have seen here a convergence in both hospitals towards adopting similar MAPs to hit the quality and productivity targets required, and this may well be the case in rural settings, as a similar mix of isomorphic pressures may be in play. However rural areas often have more traditional ways of living and approaches to solving issues such as health care, and the discourses of HCQ and targets, whether soft or MA-based hard targets, may not translate so easily to these settings. It would be interesting too to see how far local populations, as a form of public voice but also as patients, would embrace a redefinition as 'consumers' of metrics defining 'quality' in health care. Against this background it would be of interest to see what type of isomorphism is in play, but also any shifts or a similarity in this roll-out phase to what has gone before. To include a more in-depth patient perspective would require a form of access to patients which must be ethically secured. There are also other areas within KSA where there is major budgetary investment in quality outcomes, most significant of these being housing and education, education having the largest budget allocation from central government. Other public sector areas of research interest could include schools, universities, social services, or such large investment projects as the five-year budget programme itself.

In that respect, comparative studies between public sectors can be of interest, not least as the range of people involved in delivering improved HCQ within the institutional field of SEP hospitals have been diverse, as illustrated by Table 7-2. Comparisons with delivering quality in other public institutions such as universities would be interesting, not least to see how far diversity might affect quality outcomes in such settings. Another line of enquiry could be to conduct research on MA changes in one or more of the other high-income countries, e.g. the GCCs, where similar economic positions are found. It would be interesting to discover how far similar non-accounting budgetary styles might be in development or implemented, and if so how effective their implementation might be.

Future research could also focus on investigating and analysing the interplay between the roles of MAPs in delivering quality outcomes (whether under a non-accounting budget style or not), and the implications for approaches to leadership and leadership styles. The findings of this study suggest that, under the SEP approach at least, there is a significant role for a ‘partnership’ kind of approach, externally and perhaps internally. Externally, the degree of *mimetic isomorphism* involved indicated that commitment to cooperation across organisations was likely to be a valuable leadership skill; internally, the ways in which MAPs focussed all employees on hitting hard and soft productivity and quality targets made strongly focussed leadership possible. At the same time, managing groups from senior clinicians to other medical personnel to non-medical employees, and keeping them all working effectively and long-term towards HCQ targets and outcomes requires negotiating skills and diplomacy. This could therefore be a rich field of study in which a deeper understanding of MAPs and their organisational roles might be advanced. These suggested future research areas would contribute to the debate raised in and through this study.

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Appendices

Appendix A: Interviews Questions

Clinicians

- **General questions**
  - Could you please introduce yourself?
    - Occupation
    - Position
    - Responsibilities
  - How did you get to where you are today?

- **The Clinicians’ work and quality of health services**

1. What does a typical clinicians’ working day look like today?
2. Proximally how much time do you spend on medical, management and admin tasks?
3. Looking back how to what extent has a typical clinicians’ working day changed?
4. What does health care quality mean to you?
5. Looking back how has health care quality changed over time in this hospital?
6. What has been the main reason for the change of health care quality?

- **Self- Operation Programme**

7. What does the Ministry of Health’s slogan (‘Patient First’) mean to you?
8. Why has the SEP been introduced in Saudi Arabia hospitals?
9. How has the SEP been introduced in your hospital?
10. What are the objectives of this programme?

- **SEP and MA**

11. In relation to the implementation to SEP what has been the key changes in MA?
12. To what extent do you think that the MA is assisting managers in achieving the objectives of the SEP?
13. To what extent is MA part of the Clinicians’ work?
14. To what extent do you think a mix of economic and medical information supports you in achieving the hospital’s goals and supporting the quality of services?
15. To what extent do clinicians collaborate with the management team at different levels?

- **MA and the quality of health services**

16. What specific MA has been implemented to support the quality of health services?
17. How have MA (new or old) been part of that quality of care or change?
18. To what extend have these practices supported the quality of health care services?
19. What is the impact of using such practices?
20. How have these MA been implemented?

- **Ways of managing the hospital**

21. How would you characterise the management style adopted here?
22. In what ways did the style of management change when implementing SEP?
23. To what extent do you see that the hospital's managers have shifted their focus to consider the quality of health care services?

- **Factors that have influenced clinicians**

24. To what extent do you think any of the following factors have influenced your work to support the quality of services?
    1. Regulations
    2. Economics
    3. Size of the employees in the hospital
    4. Information technology
    5. Hospital structure/decentralisation
    6. Competitors/Bench mark organisations
    7. Needs of the public
    8. Training of staff
    9. Consultants
    10. Other factors do you think have influenced your work to support the quality of services?

Financial and Accounting Managers

- **General questions**
  - Could you please introduce yourself?
    - Occupation
    - Position
    - Responsibilities
  - How did you get to where you are today?
  -

- **Management accounting practices (MA)**

1. What, according to your experience, have been the key changes in MA in your hospitals?
2. Why were these changes of MA necessary?
3. How did you implement these MA changes?
4. How long did the implementation take?
5. What was the role of management accountants in these changes?
6. Who else do you think has a role in these changes?
7. What have been the most challenging factors that have influenced the MA when they are implemented?
8. To what extent does the MA assist managers in directing, controlling and managing operational activities?

- **Self- Operation Programme**

9. What does the Ministry of Health's slogan ('Patient First') mean to you?
10. Why has the SEP been introduced in Saudi Arabia hospitals?
11. How has the SEP been introduced in your hospital?
12. What are the objectives of this programme?
13. To what extend was it necessary to change existing MA in order to support the objectives of SEP?
14. What were the key changes in MA?
15. To what extent do you think that the MA is assisting managers and clinicians in achieving the objectives of the SEP? (give example)

- **The quality of health services**

16. What does health quality mean to you?

17. Looking back how has the health care quality changed in this hospital?
18. How have MA (new or old) been aimed at supporting health quality change?
19. What specific MA has been implemented to support the quality of health services?
20. How have these MA been implemented?
21. How have these MA supported the quality of health services?
22. What is the role of the following practices in supporting the quality of health services?
    1. Cost systems
    2. Budgeting
    3. Performance evaluation
    4. Strategy
23. What are the most challenging factors that influence the MA in supporting the quality of health services?

- **The role of the external and the internal environment**

24. How have each of these factors influenced the implementation of different systems of accounting practices at your hospital?
    1. Government and regulations
    2. Culture
    3. Consultants
    4. National economics
    5. Competitors /Bench mark organisations
    6. Other external factors do you think have influenced the implementation of different systems of accounting practices at your hospital?
25. How have each of these factors influenced the implementation of different systems of accounting practices at your hospital?
    1. Information technology
    2. Hospital structure/decentralisation
    3. Accountants' education
    4. Size of the employees in the hospital
    5. Training of courses
    6. Other internal factors do you think have influenced the implementation of different systems of accounting practices at your hospital?

Head of departments and admin

- **General questions**
  - Could you please introduce yourself?
    - Occupation
    - Position
    - Responsibilities
  - How did you get to where you are today?

- **Management accounting practices (MA)**

1. What, according to your experience, have been the key changes in MA in your hospitals?
2. Why were these changes of MA necessary?
3. How long did the implementation take?
4. To what extent do you think that the MA assists managers in directing, controlling and managing operational activities?

- **Self- Operation Programme**

5. What does the Ministry of Health's slogan ('Patient First') mean to you?
6. Why has the SEP been introduced in Saudi Arabia hospitals?
7. How has the SEP been introduced in your hospital?
8. What are the objectives of this programme?
9. To what extent do you think that the MA is assisting managers in achieving the objectives of the SEP?
10. In relation to the implementation to SEP what has been the key changes in MA?

- **The quality of health services**

11. What does health quality mean to you?
12. How has health quality changed over time?
13. What is your focus with respect to improving the quality of services?
14. What management techniques have you used to support the quality of health services in your department?
15. Why you have used these management techniques?
16. How have these techniques been implemented?

17. What is the role of the following practices in supporting the quality of health services in your department?
    1. Cost systems
    2. Budgeting
    3. Performance evaluation
    4. Strategy
18. To what extent do you think that the MA used in your department are useful in managing the quality of services?
19. Why were the management techniques used in your department successful or not successful?

➢ **Factors that have led to influence or change**

20. How have these factors influenced your department to support the quality of services?
    1. Information technology
    2. Size of the employees in the hospital
    3. Hospital structure/decentralisation
    4. Competitors /Bench mark organisations
    5. Accountants and their education level
    6. Training of staff
    7. Consultants
    8. Other factors do you think have influenced your department to support the quality of services

➢ **The use and influence of MA/ KPI**

21. To what extent do the clinicians interact with and the management team collaborate with each other in achieving the hospital's goals and supporting the quality of services?
22. What kind of accountability system is in place?
23. Who is involved in setting up the accountability system and measures in place?
24. What measures and techniques used to evaluate clinicians' and managers' performance and responsibilities?
25. To what extent do you think does a combination of economic and health quality information such as KPI's support the clinicians and managers in achieving high-quality health services?
26. What KPIs are used?
27. To what extent does performance measures influence clinicians' and managers' work and ultimately support the quality of their work?

Consultants

- **General questions**
  - Could you please introduce yourself?
    - Occupation
    - Position
    - Responsibilities
  - How did you get to where you are today?

- **Self- Operation Programme**

1. What does the Ministry of Health's slogan ('Patient First') mean to you?
2. Why has the SEP been introduced in Saudi Arabia hospitals?
3. How has the SEP been introduced in the hospital?
4. What are the objectives of this programme?
5. To what extend was it necessary to change existing MA in order to support the objectives of SEP?
6. What were the key changes in MA?
7. To what extent do you think that the MA is assisting managers and clinicians in achieving the objectives of the SEP? (give example)

- **Management accounting practices (MA)**

8. What, according to the experience, have been the key changes in MA in the hospitals?
9. Why were these changes of MA necessary?
10. How did you implement these MA changes?
11. How long did the implementation take?
12. What was the role of management accountants in these changes?
13. Who else do you think has a role in these changes?
14. What have been the most challenging factors that have influenced the MA when they are implemented?
15. To what extent does the MA assist managers in directing, controlling and managing operational activities?
16. What does health quality mean to you?
17. Looking back how has the health care quality changed in this hospital?

18. How have MA (new or old) been aimed at supporting health quality change?
19. What specific MA has been implemented to support the quality of health services?
20. How have these MA supported the quality of health services?
21. What are the most challenging factors that influence the MA in supporting the quality of health services?

- **The role of the external and the internal environment**

22. How have each of these factors influenced the implementation of different systems of accounting practices at the hospital?
    1. Government and regulations
    2. Culture
    3. Consultants
    4. National economics
    5. Competitors /Bench mark organisations
    6. Other external factors do you think have influenced the implementation of different systems of accounting practices at the hospital?
23. How have each of these factors influenced the implementation of different systems of accounting practices at the hospital?
    1. Information technology
    2. Hospital structure/decentralisation
    3. Accountants' education
    4. Size of the employees in the hospital
    5. Training of courses
    6. Other internal factors do you think have influenced the implementation of different systems of accounting practices at the hospital?

Appendix B: List of documents

1. Ministry of Health Strategy.
2. Employment and labour law in Saudi Arabia.
3. Demographic, education and historical data concerning the health care.
4. Economic development data.
5. Public and governmental reports in the official media.
6. Public and governmental speech in the official media.
7. National Anti-Corruption reports.
8. Joint Commission International Accreditation Standards for Hospitals.
9. Joint Commission International Accreditation reports.
10. Annual Financial Statements for both hospitals.
11. Hospitals’ websites.
12. SEP regulations.
13. SEP structure.
14. Hospitals’ charts.
15. Hospitals annual reports.
16. Hospitals’ budgeting for selected years.
17. Budget rules.
18. Employees’ contract.
19. General activity report of the hospitals such as inpatient and outpatient services.
20. Job descriptions.
21. Performance appraisals and reports.
22. Human recourses information and qualification
23. Patients’ satisfaction reports.
24. Records of complaints.
25. Monthly report of heath care quality.
26. Quality improvement indicators reports such as
    1. Waiting period
    2. Patient safety
27. Benchmarked reports.
28. Mortality and morbidity reports.
29. Training programme and scholarship.
30. Huge documents published on the internet.

Appendix C: Health care Systems around the world

	HEALTH SYSTEM AND PUBLIC/PRIVATE INSURANCE ROLE			BENEFIT DESIGN	
	Government role	**Public system financing**	**Private insurance role** (core benefits; cost-sharing; noncovered benefits; private facilities or amenities; substitute for public insurance)	**Caps on cost-sharing**	**Exemptions and low-income protection**
Australia	Regionally administered, joint (national & state) public hospital funding; universal public medical insurance program (Medicare).	General tax revenue; earmarked income tax	~50% buy complementary (e.g., private hospital and dental care, optometry) and supplementary coverage (increased choice)	No. Safety nets include 80% rebate on OOP for payments above AUD1,248.70 [USD827] annually[a]	Low-income and older people: Lower cost-sharing; lower OOP maximum (AUD624.10 [USD413]) for 80% rebate[a]
Canada	Regionally administered universal public insurance program that plans and funds (mainly private) provision.	Provincial/federal general tax revenue	~67% buy complementary coverage for noncovered benefits (e.g., private rooms in hospitals, drugs, dental care, optometry)	No	There is no cost-sharing for publicly covered services; protection for low-income people from cost of prescription drugs varies by region
Denmark	National health care system. Regulation, central planning and funding by national government; provision by regional and municipal authorities.	Earmarked income tax	~40% buy complementary coverage (cost-sharing, non-covered benefits such as physiotherapy), some supplementary coverage (access to private providers)	No. Decreasing copayments with higher drug OOP spending	Drug OOP cap for chronically ill (DKK3,775 [US$488]); financial assistance for low-income and terminally ill[a]
England	National health service (NHS).	General tax revenue (includes employment-related insurance contributions)	~11% buy supplementary coverage for better access (including to elective treatment in private hospitals)	No general cap for OOP. Prepayment certificate with GBP29 [US$42] per three months or GBP104 [US$150] per year ceiling for those needing a large number of prescription drugs[a]	Drug cost-sharing exemption for low-income, older people, children, pregnant women and new mothers, and some disabled/chronically ill; financial assistance with transport costs available to people with low incomes
France	Statutory health insurance system, with all SHI insurers incorporated into a single national exchange.	Employer/employee earmarked income and payroll tax; general tax revenue, earmarked taxes	~90% buy or receive government vouchers for complementary coverage (mainly cost-sharing, some noncovered benefits); limited supplementary insurance	No. €50 [US$60] cap on deductibles for consultations and services[a]	Exemption for low-income, chronically ill and disabled, and children
Germany	Statutory health insurance system, with 131 competing SHI insurers ("sickness funds" in a national exchange); high income can opt out for private coverage.	Employer/employee earmarked payroll tax; general tax revenue	~11% opt out from statutory insurance and buy substitutive coverage. Some complementary (minor benefit exclusions from statutory scheme, copayments) and supplementary coverage (improved amenities)	Yes. 2% of household income; 1% of income for chronically ill	Children and adolescents <18 years of age exempt
Italy	National health care system. Funding and definition of minimum benefit package by national government; planning, regulation and provision by regional governments.	National earmarked corporate and value-added taxes; general tax revenue and regional tax revenue	~15% buy complementary (services excluded from statutory benefits) or supplementary coverage (more amenities in hospitals, wider provider choice)	No. Max €46.15 [USD61] copayment per outpatient specialist consultation or diagnostic procedure; limited copayment (regional rates) on drugs[a]	Exemptions for low-income older people/children, pregnant women, chronic conditions/ disabilities, rare diseases
Japan	Statutory health insurance system, with >3,400 noncompeting public, quasi-public, and employer-based insurers. National government sets provider fees, subsidizes local governments, insurers, and providers and supervises insurers and providers.	General tax revenue; insurance contributions	~70% buy coverage for cash benefits to cover cost-sharing. Limited role of complementary insurance not covered by statutory benefits	Yes. Coinsurance reduced to e.g. 1% after 80,100 yen [USD774] monthly cap, depending on enrolee age and income. Annual cap of total OOP payments at between JPY310,000 [USD2,997] and JPY1.26M [USD12,180] per household, depending on income and ages of household members.[a]	Low-income monthly OOP ceiling: 35,400 yen [$441 USD]; reduced cost-sharing for young children, older people, those with chronic conditions/disabilities, and disabilities. Social assistance covers full costs of covered health care.a
Netherlands	Statutory health insurance system, with universally-mandated private insurance (national exchange); government regulates and subsidizes insurance.	Earmarked payroll tax; community-rated insurance premiums; general tax revenue	Private plans provide statutory benefits; 85% buy complementary coverage for benefits excluded from statutory package	No. But annual deductible of €360 [USD436] covers most cost-sharinga	Children exempt from cost-sharing; premium subsidies for low-income
New Zealand	National health care system. Responsibility for planning, purchasing, and provision devolved to geographically defined District Health Boards.	General tax revenue	~33% buy complementary coverage (for cost-sharing, specialist fees, and elective surgery in private hospitals) and supplementary coverage for faster access to non-urgent treatment	No. Reduced fees after 12 doctor visits per year/patient and no drug copayments after 20 prescriptions per year/family.	No primary care consultation charges for children under 6; subsidies for low-income, some chronic conditions, Maori and Pacific islanders
Norway	National health care system. Some direct funding and provision roles for national government and some responsibilities devolved to Regional Health Authorities and municipalities.	General tax revenue	~7% hold supplementary VHI, mainly bought by employers for providing employees quicker access to publicly covered elective services	Yes. Overall annual cost-sharing ceiling is NOK2,105 [USD234].[a]	Exemptions for children <16 yrs. somatic, <18 yrs psychiatric, pregnant women and for some communicable diseases (STDs); low-income groups receive free essential drugs and nursing care

Singapore	Government subsidies at public health care institutions and some providers; Medisave: mandatory medical savings program for routine expenses; MediShield: catastrophic health insurance; Medifund: government endowment fund to subsidize health care for low-income and those with large bills. Government regulation of private insurance, central planning and financing of infrastructure and some direct provision through public hospitals and clinics.	General tax revenue	Medisave-approved Integrated Shield Plans (private insurance plans) supplement MediShield coverage to provide catastrophic health coverage for additional ward classes. Other types of private insurance are also available, including private insurance provided by employers.	No.	Subsidized care for low-income population, with income- and asset-based means-test to target subsidies. Medifund as safety net to pay for low-income and people with no means to pay for their health care bills.
Sweden	National health care system. Regulation, supervision and some funding by national government; responsibility for most financing and purchasing/provision devolved to county councils.	Mainly general tax revenue raised by county councils, some national tax revenue	~5% get supplementary coverage from employers for quicker access to a specialists and elective treatment	Yes. SEK1,100 [USD126] for health services and SEK 2,200 [US$252] for drugs[a]	Some cost-sharing exemptions for children, adolescents, pregnant women and elderly.
Switzerland	Statutory health insurance system, with universally mandated private insurance (regional exchanges); some federal legislation, with cantonal (state) government responsible for provider supervision, capacity planning, and financing through subsidies.	Community-rated insurance premiums; general tax revenue	Private plans provide universal core benefits; some people buy complementary (services not covered by statutory insurance) and supplementary (improved amenities and access); no coverage data available	Yes. 700 CHF [USD504] max after deductible[a]	Some copayment exemptions for <19-year-olds and CHF350 [USD252] cap; income-related premium assistance (30% receive); maternity care fully covered[a]
United States	Medicare: age 65+, some disabled; Medicaid: some low-income; for those without employer coverage, state-level insurance exchanges with income-based subsidies; insurance coverage mandated, with some exemptions (13.4% of adults uninsured).	Medicare: payroll tax, premiums, federal tax revenue; Medicaid: federal, state tax revenue	Primary private insurance covers ~56% of population (employer-based and individual); supplementary for Medicare	Yes for most private insurance plans: $6,350 yearly limit for individuals; $12,700 for families as of 2014	Low-income: Medicaid; older people and some disabled: Medicare; premium subsidies and lower cost-sharing for low- and middle-income families on the exchanges; some affordability exemptions from insurance mandate

(Osborn and Anderson, 2015)

Provider Organization and Payment in 15 Countries

	Provider Ownership		Provider Payment		Primary Care Role	
	Primary Care	Hospitals	Primary Care Payment	Hospital Payment	Registration with GP Required	Gatekeeping
Australia	Private	Public (~67% of beds), private (~33%)	~90% FFS, ~10% incentive payments	Global budgets + case-based payment in public hospitals (includes physician costs); FFS in private hospitals	No	Yes
Canada	Private	Public/private mix (proportions vary by region), mostly not-for-profit	Mostly FFS (50%–85% depending on province), but some alternatives (e.g., capitation) for group practices	Global budgets + case-based payment in some provinces (does not include physician costs)	Not generally, but yes for some capitation models	Yes, mainly through financial incentives varying across provinces: e.g., in Ontario, specialists receive lower fees for patients not referred
Denmark	Private	Almost all public	~70% FFS, ~30% capitation	Mainly global budgets + limited case-based payment (does not include physician costs)	Yes (for 98% of population)	Yes (for 98% of population)
England	Mainly (66%) private	Mostly public, some private	Mix capitation/FFS/P4P; salary payments for a minority (the salaried GPs are employees of private group practices, not of the NHS)	Mainly case-based payments (60%) plus service contracts. All include physician costs, drug costs, etc.	Yes	Yes
France	Private	Mostly public (67% of inpatient, 50% of outpatient beds) some private for-profit (25% of inpatient beds) and private not-for-profit	Mix FFS/P4P/flat 40€ [US$47] bonus per year per patient with chronic disease and regional agreements for salaried GPs*	Mainly case-based payments (includes physician costs) + non-activity-based grants for education, research, etc.	No, but 85% of population register voluntarily (may be with a specialist or GP, 95% register with GPs)	Voluntary but incentivized: higher cost-sharing for visits and prescriptions without a referral from physician registered with
Germany	Private	Public (~50% of beds); private nonprofit (~33%); private for-profit (~17%)	FFS	Global budgets + case-based payment (includes physician costs)	No	Generally no, present in specific programs by sickness funds
Italy	Private	Mostly public (~80% of beds), some private (~20%)	Mix capitation (~70% of total), FFS and limited P4P (~30%)	Subject to regional variation, mainly case-based payment (except hospitals owned by regional authorities) + global budgets (includes physician costs)	Yes	Yes
Japan	Mostly private	Mainly private nonprofit (~80% of beds), some public (~20%)	Most FFS, some per-case daily or monthly payments	Case-based per diem payments + FFS or FFS only (includes physician costs)	No	No, but some large hospitals and academic centers charge extra fees to patients not referred
Netherlands	Private	Mostly private, nonprofit	Mix capitation (37% of total) / FFS (33%), some bundled payments and P4P	Global budgets + case-based payment (include physician costs)	Yes	Yes
New Zealand	Private	Mostly public, some private	Mix capitation (~50% of total) / FFS patient payments (~50%)	Global budgets (includes physician costs)	No	Yes
Norway	Private	Almost all public, some private not-for-profit	Capitation from municipal contracts (~35% of income), government-sponsored FFS (~35%) and user-charges (~30%)	Global budgets (~50%) + case-based payment (~50%) (includes physician costs)	No, but nonregistered patients face higher copayments for GP consultations	Yes
Singapore	Almost all private, with some larger public clinics for lower-income population	Mainly public, 20%–30% private based on activity	FFS	For public hospitals, combination of global budgets + case-based payments	No	No
Sweden	Mixed	Almost all public, some private for-profit and not-for-profit	Mix capitation (~80% of total) and FFS/limited P4P (~20% of total)	Global budgets (~66% of total) + case-based payment/limited P4P (includes physician costs)	Yes (except Stockholm)	No
Switzerland	Private	Mostly public or publicly subsidized private (~70%), some private	Most FFS, some capitation in managed care plans offered by insurers	Case-based payments (~50% of total) and subsidies (through various mechanisms) from cantonal government	No, except in some managed care plans offered by insurers	Free access (without referral) to specialists, except in some managed care plans with gatekeeping offered by insurers
United States	Private	Mix of nonprofit (~70% of beds), public (~15%), and for-profit (~15%)	Most FFS, some capitation with private plans; some incentive payments	Mostly per-diem and case-based payments (usually does not include physician costs)	No	In some insurance programs

Saudi Arabia: Ministry of Health Statistical Yearbook

Country Cooperation Strategy

at a glance

Saudi Arabia

http://www.who.int/Countries/

Indicator	Value
Total population, thousands	28,376
Percent population Under 15	31.4
Population distribution percent urban	82.6
Life expectancy at birth	74
Fertility rate, total (births per woman)	2.9
Under 5 mortality rate per 1000 live births	19.1
Maternal mortality ratio per 100 000 live births	14.0
Total expenditure on health as percentage of GDP	5.3
General government expenditure on health as % of the total government budget	6.9
Human Development Index Rank, out of 186 countries	57
Per Capita Gross Domestic Product (PPP current international US$	22,328
Adult (15+) literacy rate	87.4
Adult male (15+) literacy rate	91.0
Adult female (15+) literacy rate	82.6
% Population with sustainable access to water source	97.0
% Population with sustainable access to improved sanitation	100

Sources:
Saudi Arabia: Ministry of Health Statistical Yearbook for the Year 1432H.
UNDP: Human Development Report 2013,
http://hdr.undp.org/en/reports/global/hdr2013/download/

The structure of the Saudi Arabian Government is a monarchy; all political authority is vested in the Government in Riyadh, with a per-capita income (PPP, current international $) of US$ 22,328 that is ranked 57out of 186 countries in HDI. The Gender Inequality Index for Saudis is 0.682 and was ranked 145, with 83% of females above 15 who are literate.

HEALTH & DEVELOPMENT

Health System: The Ministry of Health is the main provider of health care services. Health has featured in the national five-year development plans since 1970, and is seen as a key part of overall development in the country. The ninth national development plan (2009–2013) addressed a number of public health issues. The number of primary health care centres was increased by 9.5% in the last five years, with 150 new centres planned each year until 2016 as part of the ten-year Ministry of Health strategy. The number of hospitals, physicians and nursing staff also increased. A strategy was recently developed by the Ministry of Health in partnership with other national and international agencies to reform service delivery in line with the national health strategy. The new delivery of care model is based on developing an integrated and comprehensive system of care throughout the country. Integration is performed at four levels (primary to quaternary care) with a comprehensive set of services planned based on seven elements (primary health care, hospitals, rehab, homecare, mental health, dental care and preventive health). The Ministry of Health is promoting quality assurance and improvement through use of standard operating procedures and accreditation of health care facilities. Efforts are being made to improve patient safety in both public and private health facilities. Saudi Arabia relies heavily on an expatriate population to provide its sizeable health workforce, which is responsible for the high turnover in the health care system. However, the government is continuing its efforts to develop a Saudi health workforce through the introduction of number of medical, nursing and health schools, along with development of a new training centres and scholarship programs to train medical staff abroad in leading institutions.

Life Courses: Saudi Arabia is on track to achieve their MDG targets.

Communicable Diseases: Communicable diseases have ceased to be the leading cause of mortality in the country; in fact the rates of malaria and tuberculosis are negligible according to the World Health Report 2012. The malaria cases reported are primarily due to the country's southern border with Yemen, where the disease is still prevalent.

Noncommunicable Diseases: Saudi Arabia is experiencing epidemiological and demographic transition, represented by a growing burden of chronic noncommunicable diseases, while population expectations for quality care services are expanding. There has been an alarming increase in the prevalence of chronic diseases, such as diabetes, heart diseases and cancer, for which the treatment is costly, and account for 71 % of all mortality.

Emergency and Humanitarian Crises: Saudi Arabia is host to large mass gathering events attracting more than 3 million people from more than 183 countries annually. These gatherings pose a variety of health risks including those due to infectious diseases such as seasonal, respiratory, foodborne and other gastro-intestinal illnesses, skin diseases and injuries. To address such risks, Saudi Arabia has put in place an advanced health care system infrastructure that includes 177 primary medical clinics and 27 hospitals in the immediate vicinity of the pilgrimage areas.

PARTNERS

As of 2009, Saudi Arabia became the world's largest provider of humanitarian assistance by GDP. It was instrumental in providing critical assistance in the Region in times of crisis, such as in the aftermath of the Pakistan earthquake and during Somalia's famine. Saudi Arabia is now the third-largest developing-country contributor to global development efforts after China and India.

OPPORTUNITIES	CHALLENGES
• Encouraged by the Saudi Government's commitment to finance the service delivery reform programme; • Acknowledged the country's new strategies for primary health care and for service delivery, which are patient-centred, focusing on health promotion and protection and put emphasis on social determinants of health.	• Acknowledged Saudi Arabia's undergoing epidemiological and demographic transition, represented by a growing burden of chronic and noncommunicable diseases and ageing population; • Identified the rapid escalation in the costs of health care services as a serious challenge for the country; • Increased demand for social services including health care due to the rapid population growth and high fertility rates.

• WHO STRATEGIC AGENDA 2012-2016

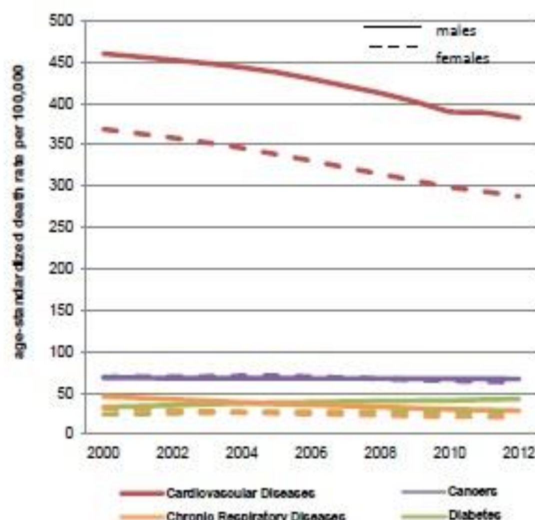
- **Health system strengthening:** Strengthening the health care system and improving partnership for health development.
- **Noncommunicable diseases:** Strengthening health promotion and control of noncommunicable diseases.
- **Communicable Diseases:** Strengthening communicable diseases control and health security.

Saudi Arabia

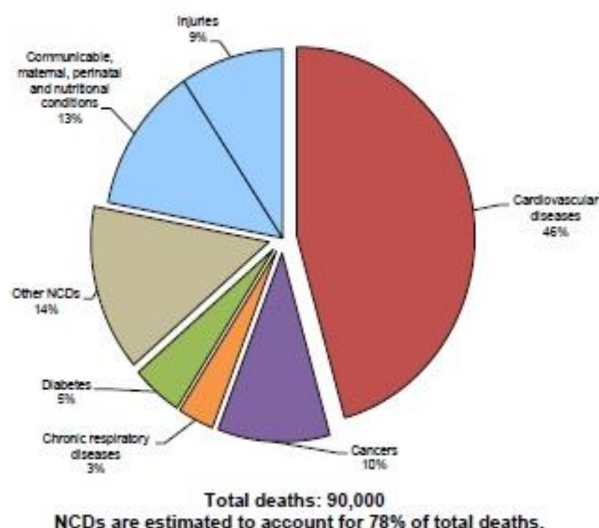
Total population: 28 288 000
Income Group: High

Percentage of population living in urban areas: 82.3%
Population proportion between ages 30 and 70 years: 42.7%

Age-standardized death rates*



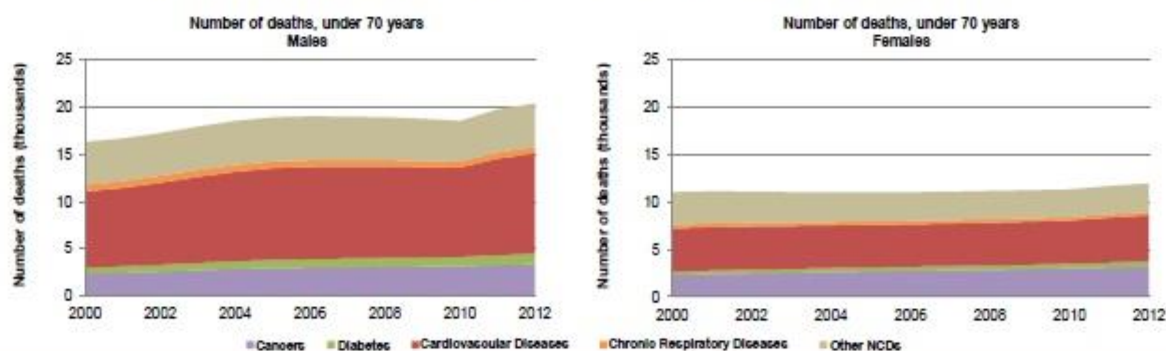
Proportional mortality (% of total deaths, all ages, both sexes)*



Total deaths: 90,000
NCDs are estimated to account for 78% of total deaths.

Premature mortality due to NCDs*

The probability of dying between ages 30 and 70 years from the 4 main NCDs is 17%.



Adult risk factors

	males	females	total
Current tobacco smoking (2011)	38%	<1%	22%
Total alcohol per capita consumption, in litres of pure alcohol (2010)	0.3	0.1	0.2
Raised blood pressure (2008)	26.0%	21.5%	24.2%
Obesity (2008)	28.6%	39.1%	33.0%

National systems response to NCDs

Has an operational NCD unit/branch or department within the Ministry of Health, or equivalent	Yes
Has an operational multisectoral national policy, strategy or action plan that integrates several NCDs and shared risk factors	No
Has an operational policy, strategy or action plan to reduce the harmful use of alcohol	No
Has an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity	Yes
Has an operational policy, strategy or action plan to reduce the burden of tobacco use	Yes
Has an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets	Yes
Has evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach	DK
Has an NCD surveillance and monitoring system in place to enable reporting against the nine global NCD targets	No
Has a national, population-based cancer registry	Yes

* The mortality estimates for this country have a high degree of uncertainty because they are not based on any national NCD mortality data (see Explanatory Notes).
DK = Country responded "don't know"

Appendix D: Kingdom of Saudi Arabia

Politics

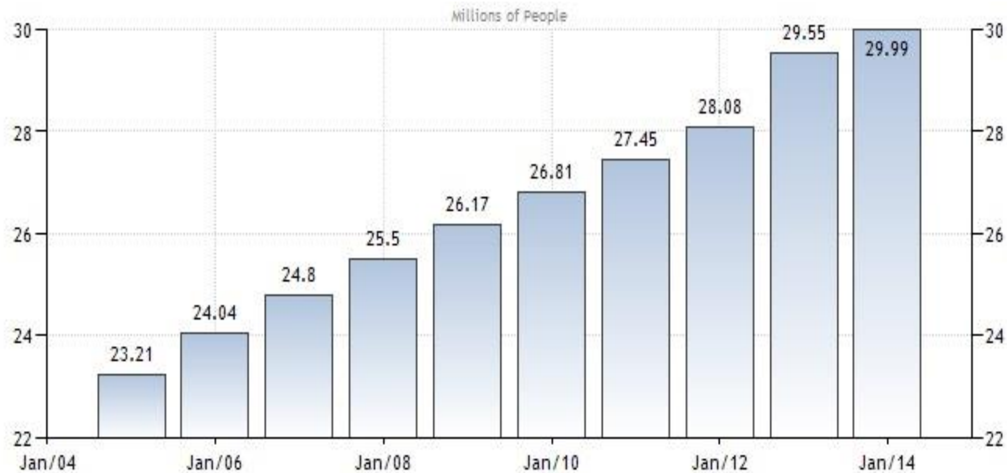
KSA is located in the Middle East, where it borders the Persian Gulf and the Red Sea. The country was founded by King Abdul AL Aziz Al Saud on 23 September 1932[12]. KSA is one of the largest countries in the Middle East; it occupies about 80% of the Arabian Peninsula between latitudes 16° and 33° N and longitudes 34° and 56° E. The size of the country is about 2,250,000 km2, which makes it the 13th largest state in the world and the fifth largest in Asia. Furthermore, the country has a very good position in the area because it has access to important seas in the Middle East: the Red Sea and the Persian Gulf (KSA, 2014). The population of KSA was 29.196 million in 2013; 90% of this is Arab.

Saudi Arabia map

The political system in KSA is a monarchy that is based on Islam. The king of the country receives assistance, support and advice from two main councils, the Council of Ministers and the Majlis Al-Shura[13]. The king has chosen the members of these councils. Each minister in the Council of Ministers is responsible for part of the government, for instance, the MOH, the Ministry of Higher Education (MOHE) or the Ministry of Commerce and Industry. When King Abdul Al Aziz passed away, the title passed to his sons Abdullah (1995-2015) and Salman (2015 to present). The king is seen as the final court for the country and has the power to issue pardons (Al-Rasheed, 2009). The monarchy has faced strong influence from both inside and outside the country; these forces have attempted to improve the legal system and reform the government to

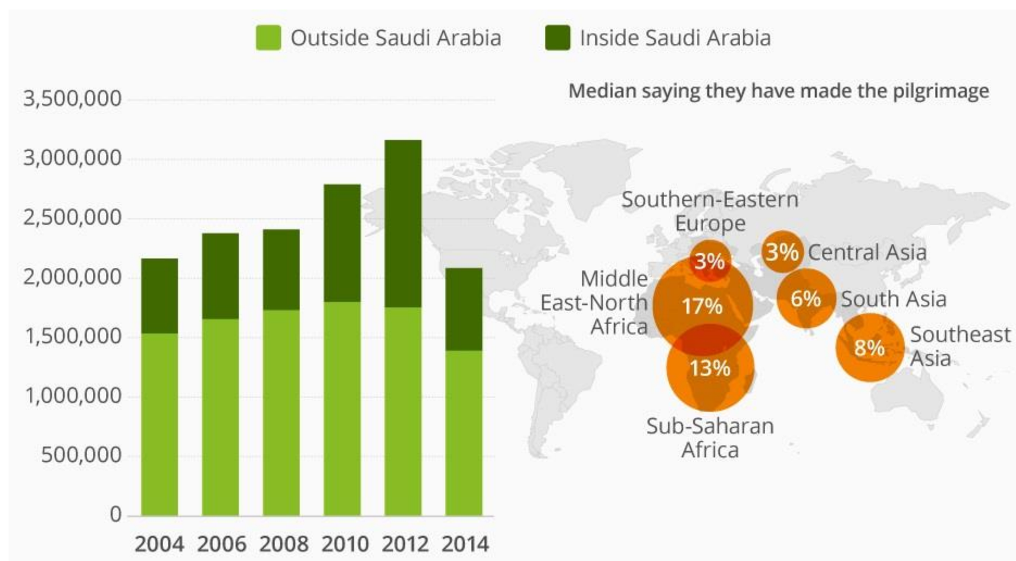
[12] For more information about KSA see the link : https://saudiembassy.net/about/country-information/history.aspx
13 A legislative body that advises the king on issues that is important to Saudi Arabia.

ensure the satisfaction and participation of KSA citizens (Al-Rasheed, 2009; Alrashid, 2007). The constitution of KSA is based on the Holy Quran and Islamic laws. Furthermore, the Sunnah[14] is also a way of life that affects the laws of the country, as well as the people within the country.



Population of KSA: Source: KSA, 2014

Finally, KSA is of great significance for all Muslims around the world because of the two holy cities (KSA, 2014), with millions of Muslims visiting these cities every year to perform their Islam obligations.



Muslims visiting Mecca: Source: KSA, 2014

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14 The way of life prescribed as normative for Muslims on the basis of the teachings and practices of Muhammad and interpretations of the Quran.

Culture

'Culture' as a concept is problematic, as seen by McSweeney's (2002) critique of Hofstede's assumptions on culture (1991, 1984, 1980), and not least given this thesis's literature review in chapter 2 and conceptual framework of NIS in chapter 3. However in order to give more of a 'cultural' context to KSA, there are regularities in ways of doing things within KSA which I here denote as 'culture'. One of these I would consider being the Islamic way of life and the Arabic language, as the Islamic system is not only a religious ideology but also a way of life. There is, at the same time, a broad socio-cultural diversity in this geographically large country which includes such groupings as urban and nomadic, tribal and non-tribal, city-dwellers and villagers, the literate and illiterate, and the open-minded and the conservative (Parssinen, 1980). However, Parssinen flags that there are still issues regarding women in KSA society, which are a principal concern for a number of scholars who study its culture. For example, Gazzaz (2009) studied the role of women in health care, and she found that women still face difficulties while working in KSA hospitals because such work is in conflict with the culture of the country. Long (2003) has argued that in the social context of KSA, men have more power than women, and this power imbalance has led women to be inactive in its society. However, in 2013, King Abdullah gave women the opportunity to participate in the Council of Majlis Al-Shura as full members.

The culture of KSA is based on the Islamic religion because it was its birthplace. All governments that have controlled the land, even before KSA was established in 1932, have been the principal political and financial supporters for Islamic institutions (Esposito, 2003). In modern KSA society, the religion council, which is responsible for controlling all the decisions of the government and ensuring that these decisions are constructed based on Islamic guidelines, holds considerable power. However, since 1979, Westernized consumer culture has increased in KSA despite not being accepted by the majority of people within the country, and therefore the country has been divided into liberals and traditionalists/conservatives (Fisher, 1990).

Social structure also plays an important role in the culture of KSA, especially within organisations. The reason for this is that the tribe is the focal point of social life, and most relationships are based on the tribe and family. For example, in business, managers prefer to work with people who they already know from their social lives because they award them greater trust (Fischer and Manstead, 2000). McLellan and Moustafa (2011) studied changes in the GCC, and noted the prevalence of a unique business culture in the region due to the significant

presence of family-owned businesses and joint ventures between local firms and multinational companies (MNEs).

Economic

The main focus of KSA's government is to improve and develop the economy so as to make it in line with those of developed countries, and therefore the KSA economy is one of the best economies in the Middle East. The oil industry has developed over the last few decades, which has led the country to become the world's largest oil producer, and oil revenue is now the main source of income (Exports of KSA, 2010). Oil prices have increased in recent years and this has led to a great increase in income. However, before 1938 KSA was one of the globe's poorer countries, with a national income of $500,000. During that time, agriculture was the main focus for both government and population.

The recent liberalisation of KSA's market and its aspiration to achieve global financial integration through economic reforms and membership in the WTO since 2005 has exposed domestic firms to foreign competition. This competition is a form of pressure that the government believes will develop the economic position of the country, making it in line with Western countries. Also, the government has the power to control and manage every sector of the economy, including agriculture, energy, transportation and communications to ensure that every sector is achieving the objectives of the country. On the other hand, the private sector has become increasingly important during the last few decades, as can be seen from its influence on GDP, of which it constitutes 48 percent (U.S. State Department, 2012).

Since 1970, KSA has created five-year plans in order to improve the economy by taking it from an oil-based economy to a modern industrial state. All of these plans have focused on achieving their objectives without changing the Islamic values and customs of the country, because these elements are important to people who live in KSA. The first and second KSA plans were created in 1970 and 1975 and focused on infrastructure and power generation. Following good results from these, the orientation shifted to consider education, health and social services because these were fundamental to the development of the country. During that time, the focus had also been on the oil industry because it was the main source of income for the country and the government built two major cities, Jubal and Yanbu, which were intended as sites for the oil industry (The World Factbook, 2013).

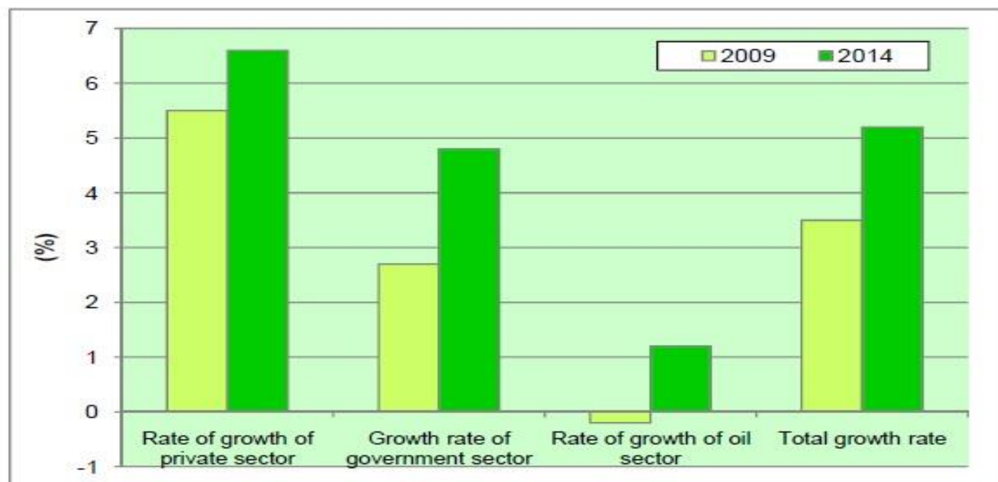
Saudi Arabia GDP: Source: World Bank, 2015

In the fourth plan, created in 1985, the focus continued to be on education and health, but the importance of the private sector also increased. International investment was encouraged within both the public and private sectors. The GDP increased in 1987 due to the improvement in the private sector, with 70% of it being non-oil-related. During that period, the government also supported all private-sector companies by giving them government financing and incentive programs. In 1990, the main focus was Saudi employees; during that time, the number of foreign workers in the country increased because of the development of the private sector, and job opportunities for Saudis became scarcer (MOF, 2013). In 1996, the issue of education rose again, especially with regards to the expansion of educational training programs and reduction of the cost of government services, but the main focus was on the shifting the economy from an oil-based one to a diversified economy. Therefore, the government provided a huge amount of support for other industries, especially agriculture (The World Factbook, 2013).

2005 saw a rise in women's issues and their participation in the economy through their roles in society and education (MOF, 2013). For example, in 2007, the government designed the 'King Abdullah Project' reform for the development of the education system with an investment of more than $3.1 billion (Smith and Abouammoh, 2013). Also, the number of universities increased to 25, and the KAFSP sends Saudis students to complete their studies in various countries around the world. Furthermore, the ideas of a knowledge-based economy and tourism received strong support during this period because they can help in achieving the main goal of the country, which is to change from an oil-based economy to a modern industrial state (The

World Factbook, 2013). During this period and during the ninth plan in 2010[15], the main focus of the government was social services, including medical services and residential housing for Saudis because they were becoming serious issues. Therefore, the government began emphasising the SAPHS in order to improve this sector and meet the requirements of the public (MOF, 2013). Reforms were applied to public sectors, such as the SAPHS, which implemented SEP to improve the HCQ in KSA hospitals. According to the report published by the ministry of economy and planning:

> The financial requirements for public health sector in the Ninth Development Plan are estimated to be about SR273.9 billion, i.e. 19% of the total amounts allotted for all development sectors; an increase over comparable expenditure under the Eighth Development Plan by 75.7%. This allocation is consistent with the increased demand for services due to population growth and the target improvement in the standards of living and quality of life of citizens.



Growth rate of GDP and its major components: Source: Ministry of Finance, 2015

Health care

The provision of health care services is largely handled by the KSA government due to the size of the public sector. The health care capital and operating expenditures are directly funded by the government based on its "Health for All (HFA)" orientation, and hospital policies are largely controlled by the government due to its role in the provision of health care services. All health care service delivered within the public domain of health care is free and citizens do not pay taxes or fees for services; in fact citizens do not pay any tax at all on their income, but all

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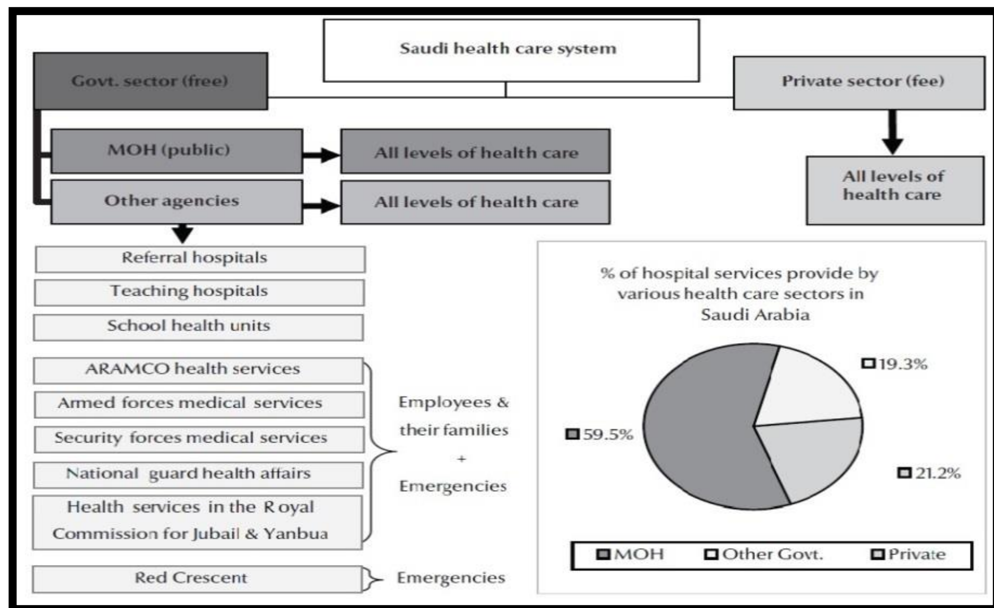
[15] For more information about the ninth plan see the link: http://www.mep.gov.sa/inetforms/themes/clasic/file/download.jsp;jsessionid=82F54B1915D71A4482B7C82AF3F6899A.alfa?FileAttribute=DownloadTranslation.Content&TableName=DownloadTranslation&DownloadTranslation.ObjectID=602.

governmental delivery of service to citizens is funded through the main source of national income, i.e. oil (please see section Economic above). The MOH deals with health care and is responsible for all matters within the SAPHS, as well the practices and activities of the private health sector. Sebai *et al.* (2001:3) stated that, "The MOH provides around 60% of the health services, free of charge, through 13 health directorates. Twenty percent of the health service is delivered free through other government agencies, and the remaining 20% is provided by the non-government sector, which is growing rapidly." However, the health sector in KSA includes other organisations that are related to the sector, such as teaching hospitals, school health units and Red Crescent .

Health care has been the main focus of the KSA government during the last decade, which has led to improvements in the sector. Gallagher pointed out that, "Although many nations have seen sizable growth in their health care systems, probably no other nation (other than KSA) of large geographic expanse and population has, in a comparable time, achieved so much on a broad national scale, with a relatively high level of care made available to virtually all segments of the population" (2002: 182). Furthermore, the WHO has ranked the health system of KSA as 26th out of 190 countries around the world. In other words, the KSA health system has become better than the health systems in developed countries such as Canada, Australia and New Zealand. However, despite this development, the health system still faces many challenges. For example, Almalki *et al*. (2011:785) have argued that, "The health sector faces many challenges which require new strategies and policies by the MOH as well as effective cooperation with other sectors."

Furthermore, the improvement of the education level in the country has led to improvements in the sector, such as increased health awareness. However, the main issue that has emerged over recent years is that there is no coordination or clear communication between the hospitals themselves, and between the hospitals and primary health care centres. This has led to a huge increase in wasted resources and duplicated efforts (Alhusaini, 2006), however the MOH has established a new "Council of Health Services" to address these coordination issues (Alkhazem, 2009). Almalki *et al*. (2011:786) have stated that the Council of Health Services will help in this regard but that it will take time to achieve the targets. The use of IT is another issue that the health sector has faced (Khudair, 2005; AlShaya, 2002; Al-Zahrani, 2002) researchers have argued that modern IT is still underutilised in KSA hospitals due to shortages of equipment and poor coordination between the units of the sector (Abu-Musa, 2006).



Structure of the health care sector: Source: Almalki et al., 2011

The health sector budget has increased during the last few years, to become the second highest government expenditure. In 2013, government spending in the health sector was nearly 16% of the total government budget, or nearly $26.7 billion, which shows that there is an increase in the demands on the health sector which should it continues, could present serious problems in the near future (MOF, 2013).

Almalki *et al*. (2011) have argued that the best thing the government can do is to improve management practices, which will guarantee decreased spending in the health sector. They suggested that using advanced IT will be the best way to help managers integrate their practices. Furthermore, Walker (2009) pointed out that the SAPHS has improved over the last few decades, but shortages remain. It has improved by offering specialist hospitals that contain specialised equipment, but the sector also has poor accountability and reporting. This had led to a lack of reliable information for decision makers. Furthermore, Almalki *et al*. (2011) have argued that the SAPHS now faces several issues that must be considered by experts and researchers to improve the health level of the country. For example, they mentioned that financing, provision, control, diversifying financial sources, implementing cooperative health insurance, the privatization of public hospitals, the establishment of an efficient national health information system, and the introduction of e-health are the most crucial issues.

Levels of health care services

The health services in KSA are divided into three levels. The first level of health services is primary health services, which are provided by health care centres around the country. The second level is the main focus of this study: the general hospitals that provide the second level of health care. The third level contains tertiary services.

The primary health services were begun in KSA after the implementation of the "Alma-Ata Declaration" in 1987, which aimed to achieve health care for all citizens (Al-Ahmadi and Roland, 2005). Since then, the numbers of primary health care centres has increased, reaching 2,259 in 2012 (MOH, 2013). These centres provide quality care, especially their prenatal care and vaccination programmes (El-Gilany and Aref, 2000 cited in Al-Ahmadi and Roland, 2005). However, in recent years, the prevalence of many diseases has been increasing in KSA, such as cardiovascular diseases, obesity, diabetes and high blood pressure. These diseases require special care that cannot be provided by primary health services. Therefore, the second level has faced all of these problems, which has placed hospitals under the pressure of providing all the care for many people.

In 2012, the number of hospitals in the country was 408. These hospitals are divided into three main groups. The first is the hospitals of the MOH, which provide 60% of the health care via 259 hospitals (Health Statistical Yearbook, 2013). The second is private-sector hospitals, which account for 125 hospitals and which run on a fee basis. The third group is non-governmental hospitals, such as those of the Ministry of the Interior (MOI) which account for 38 hospitals; these hospitals provide services to the people who work for these ministries.

The tertiary service hospitals are more developed and better equipped than those of the second level. However, all the patients in this level of health care are referred from general hospitals. Jannadi *et al*. (2008:46) mentioned that, “There are 56 specialist hospitals in the KSA. These include 20 obstetrics and paediatric hospitals; four eye and ear, nose and throat (ENT) hospitals; four chest and fever hospitals; 17 psychiatric hospitals; nine convalescence, leprosy and rehabilitation hospitals; and two cardiac and renal hospitals.”

Issues in health care

However, SAPHS has faced a backlog due to the relatively limited resources and scarce IT expertise available to local hospitals. Barrage *et al.* (2007) have indicated that KSA’s health care

system requires substantial improvement and is rated as a 'C Grade' system in terms of international standards. The research also reveals that KSA's citizens and inhabitants are underserved in the health care market, and the need to introduce comprehensive MA frameworks to improve the functioning and decision-making in KSA hospitals remains. The MOH is working towards developing an electronic health system to enable health care providers to review the past histories of their patients, and this requires a significant investment in implementing and developing MA frameworks in the country (Al-Mashari *et al.,* 2003). Moreover, Barrage *et al.* (2007) cite the increasing health care needs of the KSA market and the expected growth of the health sector in the future. However, the growing needs of the health care sector necessitate the development of private partnerships for the provision of world-class health care.

In KSA the major illnesses[16] are cancer, diabetes, cardiovascular illness and obesity problems (WHO 2014). The increase in these diseases has strongly influenced the government to raise the issue of HCQ. The MOH and the General Investment Authority are therefore actively developing plans to encourage private investment in the health care sector in an attempt to add to the medical knowledge, management skills and capital investment needed for the provision of improved health care services.

Total no of Cancer reported

Year	Total	Males	Females
94-96	16294	8791	7503
97-98	11000	5769	5231
99-2000	10152	5086	5066
2001	5100	2579	2521
2002	5876	2961	2915
2003	6516	3263	3253
2004	6969	3478	3491
2005	7563	3729	3834
2006	8054	3898	4156
2007	9124	4351	4773
2008	8848	4231	4617
2009	9823	4618	5205
2010	9572	4327	5245
Total 17y	114891	57081	57810

Source: Ministry of Health, 2014

[16] For more information about the health care in KSA see the link:
http://www.moh.gov.sa/en/Ministry/Statistics/book/Documents/Statistics-Book-1434.pdf

The use of MA at KSA hospitals is relatively recent, and most hospitals are using the basic practices while a complete integration of the IT using ERP implementation is still far from a reality. The use of computers by hospital staff is also indicative of a lack of MA integration with the hospital systems because only 29% of management and 25% of doctors have access to computers (CITC, 2008). The SAPHS before the implementation of SEP was centralising the decisions of the human and financial resource management, which has led to the sector becoming inflexible and ineffective. In this scenario, the role of hospital management teams is to lead or direct hospital activities without any ability to plan, organise, or monitor or recruit staff. One of the reasons for this shift is that some public hospitals are managed by branches of the MOH. In every Saudi region, there exists a branch of the MOH that is responsible for managing the hospitals within that region, based on government regulations and accounting practices (Al-Rasheed, 2009). Moreover, the contracting programmes that were implemented in various hospitals in 1984 failed to achieve public satisfaction as these hospitals used private sector ideology (Al-falih, 2008). However, under the SEP reform MA has changed in the SAPHS, to reflect a different management philosophy that can be successfully implemented within the health care sector and which has become known as NPM.

Self- operating programme (SEP)

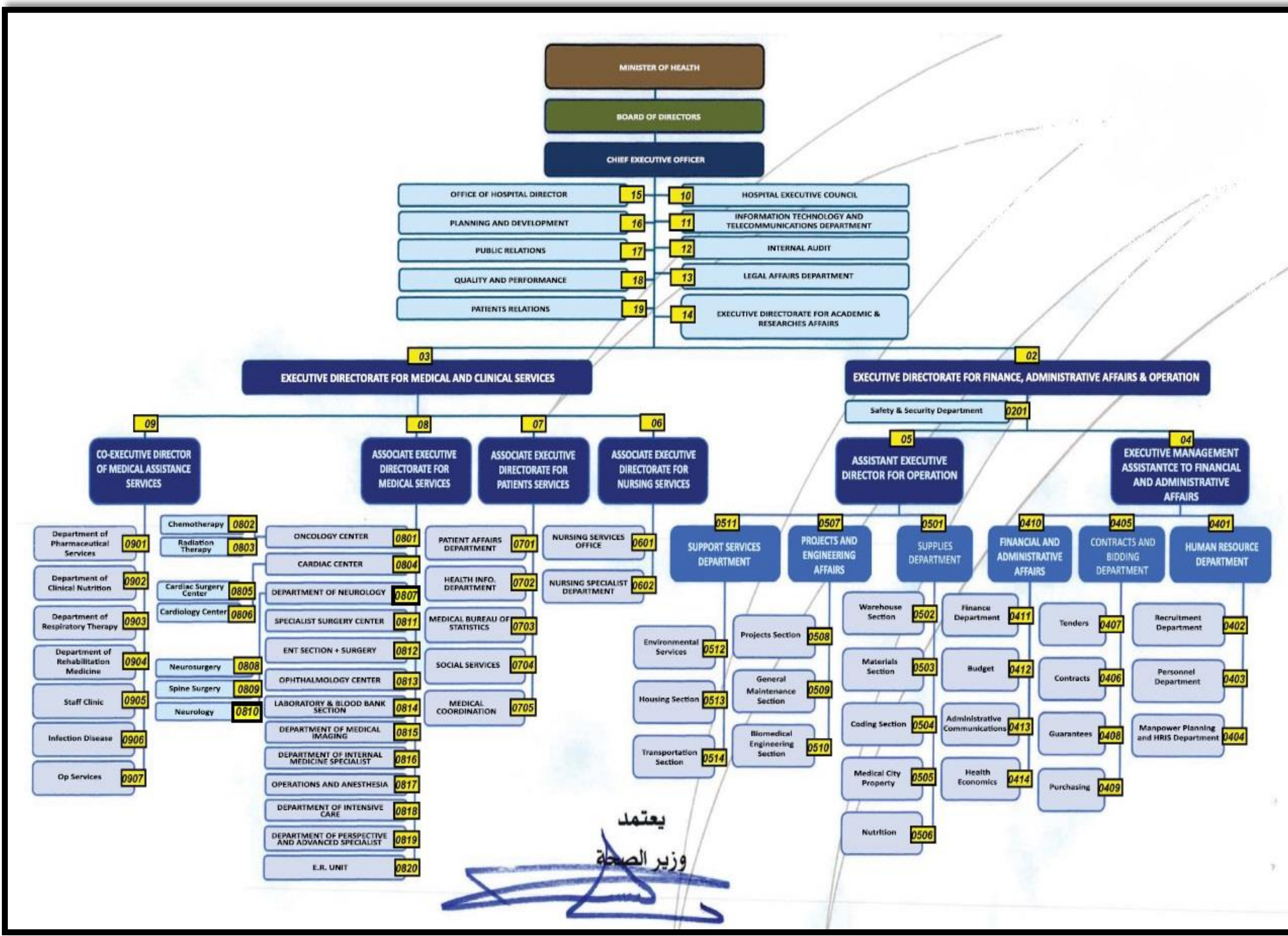
In 2007 the SEP was set up not least because of the SAPHS critique of the way of managing the public health sector, which put them under pressure to introduce new reforms. A central point was how the sector was inflexible in responding to citizens' health care needs, especially HCQ. A key cause of this was said to be the centralised structure of decision-making regarding human and financial resources, and the administrative bureaucratic way of carrying out government policies and guidelines. Human and financial resources were a matter of a formal hierarchical 'transmission' of decision and regulation from the centre (government) to and over the hospitals via 13 regions. At the end of this hospitals were merely asked to carry out the health care service, and as such were separated from the responsibility and decision-making on such issues, much like the management of public schools (Al-Rasheed, 2009).

This caused a lack of financial incentive for the clinicians and management staff, which led to a preference to work in private hospitals which offer better compensation. This in turn has led to a dire shortage of qualified experts in health management in the branches of the MOH that manage and control large hospitals with thousands of staff members or more. In most cases, these managers' decisions are delayed because of issues of distance and time (Al-falih, 2008).

Also, strong criticism has arisen in the media and social media following the government's decision to increase the budget of the public health sector without any improvement in HCQ (Alhejely, 2012). Alhejely argues that despite the great increase in the MOH budget, the country still faces problems related to public hospitals; for example, waiting times are excessive, and certain medications can only be found at private pharmacies. Alhejely supports his argument by citing the success of Western countries in decreasing expenses within the public health sector whilst improving the HCQ.

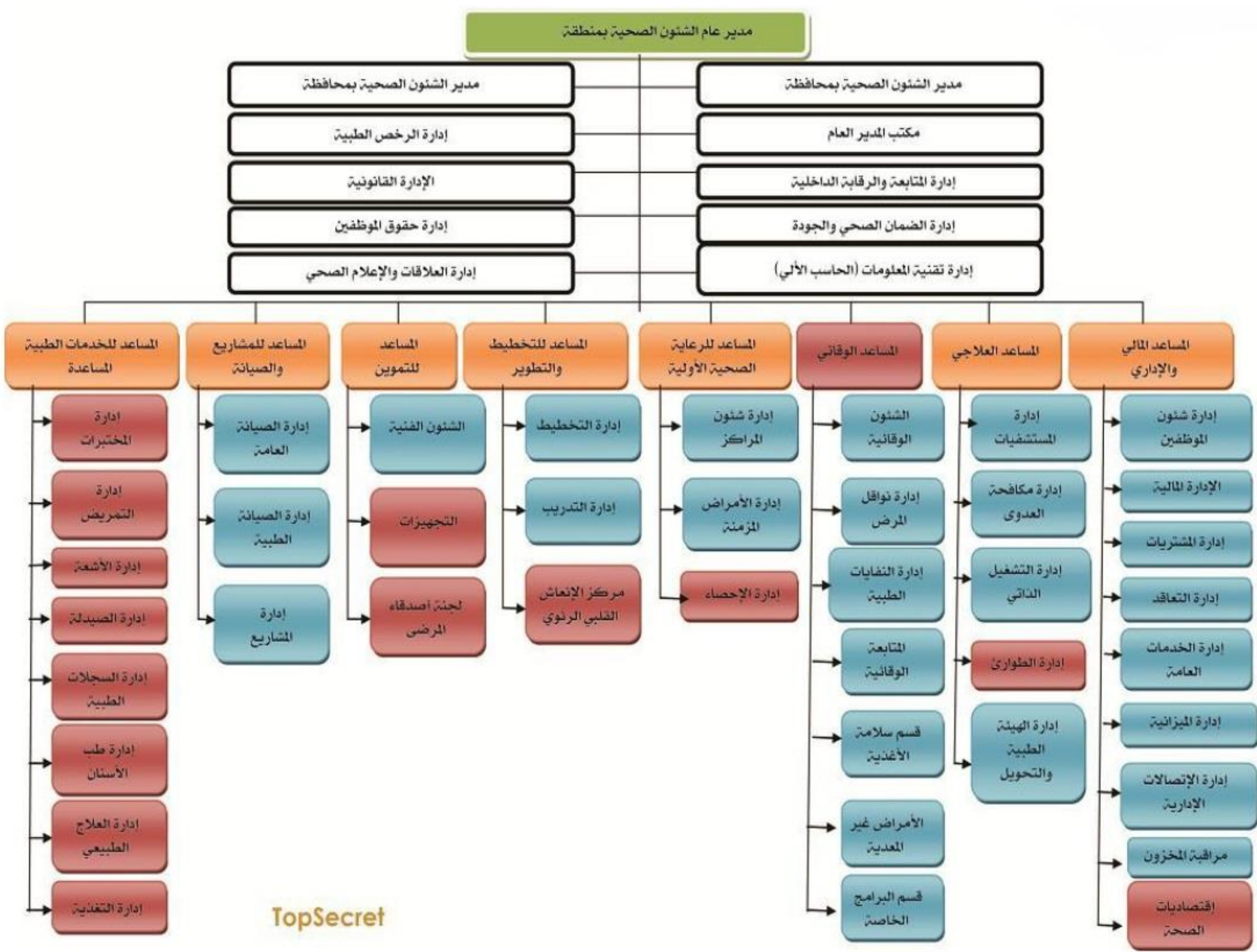
The intention of SEP was to change all of this. A key part of this solution was to set up a 'frame' for hospitals to act within where they could be both incentivised in terms of decentralised decision-making but guided by overall objectives set by the government as SEP HCQ. The frame included two simultaneous changes of decision-making. One was to decentralise to each hospital so that they could set their own budgets and organise financial and human resources. The other way was actually to centralise more, by setting government-led national objectives for reforms which must be reflected in hospital budgets; budgets would be approved and financed by MOH as long as the budget contributed to national objectives. This also required a constant reporting back to SEP so that issues could be raised and handled. It was within that frame they could 'self-operate'.

The new SEP management structure is split between two executive directors under a chief executive officer. The first executive director is in charge of finance, operations and administrative affairs. Under this director, two assistant directors have separate responsibilities. The first director oversees operations responsible for three departments: supplies, support services and project and engineering affairs. The second is the assistant director for financial and administrative affairs, who is also responsible for three departments: contracts and bidding, human resources and financial and administrative affairs. The second executive director manages all medical and clinical services. This director works with four assistant directors, each one with separate responsibilities. These are the executive directors for patient, nursing, medical and medical assistance services. In addition, some departments are linked directly to the chief executive officer. These departments are public relations, patient relations, internal auditing, planning and development, QPD and IT.



Management structure SEP hospitals: Source: Ministry of Health, 2014

Appendix E: Management structures



مدير عام الشئون الصحية بمنطقة
مدير الشئون الصحية بمحافظة
مدير الشئون الصحية بمحافظة
مكتب المدير العام
إدارة الرخص الطبية
إدارة المتابعة والرقابة الداخلية
الإدارة القانونية
إدارة الضمان الصحي والجودة
إدارة حقوق الموظفين
إدارة تقنية المعلومات (الحاسب الألي)
إدارة العلاقات والإعلام الصحي
المساعد المالي والإداري
إدارة شئون الموظفين
الإدارة المالية
إدارة المشتريات
إدارة التعاقد
إدارة الخدمات العامة
إدارة الميزانية
إدارة الإتصالات الإدارية
مراقبة المخزون
اقتصاديات الصحة
المساعد العلاجي
إدارة المستشفيات
إدارة مكافحة العدوى
إدارة التشغيل الذاتي
إدارة الطوارئ
إدارة الهيئة الطبية والتحويل
المساعد الوقائي
الشئون الوقائية
إدارة نواقل المرض
إدارة النفايات الطبية
المتابعة الوقائية
قسم سلامة الأغذية
الأمراض غير المعدية
قسم البرامج الخاصة
المساعد للرعاية الصحية الأولية
إدارة شئون المراكز
إدارة الأمراض المزمنة
إدارة الإحصاء
المساعد للتخطيط والتطوير
إدارة التخطيط
إدارة التدريب
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إدارة المشاريع
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إدارة المختبرات
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TopSecret