Health System Reform and Organisational Culture: An Exploratory Study in Abu Dhabi Public Healthcare Sector

A thesis submitted to the University of Manchester for the degree of Doctor of Business Administration in the Faculty of Humanities

2015

Nada Jammoul

Alliance Manchester Business School
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<td>Abu Dhabi Accountability Authority</td>
</tr>
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<td>ADGRC</td>
<td>Abu Dhabi Government Restructuring Committee</td>
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<td>ADIA</td>
<td>Abu Dhabi Investment Authority</td>
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<td>ADIC</td>
<td>Abu Dhabi Investment Council</td>
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<tr>
<td>AED</td>
<td>Arab Emirates Dirham</td>
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<td>AHS</td>
<td>Ambulatory Health Services</td>
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<td>BCG</td>
<td>Boston Consulting Group</td>
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<td>CPE</td>
<td>Continuing Professional Education</td>
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<td>Competing Values Framework</td>
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<td>DHA</td>
<td>Dubai Health Authority</td>
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<td>DOF</td>
<td>Department of Finance</td>
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<tr>
<td>EC</td>
<td>Executive Council</td>
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<td>EIA</td>
<td>Energy Information Administration</td>
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<td>ESCWA</td>
<td>Economic and Social Commission for Western Asia</td>
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<td>FNC</td>
<td>Federal National Council</td>
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<td>GAHS</td>
<td>General Authority for Health Services</td>
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<td>GCC</td>
<td>Gulf Cooperation Council</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GLM</td>
<td>General Linear Model</td>
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<td>GSEC</td>
<td>General Secretariat of the Executive Council</td>
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<td>HAAD</td>
<td>Health Authority Abu Dhabi</td>
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<td>Human Development Index</td>
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<td>International Monetary Fund</td>
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<td>International Patient Care</td>
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<td>KPI</td>
<td>Key Performance Indicator</td>
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<td>KSA</td>
<td>Kingdom Of Saudi Arabia</td>
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<td>MENA</td>
<td>Middle East and North Africa</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>National Consultative Council</td>
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<td>National Health Service</td>
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<td>OCAI</td>
<td>Organisational Culture Assessment Instrument</td>
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<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<td>PMS</td>
<td>Performance Management System</td>
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<td>PPP</td>
<td>Private Public Partnership</td>
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<td>SCAD</td>
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<td>Service Level Agreement</td>
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<td>United Nations Development Program</td>
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ABSTRACT

The University of Manchester

Nada Jammoul

Doctor of Business Administration in the Faculty of Humanities

Health System Reform and Organisational Culture: An Exploratory Study in Abu Dhabi Public Healthcare Sector

2015

The Health system in Abu Dhabi has undergone a series of far reaching reforms during the past six years, yet in spite of the structural transformations, public confidence in the performance of this vital sector is still skeptical at best and employee engagement is still low. The thesis was underpinned by the aim to reveal the challenges in public health system reform outside the context of western administration. This thesis is an attempt to analyse the intricate, multidimensional concept of organisational culture within the complex structure of public healthcare sector in a fast growing economy like Abu Dhabi.

Managing organisational culture is increasingly viewed as an essential part of health system reform. Organisational culture in health care organisations has gained increased consideration as an important factor that affects health systems reform and influences the quality of health care. The research project aims to explore the context of health system reform in Abu Dhabi and to understand the organisational culture of the different constituents of its public healthcare sector. Using a multi-method investigation combining both qualitative and quantitative approaches using the Competing Values Framework as conceptual framework, this research aims to provide a critical assessment of organisational culture in healthcare sector in Abu Dhabi. Semi-structured interviews were conducted in the regulator, operator, and three public hospitals prior to the use of a survey instrument based on the Organisational Culture Assessment Instrument (OCAI). The data analysis revealed that the prevailing cultural model of the Abu Dhabi public sector organisations was concurrently governed by hierarchy and market cultures while the presence of clan and adhocracy models was relatively limited. Interesting variations in assessment of clan culture were found between UAE nationals and other nationality clusters. The findings also revealed a desired cultural shift manifested by a higher emphasis on clan and adhocracy cultures and a lower emphasis on hierarchy and market culture. Those results confirm the presence of two opposing or competing cultural dimensions clan/adhocracy vs. hierarchy/market.

This research makes a considerable contribution to the sparse empirical studies in health system reforms and organisational culture in the Arab Gulf states, and proposes important explanations and possible solutions to the salient challenges facing the health system in Abu Dhabi.
DECLARATION

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DEDICATION

To my greatest supporter and mentor, my husband Azzam,

To my parents Youssef and Samira, and

To my three lovely daughters Yasmine, Sirine, and Judy
ACKNOWLEDGMENTS

Completing my DBA has been such an inspiring journey for me. I could not have completed this journey without the infinite support and encouragement I received from people around me. I feel blessed and privileged to have such support, and I would like to thank God for giving me the strength and faith to complete this journey.

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THE AUTHOR

Education Background

2009-To date  Doctorate in Business Administration, *Manchester Business School, University of Manchester*. Supervisors: Prof. Colin Talbot, and Prof. Richard Common

1996  Certified Public Accountant, Illinois, USA


Work Experience

2012-To date  Associate Vice Provost for Administration, *New York University Abu Dhabi*

2010-2012  Finance and Administration Director, *Paris Sorbonne University Abu Dhabi*

2007-2010  Finance Director, *Abu Dhabi Education Council*

2003-2005  Finance and Administration Director, *Bank Audi Saradar, Beirut*

1993-2003  Audit Manager, *Ernst & Young, Beirut*

Conference Papers

June 2013  “Cultures for performance in healthcare, myth or reality: an exploratory study in the public healthcare sector in Abu Dhabi”. MBS DBA conference. Won honorable mention for best paper at the conference.


As an auditor and finance professional, I wonder how I ended up writing a dissertation on public healthcare reform and organisational culture. The idea of researching the public sector as part of my DBA started when I was working at the Education Council in Abu Dhabi. There, I witnessed the sweeping and pioneering reforms that were taking place in every sector. Yet I realised that there was almost no academic literature or any form of published research discussing the public sector reforms in the UAE. I felt the need to build a body of knowledge that would inform policy decisions and support future generations of public servants, students, and scholars.
I knew back then that I was choosing a rocky road; the issue of access was and still is one of the biggest challenges in conducting academic research in the public sector in the Arab world. In addition, the lack of published government reports and white papers on reform initiatives compounded such challenges. After two years of trying to gain access with different public sector organisations I was fortunate enough to be granted access to the public healthcare sector in Abu Dhabi.

My dream is to break the stigma of scarcity and sensitivity of conducting academic research in the public sector in the Arab world. Hopefully my modest contribution will open doors for future academic research in this area.

Nada Messaikeh
Chapter 1 - Introduction

1.1 Background

Since the discovery of its oil reserves some 50 years back, the United Arab Emirates (UAE) has transformed itself from a region with very limited economic activity to a major economic force and a key player in the regional and international economic landscape (Nyarko, 2010). Its Capital Abu Dhabi is one of the world’s major oil producers. Over the past ten years, the Emirate has embarked into a major reform initiative to diversify its economy and support the development of its economic and social sectors. Developing the education and healthcare sectors were the pillars of Abu Dhabi vision 2030. The UAE’s health sector has evolved rapidly during the past decade. Healthcare demand has grown significantly along with the population growth and substantial public and private funding were invested to improve healthcare delivery across the emirates (UAE Yearbook, 2013).

The Public Health Care sector in the Emirate of Abu Dhabi has gone through a series of major structural reforms over the past eight years. The sector went from being highly centralized, largely managed and funded by the Federal Government, to a more decentralized structure with private-sector-style entities managing and operating public hospitals. In 2006, the Emirate of Abu Dhabi pioneered the passing of the insurance law mandating and regulating compulsory health insurance for all expatriate residents and working in the Emirate. Furthermore, in 2007, the government of Abu Dhabi introduced ‘Thiqa’ which means ‘trust’ in Arabic as the first comprehensive medical insurance coverage for UAE Nationals. Considered as cornerstones for health system reform, those pioneering developments were closely followed by other Emirates in the UAE including Dubai, and other countries within the GCC such as Saudi Arabia and Qatar. Significant improvements were realized in healthcare regulation, provision, and financing during that period evidenced by the sharp increase in hospital beds and medical facilities, increase in private investments in the healthcare sector, and public private partnerships with world renowned medical providers such as Cleveland Clinic and John Hopkins.

Despite such improvements, a number of factors present a huge burden on government resources including (1) a population growing at a compounded rate of close to 5% per annum-one of the highest in the region, (2) increasingly aging citizens with very high risk of non-communicable diseases, (3) a huge influx of migrant workers to keep up with the country’s economic development plans, and (4) a unique, eclectic mix of population
distribution where nationals representing less than 20% of the total population are considered minority in the own country. As such the Abu Dhabi healthcare sector faces a number of challenges including raising costs, inconsistent quality of care, recruiting and retaining qualified medical professionals, and capacity to meet the ever growing demand for health services.

The presence of an engaged, motivated, and satisfied workforce appears to be one of the key factors to realize the ambitious and sweeping reforms in the healthcare sector. That is probably true for any sector, but the particular emphasis on the human capital in healthcare was due to the fact that over the past 20 years, policymakers simplistically - or rather naively- thought that investing in buildings and equipment, introducing tougher healthcare regulations, and implementing a performance driven regime would lead to better health services. It took years, many mistakes, and thousands of lives to come to the realization that in a complex, multidisciplinary, human-capital intensive environment such as healthcare, people are and will always be the heart of any successful health system reform and performance improvement. There has been growing emphasis from the policymakers, practitioners, and the academic community to understand human, behavioral, cultural, and organisational issues and how they can impact performance in healthcare contexts. As suggested by Ferlie and Shortell (2001:287), “developing a culture that emphasizes learning, teamwork, and customer focus may be a ‘core property’ that health care organisations…will need to adopt if significant progress in quality improvement is to be made”.

The aim of this thesis is to make a contribution to the analysis of public healthcare organisation and management in the Emirate of Abu Dhabi. The study of organisational culture has been chosen because it is both of current interest and of enduring importance as a lever for health care improvement (Mannion et al., 2005). Building on theoretical and empirical literature in this area, this research aims to make a contribution in the highly scrutinized and controversial topic of health systems reform and the role that organisational culture can play in improving healthcare outcomes, in a context such as Abu Dhabi where academic research is rare if not inexistent. It answers the scholarly call for more empirical work within the distinctive cultures of the healthcare industry to particularize the findings to local circumstances (Davies et al., 2000).

1.2 Statement of the Problem

*The 800 pound gorilla that impairs performance and stifles change is culture (Pascale et al. 1997).*
The past two decades have seen unprecedented levels of structural healthcare reforms in pursuit of efficiency, effectiveness and wider access, in most developed nations. It is increasingly recognised, however, that structural change alone will not secure sufficient gains in health care performance (Institute of Medicine, 2000). Policies over the past years have also begun to emphasize the importance of developing cultural changes alongside structural reform (Scott et al., 2003c). The recognition of the relevance and importance of organisational culture for supporting quality care by governments and healthcare regulators became apparent in the early 2000s. Two landmark reports from the Institute of Medicine, ‘‘To Err is Human’’ (Kohn et al., 1999) and ‘‘Crossing the Quality Chasm,’’ (Institute of Medicine, 2000) have stressed the cultural transformation in Healthcare. This call for cultural transformation has been also a central component of National Health Service (NHS) reform in the UK (Department of Health 2000, 2002).

In Abu Dhabi, despite the radical transformations that took place in the public healthcare sector in Abu Dhabi, and New Public Management (NPM) (Hood, 1991) reforms, the sector is still suffering from a number of challenges including most notably those related to human capital and organisational culture. The public health system in Abu Dhabi is unique in that the workforce consists of less than 20% UAE Nationals, and 80% are expats from 94 different nationalities (SEHA, 2012). UAE Nationals predominately hold administrative or managerial positions. Less than 18% of SEHA physicians and 3% of nursing and clinical staff are Nationals. UAE tops the chart among GCC countries with 82% reliance on expat physicians, and 96% reliance on expatriate nurses (Mourshed et al., 2008). What is also unique about this context is that not only those medical professionals come from different medical training systems with differing medical practices and approaches to medical care (Moursheed et al., 2008, Hamidi et al., 2014), but they also come from very different cultures, and in some cases do not even speak the same language. Those groups still have to work together in complete harmony in order to ensure that best quality of care is delivered to patients.

A combination of many factors including dissatisfaction with working conditions, lack of opportunities for medical research and professional development, restricted professional freedom, limited opportunities for advancement, and job insecurity led to serious issues relating physicians and staff retention. This is coupled with a working environment perceived by many as highly bureaucratic and over-regulated; where policies, procedures and KPIs are thought steer the health care organisations. According to a recent report by the Health Authority in Abu Dhabi, about 15% of physicians and 13% of nurses quit their
jobs annually (Deloitte, 2011). Moreover, the public healthcare sector has consistently scored very low on employee engagement surveys. The results of employee engagement surveys conducted in 2012 and 2013 by a third party consulting firm seem discouraging. Public hospitals achieved a 48% engagement score in 2012, and 52% in 2013 which compares unfavorably with 59% average score for GCC norms in 2012 and 59% for Global Health Care Providers average score in 2012 (source: SEHA employee engagement study reports, May 2012 and May 2013). The healthcare regulator (HAAD) achieved an overall 66% score in employee engagement survey in 2012, placing HAAD in the second quartile among Abu Dhabi entities benchmarks. Performance management and employee recognition were cited as the major areas for improvement (source: GSEC/HAAD employee opinion survey, 2012).

Combined, the factors indicated above, motivated the researcher to perform this study to seek explanations and possibly some answers to those salient problems in the Abu Dhabi healthcare system in Abu Dhabi. This inquiry could be addressed from many angles including studying networks and formal and informal structures (Ferlie et al., 2013), human resource policies, culture, leadership, and policy implementation. The choice of organisational culture as a line of inquiry was thought to be appropriate for this study as it allows a deeper investigation of what values the different constituents and professional groups share - or do not share - in common and how those values impact the organisational performance. Furthermore, the Competing Values Framework (Cameron and Quinn, 1999), used as a conceptual framework for this study was justified on the basis that it combines both organisational and individual factors, and allows the investigation of the organisational culture from different angles including dominant characteristic, leadership style, management of employees, organisational cohesion, strategic emphasis, and Criteria for success.

1.3 Objectives of the study

This thesis aims to make a contribution at theoretical, methodological and practical levels. To do so, both applied and theoretical approaches have been studied, as well as the ontological and epistemological bases of organisational culture and performance management in the public Healthcare sector. Using the Competing Values Framework (Quinn and Rohrbaugh, 1981) as a conceptual framework for the study, the thesis consists of three staged multi-method investigation. Stage one starts with an exploratory phase, the aim of this phase is to have a deeper understanding about the environmental factors affecting the public healthcare sector in Abu Dhabi, including the health system reform
trajectory. This part provided an important analysis that helped the researcher in contextualising the informants’ understanding of organisational culture in their organisations and the different factors that impact their cultural assessment. The second stage comprises a qualitative analysis of current and preferred organisational culture prevailing within public healthcare organisations. Using in-depth, semi-structured interviews, the aim of this second phase is to provide a qualitative analysis of organisational culture to identify how participants assess the current and preferred cultures of their organisation. Stage three consists of quantitative analysis, the objective of which is to complement and triangulate the study results obtained during the qualitative phase. Using an OCAI based survey instrument based on the competing values framework (Cameron and Quinn, 2011), the quantitative phase complements the in-depth interviews used in stage two by providing a wider representation, and allowing a more detailed level of analysis across a range of demographic and organisational factors.

The thesis was motivated by the aims to explore and analyze the organisational culture in the public healthcare sector in Abu Dhabi, analyze differences/complementarities in cultural assessment across its different constituents and nationality clusters, and explore how organisational culture can be used as a lever for performance improvement. The main objectives of the research are:

1. To critically examine the strategic environment of public healthcare regulation, financing, and provision in the Emirate of Abu Dhabi.
2. To determine the current dominant types of organisational culture across the three constituents of public Healthcare sector in Abu Dhabi (Regulator, Operator, and public hospitals), and analyze the alignment, complementarities and/or tensions in cultural assessment between those different constituents.
3. To identify the preferred type of culture that would best support efforts to improve public healthcare services in Abu Dhabi.
4. To identify whether demographic factors, particularly nationality impact the current and preferred cultural assessment of the public health sector organisations.
5. To recommend ways to improve public healthcare regulation and delivery in Abu Dhabi.

1.4 Research Questions

In order to achieve the above objectives, the empirical study was carried out with the objective of answering the five core, and two secondary research questions stated below. The primary research questions address the contextual factors affecting healthcare
financing, provision and regulation in Abu Dhabi, the cultural assessment of the different constituents its public healthcare sector, and more generally the challenges facing this sector in Abu Dhabi.

**Core Questions**

1. What are the environmental and contextual factors impacting the public healthcare reform in Abu Dhabi?
2. What are the current dominant types of organisational culture across the three constituents of public Healthcare sector in Abu Dhabi (Regulator, Operator, and public hospitals)?
3. What are the preferred types of organisational culture that would best support efforts to improve healthcare performance in Abu Dhabi?
4. What are the challenges facing the public healthcare sector in Abu Dhabi?
5. What are the implications for Abu Dhabi policy makers, and what are the recommendations that would support improvement in public healthcare services?

The secondary questions seek to explore in more details how contextual, institutional and demographic factors influence the cultural assessment of public healthcare organisations in Abu Dhabi.

**Secondary Questions**

6. How do healthcare personnel’s perceptions of current and preferred organisational cultures vary in the different organisations studied?
7. How do healthcare personnel’s perceptions of current and preferred organisational cultures vary according to their demographic characteristics especially nationality?

In an inherently complex environment such as healthcare, the answers to the first core question aim at understanding the specific environmental factors affecting healthcare regulation in Abu Dhabi. The external environment is made of many factors including socio-economic, political, demographic, and regulatory aspects. Collectively those factors have a deep impact on the assumptions regarding organisational culture (Scott et al., 2003c). Since little is known about the UAE and Abu Dhabi healthcare context, it is important for this study to start by ‘contextualization’ (Rousseau and Fried, 2001, Mark, 2006) to ensure that those unique environmental, societal, and organisational features are
captured in the research constructs. The answers to the second and third core research questions were firstly aimed at extending knowledge in the domain of organisational studies, specifically regarding understanding the role of organisational culture in public healthcare where there is a scarcity of research that examines the cultural characteristics of public healthcare sector in an Arab context. Second, by using the Competing Values Framework (CVF) (Cameron and Quinn, 1999) as a conceptual framework for data collection and data analysis, those questions also aim to fill knowledge gap regarding the applicability of CVF in non-western context and allow comparability of results across different contexts. The fourth and fifth questions are expected to address existing gaps in academic literature regarding health system reforms in the Arab World. They also aim to identify challenges and provide practical recommendations to policy makers and practitioners in this sector.

The secondary questions are included firstly in order to identify the manner in which contextual, demographic, and institutional factors could exert potential influence on organisational culture. They have the purpose of revealing potential divergences in cultural assessment that may exist between the different constituents of the public healthcare sector in Abu Dhabi and across different nationality clusters.

### 1.5 Importance of the Study

The aim of this research is to contribute to the debate in healthcare reform and public healthcare performance by providing an assessment of organisational culture, a concept that scholars agree could exert a powerful effect on individual and organisational performance (Kotter and Heskett, 1992), in a unique context such as Abu Dhabi that, to the best of the researcher’s knowledge, has not been researched before. Public management in healthcare sector in the UAE and the Arab world generally has not been the topic of much literature. The main reason for this is that research in this area is hindered by the lack of official documentation concerning reform efforts, and what there is may not be available to the public (Al-Otaibi, 2010).

The originality in this research relates also to the context of the study, Abu Dhabi Healthcare sector, where there is scarcity of academic research in this area. Although in recent years, the profound changes in the healthcare system in Abu Dhabi have attracted some scholarly interest (Koornneef et al., 2012, Podolak et al., 2012, Vetter and Boecker, 2012, Mosaad and Younis, 2014, Hamidi et al., 2014), those studies remain largely descriptive, normative in nature. Empirical studies assessing the impact of those structural changes on organisations and quality of care in the Emirate are almost non-existent.
This study aims to make a contribution both at methodological and practical levels. In terms of methodological contribution, the study combines qualitative and quantitative approaches in order to reach a deeper understanding of organisational culture in Abu Dhabi healthcare sector. In addition, to the best of the researcher’s knowledge it is the first attempted replication of the CVF framework developed by Cameron and Quinn (1999) in the assessment of organisational culture in public healthcare sector in the UAE. Although the CVF has been extensively used in western contexts, both in healthcare and non-healthcare organisations, its application in the Arab world has been very limited. It is only during the past few years that some empirical studies in Arab countries such as Qatar, Libya and Saudi Arabia, using CVF as conceptual framework to study various aspects of organisational culture began to emerge (Al-Khalifa and Aspinwall, 2001, Twati and Gammack, 2006, Al-Otaibi, 2010, Jaeger and Adair, 2013).

The second contribution relates to the fact that this research is attempting to capture the different constituents of the public healthcare sector including regulator, operator, and public hospitals, and analyse the differences and complementarities in their cultural profiles and the potential impact on health care performance. Previous empirical studies in that area largely focused on healthcare provision i.e. hospitals and did not cover their relationships with the regulator and the operator agencies.

From a practical perspective, the thesis seeks to address many questions raised by policymakers and practitioners regarding the impact of healthcare reform in Abu Dhabi, and the salient challenges of human capital in this sector particularly the high turnover in some professional groups and the difficulty in attracting UAE nationals to the healthcare sector. It is hoped that this study will create heightened awareness of the organisational culture that exists within the different organisations and hospitals constituting the public healthcare system in Abu Dhabi, and how the prevailing cultural characteristics support or hinder organisational performance. Finally, the study aims to provide practical recommendations regarding the many challenges facing the public healthcare sector in Abu Dhabi.

1.6 Conclusion

The public healthcare system in Abu Dhabi has undergone impressive reforms over the past eight years. Yet despite the massive structural, regulatory, and healthcare delivery transformations, the sector still faces a number of systemic, operational, and human capital challenges. Those challenges, if they remain unaddressed, could jeopardize government’s ability to cope with the sharp increase in health services resulting from population growth. Issues such as shortage in hospital beds, long wait times, poor primary care coupled with
limited availability of tertiary care, high turnover in medical professionals, over-reliance on expatriate physicians and nurses, and limited ability to attract and retain UAE nationals in the medical profession remain high on the government’s agenda.

The study of organisational culture in healthcare organisations has gained an increasing importance over the past ten years not only as a way to understand the particular organisational dynamics that steer those systems, but also as a lever to improve performance and improve quality of care (Davies et al., 2000, Ferlie and Shortell, 2001). Accordingly, this study explores the role of organisational culture and assesses its impact on public healthcare services in Abu Dhabi. Its findings are intended to provide the basis for sound recommendations and suggestions to health policy makers in Abu Dhabi which will help them to provide a good health service that will match their reform objectives and ensure sustainable growth in this sector.

1.7 Outline of the Thesis

The body of this thesis is divided into nine chapters as follows:

Chapter 1 constitutes the introductory part, which covers four major elements including the problem statement, research objectives, research questions, contribution of the study, and the thesis plan. The aim of this chapter is to highlight the role of organisational culture in improving healthcare performance and its importance in the implementation health systems reforms. It also seeks to expose the salient challenges faced by the public healthcare system in Abu Dhabi, and how the study of organisational culture in this sector would help policymakers and practitioners in understanding and addressing some of those challenges especially those relating to human capital.

Chapter 2 presents a review of the existing literature on health system reforms with a particular emphasis on health system reform and healthcare challenges in the Arab World and the GCC. It also presents a review of literature in the domain of organisational culture as a generic concept as well as its relationships to national culture. Next, the Competing Values Framework (CVF) and the cultural typologies using CVF are explored. The chapter ends with a discussion of the specific notion of organisational cultural in healthcare contexts and reviews previous empirical studies exploring the relationship between organisational culture and different determinants of healthcare performance.

The next two chapters explore in detail the context and strategic environment of public healthcare regulation and provision in the UAE and the Emirate of Abu Dhabi. Recognizing that any study of organisational culture needs to start by a deep understanding
of the environmental, socio-economic and political factors, collectively known as ‘context’, Chapter 3 presents a critical examination of the environment in the UAE and Abu Dhabi in order the gain a deeper understanding how those factors affect organisational culture. It also seeks to expose the eclectic mosaic of the UAE society, where UAE Nationals who constitute less than 12% of the total population are a minority in their own country; and where the remaining 88% of the population is made up of expatriates from more than 180 different nationalities, and how this unique societal composition affects organisational culture especially in healthcare context. This chapter starts by providing general information about the UAE, and then gives detail of its geography, population and ethnic composition, economy, and political system. Subsequently, an analysis of the UAE labour market and the nationalisation of the workforce in the UAE known as ‘Emiratisation’ is presented. The following sections provide a detailed outlook about the Emirate of Abu Dhabi including its population, economy, social system, and political and public administration system. The chapter ends by giving a brief outlook about the health status of the UAE population.

Chapter 4 presents the background to the public healthcare in Abu Dhabi and the key aspects of the recent large-scale government reform programm in public healthcare in the Emirate. Following the framework suggested by Health Systems in Transition (HiT) (Boyle, 2011), this chapter examines the Abu Dhabi Healthcare system including the organisation, financing and delivery of health services, regulation, and the role of the main actors in this system. The chapter starts by providing an overview of the public healthcare system of the Emirate of Abu Dhabi before tracing its historical background and reform trajectory. It then proceeds to provide an organisational overview explaining the roles of the different actors in this system. The chapter also provides a detailed account of the healthcare financing system and an analysis of the public healthcare expenditures. Finally, a brief overview of healthcare regulation is provided before ending with an analysis on the personnel composition and the salient challenges relating to human resources including high physicians and staff turnover, and consistently low employee engagement.

The methodological aspects of the research are discussed in Chapter 5 which starts with a philosophical discussion about the ontological and epistemological positions underpinning the decisions behind the research design. The next sections provide the key arguments that justify the appropriateness of CVF in the current study, followed by a comprehensive review of the various research methods and instruments that have been adopted in previous empirical studies that investigated organisational culture specifically in healthcare.
contexts. Subsequently, the methods utilised in the current study which includes a mixture of qualitative and quantitative techniques, are elucidated with supporting rationales. The next sections provide the details of data sources, data collection methods, sampling strategies and pilot studies. The last part of this chapter explains the approaches to data analysis of both qualitative and quantitative data covering the benefits of triangulation and combining dissimilar methods that complement each other.

Chapter 6 reports the results of the analysis of the qualitative data obtained from a series of in-depth interviews. This chapter is divided into three distinct parts mirroring the research questions it addresses. The first section presents the current organisational culture attributes-based on the four cultural typologies suggested by the CVF of the different entities studied. The findings regarding the preferred organisational culture as perceived by the interview informants are presented in the next section, with a particular emphasis on the extent and direction of perceived cultural change within the different entities and nationality clusters. The final section summarises the different challenges facing the public healthcare sector that are perceived to hinder performance improvements in this sector.

Chapter 7 presents research findings from the analysis of quantitative empirical data acquired through the on-line, OCAI based survey instrument. Since the quantitative data was used as a mean to triangulate findings derived from the qualitative interviews and to provide more detailed analysis across different organisational and demographic variables, this chapter follows more or less the same structure as the previous chapter. The first part offers general descriptions regarding the characteristics of the respondents of the questionnaire survey. The second and third parts of this chapter portray the overall current and preferred cultural profiles of the different entities examined and the observed change between the current and future cultural profiles. The fourth and fifth parts present and analyse the identified relationships between the cultural values (present and preferred) and key demographic factors. The analysis of the results is presented in terms of organisational affiliation and among different nationality clusters in order to address the secondary research questions.

In Chapter 8, the key aspects of the findings reported in the previous two chapters are combined, compared and discussed in the light of existing literature in order to provide further analysis. It begins by locating the empirical findings within the bigger context of socio-economic and political factors affecting the healthcare sector explained in chapters three and four. The chapter also summarises the challenges facing the public healthcare sector in Abu Dhabi locating those challenges within both the universal and contextual
factors affecting health systems reforms. The next section critically examines the current and preferred cultural profiles across the different constituents of the public healthcare sector and the different nationality clusters in the context of existing literature on organisational culture in healthcare contexts. The discussion subsequently moves on to discuss the different factors that could potentially account for the variation in cultural values among different constituents and nationality clusters. As a final point, the chapter includes evaluations of the strengths of the methodological approach and limitations of the current research.

The final part of the thesis, Chapter 9, brings together the empirical findings and key arguments that highlight the significance of the research. It begins by returning to the research objectives and provides an assessment of their achievement. It consists of a result summary, which is arranged in terms of the current and preferred cultural profiles of the different constituents of public healthcare sector in Abu Dhabi and summarises the extent and direction of change between those two assessments. The chapter also identifies the principal methodological and theoretical contributions of the study in the domains of public management as well as organisational studies specifically those relating to organisational culture in healthcare. The practical implications of this study at policy, organisational and individual levels are then discussed. Suggestions of opportunities for further research are provided in the final part of the chapter followed by the concluding remarks.

The appendices comprise the list of core interview items (Appendix 1), interview covering letter (Appendix 2), covering email for survey participants (Appendix 3), covering letter for the survey (Appendix 4) as well as elements that are included in the questionnaire (Appendix 5). Finally, the Arabic translation of the questionnaire is included in Appendix 6.
Chapter 2- Literature Review

2.1 Introduction

As mentioned in the previous chapter, Abu Dhabi health system faces a number of challenges including raising costs, inconsistent quality of care, and low employee engagement leading to staff dissatisfaction and high staff turnover rates. Locating those challenges within the wider context of health system reforms, and understanding the role that organisational culture can play in comprehending and addressing those challenges are the objectives of the study. This chapter explores the existing literature in the field of health systems reforms and how organisational culture plays a role in understanding a number of salient challenges facing health systems and improving healthcare outcomes. It identifies gaps in the existing literature and provides a comprehensive review of the main concepts relating to the study.

Three key words were identified as a guide for the literature review were ‘health system reform’, ‘organisational culture’, and ‘Arab world’. Electronic review involved major databases such as EBSCO, ProQuest, Elsevier, Pubmed, and Scopus. The review covered mainly the years 2000 till 2014. Only English language articles were included. The initial review of literature revealed a substantial number of studies in health system reform and organisational culture in healthcare contexts, however those studies focused primarily on health systems in developed countries such as OECD. The number of studies focusing on health system reform in the Arab world was almost inexistent. The few contributions found were exploratory or descriptive evaluations. Therefore the researcher relied on non-electronic data searches including outreach activities with a number of practitioners and academic in the field, in addition to articles and publications in non-academic journals.

The review of literature is divided into three major parts as illustrated in Figure 1-Literature Review Structure. The first part of this chapter deals principally with health system reforms. This part is divided into two main sections. The first section introduces the various elements and the different types of health systems before turning to the international reform trends specifically in OECD countries, and the salient organisational and human capital challenges that are shared across a number of health systems across the world. In the second section, the scope is narrowed down to the Arab World exposing the mosaic composition of this region and highlighting the unique challenges facing
governments in their health reform initiatives. Recognizing the pivotal importance of organisational culture in addressing organisational and human capital challenges, parts two and three focus on organisational culture, and the role of organisational culture in healthcare organisations.

**Figure 1- Literature Review Structure**

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<thead>
<tr>
<th>Health System Reforms</th>
<th>Organisational Culture</th>
<th>Organisational culture in healthcare</th>
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<tr>
<td>• Elements and types of health systems</td>
<td>• Definition</td>
<td>• Importance of organisational culture in healthcare contexts</td>
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<tr>
<td>• International reform trends and salient challenges</td>
<td>• Organisational culture and National Culture</td>
<td>• Review of empirical studies</td>
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<tr>
<td>• Health system reforms in the Arab World</td>
<td>• Competing Values Framework</td>
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<td>• Measuring Organisational Culture</td>
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Part two starts with the various definitions of the organisational culture and its relationship to national culture. Later the Competing Values Framework used as the conceptual framework for this study and the key arguments that justify the appropriateness of its application in the current study are explained. In the final section of this part, the qualitative and quantitative approaches used to assess and measure organisational culture are analysed. The focus in part three is placed on organisational culture in healthcare contexts. This part also reviews empirical studies addressing the relationship between organisational culture and health systems performance. Finally, gaps in the existing literature, which this study purposefully aims to address, are identified.

### 2.2 Health Systems Reforms

Health systems around the world seem to be in constant state of transformation. Demographic changes and advancements in medical technology pushed governments to implement reform initiatives that would enable them to contain the increasing costs while at the same time ensuring access and delivery of quality healthcare services and improving the health status of their growing population (Rothgang et al., 2010, Hurst, 2010, Marmor and Wendt, 2012). Pierson (2001) argues that while for many years governments have effectively exercised full control over their social institutions and institutionalized ‘welfare states’, profound changes within the political, economic and social environment forced the
states to rethink their welfare system. This led in many cases to a retrenchment in welfare activities and privatization of healthcare financing and healthcare delivery (Pierson, 2001).

2.2.1 Elements of Healthcare Systems

According to Went et al., (2009), healthcare systems depict a complex interplay of relationships between providers of services, the beneficiaries, and financing agencies which somehow needs to be regulated. Following from that, Rothgang et al., (2010) posit that the analysis of health system reforms and the role of the state thereto, should focus on three main functional processes, financing, service provision, and regulation. The complex interplay between the actors in health systems e.g. financing agencies, service providers, and beneficiaries along those three dimensions is depicted in Figure 2 - Conceptualization of a Healthcare System (Rothgang et al., 2010) below.

Figure 2 - Conceptualization of a Healthcare System (Rothgang et al., 2010)

Financing is usually measured as the proportion of GDP spent on healthcare via government expenditure, or the ratio of public versus private health expenditures. Service provision refers mainly to the ownership of healthcare services. According to Field (1973), the share of public sector in the provision of health services is considered an indicator of the level of state activity in the health sector (Field, 1973). Finally, regulation refers to the relationship between providers, financing bodies, and beneficiaries (Rothgang et al., 2010).

2.2.2 Types of Healthcare Systems

There are numerous typologies of healthcare systems. Earlier categorisations developed by Field (1973) focused on the extent of public sector control over healthcare resources compared to professional autonomy. According to Marmor and Wendt (2009), the most common classification used by researchers is the OECD classification depicted by
(Scheiber, 1987). This classification distinguishes health systems based in three dimensions (1) access to healthcare, (2) sources of financing, and (3) public private mix of healthcare provision. This results into three basic healthcare arrangements: National Health Service model, Social Health Insurance model, and Private Health Insurance model.

This study will not discuss in detail the different typologies of health systems, however it will highlight few that inform the typologies used in the current study. Moran (1999) classified healthcare systems according to three central concepts: “consumption”, “provision”, and “production”. Based on those dimensions, Moran identified four ideal types of healthcare politics: (1) the “entrenched command-and-control state,” illustrated by the Scandinavian countries and Great Britain; (2) the “supply state,” represented by the US; (3) the “corporatist state,” represented by Germany; and (4) the “insecure command-and-control state,” exemplified by Greece and Portugal (Marmor and Wendt, 2012). Wendt et al., (2009) distinguished healthcare arrangements by the role state, societal, and private actors have in the financing, provision, and regulation of healthcare. The result is a classificatory scheme of 27 types of healthcare politics, three of which are ideal types. “State healthcare systems,” where financing, service provision, and regulation are carried out by the state, “societal healthcare systems,” where societal actors dominate all three dimensions, and “private healthcare systems,” where private non-for profit and for-profit actors dominate all three dimensions (Wendt et al., 2009).

Rothgang et al., (2010) used the three ideal classification identified by (Wendt et al., 2009) to arrive at three types of healthcare systems to classify OECD health systems, national health service (NHS), social insurance system, and private healthcare system (Table - 1) describes those typologies with their respective dimensions of financing, service provision, and regulation.

According to Böhm et al., (2013), Rothgang and Wendt’s classification of health systems offers a coherent and robust taxonomy. Unlike other typologies developed by inductive, observation methods, the Rothgang and Wendt classification is based on a systematic deduction of health system types (Böhm et al., 2013). Rothgang and Wendt’s classification has been used as comparative framework for broad descriptions of health systems in England, Germany and the US, as well as for the qualitative clustering of health systems based on service provision and access (Wendt, 2009). It has also informed the explanatory approaches to health system changes (Schmid and Götze, 2009).
### Table 1 - Healthcare system types (Rothgang et al., 2010: 17)

<table>
<thead>
<tr>
<th>Healthcare system type</th>
<th>Underlying values and principles</th>
<th>Financing</th>
<th>Service Provision</th>
<th>Regulation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Service</td>
<td>Equity: equal access to services for everyone</td>
<td>Public: direct and indirect taxes</td>
<td>Public Providers</td>
<td>State Hierarchical: comprehensive planning and tight control by the state</td>
<td>UK, Sweden</td>
</tr>
<tr>
<td>Social Insurance System</td>
<td>Solidarity: equal access to services for all members of insurance funds</td>
<td>Societal: social insurance contribution according to income</td>
<td>Societal: private non-profit providers</td>
<td>Collective bargaining of corporatist actors, legal framework, and some state control</td>
<td>Germany, Canada</td>
</tr>
<tr>
<td>Private Healthcare System</td>
<td>Principle of equivalence: services according to pay</td>
<td>Private: Private insurance premium according to risk</td>
<td>Private for-profit providers</td>
<td>Competition of private actors; limited state regulation</td>
<td>United States</td>
</tr>
</tbody>
</table>

Health system typologies in general and Rothgang’s framework in particular provide a simple way to classify health systems, and a useful platform for comparison of healthcare politics and policies (Marmor and Wendt, 2012). However according to Marmor and Wendt (2012) those typologies have certain limitations as they serve mainly descriptive purposes and therefore, do not capture the outcome dimensions related to healthcare system types such as ‘health status’, ‘clinical quality and appropriateness of care’, and ‘equity’. Moreover, Böhm et al., (2013) argue that the three dimensions of financing, service provision, and regulation are not independent but rather follow a clear order and hierarchical relationship led by regulation, followed by financing, and finally service provision.

Notwithstanding the limitations cited above, the current study uses the Rothgang et al., (2010) classification as a basic framework to understand Abu Dhabi’s health system. The exploratory nature of this research provides a justification for the use of Rothgang’s classification.

### 2.2.3 Reform Objectives and Direction of Change

Hurst (2010) posits that it is important to assess the performance of health system and their reform against the main objectives of health policy. OECD work has long focused on
access, quality, responsiveness, sustainability, equity and efficiency (Hurst, 2010). In their review of health policy agendas across eleven high income countries, Tenbensel et al., (2012) identified four main objectives that are thought to be universal to any health system. The primary objective, which is outcome driven, is improving health outcomes for the population (Tenbensel et al., 2012). Three further objectives oriented towards process and structure are access/equity, efficiency/cost-containment, and quality (Blank and Burau, 2007). Health systems reforms aim to address some or all those objectives. Invariably, the process of reform could involve some trade-offs. For example, the process of ensuring equity in access to primary care to various population groups could lead to longer wait times which have negative impact on timely access (Tenbensel et al., 2012).

Driven by socio-economic pressures, growing and aging population, and technological advancement, “the need for reforms that assure cost containment and at the same time guarantee high quality healthcare services for the population has increased” (Rothgang et al., 2010: 3). Comparative literature on healthcare systems attempted to analyse whether health system transformations or reform objectives differed across the different healthcare systems (Rothgang et al., 2010, Tenbensel et al., 2012) and to what extent those reforms were influenced by political and health policy actors (Marmor and Wendt, 2012, Tenbensel et al., 2012). The analysis performed by Tenbensel et al., (2012) did not reach conclusive evidence on material difference in health reform objectives between the different healthcare systems.Nevertheless, their analysis seem to suggest that health systems funded through social insurance are generally more preoccupied with efficiency and cost-containment than tax-funded, national health service systems. A deeper, longitudinal analysis was performed by Rothgang et al., (2010) using quantitative healthcare data of 23 OECD countries from the period extending between 1970 and 2005, and qualitative data compiled from three case studies performed on United Kingdom, Germany, and United states representing each of the three health system typologies described in table 2 above. The analysis indicated that over the past 40 years “distinct healthcare system types have become hybrid” (ibid: 237). Over that period, the authors observed that, driven by reform initiatives, differences between the healthcare systems and the role of the state therein gradually became more and more blurred, and that those systems converged in many aspects. Similar shifts were observed by Böhm et al., (2013).

With respect to financing, the analysis did not show a decline in the public financing share of healthcare expenditure across most OECD countries. However, findings seem to indicate that as opposed to almost polarized systems of heavy reliance on state funding
versus heavy reliance on private financing, reforms seem to move in converging public and private mix in healthcare financing (Rothgang et al., 2010). According to the authors, extreme shares of public financing could lead to dysfunctional effects, therefore a certain mix of private financing seem necessary to prevent ‘moral hazards’ (ibid: 239). On the other hand in systems characterised by heavy reliance on private financing such as the US, some form of public financing is necessary to ensure access to healthcare to low income and high risk groups who cannot afford private medical insurance.

As for the role of the state in service provision, the authors observed a common privatization trend across most OECD countries. Three categories of privatization were identified, material, formal, and functional. Material privatization refers to changes in ownership, whereas formal privatization refers to changes in legal status of entities, which mostly preserves their public ownership, but grants them more financial and operational independence. Finally, functional privatization refers to the outsourcing of certain non-core functions such as catering, cleaning, and laundry services to private sector providers. The analysis revealed weak ‘material’ privatization across the board, but considerable formal and functional privatization especially in tax funded and social healthcare systems (Rothgang et al., 2010: 241).

Regarding regulation, the complex healthcare reform initiated across the board in the different healthcare systems, and the introduction of competition and market elements in order to improve efficiency, has profoundly changed the regulatory structures (Rothgang et al., 2010). In order to cope with the new hybrid financing and delivery systems created as a result of the reforms, regulatory systems became more complex. Rothgang et al., (2010) observed the increasing role of the state in the regulation of service providers. Even in private sector dominated, competition based systems such as the US, the managed care revolution increased regulation albeit not necessarily through state hierarchy but rather through a combination of state and private hierarchies.

To summarise, whether to increase efficiency and contain healthcare spending or to ensure access to quality health services to their population, governments across the world seem to be constantly preoccupied with new ways to reform their healthcare systems. In spite of apparent structural and governance differences across the different health systems, it seems that reforms are moving to more convergent hybrid systems, that mirror the complex financing, delivery, and regulation structures created as a result of the healthcare reforms.
2.2.4 Salient Challenges: Competing Alternatives, Organisational Changes, and Human Capital

In the previous section, the direction of change in healthcare reforms and how over time different systems tend to converge into hybrid systems was discussed, in the current section some of the salient challenges, common to most healthcare systems across the world are explored.

Decades of reforms, led to wider access to health services to a larger percentage of the population; technological and medical advances means that we live longer, and have fewer infant deaths (Mintzberg, 2012). Moreover, many countries who suffered from extreme shortage of skilled health professionals, improved the availability of health professionals both in urban and rural areas (Campbell et al., 2013). However, despite such developments, access and equity, and managing costs remain very important challenges. “A closer look shows that nearly all health care systems worldwide are wrestling with problems of rising costs and lack of access to care” (Tanner, 2008). While it is beyond the scope of the study to fully survey those salient challenges in health systems, we focus on three important challenges that are relevant to the current study, competing alternatives, impact of organisational changes, and human capital.

Competing Alternatives

The pressure of raising costs of healthcare systems around the world, is forcing government to choose between often competing alternatives. It is never effectively a zero sum game. Politt (2007) argues that public administration reforms lead inevitably to a series of competing policy alternatives and that choices made in one area could lead to unintended consequences in another areas. Politt gives the example of NHS to portray those competing choices:

“In the case of the NHS, for example, ministers and their advisors may be faced with multiple trade-offs between centralization (a national service) and local ‘ownership’ and flexibility, between professional expertise and political control, between equal access and efficiency and between quality and affordability” (Politt, 2007: 535).

Similarly, Canada was relatively effective in controlling its spending in health care compared to other OECD countries, however analysts argue that such cost control came at the expense of access to care manifested as either delays in receiving care or outright rationing (Tanner, 2008).
There is no easy way to address those competing priorities, which will continue as long as citizens demand better quality of care, as governments strive to achieve access and equity, and as pressure to control costs increases. Porter (2009) argues that the only way to truly contain costs in health care is to improve outcomes. “The central focus must be on increasing value for patients — the health outcomes achieved per dollar spent” (Porter, 2009: 109). Porter posits that government must look beyond ‘false savings’ usually achieved as a result of cost shifting, and restricting access to achieving and sustaining better quality of care. Similarly Marmor and Wendt (2012) stress the importance of outcome based measures as a way to understand the impact of healthcare reforms on patients. They also argue that understanding the outcomes of reform initiatives would enable governments to assess whether policy reforms actually deliver results (Marmor and Wendt, 2012).

**Impact of Organisational Change**

During the last decade, organisational change in the public sector in general and in healthcare in particular has gained increasing popularity. Brugue (2004) argues that New Public Management, post-bureaucratic paradigm, and reinventing government have become common concepts among academics and practitioners. Those techniques are thought to bring about radical rather than gradual change to public sector organisations that would facilitate the implementation of reform initiatives (Hood, 1991, Pollitt and Bouckaert, 2004, Pollitt, 2007). According to Kettl (1997) the driving force behind the reforms is that traditional bureaucratic bureaucracies have become unresponsive. Therefore reform implementations in public sector were largely an attempt to decrease costs, to secure legitimacy through the reduction of red tape and increased customer service, and to introduce an element of competition through market-style re-organisation (Kettl, 1997).

However as promising and appealing as those concepts can be, the reality is that organisational change in highly complex and politicised systems such as healthcare is far from straightforward. McNulty and Ferlie (2002) present a case in point where the authors study the impact of implementation of business process reengineering in Leicester Royal Infirmary. The empirical study concluded that the transformation and outcome of change is highly uneven. The authors point to the complex environments in which hospitals operate, and more generally to the particularity of the public sector (meso and macro levels of organisations) which often makes the implementation of private sector management models in public sector settings limited at best (McNulty and Ferlie, 2002).
Organisational change in healthcare contexts do not only impact structures and processes, but also people, that is both healthcare workers and patients. Mintzberg (2012: 4) considered that the recent wave of healthcare transformations across the world that “apply the management technique of the month, reinvent health care every few years, and drive change from the top for the sake of participation at the bottom” do not necessarily lead to true involvement from the care givers (i.e. physicians and nurses) which in turn impact the effectiveness of the reform initiatives. Mintzberg highlighted the growing wave of ‘social engineers’ such as economists, system analysts, and consultants that governments are reverting to in order to fix salient challenges. Similarly, Politt (2007: 537) refers to the larger constituency of ‘managerialists’, “consultants and public servants trained and socialized to see ‘better management’ as the solution to a wide variety of public sector ills”.

Another aspect of organisational reforms that accompanied the implementation of NPM is the healthcare sector is the introduction of performance measurement, monitoring, and management systems (Kettl, 1997, Pollitt and Bouckaert, 2004). Healthcare organisations are characterised by diffuse power, ambiguous goals and a plurality of actors legitimised to participate in strategy-making and goal-setting, they constantly face the competing objectives of access, quality and affordability (Koornneef, 2010). Defining performance in healthcare poses a set of challenges as there exists a wide range of possible measures. Those can range anywhere from access, efficiency, clinical outcomes, clinical processes, patient safety, patient satisfaction, reduction in medical errors and mortality rates, staff satisfaction and others (Davies et al., 2000). Those challenges are compounded by the fact that given the subjective nature of some of those measures (e.g. patient satisfaction, staff satisfaction, and medical outcomes), it is often very difficult to arrive at an objective measure of performance that truly reflects healthcare outcomes. Mintzberg (2012) further argues that while treatments might exist in certain categories, their outcomes are often not standard, and therefore can be tricky to pin down by measurement. Finally, Scott et al. (2003c) argue that behind the bold statistics and league table of performance data lies a number of complex socio-technical processes that shape and define performance in healthcare organisations.

“Managing performance continues to increase and is arguably a dominant idea for governments” (Bouckaert and Halligan, 2008: 13). Talbot (2010) points to the pervasive presence of performance monitoring in all aspects of British public services and from central government ministries down to front-line services. The author argues that this
system has contributed to substantial improvements in actual performance in a wide range of policy areas, especially large volume services such as health, education and criminal justice. However, Talbot (2010: 30) points to significant cases of perverse outcomes and “gaming” of performance monitoring systems by those being monitored, in addition to some dysfunctional problems resulting from changing political priorities and timescales. Mintzberg (2012: 5) reinforces the same idea, he argues that: “The Myths of Measurement and of scale of measurement is a fine idea, as long as it does not mesmerize the user. Unfortunately it so often does: both managers who rely on it for control and physicians who believe that ‘evidence based’ always has to trump ‘experienced based’ ”. Mintzberg questions the saying ‘if you can’t measure it, you can’t manage it’ in healthcare and calls for increased use of professional judgment in order to counter the effect of measurement fixation.

The section above points to a number of challenges that health system face as a result of organisational changes accompanying reform initiatives. The use of social engineering to reinvent organisation, the reliance on ‘management reform community’ to implement the organisational changes, and the fixation on measuring performance as means to meet performance targets would not necessarily lead to better health outcomes. One way to address those challenges as Mintzberg (2012) puts it is to move from ‘machine oriented’, control and number driven organisation to a ‘professional organisation’ with greater collaboration and commitment from healthcare professionals. This conclusion leads us to the final and most salient challenge in health systems, human capital.

**Human Capital**

Becker (1964) defines human capital as “activities that influence future monetary and psychic income by increasing resources in people”. According to Becker, investment in human capital include not only individual’s potential earnings but expand to factors that are not measurable in monetary terms (referred to as psychic income) such as on-the-job training skills and job satisfaction. Human capital represents the total value of the human resources of an enterprise, and is composed of the staff and their ability to successfully complete their work (Wang et al., 2008).

The centrality of human capital in achieving health reform objectives across the world has gained increased importance during the last decade. Healthcare organisations work to provide good quality, safe and increasingly patient-centred services through the recruitment, retention and management of high-caliber employees. But beyond quality
concerns, salary costs can account for up to 70 per cent of healthcare expenditure, as a result managing people is a cornerstone component of delivering effective and efficient healthcare (McDermott and Keating, 2013). Smith et al., (2007) echo those findings indicating that investing in human capital creates a positive culture for all staff levels. A positive supportive culture would in turn enable healthcare organisations to reduce costs, reduce medical errors, and improve patient satisfaction and quality of care (Smith et al., 2007). The World Health Report 2006 (W.H.O, 2006b) highlighted issues relating to the availability of qualified workforce, accessibility, acceptability, and quality dimensions. Noticeable progress has been made since 2006 on many aspects including the adoption of the WHO Global Code of Practice on the international recruitment of health personnel. As a follow up for the 2006 report and in an attempt to press the agenda of universal health coverage, Global Health Workforce Alliance and World Health Organisation issued a recent report entitled: “A universal truth: No health without a workforce” (Campbell et al., 2013). The report concludes that:

“The goal of universal health coverage requires a paradigm shift, going beyond a discourse on shortages but rather focusing more explicitly on the accessibility, acceptability, quality and productivity of the health workforce, placing equity at the centre of the agenda” (Campbell et al., 2013: iv).

The report notes that availability and accessibility continue to vary widely within countries because of difficulty in attracting and retaining health workers. It urges transformative action on human resources for health calling for the recognition of the centrality of the health workforce in translating the vision of universal health coverage into improved health care on the ground.

Similarly, scholars increasingly recognise the importance of studying human resource management in healthcare. A number of recent articles and academic conferences illustrate this trend. Dickinson and Mannion (2012) present a number of empirical studies stressing the central role of professionals in implementing health policy. The 8th International Organisational Behaviour in Healthcare Conference (OBHC) entitled “Managing people to manage care: from patient to people-centredness” concluded that “people are the true drivers of performance in healthcare” (McDermott and Keating, 2013: 2). Papers presented at the conference focused on people management in healthcare and whether the adoption of HR practices is associated with enhanced performance across clinical, employee and financial outcomes; and the influence of organisational climate and organisational culture on different aspects of performance outcomes. For example, McDermott et al. (2013)
examined the role of work engagement in the quality of care delivered to patients and in
general health of the midwives delivering care. The study revealed work engagement to be
a significant partial mediator between organisational and supervisor support and quality of
care. Finally, Saame et al., (2011) argue that the rapidly changing environment and
restructuring processes in healthcare institutions have an impact on values shared in the
organisation which in turn may influence the various aspects of performance.

2.2.5 Conclusion
Literature on health systems reforms focuses on three main dimensions: financing,
delivery, and regulation. Health systems across the world are organized according to their
financing model, the role of the state in healthcare delivery, and their regulation structure.
In spite of apparent structural and governance differences across the different health
systems, it seems that reforms are moving to more convergent hybrid systems. While
developments have been made in many areas, many structural, organisational and human
capital challenges remain to be addressed.

2.3 Health Systems Reforms in the Arab World
The ‘Arab World’, however defined, is a region characterised by great diversity in terms of
ethnicity, culture, religion, economy, and political systems. This region has always been at
the heart of political turmoil and unrest as evidenced in the series of wars and conflicts that
affected the region for hundreds of years. Structurally health systems across the Arab
world have diverse arrangements ranging from public sector dominated, free health
services and no taxes in GCC countries; to social insurance systems with weak central
government and high reliance of private providers in countries such as Lebanon; to
underdeveloped health systems in countries such as Somalia and Yemen (Jabbour and
Rawaf, 2012). Health system reforms across the region strive to improve access, contain
costs by reducing government involvement and increasing private sector participation,
upgrade regulations, and above all ensure equity and improve population health (Mourshed
et al., 2008, Jabbour and Rawaf, 2012, Batniji et al., 2014). Driven by availability of
resources, population structure, and political systems, varying strategies are used by
different countries to address health system challenges and implement reform initiatives.
However, scholars agree that the road to health system reform and improved governance in
the Arab world is long, bumpy, and uneven (Jabbour et al., 2012). Serious engagement and
collaboration between governments, the civil society, practitioners, and academics are
needed to ensure lasting and meaningful reforms.
For all its diversity, natural, and human resources, the Arab world has low health-research productivity (Benamer and Bakoush, 2009). According to Jabbour (2014), the reasons are many, from lack of funding and national support for health research to weak research-for-health systems to low social value of research. Horton (2014) indicates the ‘invisibility’ of the Arab world in global health and medical journals. What is also striking is the scarcity of academic literature and empirical and comparative studies in health systems reform in the Arab world. Surprisingly, the Arab world has only recently emerged as a unit for analysis and as a legitimate subject for discussion in global health (Jabbour et al., 2012). As such, the current study contributes to fill the knowledge gap in health system reform in the Arab world.

2.3.1 The Arab World, A diverse landscape

Different and overlapping terms are used to refer to the ‘Arab World’ which has been defined differently for different purposes, at different times and by different actors (Jabbour and Yamout, 2012). The most common definition is the 22 member states of the league of Arab states officially founded in 1945. The region divides geographically between the Maghreb, the Mashreq, and the Gulf. The ‘Eastern Mediterranean Region’ (EMR) used by World Health Organisation (WHO) includes 19 Arab countries. Algeria, Mauritania, and Comoros are classified by WHO in the African region and three non-Arab countries are added to the EMR region: Afghanistan, Iran, and Pakistan. Despite linguistic, historical, religious, and socio-cultural links that exist within the Arab region, it is far from being homogenous. Diversity in terms of culture, religion, ethnicity, economy, and the political systems are the defining features of the Arab World (Jabbour and Yamout, 2012). In terms of understanding health systems in this region, it is important to seek a classification that captures this diversity. WHO classifies EMR countries into three categories: The first group includes high income countries characterised by rapid social and economic development and includes the six Gulf States. The second group includes middle income countries characterised by well-developed public health services but with limited resources and includes Middle Eastern and Maghreb countries. Finally, the third group includes low income countries characterised by low population health outcomes, political instability, and lack of resources for health (W.H.O, 2012). The most important differences between those groups relate to the levels of economic development, demography, population health status, political stability, history of conflict or war, presence of refugees, and health system organisation (Blair et al., 2014). With such a varying landscape, understanding health systems in the Arab world and the various strategies adopted by different countries in reforming their health sector is a challenging
task. Countries in the Arab world have remarkable diversity; they paradoxically include some of the least developed countries and some of the richest countries (Jabbour, 2014). Political regimes are also very diverse they range from absolute monarchies (e.g. Saudi Arabia, Oman), to constitutional monarchies (e.g., UAE, Morocco) to parliamentary and presidential republics (e.g. Lebanon, Egypt).

2.3.2 Social Inequalities and the ‘Arab Spring’

Health indicators in the Arab world have sharply improved since 1970 with an average increase in life expectancy of 19 years, the largest gain among world regions, and an average reduction in infant mortality of 60 deaths per 1000 livebirths (Batniji et al., 2014). However, despite such progress in human development, the political elite who governed Arab regimes during most of the post-colonial era failed to provide basic public services for a large majority of their population and neglected basic methods of transparency and accountability (Batniji et al., 2014). Bantaji et al., (2014: 343) argue that “what distinguishes the Arab world-almost as much as the Arabic language itself-is the absence of political accountability throughout the region”. Deeply rooted social inequalities, youth unemployment, corruption, and lack of political representation of segments of population (Jabbour et al., 2012, Coutts et al., 2013, Batniji et al., 2014) led in late 2010 to social movements where populations demanding equality and government accountability overthrew long standing dictators and oppressive regimes.

The ‘Arab Spring’ movement that erupted in Tunis in December 2010 has touched almost all countries in the Middle East and North Africa from Egypt, Libya, and Bahrain to Syria and Yemen where movements and fighting continue until current days. Monarchies in Morocco, Jordan, and Gulf States were able to relatively contain unrest by implementing social, political, and economic reforms (Coutts et al., 2013) and increasing both direct and indirect social allocations. Although social inequality is often pointed to as an impetus for the Arab uprisings, Cammett and Diwan (2013) note, that neither economic growth rates nor absolute levels of income inequality can explain popular movements that shaped the Arab Spring. “Instead, the perceptions of socioeconomic trends, driven by declining welfare regimes and the rollback of the state, could be more explanatory” (Cammett and Diwan, 2013) as quoted in (Batniji et al., 2014). Citizens dissatisfaction with education and healthcare systems led newly formed governments to consider reform to their health systems. Moreover, health professionals who participated in the Arab Spring uprisings advocated health system reforms and regarded health systems as central to the democratization process of their governments (Jabbour, 2012).
It is too early to talk about impact or even direction of health system reform in many Arab countries post upspring. Arguably things could get worse before they get better especially in areas that are still held in political and military struggles (Cammett and Diwan, 2013). Moreover, public health social policies may lag behind when narrow economic interests and political agendas steer the reforms (Jabbour et al., 2012). However, analysts and scholars agree that there is hope for a better future and for building fair and accountable health systems. Rashad (2011) points to an interesting direction where health systems are being transformed from a ‘charity based approach’ to a ‘right based approach’, a movement which is thought to empower citizens to push for reforms that demand health equity which would lead to better health outcomes for the population.

2.3.3 Health System Challenges in the Arab Countries

The political, social, and economic changes that swept the Arab World over the past few years have affected every aspect of health systems from financing, to delivery, to regulation. In spite of progress made by a number of Arab countries in improving the health status of their population, the region still faces a number of pressing challenges. The top five challenges identified by WHO Eastern Mediterranean Region are health systems strengthening towards universal health coverage; maternal and child health; non-communicable diseases; communicable diseases, particularly health security; and emergency preparedness and response (Alwan, 2014). A recent World Bank report, suggests that Middle East and North Africa (MENA) countries still have low government spending on healthcare. The analysis indicates that between 2006 and 2011, MENA governments spent on average 8.2 per cent of their budget on healthcare, resulting in unacceptably high levels of out-of-pocket expenses on healthcare especially in the Maghred and Mashreq regions which could reach 80% in certain countries (World Bank, 2013, W.H.O, 2010). Furthermore the report highlights the increasing burden of non-communicable disease with four MENA countries, Kuwait, Egypt, UAE, and Bahrain cited as having among the world’s highest obesity rates; in addition to increasing rates of road traffic accidents leading to high levels of accident and injury related deaths among young people.

There is no unique pathway to address those challenges and ensure universal and equitable access to quality health services to the population irrespective of financial means. As indicated above, countries in the Arab region include high income, middle income, and low income countries. Strategies that governments usually adopt to ensure universal coverage and address their health system challenges vary from providing free basic primary care and
disease control in low income countries, to focusing on implementing compulsory social health insurance, increasing government subsidies and strengthening private sector provision in middle income countries, to managing government funded programmes to ensure comprehensive coverage to nationals and expatriate community in high income countries (W.H.O, 2010).

To illustrate, countries in the EMR high income group have unique population structures with large expatriate population relative to their national population. This population structure along with rapid population growth from high inward migration has necessitated high and increasing spending on healthcare (Blair et al., 2014). In GCC countries, governments have traditionally financed full health coverage for their citizens as part of the redistribution of oil wealth. However, with the increasing expatriate population, those countries have started implementing compulsory health insurance schemes for expatriates. Coping with increasing demand, raising costs of health coverage for national citizens and ensuring equitable and fair coverage for expatriates are commonly cited as unique challenges faced by those countries (Mourshed et al., 2008, W.H.O, 2010). Reform strategies in GCC countries focus on reducing government involvement in health sector and controlling expenditures by shifting payment and provision to the private sector (Mourshed et al., 2008, Alkhamis et al., 2014).

2.3.4 Research Gaps and Avenues for Future Research

Despite slow progress and glimpses of hope, much remains to be done to address the serious gaps in healthcare research in the Arab World. The diversity of the Arab world, the massive political, social and economic changes that have altered the region over the past four years, and the polarised differences in health systems across the region, provide a fertile ground for academic and clinical research. Empirical research across all areas of health systems from financing, to delivery, to regulation, and human resources offers the hope for a better understanding of the unique challenges facing the health systems in the region. Such research would greatly benefit governments, public servants, practitioners and the public at large in directing reform initiatives to achieve improved health outcomes for the population.

2.4 Organisational Culture

As noted in the sections above, health systems reform is a complex process entailing structural, organisational, and behavioral changes. Health policies are mostly concerned with improving the quality of healthcare. Whilst structural reforms are important, they are
not usually sufficient in themselves to deliver tangible improvement in the quality of care (Mannion et al., 2005). Scholars have recognised that cultural change needs to be addressed alongside structural reorganisation and systems reform to bring about a culture in which excellence can flourish (Donaldson and Gray, 1998, Mannion et al., 2005). In the US and the UK, a series of recent events and scandals have brought the issue of organisational culture in healthcare organisations to centre stage as a potential lever for health care quality and performance improvement (Institute of Medicine, 2000, Institute of Medicine, 2012, Department of Health, 2011, Department of Health, 2013). As a result, two new fields have gained considerable interest in healthcare literature over the past ten years, complexity theory and organisational culture (Edwards, 2005). Both fields promise interesting avenues for addressing salient challenges in health systems that are thought to be notoriously difficult to change (Davies et al., 2000, Mannion et al., 2005). However, despite the fact that the notion of culture promises to provide a way to understand organisational dynamics and what goes on inside organisations, it does not automatically prescribe how cultural change can be implemented (Edwards, 2005). Moreover, even when desired, cultural change cannot be brought about in isolation of environment within which organisation operate (Davies et al., 2000, Mannion et al., 2005, Ferlie and Shortell, 2001). The macro contextual factors including political, regulatory, social, and economic factors affect the direction and magnitude of cultural shift. A cultural change can only happen when the macro, micro (i.e. organisational), and individual factors are aligned, or have a certain level of harmony. Under this backdrop, the next section of the literature review focuses on organisational culture, its definitions, levels, and approaches to its measurement.

2.4.1 What is Organisational Culture?

The term “organisational culture” first appeared in the academic literature in an article in Administrative Science Quarterly by Pettigrew (Pettigrew, 1979, Hofstede et al., 1990). Although the concept of organisational culture dates back to early sociological studies in the 1950s, with Jacques referring to the culture of a factory as early 1952 (Jacques, 1952) as cited in (Scott et al., 2003a), it took up until the late 1970s and early 1980s for researchers and practitioners to appreciate its importance in organisational life. The constituent themes of organisational culture can be traced to earlier literature on organisational analysis. Attempts to explain the superior performance of companies like IBM, Hewlett Packard and Walt Disney have focused on beliefs and values that shape the organisational culture of those firms (Peters and Waterman, 1982, Barney, 1986, Collins
and Porras, 1994). Scholars identified that those shared values and beliefs create strong cohesive cultures which in turn leads to improved financial and operational performance.

Organisational culture is an anthropological metaphor used in organisational and management research (Scott et al., 2003c, Mannion et al., 2005, Davies et al., 2000). Culture is often regarded as the black box of organisational theory (Melitski et al., 2010). Rainey and Steinbauer (1999) asserted that organisation culture is the most overused and loosely used term in the study of management (Rainey and Steinbauer, 1999). Indeed, “very few concepts in organisational theory have as many different and competing definitions as organisational culture” (Barney, 1986: 657), as such reaching a universally agreed upon definition of this concept is almost impossible. Organisational culture has been variously defined (Schein, 1990, Ott, 1989, Davies et al., 2000, Alvesson, 1989, Howard, 1998). Most of the definitions implicitly recognise the socially constructed nature of this concept (Mannion et al., 2005, Hofstede et al., 1990, Scott et al., 2003c, Cameron and Quinn, 1999) typically associated with notions of shared beliefs, values, assumptions, and significant meanings (Schein, 1990, Ott, 1989). Edgar Schein provides one of the most commonly used definitions of organisational culture as,

“The pattern of shared basic assumptions—.invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration—that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems” (Schein, 1985: 6).

Schein (1985) contends that culture exists simultaneously at three levels, artifacts, values and beliefs, and basic underlying assumptions (Table 2). Those three levels are thought to have ascending importance from level one to level three and provide a widely acknowledged framework for analysis (Scott et al., 2003c). Ott (1989) argues that the first level of organisational culture opens little room for identifying strategies for changing the basic orientation of an organisation; whereas the second and third levels can be considered as the guiding theoretical framework for studying and changing cultures of organisations.

The importance of studying cultures in organisations condenses to the recognition that organisational culture is an “important social characteristic that influences organisational, group, and individual behavior” (Hartnell et al., 2011: 677); organisational culture equally provides a framework to understand the collective thought process informing that behavior at both conscious and unconscious levels (Scott et al., 2003a).
2.4.2 Culture as Something that an Organisation “has” versus “is”

The literature on organisational culture is divided into two broad streams (Smircich, 1983). One stream approached culture as a ‘critical variable’ or attribute, something that an organisation has along with other attributes such as structure and strategy. The presence of culture it manifested in the patterns of attitudes and actions of individual organisation members. The other stream approached culture as a ‘root metaphor’. This approach recognises organisations as organisms created through social interactions of their participants. Organisations are viewed as a particular form of human expression and culture is considered as something an organisation is (Smircich, 1983). The differences between those two schools led to quite different research agendas. On one hand, scholars interested in principles of causality, prediction, and control view organisational culture as a critical variable. On the other hand scholars interested in meanings and interpretations of organisational dynamics treat culture as a metaphor. According to Mannion et al., (2005), the view of culture as an independent variable capable of manipulation to satisfy organisational objectives dominated the modernist approach to organisational studies. Critics of modernist approach contest the idea that cultures can be measured and manipulated. Indeed post-modern perspectives attempt to deconstruct processes to reveal the hidden contradictions and tensions of human expressions (Mannion et al., 2005).

Finally, while each of those conceptualizations holds its promises to bring a new level of understanding complex organisational dynamics, the modernist approach treating culture as an attribute has long dominated organisational research in healthcare contexts (Mannion et al., 2005, Bellot, 2011). Such conceptualization will be used in the current study.
2.4.3 The Role of Sub-Cultures
Organisations, rarely, if at all, exhibit uniform culture across their different divisions, occupational or professional groups (Ott, 1989, Cameron and Quinn, 1999, Hofstede, 2005, Schein, 1990). Ott (1989) posits that subcultures may develop in any organisational groups. Although sub-cultures might be easily identifiable in different divisions or functions (e.g. sales, manufacturing, HR) or organisational levels (e.g. partners and senior managers, managers, and senior auditors and auditors in audit firms), organisations may have subcultures made up of people working on the same programme or project, or sharing similar ethnic and religious backgrounds (Ott, 1989). Different cultures might also emerge within different occupational or professional groups. Hofstede (2005) observed that individuals usually have strong association with practices. Such associations are usually dictated by the nature of their occupation; for example handling people versus handling things (e.g. nurse versus engineer), or structured versus unstructured (e.g. system analyst versus graphic designer).

In healthcare contexts, differentiated among clear occupational lines, subcultures created mainly as a result of professional associations, but also departmental, ward, specialty and other affiliations interact and impact organisational culture (Bloor and Dawson, 1994, Scott et al., 2003b). Professional cultures are defined as the values and attitudes developed by an independent professional group affecting the production of healthcare (Van Maanen and Barley, 1982) quoted in (Carlstrom and Olsson, 2014). Such subcultures may share common orientation and espoused value as the dominant organisational culture, but can also clash with the common cultural orientation creating challenging organisational dynamics (Martin and Siehl, 1983). For example clinical subcultures may emphasise group affiliation, teamwork, and coordination, whereas administrative subcultures may emphasise formal structures and regulation. Martin (1992) argues that even when desirable, achieving cultural integration in organisations especially where there is strong dominance of subcultures as indicated above is often very challenging.

2.4.4 Impact of National Culture
As discussed earlier, organisations cannot be isolated from their environments. National culture has been identified as an important element of context in organisational studies (Chenhall, 2003). The basic proposition is that different countries and human groups possess different cultural characteristics (Hofstede, 1980). National culture in turn fundamentally shapes organisational culture (Ott, 1989). Among the many scholars who proposed models to classify national cultures, Greet Hofstede’s model is considered
amongst the most dominant and influential. Using a large scale survey, which involved more than 100,000 IBM employees, Hofstede developed a model which could draw distinctions between cultures across four primary dimensions: power distance, individualism/collectivism, masculinity/femininity and uncertainty avoidance. A fifth dimension long-term/short-term orientation was added subsequently. Hofstede’s study had a considerable influence on a number of subsequent researchers to delve deeper into the dimensions of national culture. For example Triandis (1995) conducted a study focusing upon the individualism and collectivism facets and separated them further into vertical and horizontal dimensions. Hofstede’s approach also influenced the Global Leadership and Organisational Effectiveness Study (GLOBE) led by House in 2002. The output of the Globe study was the extension of Hofstede’s five dimensions to nine separating collectivism into two types in addition to adding three more categories: human orientation, performance orientation, and assertiveness (House et al., 2004). Hofstede’s model was also employed in some Arab countries. Twati (2014) used a structured survey based on Hofstede’s model to examine the attitude of middle and top management in 15 Libyan government and public organisations. He found that generally employees had high scores in power distance and uncertainty avoidance dimensions and low scores on masculinity and individualism dimensions.

National culture is also shaped by specific societal values, beliefs, norms, and work and social experiences (Ali, 1996). Tayeb (1988) noted that Arab Nationals, especially those residing in the GCC are highly influenced by their Bedouin roots and traditions. They are characterised as being highly collectivist with a strong sense of group loyalty. Social formalities are very important, and loyalty to the group is generally emphasized over efficiency. In turn those characteristics are reflected in highly hierarchical and centralized organisations with ‘paternalistic, authoritarian management style’ (Tayeb, 1988: 76). Common (2008) notes that the Gulf states are characterised as centralized, with strong organisational cultures rooted within a regional culture that is based on tradition, religious values and community, supported by the social culture. Previous empirical studies on organisational culture in the GCC, suggested the significant influence of national culture on organisational culture (Al Otaibi, 2010, Al Yahya, 2009). Using Hofstede’s framework, the Arab National culture is characterised by high power distance, collectivism, femininity and risk aversion. The organisational culture of the health service and its hospitals is thought to reflect these societal characteristics (Al Otaibi, 2010).
What is particular about organisational research in the GCC countries in general and the UAE in particular, is that besides the fact that it is highly influenced by the Arab national culture, it also happens to be a place that is ethnically very diverse (Suliman and Moradkhan, 2013). With over 180 nationalities represented in its workforce, UAE is inhabited by a variety of cultural groups such as Emirati, Iranians, Indians, Filipinos, Arabs, Europeans, Americans, and many others. This diversity shapes managerial and leadership styles within UAE organisations and brings unique challenges in integrating culturally different leadership styles in organisational contexts (Suliman and Moradkhan, 2013). Therefore this study addresses the aspects of national culture particularly the Emirati culture that are felt to be a contributory factor shaping the context within which organisations operate.

Howard (1998: 234) indicates that “an organisation’s culture can be reliably represented by the values-preferences for means and ends-which drive its members’ attitude and activities”. Literature indicated a number of different definitions, approaches, and conceptualizations of organisational culture. Furthermore, organisations rarely exhibit uniform cultural characteristics across their different constituents and professional groups, and national culture plays a role in shaping some aspects of the culture of organisations. However, despite the multi-layered, complex nature of organisational culture, it still appears to be the force that shapes members values and the glue that holds them together.

### 2.4.5 Organisational Culture and Performance

One of the most crucial yet most intriguing aspects of studying organisational culture remains its relationship to organisational performance and various aspects of organisational effectiveness. Linkages between organisational culture and performance originated outside healthcare. The idea that a “strong culture” per se will be associated with high organisational performance originated in the 1980s with the work of Deal and Kennedy (Deal and Kennedy, 1982). Such explanations suggest that firms with sustained superior financial performance typically possess a set of strong managerial values that define the way the conduct business and create an environment that fosters creativity and innovation (Barney, 1986). Equally, during the same period, the development of Ouchi (1981)’s ‘Theory Z’ linking successful and unsuccessful organisational performance to the type of culture created by American and Japanese firms gained increased popularity among practitioners as well as academic researchers. Over the years, organisational culture has been recognised by many scholars as crucial in understanding organisational change and organisational performance. Numerous studies indicated that major organisational
transformation is precarious unless accommodated by a change in the underlying values. Culture therefore represents a crucial part of transformational change literature (Harris, 1996, Harris and Ogbonna, 1999). Other scholars recognise the importance of organisational culture as a powerful predictor of organisational performance (Cameron and Ettington, 1988, Cameron and Quinn, 2011, Brewer and Selden, 2000, Hartnell et al., 2011, Kotter and Heskett, 1992, Pollitt and Bouckaert, 2004).

In recent years, there has been renewed interest in studying the impact of organisational culture on both organisational and individual performance (Brewer and Selden, 2000), yet there are diverse methodological difficulties that preclude the drawing of strong conclusions supporting the link as causal. Those difficulties are in part linked to the ambiguities around definitions of both culture and performance (Scott et al., 2003c, Alvesson, 1989, Denison and Mishra, 1995), and in others to the skepticism around how, if at all, organisational culture and be objectively measured (Denison and Mishra, 1995). According to Scott et al. (2003c), a simple causal linear relationship between organisational culture and performance is difficult to be supported. “Unsurprisingly, such relationship is highly contingent on definitions of success and a wide range of other internal and external factors” (Trice and Beyer, 1993) in (Davies et al., 2000). A third level of complexity in determining the relationship between organisational culture and performance is the direction of causality i.e. it might be true that certain types of culture could lead to better performance, but it is equally possible that performance may drive culture. Scott et al. (2003c: 115) posit that “it is possible that culture and performance are created together in a reciprocal and mutually constructed manner”.

Nonetheless, while some economists and organisational theorists believe that culture is epiphenomenal and question its relevance in understanding organisational performance (Wilkins and Ouchi, 1983), organisational culture appears to be a crucial factor in understanding the ability of organisations to perform and deliver results. A supportive organisational culture is often cited as a key component of successful quality improvement initiatives in a variety of organisations including healthcare (Kotter and Heskett, 1992, Sheaff et al., 2003, Denison and Mishra, 1995).

2.5 Competing Values Framework CVF

The conceptual framework for organisational culture used in this study is based on the Competing Values Framework (CVF). CVF has been recognised as one of the 40 most important models in the history of business (Cameron et al., 2006), and is one of the most widely used frameworks in empirical studies of organisational culture (Cameron and
Quinn, 2011, Scott et al., 2003a, Gerowitz et al., 1996, Stock et al., 2007). This framework has been used to examine various organisational phenomena, including culture (Zammuto and Krakower, 1991). CVF was empirically derived and has found to have both face and empirical validity as it helps integrate many of the different dimensions of organisational culture (Cameron and Quinn, 2011).

The framework was developed by Quinn and Rohrbaugh (1981) through their analysis of the values held by individuals regarding the desirable organisational performance. Using the list of organisational effectiveness criteria compiled by Campbell, (Campbell, 1977), Quinn and Rohrbaugh developed the Competing Values Model as a theoretical framework for organisational effectiveness. The authors recognised the challenges in formulating theory and constructs that would reflect organisational effectiveness which they argue may reflect outputs, inputs, or process; may be dynamic or static; may be derived from objective or subjective measures; and may be based on dominant coalition, managers, or external parties. Using multidimensional scaling, the authors developed a unified set of indicators of effective organisations which they sorted according to three sets of values: organisational focus, organisational structure, and organisational means and ends. The analysis led to a proposed definition of organisational effectiveness as “a value-based judgment about the performance of an organisation” (Quinn and Rohrbaugh, 1981: 138).

The resulting model referred to as the ‘Competing Values Framework’ (
Table 3) incorporates two sets of competing values along two axes: (i) the control/flexibility dilemma which refers to preferences about structure, stability, and change, and (ii) the internal/external orientation dilemma which refers to differences in organisational focus from an internal micro emphasis on the well-being and development of people to an external, macro focus on the development of the organisation itself (Quinn and Rohrbaugh, 1983). From these two axes emerge four quadrants which reflect four types of culture representing distinct sets or organisational effectiveness indicators. Authors such as Zammuto and Krakower (1991) and Cameron and Quinn (1999) who later adopted the framework to examine organisational culture referred to the four models as four cultural categories as illustrated in Figure 3. The four cultural types are Hierarchy (Internal process model), Market (Rational goals model), Clan (Human relations model), and Adhocracy (Open systems model).

Figure 3 - The Competing Values Framework of Organisational Effectiveness (Quinn and Rohrbaugh, 1981, Cameron and Quinn, 2011)

According to Talbot and Wiggan (2010: 66), “the really unique aspect of the CVF is the idea that this is not a “zero sum” model. That is, all four “quadrants” are likely to operate in all organisational contexts, although the balance between them will differ – it is a “both/and” rather than an “either/or” model”.

---

**Flexibility and Discretion**

- **Clan** (Human relations model)
  - Means: Discussion, participation, consensus, teamwork, employee development
  - Ends: Morale & cohesion, Commitment, Human resource development

- **Adhocracy** (Open systems model)
  - Means: Commitment to experimentation, individual initiative, adaptation, readiness, insight
  - Ends: Creativity, Cutting edge output, Growth & external support

**Stability and Control**

- **Hierarchy** (Internal process model)
  - Means: Information management, communication, standardized decision making, formalized & structured
  - Ends: Timeliness, Stability, Efficiency

- **Market** (Rational goals model)
  - Means: Goal clarification, External positioning, direction, decisiveness, planning, achievement of measurable goals
  - Ends: External positioning, Productivity, Goal achievement
2.5.1 Cultural Typologies Using CVF

Each quadrant represents those features a company feels is the best and most appropriate way to operate. In other words these quadrants represent their basic assumptions, beliefs, and values. None of the quadrants—Clan, Adhocracy, Hierarchy, and Market—is inherently better than another just as no culture is necessarily better than another (Cameron and Quinn, 2011, Cameron and Freeman, 1991). Quinn and Kimberly (1984) suggest that all four approached co-exist in most organisations, with some values more dominant than other Quinn and Kimberly (1984). CVF theory suggests that culture types are expected to relate to different organisational effectiveness indicators (Hartnell et al., 2011).

2.5.1.1 Hierarchy (Internal Process Model)

Hierarchical organisations place a great emphasis stability and control as well as internal focus and integration. Hierarchical organisations share similarities with the stereotypical large, bureaucratic corporation. They value standardization, control, and a well-defined structure for authority and decision making. “This model would commend an orderly work situation with sufficient coordination and distribution to provide participants with a psychological sense of continuity” (Quinn and Rohrbaugh, 1983: 371). It has been widely suggested that organisations in the public sector are best described as having this type of culture which relies on formal rules and procedures as control mechanisms to ensure conformity (Zammuto and Krakower, 1991).

2.5.1.2 Market (Rational Goal Model)

Another form of organizing became popular during the late 1960s as organisations faced new competitive challenges. These companies are similar to the Hierarchy models in that they value stability and control; however, instead of an inward focus they have an external orientation and they value differentiation over integration. The primary belief in market cultures is that clear goals and contingent rewards motivate employees to aggressively perform and meet shareholders expectations (Hartnell et al., 2011). Market organisations are concerned with competitiveness and productivity through emphasis on partnerships and positioning, they stress on the planning and goal setting (as means) to achieve productivity and efficiency (as ends) (Quinn and Rohrbaugh, 1983).

2.5.1.3 Clan (Human Relations Model)

Clan cultures emphasize flexibility and discretion and internal focus. The main assumptions underlying clan cultures is that “human affiliation produces affective employee attitudes directed towards the organisation” (Hartnell et al., 2011: 679). This cultural type is characterised by high trust, teamwork, group cohesiveness, employee
involvement, empowerment and corporate commitment to employees. These means are expected to increase employees’ morale, satisfaction, and commitment (Cameron and Ettington, 1988). Clan organisations operated more like families—hence the name—and they valued cohesion, a humane working environment, group commitment, and loyalty.

2.5.1.4 Adhocracy (Open Systems Model)

In the values matrix, Adhocracy are similar to Clan cultures in that they emphasize flexibility and discretion; however, they do not share the same inward focus. Instead they are like Market cultures in their external focus and concern for differentiation. A fundamental belief in Adhocracy cultures is that “an idealistic and novel vision induces members to be creative and take risks” (Hartnell et al., 2011: 679). Adhocratic organisations value flexibility, adaptability, growth, autonomy, and attention to detail (Quinn and Rohrbaugh, 1983), as means which are thought to cultivate innovation and cutting edge output (Denison and Spreitzer, 1991).

2.6 Organisational Culture in Healthcare

Research has also demonstrated that, in the health care industry, organisations with core characteristics including involvement, empowerment, trust, goal alignment, training, teamwork, communication, and performance-based rewards are more likely to have higher employee engagement leading to higher levels of patient satisfaction (Pellegrin and Currey, 2011). Although that might be true across the board, organisational culture, as indicated earlier, is influenced by contextual factors including political, social, and national factors. Therefore it is expected that those factors influence the cultural types prevailing in healthcare organisations. Gerowitz et al., (1996) examined the role of top management team culture in hospitals across Canada, UAS, and UK. The study found evidence that political and contextual factors influenced the distribution of cultural types. Hospitals in Canada were frequently clan and rational cultures, whereas in the USA, hospital were more frequently and adhocracy and rational cultures; finally, in the UK hospital management teams’ culture was more frequently clan and hierarchical (Gerowitz et al., 1996, Scott et al., 2003c).

The emphasis on organisational culture is clear from policy documents of the UK government. Notions of cultural changes have been at the heart of NHS reform since the 1980s, managing the culture and fostering a culture of openness and engagement is one route towards improving health care (Davies et al., 2000). A recent report by West et al., (2011) draws on data from the annual NHS Staff Survey and other sources; the report shows how good management of NHS staff and a supportive organisational culture not
only lead to higher quality of care, more satisfied patients and lower patient mortality but also offers significant financial savings for the NHS. The report concludes that: “Human resource management, staff attitudes and behaviors, and organisational culture and climate, have all been demonstrated as correlates and predictors of effectiveness and innovation” (West et al., 2011: 4). Similarly, healthcare reforms in the U.S place significant importance on developing culture of teamwork, collaboration, transparency, and adaptability to create learning healthcare systems that foster continuous improvements (Institute of Medicine, 2012).

Organisational culture in healthcare contexts operate at multiple levels from the macro/institutional level to the organisational, and small group levels (Ferlie and Shortell, 2001). The existence of sub-cultures is even more pronounced in healthcare organisations given the wide variety of professionals, sub-groups, divisions, and teams operating with them. Ferlie and Shortell (2001) argue that a major cultural divide exists between ‘clinical culture’ that characterises physicians and medical staff and ‘managerial culture’ that characterises managers and administrators. Clinical cultural is primarily influenced by biological sciences and favors professional discretion in deciding how best to treat patients. In contrast, managerial culture is principally based on social and behavioral sciences. The distinctive feature of such culture is an emphasis on rules and regulations, and standardizing practices in order to achieve organisational objectives (Ferlie and Shortell, 2001). Professionals in healthcare come from very different backgrounds and cultures, subcultures are created as a result of different occupational, departmental, ward, specialty, clinical networks and other affiliations (Scott et al., 2003b). With such a diversity of subcultures seeking an integrated set of cultural attributes and attempting cultural transformations would be challenging, moreover, Mannion et al., (2005: 32) question if it is even desirable. The authors argue that rather than attempting to perfect cultural integration, healthcare organisations should recognise the importance of “managing cultural diversity in order to achieve cultural fit”.

The number of empirical studies seeking to identify relationships between culture and performance in healthcare contexts witnessed an upward trend during the past ten years. This trend possibly reflects the importance placed by governments on the central role of organisational culture in healthcare reform. A review of ten empirical studies linking organisational culture and performance in healthcare organisations undertaken by Scott et al (2003) suggests some supportive evidence for the relationship, however such relationship is difficult to be clearly articulated. The authors analysed the studies in terms
of types of healthcare organisations studies, participants included, level of culture assessed, set of performance indicators, and methodologies applied. The review concluded that relationships between culture and performance are multiple, complex, and contingent. The authors observed that healthcare organisations differ in measurable ways in the cultural orientation and that the way to understand relationship between organisational culture and performance is to explore aspects of performance that are valued in the dominant culture (e.g., employee engagement is more valued in clan oriented organisations) (Scott et al., 2003c).

Using the same review framework suggested by Scott et al. (2003c), the researcher identified six recent quantitative studies examining linkages between organisational culture and various aspects of healthcare performance as summarized in
Table 3. The review revealed again the existence of a positive but contingent relationship between organisational culture and performance. Organisational culture has been found to be an important factor for improving quality of care within the healthcare systems (Stock et al., 2007). Brazil et al. (2010) found that organisational culture have a significant effect on employee loyalty and commitment, which in turn reflects positively on organisational performance. In addition, a positive relationship was found between group cultures and patients’ satisfaction (Gregory et al., 2009). Stock et al. (2007) found that supportive cultures help reduce medical errors, while a culture of stability, control, and goal setting contribute to a reduction in patient uncertainty and improved medical outcomes (Alharbi et al., 2012). Finally, two recent studies linking organisational culture to composite measures of performance in NHS hospitals (Davies et al., 2007, Jacobs et al., 2013a) found a contingent relationship between culture and performance suggesting that aspects of performance valued within the dominant culture are those aspects at which the organisation excels.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Participants</th>
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<th>Culture Levels</th>
<th>Culture Assessment</th>
<th>Performance Indicators</th>
<th>Summary of Findings</th>
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<tr>
<td>(Stock et al., 2007) US</td>
<td>Nomothetic</td>
<td>Impact of organisational culture and specific management techniques on the reduction of medical errors</td>
<td>549 participants (in the areas of quality management, performance, and risk) from US hospital</td>
<td>Level 2: values</td>
<td>CVF based instrument (OCAI)</td>
<td>Error reduction outcomes, operational benefits, knowledge-related benefits</td>
<td>Organisational culture plays an important role in dealing with the problem of hospital errors.</td>
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<tr>
<td>(Davies et al., 2007) UK</td>
<td>Nomothetic</td>
<td>Explore relationships between senior management team culture and organisational performance in English hospital organisations (NHS trusts)</td>
<td>899 senior managers from 189 NHS hospital trusts</td>
<td>Level 2: values</td>
<td>CVF based questionnaire</td>
<td>Star ratings and various published performance data such as patient respect, staff opinion survey, median waiting time, management salaries</td>
<td>The findings provide particular support for a contingent relationship between culture and performance. Aspects of performance valued within the dominant culture are those aspects at which the organisation excels.</td>
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<tr>
<td>(Gregory et al., 2009) US</td>
<td>Nomothetic</td>
<td>Examining employee attitudes as a potential mediator of the relationship between organisational culture and diverse measures of organisational effectiveness</td>
<td>Top management teams (n=354) from 99 hospitals across the US</td>
<td>Level 2: values</td>
<td>CVF based instrument</td>
<td>Controllable expenses and patient satisfaction</td>
<td>Positive relationship between group culture and patient satisfaction</td>
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<td>Study</td>
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<td>(Brazil et al., 2010)</td>
<td>US</td>
<td>Nomothetic</td>
<td>Examine the relationship of organisational culture on provider job satisfaction and perceived clinical effectiveness in primary care pediatric practices</td>
<td>374 participants (127 clinicians and 247 non-clinicians) from 36 primary care pediatric practices located in Connecticut</td>
<td>Level 2 values: CVF based Organisational Culture Scale instrument</td>
<td>Group culture was positively associated with both satisfaction and perceived effectiveness</td>
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<td>(Albari et al., 2012)</td>
<td>Sweden</td>
<td>Nomothetic</td>
<td>Study of the impact of organisational culture on patient uncertainty during the implementation of PCC (person centred care)</td>
<td>Nurses (n=117) and patients (n=220) in five Swedish hospitals wards</td>
<td>Level 2 values: Competing Values Framework, Organisational Values Questionnaire (OVQ) developed by Reino (2007).</td>
<td>Uncertainty Cardiovascular population Scale (UCPS) Culture of stability, control, and goal setting contribute to a reduction in patient uncertainty more than a culture characterised by flexibility, cohesion, and trust.</td>
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<tr>
<td>(Jacobs et al., 2013b)</td>
<td>UK</td>
<td>Nomothetic</td>
<td>Study assessing the relationship between senior management team culture and organisational performance in English acute hospitals (NHS Trusts)</td>
<td>Senior management (n=899, 816, and 739) in three acute hospital trusts (n=187, 143, and 140) over three time periods between 2001/2002 and 2007/2008.</td>
<td>Level 2 values: CVF culture rating instrument</td>
<td>Composite star rating for period T1 Various performance variables (clinical negligence, number of imaging tests per available bed, management and consultants salaries) Results tend to support linkages between Organisational Culture and Performance. Findings also suggest which sorts of cultures might be expected to enhance which aspects of performance.</td>
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2.7 Identified Gaps in Literature

Having reviewed a wide range of important issues surrounding health systems reforms, the theoretical foundations of organisational culture, the methodological challenges of studying and measuring organisational culture, and the importance of organisational culture in healthcare contexts, the researcher identified gaps in literature in two main areas.

The first gap relates to studying healthcare reforms. Given reports of the evidence of salient challenges in health systems in Western countries, particularly organisational and human capital challenges, and the impact of reforms on cultural values, it seems essential for governments in different parts of the world to be more cautious regarding the implementation of similar reform initiatives in their own nations. While ample literature exists on health system reform in western and OECD countries, academic research on reforms in the Arab World is very slender. Indeed, both descriptive and evaluative studies on health systems reforms in Arab countries are very rare. This represents a significant gap in the existing knowledge on health system reforms. Lack of transparency and challenges in access to data are often cited as the main reasons for such low level of empirical research in this region.

The second gap related to the study of organisational culture in Arab countries. Indeed our review revealed a dearth of research that examines the cultural characteristics of public healthcare organisations outside western contexts. Therefore, by offering an insight into the forces shaping the reform initiatives in the public healthcare sector in Abu Dhabi, the distinct cultural attributes of the Abu Dhabi health care sector, and the role of human capital in healthcare in a culturally diverse, expatriate driven environment, this study extends the knowledge boundary of organisational culture in healthcare context beyond what is currently known.

Finally, the number of research papers using competing values framework to measure organisational culture in the Arab world is very limited, therefore there is an opportunity for this research to offer a methodological contribution through the application of CVF in the context of public healthcare administration especially outside the western context.

2.8 Concluding Remarks

As Peter Drucker explained in his book ‘Management Challenges of the 21st Century’, healthcare is one of the three industries besides financial services and education with the greatest potential for growth. The decision making process for the managers of healthcare institutions is of considerable interest because of the conflicts between resource
availability, expectations, scientific advances and the variety of political and economic constraints (Drucker, 2007). In recent years, improving healthcare has become a critical global issue. Recent studies indicated that improving quality in healthcare requires not only systemic and procedural changes but more fundamentally encompass attitudinal change and the installation of new values (Davies et al., 2000).

This chapter has provided a review of various aspects of health systems reform and the role of organisational culture in healthcare contexts. Empirical evidence largely supports the hypothesis that organisational culture has an impact on organisational performance in healthcare organisations. Such impact is arguably contingent on the type of the predominant culture within the organisation. Organisational culture is and is likely to remain a complex and contested concept (Hofstede, 2001). Researchers suggest that empirical work in the area of organisational culture is still slender (Walker et al., 2010, Chenhall, 2003, Pollitt and Bouckaert, 2004, Moynihan and Pandey, 2010), as such, more empirically informed research is needed in this area. Such research has potential both as a lever for quality improvement and as an aid for understanding the management of change in healthcare organisations (Scott et al., 2003a). Therefore, by investigating the unique aspects of health system reform and the role of organisational culture in the context of Abu Dhabi, this study aims to fill the knowledge gap in this area and to contribute to the debate in health systems reform in the Arab World.

The next two chapters provide a detailed account of the first exploratory phase of this study. Given the scarcity of academic literature on the UAE in general and Abu Dhabi healthcare sector in particular, and the importance of understanding context before embarking into empirical investigation (Blaikie, 2010, Rousseau and Fried, 2001, Pollitt, 2001), the next two chapters attempt to explain the socio-economic and political system in the UAE and Abu Dhabi and draw a detailed account of the healthcare system in Abu Dhabi.
Chapter 3- UAE and Abu Dhabi Context

3.1 Introduction

Since the discovery of oil some 50 years ago, the UAE has transformed itself from a collection of seven Trucial sheikdom states with very limited economic activity to a major economic force and a key player in the regional and international economic landscape (Nyarko, 2010). An impressive development in social, economic and political aspects placed the UAE amongst the world wealthiest economies. With its strong fiscal position, an open economy, and diverse population, the UAE is considered one of the most modern and liberal states of the region. Abu Dhabi, its capital is the largest and richest of seven Emirates constituting the UAE. Abu Dhabi has the largest oil reserve in the country and one of the highest GDP per capita in the world (Al Khaleej Times, 2013). The rapid economic development financed by oil revenues, coupled with a shortage of supply of local manpower, forced the UAE to revert to foreign workers to support and sustain this rapid growth (Randeree, 2009). Initially foreign labours from the Indian subcontinent were imported to fulfill this role. Over time, with the rapid growth of other economic sector besides oil and gas, including banking, construction, services, tourism, manufacturing and others, the number of professional white collar expatriates fulfilling increasing demand for technical, operational, and managerial roles showed a sharp growth. At recent estimates, the total UAE population is around 8.3 Million in 2010; UAE nationals represent slightly less than 12% of the total population (National Bureau of Statistics, 2011). The other 88% of the population are migrant workers and professional expatriates from over 180 different nationalities (UN Human Rights Council, 22 February 2013). As such, the UAE displays highly unusual characteristics in terms of its population mix, labour force composition, and human and economic development characteristics (Madichie et al., 2013). In this eclectic mosaic of a population, where nationals are considered a minority in their own country, managing inherently complex public healthcare systems is even more challenging as those different demographic groups have different, sometimes conflicting needs and expectations for health services.

This chapter examines the strategic environment of health care provision in the UAE and the Emirate of Abu Dhabi. This environment includes UAE’s geography, its population, its history and its political, economic and social culture. This chapter sheds light on those elements which influence Abu Dhabi’s healthcare systems in many respects. It starts by
providing general information about the UAE including its geography and its economy. It then proceeds to give more details of the UAE population and its ethnic composition. Given the importance of understanding the unique characteristics of the UAE labour market, the following sections discuss the labour market segmentation and issues relating to the nationalization of the workforce or ‘Emiratisation’. An overview of the UAE’s political system is presented afterwards. Following the overview of the UAE, a detailed outlook about the Emirate of Abu Dhabi is presented in the following sections including its population, economy, social system, and political and public administration system. The final section gives a brief outlook about the health status of the UAE population.

3.2 Overview of the UAE

The United Arab Emirates (UAE) is a member of the Gulf Cooperation Council (GCC) along with Saudi Arabia, Kuwait, Bahrain, Qatar, and Oman. The UAE is a relatively young federation of seven distinct Emirates that came to existence under the leadership of late Sheikh Zayed bin Sultan Al Nahyan following Britain’s 1968 announcement of its decision to withdraw from its colonial holdings in the east of Suez over the next three years (Suleiman and Hayat, 2011). On the second of December 1971, six of Emirates - Abu Dhabi, Ajman, Al Fujayrah, Sharjah, Dubai, and Umm al Quwain - merged to form the United Arab Emirates. They were joined in 1972 by the Emirate of Ras al Khaimah (Davidson, 2009).

Just 50 years ago, the region where the United Arab Emirates (UAE) is located had very limited economic activity, with pearl fishing and some trading activities constituting the main source of income for its small population. The UAE was sparsely populated with low physical and human development indices. Infrastructure was poor; there were only a few roads, hospitals, trained professionals, and education levels were low (Nyarko, 2010). The pearl trade took a beating following the economic depression and the Wall Street crash of 1929, and later with the introduction of Japanese cultured pearls (Nyarko, 2010, UAE Yearbook, 2013). The area changed tremendously with the discovery of oil in the late 1950s and early 1960s. As revenues began to grow, so the pace of development in other areas of the economy began to accelerate (UAE Yearbook, 2013). Through the discovery of oil, the UAE put itself on the world map. The UAE is now a central hub for business development in the eastern hemisphere, and is one of the major countries on the international economic playing field (Nyarko, 2010, Mosaad and Younis, 2014). With 10 per cent of the currently known world reserves of crude oil located in UAE, and a booming economy, the UAE has become a major economic force—be it in tourism, investments
through its massive sovereign wealth funds, or large companies such as Dubai Ports (Nyarko, 2010). The UAE in terms of its open economy and the diversity of its population is considered one of the most liberal and modern countries in the Persian Gulf (The Chronicle of Higher Education, 2014).

### 3.3 Geography

The UAE is situated in the heart of the Arab Gulf. It is bordered from the North and the North West by the Gulf and from the West by Qatar and the Kingdom of Saudi Arabia and from the South by the Sultanate of Oman and the Kingdom of Saudi Arabia and from the East by the Gulf of Oman and the Sultanate of Oman (Figure 4). It occupies an area of 83,600 sq. km. The coastline overlooking the Southern coasts of the Arab Gulf extends over 644 Km; the coastline of the seventh Emirate, Al Fujairah, extends along the coast of Oman for 90 km. The UAE has a tropical desert climate with very little annual rainfall.

![Figure 4 - Map of the UAE](www.aidcin.com)

### 3.4 UAE Economy

“From its very humble beginnings some half a century ago, the UAE is currently one of the most dynamic economies in the world” Nyarko (2010: 4). The UAE is frequently featured in the news as housing the world’s tallest building, Burj Khalifa, its impressive museums development including Louvre and Guggenheim, its Formula One circuit, indoor ski slopes, and many other eye-catching flagship projects. The high oil revenues of the UAE and its moderate foreign policy stance have allowed the UAE to play a vital role in the
The success of the UAE is mainly attributable to the political stability of the country and the visionary leadership of its leaders (bin Khirbash, 2005). Suleiman and Hayat (2011: 106) attribute this vision to a myriad of strategies working together “The vision is that of breaking down the barriers to the operations of the market, openness, and competition. The strategy is one of economic diversification, and regional and international economic and financial integration”.

Totaling more than US$375 Million in 2012, the UAE economy is the second biggest in the Arab world, after Saudi Arabia, and accounts for more than a quarter of the gross domestic product (GDP) of the GCC (UAE Yearbook, 2013).

According to IMF estimates, the GDP of the UAE grew almost eight fold between 1990 and 2013 from US$49 Billion to US$396 (IMF, 2014). The economy of the UAE showed relatively consistent growth between the years 2000 and 2008 (Figure 6). In 2008-2009, the confluence of falling oil prices, collapsing real estate prices, and the international banking crisis hit the UAE especially hard. Dubai lacked sufficient cash to meet its debt obligations, prompting global concern about its solvency. The UAE Central Bank and Abu Dhabi-based banks bought the largest shares of Dubai’s major investments, in addition Dubai received a US$10 Billion loan from the Emirate of Abu Dhabi to meet its short term debt obligations (www.cia.gov, 2014). However driven by continuing diversification efforts that paved the way for strong performance in trade, financial services, tourism, real estate, logistics and manufacturing, the UAE economy was able to recover in 2011. The GDP growth showed a healthy 4% increase in 2012 and 2013 (Figure 5).

Figure 5 - UAE GDP Growth (source IMF World Economic Outlook, April 2014)

The UAE's strategic plan for the next few years focused on diversification especially in the tourism sector (contributing to 14% of the GDP in 2012), transport and logistics (15% of GDP), real estate (10% of GDP) and banking (7% of GDP) (UAE Yearbook, 2013). In
addition to economic diversification, the UAE government is focusing on creating more opportunities for nationals through improved education and increased private sector employment.

For more than three decades, oil and global finance drove the UAE’s economy. Oil and gas accounted for 42 per cent of the UAE’s GDP in 2012, with Abu Dhabi holding well over 90 per cent of the country’s reserves (UAE Yearbook, 2013). In 2012, hydrocarbon export revenues were $118 billion according to the International Monetary Fund (IMF), up from approximately $75 billion in 2010. Overall, the hydrocarbon economy accounts for approximately 80% of government revenue and more than half of the country's goods exports (E.I.A, 2013). The UAE is both a major exporter and consumer of petroleum and petroleum products (Figure 6). The EIA estimates that the UAE exported more than 2.5 million barrels per day of crude oil in 2012, with the vast majority going to markets in Asia. In addition to being a major global petroleum exporter, the UAE domestic market relies heavily on petroleum and petroleum products to meet energy demand. Most of the UAE's petroleum imports are of residual fuel oil, with limited imports of motor gasoline and diesel fuel. When it comes to natural gas reserves, the UAE holds the seventh-largest proved reserves of natural gas in the world, at just over 215 trillion cubic feet (E.I.A, 2013). The UAE's natural gas has a relatively high sulfur content that makes it highly corrosive and difficult to process. The UAE became a net importer of natural gas in 2008.

Figure 6 - UAE supply and consumption of petroleum products 2003-2012

The UAE is making notable progress in diversifying its economy through tourism, trade, and manufacturing and technology. Investments in non-energy sectors continue to provide
the UAE with insurance against oil price declines and global economic stagnation (UAE Yearbook, 2013). However, in the short term, oil, natural gas, and associated industries will continue to account for the majority of economic activity in the seven emirates (E.I.A, 2013).

3.5 Demographic and Ethnic Composition

Many of the current Emirati population living within the present-day borders of the UAE are descendants of Bedouin tribes, organized into a number of independent Emirates. Most of the those Emirates have been ruled by the same families since 1800s until present times (Nyarko, 2010, Davidson, 2009). The population of the region was relatively small until the 1950s, up to that point, the principal economic activities were pearl trading and general trading of merchandise. The population of the UAE has consistently increased since the discovery of oil in the late 1950s and the formation of the federation in 1971. Driven by both natural growth (births minus deaths) and net migration, the UAE population rose from 500,000 in 1971 to 8.4 million in 2010 (ESCWA, 2012). The UAE has tracked its way up the United Nations’ Human Development Index (HDI) which assesses long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living. UAE’s HDI value for 2012 is 0.818 - in the very high human development category - positioning the country at 41 out of 187 countries and territories, ranking second amongst the Arab States after Qatar (UNDP, 2013).

Similar to other oil-rich GCC countries, the UAE has, over the past four decades, heavily relied on foreign workers to build its basic infrastructure and facilitate economic growth (Al-Waqfi and Forstenlechner, 2013). The huge influx of foreign workers to compensate for the shortage in local workforce, contributed to a massive population growth in the UAE. Expatriates represent 88% of the UAE population and account for 85% to 90% of its labour market. Nationals on the other hand, represent 12% of total the population, they make up only 10 to 15 percent of the labour market (National Bureau of Statistics, 2009, National Bureau of Statistics, 2011). Although the presence of expatriate workforce has and continues to be indispensable to sustain economic growth in the UAE, the economic, political, social, and cultural cost of having this workforce should be taken into account (The Emirates Center for Strategic Studies and Research, 2009). According to analysts, this rather unique, ethnically diverse population brought forward important challenges including demographic imbalance, labour market segmentation, and raising unemployment between UAE Nationals.
Dr. Abdel Khaleq Abdullah of United Arab University argues that economic development in the UAE is happening at a rapid pace and the booming economic growth is outpacing the demand of the small population of the UAE. This situation has created an imbalance between the two variants, economic development on one hand, and demographic structure on the other hand (The Emirates Center for Strategic Studies and Research, 2009). Therefore, although the impressive economic development placed the UAE as the second largest economy in the Arab world and allowed the majority of UAE Nationals to enjoy high standards of living, this came at a high social cost to the country, creating an imbalanced demographic structure that potentially threatens the social fabric of the society (The Emirates Center for Strategic Studies and Research, 2009).

Moreover, the huge influx of expatriate workers created a duality in the UAE labour market. According to Abdalla et al., (2010), this market is believed to be highly segmented based on sectors (public versus private) and nationality (UAE nationals versus non-nationals). The vast majority of UAE nationals are employed in the public sector. Public sector employment is considered the primary way through which oil wealth is distributed amongst national citizens (Forstenlechner and Rutledge, 2010), and a unique feature of the ‘social contract’. The big disparity in wages and benefits levels between private and public sectors led to a situation where more than 90% of the national workforce is employed in the public sector, coupled with a severe under-representation of nationals in the private sector. However, with the near saturation of the public sector, national unemployment is on the raise. The latest estimates from the UAE labour force survey in 2009 indicated unemployment rates amongst the national population at 14% (National Bureau of Statistics, 2009).

### 3.5.1 Population Demographic Composition

The constant mobility of migrant workers renders obtaining accurate demographic statistics for the GCC region in general, and the UAE in particular often very challenging. Randree (2009) argues that data for the region’s demographic statistics are still rather fragmented and often contradictory depending on the sources utilized (Randeree, 2009). In order to better understand the demographic composition of the UAE population, it is important to look at the different groups displaying similar characteristics within that population. As it stands, the UAE population can be divided into three demographic groups; UAE nationals (NATS), non-nationals skilled professionals (NNSP), and non-national unskilled workers (NNUW). According to the National Bureau of Statistics data for 2010 (Table 4), UAE nationals account for just under one million (947,947),
representing slightly less than 12% of the total UAE population (National Bureau of Statistics, 2011). The non-nationals or expatriates account for 7.3 million or 88% of the population. Males outnumber women by around three to one, due to the migration flow of working-age men.

Table 4 - UAE Population Distribution by Gender and Nationality

<table>
<thead>
<tr>
<th>Gender</th>
<th>UAE Nationals (000)s</th>
<th>Non-Nationals (000)s</th>
<th>Total (000)s</th>
<th>Percentage Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>479</td>
<td>5683</td>
<td>6162</td>
<td>74.6%</td>
</tr>
<tr>
<td>Female</td>
<td>469</td>
<td>1633</td>
<td>2102</td>
<td>25.4%</td>
</tr>
<tr>
<td>Total</td>
<td>948</td>
<td>7316</td>
<td>8264</td>
<td>11.5% 88.5%</td>
</tr>
</tbody>
</table>

Source: (National Bureau of Statistics, 2011)

The NNSP comprise the skilled technical and professional expatriates working predominately in national and multinational private sector corporations, in addition to occupying some positions in the federal and local public sector agencies. The NNUW comprise the low-income unskilled and semi-skilled foreign workers. This group is predominantly composed of male expatriate workers of Asian origins predominately between the ages of 21 and 40. According the National Human Resource Development and Employment Authority (TANMIA), foreign workers account for 3.8 million in 2010, 3 million or 79% are unskilled and semi-skilled (NNUW) and 21% are skilled (NNSP).

3.5.2 Ethnic Composition

The expansion of the oil industry in the last four decades in the United Arab Emirates brought with it rapid economic growth which, at the same time, resulted in a heavy reliance on foreign expertise and labour. This heavy reliance on expatriates coming from different cultural groups and ethnic backgrounds placed the UAE amongst the most ethnically diverse nations and led to a diversified workforce in organisations (Suliman and Moradkhan, 2013). People from all over the world, including unskilled, low, and semi-skilled workers come to work in the United Arab Emirates. The country has a small indigenous population, with foreign labour making up 90 per cent of its working population (Muiagai, 2010). Foreign workers are mostly employed in labour intensive sectors, such as the construction industry, and in other service sectors as taxi drivers, security guards, restaurant workers, cleaners, lower-end hotel employees and domestic workers. Migrant workers account for over 170 different nationalities and are governed by the sponsorship system known as kafala (UN Human Rights Council, 22 February 2013) whereby all unskilled laborers are required to have an in-country sponsor, usually their employer, who is responsible for their visa and legal status. Among foreign nationals,
Indians constitute the largest group (29.2 per cent), followed by Pakistanis (20.8 per cent) and Bangladeshis (8.3 per cent). Members of other Asian communities, including China, the Philippines, Thailand, Korea, Afghanistan and Iran make up approximately 16.6 per cent of the total population. Expatriates from Europe, Australia, North Africa, Africa and Latin America make up 8.3 per cent of the overall population (Muigai, 2010). The UAE is therefore a unique country where non-nationals constitute the vast majority of the population and where nationals represent a minority in their own country. The influx of foreign workers, which has been supported by the government to satisfy the demands of a fast-growing economy in the last three decades, has deeply modified the demographic balance within society. “With more than 180 nationalities represented on its soil, the United Arab Emirates has undoubtedly become one of the most culturally diverse countries on earth” (Muigai, 2010: 5). Nyarko (2010: 9) argues that “a major concern reported by political is the stability of a society where the majority of the residents lack basic citizenship rights and who are also on the bottom of the economic ladder”. Analysts further foresee that this group could become the source of political agitation in the future (Davidson, 2009, Nyarko, 2010).

3.5.3 UAE Population Growth and Demographic Indicators

Characterised by high natural and growth and high net migration, UAE was ranked sixth in the world in annual population growth in 2009 (Blair and Sharif, 2012). Table 5 provides a range of demographic indicators for the UAE. The population has steadily grown since 1980 at an average rate of 5.6%. The period between 2005 and 2010 has shown the highest increase in population at 14.21% (Figure 7) mainly driven by the increase in economic activity and the high influx of expatriates and migrant workers during this period. The population growth rate is projected to gradually decrease to reach 1.43% in 2030. Females represents a third of the UAE population, this gender imbalance is largely due to the high percentage of male migrant workers within the population. According to the United Nations, 2012 world population prospects, life expectancy at birth in the UAE has gained 7.2 years from the period 1980-1985 to the period 2005-2010 increasing from 68.7 years to 75.9 years. It is projected to reach 78.5 years in 2020. The infant mortality rate decreased from 29.6 infant deaths per 1,000 live births in 1980-1985 to 6.9 infant deaths per 1,000 live births in 2005-2010. It is projected to continue its downwards trend in 2020 and beyond. Fertility rate on the other hand decreased from 5.23 children per women in 1980-1985 to 1.97 children per women in 2005-2010. Declining birth rates are attributed to urbanisation, delayed marriage, changing attitudes about family size, and increased
education and work opportunities for women (Health Authority Abu Dhabi, 2013). Fertility rate is expected to decline further to 1.66 in 2020 (ESCWA, 2012).

Table 5 - Demographic indicators for UAE 1980-2020

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</thead>
<tbody>
<tr>
<td>% females</td>
<td>30</td>
<td>35</td>
<td>34</td>
<td>33</td>
<td>32</td>
<td>32</td>
<td>29</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>0-14 years %</td>
<td>28</td>
<td>31.8</td>
<td>31.3</td>
<td>26.8</td>
<td>25.4</td>
<td>20.1</td>
<td>13.9</td>
<td>16.1</td>
<td>16.8</td>
</tr>
<tr>
<td>65+ years %</td>
<td>1.3</td>
<td>1.3</td>
<td>1.1</td>
<td>1.0</td>
<td>0.8</td>
<td>0.3</td>
<td>0.5</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Life expectancyᵃ</td>
<td>68.7</td>
<td>70.7</td>
<td>72.2</td>
<td>73.5</td>
<td>74.8</td>
<td>75.9</td>
<td>76.7</td>
<td>77.6</td>
<td>78.5</td>
</tr>
<tr>
<td>Infant Mortality rateᵃ</td>
<td>29.6</td>
<td>21.7</td>
<td>16.5</td>
<td>12.4</td>
<td>9.2</td>
<td>6.9</td>
<td>5.7</td>
<td>4.9</td>
<td>4.3</td>
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* Projections (medium variant)
a: compound rate of growth over the previous five years

Figure 7 - Population growth UAE 1980-2030 (ESCWA, 2012)

According to the latest UN world population reports published in 2012, the population pyramid for the UAE shows an unbalanced age-sex structure (Figure 8) due to the high immigration rates and reliance on foreign labour (ESCWA, 2012).

Figure 8 - Population Pyramid of the UAE, 2010 (ESCWA, 2012)
The UAE has a relatively young population, however it is predicted that within the next 25 years, the population will start aging and there will be a significant increase in number of elderly and decrease in youth. The proportion of the population under 15 years of age has been decreasing since 1990 and is projected to continue this downward trend to the year 2050. At the same time, the proportion of the working-age group (15-64) has been increasing since 1990, where it rose from 68.0 per cent to reach 85.8 per cent in 2010. It is projected to reach a peak of 86.2 per cent in 2030 after which it will start a downward trend. The proportion of the elderly (65+) population declined from 1.3 per cent in 1980 to 0.3 per cent in 2010. Projections show that the proportion of the elderly (65+) population will start an upward trend afterwards and will reach 24.6 per cent in 2050 (Figure 9).

Figure 9 - Population Pyramid of the UAE, 2050 (ESCWA, 2012)

3.5.4 UAE Labour Market

The UAE has been successful in attracting cheap labour from the Indian sub-continent along with western knowledge and human capital to build its basic infrastructure and support its economic development. To do so, the UAE adopted liberal immigration policies which allowed the importation of a large number of workers in the country (Al-Waqfi and Forstenlechner, 2013). Immigration and labour policies were based on the conscious decision to allow large influx of labour into the country, albeit on short term residency and without any prospects of citizenship. Labour laws were not formulated to cater for a permanent workforce (Forstenlechner et al., 2011). The labour policy with regard to foreign workers in the UAE and other GCC countries follow the ‘guest worker’ or ‘contract worker’ model, where foreign workers are hired based on temporary contracts and are concentrated in jobs and economic sectors where local skills and expertise are
lacking or where work is unattractive to nationals for various reasons (Abdalla et al., 2010). Expatriate workers are admitted in the UAE through an employment visa, they are granted a two year renewable residency permit. Employment visas are typically granted to expatriates below the age of 60 years. Employment visas for expatriate personnel exceeding 60 years are granted on a case by case basis, usually for senior level executives and specialized consultants; such visas are renewed on annual basis. The ‘laisser faire’ (Al-Ali, 2008) or ‘business friendly’ (Forstenlechner et al., 2011) approach to labour laws, characterised by no minimum wage requirement, no trade unions, and the ability to easily recruit and lay-off staff, has facilitated the influx of expatriate workers to the UAE from the 1960s to date. Those labour policies created a system whereby employers heavily rely on transient, relatively cheap expatriate labour, and operate in a legal framework where employment relationships are largely contractual, effectively giving employers virtually unlimited rights (Al-Waqfi and Forstenlechner, 2012: 621).

For UAE nationals seeking a working environment with job security and strong employee rights (Al-Waqfi and Forstenlechner, 2012), the private sector would clearly not constitute a viable first choice option. Forstenlechner and Rutledge (2010) estimate that less than 1.3% of the UAE nationals’ labour force is employed in the private sector. The public sector, on the other hand, offers clear advantages and benefits for UAE nationals compared to the private sector. Such benefits considered part of the ‘social contract’ referred to below, include secure employment, higher salaries, competitive benefits, generous retirement plans, coupled with the perceived prestige and pride associated with a government job (Forstenlechner and Rutledge, 2010). Those factors make the public sector the employment of choice for the vast majority of UAE nationals job seekers, with more than 90 percent of all employed UAE nationals employed in the public sector (National Bureau of Statistics, 2009).

3.5.4.1 Social Contract
According to Forstenlechner and Rutledge (2010: 38), the provision of well-remunerated and relatively undemanding public sector job to their citizens, is considered the primary way through which the ruling elites in the GCC region distributed the oil wealth amongst their citizens. Highly paid jobs in the public sector available for nationals are therefore considered as a primary transmission mechanism for what is known as ‘social contract’. A job in the public sector provides a secure employment with salary several times higher than the private sector, and comes with very generous benefits including shorter working hours and considerable pension packages. Abdalla et al., (2010) estimate that the gap between the
private sector and the public sector wages is around 68 per cent in favour of public sector workers. This has led to a situation in which UAE nationals prefer to remain unemployed, and are even prepared to wait many years until they obtain a job in the public sector (Abdalla et al., 2010, Al-Waqfi and Forstenlechner, 2012). The findings of a recent study on newly graduated UAE nationals indicated their higher preference for a career in the public sector. 66% of Emirati youth prefer to work for the government, while only 10% would prefer to start their own business, and less than 8% would consider a job in the private sector (Gallup, 2009). Finally, according to Al-Waqfi and Forstenlechner (2012), this preference of Emirati youth for public sector employment comes with a strong sense of entitlement to such jobs and the benefits levels associated with them, reinforcing even more the deeply rooted idea of social contract and its implication. “A career in this environment is viewed as an entitlement and a service to be expected from the government and others in one’s social network as opposed to a project of the self …and a self-directed attitude towards career management” (Briscoe et al., 2006) as quoted in (Al-Waqfi and Forstenlechner, 2012).

Another form of the social contract’s transmission mechanism is manifested by the opportunities for nationals to open their own private business and employ relatively cheap expatriates labour by sponsoring their work visa through a system known as kafala without any form of taxation. Nationals have therefore benefited from this system and have little or no incentive to employ UAE nationals whose command a much higher salaries and benefits (Forstenlechner and Rutledge, 2010). However, with the growing number of young UAE nationals seeking employment in an already saturated public sector, the provision of public sector jobs to all nationals became impossible. Moreover, apart from its negative impact on the productivity and employability of individual citizens, the dominance of public sector employment of citizens is seen as a major budgetary burden and a hindrance to real growth and economic diversification (Shaban et al., 1995).

According to Forstenlechner and Rutledge (2010), the factors above have created a highly distorted labour market. In some respect, this market is very rigid with pronounced differences in wage, benefits, and working conditions between expatriates and nationals. In other aspects, it is very flexible with a laissez faire approach and employment laws allowing easy hiring and firing of expatriate employees. Not only that, those autonomous factors relating to the labour market mechanisms coupled with the social attitudes and expectations from different societal segments, led to a pronounced duality in the UAE labour market (Abdalla et al., 2010).
3.5.4.2 Segmentation of the Labour Market

The high reliance on foreign workers coupled with the concentration of local UAE National workers in the public sector created a unique labour market situation (Al-Waqfi and Forstenlechner, 2013, Abdalla et al., 2010). Abdalla et al (2010: 175) used data collected from 1,099 workers as part of the Dubai Labour Market Survey (DLMS) in 2007 to estimate probabilities of employment and wages in the UAE labour market. Results of the study were consistent with the dual labour market theory and indicated that the labour market in the UAE is segmented based on sectors (public versus private) and types of workers (nationals versus non-nationals). Al-Waqfi and Forstenlechner (2012) point that the higher wage levels, favourable working conditions coupled with perceived sense of prestige and false sense of career success associated with public sector employment for UAE nationals lead to a duality in the labour market in the UAE. This duality, according to Al-Waqfi and Forstenlechner (2012), is manifested in the fact that for UAE nationals good jobs are perceived to exist only in the public sector while private sector jobs are viewed as inferior and unattractive.

Data from labour market survey in 2009 (Table 6) clearly indicates the segmentation of the labour market in the UAE. According to this survey, 91% of the UAE nationals are employed in the public sector, whereas the private sector has an overwhelming majority of expatriates. Together the labour market segmentation, its duality, and the overwhelming percentage of UAE nationals considering employment in the public sector as the first and most often only employment option, led to increasing levels of unemployment among UAE nationals. According to labour force 2009 survey, unemployment among UAE nationals rates run at 14%, up from 12% in 2005 (National Bureau of Statistics, 2009). Table 8 below further indicates that unemployment of UAE nationals’ youth (between 20 and 24 years) is even higher at 24%.

Table 6 - UAE Labour Market Composition and Unemployment Rates

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<thead>
<tr>
<th></th>
<th>UAE Nationals (%)</th>
<th>Non-Nationals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Sector*</td>
<td>90.9</td>
<td>18.7</td>
</tr>
<tr>
<td>Private Sector</td>
<td>7.4</td>
<td>64.6</td>
</tr>
<tr>
<td>Others</td>
<td>1.7</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Unemployment Aged 20-24</strong></td>
<td></td>
<td></td>
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<tr>
<td>Unemployment Aged 20-24</td>
<td>23.9</td>
<td>7.6</td>
</tr>
<tr>
<td><strong>Unemployment Aged 25-34</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total unemployment</td>
<td>14.0</td>
<td>2.8</td>
</tr>
</tbody>
</table>

*includes joint and semi-government sectors

According to Forstenlechner and Rutledge (2010) the growing level of national unemployment in the GCC countries and the UAE in particular, remains one of the region’s key domestic policy challenges that calls for an urgent intervention.

### 3.5.5 Emiratisation

One of the greatest challenges focused upon in the literature on labour market in the UAE, is balancing the need for skilled and unskilled expatriates and their vital contribution to the economic development of the UAE, with the importance of supporting and increasing the employment of UAE Nationals (Al Ariss, 2014). The growing levels of national unemployment coupled with the social experience of isolation of UAE nationals in a dynamic and inconsistent expatriate environment (Al-Ali, 2008), and a pronounced labour market segmentation (Abdalla et al., 2010) led to demographic imbalance and heavy distortion of labour force. To address those challenges, the UAE government embarked on a policy of workforce nationalization, known as Emiratisation. According to Al Ali (2008: 368), “Emiratisation as a focused social capital programme, seeks to overcome structural barriers to Emirati employment in organisations, and address social issues rising from citizens entry to the labour market”. Emiratisation programme included initiatives to fast track education reform, implementation of ‘education to employment’ strategies, and providing subsidies to the private sector to employ UAE nationals (Al-Ali, 2008). The UAE government initially implemented the Emiratisation policies through structural reform such as mandating industry based quotas on employing UAE nationals, wage subsidies, charges as well as quotas for expatriate labour, and targets for employing UAE Nationals in both the public and private sectors (Al-Ali, 2008).

According to recent studies, to date Emiratisation policies have been largely unsuccessful especially in attracting nationals to the private sector (Randeree, 2009, Al-Ali, 2008, Forstenlechner and Rutledge, 2010). Those studies quote many reasons for the failure of Emiratisation programmes to realize their objectives including insufficient coercive powers to implement the policy (Al-Ali, 2008), heavy financial burdens leading to less competitive private sector (Forstenlechner and Rutledge, 2010), unrealistic salary expectations from national job seekers leaving little opportunity for profit oriented organisations to match them (Al-Waqfi and Forstenlechner, 2012), gaming, and ineffectiveness of the quota system. Moreover, according to Davidson (2008), the labour nationalization policies acted to generate resentment and distrust between employers and expatriates employees, on the one hand, and their national counterparts, on the other hand.
3.5.5.1 Employment of Nationals in the Public Healthcare Sector

Despite the lack of success in attracting UAE nationals to the private sector, Emiratisation arguably has largely been successful in the public sector organisations, with the majority of organisations in both federal and emirate level reaching their target Emiratisation levels (Al-Ali, 2008). According to Federal Authority for Human Resources, across the board, UAE federal government agencies achieved 57% Emiratisation in 2010, with Federal Ministries exceeding 67% (Federal Authority for Government Human Resources, 2010).

However, even with the relatively high percentage of nationals in the public sector, sectorial differences in Emiratisation within the public sector itself still exist. For example although some ministries such as labour and foreign affairs were able to achieve 98% Emiratisation, the ministry of health is consistently ranked at the bottom with less than 33% Emirati in its workforce (Federal Authority for Government Human Resources, 2010). The number of Emirati physicians is very low; about 10% of physicians are Emirati (SEHA, 2012). Emirati nurses constitute less than 1% of total nursing population estimated at around 8,200 nurses (Brownie, 2013). So in order to address the needs of its growing population, and fill the demand gaps, the UAE has to rely on foreign experts and professionals. A study by McKinsey & Company estimated that up to 80 per cent of medical staff in some hospitals and clinics in the UAE are expatriates and have been trained in more than 50 different countries (Todorova, 2014).

The public healthcare sector has always faced unique challenges when it comes to Emiratisation. According to a recent article published in the National newspaper, “the UAE’s health sector now has world-class facilities, technologies and expertise coming to this country, but one thing is still lacking: home-grown health specialists” (Almazroui, 2014). Two main reasons appear to contribute to the low number of Emirati physicians and nurses: The perceived unattractiveness of the medical profession amongst UAE nationals, and the lack of well-developed medical education and residency programmes in the UAE.

A smaller number of Emirati students are attracted to the medical profession compared to other professions. Healthcare in general has not been perceived as attractive to local talent as other industries such as financial services or oil and gas (Bell, 2014a). A recent report by the Federal Authority for Government Human Resources indicated that most UAE national graduates study in business administration, engineering, IT, and Arts. The study indicated a shortage in other specialisations including accounting and law, with the medical and associated technical specialisations cited amongst the most demanded, and with the most severe shortage in graduates. Only four per cent of Emirati students are studying
medicine and health sciences - against 36 per cent studying business and Information Technology (Salem, 2011). Socio-cultural factors and lower pay compared to other professions appear to be the contributing factors behind the low Emirati representation in healthcare. Despite the usual prestige associated with the medical profession, its social acceptability among Emirati nationals appears to be low. Indeed the conservative nature of the Emirati society makes it socially difficult for young graduates, especially women who constitute more than two thirds of graduates to pursue a career in the medical field where they are expected to work long hours and often night shifts. Un-competitive pay and benefits also appear factors to reduce the attractiveness of the medical profession among young Emirati graduates. A recent report in the National newspaper analysed the reasons why Emirati are not very interested in a medical career. According to the report, most of the doctors interviewed gave almost the same answer: “relatively low income, lack of benefits and promotions, inadequate specialisation and training opportunities inside the country” (Almazroui, 2014).

Second, despite increasing demand for health services and healthcare professionals in the UAE, there are few medical schools in the UAE. With only six universities offering medical studies in the UAE, very limited opportunities for specialization and clinical training, and a severe lack of medical research infrastructure, the UAE higher education system both at federal and the emirates level, in private and public universities alike, still has gaps in terms of providing adequate medical training for its national graduates. Moreover, there are limited opportunities for residents’ training after graduation in UAE; exciting residency programmes are not well developed and offer very limited placement opportunities for non UAE national graduates (Hamdy et al., 2010). Finally, there are no medical boards to oversee and accredit medical specialisations albeit the affiliation with the Arab Board which is regarded to be not well suited to meet local needs.

Both HAAD and SEHA introduced a number of initiatives to promote Emiratisation in the healthcare sector. Example of such initiatives include establishing partnerships with local and regional universities, accreditation of residency programmes, and implementing campaigns aimed at introducing high school graduates to the medical profession and the hospitals. However, it looks like challenges are bigger. Mr. R. Smith, head of healthcare division at PWC, indicated in a recent interview with the National newspaper that: “I am not sure as a region, we realise the size of the problem. Emirati do not see healthcare as an attractive career choice, while expatriates are transitory” (Bell, 2014a).
3.6 UAE Constitution and Political System

The UAE is governed by a federal system founded on 2 December 1971. Since its establishment, the UAE has adopted the Constitution, which declares the main purpose of the establishment of the federation, its objectives and its components on the local and regional levels. The Constitution enumerates public rights, responsibilities and freedoms (IAEA, 2013). The UAE’s Constitution allows a certain flexibility in the distribution of authority between the Federal and Local Governments. It stipulates that the Federation exercises its sovereignty inside the international borders of the member Emirates, while the member Emirates exercise their sovereignty through own local government over all matters for which the Federation does not have competence under this Constitution (Muigai, 2010).

Islam is the official religion and Arabic is the official language. The UAE is not considered by any outside organisation to be a democracy, but is perceived social openness and tolerance, coupled with ample wealth distributed to its citizens, have long rendered the overwhelming bulk of the population apparently satisfied with the political system (Katzman, 2013).

The Federal system of government includes the Federal Supreme Council (FSC), the Council of Ministers (Cabinet), and the Federal National Council (FNC). Furthermore, the traditional ruling system ensures a certain degree of cooperation from the citizens through the open majlis (councils) held by many UAE leaders (Katzman, 2013, Nyarko, 2010).

3.6.1 Federal Supreme Council

The Federal Supreme Council (FSC), which is composed of the UAE President and ruler of Abu Dhabi, H.H. Sheikh Khalifa bin Zayed Al Nahyan and the rulers of each of the six Emirates, is the top policymaking body of the UAE, and is charged with ratification of international treaties and agreements (Constitution, art. 47). The FSC is the highest constitutional authority in the UAE, it is also the highest legislative and executive authority, it draws up the general policies and approves the various federal legislations (IAEA, 2013). By convention, the ruler of the second biggest emirate, Dubai, is the deputy president. The two emirates have effective veto power over FSC decisions (Nyarko, 2010).

3.6.2 The Council of Ministers or the Cabinet

The federal cabinet is the executive authority for the federation. Headed by the Prime Minister, the cabinet is the executive authority for the federation. Under the supreme control of the President and Supreme Council, it manages internal and foreign affairs of the federation, as laid down by the constitution and federal laws. The cabinet consists of the
cabinet’s president and two deputies and 21 ministers. The cabinet has six established committees and eight established councils (www.uaecabinet.ae, 2013).

3.6.3 Federal National Council

The Federal National Council (FNC) has both a legislative and supervisory role under the Constitution. It is responsible for examining all proposed federal legislation. Effectively, the FNC can review, but not enact or veto, federal legislation, and the government frequently accepts the FNC’s legislative recommendations (Katzman, 2013). Prior to 2006, all FNC members were directly appointed by the rulers of the seven Emirates (M’jid, 2010). In late 2006, as part of the first phase of the President’s political empowerment programme and in response to the reform in electoral processes in several Gulf States, half of the FNC forty members were elected by indirect vote through local electoral bodies, with the other 20 FNC seats still appointive. A further development to address the growing reform needs came about in March 2011 when the UAE government expanded the size of the electorate for “selecting” candidates for the FNC from 6,000 to 129,000 (Forstenlechner et al., 2012, Katzman, 2013). With a population of just under one million, half of which is under the age of 18, effectively just under 30% of the UAE population is eligible to vote. This is also coupled with the fact that the powers of the FNC are quite limited (Forstenlechner et al., 2012).

Perhaps inspired by the 2011 Arab spring, and dissatisfied with the slow pace of the reform, on March 2011 a group of 133 UAE intellectuals, businessmen, and students petitioned against the reforms. Petitions demanded primarily more political space, more legislative authority, and a fully elected body for the FNC (Forstenlechner et al., 2012, Katzman, 2013). However, insisting on implementing political opening at a gradual pace, the UAE government was able to put limits to further FNC reform (Katzman, 2013). A number of the activist groups who signed the petition were arrested and some were convicted but later pardoned through presidential pardon (Yasin, 2012). Moreover, even after submitting the petition, many activists realised that “there simply was not much demands or even support for a more representative political structure” (Forstenlechner et al., 2012: 59). In an editorial in a UAE paper (The National), Minister of state for foreign affairs, Anwar Gargash wrote on August 26, 2012, saying that “The UAE’s end goal is not a liberal multiparty system. This model does not correspond with our cultural or historical development” (Gargash, 2012). As an alternative to political reforms, the government has attempted to address the growing demands for accountability and political powers through more public allocations. The government announced US $1.5 Billion infrastructure
development plans in the less affluent northern emirates (WAM, 2011). It also announced the creation of job opportunities in the public sector for more than 6,000 national job seekers, in addition to increasing public allocations and raising pension payment (Forstenlechner et al., 2012).

3.6.4 The Majlis

The existing UAE political environment is often referred to by Emirati as ‘majlis style democracy’ (Khondker, 2011, Forstenlechner et al., 2012). The political environment in which government operated, valued consensus as well as participation, and the traditional form of such participation exist within the context of a ‘majlis’. Hereditary tribal leaders and rulers at different levels of government hold open meetings or courts where people can approach the rulers to seek favours, plead their cases, and discuss developments (Nyarko, 2010, Forstenlechner et al., 2012). In this framework, issues relevant to the community were discussed and debated. Opinions were expressed and the sheikh would take these opinions into consideration prior to taking a decision.

Despite the change in times, a unique aspect of life in the UAE even today and one that is essential to better understand its political system is the way in which the institution of the majlis maintains its relevance (www.uaeinteract.com, 2013). Rulers ascertain the citizens buy-in and ensure a certain degree of social harmony through those majlis (Nyarko, 2010). This is possible because there are currently just under one million citizens, half below the age of 20, and seven ruling families (Forstenlechner et al., 2012). This system was in place before British colonial rule, and remains an important parallel of political participation. It is through this system that unity amongst the seven Emirates was achieved in 1971, and many other social reforms including significant increases in wages of Emirati civil servants were able to see the light (Forstenlechner et al., 2012). Many Emirati believe that such elements of governance have served as a solid foundation in maintaining the unique identity of the country against a backdrop of rapid economic and social changes (www.uaeinteract.com, 2013, UAE Yearbook, 2013).

3.6.5 Future Political Outlook

The shape and extent of future political reforms in the UAE remains unclear. Political analysts argue that UAE leaders consider western-style democracy with multiple political parties and elections would inevitably lead to political instability, aggravate long dormant schisms and divides among tribes and clans, and potentially cause higher threats from Islamist and radicals groups (Katzman, 2013, Gargash, 2012). However, despite criticism, most citizens seem content with the comparatively tolerant and liberal status quo and the
socio-economic reforms underway (Al-Noaimi, 2012). Moreover, despite the fact that the absence of well-developed democratic institutions could cause some vulnerability to current political system (Nyarko, 2010), and concerns about the long-term sustainability of this system, the UAE was able to establish and maintain one of the most growing, politically stable economies in the region over the past two decades.

Whether such economic and social stability can be sustained in the future is unclear. Two main factors seem to suggest that at least for the short to medium term such stability might be achievable; first the UAE is considered a rich oil state, characterised by a highly allocative social system gives the state the power and legitimacy to sustain its regime; second an open economy, coupled with impressive growth and financial performance, secured a major place for the UAE in the international playing field. Scholars such as Gause (1994) argue that oil states in the Gulf were so empowered because of oil rents that they were effectively able to mold and shape powerful social actors. Oil rents decisively shifted the balance of power between state and society in the state’s direction. Robinson (2012) argued that as long as the rents flowed, this political economy produced greatly enhanced regime stability. Compared to other more politically liberal ‘participatory’ gulf states such as Kuwait who has a very protectionist economic policy and is still struggling in diversifying its economy, the UAE described as politically conservative and monarchical has opted for an open, laisser-faire economic approach that encouraged foreign investments and placed itself as a top player in the regional and international economy (Forstenlechner et al., 2012).

Yet against the rosy prospects of economic development and apparent political stability, the UAE does face a number of challenges and vulnerabilities that might pose some risks to its future development. Amongst those challenges are continued over-reliance on foreign workers, with expats representing more than 80% of the population, increasing wealth gap between the emirates, potential federal unrest, in addition to media and internet censorship, and reports of human rights violations (Davidson, 2009). All those outstanding issues, if they remain un-addressed, could hamper the development of the economic development of the country and threaten its longer-term political stability.

3.7 Abu Dhabi Emirate

As highlighted in the previous section, the identifying characteristics of the UAE are open economy, political stability, high economic development, and diverse population with high majority of expatriates. The Emirate of Abu Dhabi, the political capital for the Federation shares those same characteristics with even more pronounced wealth given that it controls
the majority of oil reserves of the UAE. Abu Dhabi is rich in natural resources, and is considered one of the world’s major oil producers. Abu Dhabi enjoys an AA long term sovereign credit rating and is considered by Standard and Poor’s “among the wealthiest economies in the world” with a GDP per capita at US$106,400 in 2012 (SCAD, 2013). Oil is a major source of revenues for the Emirates and explains much of its economic development (Nyarko, 2010). The energy-rich capital accounts for well over 60 per cent of UAE economic output and in 2012 saw GDP grow by an estimated 3.9 per cent (UAE Yearbook, 2013). According to Oil & Gas Journal estimates, the UAE holds the seventh-largest proved reserves of oil in the world at 97.8 billion barrels, with the majority of reserves located in Abu Dhabi (approximately 94% of the UAE's total). The other six Emirates combined account for just 6% of the UAE's crude oil reserves, led by Dubai with approximately 4 billion barrels (UAE Yearbook, 2013). The US Energy Information Administration (EIA) estimates that the UAE holds approximately 6% of the world's proved oil reserves (E.I.A, 2013). With an average daily production of 2.591 million barrels of oil in 2012, oil and gas production contributes to 56.1% of the Emirate’s GDP (SCAD, 2013). Although Abu Dhabi holds the majority of the oil reserves in the country, the other Emirates benefit from the oil revenues through the federal budget, as well as through development grants from Abu Dhabi and employment opportunities through diversification efforts (UAE Yearbook, 2013).

3.8 Abu Dhabi Population

Abu Dhabi is the second largest federal state, population wise, within the United Arab Emirates, with an estimated total population of around 2.33 million in 2012 according to mid-year 2012 population estimate (SCAD, 2013). The population is multi-cultural, diverse and young. Of the total Abu Dhabi Emirate population, 476,722 people (20.4%) are Emirati citizens (SCAD, 2013), of whom around 60% are under the age of 30, and 2.2% are over 65 years of age . Expatriates, or non-resident population is estimated at 1,857,841 people in 2012 and comprise 79.6% of total resident population in Abu Dhabi (SCAD, 2013). Expatriates are overwhelmingly male and of Asian origin and predominantly aged between 20 and 40. More than 71% of the population of Abu Dhabi Emirate are males due to an influx of male migrant workers (SCAD, 2013). In Abu Dhabi fertility is comparable to most developed regions in the world, and mortality remains very low. In 2012, crude birth rate was 14.6 births per 1000 population, and crude death rate was 1.3 deaths per 1000 population (SCAD, 2013). Average life expectancy is relatively high with 78.7 years for females, and 75.2 years for males.
In 2012, the estimated total number of employed persons who are aged 15 and above amounted to 1,577,013 of which 85.3% are males and only 14.7% are females. Only 8.8% of the labour force is Emirati (Health Authority Abu Dhabi, 2013). For those Emirati employees, 86.4% are employed in the Government sector and 5.7% in the private sector (SCAD, 2013). Unemployment rate was about 3.2% in 2012 compared with 2.8% in 2011 estimates. Unemployment rates is significantly higher for females (10.6%) compared to males (1.8%) (SCAD, 2013).

3.9 Abu Dhabi Economy

Following the declaration of the United Arab Emirates’ federation in 1971, Abu Dhabi was declared capital of the UAE. The UAE Constitution provided for two formal layers of government: federal and local (Emirate) levels. The constitution allowed emirate level control over their internal affairs while building a unified federal government and most importantly unifying the defense forces. Article 13 of the 1971 constitution allowed for Emirate-level health and education departments, while article 23 guaranteed that the emirates would continue to manage independently their own hydrocarbon industries (Davidson, 2009). Each of the seven emirates is responsible for regulating the oil industry within their borders, giving them full control over their economic resources. At the same time, each emirate was required to contribute a certain percentage of its oil revenues to the federal budget to ensure a more even distribution of wealth. Effectively, the federal government is wholly dependent on the Emirates’ financial contribution to the federal budget, with a relatively minor contribution from self-generated revenues. In practice only the rich Emirates contributes to the federal budget, with Abu Dhabi contributing 75% of federal budget, and Dubai around 15% (Elhussein, 1991).

According to Statistics Centre Abu Dhabi (SCAD), the GDP estimates in 2012 amounted to US$ 248,390 million. GDP growth in 2012 is estimated at 7.7%, and GDP per capita amounted to US$ 106,400 in 2012 (SCAD, 2013). Oil and petroleum products contribute to around 57% of the GDP, whereas non-oil sectors contribute to 43%. Motivated by an aggressive economic diversification strategy, non-oil sectors have shown consistent growth averaging between 10% and 20% since 2006 with the real estate, trade, and manufacturing sectors leading the way in annual growth (SCAD, 2013). Preliminary estimates for 2013 indicate a lower GDP growth at 4.8% compared to 2012 (Everington, 2014). Whilst the oil and gas sector is showing a narrower growth with a mere 1% increase in 2013 (compared to 7% in 2012) according to SCAD estimates, the non-oil sectors have shown steady growth since 2006, growing by an estimated average rate of 10% in 2013 (Everington,
2014). This data solidifies Abu Dhabi’s strategy of economic diversification as a way to ensure sustainable economic growth in the future.

3.9.1 Abu Dhabi Oil-Based Economy

Abu Dhabi, with the largest oil reserves among the seven emirates, entered the twenty first century armed with ever-increasing oil revenues, well established petrochemical industries, and massive oil-financed investments (Davidson, 2009). The economy in Abu Dhabi is heavily reliant on oil. With a production of 2.8 Million barrels per day, Abu Dhabi, through its ADNOC led consortia, is near the top list of the world largest crude oil producers, ranking eighth in 2012, just behind Iraq (E.I.A, 2013) The likelihood of further major oil discoveries is low, but Abu Dhabi uses enhanced oil recovery (EOR) techniques to increase the extraction rates of the country's mature oil fields and extend the lifespan of the Emirates' existing oil fields. Such techniques helped the UAE to nearly double the proved reserves in Abu Dhabi over the past decade (E.I.A, 2013). At current production rates, it is estimated that the oil reserves of Abu Dhabi should last for almost a hundred years (Nyarko, 2010).

Oil is major source of revenues for the emirate, contributing between one third and half of its GDP, and a much higher percentage of government spending (Nyarko, 2010). However since 2005, Abu Dhabi has targeted non-oil growth in line with its bid to diversify the emirate’s economy and reduce dependence on oil revenue. Initiatives include a plan to increase non-oil exports from 1.7% of GDP in 2012 (SCAD, 2013), to 11% by 2030.

3.9.2 Abu Dhabi Sovereign Wealth Funds

Of equal, if not greater importance to Abu Dhabi’s economy since the 1970s has been the channeling of surplus oil revenues into long term overseas investments (Davidson, 2009). The combined assets of government owned authorities holding those investments is estimated to be in excess of $1 trillion, generating around 10% return per year (Davidson, 2009, Nyarko, 2010). The Abu Dhabi Investment Authority (ADIA) is the main sovereign wealth fund of Abu Dhabi. Holding assets in excess of US$ 770 Billion, ranging from index-linked blue chip investments, to real estate, and investments in emerging markets including south-east Asia, Middle East and Eastern Europe, ADIA is considered one of the world’s largest sovereign funds. According to Sovereign Wealth Institute ranking, ADIA has the second largest sovereign wealth fund in the world after Norway, ahead of Saudi Arabia’s SAMA ranked third, and Kuwait Investment Authority ranked sixth (www.swifinstitute.org, 2014).
Abu Dhabi Investment Council (ADIC), the second major investment arm of Abu Dhabi was established in 2007 as a spin-off from ADIA. With estimated assets holdings at US$90 Billion, ADIC is responsible for the government’s surplus financial resources through a globally diversified investment strategy (www.swifinstiute.org, 2014).

Mubadala is another vehicle created by the government of Abu Dhabi to invest sovereign funds both inside and outside the country. Though smaller in size than ADIA and ADIC, with estimated assets holdings in excess of US$60 Billion (www.swifinstiute.org, 2014), Mubadala’s strategy has focused on building local infrastructure and industrial activities in support of the Emirate’s economic diversification goals. Mubadala’s investments focus on social development as well as infrastructure and other projects designed to connect different sectors of the economy (Nyarko, 2010). Amongst Mubadala’s projects is the flagship development of Cleveland Clinic Abu Dhabi, a 490-bed, specialty clinic and research centre set to open in 2015, a multi-billion campus development for New York University Abu Dhabi, investments in tourism and leisure sectors such as Formula 1 circuit in Yas Island and MGM Grand Abu Dhabi Project, in addition to investments in Aerospace parts, shipbuilding and other activities (www.mubadala.ae).

3.9.3 Abu Dhabi Economic Vision 2030

Led by the desire to diversify Abu Dhabi’s economy away from sole reliance on hydrocarbons, and to support the development of new economic sectors in an orchestrated and planned manner, Abu Dhabi government introduced Abu Dhabi 2030 in 2008. With its comprehensive long-term objectives and priorities, the plan is pioneering not only in Abu Dhabi but in the GCC and the Arab world. It breaks the mold of the usual short and medium term plans and provides a clear roadmap for expansion for the different economic sectors. (Davidson, 2009). The plan has already seen the development of strategic plans for all ranges of economic activities and public services. Premium education, healthcare and infrastructure assets have been identified amongst the nine pillars that will form the architecture of the Emirate’s social, political and economic future (GSEC, 2007, GSEC, 2009). These strategies have played a key role in focusing on the strengthening of a secure and stable society and a dynamic open economy based on pillars such as education, healthcare, enhanced privatization, sustainable development within a transparent regulatory environment (Koornneef et al., 2012).

3.9.4 The Allocative State

Generous social allocations to all citizens have always been a distinctive feature of the social system in Abu Dhabi since the rule of the late Sheikh Zayed bin Sultan Al Nahyan.
Oil surpluses have been channeled to meet the needs of its national citizens from cradle to grave (Davidson, 2009: 128). Allocations fall into three broad categories, direct transfer of wealth and free services such as education, healthcare and heavily subsidized utility bills, low cost and even free housing, and significant employment and business advantages. Another distinctive feature of such allocation concerns the law on foreign ownership. Federal Commercial Companies law of 1984 specifies that companies with foreign investors need to have a national sponsor of Kafil who has a controlling stake of no less than 51% of the company’s capital. Full foreign investment is only allowed within the designated economic export zones. Nyarko (2010:4) maintains that although the foreign ownership policy could be seen as potentially discouraging foreign investment, it gives the UAE nationals a “stake in the advancement of the country, and allows Emirati to acquire skills from foreign business partners”.

According to Davidson (2009), the generous wealth distribution and allocative state has served multiples aims: first it ensured continued connection of all families and tribes to state institutions, second it created a sense of contentment and gratitude towards such a benevolent, traditional monarchy, and finally, it provided means of reducing or even evading pressure for political reforms. With a relatively small national population of less than 480,000 (SCAD, 2013), and ample wealth, such generous social allocations are likely to remain in the near future.

3.10 Political System and Abu Dhabi Government Structure

The Abu Dhabi government was built upon the hybrid foundations of traditional and tribal politics providing some elements of transparency, accountability and separation of powers (Davidson, 2009). The Abu Dhabi Government structure rests upon two main bodies, the Executive Council (EC) and the National Consultative Council (NCC); those bodies are supported by a local judicial system. The Executive Council, which is the governing body, represents the executive branch in Abu Dhabi Emirate. The National Consultative Council (NCC) works as a legislative body that is part of the Abu Dhabi Government’s public legislative authority. The Abu Dhabi Judicial Department (ADJD) was established on June 15, 2007. Abu Dhabi court system has three stages of adjudication and recently gained further independence with the issuance of Law No (23) of 2006 which restricted the influence of executive bodies on the jurisdiction (www.abudhabi.ae, 2014).

Since the 1960s, Abu Dhabi has seen an abundance of councils, authorities, and other formal institutions that have been built to oversee the expansion in Abu Dhabi’s Government services. The Abu Dhabi Executive Council is the emirate’s highest executive
authority; the National Consultative Council provides recommendations and feedback on legislative matter to the executive Council.

3.10.1 Abu Dhabi Executive Council
The Abu Dhabi Executive Council is the most significant institution in the Emirate, and since its inception in 1971, it has continued to be the real engine of development (Davidson, 2009). In many ways, the executive Council is similar to the Council of Ministers and the chairman of the Council is effectively Abu Dhabi’s prime Minister. The Council is responsible for all public spending in the Emirate and has an annual policy agenda that lists the goals of the different departments and sectors. The Council supervises the government departments which are equivalent to ministries and have clearly specified mandates. They administer various areas of activities ranging from economic development to pensions, environment, health, food control, education, culture and heritage, tourism, and urban planning among others. In addition to the Supreme Petroleum Council, three municipalities and three police forces report to the Council. The Executive Council monitors the progress of the government-sponsored projects, the development of services and the improvement of governmental performance in Abu Dhabi (www.abudhabi.ae, 2014).

3.10.2 National Consultative Council (NCC)
Established by Emiri decree in late 1971, the National Consultative Council (NCC). The NCC is a legislative body that is part of the Abu Dhabi Government’s public legislative authority. The NCC is charged with considering draft laws, discussing public subjects, and receiving citizens’ complaints and petitions. The aim of the establishment of NCC by Law No (2) of 1971 was to keep the traditional element of Shura (consultation) alive in the modern administrative structure of the emirate. NCC consists of 60 members who are appointed from among the Abu Dhabi Emirate's main tribes and families (www.abudhabi.ae, 2014). As a consultative council, the NCC usefulness is somewhat questionable given that the Executive Council is not required to consider all of the recommendations its receives (Davidson, 2009).

3.11 Population Health Status
The UAE and the Emirate of Abu Dhabi has the characteristics of both developing country features (high fertility rate, few elderly, strong traditional culture values) and developed country characteristics (high-income economy, urbanized population, high growth rate of people aged 65+ years) (Margolis et al., 2003). High rates of industrialization and
modernization, coupled with affluent financial resources have had significant impact on the health status of Abu Dhabi population. A recent study on the impact of such socioeconomic changes on the health of the population in the UAE found that modernization was correlated with lower fertility and communicable or infectious diseases, but increased the chronic lifestyle related diseases along with the increase in life expectancy. UAE suffers from high rates of obesity and diabetes. A study by the UAE ministry of health in 2009 estimated that more than 70 percent of the UAE population is overweight (Salama, 2009). International Diabetes Federation indicates that in 2012, around 19% of the UAE population suffer from Diabetes (International Diabetes Federation, 2013). Important factors leading to such high prevalence of obesity and diabetes include high percentage of consanguine relationships and intra-familial marriage, elevated genetic risk of diabetes, in addition to lifestyle trend characterised by lack of physical exercise (Mosaad and Younis, 2014).

According to the health statistics published by HAAD, the diseases of circulatory system caused the highest number of deaths in 2012, accounting for 38.8% of all death cases registered in the Abu Dhabi Emirate. External causes of morbidity and mortality and neoplasms are the second and third highest causes of death. Abu Dhabi has one of the highest rates of injuries resulting from road traffic accidents. They account for 10.4% of all deaths and are the leading cause of death amongst young males. Cancer caused 13.9% of all deaths in the Emirate in 2012. The Emirate has high rates of chronic non-communicable diseases related to life style, such as obesity, diabetes, and cardiovascular diseases. Cardiovascular diseases accounted for over a quarter of deaths in 2012. Rates of childhood communicable diseases are very low, due to immunization programmes targeting children aged less than five years. Respiratory infections are the second most common non-life threatening condition in the Emirate accounting for 12.3% of episodes across all healthcare facilities (HAAD, 2013).

### 3.12 Conclusion

The combination of literature and documentary review covering the socio-economic, political, demographic and social aspects of the UAE and Abu Dhabi Emirate presented in this chapter has offered a comprehensive context for the research. The chapter started with an overview of the UAE’s history and its geography. The chapter also discussed the UAE economy with its heavy reliance on hydrocarbon exports, highlighting recent initiatives by the UAE government to achieve wider economic diversification in different sectors such as tourism, manufacturing, and trade. Such strategies have contributed to placing the UAE as
a top player in the regional and international economy. After that particular emphasis was placed on understanding the unique demographic, ethnic and composition of the UAE population where less than 12% of the total population is UAE national, and the other 88 percent is constituted of migrant workers and professional expatriates from over 180 different nationalities. With such an ethnically diverse population, where nationals represent minority in their own country, unique challenges including demographic imbalance, labour market segmentation, and raising unemployment among UAE nationals were discussed. Attempts of the UAE government to increase the participation of the national workforce in the labour market, particularly in the private sector known as ‘Emiratisation’ have contributed to a more pronounced segmentation of the UAE labour market, tipping the balance of UAE national employment heavily towards the public sector. However, despite of the inherent attractiveness of public sector employment for UAE nationals, who consider that a job in the public sector is part of the ‘social contract’, the system failed to attract UAE nationals to the public healthcare profession, which continues to rely heavily on expatriate healthcare professionals. The unique characteristics of the UAE political system which combines a constitutional monarchy with some democratic aspects represented in semi-elected Federal National Council, and a federal government with strong local governments especially in rich emirates including Abu Dhabi and Dubai, allowed the UAE to maintain its political stability and sustain its economic growth.

Abu Dhabi emirate which acts as the political capital for the federation holds the majority of the country’s oil reserves enjoys a strong economy and a healthy GDP growth. Abu Dhabi’s sovereign wealth fund, ADIA is considered the second largest sovereign fund in the world. Generous social allocations to all citizens have always been a distinctive feature of the social system in Abu Dhabi with free education, healthcare, free housing, and significant employment and business advantages provided to all national citizens. Like the rest of the UAE, Abu Dhabi population is characterised by demographic imbalance with UAE nationals representing then less than 20% of the population. Its population suffers from increasingly high rates of non-communicable diseases related to life style, such as obesity, diabetes, and cardiovascular diseases. Over the past eight years, the government of Abu Dhabi has embarked in a series of sweeping reforms to address shortcomings in its public healthcare system. The government has also allocated significant funds to modernize its healthcare facilities. However, despite of notable improvement in many aspects including enacting health insurance laws, improving access, and upgrading medical equipment and medical facilities, major challenges relating in particular to the quality,
productivity, and sustainability of the health workforce remain to be addressed. Those reforms and challenges are addressed in details in the next chapter.
Chapter 4- Public Healthcare System in Abu Dhabi

4.1 Introduction

This chapter examines critically the strategic environment of health care provision in the UAE and the Emirate of Abu Dhabi in order to understand better how Abu Dhabi public healthcare system operates in such an environment. The objective of this review is to provide a rich description of the contextual framework shaping the Abu Dhabi health system. Such contextual framework is important in understanding and analysing the organisational culture of the different constituents of this system, and how certain forces shaping this culture are linked to the bigger context within which those organisations operate.

The chapter presents the background to the public healthcare in Abu Dhabi and the key aspects of the recent large-scale government reform programme in public healthcare in the Emirate. Following the framework suggested by Health Systems in Transition HiT (Boyle, 2011), this chapter examines the Abu Dhabi Healthcare system including the organisation, financing and delivery of health services and the role of the main actors in this system. The chapter starts with describing the organisational structure and institutional framework of Abu Dhabi public healthcare system. This section also provides a detailed account of the reform trajectory that this system went through from 2001 to date. It describes the process, content, and implementation of health care policies. The next section provides a detailed account of the healthcare financing system and an analysis of the public healthcare expenditures. Finally, a brief overview of healthcare regulation is provided before ending with an analysis on the personnel composition and the salient challenges relating to human capital including high physicians and staff turnover, and consistently low employee engagement.

4.2 Health System in the UAE

Healthcare systems operate within an environment of rapid social, economic and technological change. Those systems are also under close scrutiny by planners, regulators, and users of the system (Dickinson and Mannion, 2012). The GCC governments have made substantial investments in healthcare during the past 25 years, and were able to achieve significant progress in healthcare indicators including increased average life expectancy from 72 years in 1990 to 78 years in 2011, and decreased infant mortality from 23 per 1,000 live births in 1990 to 8 in 2011 (W.H.O, 2013). A recent study by McKinsey
& Company (Mourshed et al., 2008) projected an unprecedented rise in demand for healthcare services in the GCC region over the next 20 years. Healthcare expenditures are expected to increase five fold compared to 2008 levels. The study estimated that healthcare spending in the region will reach US$60 Billion in 2025, up from an estimated US$12 Billion in 2008. Mourshed et al. (2008: 1) posit that “no other region in the world faces such rapid growth in demand with simultaneous need to re-align its healthcare systems to be able to treat the disorders of affluence”. The study estimated a 240% increase in treatment demand over the next 20 years with a much steeper increase in cardiovascular and diabetes related treatments. Moreover, to cater for this increasing demand, the study estimated that hospital beds in the region will more than double by 2025, with UAE leading the way with an expected increase of 160%, followed by Saudi Arabia at 145%.

The UAE has emerged as one of the fastest growing healthcare markets in the Middle East and the GCC region. The UAE healthcare sector is one of the most developed in the GCC region after Saudi Arabia with a strong demand for best-in-class healthcare (Schildgen and Tahsili, 2010). The UAE’s health sector has evolved rapidly during the past decade. Healthcare demand has grown significantly along with the population growth; moreover, substantial public and private funding were invested to improve healthcare delivery across the emirates (UAE Yearbook, 2013). Based on the WHO, the estimated total expenditure on health as a percentage of GDP in the UAE in 2012 is around 2.8%, and the per capita expenditure on healthcare is US$1,343 (W.H.O, 2014). The UAE government plays a central role in providing healthcare services and contributes to around 68% of the total healthcare spending in 2012 (W.H.O, 2014). However, with increasing pressure on the public healthcare system, the government is rapidly promoting the involvement of private sector in all areas of medical services ranging from diagnosis to treatment.

According to Boyle (2011), compiling the profiles of health systems poses a number of methodological problems. In many countries, including the UAE, there is relatively little information available on health systems and the impact of reforms. Due to the lack of a uniform data source on Abu Dhabi’s health system, quantitative data on health services are based on a number of different sources, including the World Health Organisation (WHO), National Statistical Office (SCAD), Health Statistics, the Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the author. In addition, due to the lack of any form of published government publications or white papers on healthcare reform in Abu Dhabi, the author relied on information gathered through
primary data sources such as interviews and secondary data in the form of management reports and presentations in order to reconstruct a narrative of healthcare transformation in Abu Dhabi. To complement the analysis a comprehensive review of media coverage was performed on the three English medium daily newspapers published in the UAE, namely ‘The National’, ‘Gulf News’, and ‘Khaleej Times’, in addition to other on-line publication such as ‘uaeinteract.com’ and ‘arabianbusiness.com’. The review covered the period from 2001 to 2014, as this is considered the period where major healthcare reforms in the UAE and in the Emirate of Abu Dhabi in particular.

In order to organise data on health system in Abu Dhabi, the current study largely adopted the framework used by HiTs which are country-based reports published by W.H.O’s European Observatory on Health Systems and Policies. Those reports provide a detailed description of each health care system and of reform and policy initiatives in progress or under development. The HiT health system reviews cover the countries of the WHO European Region as well as some additional OECD countries (European Observatory on Health Systems and Policies, 2015). To facilitate comparison between health systems, HiTs are based on specific templates that are reviewed periodically. Although the current analysis is not intended to provide a detailed and exhaustive HiT review for the Abu Dhabi system, the main components of HiTs templates including organisation and governance, financing, physical and human resources, service provision, and health reforms are used in the current study.

4.3 Organisational Structure

This section provides an overview of how the health care system in Abu Dhabi is organized. It outlines the main participants and their roles and responsibilities. The first section provides a brief summary of the structure of the health care system in Abu Dhabi. The next section outlines how the system has evolved over time followed by a section describing the nature and roles of key organisations. Finally, the last two sections discuss the extent of decentralization in the system and review a range of issues relating to healthcare professionals.

Prior to 2001, the healthcare system in the UAE was regulated and operated at a federal level by the Ministry of Health. The period since 2001 witnessed massive reforms in the healthcare system in the UAE, with the Emirate of Abu Dhabi leading the way. The organisational changes were designed to shift responsibilities away from a federal, centralized system controlled by the Ministry of Health, to a decentralized Emirate run system. The establishment of independent regulator and operator bodies and the passing of
the insurance bill paved the way to a number of healthcare reforms not only across the UAE, but in the GCC region as well.

The health system in Abu Dhabi has strong characteristics of government controlled system, with some elements of liberal, market oriented system. Government controls all aspects of healthcare regulation in both public and private hospitals. It is also the major stakeholder in ‘Daman’, the insurance company which controls more than 30% of the market and has exclusive rights to administer the ‘Basic Insurance Plan’, and the ‘Thiqa’ plan for UAE Nationals (Hamidi et al., 2014). Until recently, public hospitals and primary care units largely provided health services across the Emirate. Interest from the private sector to invest in healthcare began to gain momentum over the past eight years. During this period, the Emirate witnessed increased investments from local and regional players in healthcare facilities and specialty clinics. The same period saw also an increased influx of health insurance providers aiming to capture a share of the ever increasing medical insurance market.

4.3.1 Overview of Public Healthcare System

Abu Dhabi’s health system has undergone some truly impressive transformation in the past thirteen years. Those profound modifications included the introduction and enforcement of tiered mandatory health insurance for all nationals and foreigners in the Emirate; splitting regulation from provision of care, establishing licensing, credentialing, independent accreditation, and inspection procedures across the sector; and forging long-term partnerships with international healthcare industry leaders (such as John Hopkins and Cleveland Clinic) to promote knowledge transfer (Vetter and Boecker, 2012). According to Vetter and Boecker (2012), the impact of the reforms has been remarkable, and Abu Dhabi is being used as a best-practice example in the region. It is difficult to quantify the impact of the reforms, as they do not translate easily into better outcomes, increased patient satisfaction, or efficient medical cost management. However, the one parameter improving steadily is the trust in the system reflected in numerous encouraging customer satisfaction survey results and, more tangibly, in significantly increased private sector investment in the provision of health services (Vetter and Boecker, 2012).

Government, insurers, public and provide providers, and regulators each play an important role in in the Abu Dhabi health care system. In Abu Dhabi, the government finances around 68% of health services through direct government appropriations. As of 2012, the public sector accounts for around 60% of patient activity and provides more than 60% of hospital beds in the Emirate (HAAD, 2013). UAE Nationals, representing 18% of the total
population are provided free comprehensive health coverage through the ‘Thiqa’ programme. Expatriates, who account for around 82% of the total population, are covered through various private insurance plans paid largely by employers, with some out-of-pocket payments. The Abu Dhabi Government provides some level of subsidy to the ‘Basic Insurance Plan’ geared to low income workers. According to HAAD, more than 98% of the population is covered by medical insurance through private sector providers, resulting in most comprehensive coverage in the GCC region (HAAD, 2011). Public health services are provided through 12 public hospitals, and 62 ambulatory and primary healthcare centres.

There are a multitude of players in the Abu Dhabi Healthcare system. The Executive Council (EC) is the ultimate decision making body for key healthcare issues. The General Secretariat of the Executive Council (GSEC) reviews the public policies relating to healthcare and presents them to the EC for approval. Department of Finance (DOF) plays a key role through its influence on reviewing and approving budget for all publicly funded healthcare organisations. The Health Authority Abu Dhabi (HAAD) sets and monitors standards and regulates the healthcare system. Delivery of public healthcare is assured through Abu Dhabi Health Services Company (SEHA) and 12 public hospitals. Finally, the National Health Insurance Company (DAMAN) provides health insurance plans for UAE Nationals and Basic Insurance Plan for low income expats. Table 7 provides a summary of key players in Abu Dhabi Healthcare system.

### Table 7 - Key Players in the current Abu Dhabi Healthcare system

<table>
<thead>
<tr>
<th>EC</th>
<th>Decision making body for key healthcare sector issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSEC</td>
<td>Set Executive Council Policy Agenda and Executive Council Priorities</td>
</tr>
<tr>
<td>DOF</td>
<td>Finances the public healthcare system, approves all budgets</td>
</tr>
<tr>
<td>HAAD</td>
<td>Regulates the healthcare sector (both private and public) and ensures compliance</td>
</tr>
<tr>
<td>SEHA</td>
<td>Provides majority of inpatient services and significant outpatient services</td>
</tr>
<tr>
<td>DAMAN</td>
<td>Provides government funded health insurance services all Emirati (Thiqa), compulsory health insurance for and non-Emirati workers, and optional health insurance coverage for other expats.</td>
</tr>
</tbody>
</table>
Responsibility for healthcare regulation rests with the Chairman of HAAD who is accountable to the Abu Dhabi Executive Council. Leadership in public healthcare delivery is provided by the Managing Director (MD) of SEHA who is accountable to the SEHA Board of Directors that includes representatives from HAAD and the EC.

4.3.2 Historical Background

In the years before the discovery of oil, the health situation in the emirates was poor. Those who could afford it obtained medical treatment abroad; those who could not had to make do with traditional remedies (W.H.O, 2006a). The first ever built hospital in the Emirate of Abu Dhabi dates back to the 1960 when late Sheikh Zayed bin Sultan Al Nahyan, then ruler of Buraimi, invited two North American missionary physicians, Doctors Pat Burwell and Marian Kennedy to set up a clinic in Al Ain. In 1963 their practice expanded into a larger building and became Buraimi’s Oasis Hospital (Davidson, 2009). The motives behind building this clinic was to reduce the high death rates in the community at a time when only half of babies survived, one in three mothers died during childbirth. During that period, malaria, tuberculosis, eye diseases and internal parasites were also rife (Bell, 2013b).

Subsequent to his nomination as ruler of Abu Dhabi in 1966, Sheikh Zayed formed the first Council of Planning in 1967 with a mandate to set up and manage annual budgets and multi-year development plans. One of the Council’s first priorities was to expand the Emirate’s underdeveloped medical and healthcare facilities. Significant budgets were allocated to build new hospitals and improve healthcare access (Davidson, 2009). In 1968, Abu Dhabi Central Hospital, a 200 bed facility was opened to serve Abu Dhabi Island’s needs, this was followed in 1970 by Al Jimi Hospital in Al Ain (Bell, 2013a). Following the formation of the Federation in 1971, and the increased exploitation of the Emirate’s oil reserves, the focus on healthcare increased to serve the needs of the UAE’s growing population which witnessed a threefold growth from around 1 million in 1980 to more than 3 million in the year 2000 (ESCWA, 2012). Healthcare in the Emirate of Abu Dhabi was still primarily delivered through public hospitals managed by the Federal Ministry of Health. Bed capacity was strengthened through Al Jazeera’s 300 bed hospital in 1978, and Al Mafraq hospital in 1983.

Primary Care

The UAE was one of the first countries in the region that adopted primary health care after signing the WHO Alma Ata or ‘Health for All’ declaration and started introducing the
service in 1984. Primary Health centres provided basic medical care in addition to dental care. Other services such as maternal and child health were also provided including: antenatal care, vaccination, and nutrition education. The number of health centres increased gradually to reach 106 centres by the year 2000 distributed in all medical districts (Margolis et al., 2003, W.H.O, 2006a). The focus on primary care was established as one of the strategic priorities of the health system reform in Abu Dhabi. Significant investments were made to increase the number of primary care units and increase access to care for all population even in remote areas.

4.3.3 Reform Trajectory of Abu Dhabi’s Public Health Care System

The reform trajectory of the public healthcare system in the Emirate of Abu Dhabi started in the mid-1990s with the gradual transfer of healthcare regulation and healthcare delivery from the federal Ministry of Health to Abu Dhabi’s General Authority of Health Services (GAHS). During the period extending from 2001 to 2012, massive reforms were introduced in Abu Dhabi’s health system. Starting with the introduction of the insurance bill regulation in 2006, to the re-organisation of medical coverage for UAE nationals through ‘Thiqa’ programme, the enactment of licensing procedures for medical professionals and medical facilities, and the Public Private Partnerships (PPP) with world renowned private providers, those reforms had far reaching effects on shaping the health system in Abu Dhabi. Table 8 shows the major milestones of the Abu Dhabi healthcare system reform trajectory from 2001 to date.

Table 8 - Abu Dhabi Healthcare system reform trajectory

<table>
<thead>
<tr>
<th>Period</th>
<th>Reform Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Creation of General Authority of Health Services (GAHS)</td>
</tr>
<tr>
<td>2004-2006</td>
<td>Transfer of healthcare regulation and delivery from Federal Ministry of Health to GAHS</td>
</tr>
<tr>
<td>2006</td>
<td>Passing of Insurance Regulation Bill for expatriate workers</td>
</tr>
<tr>
<td>2007</td>
<td>Introduction of ‘Thiqa’ medical scheme for UAE Nationals</td>
</tr>
<tr>
<td>2007</td>
<td>Enactment of Law No. 1 of 2007 regarding the formation of HAAD</td>
</tr>
<tr>
<td>2007</td>
<td>Enactment of Emiri Decree No.10 of 2007 regarding the formation of SEHA</td>
</tr>
<tr>
<td>2007-2012</td>
<td>Implementation of new Public Healthcare Model</td>
</tr>
<tr>
<td>2012</td>
<td>Introduction of Clinical Integration model</td>
</tr>
<tr>
<td>2014</td>
<td>Implementation of new Access policy to public hospitals</td>
</tr>
</tbody>
</table>
4.3.3.1 Creation of General Authority of Health Services (GAHS)

The UAE Ministry of Health was established pursuant to Federal Law No. 1 of 1972 to, among other things, license companies and individuals providing healthcare services, build and manage health facilities and regulate various areas of healthcare, including the practice of medicine, dentistry, nursing, pharmaceuticals and laboratories (Watkins, 2013). The Federal Ministry of Health (MOH) regulated, managed, and operated all public healthcare facilities in the UAE until 1999. The sharp increase and wide distribution of the population in UAE following the vast socio-economic development during the last three decade made it imperative for the MOH to seek a more decentralized strategy for providing health services (W.H.O, 2006a). The Emirate of Dubai was the first to administer its own healthcare system through the establishment of the Department of Health and Medical Services (DHMS) in 1973 which initially focused exclusively on health service delivery (www.dha.gov.ae, 2014). Article 36 of the Council of Ministers Order No (11) of 1989 concerning the organisational structure of the ministry stipulated the formation of nine medical districts across Abu Dhabi and the Northern Emirates with certain level of administrative and operational independence (W.H.O, 2006a); this was considered the first step towards the decentralization of the health system in the UAE.

The Emirate of Abu Dhabi began planning to establish its own healthcare system since the mid-1990s. At that time, Abu Dhabi Emirate had five hospitals managed and operated by MOH; Central Hospital, Al Jazeera hospital, Mafraq Hospital, Al Ain Hospital, and Al Gharbia Hospitals. All primary healthcare and preventive health clinics in Abu Dhabi were also managed by MOH. In addition to the hospitals operated by MOH, the Emirate had three hospitals built and funded directly by the government of Abu Dhabi; Sheikh Khalifa Medical Centre (SKMC), Twam Hospital in Al Ain, and Corniche Hospital. SKMC, a 335-bed acute care hospital was commissioned in 2000, and was managed and operated under a four years management agreement with InterHealth Canada. Corniche Hospital, the first specialized maternity hospital in Abu Dhabi opened in 1976 was managed by a British medical provider, United Medical Group.

As a measure to improve healthcare services in Abu Dhabi to match that of its economic growth, and driven by the desire to provide an oversight over the hospitals funded and operated by Abu Dhabi Emirate, particularly SKMC and Twam hospitals, the Abu Dhabi government established the General Authority of Health Services (GAHS) in 2001 under Law No. (8) of 2001. The mandate of GAHS was to oversee all public healthcare institutions in the Emirate of Abu Dhabi. The Emirate of Abu Dhabi was divided into four
healthcare zones, Abu Dhabi City, Al Ain, Middle Region, and Western Region (www.skmc.ae). The Goals of GAHS included:

- Establishment of health care standards in the Emirate
- Management of government hospitals and primary health centres
- Promotion of public awareness of healthcare issues in the community
- Evaluation and directing of contracts awarded to hospital management companies
- Provision of training to national staff
- Planning for future healthcare needs in Abu Dhabi (Wlikie, 2007)

GAHS had a very strong leadership with an implied position of power and authority to implement reform in public healthcare. According to one director in SEHA who has witnessed the creation of GAHS, “this was the golden era for change, budget was not an issue, we had an open cheque to implement any change we deemed necessary however according to staff who lived through this change”. GAHS was based on a culture of excessive power, and policing mentality. By 2005, GAHS took over the management of all hospitals in emirate of Abu Dhabi from the MOH, and transferred all staff working in those hospitals to GAHS. Starting 2005, MOH gradually withdrew from regulating and direct healthcare delivery system in the Emirate of Abu Dhabi. This was replaced by GAHS.

4.3.3.2 Early Challenges

In 2005, the health system in Abu Dhabi was as described by Vetter and Boecker (2012: 106), not any different to what you would expect in one of the fastest growing, and richest economies in the world: “over-administrated and over-funded, yet in-transparent, under-regulated and under-achieving, none-the-wiser for all its historic planning errors and inefficiencies”. GAHS inherited a mediocre health system judged by quality of services and customer experience, but costing the same or more than many of the world’s best health systems. This system was largely viewed by the leadership in the Emirate as stubbornly resistant to change in the face of the complex interrelationships, perceived problems and risks, and the lack of shared strategy among leaders and decision makers (Vetter and Boecker, 2012). The challenges were at different levels:

1- Operational: long waiting times, over-utilization of the system, very weak primary care and referral system.

2- Organisational: centralized authority and decision making especially in procurement and HR matters, with high level of bureaucracy and red-tape. Very limited accountability in the public sector provider administration.

3- Regulatory: Lack of transparent regulatory framework with many gaps in critical areas including licensing and accreditation.
4- Human capital: shortage in qualified health professionals, more than 80% of all healthcare professionals recruited abroad, but also very high turnover rate (16-25% p.a.). Few Emirati nationals interested in pursuing healthcare careers.

5- Lack of trust by health system users leading to increasing number of Emirati patients treated abroad, consuming more than 25% of total healthcare expenditures

6- Very poor clinical documentation, lack of unified records.

7- No reliable information about epidemiology,

8- Dispersed information about true demand and capacity.

9- Lack of clear public health strategy.


One of the first challenges that GAHS had to address was dealing with inconsistent industry standards and the prevalence of unlicensed medical staff in the private sector. “They (the clinics) apply for a secretary or a porter’s visa, then allow that person to work on a medical team” (www.arabianbusiness.com, 2014). GAHS had to work closely with MOH to close those gaps by introducing tighter regulations for the issuance of medical staff visas and revamping procedures for licensing of clinics and hospitals. In March 2007, GAHS outsourced the verification of healthcare workers’ credentials to a private independent firm, IntegraScan in a move to clamp down on unlicensed and fraudulent employees in the emirate’s healthcare sector.

GAHS initial strategy was to introduce a private sector model to the public healthcare system with the idea to gradually privatize the public hospitals through Public Private Partnerships and to move a self-funded, self-sustained system. As put in the words of one its Directors, GAHS created a vision for the future of healthcare in Abu Dhabi in which an “efficiently regulated, predominantly private sector delivers world class healthcare” (www.arabianbusiness.com, 2014).

4.3.3.3 Insurance Regulation Bill

Healthcare used to be free to all, but in 2006 the government introduced charges for expatriates, a move that partly sought to reduce the draw of healthcare on public funds (W.H.O, 2006a). The passing of law No. 23 of 2005- The Abu Dhabi Health Insurance Regulation bill represented a major milestone in the transformation of Abu Dhabi’s healthcare system. This law mandated all employers/sponsors in Abu Dhabi to provide
health insurance for expatriates residing and working in the Emirate of Abu Dhabi. This law was implemented in two phases:

- **Phase 1** - Effective July 1, 2006, the law will be applicable to all local and federal government, quasi-government organisations, and private companies employing over 1000 expatriate staff.
- **Phase 2** - Effective January 1, 2007, all expatriates residing in Abu Dhabi must have health insurance provided by their employer/sponsor (Lloyds Emirates, 2006).

GAHS authorized 18 insurance providers in addition to the national insurance company ‘Daman’. As part of its remit, Daman offered government subsidized ‘basic’ insurance coverage for expat workers with a monthly salary not exceeding AED 4,000, in addition to other ‘enhanced’ insurance products.

The implementation of mandatory insurance law came under fire from government hospitals, which have struggled with the transition to a private healthcare system. Public hospitals witnessed a sudden surge of demand with raising number of patients. In addition, the hospitals’ costing and billing systems were not equipped to deal with the administrative burdens of the new insurance billing and collection requirements. There was also the expectation that Abu Dhabi public hospitals would be able to accommodate the increased patients’ volume without added government funding. In an interview in February 2007, the then acting CEO of Sheikh Khalifa Medical City, expressed his concerns over the impact of the implementation of the insurance bill both on hospital capacity, hospital funding, and payment recovery especially from emergency clients (Bladd, 2007). An additional challenge in the early implementation of the insurance bill was the restrictive nature of the ‘basic’ insurance coverage offered by Daman. The plan was heavily criticized as being highly restrictive, requiring multiple pre-authorization for medical tests, and most importantly excluding basic coverage for preventive screening and care (Bladd, 2007). Few regional insurers include annual screening or check-ups in their plans. Physicians also expressed concerns that this plan would have negative impact on quality of patient care particularly in what they saw as “the loss of preventive care in the transition to private healthcare” (www.arabianbusiness.com, 2007). At the time of major changes to healthcare systems, physicians emphasized the need to include preventive care as a standard element of health plans, and to build a comprehensive primary care infrastructure. In response to those criticisms, GAHS assured that such shortfalls in the basic plan would be addressed through additional government funding. To date progress towards addressing the issue of
loss of preventive medicine, and the over-crowding of public hospitals in the transition to private healthcare delivery model remains largely unresolved.

4.3.3.4 ‘Thiqa’ the medical Coverage Scheme for UAE Nationals

The former model of care in Abu Dhabi did not adequately support self-care, primary care and preventive care. Patients had undirected access to services and specialty care which lead to inappropriate use and, in turn, over-demand of services. On the other hand, while the UAE nationals in Abu Dhabi benefit from free healthcare in public hospitals, many of them travelled abroad searching for high quality treatment or paying out-of-pocket for private facilities in Abu Dhabi, as these were perceived to offer better services and shorter wait time. To reach its goals, HAAD has created a new model for health system that focuses on pro-active checkups and convenient routine follow-up which should help prevent diseases. The priority for the Health Authority and the Executive Council was for UAE nationals to become enrolled under the insurance system to achieve the following goals:

- Allow for patient choice (public or private)
- Drive quality through better information on the health status of the population
- Allow public hospitals to be self-financing through insurance revenues
- Set (financial) incentives for providers and payers to compete for quality and cost
- Screen the entire adult nationals’ population for cardiovascular risk (Sirgi, 2012)

In 2007, the Crown Prince of Abu Dhabi issued Resolution 83 of 2007 directing the Health Authority – Abu Dhabi (HAAD) to launch an initiative offering health insurance for UAE nationals (www.thiqa.ae). Based on that resolution, The Health Authority Abu Dhabi (HAAD) implemented in 2008 a compulsory health cover scheme for nationals, including a health insurance scheme, ‘Thiqa', and a programme for periodic medical examination called ‘Weqaya' which means ‘prevention’ in Arabic. The aim of the Weqaya programme is to screen 95% of the Emirati Nationals for what has been identified as the greatest healthcare challenges; diabetes and cardiovascular diseases. The programme included planning for care pathways, and implementation of targeted behavioral changes both at the personal and population levels. With the implementation of the Thiqa scheme, UAE nationals were given wider choice of seeking treatment and services in both public and private hospitals, in line with benefits schedules legalized by the Abu Dhabi's health authority. The law made it mandatory for all UAE nationals to subscribe to the Thiqa plan,
but the plan was provided free of charge to the 470,000 or so UAE nationals residing in Abu Dhabi.

The move by Abu Dhabi to provide its National population with free medical insurance coverage in both public and private facilities, a first in the GCC region, was seen as positive by many analysts especially when government are seeking to implement a strategy to increase private sector involvement in the healthcare financing and delivery (Mourshed et al., 2008). Through the new plan, it is expected that patients’ volumes for private providers will increase as patients are allowed to pursue reimbursement in private as well as public institutions. Qatar followed the footsteps of Abu Dhabi by issuing its own insurance law No.7 of 2013, providing free medical insurance for its national population and mandating insurance coverage for its expatriate community (Shalah and Waynes, 2014). The Emirate of Dubai was bit slower in issuing its own insurance law. Originally anticipated for release in 2008, the economic crisis of 2008 delayed its enforcement. Dubai passed its own insurance bill in December 2013 with full implementation expected to stretch until 2016. At a Federal UAE level, a draft federal insurance law is being discussed since 2013 with the aim to provide medical insurance coverage for UAE nationals and expatriates across the remaining Emirates (The National, 2013).

4.3.3.5 2007, the year of change: New Public Healthcare Model

In 2007, less than two years after the transfer of all hospitals and medical staff from the MOH to GAHS, a major restructuring of the healthcare system of Abu Dhabi led to splitting GAHS was into two organisations, Health Authority of Abu Dhabi (HAAD), the regulatory body of healthcare in Abu Dhabi, and Abu Dhabi Health Services Company (SEHA), the operator of public healthcare entities. The key objectives of that transformation as highlighted in the Policy Agenda were:

1. Improve quality of care
2. Expand access to services, and promote excellence through free market competition
3. Shift from public to private providers safely and efficiently
4. Implement new financing model through a system of mandatory health insurance (GSEC, 2007)

It was thought that the system would benefit from segregating the regulator and operator roles, which up to that point were’ under dual management and operation by the Federal Ministry of Health and GAHS. As a result, Law No. (1) of 2007 clarified the role of HAAD as “a regulator whose function is to adopt, monitor and enforce internationally recognised quality standards of its healthcare programmes” (www.haad.ae). In effect the
role of HAAD is to set up evidence based protocols and develop structured programmes aimed at hospitals and physicians’ compliance and geared towards measurable results (Mosaad and Younis, 2014). Emiri Decree No. 10 of 2007 mandated SEHA to operate and manage the public health facilities through contracting management services to reputable international healthcare institutions as well as developing the healthcare sector in Abu Dhabi through direct investments (www.skmc.ae).

4.3.3.6 Abu Dhabi Healthcare Vision

In response to the Policy Agenda, HAAD established a vision for Abu Dhabi Health system, ensuring ‘reliable excellence in healthcare’ for the community (www.haad.ae). The HAAD reform strategy evolved along three main pillars, Population, Providers, and Payers (Figure 10). The main elements of the healthcare strategy included a vision of universal comprehensive health coverage for all residents, with freedom to choose their providers; independent and predominantly private providers; and a self-financed health system through mandatory insurance coverage for all residents. Quality driven, ambitious improvement targets, measured and monitored through transparent key performance indicators were set to steer the implementation of this ambitious strategy (HAAD, 2011). HAAD embarked on a series of far reaching reform initiatives to implement this strategy during the period extending between 2008 and 2012.

Figure 10 - Abu Dhabi Healthcare Vision (HAAD, 2011)
4.3.3.7 International Public Private Partnerships

Historically, Abu Dhabi has primarily drawn on international expertise in healthcare by funding overseas treatment for Emirati nationals (referred to as International Patient Care or IPC) with Germany, USA, UK, Singapore and Thailand as top destination for IPC. While this practice proved an appropriate interim solution, the longer term sustainability of this practice was questionable, first in terms of excessive costs involved, and second in terms of missed opportunities to attract the world’s best institutions and healthcare professionals to Abu Dhabi (GSEC, 2008). As a result, establishing partnerships with internationally renowned healthcare institutions was considered as a cornerstone for the implementation of the healthcare reform. During a period of rapid sweeping changes in public administration, the Abu Dhabi Government was advised by a number of consultants and experts that the Public Private Partnership (PPP) model is the way to ensure quick and consistent implementation of planned reforms. Between 2006 and 2010, international providers were invited to manage and operate public facilities not only in the healthcare sector, but in the education sector as well. The PPP model was thought to be the quickest and most reliable method for elevating the quality of care and ensuring hands-on training and knowledge transfer to local staff. The vision was that by the end of the PPP contract, hospitals would be armed with best practices, best systems, and trained personnel so they can self-sustain their operations.

In March 2006, a ten-year agreement was signed between HAAD and John Hopkins Medicine to manage and provide operational oversight of the 469-bed Twam hospital. Later that year, two additional hospitals Corniche and Rahba were added to the agreement with the same provider. In 2007, an agreement was reached Cleveland Clinic, one of the top three hospitals in the United States to manage the 550 bed multi-specialty Sheikh Khalifa Medical Hospital as well as more than 12 specialized out-patients clinics and 9 primary healthcare centres (GSEC, 2008). In the same year, another agreement was signed with VAMED and the Medical University of Vienna to manage and operate Al Ain hospital. In 2007, SEHA also signed an agreement with Bumrungrad International, a top Asian healthcare operator to manage Al Mafraq Hospital. Management agreements with those different providers have some variations, but to a large extent they cover the same basic areas; implementation of management systems, establishment of centres of excellence, training of local medical staff, knowledge transfer in both clinical and operational areas and the promotion of healthcare practice, including laying the groundwork for future medical research at SEHA facilities (SEHA, 2012).
In addition to the above, two partnerships supported by Mubadala Development Company (one of Abu Dhabi’s government investment arms) paved the way for a new model whereby the government funds the full infrastructure and operational costs related to setting up medical facilities, and international providers are invited to manage and operate those facilities. In 2006, Imperial College London Diabetes Centre was invited to set-up a centre in Abu Dhabi that is expected to become the leading resource in diabetes treatment and research in the region. Another agreement was reached in 2006 with Cleveland Clinic to set up a flagship, multi-billion Dollars development of Cleveland clinic Abu Dhabi, a 490-bed, multi-specialty clinic and research centre set to open in 2015.

4.3.3.8 2012: Assessing the Healthcare Reform and Identifying Challenges

By 2012, six years into the implementation of healthcare reform initiatives, major changes were introduced to the Abu Dhabi healthcare system. Considered as the building blocks for a new healthcare infrastructure, this phase laid the foundation for future reforms as depicted in Figure 11. By securing access and universal coverage for all its residents, building infrastructure, investing in systems to capture electronic (e-health) data, and establishing a payment system, Abu Dhabi has built a solid foundation for the future (HAAD, 2013). In term of outcomes, an increase in life expectancy, decline in mortality rates and significant drop in communicable diseases provided tangible evidence that reform was going in the right direction. However as argued by Hurst (2010) it is almost impossible for a set of reforms, no matter how comprehensive and far-reaching to fix all problems with a healthcare system at one go. Hurst (2010) refers to un-intended or un-anticipated consequences of reforms that would call for systematic changes. Moreover, changing consumers’ expectations, changing technology or changing resources are factors that could lead to more reforms, or shift the focus of current reforms in different direction.

In 2012, HAAD engaged consultants to perform a formal assessment of the health sector in Abu Dhabi and review the status of the reform initiatives set as part of the 2007 healthcare vision. Among the pertinent problems cited were increasingly high rates of chronic diseases related to life style such as obesity, diabetes, and cardiovascular diseases, low penetration of good primary care, inconsistent quality of care, and raising costs. Moreover, the realization of the vision of ‘predominantly private providers’ was being questioned through continued reliance on public funding and government subsidies and strong market positioning of public hospitals in healthcare provisioning especially for in-patients treatments.
The implementation of the insurance bill lead to an increase in insurance claims especially amongst ‘Thiqa’ policyholders who were making as much as four times the number of in-patients and out-patients claims compared to the other basic and enhanced policyholders (Hamidi et al., 2014). This lead to an over-utilization of the system which in turn pushed the insurance premiums up, and to overcrowding of medical facilities which had a negative effect on patients waiting time. Finally, with more than 80% of healthcare professionals recruited abroad, a turnover rate of more than 15%, long licensing procedures, and very few Emirati nationals interested in pursuing a medical career, the human resource factor still posed a real challenge for the sustainability of the healthcare sector as a whole.

4.3.3.9 2012-2013: Integration and Focus on Value

From 2012, the government of Abu Dhabi embarked on phase two of the reform (refer to figure 12). Motivated by increasing costs, insufficient capacity and low levels of trust in the system, the focus of phase two was to improve cost and quality. In addition, the aging of the population and the changing lifestyles led to an increase in diseases requiring extensive treatment and care including cancer, and cardiovascular diseases. According to the International Diabetes Federation, the UAE is ranked 15th in the world with prevalence of diabetes of 18.9% of its population (International Diabetes Federation, 2013) and a very high prevalence of asthma and obesity in children.

Seven key themes were identified to drive the health system development during this phase:
1. Improve access to care across an integrated ‘cradle to grave’ continuum of care for individuals.

2. Drive quality and safety and enhance patient experience by tracking and publishing outcomes and processes from healthcare providers and implement a quality assurance framework.

3. Attract, retain, and train workforce with a special focus on Emirati nationals.

4. Create and enhance emergency preparedness planning.

5. Develop wellness and prevention public health approach.

6. Ensure value for money and sustainability of healthcare spend by monitoring utilization, reducing waste, establishing adequate reimbursement levels, ensuring effective management of IPC, and reducing government subsidies.

7. Implement integrated health informatics and E-health initiatives including telemedicine and E-health financing (HAAD analysis)

4.3.3.10 Service Line rationalization and Clinical Integration

Motivated by abundant resources, generous budget, and over ambitious expansion plans, the first phase of healthcare reform in Abu Dhabi saw the creation of specialized service lines usually requiring heavy investment in equipment and human capital such as cardiovascular, orthopedics, or oncology in a number of public and private hospitals sometimes in very near physical proximity, and without consideration to patient threshold volumes. Moursched et al. (2008) argue that patient threshold volume is important for two reasons. First to ensure viable economies for interventions requiring heavy investment in specialized equipment, and second, the outcomes of many procedures are correlated to volumes. Higher volume per physician increases clinical quality due to specialization and the repetitive nature of the interventions (Moursched et al., 2008, Mosaad and Younis, 2014).

It was not sustainable to continue to fund say a cardiovascular centre in every public hospital. The costs were too high, and, in smaller centres, the quality was not up to standards. Therefore, in late 2012, SEHA started restructuring its clinical services delivery model to an integrated population-based service line approach that addresses the needs of a patient throughout the continuum of care whether in-patient or out-patient. ‘Service line’ is used to describe single services grouped together to provide more seamless functioning within a higher-order organisational unit. The components of the new service model include (1) providing basic/standard services in all locations, (2) establishing Centralized Centre of Excellence due to rarity of disease process or complexity of service required,
within a single facility providing multidisciplinary care (eg, pediatric cardiac surgery); and (3) providing regional services on a geographic basis dependent on quality, cost, and access (eg, coronary stenting). The integration strategy was thought to enhance quality of care, improve customer satisfaction, ensure better accountability, and assure stronger operational efficiencies (SEHA, 2012). Initially, seven service lines were identified, and four clinical shared service councils were formed to oversee the implementation of this initiative. Centralization of specialist services was thought to be a more efficient way of delivering healthcare services, while at the same enhancing the quality of care for patients.

Though the principles guiding the service integration initiative were more or less agreed upon by all parties in SEHA, the project was heavily criticized by many stakeholders particularly in hospitals’ leadership. Stakeholders questioned the timing of this initiative and whether the healthcare system had matured enough to enable such a drastic change. They also cited issues concerning the planning for this project, stakeholders’ involvement and engagement, adequacy of resources allocated, and ability of hospitals infrastructure and systems to cater for this change (Zoughbi et al., 2013). Like many projects in Abu Dhabi, this was probably another ‘too quick, too soon’ initiative. It is probably too early to assess the outcomes of this project, but time will tell whether the clinical integration could be one of the solutions to the many health system issues in Abu Dhabi.

4.3.3.11 2014: Capacity and Access Challenges

In 2014, the access challenges to public hospitals became more and more apparent. The increasing population size coupled with the 2007 opening up of public hospitals to both Emirati and expatriate communities, created a pressing capacity issue in public hospitals. Moreover, the lack of well-developed primary care to act as a gatekeeper for the secondary and tertiary care provided in public hospitals aggravated this challenge. Waiting times increased, and complaints especially from Emirati population increased accordingly. In a measure to address this pressing challenge, SEHA took a decision in October 2014 to limit access to a number of public hospitals in Abu Dhabi to the Emirati patients only (Bell, 2014b). Expatriate patients have been forced to find alternative care in private hospitals. This decision was faced with big concerns from the expatriate communities who thought that limiting their access to well established public hospitals in an environment where private healthcare is still developing, and government is still struggling to attract providers who can deliver top quality care, might not be an efficient and just way to address the overcrowding challenges. According to the new policy, access of non-Emirati patients to a number of public hospitals is restricted to emergencies and treatments not available
elsewhere in private hospitals (Bell, 2014b). The impact of the new access policy remains to be seen. Whether the new policy would lead to lower waiting time, better access, and improved services in public hospitals, and whether the private sector would be able to provide quality healthcare services to cater for a growing expatriate community remains to be evaluated by SEHA over the next few years.

4.3.4 Organisational Overview

The public healthcare system in Abu Dhabi is organized around four main pillars; a regulator body, an operator body, publicly owned hospitals, and ambulatory and primary care centres. The current structure was put in place in 2007 as part of Abu Dhabi government initiatives to reform the public health care sector in the Emirate.

4.3.4.1 Healthcare Regulation

Health Authority Abu Dhabi (HAAD) is the regulative body of the Healthcare Sector in the Emirate of Abu Dhabi. HAAD was established on February 6th, 2007 in accordance with law No. (1) of 2007 issued by the President of the UAE. Under this law, HAAD was established as a corporate body under the Executive Council with financial and administrative independence to act as the regulator for all public and private healthcare providers in the Emirate (www.haad.ae). HAAD defines the strategy for the health system, monitors and analyses the health status of the population and performance of the system. It regulates the Healthcare sector through licensing of health professionals, registration of health facilities (both public and private), annual inspections, monitoring complaints, and enforcement. HAAD employed a total of 425 staff in 2012; it is organized around six core business sectors, Public Health and Policy, Health Regulation, Health System Compliance, Health System Financing, International Patient Care (IPC) and Customer Care and Communication (www.haad.ae).

4.3.4.2 Healthcare Delivery

Healthcare delivery in the Emirate of Abu Dhabi is assured through public hospitals and ambulatory and primary care centres. Abu Dhabi Health Services Company (SEHA) manages and provides operational oversight to the public hospitals and primary care centres.

Abu Dhabi Health Services Company (SEHA) was established on 29th December 2007 under Emiri Decree No. (10) of 2007 as an independent public joint stock company fully owned by the Government of Abu Dhabi (www.seha.ae). The corporate name is SEHA means ‘Health’ in Arabic. Founded to manage the curative activities of the public hospitals
and clinics of the Emirate of Abu Dhabi, SEHA owns and operates 12 hospital facilities, 2,644 licensed beds, and 62 Ambulatory and Primary Care Health Clinics (SEHA, 2012). SEHA corporate office employs 262 staff across its four core business areas, Clinical Health Systems services, Clinical Affairs, Acute Care Hospitals, and Facilities and Construction, in addition to support services such as Finance, Procurement, and IT (SEHA, 2012).

**Public Hospitals:** SEHA oversees the operations of 12 hospitals across the Emirate of Abu Dhabi. Three Public hospitals are managed by John Hopkins Medicine under a management agreement with SEHA; Abu Dhabi’s main Medical Centre (Sheikh Khalifa Medical City) is managed by Cleveland Clinic. The rest of the hospitals are managed and operated directly by SEHA. As of 2012, SEHA hospitals employed more than 17,000 full time professional staff across its hospitals. 18.6% of SEHA workforce is comprised of UAE Nationals, whereas 83.4% represent expats from 91 different nationalities. SEHA employs more than 2,600 Physicians (15% of total workforce), and 6,600 nurses (38% of total workforce) across its 12 hospitals (SEHA, 2012). SEHA hospitals command more than 50% of the healthcare market in Abu Dhabi.

Public hospitals have traditionally dominated the delivery of healthcare services across Abu Dhabi, however with the implementation of the insurance bill, and the new Thiqa medical plan for UAE nationals, the market share of private sector especially in outpatient treatments began to increase, suggesting a shift towards an increased private sector contribution. In terms of patients volumes treated as of 2012, SEHA hospitals handled 60% of all inpatients and 40% of outpatients. Private hospitals provide 60% of the outpatient and the non-critical inpatients cases. In terms of bed capacity, SEHA hospitals provide around 60% of total hospital bed capacity in Abu Dhabi (Health Authority Abu Dhabi, 2013).

**4.3.4.3 Ambulatory and Primary Care Centres**

Primary care in Abu Dhabi is provided through 62 ambulatory and primary healthcare clinics operated and managed by SEHA. Primary care centres are intended to provide access to medical services in geographically defined populations, with a particular focus on remote areas with low population density such as in the western region and some parts of the middle region. Public hospitals manage a number of primary healthcare clinics. In addition to those primary care centres managed by hospitals, SEHA created an Ambulatory Healthcare Services Division (AHS) that operates 24 ambulatory and primary healthcare clinics. Seeking to bridge the comprehensive healthcare facilities provided by Government
hospitals and the personalized care and attention given by the private sector, the concept of ambulatory healthcare services is to provide a wide range of treatment and facilities for patients who are not admitted overnight to a hospital. These services are generally available at outpatient clinics, urgent care centres, emergency rooms, ambulatory or same-day surgery centres, diagnostic and imaging centres, primary care centres, community health centres, occupational health centres, mental health clinics, and group practices (SEHA, 2012). Services in ambulatory and primary care clinics are typically provided by GP doctors, practice nurses, and other healthcare professionals. As of 2012, AHS employed 255 doctors, 729 nurses, and 447 paramedical staff (SEHA, 2012).

The organisation of primary care services in Abu Dhabi has improved over recent years as centres benefit from has a high level of physical and economic resources, similar to that seen in developed and mature healthcare systems. However, the primary care system in the UAE in general and Abu Dhabi in particular suffers from structural as well as cultural barriers. The lack a quality governance framework that governs the primary care services, and the existence of small, low quality private providers, coupled with over-utilization and low reimbursement level are but some of the indicators of the quality issues faced by the system. Existing primary care services are largely used as urgent care rather than being based in long-term relationships. Primary care in Abu Dhabi does not play a gatekeeping role in determining access to more specialized, often hospital-based, health care services. Patients in general are either passive, i.e. they wait until something happens until they go to the doctor (Mosaad and Younis, 2014), or do not believe in primary care altogether and prefer going directly to specialists. This may be because their access to primary care services is poor, because they are not aware of how best to use the services available or it may be more convenient for them to attend their local hospital (Boyle, 2011). Moreover, the primary care workforce suffers from a chronic shortage in number and mix of well-trained healthcare professional creating a major obstacle against the development of primary care service in the Emirate.

4.3.4.4 Oversight Agencies

The responsibility of financial oversight of all government, semi-government, and government owned entities in Abu Dhabi lies with the Abu Dhabi Accountability Authority (ADAA). ADAA, established as an independent body in 2008, is primarily responsible for enhancing and promoting transparency and accountability across Abu Dhabi government and public entities. ADAA audits the government of Abu Dhabi consolidated financial reports and examines governmental and public entities’ financial
reports. The authority also reviews performance and risk by examining the efficiency, effectiveness, and economy of the financial and operational activities of subject entities and ensuring compliance with laws, regulations, and governance guidelines (www.adaa.abudhabi.ae). To date, ADAA performed a number of independent audits and reviews on HAAD and SEHA, however such reports are not made public, instead findings and recommendations are reported to the ADAA board and subject entities and necessary corrective actions are taken.

4.3.4.5 Healthcare Professionals and Physicians Organisations

As discussed earlier, Abu Dhabi relies heavily on expatriate human resources. The majority of physicians are recruited from western Anglo countries such US, UK, Canada, and South Africa in addition to neighboring Arab countries such as Egypt, Jordan, Lebanon, and Palestine. Most of the nurses and allied medical professional are recruited from South East Asia with India, Philippines and Pakistan leading the way. All healthcare professionals including physicians and nurses (whether working in public or private hospitals) are required to be licensed by HAAD. The licensing procedure involves a review of credentials and certifications; in addition all applicants are required to pass the HAAD examination for licensure. Licensing procedures are long and can take anywhere between six to nine months for physicians. In 2013, in order to encourage qualified and skilled healthcare professionals to apply for a HAAD license to practice in Abu Dhabi and to ensure that regulations are applied in an efficient and effective manner, HAAD issued a standard for exemption from HAAD examination. Under this standard, healthcare professionals from United States, United Kingdom, Canada, Australia, Ireland, New Zealand, and South Africa are eligible for an exemption from HAAD examination based on equivalency assessment with the respective medical boards and council in those countries (www.haad.ae).

There are very few independent physicians in Abu Dhabi; those in private practices are usually providing medical services in dental and pediatric care. The licensing procedures specify that physicians and healthcare professionals are associated with the health facility they are working for. Except for the few UAE physicians who are allowed to practice in both public and private sector simultaneously, 90% of the physicians are only allowed to practice in their own hospitals. This practice can severely limit the exposure of physicians and consultants especially in specialized fields such as cardiac surgeries, and neo-natal surgeries.
Similar to most GCC countries, the UAE and Abu Dhabi have a very weak civil society. Physicians’ organisations, associations, or syndicates are non-existent. In a system strongly based on centralized state control in all aspects of civic life including political, financial, and economic areas, the role of civil societies, except those dealing with charitable and humanitarian causes, is largely absent. This is compounded by the fact that healthcare is composed of a workforce based primarily on expats who are not free to form civil societies or organisations.

4.3.5 Decentralization and Centralization

The UAE Healthcare system is mixture of centralized and decentralized system. The two largest and wealthiest Emirates Abu Dhabi and Dubai operate and regulate their own health system. The less resource abundant, and less populated northern Emirates are still largely regulated and operated by the federal Ministry of Health. Though licensing and accreditation of medical facilities and healthcare professionals remains decentralized and often exhibits some level of inconsistency across the Emirates, the MOH still maintains the role of issuance and enforcement of federal law applicable to the healthcare profession (e.g. Federal law No. 10 of 2008 in respect of medical liability, federal law No. 11 concerning fertilization centres, Pharmacy Law of 1983).

Abu Dhabi public healthcare system can best be described as centralized with SEHA exercising control over hospitals operations and dictating major strategies. The regulation of healthcare services including setting standards, monitoring and enforcement is largely centralized at the regulator level. HAAD, in theory, has oversight responsibilities over the healthcare expenditure over the entire sector; however, role ambiguity between HAAD and SEHA and obscured lines of authority often prevents HAAD from playing this oversight role at least in terms of budgetary allocations. SEHA corporate office plays a central role in budget appropriation and negotiation for SEHA hospitals. Hospitals, including those managed by external providers prepare and submit their budget to SEHA, who reviews and negotiate the budget and in turn submit to the DOF and EC for approval. Often times allocation to individual hospitals are dictated by block funding allocated to healthcare by DOF. The presence of joint committees between SEHA and public hospitals established communication channels between corporate office and hospitals on clinical, operational, and financial matters. There is however limited delegation for hospital management especially in HR and procurement matters. Long approval procedures, red tape and bureaucracy are often cited by hospitals as obstacles towards achieving their objectives.
4.4 Financing

To a large extent, health services in GCC countries are financed by governments. It is estimated that public sector shoulders more than 75% of healthcare costs (Mourshed et al., 2008). There is every indication that, in the near future, GCC governments will continue to heavily subsidize the robust medical benefits, at least to their own citizens. However, as discussed earlier, those governments face several challenges including a growing population, and unique patterns of medical risk factors among GCC nationals including Type II diabetes and cardiovascular diseases. With those challenges, even governments the deepest of pockets will find it difficult to cope with the ever increasing healthcare costs in the next 20 years (Mourshed et al., 2008). Recognizing such challenges, most governments in the region are increasingly turning to private sector for support with both provisioning and financing of health services.

4.4.1 Expenditure on Healthcare

UAE and Abu Dhabi in particular are no exceptions to the rest of the GCC countries. Health services are mainly financed through direct government appropriations. The World Health Organisation (WHO) reported total expenditure on healthcare in the UAE in 2012 to be close to US$11 Billion; 68% of healthcare expenses are funded by the government, and 32% by private household (W.H.O, 2014). As a result of the economic expansion and the increasing population, total expenditure on health in the UAE showed a five-fold increase between 1995 and 2010, increasing from less than $2 Billion in 1995 to around $10 Billion in 2010 as shown in Table 9 below. The period between 2010 and 2012 showed a much slower growth in total healthcare expenditure, driven mainly by slower population growth and tighter government spending. Healthcare expenditure shows a negligible growth between 2011 and 2012.

Table 9 - Trend in UAE National Health Expenditures, selected years (W.H.O, 2014)

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<tbody>
<tr>
<td>Total expenditure on health (in million current US$)</td>
<td>1,733</td>
<td>2,280</td>
<td>4,191</td>
<td>9,640</td>
<td>10,851</td>
<td>10,885</td>
</tr>
<tr>
<td>Population (thousands)</td>
<td>2,349</td>
<td>3,033</td>
<td>4,069</td>
<td>7,512</td>
<td>7,891</td>
<td>8,106</td>
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<tr>
<td>Total expenditure on health/capita at exchange rate</td>
<td>738</td>
<td>752</td>
<td>1,030</td>
<td>1,283</td>
<td>1,375</td>
<td>1,343</td>
</tr>
<tr>
<td>Total health expenditure (THE) % Gross Domestic Product (GDP)</td>
<td>2.64</td>
<td>2.19</td>
<td>2.32</td>
<td>3.24</td>
<td>3.11</td>
<td>2.84</td>
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</table>
Total spending on healthcare as percentage of GDP remains low. Averaging at 3%, healthcare expenditure as % GDP is comparable to most GCC countries, but slightly lagging behind KSA, Bahrain, and the average for Arab World at 3.9% (Figure 12). When compared to the average of high income non-OECD countries, and the OECD member countries, standing at 4.9% and 12.6% respectively in 2012, the healthcare expenditures as a percentage of GDP is materially lower. (OECD, 2013, The World Bank, 2014). One of the ways to interpret this low percentage is that UAE, with an oil based economy, has one of the highest GDPS in the world for a relatively small population.

Figure 12 - Spending on Healthcare as % of GDP-2012 data, GCC and select indicators (The World Bank, 2014)

Another probably more realistic way to look at spending on healthcare in the UAE is to compare the per capita total expenditure on healthcare. Standing at US $1,342 in 2012, the per capita expenditure on healthcare in the UAE is third amongst the GCC countries after Qatar and Kuwait; Bahrain, KSA and Oman lagging behind at around 50% less per capita expenditure on healthcare compared to Qatar, Kuwait and UAE (Figure 13).
The health expenditure per capita compares favorably to the high income-non OECD average standing at US $967 in 2012, but remains at a quarter of OECD average standing at US $5,382. Public expenditures on health accounted for 9% of total government spending which is amongst the highest in GCC countries (Figure 14); however, at 2%, the total government spending on health as a percentage of GDP is still considered low.

**Table 10 - Trend in Government expenditure on Health in the UAE**

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<tr>
<td>Gross Domestic Product</td>
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<tr>
<td>Domestic expenditure in million current US$</td>
<td>65,744</td>
<td>104,337</td>
<td>180,617</td>
<td>297,648</td>
<td>348,595</td>
<td>383,799</td>
</tr>
<tr>
<td>General government expenditure in million current US$</td>
<td>16,926</td>
<td>22,694</td>
<td>27,434</td>
<td>71,758</td>
<td>81,094</td>
<td>79,099</td>
</tr>
<tr>
<td>General government expenditure as % of GDP</td>
<td>26</td>
<td>22</td>
<td>15</td>
<td>24</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>Private expenditure on health as% of THE</td>
<td>21</td>
<td>23</td>
<td>41</td>
<td>31</td>
<td>31</td>
<td>32</td>
</tr>
<tr>
<td>General government expenditure on health (GGHE) as % of THE</td>
<td>79</td>
<td>77</td>
<td>59</td>
<td>69</td>
<td>69</td>
<td>68</td>
</tr>
<tr>
<td>General government expenditure on health as % of GDP</td>
<td>2.08</td>
<td>1.68</td>
<td>1.37</td>
<td>2.24</td>
<td>2.16</td>
<td>1.92</td>
</tr>
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</table>
4.4.2 Healthcare Expenditure in Abu Dhabi

Total health system expenditure in Abu Dhabi (excluding capital expenditures) are estimated at AED 16 Billion (US$4.4 Billion) in 2012. Public sources constitute 68% of the healthcare expenditures, private third party payments for basic and enhanced insurance products constitute 20%, with the remaining 7% being paid by individuals out-of-pocket (Table 11). Public funding covers all the UAE nationals’ healthcare expenditures through the ‘Thiqa’ programme, and subsidizes the mandatory basic insurance plan for low income workers. In addition public funding is used towards block funding for public hospitals and IPC. Table 13 below shows the allocation of government funding for healthcare in 2012.

Table 11 - Allocation of government funding on healthcare in Abu Dhabi

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiqa claims and admin fees</td>
<td>40%</td>
</tr>
<tr>
<td>Public Hospitals block funding and loss subsidy</td>
<td>43%</td>
</tr>
<tr>
<td>International Patient Care</td>
<td>12%</td>
</tr>
<tr>
<td>Subsidy of Basic insurance products</td>
<td>4%</td>
</tr>
<tr>
<td>Others</td>
<td>1%</td>
</tr>
</tbody>
</table>

Healthcare sector spending in Abu Dhabi is expected to grow at an annual rate of 10% by 2020 (source: HAAD analysis). The main drivers for this spending growth are: (1) population growth expected to continue at an annual rate of 5% consistent with the actual average growth of the last three years, (2) medical inflation estimated at around 3%, and (3) utilization increase estimated at 2% mainly driven by aging population and increased disease burden. Public hospitals derive 43% of their funding from insurance claims, the
government covers 40% of the budget through block funds and loss subsidies, and funds the remaining 17% to cover specific mandates relating to public health.

The per capita expenditure on healthcare in Abu Dhabi estimated at US $1,571 is 17% higher than the UAE overall per capita level. At this level, Abu Dhabi compares with similar high income, non-OECD countries such as Singapore and South Korea, but remains 30% lower than OECD countries (Figure 15). An eclectic population mix with varying degrees of healthcare coverage among different population segments (e.g. UAE nationals, non-nationals skilled professionals, and non-national unskilled workers) makes the interpretation of this indicator slightly complicated. However, when per-capita expenditure on healthcare is broken down per coverage type as shown in Figure 16, the analysis shows a completely different picture. The analysis indicates a high level of per capita expenditure for Emirati nationals (Thiqa policy holders) comparable to OECD countries, and four times more than the average for enhanced policy holders (i.e. white collar expats).

**Figure 15 - Healthcare expenditure per capita-Abu Dhabi vs. OECD and High-income, non-OECD countries**

![Healthcare expenditure per capita current US $ (2012)](chart)

4.4.3 Population Coverage and the Basis for Entitlement

All residents in UAE received free medical care until 1982. In that year, escalating costs, shrinking oil revenues, and a change in attitude toward foreign residents caused the UAE to begin charging noncitizens for all services except emergency and child and maternity care (W.H.O., 2006). In 2001 the government introduced charges for expatriates, a move that
partly sought to reduce the draw of healthcare on public funds, but also aimed to increase the cost of expatriate labour and thus encourage the employment of local staff (W.H.O., 2006). Up until 2007, the public health services in Abu Dhabi were mainly financed through direct contributions from Abu Dhabi Government. Abu Dhabi public hospitals provided free access to all UAE nationals. In the transition period before the introduction of the mandatory health insurance law, expatriates were also provided free access when admitted to emergency care, when they needed special care not available in private hospitals (e.g. cardiovascular surgeries), or when they obtained special referral by other physicians in private hospitals. In addition, the government financed overseas treatment for patients with severe medical conditions, or needing specialized care that was not available in the Emirate’s hospitals. By 2004, the International Patient Care (IPC) practice was consuming more than 25% of the total healthcare budget (GSEC, 2008).

The introduction of the insurance law in 2005, and the Thiqa medical plan in 2008, ensured universal equitable access to medical services to all the population. Table 12 below shows the different type of medical coverage for different types of population.

Table 12 - Summary of medical insurance plans in Abu Dhabi (adapted from (Hamidi et al., 2014))

<table>
<thead>
<tr>
<th>Product</th>
<th>Enrollment</th>
<th>Beneficiaries</th>
<th>Payers</th>
<th>Premium</th>
<th>Paid By</th>
<th>Coverage</th>
<th>Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Mandatory</td>
<td>Low income expats</td>
<td>Daman plus 11 other insurance companies</td>
<td>AED 600</td>
<td>Employer</td>
<td>Abu Dhabi (plus UAE for emergency)</td>
<td>HAAD set and subsidized</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Mandatory</td>
<td>Higher income expats</td>
<td>Insurers</td>
<td>Risk Adjusted</td>
<td>Employer</td>
<td>Varying (local, regional or international coverage)</td>
<td>Negotiation between payer and provider. HAAD sets floor and ceiling</td>
</tr>
<tr>
<td>Thiqa</td>
<td>Mandatory</td>
<td>UAE Nationals</td>
<td>Daman</td>
<td>Free</td>
<td>DOF</td>
<td>UAE plus worldwide emergency</td>
<td>HAAD</td>
</tr>
</tbody>
</table>

The basic plan is for expatriates with a total monthly salary of equal to or less AED 4,000 (US$1,090). Enrollment is mandatory and premiums are set by HAAD and approved by EC at government subsidized prices. The plan offers basic coverage including hospitalization, medical exams, treatment, primary care, medical tests and X-rays and regular dental coverage. The plan levies a deductible amount per out-patient visit, copayment for required laboratory tests or radiology, and 30% copayment for pharmaceuticals. The enhanced insurance plans are offered for all other expatriates with varying degree of coverage, deductibles, and copayments depending of the insurance plan.
selected. Premiums are set at risk adjusted market rates (Hamidi et al., 2014). Thiqa insurance plan is offered to all UAE nationals working and residing in the Emirate of Abu Dhabi with comprehensive free coverage to all public and private hospitals registered within Daman network (www.thiqa.ae). Coverage for in-patient, out-patient and pharmaceuticals is provided free of charge in Daman network, however Nationals pay a co-insurance of 50% for dental treatment and pharmaceuticals in private sector facilities. Services provided outside of Abu Dhabi are subject to 10% co-insurance. Coverage for medical treatments outside the UAE are subject to special approval by HAAD and are administered and funded through the International Patient Care (IPC) programme. Visitors to Abu Dhabi have to pay for medical services in public and private hospitals. They can however elect to purchase a visitor plan. Premium for visitor plans is determined based on duration of stay and market rates (Hamidi et al., 2014).

The payer market in Abu Dhabi consisted of 39 companies dominated by Daman which almost exclusively administered the Basic Health Insurance plan and the Thiqa plan until 2011. Starting 2011, 11 additional providers were allowed to offer Basic Insurance plan, but Daman remains the sole provider of Thiqa plan. As far as Enhanced plans are concerned, the Abu Dhabi health insurance market is highly concentrated with 46% of the market dominated by two players, a further 17 companies control 51% of the market that is an average of 3% per member, and the remaining 20 companies have about 1% of the market that is an average of 0.05% for each company (Hamidi et al., 2014).

4.5 Regulation

As indicated earlier in this chapter, healthcare regulation in the Emirate of Abu Dhabi is largely centralised in HAAD, the government’s regulatory agency. HAAD regulates both public and private medical practices, along with insurance companies, and licenses medical facilities and healthcare professionals in the Emirate. Besides HAAD, the Ministry of Health regulates the healthcare sector at a Federal level. Mourshed et al., (2008) argue that establishing a strong regulatory body to define and firmly enforce higher quality standards for healthcare providers and medical professionals is essential for building confidence of patients in the quality of healthcare. In Abu Dhabi, significant efforts were invested by HAAD to build a sound regulatory framework that regulates the various aspects of healthcare system. HAAD aims to regulate the three main aspects of the health system: (1) cost, by setting reimbursement levels for the various activities provided by healthcare providers, (2) access, by enforcing mandatory health insurance, and (3) quality, by
licensing all medical professionals and medical facilities and developing a quality rating system for all medical providers in Abu Dhabi (Koornneef et al., 2012).

However, despite the government’s new reforms, the system still faces various regulatory challenges including long licensing procedures for medical professionals, limited mobility of physicians between hospitals, and management of medical complaints and medical malpractices. At the federal level, the regulatory system is still fragmented with often inconsistent standards and licensing procedures applied in different emirates (Deloitte, 2011).

4.6 Human Capital

Recruiting and retaining qualified healthcare professionals in particular physicians and nurses remains one of the most important and pressing challenges in the healthcare system in the UAE (Mourshed et al., 2008, Mosaad and Younis, 2014, Podolak et al., 2012, Deloitte, 2011). Presently, most GCC countries are unable to produce sufficient number of clinical staff to provide healthcare services for their growing populations. UAE tops the chart among GCC countries with 82% reliance on expatriate physicians, and 96% reliance on expatriate nurses (Mourshed et al., 2008). Despite Emiratisation programmes, the majority of the UAE Nationals, who see the healthcare profession as less prestigious, much less lucrative, and demanding much higher commitment than other professions, have not been attracted to seek career opportunities in the healthcare sector. Reliance on imported physicians and nurses will continue in the foreseeable future as the number of new medical graduates are not likely to keep pace with the population increase. Such heavy reliance on expatriate healthcare professionals poses a number of risks. First, expatriate physicians, nurses, and healthcare professional must work together while coming from different cultures, with different medical training systems and differing medical practices and approaches to medical care, and in some cases not even speaking the same language (Mourshed et al., 2008, Hamidi et al., 2014). Second, the GCC in general, is viewed by very few physicians and nurses as a permanent home and long-term employment. Staff coming from developing countries such as Philippines and India view their career in GCC hospitals as a stepping stone towards a more lucrative and challenging career in the west; whereas western physicians view their employment in the GCC as an opportunity to save some money while experiencing high profile ‘expat living’ before returning home (Mourshed et al., 2008). The third risk relating to the heavy reliance on expatriate medical professionals relates to the cultural understanding between physicians and patients. When this rapport is broken because of cultural and language barriers, frustration levels and
dissatisfaction increase with both physicians and patients (Hamidi et al., 2014, AL-Ahmadi and Roland, 2005).

All those factors lead to high turnover rates amongst healthcare professionals. According to a report by HAAD, in 2010 about 15% of physicians in the UAE resigned, while about 13% of nurses leave their positions annually (Deloitte, 2011). HAAD estimates that by 2022 over 2000 additional doctors and over 5000 nurses will be required. If turnover remains high, this translates into 1,500 doctors and over 2000 nurses to be recruited annually (HAAD, 2013). Part of addressing this challenge is providing competitive pay scales and other incentives to attract top healthcare professionals. However, pay is not the only determining factor especially in the healthcare profession. Limited opportunities for continuing education (Deloitte, 2011), lack of proper medical research infrastructure, and restricted funding allocated for medical research and professional advancement of healthcare professionals, are all important factors that lead to higher dissatisfaction and disengagement and among healthcare professional. This dissatisfaction usually translates into higher turnover rates. In addition, the slow and tedious licensing process may discourage qualified candidates coming from abroad who are not prepared to wait that long (Deloitte, 2011).

Recognizing that structural, legal and regulatory changes are not sufficient in realizing the ambitious objectives of the reform in the healthcare sector, and that bigger buildings and new equipment alone do not by themselves create a better healthcare system, both HAAD and SEHA embarked into a number of initiatives since 2010 to address the human and cultural challenges within their organisations. Those initiatives included extensive employee satisfaction surveys administered both internally and externally, including ‘GSEC Employee Opinion Survey’, ‘Great Places to Work’ survey, ‘Employee Engagement Survey’ and most recently a collaboration with the Armstrong Institute for Patient safety and Quality addressing issues around patient safety, and physician-patient relationship. HAAD also identified the need to establish world class clinical training and education in order to build a sustainable healthcare workforce and service supply (Health Authority Abu Dhabi, 2013).

4.7 Conclusion

The aim of this chapter was to present a detailed account of the public healthcare system in the Emirate of Abu Dhabi. Using a combination of literature and documentary review, coupled with an extensive review of media coverage of health systems in Abu Dhabi, the chapter depicted a picture of Abu Dhabi’s public healthcare reform trajectory. From its
humble beginning in the late 1960s, the public healthcare system in the Emirate came a long way through. The establishment of the GAHS in 2001, considered as a first step towards decentralisation of healthcare regulation and delivery from a centralised federal system to an Emirate level paved the way to a series of far reaching reform initiatives geared at ensuring ‘reliable excellence in healthcare’ for the community.

Abu Dhabi addressed the access to health care to all its citizens by passing the insurance regulation bill in 2007 followed by the implementation of compulsory health cover scheme for UAE nationals in 2008. Other reform initiatives included splitting regulation from provision of care, establishing licensing, credentialing, accreditation, and inspection procedures across the sector; and forging long-term partnerships with international healthcare industry leaders. Like any health systems transformation, some reform initiatives had lasting impact (e.g. insurance regulation) while other more recent ones including access limitation to public hospitals are thought to have come about as a reaction to pressing issues rather than as a well-thought policy change.

Finally, despite notable progress in healthcare regulation and delivery in the Emirate, the Abu Dhabi public healthcare system faces a number of challenges that might jeopardize the progress made if they remain unaddressed. First, it seems that the reform initiatives could not fully address the issue of raising costs driven mainly by the over-utilization of medical services by Emirati patients, increased government subsidy for expatriate workers’ basic insurance scheme, and high turnover of healthcare professionals. Second, in spite of increase in hospital beds and significant investment in state-of-the-art medical facilities and equipment, patients, both Emirati and expatriate seem to not fully trust the healthcare system. This is evident in the number of patients treated abroad. Although no official statistics on IPC exist, sources seem to suggest that the number of Emirati patients treated abroad is increasing. Moreover, anecdotal evidence indicates that expatriates prefer to be treated in their home countries when it comes to critical non-routine treatments. The third challenge is access to public hospitals. This remains an issue as evident in the long waiting time and overcrowding of public hospitals for which the government reacted by limiting access to certain public hospitals to Emirati patients only. Finally, the recruitment and retention of qualified healthcare professionals to fill the increasing demand for health services for a diverse population with high risk of non-communicable diseases remains one of the most pressing challenges. The heavy reliance on expatriate health professionals coming from diverse systems and cultures coupled with the very small number of Emirati in the medical profession, create unique issues that threaten the sustainability of the
healthcare system in Abu Dhabi. One way to address those challenges is to create an environment in which healthcare professionals, both expatriate and Emirati, thrive; and to cultivate a nurturing, supportive culture where patients come first and where individuals’ contributions are aligned with the organisational objectives. It is from this angle that this study focuses on organisational culture as a way to understand and address the unique challenges facing the human capital in Abu Dhabi healthcare system.
Chapter 5- Research Design and Methodology

5.1 Introduction

The objective of the proposed study is to understand the context of healthcare reform in the Emirate of Abu Dhabi and to provide an assessment of the organisational culture in the public healthcare sector in Abu Dhabi. Organisational culture remains a ‘elusive concept, fraught with competing interpretations” (Davies et al., 2000: 111). As such, it is a difficult phenomenon to assess, and it appears there is no right or wrong way to do so. The research methodology and selection of appropriate research methods depend on the research questions being addressed and are guided by the ontological and epistemological positions adopted.

This chapter presents the philosophical and methodological bases of the research. The chapter starts by a discussion on the philosophical stances underpinning the decisions behind the research design. Subsequently, the chosen methodology for the current study, which includes a mixture of qualitative and quantitative techniques, is elucidated with supporting rationales. The next parts provide the details of data sources, data collection methods, sampling strategies, pilot studies and approaches to data analysis. The explanation covers the benefits of triangulation and combining dissimilar methods that complement each other.

5.2 Paradigm Debate and Ontological and Epistemological bases

The current investigation touches upon a number of academic disciplines including: public administration - through the study of public healthcare system, social science - central to the study of organisational culture, and organisational behavior - though the study of the complex interplay between organisational context, people, and structures in healthcare organisations. It attempts not only to describe the healthcare system in Abu Dhabi (context), but to drill down to explore the different actors within that system, and how their interactions and relationships define and shape the performance of this sector. Understanding the philosophical stances underpinning the decisions behind the research design is paramount to any research project. As described by Grix (2010: 57) “ontology and epistemology are to research what footings are to a house: they form the foundation of
the whole edifice”. Methodology, methods, and sources are closely connected to and built upon the ontological and epistemological foundations.

5.2.1 Importance of context in healthcare research

The very nature of the healthcare sector described by Glouberman and Mintzberg (1996) as ‘one of the most complex systems known to contemporary society’ (Glouberman and Mintzberg, 1996) is inherently complex with fuzzy boundaries (Plsek and Greenhalgh, 2001). Healthcare environment usually incorporates multiple stakeholders from the industrial, scientific, and professional spheres that sit within a public and very political system (Dawson, 1999). The scope of health systems and healthcare provision is broad. It encompasses regulation, financing, and access on one hand, and ranges from traditional healers to medical consultants practising in sophisticated multi-speciality hospitals on the other hand. Mark (2006:851) argues that “what those systems have in common is participation in an activity that requires trust between the parties concerned, to deliver a change in the patients’ well-being” (Mark, 2006). However, Mark (2006) adds, healthcare systems differ in the organisational and social context and infrastructure that surround such encounters. “Contexts are not simply given in the physical settings,… nor in combinations of personnel… rather, contexts are constituted by what people [do and where and when they do it]” (Erickson and Schultz, 1997: 28). The behavior in those different contexts will not be the same, and it is important to be aware of how those differences shape the assumptions about what matters and what can be applied elsewhere. These contextual differences exist over both space that is between different systems and locations nationally and internationally, and time when looked at historically and between different periods of time (Mark, 2006).

5.2.2 Ontological and Epistemological Bases

5.2.2.1 Paradigm debate

Various attempts at providing foundations for judging truth claims of social research have come and gone. Underpinned by a number of often conflicting philosophical schemes, ranging from empiricist foundationalism, to refuting the very idea of foundationalism and considering anti-foundationalism as itself being the philosophical foundation for social research (Seale, 1999), the field has faced unique challenges both in identifying the philosophical claims around knowledge (ontology and epistemology) and how it is generated (methodology). The study of public administration, considered as a branch of social sciences is itself suffering from what Raadschelders (2011) refers to as ‘identity crises’. According to Raadschelders (2011:916), “Twenty-first-century social sciences
research seeks to establish a science that is replicable, objective, and generalizable, on the assumption that this is possible through “quants” and maths”. However, working within an inherently interdisciplinary field, public administration scholars cannot reduce the complex problems of society and government to mere empirical measurement. Raadschelders does not refute the idea of evidence-based knowledge, but stresses that research findings need to be probed for their deeper meaning (Raadschelders, 2011). The nature of the multiple, often complex relationship between government and society is heavily influenced and deeply rooted in the local context of the national state. This complex interaction renders the reductivist, empirical approach often adopted by natural sciences too simplistic to capture those convoluted dynamics. As put by Kaplan (1964:348), “the “soft” sciences are more challenging because they deal with phenomena that are inherently unstable, variable, and irregular”. Following from this, Raadschelders highlights another challenge; that of connecting micro- (individual, group), meso- (organisation), and macro-level (society) analyses, as only that will help address big questions of modern society. One cannot assume that analyses of data sets and empirical data collected at the micro level provide adequate understanding of trends at the macro level (Raadschelders, 2011).

Research in health organisations has often been criticised of using the ‘black box’ approach with a focus of what goes in and what is produced, but with little or no emphasis on what happens inside those organisations (Sheaff et al., 2003). Mark (2006) adds that research in healthcare reveals a separation between the literature on organisations and structures, and the behaviour of groups and individual within those structures and how such behaviour is shaped by context and social interactions. As such, attempts to simplify those factors from a positivist research perspective, the dominant paradigm at the heart of healthcare, often fail to reflect the complexity of the organisational and contextual dynamics (Mark, 2006). Rousseau and Fried (2001:3) suggest that “the common demands for clean models do not always fit with the messy reality of contemporary work and organisational life”. The importance of studying healthcare systems and health policy reforms from a social research perspective have been emphasized by a number of scholars (Orosz, 1994, van Etten and Rutten, 1986, Currie et al., 2012). Social research is able to provide knowledge about socio-economic and political factors influencing health status, healthcare systems and health policy making across international, national, and local levels. As such it helps in achieving a vision for the future of health systems embedded in the wider socio-economic context (Orosz, 1994).
5.2.2.2 Epistemological and ontological positions

Research in healthcare has traditionally been dominated by the positivist model (Mark, 2006, Cohen and Crabtree, 2008, Plsek and Greenhalgh, 2001). Inspired by the scientific method, often forming the basis of biomedical and clinical research, the quest for evidence-based knowledge extended beyond medical research. Current research in health policy and practice is thought to be influenced by the empirical positivist paradigm (Orosz, 1994, van Etten and Rutten, 1986, Cohen and Crabtree, 2008). As described by Plsek and Greenhalgh (2001:625): “Newton’s ‘clockwise universe’, in which big problems can be broken down into smaller ones, analysed, and solved by rational deduction, has strongly influenced both the practice of medicine and the leadership of organisations”. However, according to Orosz (1994), the traditional bio-medical thinking which is usually prevalent in systems with heavy dominance of medical professionals in healthcare administration and policy making, often fails to appreciate the importance of social and economic implication of policy proposals. Such thinking also fails to appreciate how different perceptions, behavioural patterns, and contextual pressures might play a role in the implementation of the different policy changes (Mark, 2006). Plsek and Greenhalgh (2001:628) argue that in order to cope with escalating complexity in healthcare systems “we must abandon linear models, accept unpredictability, respect (and utilise) autonomy and creativity, and respond flexibly to emerging patterns and opportunities”.

Dawson (1999) points out that epistemologically, it is essential for researchers to make decisions about research designs, before beginning the research process in healthcare, because identifying the most appropriate framework for what is being researched is critical to the development of knowledge (Dawson, 1999). Contextualizing both what we know, as part of this ontology, and how we know it, through appropriate epistemologies, is a fundamental starting point for researching organisations (Rousseau and Fried, 2001) including healthcare, across both time and space.

“Ontology is the starting point of all research, after which one’s epistemological and methodological positions logically follow” (Grix, 2010: 59). Ontological assumptions are concerned with the nature of social reality. These assumptions attempt to understand the nature of the social and political reality, claims about what exists, what it looks like, what units make it up and how those units interact with each other (Blaikie, 2010). Ontology generates theories about what can be known (epistemology), how knowledge can be produced (methodology), and what research practices can be employed (methods) (Raadschelders, 2011).
“Epistemology is concerned with the possible ways of gaining knowledge of social reality... it focuses on the knowledge gathering process and is concerned with developing new models or theories” (Grix, 2010: 64). Epistemological positions are often divided between those based on foundationalism and those based on anti-foundationalism. Central to a foundationalist view is that reality is thought to exist independently of our knowledge; foundationalism is the starting point for positivist and realist research traditions (Grix, 2010). Figure 16 highlights the key research paradigms on a continuum ranging from explaining to interpreting.

**Figure 16 - The Key Research Paradigms (Grix, 2010: 79)**

![Figure 16](image)

Positivist epistemology holds that what we can know are observable facts; positivists believe that reality is stable and can be observed and described from an objective standpoint. Interpretivists, on the other hand, accept that we can know much more (feelings, intuitions, understandings), they focus on the meaning of social phenomena rather than measurement (Raadschelders, 2011). On this continuum, post-positivism, often referred to as realism, can be viewed as a research paradigm placed between positivism and interpretivism (Grix, 2010). Positivism and post-positivism share a realist foundationalist epistemology, but positivism tends to apply scientific, empirical methods to human affairs, whereas post-positivism or realism offers a more layered conception of ontology. According to Kerr (2003), “realism works on the assumption of ‘depth ontology’- i.e. that these generative mechanisms are highly complex, often structural, and more crucially, not always directly observable. In this sense, part of the explanatory schema must be an attempt to ‘interpreting’ casual links from observable outcomes” (Kerr, 2003: 122).

These ontological and epistemological bases of this research which firstly adopts an objectivist, positivist view of ontology by implying that organisational culture ‘exists’ as a critical variable as highlighted in section 2.4.2 above. Additionally, the study adopts a realist epistemological perspective meaning that our understanding of organisational culture is shaped by the experience of social actors. The context, structures and mechanisms in which those events occur, are consistent with the realist paradigm. Finally, measurement of organisational culture is seen as a way to guide interpretations, rather than the true knowledge of how organisations perform. The next section discusses how this study adopts both a positivist and realist paradigm by taking on a critical realist approach.
5.2.2.3 Research Strategy and Research Paradigm

The research questions in this thesis seek to (a) explore the context of healthcare regulation, financing, and delivery in Abu Dhabi, (b) describe the type of organisational culture prevailing in the different constituents of this sector, and (c) understand the types of organisational culture that are considered to be conducive to performance improvement. The research strategy adopted was mainly inductive, with some elements of abductive strategy (Blaikie, 2010) used especially when attempting to understand the meanings and interpretations that social actors associate with the culture of their organisation and how the bigger context in which they operate affect those meanings and interpretations. Following from that, the research paradigm used in this research is ‘critical realism’. Realism, in its different forms has been advocated by a growing number of scholars (Dawson, 1999, Raadschelders, 2011) as an appropriate research paradigm that addresses the shortcomings of adopting empirical scientific methods in healthcare research.

“Critical realism straddles both positivist and interpretivist paradigms sharing a foundationalism epistemology with positivism and allowing for interpretation in research” (Grix, 2010: 86). Critical realism has grown in importance since the 1970s as a powerful alternative to both positivism, with its search for reality through observable phenomena, and interpretivism with its focus on subjective meaning of social actions (Sayer, 2000). Influenced by the work of the philosopher Roy Bhaskar, “critical realists scholars have attempted to combine the ‘how’ (understanding-which is linked to interpretivism) to the ‘why’(explanation-which is linked to positivism) approaches by bridging the gaps between the two extremes (May, 2001: 15).

“Critical realists do not deny reality of events and discourses, on the contrary, they insist upon them. But they hold that we will only be able to understand –and so change- the social world if we identify the structure at work that generates those events and discourses alike. These structures are not spontaneously apparent in the observable pattern of events. They can only be identified through the practical work of social science” (Bhaskar, 2011: 2). As such in the current study, structures are not confined to healthcare organisations studied, but expand beyond those institutions to encompass the economy, public employment, nationalisation and emigration policies that are thought to shape how organisational culture is assessed.

Certain aspects of the methodological approach employed in the current study could also be seen as being partially underpinned by a positivist philosophy given the presence of quantification through the use of surveys and the adoption of a priori theory through the
reliance upon an existing theoretical framework. Yet, the decision to use of interviews to gain a better understanding of the context shaping the healthcare sector and how different actors interpret organisational culture shows an interpretivist overtone. In other words, this choice suggests that the researcher’s underlying belief is that it is indispensable to comprehend the meaning of social actions. The fact that both qualitative and quantitative techniques were applied in the current research could be viewed as critical evidence of ‘paradigm complementarity’ (Yaugh and Steudel, 2003, Scott et al., 2003a, Jung et al., 2009) that facilitated a more comprehensive understanding regarding the complex nature of organisational culture hence allowing the study to achieve its prime objectives.

5.3 Justification for the Use of CVF

There are various reasons for adopting CVF in the study of organisational culture. CVF connects the strategic, political, interpersonal, and institutional aspects of organisational life by organizing the different patterns of shared beliefs, assumptions and interpretations that define and organisation’s culture (Denison and Spreitzer, 1991). Howard (1998: 245) posits that “the competing values perspective provides a valid metric for understanding organisational cultures, comparing organisational cultures and evaluating organisational cultures relative to other variables”. Various studies were conducted confirming the reliability and validity of CVF. Quinn and Spreitzer (1991) tested the CVF based instrument, Organisational Culture Assessment Instrument (OCAI) in a large scale survey including executives from public utility firms. The instrument was found to have high reliability across the four cultural types. In addition Quinn and Spreitzer (1991) found evidence of convergent and discriminant validity in the CVF; their analysis indicated a high level of consistency between the espoused values and organisational characteristics and each of the four cultural types. CVF has therefore been established as an instrument that combines various well established typologies proposed by prominent scholars (Zammuto and Krakower, 1991), (Yeung et al., 1991), (Cameron and Freeman, 1991) and (Howard, 1998). Furthermore, Cameron and Quinn (2006: 150) argued that the framework can effectively reveal the fundamentals of organisational culture because it manages to capture the underlying structure of the psychological archetypes in these core dimensions.

CVF has been widely used in literature to assess organisational culture directly or indirectly. According to Cameron and Quinn (2011) CVF has been administered in over 10,000 organisations globally. CVF has been used in various empirical studies to investigate organisational culture and its relationship to various aspects of corporate performance, and impact on implementation of various management strategies (Kloot and
Martin, 2007, Al-Khalifa and Aspinwall, 2001). CVF has been used in both public and private sectors and in a wide range of industries ranging from education to healthcare to military organisations, airline and others. Finally, CVF has been used in various national settings including USA, Europe, Africa, Asia, and the Arab World (DAVIDSON et al., 2007, Sharimllah Devi et al., 2011, Twati and Gammack, 2006, Jingjit, 2008, Al-Otaibi, 2010, Aktaş et al., 2011, Jaeger and Adair, 2013).

Researchers in healthcare have frequently used CVF to assess organisational culture and its association with important indicators of healthcare processes and outcomes. CVF has been offered as an explanation for organisational differences in implementation of quality improvement activities and quality of care (Helfrich et al., 2007). CVF based assessment instruments have been used in a number of empirical studies on organisational culture in healthcare contexts (Stock et al., 2007, Davies et al., 2007, Gregory et al., 2009, Brazil et al., 2010, Jacobs et al., 2013a, Alharbi et al., 2012). Although those studies are mainly performed in western contexts (UK and USA in particular), there has been a recent interest in using CVF in healthcare sector in other parts of the world. For example (Al-Otaibi, 2010) used CVF to assess the role of organisational culture in healthcare provision in Saudi Arabia, (Aktas et al., 2011) examined the effect of organisational culture on organisational efficiency in Turkish hospitals using CVF, and (Saame et al., 2011) used CVF to examine organisational culture in Estonian hospitals. However, research in this area still appears to be meager to allow for meaningful comparative studies on organisational cultural assessments in healthcare organisations in developing nations.

Notwithstanding its merits, the CVF as a conceptual framework for measuring organisational culture has a number of limitations. Talbot and Wiggan (2010) argue that CVF approach lacks the foundational model or theory of human motivation and decision-making. Helreich (2007) found problems with internal, external and construct validity of CVF instruments when applied to non-supervisory employees. Hartnell et al., (2011), conducted a meta-analytic investigation to the theoretical suppositions underpinning CVF. Findings indicate modest support for the CVF’s nomological validity that is culture types’ associations with organisational criteria for success. Results also suggest that the CVF’s culture types in opposite quadrants are not competing or paradoxical. Instead, they coexist and work together. Organisations do not necessarily have dominant cultural type; instead their culture is defined by the unique aspects of multiple cultures that co-exist simultaneously (Hartnell et al., 2011).
CVF, like any other cultural assessment framework has its advantages and limitations. It appears from the review of literature and empirical studies using CVF that the main limitations are establishing direct and clear relationships cultural types and unique aspects of organisational effectiveness. However when used as an exploratory tool for cultural assessment as suggested in the current study, CVF has merits in providing a way to frame qualitative and quantitative information about organisational culture especially in healthcare contexts (Scott et al., 2003b). Moreover, the use of CVF in the context of Abu Dhabi offers the potential for a methodological contribution of CVF applicability outside western contexts, and opens forums for future comparative studies.

5.4 Measuring Organisational Culture

Organisational culture is and is likely to remain a complex and contested concept. Despite its widespread use by researchers, managers, and policy makers, it is conceptualized in many different ways (Ott, 1989, Jung et al., 2009). There are various ways and methodological approaches to explore organisational culture ranging from qualitative ethnographic studies to quantitative surveys. Influenced by the anthropological origins of cultural studies, initial scholarly literature on organisational culture used mostly qualitative rather than quantitative research methods (Ott, 1989). Early studies of organisational culture largely used ethnography or participant observation to describe cultures, one institution at a time (Druckman et al., 1997). Yaugh and Steudel (2003) argue that the primary strength of the qualitative approach to cultural assessment is the ability to probe for underlying values, beliefs, and assumptions. Researchers in favor of the qualitative methods believed that standardized, quantitative instruments were inappropriate for cultural assessment because they would be unable to capture the subjective and unique aspects of each culture (Bellot, 2011). Qualitative methods dominated the studies of organisational culture up to the 1980s; however, frustration with the limited generalizability and time intensiveness of qualitative methods led to the development of quantitative instruments designed to measure and assess organisational culture (Bellot, 2011, Jung et al., 2009). A upward trend is quantitative studies began to be noted from the late 1980s onwards (Jung et al., 2009). Advocates of quantitative methods cite systematization, repeatability, comparability, convenience, large scale, unobtrusiveness and cost-effectiveness as the many advantages of using quantitative instruments to organisational assessment (Tucker et al., 1990). Table 13 highlights the advantages and shortcomings of each of the qualitative and quantitative approaches in the study of organisational culture.
### Table 13 - Quantitative and qualitative approaches to organisational culture

<table>
<thead>
<tr>
<th>Quantitative Approach</th>
<th>Qualitative Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td><strong>Advantages</strong></td>
</tr>
<tr>
<td>Can be administered and evaluated relatively quickly</td>
<td>Ability to identify structures through the patterns displayed</td>
</tr>
<tr>
<td>(Yaugh and Steudel, 2003)</td>
<td>by individual behavior (Morey and Morey, 1994)</td>
</tr>
<tr>
<td>Allows comparison between organisations and groups</td>
<td>Richness of details, intensive insights (Jung et al., 2009)</td>
</tr>
<tr>
<td>(Yaugh and Steudel, 2003), able to answer comparative</td>
<td></td>
</tr>
<tr>
<td>questions</td>
<td></td>
</tr>
<tr>
<td>Can be applied to organisational change and organisational</td>
<td>Ability to capture context, meanings, and interpretations (Jung</td>
</tr>
<tr>
<td>development issues (Cameron and Quinn, 2011)</td>
<td>et al., 2009)</td>
</tr>
<tr>
<td>Focus on universal dynamics of social systems</td>
<td>Focus on specific contextual factors</td>
</tr>
<tr>
<td>Generalizable, convenient, allows large scale investigations</td>
<td>Ability to identify the cultural dynamics and complexity within</td>
</tr>
<tr>
<td>(Jung et al., 2009)</td>
<td>an organisation (Yaugh and Steudel, 2003)</td>
</tr>
<tr>
<td><strong>Quantitative Approach</strong></td>
<td><strong>Qualitative Approach</strong></td>
</tr>
<tr>
<td><strong>Shortcomings</strong></td>
<td><strong>Shortcomings</strong></td>
</tr>
<tr>
<td>Superficial meaning of organisational culture</td>
<td>Time consuming (Yaugh and Steudel, 2003)</td>
</tr>
<tr>
<td>(Denison and Spreitzer, 1991)</td>
<td>Looseness in researcher and measurement objectivity</td>
</tr>
<tr>
<td>Cannot assess basic assumptions and values</td>
<td>Difficult to establish internal validity (Cohen and Crabtree,</td>
</tr>
<tr>
<td>(Schein, 1985)</td>
<td>2008)</td>
</tr>
<tr>
<td>Cannot capture the meaning of social systems from the</td>
<td>Rarely generalizable, limited external validity</td>
</tr>
<tr>
<td>perspective of individual members (Denison and Spreitzer,</td>
<td></td>
</tr>
<tr>
<td>1991)</td>
<td></td>
</tr>
<tr>
<td>Rigid categories operationalized by the research</td>
<td>Observations and results depend on interpretation(s) of a</td>
</tr>
<tr>
<td>instrument, inability to uncover deeper layers of culture</td>
<td>positioned subject(s) (Yaugh and Steudel, 2003)</td>
</tr>
<tr>
<td>(Jung et al., 2009)</td>
<td></td>
</tr>
<tr>
<td>Difficulty in identifying sub-cultures (Yaugh and Steudel,</td>
<td></td>
</tr>
<tr>
<td>2003)</td>
<td></td>
</tr>
<tr>
<td><strong>Research Methods</strong></td>
<td><strong>Research Methods</strong></td>
</tr>
<tr>
<td>Surveys and questionnaires</td>
<td>Ethnographic studies, participant observation, interviews, and</td>
</tr>
<tr>
<td></td>
<td>documentary analysis (Ott, 1989)</td>
</tr>
</tbody>
</table>

If qualitative and quantitative approaches offer different strengths and weaknesses, choosing between the two paradigms hinges on a trade-off between depth and breadth of
data: qualitative approaches offer detailed insights, while quantitative approaches allow for the examination of larger sample sizes (Ott, 1989, Yaugh and Steudel, 2003, Jung et al., 2009). Scholars seem to agree that the complex, multi-layered and multidimensional nature of organisational culture dictates the use of a multitude of methods. Ott (1989) argues that regardless of how organisational culture is defined, the study of organisational culture requires multiple research methodologies. The same idea is echoed by Scott et al., (2003: 942) in the following statement “culture is sometimes ambiguous, often slippery, and difficult to pin down. Singular attempts to define and measure organisational culture are misplaced; instead, a plurality of conceptualizations, tools, and methods are more likely to offer robust, subtle, and useful insights”.

The advantages of combining qualitative and quantitative approaches in studying organisational culture have been stressed by many scholars (Yaugh and Steudel, 2003, Scott et al., 2003a, Jung et al., 2009, Bellot, 2011). Qualitative approaches offer detailed insights, while quantitative approaches allow for a broader coverage, opportunities for examining larger samples and possibly the drawing of more generalizable conclusions. One way to overcome the inherent limitations of both methods is to use a multi-method approach combining both paradigms (Scott et al., 2003c, Jung et al., 2009). Yauch and Streudel (2003) argue that one could start cultural exploration with a period of qualitative assessment which offers rich descriptions and have the potential of addressing discrepancies between observed beliefs and values and underlying assumptions (Scott et al., 2003a). The insights gained from the qualitative assessment can then be used inform and eventually triangulate the results of the broader quantitative assessment (Yaugh and Steudel, 2003). Furthermore, Scott et al. (2003a) argues that triangulation may be particularly relevant to the examination of organisational culture, as different methods can be used to target different layers of culture. For example, the surface manifestation of culture, the artifacts, may be examined by observation; values may be examined using quantitative questionnaires; and underlying assumptions explored through in-depth interviews (Scott et al. 2001). “By addressing more than one layer or aspect of an organisation’s culture, congruence between methods can be tested and a composite picture of the culture drawn” (Scott et al., 2003a: 935).

The researcher believes that significant benefits can be realised in the current study through the use of qualitative and quantitative methods as a mean to answer the research questions. First of all, while qualitative in depth interviews were employed in order to collect more profound and richer data with the aim of producing “thick descriptions” (Geertz, 1973) of
organisational culture throughout the organisations being studied, they did not necessarily allow a more detailed view of organisational culture across different demographic and organisational parameters. Such detailed analysis was made possible through the use of the quantitative data derived from the on-line survey. Moreover, the quantitative analysis allowed the measurement of the nature and extent of change between current and preferred culture, and allowed the validation of differences in the assessment of organisational culture across different nationality clusters observed during the interviews. Finally, the flexibility provided by using mixed methods allowed the researcher to look at complementarities and paradoxes in meaning and interpretations, providing fresh insight on a number of issues specific to the context being studied.

5.5 Research Design

The objective of the proposed study is to provide an assessment of the organisational culture in the public healthcare sector in Abu Dhabi from the perspective of senior managers working across the three different constituents of the sector; regulator, operator, and public hospitals. The various roles of those different players were highlighted in Chapter Four. The research is designed as a three staged multi-method investigation: 1) exploratory phase, 2) qualitative analysis, and 3) quantitative analysis. Stage one starts with an exploratory phase, the aim of this phase is to have a deeper understanding about the environmental factors affecting the public healthcare sector in Abu Dhabi. Blaikie (2010) emphasizes the importance of the exploratory phase to have a better understanding about the context shaping the research before moving to the descriptive and explanatory phases (Blaikie, 2010). This exploratory phase is especially relevant to the research project as very little is known about the public healthcare sector including the socioeconomic and demographic characteristics of the major actors within this sector, and the ways in which those characteristics shape their behavior and social relationships between those actors.

The second stage comprises a qualitative analysis of current and preferred organisational culture prevailing within public healthcare organisations. Using in-depth, semi-structured interviews, the aim of this second phase is to provide a qualitative analysis of organisational culture to identify how participants view organisational culture and its role in improving healthcare performance. Stage three consists of quantitative analysis, the objective of which is to complement and triangulate the study results obtained during the qualitative phase. Using an OCAI based survey instrument based on the competing values framework (Cameron and Quinn, 2011), the quantitative phase complements the in-depth
interviews used in stage two by providing a wider representation, and allowing a more detailed level of analysis across a range of demographic and organisational factors.

5.6 Data Sources

The study uses secondary and primary data as detailed below:

5.6.1 Secondary Data Sources

When trying to map out and reconstruct the reform in public healthcare that took place in Abu Dhabi since 2001, the researcher was faced with a number of challenges. The lack of official publications, policy documents, or white papers documenting and analyzing the reform initiatives created one of the fundamental challenges to data gathering. The researcher had to rely on alternative data sources including various media and newspapers reports and information available online through the organisations websites. In addition, when documenting certain incidence or milestones relating to the healthcare reform where written documentation was not available, the researcher relied on anecdotal evidence collected through observations and informal discussion with staff members in the different organisations where field work was conducted.

The secondary data sources included the following:

a. Organisations websites (HAAD, SEHA, public hospitals, MOH, Abu Dhabi Government portal, GSEC, etc.)

b. Newspapers; an extensive review of media coverage of healthcare reform was conducted by reviewing English medium newspapers coverage (National, Gulf News, and Khaleej Times) from 2005 to date using key word search including ‘public healthcare’, ‘reform’, ‘Abu Dhabi’, and ‘UAE’.

c. On-line business journals such as http://www.arabianbusiness.com

d. Reports issues by Business Monitor International at www.businessmonitor.com

e. Official government publications on population and healthcare statistics e.g. HAAD Health Statistics 2012, UAE yearbook 2012 and 2013, Abu Dhabi statistics yearbook 2012 and 2013

f. Reports issued by international organisations such as the World Bank, UNDP and WHO.

5.6.2 Primary Data Sources

The researcher collected primary data in a field study, using a mixed-methods approach combining semi-structured interviews conducted with a sample of senior managers and directors working in public healthcare sector in Abu Dhabi with the on-line, cultural assessment survey based on OCAI (Cameron and Quinn, 2011). In addition, data available
through reports issued by external consultants (Booz, McKenzie, Deloitte, Boston Consulting Group) for which the researcher was granted access while conducting the field work were used as primary data sources.

**Research Ethics**

Prior to the commencement of field work, ethics approval was obtained from the Post Graduate Research (PGR) Ethics Committee at the University of Manchester. After that, the researcher discussed research ethics and confidentiality issues with the organisations studied in this research project; confidentiality agreements were signed with those respective organisations. Participants in both interviews and online survey were informed that the research initiative is subject to the Confidentiality and Ethics Guidelines of both their organisation and the University of Manchester (Appendix 2 and Appendix 3). Furthermore, respondents had access to the ‘participant information sheet’ through the online survey tool. This document was submitted as part of the ethics approval application and contained information about the use of the survey responses and the confidentiality statement. Finally, since the tool to capture the inline survey data was developed by a third party professional web development firm, and in order to preserve the confidentiality and integrity of the research data, a Service Level Agreement (SLA) was signed with the company in order to ensure compliance with data protection and confidentiality.

5.6.3 Semi-Structured Interviews

The research commenced with semi-structured interviews conducted with a sample of senior managers across the organisations studied. Sampling techniques are discussed in section 5.8.1. Interviews were largely conducted in English. The researcher considered the use of the Arabic language during the interviews, however it was apparent from the pilot and the initial interviews conducted that respondents were comfortable with the use of the English language. This is probably because although the Arabic language was considered the official language in all government departments, all internal communication including email and memos, executive meetings, and presentations were conducted in English.

The choice of semi-structured interview was determined by the research questions highlighted in Chapter 1. The reason for not employing structured interviews was based upon the idea that they would not be flexible enough to provide interviewees with the opportunity to include additional issues that may be of interest. On the other hand, semi-structured interviews, considered one of the most popular methods of interviewing, allow a certain degree of flexibility and pursuit of unexpected lines of enquiry during the interview
(Grix, 2010). Saunders et al. (2007) suggested that semi-structured rather than structured interviews should be adopted when the research questions are either complex or open-ended. Furthermore Blaikie (2010: 207) adds that “qualitative interview, particularly the in-depth variety, can get close to the social actors’ meaning and interpretations, to their account of the social interactions in which they have been involved”. Given that both situations appeared to be the case for this research, these arguments provide additional rationales for the decision to rely upon semi-structured interviews to collect the empirical data.

Notwithstanding the appropriateness of the semi-structured in-depth interviews for the current study, the researcher considered the potential weaknesses associated with interview techniques in general. The main stream schools of social sciences have tended to evoke a number of objections about the quality of interviews (Kvale and Brinkmann, 2009). According to Kvale and Brinkmann, the critiques fall into three general categories: (a) subjectivity of interview techniques and their inability to claim ‘scientific knowledge’, (b) interviewing process and data analysis, and (c) validity and generalizability. The subjectivity issues will not be addressed in details as the epistemological position adopted in this study provides ground to use data generated from interviews as an acceptable, if not desirable, data collection method, albeit when complemented with other methods. With respect to the risks associated with interview process and its reliability, the issues of interviewer and interviewee bias need to be considered. ‘Interviewer bias’ occurs when the interviewer’s comments or non-verbal language influence the interviewees. On the other hand, ‘interviewee bias’ may arise when the informant avoids discussing certain aspects of the topic, which he/she may consider to be sensitive information. The bias may also occur when the interviewees have specific expectations about the research or have the feeling that they may be judged by their responses which results in them providing what they regard as the ‘good’ or ‘right’ answer (Jingjit, 2008). Kvale and Brinkmann (2009) posit that un-acknowledged bias might invalidate results of an interview enquiry.

During the initial phases of the pilot studies, and by listening to the interviews recording, the researcher realised that in some cases she was unintentionally getting slightly involved with the interviewees by sharing her own experience and perspective on topics discussed during the interviews. The researcher felt that this approach would potentially increase interviewer bias and decided to change her approach during the subsequent interviews. Various practices were applied in an attempt to minimise bias. First of all, the questions were posed in a way that ensured that all the respondents would to a large extent have a
similar understanding of the meaning. Second, although the interviewer tried to encourage the informants to answer the questions, most of the times neutral replies were given to their responses without adding comments. Third, producing as true and full account of the interviews as possible reduced subjectivity and bias (Kvale and Brinkmann, 2009). Permission was sought from the respondents to record the interviews, who were also given the choice of pausing the recording at points when it involved sensitive issues in order to enhance the interviewees’ confidence hence improving their relationship with the interviewer. Finally, one important technique used in this study to address subjectivity and improve reliability of findings is triangulation of research methods. “Stripped to its basics, triangulation is supposed to support a finding by showing that independent measures of it agree with it, or at least, do not contradict it” (Miles and Huberman, 1994: 266). The researcher decided to use OCAI based on-line questionnaire as detailed the section below as a mean to triangulate results and therefore increase reliability of findings. However, despite the best efforts, it was practically impossible to eliminate all bias. Paradoxically, a small dose of recognised subjectivity might bring new dimensions forward contributing to multi-perspectival knowledge (Kvale and Brinkmann, 2009), and can be viewed as consistent with the realist paradigm applied in the current study. Indeed, the researcher noticed that certain questions relating to organisational culture, organisational leadership, and Emiratisation were viewed by some informants as rather sensitive; those informants gave quite conservative, neutral answers to those questions. The researcher felt that those respondents were giving the ‘politically correct answer’ rather than their true opinion about those topics. However, the researcher observed that as confidence was built throughout the interview, and towards the end of the interview time, a number of interviewees opened up and became quite open about those issues and frankly shared their personal opinion of matters discussed.

5.6.3.1 Interview Protocol
The core interview questions are presented in Appendix 1. The interview protocol had five main sections. Section one sought general information such as job title, educations level, and organisational tenure, while section two consisted of specific information about the role of the informant and her general views about their working experience. Those questions were thought to be necessary and helped the researcher to ‘break the ice’ and establish the rapport with the interviewee before asking the specific questions about organisational culture. Part three addressed questions taken from the OCAI about the types of organisational culture (hierarchy culture, market culture, clan culture and adhocracy) prevailing in the organisation. The model defines these cultures in terms of six dimensions:
dominant characteristics, organisational leadership, management of employees, organisation glue, strategic emphasis and criteria for judging success. Section four asked questions about performance management systems and the factors influencing performance in the public healthcare sector in Abu Dhabi, whether negatively or positively. Finally, section five consisted of additional questions which were designed to be open-ended and seek participants’ opinion about challenges facing the healthcare sector, Emiratisation, and their ideas about the changes needed to address those challenges and improve performance in the public healthcare sector.

The core questions for the interviews conducted with the hospitals were slightly amended compared to the questions used in HAAD and SEHA reflecting the different organisational focus and priorities of hospitals. The interview questions with hospitals’ CEO focused primarily on challenges faced by hospitals and on organisational culture, and less focus on performance questions, mainly because detailed performance information on every hospital was readily accessible through SEHA corporate office.

5.6.3.2 The Interview Process
The researcher submitted a formal letter to his/her sponsor requesting permission to conduct the interviews. Subsequently, the sponsor sent correspondence (Appendix 2) to the sample of interviewees selected. This correspondence was accompanied by a short presentation prepared by the researcher explaining the objectives of the study, its timelines, and its potential benefits to the organisation. The researcher noticed that sending this short presentation along with the request for the interview helped during the interview process as it gave the majority of participants a general idea about the context of the study and its objectives and how their contribution is essential to the success of this research initiative. In general, participants were happy to share their views and opinion; for more than 50% of them, it was the first time they participated in academic research, as such they viewed this interview as a new opportunity to express their opinion in a non-professional context.

At the start of each interview, the researcher introduced herself (using Arabic then switching to English as appropriate), obtained permission from each interviewee to proceed and explained the research aim, the objectives and the ethical position, which was to assure the confidentiality and anonymity of the interviews in order to give the interviewees the confidence to answer the questions freely. Out of a total of 26 interviews, 23 were fully recorded; for the three interviews were no recording was permitted, the researcher took note while interviewees talked. All interviews were transcribed by the researcher.
5.6.4 Questionnaire Survey

At the subsequent stage of the research, an online-survey was carried out in SEHA corporate office and nine public hospitals. The main rationale for conducting a survey is that the data acquired would provide more representative results than in-depth interviews alone. Grix (2010) posits that questionnaires are most effective when used in conjunction with other methods of enquiry, especially interviews. The technique normally allows a greater coverage of cases with fewer resources, a more systematic comparison across different settings, and a potentially higher degree of objectivity (Sackmann, 1991). Saunders et al. (2007) add that questionnaires are useful for research which needs to be descriptive and explanatory, particularly in gaining an insight into opinions, attitudes and organisational practices.

However, questionnaires have their limitations. A major one according to Kumar (2005) is that if questions are ambiguous or not clear, the risk of misinterpretation by respondents, or that different respondents interpret the questions differently, is high which would affect the reliability of results. Another limitation in cultural assessment questionnaires is that they tend to be rigid both in terms of categories and the choice of responses offered to respondents (Jung et al., 2009). Finally, according to Yaugh and Steudel (2003), it is important to be clear about the cultural integration of the sample under consideration. If the organisation is assumed to possess a homogeneous culture, then a representative sample might give a fair assessment of the prevailing cultural profile. If however the organisation studied have strong subcultures, then a more stratified sample that would ensure proper representation of those sub-cultures is more appropriate. In order to circumvent the limitations above, the researcher used multiple pilot tests as highlighted in section 5.7.

During the initial study design, the intentions behind using the cultural assessment survey as a method of collecting primary data were (a) to triangulate the results from the qualitative interviews, and (b) using quantitative techniques (e.g. correlation analysis), to investigate the relationship between the organisational culture typologies and different measures of hospital performance. However, with an average of five respondents per individual hospital as detailed in Table 15, the sample collected was considered relatively small, and would not provide a fair representation of the prevailing culture(s) in each individual hospital to allow for statistical correlation between culture and performance. Instead the researcher used the compiled results of all responses from hospital staff to form a cultural assessment of all public hospitals. Moreover, data collected from the surveys was
used as a mean for triangulation of results from the qualitative assessment and to allow a more detailed level of analysis across different demographic variables.

5.6.4.1 Organisational Culture Assessment Instrument (OCAI)

The questionnaire employed in the survey was designed based on the Organisational Culture Assessment Instrument (OCAI) developed and validated by Cameron and Quinn (2006: 26-28) which has the CVF as its core structure. The OCAI was selected because it has already been employed in more than a thousand organisations in both private and public sectors and was found to be effective in diagnosing the major attributes of organisational culture (Cameron and Quinn, 2006: 23).

The OCAI based questionnaire was administered using an on-line based survey tool designed by the researcher. The survey (Appendix 5) has two parts. The first part elicited information about demographic characteristic of participants such as gender, age, nationality, and educational level. Organisational characteristics were also captured in this section including the name of organisation/hospital, position, professional group (physicians, nurses technicians, administrators), and organisational tenure. The researcher included these questions to establish whether there was a correlation between those characteristics and cultural typologies scores measured in the second part of the survey.

The second part of the survey is designed to investigate the main variables of the study. It assesses the cultural typologies based on the six elements of organisational culture identified by (Cameron and Quinn, 2011) as follows:

1. Dominant characteristic of the organisation
2. Leadership style
3. Management of employees
4. Organisational cohesion
5. Strategic emphasis
6. Success criteria

In order to enhance the clarity of the on-line questionnaire, and ensure that respondents understand the objective of the questionnaire, and in particular the measurement scale discussed below, an overview email (Appendix 3) was sent to every selected participant through the HR department of each organisation. In addition, a letter introducing the survey (Appendix 4) was prepared and included in the on-line version of the survey.
5.6.4.2 Response Scale

Participants were asked to rate their organisational culture based on the six dimensions referred to above twice. The first assessment reflects their current view of organisational culture in their respective organisations; the second assessment reflects their preferred view of organisational culture, in other words what are the cultural characteristics that in their opinion would support their organisation in achieving its strategic objectives and lead to performance improvement. In order to reduce interviewee bias in assessing both their current and preferred organisational culture, the researcher decided, following a number of pilots and discussion with participants who tested the on-line survey, that it is preferable for participants to first score the current culture across the six dimensions, and then proceed to scoring the preferred culture across the same dimensions. Compared to the approach of scoring each dimension on current based on current and preferred cultures at the same time used in previous studies (Al-Khalifa and Aspinwall, 2001, Jingjit, 2008, Al-Otaibi, 2010), the approach used in this study was thought to better allow the participant to form an idea about their current culture before proceeding to their preferred culture.

The current research relied upon ipsative rating scale. Using the ipsative scale, respondents are required to distribute 100 points among available choices for each question. The scale was considered to be more appropriate for the current study than the Likert scale, which is the most commonly applied method (Jung et al., 2009), because, as Cameron and Quinn (2006: 160) explained, it appears to be effective at highlighting and differentiating the distinctiveness of a culture in an organisation. This is because it offers a 100 point scale rather than a 5 or 7 point scale in a Likert format. The ipsative rating thus provides greater differentiation. Another strength of the technique is that it forces respondents to specify the trade-offs between the four different types of culture advocated by the CVF (Cameron and Quinn, 2011). Thus greater differentiation is likely to appear than when the Likert scale is employed, as people tend to give all quadrants high or all quadrants low scores (Jingjit, 2008). Al Otaibi (2010) used 5 points Likert scale to analyse the current and preferred culture in Saudi public hospitals. The quantitative analysis of his survey data revealed similarities between the four types of organisational culture in the Saudi health care provision in both the current and preferred situations. Al Otaibi (2010: 247) attributed those results to the use of Likert scale which allowed little differentiation of responses and concluded that “adopting an ipsative scale would have been better at showing these differences”.

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Both of the benefits of using ipsatve scale, e.g. differentiation, and forcing trade-offs, are especially significant for the current study, which had the main aims of examining the cultural characteristics of the Abu Dhabi Healthcare sector and the perception of the different players in this sector regarding the preferred culture that would lead to performance improvement.

5.6.4.3 Design and testing of the online survey

In order to facilitate the data collection, distribution of the survey among the participants, and analysis of the results, the researcher developed an online tool to capture and analyze the survey data. The development and testing, of the website took place between February 2012 and December 2012. The survey instrument can be accessed through the following address, www.nmessaikeh.com. Through this website, participants enter their demographic data through a sign-up page; they can then complete the survey instrument online in English or Arabic language according to their preference (the entire website translates to English or Arabic when language preference is chosen). The online tool also allows the back-end processing of survey data both on individual participant level and consolidated level based on criteria defined by the researcher (e.g. age, nationality, occupation, etc…). Participants have the option of receiving the results of their individual assessment should they so wish. They receive the graph depicting the ‘now’ and ‘preferred’ cultures and a high level description of the different cultural types. As became apparent from the pilot tests performed, most participants appreciated this feature as unlike other surveys where they usually do not get to see the results, this tool allowed the real-time, graphical representation of their scores together with an explanation of the meaning of each cultural typology. Furthermore, the on-line tool facilitated the data analysis by automating the calculation of the response scores, thus allowing the researcher to instantly view and analyze the consolidated results including both organisational assessment scores and related graphs.

5.7 Pilot Studies

Before embarking in the major field work, pilot studies on research methods and data collection tools to be used during the study were undertaken. Van Teijlingen and Hundley (2001: 33) argue that “pilot studies are crucial elements of a good study design”. The authors identified a number of reasons for conducting pilot studies ranging from developing and testing the adequacy of research instruments, to establishing the sampling framework, identifying logistical and recruitment issues, assessing the proposed data analysis techniques, and convincing funding bodies and other stakeholders of the
feasibility and worthiness of the study. Testing of questionnaires is of particular importance in pilot studies. Piloting questionnaires before any large scale dissemination has the advantage of improving the internal validity of the questions (Peat et al., 2002), and the level of reliability of data to be collected (Saunders et al., 2007). Pilot studies also enable the refinement of research questions and their adaptation to the local context of the study, they help to identify ambiguities and difficult questions, and to assess whether each question gives an adequate range of responses (Peat et al., 2002).

Given that the study employed both qualitative and quantitative approaches to address the research questions, pilot studies were conducted in two phases. During the first phase of the pilot, in-depth interviews were conducted with three individuals working in the public healthcare sector in Abu Dhabi to pilot the interview questions and the interview schedule. The second, more detailed phase of the pilot involved the testing of the cultural assessment survey used in the quantitative part of the study. This second phase was thought to be of particular importance to the investigation in order to ensure the ‘cultural fit’ of the questionnaire to the context being studied. To the best of the researcher’s knowledge, the OCAI and CVF have not been used in cultural assessment studies in the UAE, at least not in healthcare contexts. This pilot was conducted in three sub-phases. In the initial phase conducted between April and May 2012, 20 participants working across different industries in both private and public sectors were asked to complete the paper based version of the survey. Through this first pilot, feedback about the clarity of the instructions and the survey questions, clarity of the terms and language used, and time needed to complete the survey were gathered. As a result, some of the survey questions were refined. The questions were slightly adapted to fit the local context, particularly certain terms e.g. ‘no-nonsense’ used in the original version of the survey were slightly confusing to certain respondents.

During the second phase, the research instrument was piloted with 10 participants at HAAD in October 2012. The pilot was conducted using paper based survey as the online version of the survey was still under development at that time. The 10 participants, who participated on a voluntary basis, represented the majority of the divisions and business units at HAAD. Participants were asked to fill out the survey first; this was followed by a 45 minutes focus group discussion facilitated by the researcher, to discuss feedback on research instrument. The questions raised during the feedback sessions were guided by the checklist compiled by (Fowler, 1995) that lists the type of questions that researcher should
address during the pilot. Those include clarity of wording, questions that could raise confusion or potential bias, and length of the questionnaire among other things.

The feedback received focused on four main areas; first clarifications were sought on a number of variables relating to demographic information (e.g. age group, education, position), in addition to minor changes in some wordings used which were thought to be ambiguous. Those clarifications were taken into consideration and amended in the revised version of the survey. Of particular interest was the question relating to the nationality of the participants. During the initial pilot of the survey, the nationality question was marked as ‘country of origin’; respondents expressed confusion as to whether country of origin indicates nationality at birth, current nationality, or even both for people holding dual nationality. Eventually the researcher opted to rename this field as ‘nationality’ and indicated that the value chosen should be based on nationality as per currently hold passport, or current nationality as reported in the human resources records of the organisation.

The second feedback from participants was about the measurement scale used in the survey. In fact participants felt unfamiliar with the Ipsative scale in comparison to the Likert scale they were mostly used to. However after discussing their concerns, the majority agreed that the Ipsative scale was more appropriate to the investigation as it forced them to make choices relating to the type of organisational culture in each of the six dimensions. In addition, participants recommended an electronic version of the survey to facilitate recording of the responses and minimize mathematical errors in allocation the total score of 100 across the four possibilities. Thirdly, participants expressed confusion around the question relating to their assessment of leadership of their organisation. The confusion focused around who is considered the leader, is it their direct supervisor, the divisional director, or the CEO? This was probably expected in an organisation like HAAD that does not have one culture, but is rather characterised by multitude of fragmented subcultures. Nevertheless, the feedback was taken into consideration and clarifications regarding the definition of the leader were considered in the final version of the survey.

Finally, the fourth recommendation received from participants focused around the language used in the survey which was English. The feedback received during the pilot revealed that some native Arab participants especially UAE Nationals felt that it would be easier for them to fill the survey if it was translated to the Arabic language. As a result the survey instrument was translated to the Arabic Language. Issues relating to language and interpretation of certain questions noted during the pilot are consistent with other
quantitative studies of organisational studies. Yaugh and Steudel (2003) and Jingjit (2008) have noted similar challenges when administering cultural assessment surveys.

The third phase of the pilot was conducted after the completion of the on-line version of the survey in March 2013. Ten participants from SEHA corporate office and SEHA hospitals were selected by SEHA management to test the on-line survey. Participants were provided with laptops which they can use to access the electronic version of the survey and complete the online survey. Overall the feedback from the pilot was very positive, participants thought the questions were clear and the Ipsative scale used forced them to make choices. Another feedback received during the final pilot phase is the organisational level of people who will participate in the survey. Participants thought that respondents need to have a certain organisational and managerial experience to be able to provide a comprehensive feedback on the questions. Participants thought that possessing some level of managerial exposure would enable respondent to provide a comprehensive, organization-wide assessment of the various cultural aspects referred to in the survey. In contrast, respondent with no or limited managerial exposure might provide a cultural assessment reflecting the narrow view of their unit or function. Such feedback, triangulated by the strategies adopted in previous studies was taken into consideration when designing the sampling strategy for the survey as referred in section 5.8.2.

5.7.1.1 Translation of the survey instrument

Since the survey instrument was intended to be distributed among public healthcare sector entities where the Arabic language is predominant among some participants especially UAE nationals, the questionnaire was translated into the Arabic language. The online version of the survey was available in both English and Arabic. This enabled participants who are not fully comfortable with the English language the choice to complete the survey in Arabic, thus ensuring wider participation.

Sperber (2004: 124) argues that “it is not enough to translate the questionnaire literally, the additional challenge is to adapt it in a culturally relevant and comprehensible form while maintaining and intent of the original items”. To overcome those challenges, back translation was then used in order to check the accuracy of the translated questionnaire. According to Brislin, (1970), this technique is particularly relevant in cross-cultural studies, it involves two phases. First translating the source to the target language, and then blindly translating from the target to the source by a different professional. The two versions are then compared and adjustments are made to the translated document as deemed necessary (Brislin, 1970).
Using this technique, the translation of the survey questions to Arabic was completed in June 2012 using a professional translator. The survey was then translated back into the original language (English). The back translation was performed by the researcher’s Arabic speaking colleagues who were fluent in both English and Arabic. The back-translation and the original translation were compared and the translation was then adjusted if necessary. The Arabic version of the cover letter and survey questions are available in Appendix 6.

5.8 Sample Selection

The number of individuals that need to be surveyed to assess the culture of an organisation usually depends upon the aims and budget of the study. According to Scott et al. (2003a), if the quantitative data from the survey is used is used to triangulate other data sources, then the sample size can be selected on pragmatic grounds. If, however, the aim is to examine the statistical relationship between culture and a potential dependent variable, such as the performance of the organisation (Shortell et al., 2000, Stock et al., 2007, Jacobs et al., 2013a), then the size of the sample will be determined by the anticipated effect size and the desired power of the study. When searching for such statistical relationship, the sample would probably have to be very large if any effect is to be found (Shortell et al., 2000).

Another factor to be taken into consideration is the existence of subcultures within an organisation, particularly in health settings where professional cultures are strong (Hofstede 1980; Degeling, Kennedy, and Hill 1998). It is therefore important to select an adequate sample to allow subgroup analysis alongside whole organisation analysis (Yaugh and Steudel, 2003). The Competing Values Framework is specifically designed to represent the balance of different cultures within the same organisation. (Scott et al., 2003a).

5.8.1 Sample for the Semi-Structured Interviews

In the original research design, the researcher intended to gather primary data through semi-structured interviews in the regulator (HAAD) and Operator (SEHA corporate office), and rely on on-line survey to gather data from public hospitals. However as the response rate from hospitals came low, the researcher conducted five additional interviews with CEOs and Deputy CEOs of three different public hospitals; the hospitals selected were SKMC, Al Ain Hospital, and Al Rahba hospitals. The choice of those three hospitals was intended to provide a mix of different types and sizes of public hospitals in Abu Dhabi. SKMC is the largest public hospital in Abu Dhabi managed by Cleveland Clinic with over 600 beds; Al Ain hospital is a medium sized 378 bed public hospital managed
directly by SEHA, and Al Rahba hospital is a relatively small 93 bed hospital managed by John Hopkins.

This group of senior managers and executives was chosen because they were qualified to provide answers to ‘what’ and ‘why’ questions about the specific types of organisational culture, which were prevalent in the division/organisation/hospital. The researcher also considered that they would be most likely to have adequate knowledge and information to enable them to answer research questions about the type of organisational culture which would best support efforts to improve health care services in their hospitals. In addition, they would be more able to provide information about the performance management system and the internal and external factors that are thought to impact the performance of the healthcare sector. Finally, the group of senior managers and executives was thought to be in the best position to answer the additional questions addressed through the interview questions especially those related to the challenges facing the healthcare sector and their views on Emiratisation.

The choice to interview senior managers as part of the qualitative assessment is consistent with previous research on organisational culture (Gerowitz et al., 1996, Davies et al., 2007, Jacobs et al., 2013a, Gerowitz, 1998, Gregory et al., 2009). Although this approach is thought to exclude certain segments of organisations, prior research argued that this is an important group in terms of their formal leadership role in their organisation (Gerowitz et al., 1996, Scott et al., 2003a). Second, as indicated earlier, it was highlighted through the two pilots conducted that participants felt that lower level staff might not be able to provide a holistic view of organisational culture needed in those types of empirical investigation. The researcher is aware of the limitations posed by restricting the sample to the senior managers and executives, and the risks that this might provide a biased view of organisational culture. However, given the time limitation and access challenges faced, this was considered the most suitable approach for this study. The potential impact of sample selection and sampling approach on the study results is discussed in more detail in Chapter Eight.

In total, 26 interviews were conducted; Table 14 shows the numbers of interviews conducted in each entity. Interviews in HAAD were conducted between September and October 2012, interviews in SEHA were conducted in April 2013, and interviews in public hospitals were conducted in December 2013 and January 2014. The reason for the time span between the interviews is due to the time it took to secure approval for access from the executives of the entities studied. In planning for the interviews, an hour meeting was
requested and booked with every interviewee. Actual interview time recorded was between 45 and 90 minutes, with the majority of the interviews lasting around 60 minutes. Of the 26 informants, 16 (62%) percent were males, while 10 (38%) were females. 50% of the informant were UAE nationals, while the other 50% were non-national expatriated from 7 different nationalities.

Table 14 - Interviews conducted by entity

<table>
<thead>
<tr>
<th>Entity</th>
<th>Number of interviewees</th>
<th>Males</th>
<th>Females</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulator (HAAD)</td>
<td>11 interviews</td>
<td>7</td>
<td>4</td>
<td>Includes CEO and all divisions directors</td>
</tr>
<tr>
<td>Operator (SEHA)</td>
<td>10 interviews</td>
<td>4</td>
<td>6</td>
<td>Includes CEO and 80% of Divisions Directors</td>
</tr>
<tr>
<td>Public Hospitals</td>
<td>5 interviews</td>
<td>5</td>
<td></td>
<td>Includes CEO and deputy CEO of three public hospitals</td>
</tr>
<tr>
<td>Total</td>
<td>26 interviews</td>
<td>16</td>
<td>10</td>
<td>50% Emirati and 50% Expats</td>
</tr>
</tbody>
</table>

5.8.2 Sample for the Online Survey

As indicated earlier, the on-line survey was distributed to participants in SEHA corporate office and nine public hospitals. Because a change in leadership occurred at the regulator agency (HAAD) following the completion of the interviews and the survey pilot, HAAD could not be included in the survey. Despite of numerous attempts by the researcher to get permission to conduct the survey, the new management was not responsive. Therefore the data collection at HAAD relied solely on interviews and document analysis.

The sample selection for the quantitative phase was therefore dictated by the access permission granted across the different research sites. At SEHA, given the relatively small population (262 in total), management agreed to distribute the survey the all employees. Although the focus of the study is to analyze organisational culture from the point of view of managers as discussed in section 5.8.1, the researcher agreed to administer the survey for all SEHA employees and use the responses relating to middle and senior managers for the purposes of the data analysis. Staff were informed that their participation is completely voluntary and that some of the responses might not be included in the final analysis. In total 79 responses from SEHA were received of which 65 pertained to staff holding senior, middle management and management positions. The 14 responses relating to junior staff and coordinator positions were excluded from the analysis. Of the 65 responses, nine incomplete surveys where respondents did not complete all six questions for current and
preferred culture were deemed unusable and therefore excluded from the analysis. In addition two cases which had scores of 100 applied to one of the four culture types, and zero score applied to the other three types were considered as extreme outliers and also excluded from the analysis. With respect to public hospitals, a purposeful sample was selected from every one of the nine public hospital owned and/or managed by SEHA. This sample was selected in coordination with SEHA management and included managers and senior managers across the different professional groups (e.g. Physicians, Nurses, Technicians, and Administrators) in each public hospital. The targeted response rate was 10-15 respondents per hospital.

The survey at SEHA corporate office was launched in June 2013 and open for participants for a period of six week. During this period, three reminders were sent in order to increase the response rate. In July 2013, the survey was launched in all nine public hospitals managed by SEHA. In spite of sending three reminders to participants including a final reminder sent directly from the CEO of SEHA to the CEOs of individual hospitals requesting their cooperation in completing this survey, the response rate in all but one hospital was below the target of 10 responses.

<table>
<thead>
<tr>
<th>Entity</th>
<th>Total Population</th>
<th>Number of Surveys Distributed</th>
<th>Number of Respondents</th>
<th>Usable Replies</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abu Dhabi Health Services (SEHA)</td>
<td>262</td>
<td>262</td>
<td>65</td>
<td>54*</td>
<td>21%</td>
</tr>
<tr>
<td>Al Ain Hospital</td>
<td>1,443</td>
<td>22</td>
<td>6</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Al Corniche Hospital</td>
<td>1,021</td>
<td>21</td>
<td>5</td>
<td>4</td>
<td>19%</td>
</tr>
<tr>
<td>Al Rahba Hospital</td>
<td>773</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>14%</td>
</tr>
<tr>
<td>Ambulatory Healthcare Services</td>
<td>2,475</td>
<td>18</td>
<td>5</td>
<td>4</td>
<td>22%</td>
</tr>
<tr>
<td>Al Mafraq Hospital</td>
<td>1,947</td>
<td>27</td>
<td>5</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td>RCMS</td>
<td>1,435</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>20%</td>
</tr>
<tr>
<td>Sheikh Khalifa Medical City</td>
<td>3,034</td>
<td>53</td>
<td>8</td>
<td>7</td>
<td>13%</td>
</tr>
<tr>
<td>Tawam Hospital</td>
<td>2,936</td>
<td>47</td>
<td>10</td>
<td>9</td>
<td>19%</td>
</tr>
<tr>
<td>Al Gharbia Hospitals</td>
<td>1,173</td>
<td>19</td>
<td>6</td>
<td>5</td>
<td>26%</td>
</tr>
<tr>
<td>Not indicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,499</strong></td>
<td><strong>491</strong></td>
<td><strong>114</strong></td>
<td><strong>100</strong></td>
<td><strong>20%</strong></td>
</tr>
</tbody>
</table>

Two cases were identified to be extreme outliers using box plot identification criteria and were therefore excluded from the quantitative analysis.
The resulting overall response rate was about 23% as indicated in Table 15. Scott et al., (2003) argue that a low response rate may be predicted in a health settings. When impersonal questionnaires are administered to staff about what some might perceive to be a ‘nebulous issue’, or others perceive as a ‘hidden agenda’, lower participation might be expected. From the researcher’s standpoint, one way to interpret the low response rate in the hospitals is the lack of awareness and appreciation by hospital staff of the importance of academic research conducted outside the classical clinical research. Another possible interpretation could relate to the timing of the launching of the survey that happened right after a large scale management survey sent by SEHA corporate office, Employee Engagement Survey. Subsequently for the purpose of analyzing the findings, participants were grouped into two categories only: SEHA Corporate office, and Hospitals.

5.9 Data Analysis

Given that the research relied upon a combination of qualitative and quantitative methods of data collection, the process of data analysis comprised two main approaches that dealt exclusively with each data type.

The qualitative analysis stage involved the process of organising and interpreting the data obtained from the semi-structured interview transcript materials. The researcher used content analysis to analyze the interview responses. Kvale and Brinkman (2009: 203) describe content analysis as “… a technique for making quantitative descriptions of the manifest content of communication”. Content analysis was developed in World War II and has since been used extensively for qualitative data analysis especially media analysis and interviews (Kvale and Brinkmann, 2009). The reason for choosing this technique here was that it was considered the most appropriate for varied qualitative data collected though semi-structured interviews. Gillham (2000) states that content analysis examines how interviewees perceive and understand certain issues or phenomena. Each statement is analyzed for content and placed under an appropriate heading, with any other closely related statements. Content analysis starts with defining codes referred to as “tags or labels for assigning units of meanings to the descriptive and inferential information compiled during a study” (Miles and Huberman, 1994: 56). The coding of text’s meaning into categories makes it possible to quantify how often specific themes are present in a text, the frequency of themes can be then compared to other measures, or correlated to research hypothesis (Kvale and Brinkmann, 2009). The researcher analysed the content of the responses by categorizing them under three headings based on interviewees’ answers to
questions about the type of organisational culture that was dominant in their organisation, as follows:

- What is the dominant type of organisational culture in your organisation?
- What is the preferred organisational culture in your organisation that is conducive of performance improvement?
- What are the potential challenges facing the healthcare sector in Abu Dhabi?

To address the first two questions, data was categorised into a theme-based pattern (Kellehear, 1993) structured according to the CVF, the core framework of the study. Therefore, all the statements and responses were judged on whether they were indicative of hierarchy, clan, market or adhocracy cultural models both in current and preferred cultures.

To address the third question, themes were derived inductively by analysing the interview data. Themes such as role ambiguity, fragmentation, subcultures, lack of clear strategy, communication, employee engagement, Emiratisation, staff turnover, and other were identified as recurring and important themes throughout the interviews. Those themes and content analysis of interviews are discussed in more details in Chapter Six, Empirical Findings-Qualitative Data.

Data collected from interviews was analysed and coded using manual techniques. Although an analysis of the qualitative data through NVivo software was initially explored and tried out, the researcher decided to rely on the manual approach rather than utilising NVivo. This is because the manual approach allowed more reflexivity and flexibility to data analysis. Furthermore, the latter was found to be more accurate given that NVivo sometimes failed to include all the relevant statements/responses and the coding process appeared to be more time-consuming.

The quantitative survey data was first extracted from the proprietary database into Excel and subsequently imported into SPSS version 22. SPSS was used for more quantitative analyses and tests of statistical significance. The statistical tests used to analyse the quantitative data including descriptive statistics, General Linear Modelling, and regression analysis are described in more details in Chapter Seven, Empirical Findings -Quantitative Data.

5.10 Conclusion

This chapter has offered a comprehensive discussion of the methodology adopted in the current study. Starting with the key philosophical underpinnings of the study, this section provided an account of the particular nature of research in the healthcare sector. It
highlighted the importance of understanding the unique contextual factors and the role that different social actors play in any policy reform. It then discussed the different research paradigms adopted in public administration and healthcare research emphasising the importance of embedding research into its wider socio-economic context in order to capture the multiple, often complex relationship between government and society. The use of CVF as a conceptual framework for this study provided clear advantages in framing data analysis and offered the potential for a methodological contribution stemming from the implementation of CVF outside western contexts. Subsequently, the research instruments and data collection tools employed in the current study, including semi-structured interviews and the OCAI based on-line survey were explained in detail with justification for their application. Particular attention was placed in this chapter to explain the challenges faced in data collection and the methods used by the researcher to overcome those challenges.
6.1 Introduction

This chapter contains a report of the empirical findings from the analysis of the qualitative data acquired from the in-depth, semi-structured interviews. It is organized into three major parts. The first part is largely concerned with the presentation of the key characteristics of the organisational culture of the different entities studied based on the four cultural typologies suggested by the CVF. The next section presents findings regarding the preferred organisational culture as perceived by the informants. Each of the four CVF cultural types is addressed in turn in both sections; moreover, the extent and direction of perceived cultural change within the different entities and nationality clusters are emphasised in the analysis. While the prevalence of hierarchy and market cultures was obvious in analysing the current cultural characteristics of public healthcare entities in Abu Dhabi, different organisations and nationality clusters expressed divergent assessment of organisational culture especially with respect to clan culture. The final section summarises the different challenges facing the public healthcare sector that are perceived to hinder performance improvements in this sector.

The full interview protocol is presented in Appendix 1. The five main areas addressed in the interview include the informants’ role in the organisation, their assessment of the organisational using CVF, their views of performance management system implemented in their organisation, and their assessment of the different challenges facing the public healthcare sector in Abu Dhabi. The informants’ responses are indicated by quotes. All names have been left out to ensure anonymity. The respondents’ organisations (denoted by HAAD = Health Authority Abu Dhabi, SEHA = Abu Dhabi Health Services Company, and HOSP = Public Hospitals), and interviews number are provided in brackets after the quotes. The findings in this chapter are reported principally in terms of the four cultural typologies of the CVF namely:

1. Hierarchy Culture
2. Market Culture
3. Clan Culture
4. Adhocracy Culture

The analysis of the qualitative data attempts to answer the following research questions
1 What are the current dominant types of organisational culture across the three constituents of public Healthcare sector in Abu Dhabi (Regulator, Operator, and public hospitals)?

2 What types of organisational culture would best support efforts to improve healthcare performance in Abu Dhabi?

3 What are the challenges facing the public healthcare sector in Abu Dhabi?

6.2 Dominant Organisational Cultures

6.2.1 Hierarchy Culture

The majority of the respondents described their organisations as dominated by bureaucratic cultural attributes, they view that rules and procedures represented the primary element that governed how the organisations functioned. This feature was especially pronounced in HAAD where seven out of ten respondents described their organisation as operating a hierarchy. Hierarchy was intrinsically seen as the dominant cultural characteristic given HAAD’s role as a regulator. The practice seemed to be underpinned by the basic assumptions that formal policies, rules, and regulations were essential in order to ensure compliance with health regulations and protect the public. This feature is clearly illustrated by the following statement from one of the directors at HAAD: “We have the stigma of being a governmental entity. The nature of our organisation defines our culture, we are regulatory authority we need to be hierarchy” (HAAD 5).

Constitutionally mandated by the Executive Council to regulate all healthcare matters in the Emirate of Abu Dhabi including licensing of medical facilities and healthcare professionals, enacting healthcare regulations and ensuring compliance across all medical facilities, HAAD’s role was seen by its management as ensuring compliance with regulations: “HAAD’s mission is achieving the overall objective of improving the healthcare system by implementing instructions from the government and executing things in accordance with the law” (HAAD 2). Furthermore, the nature of the compliance functions at HAAD dictated some aspects of hierarchy culture as elucidated by one of the directors: “Take for example licensing and health care compliance, these are definitely hierarchy, it is consistent with their core functions, there are some predefined rules and regulations that should be strictly adhered to” (HAAD 3).

The hierarchy culture was clearly manifested in the command and control management style, placing particular emphasis on compliance with rules and regulations “Respect is really important because managers do their own work and respect the rules and
regulations and what is expected from them” (HAAD 2). The command and control mentality was equally reflected in respect for hierarchy, “I respect you because you have a higher position, you are the leader” (HAAD 5).

Criteria for success are defined in most cases as completing the work within the boundaries set by the system: “success in the current situation is to do one’s work or exceed expectations within the boundaries that are set for the employee” (HAAD 4).

However, those bureaucratic rules are seen by many directors as too rigid to facilitate change in a fast moving, dynamic environment as put by one of HAAD’s directors: “Working at HAAD is exciting because we were able to achieve so much in six years. But it is frustrating at the same time because we have bureaucratic, heavy policies and systems that pull us down and hinders us from achieving our strategic objectives. You still need those checks and balances, but when those processes become too bureaucratic and inefficient, they impact the results we are trying to achieve. HAAD is under-siege in all those bureaucracies” (HAAD 3).

In particular, informants reported that the bureaucratic policies in procurement and human resources were thought to be very rigid, creating more red tape across the organisation, and resulting in some cases in substantial delays in completing projects. To illustrate, one of the informants indicated that ordering critical equipment to one of the hospitals was delayed by more than two months because of long procurement procedures. This affected the hospital’s ability to serve its patients.

In SEHA, hierarchy is also clearly manifested, though to a lesser extent compared to market culture. Initially considered as part of the same of HAAD, SEHA was thought to be influenced by the formalised, structured place that characterised HAAD. A director in SEHA indicated “we started six years back as full hierarchy” (SEHA 1). Standardised rules and regulations steer SEHA to a large extent: “coming from government background, and following policies and procedures, which are great things to do, shows that we are a hierarchy culture” (SEHA 4).

Similar to HAAD, those heavy bureaucratic rules were seen as hindering progress in certain areas: “There are still governmental rules and regulations that prevent us from achieving our strategic objectives, we have to follow those heavy rules and regulations in HR and procurement primarily” (SEHA 3).
The heavy influence of support services including HR, procurement, and finance on creating a culture where formal policies hold the organisation together was very obvious at SEHA to the extent that one informant indicated that SEHA was steered by budgets:

“The organisational culture is heavily dominated by finance and budgets, there is very little discussion about quality and patient safety, it is all about budget” (SEHA 2).

The hierarchy culture in SEHA was clearly cascaded to hospitals. Hospitals in turn saw that SEHA corporate office is micromanaging the hospitals with a command-and-control mentality as indicated in the following statements:

“SEHA corporate is seen as bureaucratic organisation exercising power over hospitals in decision making. SEHA is injecting a micromanagement philosophy in hospitals” (HOSP 4).

“I see the healthcare system in Abu Dhabi as a centralised bureaucratic system, with lots of power exercised by SEHA” (HOSP 1).

Even though a number of initiatives were put in place in order to better integrate the hospitals within the overall SEHA group through monthly and quarterly meetings and discussion forums, hospital were largely seen by SEHA as operational units where the healthcare strategy is implemented. Their involvement in shaping that strategy was limited: “The role of CEOs in hospitals are implementers and not strategists” (SEHA 2).

Organisationally, it appeared that divisions and units within HAAD and SEHA operated mostly in siloes which led to the presence of strong, often disconnected sub-cultures and in turn hampered the implementation of reform initiatives. The following statements illustrate this observation:

“The biggest thing is that we are so siloed. We are not flexible, we do not have one culture, because each department function on their own and in their own angle, and it is based on what each director wants. We do not have cohesiveness. Everybody here march to their own drums, there is no orchestra that pull everyone and everything together” (HAAD 7).

“One of the most important challenges we are facing is the transition from a siloed based organisation to a service delivery organisation, and the introduction of the integrated service based model” (SEHA 2).

Finally, in atomised, hierarchical organisations, communication appeared to be amongst the factors that contributed to slow implementation of reform initiatives and poor buy-in
and engagement from staff. There are many reasons for the poor communication including the fragmented nature of organisations and the divide between its different constituents. Informants indicated that communication both within the organisation (internal) and with other external stakeholders and the public at large (external), and within departments (vertical) and across departments (horizontal) was lacking: “The general feeling is that people are not communicating with each other’s. We have very high need for better communication” (HAAD 10)

6.2.2 Market Culture

Though not the most common organisational culture prevailing in public sector organisations, the dominance of market culture was observed in the public healthcare sector in Abu Dhabi. Elements of market culture with a marked emphasis on addressing and meeting external stakeholders’ expectations, and meeting performance targets are apparent in those organisations.

In HAAD, the majority of informants (eight out of ten) highlighted the external focus of their organisation. The systemic reform in the sector that happened in 2008 splitting healthcare regulation from operations, and the new mandate of HAAD focusing on regulation, licensing, and public health, were considered as important factors that drove HAAD to have an external focus and to build a performance driven culture. The external focus appears to be consistent with HAAD’s mission as indicated by one of the informants: “In HAAD, we look at things from a regulator perspective; our job is to protect the public interest” (HAAD 9). This view was equally shared by another director when asked about the dominant culture at HAAD, “without hesitation, it is hierarchy and market. We look into what happens in the market and we try to adjust our rules and regulations accordingly” (HAAD 8).

HAAD’s external focus was also manifested in the need to be responsive to the public and share data about the sector’s performance as stated in the following statement by one of the directors: “We need measurement and transparency, we are constantly scrutinized by the public and we are publishing data on a regular basis (shafafia reports), in that context we are externally focused” (HAAD 3). Indeed, HAAD is considered the pioneer amongst Abu Dhabi government’s entities in publishing annual reports (HAAD, 2011) and health statistics reports (HAAD, 2013) that were made available to the public for the first time in 2011.
But it is not only the external focus that shapes the market culture at HAAD, the heavy emphasis on measuring performance, setting objectives, and meeting performance targets clearly appeared in the majority of interviews: “We are a market culture for sure, our motto as communicated by our CEO is you cannot manage what you cannot measure; he believes in it, we believe in it. You cannot manage if you do not have clear KPI. We have KPIs and project plans that go milestone through milestone, including quarterly and monthly milestones. We operate at this level of rigour” (HAAD 10).

The focus on performance measurement appears to be largely driven by the leadership at HAAD who is seen to place significant emphasis on performance: “Our CEO pushes people to perform” (HAAD 4), “I see our leader as data driven, externally focused, who wants to achieve organisational targets” (HAAD 10).

Finally, the criteria for success at HAAD is seen as meeting targets and strategic objectives. KPIs are seen as steering the organisation in the right direction: “To me, success is meeting my targets. Satisfying my customers and doing the job more accurately to improve performance” (HAAD 8). Success was also seen in relation to the external patient oriented focus: “Defining criteria for success is fundamentally the measures relating to patient satisfaction, patients are our ultimate customers” (HAAD 7).

There seemed to be a consensus amongst among HAAD’s management about the importance of having clear objectives and performance targets against which they can measure their personal and organisational success. Nevertheless, a number of informants highlighted some challenges relating to performance management systems that indicate the potential risks of ambiguous targets and measures: “I think the whole topic of performance is not fully mature enough in our organisation. They (management) want to put performance everywhere, they want to link rewards to performance, but what is going on in the field is the lack of clear requirements. This is one of the reasons for conflicts” (HAAD 5).

Although to a large extent, informants seemed satisfied with the performance measurement reports, some directors indicated that KPIs reported do not necessarily reflect their strategic priorities: “Performance reports focus on strategic initiatives mainly, not necessarily the KPIs I need to manage my business. The KPIs they are measuring do not really reflect my priorities. For example in licensing, the performance indicator they report is the number of cases I should license in a given period. But things are not always black or white, we
license professionals from more than 50 different countries and different credentials and education systems. Many cases need to be looked at individually” (HAAD 9).

Finally, informants indicated the difficulty in measuring the true impact of certain programmes especially those relating to public health and preventive care. The following statement by one of the informants in the context of the campaign to encourage new parents to use car seats for the new born babies, illustrates this point:

‘Quantitative measures are easy to get, I can tell you how many awareness programmes I did, how many car seats I delivered, but I will never be able to tell you how many lives I saved” (HAAD 5).

In SEHA, the market culture seemed even more dominant, with nine out of ten informants indicating an organisational focus on performance and KPIs. The presence of a market culture is not unusual as SEHA was initially set up with a private sector model in mind to manage the operations of public hospitals, and gradually move them to become self-sufficient. Though management believed that SEHA initially started as a hierarchy, it gradually moved to a dominant market culture: “Most of our objectives and priorities are moving us to a market culture” (SEHA 1), “SEHA is definitely a hierarchy but equally KPI driven, these are the values: Hierarchy is very important, and KPIs are very important “(SEHA 2)

Another indicator of the dominance of market culture is the emphasis placed on performance management and performance measurement. SEHA has invested millions of Dirhams in implementing organisation-wide Enterprise Resource Planning (ERP) and database systems to measure and track performance indicators across all SEHA hospitals. The quarterly performance reports compiled by SEHA corporate office contain data on public hospitals’ performance as tracked by hundreds of performance indicators ranging from patient safety, to clinical effectiveness, operational excellence, financial management, Emiratisation and others. As the number of KPIs tracked exceeds 100 indicators, management has grouped those KPIs into 14 different indices that are compiled and reported for each hospital on quarterly basis.

This KPI driven culture led one of the director to indicate that “data drives performance” (SEHA 3), Indicating that the clinical, financial, and operational data that SEHA is able to generate allowed the corporate office to better manage its hospitals’ operations. Another informant indicated that performance reports are used to monitor and steer hospital performance in a formal contractual manner as indicated in the following statement:
“We are owned by the government of Abu Dhabi, and we have a contractual relationship to make sure that those milestones that are set that lead to a better quality of care and optimal patient services are achieved” (SEHA 6)

With such a strong performance dominated culture in SEHA, it was not unusual to see this culture cascaded to public hospitals. The hospital executives interviewed recognised the importance of having a PMS to ensure accountability and transparency: “PMS is a tool to use to ensure commitment and excellence in providing services. It is key to ensure accountability; there are a lot of benefits derived from the implementation of a PMS” (HOSP 2).

However, the same executive indicated that having KPIs and reporting performance information is not sufficient; staff buy-in and trust in the PMS were thought to be prerequisites for lasting performance improvement: “PMS is a must have but you need a strong operational plan to achieve your performance targets. A good PMS is not enough, ensuring buy-in of people is key, also trust and involvement of staff in PMS are key to success, in addition to proper application and interpretation of key performance metrics” (HOSP 2).

Other challenges highlighted by hospital executives are measurement fixation, focusing on achieving measurable targets especially relating to wait time at the expense of quality of care in addition to unrealistic targets set by SEHA corporate office: “We need to stay focused on real core business, access, timeliness, and quality. We tend to be totally fixated on timeliness at the expense of quality of care” (HOSP 1); “We sometimes put totally unrealistic wait time targets that are way off international benchmarks. For example wait time target for emergency admission is 30 minutes; in NSF hospitals it is four hours. This creates unrealistic pressure on the system” (HOSP 1).

6.2.3 Clan Culture

While the majority of informants viewed their organisation as typified by the hierarchy and market cultures, the presence of clan culture was less obvious. About 30% of the informants indicated that presence of clan culture in their organisation. However, the interesting finding in the assessment of clan culture is the almost polarised view between Emirati and expatriates. Responses from interviewees from both groups were quite divergent. Whereas the majority of Emirati informants believed that their organisation was doing enough to encourage them and provide a healthy working environment where they can thrive, their expatriates counterparts did not quite see the same picture. Expatriate staff
felt discriminated against when it comes to promotion opportunities, and job security was
gen generally low among this group. Moreover, expatriate staff did not believe that their
organisation was providing enough learning and development opportunities compared to
their Emirati co-workers.

Those divergent views were especially obvious in HAAD and SEHA corporate office, but
to a lesser extent in hospitals. A possible explanation is the presence of higher percentage
of Emirati in those two entities. Emirati constitute around 40% of the workforce in HAAD
and SEHA, but in public hospitals, they represent less than 10%. In HAAD and SEHA,
Emirati mainly occupy managerial and administrative jobs in a relatively small
organisational structure (400-500 staff). In such structures, advancement opportunities for
Emirati are relatively high. Moreover, the closeness of HAAD and SEHA’s Emirati staff to
their executive leadership could explain their higher job satisfaction. Hospitals on the other
hand, are much more complex, bigger structures, where Emirati constitute the minority.
Advancement opportunities especially in medical field are less ample and in most cases are
tightly linked to advancement in skills level.

The following statements extracted from the interviews illustrate the finding above.
Emirati informants describe their organisation as providing a friendly environment, where
people thrive: “HAAD environment is very enriching; it is a friendly atmosphere” (HAAD
8); “HAAD is unique. It is the only health regulator in Abu Dhabi. I believe most people
are proud for working with HAAD” (HAAD 9); “I really enjoy working at SEHA, I enjoy
the environment and work challenges. Management is very appreciative” (SEHA 5).

The feeling of working in an extended family where team work is prevailing is very clear:
“I can describe my experience of working at SEHA as ‘Wow’; it is really great to work in
SEHA in terms of environment. People are open minded, we have open door policy, we
deal with each other as family and friends, we don’t have barriers” (SEHA 4); “I would
say this is the best culture I have ever worked in, because I am blessed to have such an
amazing team. We are sticking together because we can see we make a big difference
(HAAD 10).

The leader is seen a role model and a mentor as obvious in the following statement: “We
really appreciate our leader, he is really adding value. He is visible, his door is open, he is
a role model, we learned a lot from him” (SEHA 5).

Finally, informants felt that they are empowered, that they have full support from
leadership to achieve their objectives: “I feel that I have a very promising future, I don’t
have a ceiling of limitations, indeed I feel that I have endless opportunities, I have 150% support from leadership, no barriers, no obstacles” (SEHA 7).

However such statements indicating the obvious presence of a strong clan culture were not necessarily shared with the majority of expatriates and some Emirati interviewees. What is interesting is that some Emirati informant who seem to recognize this challenge, attributed it to the relationship between staff and management rather than between staff themselves. The following statements illustrate the general feeling regarding clan culture:

“I don’t look at HAAD as a clan, though management is trying to push for it there. We have some social committees trying to increase the relationship between employees and the management but still there are some challenges to become a clan” (HAAD 4).

“We are striving to be amongst the best places to work for, but we are far from being there” (SEHA 1).

Such disconnect could be attributed to a number of factors including low job security, the feeling of discrimination when it comes to advancement and learning and development opportunities, and apparent lack of recognition.

Low job security appears to be a major factor in low staff engagement and employee dissatisfaction. Expatriates feel threatened by the Emiratisation wave. The following statement from one director at SEHA helps illustrate the feelings shared by some expatriate staff: “Staff and physicians are extremely oppressed. UAE nationals feel that expat are dispensable, if you treat 80% of your workforce as dispensable, then how would you expect them to be as engaged as you would want them to be?” (SEHA 2)

It would be difficult to judge whether such sentiments are shared across the board throughout the healthcare system in Abu Dhabi, but two important factors are indicative of the magnitude of the problems: The consistently low employee engagement scores, and high staff and physicians’ turnover. Those two factors are discussed in more details in section 6.4.1 ‘human capital challenges’.

According to one informant, low job security could help explain the high turnover especially among physicians:

“People do not just leave for better salaries; fundamentally we have an issue of stability here. Staff leave because they do not feel stable and secure in their job. Pay is not an issue in my opinion; it is stability and job security” (HAAD 9)
Another factor that helps explaining the conflicting views of clan culture between Emirati and expatriate staff is the scarcity of advancement opportunities for non-Emirati staff, and the apparent discrimination in promotion policies between Emirati and non-Emirati. Indeed, part of the implementation of the Emiratisation programme in public sector entities calls for giving priority for Emirati staff in promotion and training and development opportunities. Although this might be understandable from a policy perspective, this practice seems to create a sentiment of discrimination among the expatriate staff, who constitute more than 80% of the total workforce in the healthcare sector. The statements below illustrate the apparent frustration regarding the lack of advancement opportunities for expatriate staff: “At this point, expatriates cannot be rewarded at all. No increment, no promotion. Expatriates are not happy, they feel they are discriminated against, that is why they leave” (HAAD 7); “Opportunities for promotion are mainly for nationals, it is very difficult to promote expatriate staff” (SEHA 8).

Some informants reported losing some of their star performers because of the lack of promotion opportunities for expatriate staff as indicated in the following statement: “It is usually the good staff who leave, because they have options, the organisation is then left with average and mediocre staff and of course performance will be affected” (HAAD 7).

The frustration with what is seen as discriminative promotion policies is obvious: “Promotions to expatriate staff are very difficult, staff become demotivated if they don’t grow. Sometimes in order to compensate for this fact, staff are given monetary rewards, but not the grade or the title. But it is not all about money, people need to see their career progression in the organisation” (HAAD 4).

Besides promotion and advancement, lack of learning and development opportunities seem to also create a sense of dissatisfaction. The lack of learning and development opportunities appeared to be the case across all employee groups and not just expatriates. The following statements illustrate this idea:

“Training and development is also another area of concern, this budget has been frozen across the board by SEHA for the past two years, expect for mandatory CPE for physicians and medical staff. This has negatively impacted employee morale, motivation, and retention” (HOSP 1).

“HAAD is not doing enough in training and development of staff. Professionalism is lacking, this is affecting staff productivity” (HAAD 3).
Informants also recognise the challenges in trying to marry the Emirati culture to the different expatriates’ cultures in the workplace to create a proper clan culture. The different lifestyles, social habits and beliefs that people bring with them to their workplace could potentially create some hard to reconcile differences that affect team work.

The main challenge is trying to create a cohesive culture with a diversified workforce made up of over fifty nationalities from different ethnic and cultural background and different education systems as indicated by one of the informants:

“Staff and medical teams have not yet developed the ties to be able to work together as a cohesive team. It is the glue that holds those people together in turn holds them to their organisation that is missing. Without that glue, it is very difficult to improve healthcare services” (HAAD 6).

6.2.4 Adhocracy Culture

Strong evidence of an adhocracy culture which is characterised by external focus and innovation, was not apparent from the qualitative data given that very few informants mentioned its existence across the three organisations studied. The three informants who mentioned some elements of adhocracy in their organisations tended to mention its limitation which mainly appeared to be due to a lack of system maturity, and preoccupation with building the foundations of the healthcare system before they can talk about innovation and new ideas. In addition, a culture of hierarchy with high level of conformity, and a strong focus on achieving results is not typically the ideal culture to foster innovation.

According to some informants elements of adhocracy culture are apparent in the nature and scale of the reform in the sector that took place over the past few years: “we are introducing all those new standards, we are asking people to go and find ways to reduce costs, we are implementing new systems and we are automating our processes, that can be considered innovation as well” (HAAD 5)

Moreover, in certain areas such as public health for example, the nature of work and the objectives to be accomplished pushed some elements of adhocracy as indicated in the following statement: “When it comes to public health you feel that we need to do things differently, we cannot just print a brochure or do a campaign on public health issues and expect to see improvement. You need to be innovative, bring new ideas” (HAAD 2).
Informants, however, highlighted a number of challenges that would prohibit their organisation from fostering research and innovation. Of paramount importance is the lack of research infrastructure and funding mechanisms in both clinical and non-clinical research. As discussed in Chapter 4, the first few years of health system reform in Abu Dhabi focused mainly on improving access and addressing operational challenges; the foundations for building and promoting a proper research infrastructure are still in early stages and this is affecting the ability of hospitals, HAAD, and SEHA to conduct clinical and non-clinical research in the healthcare sector. Another indicator of the low research productivity in Abu Dhabi is the share of healthcare research as a percentage of GDP estimated at 0.025%. This percentage is very low in comparison to other high income countries including USA at 0.33%, UK at 0.11% and South Korea at 0.09% (BCG analysis). This issue is clearly articulated in the following statements:

“We need a clear strategic direction and plan to implement a medical research infrastructure” (HOSP 2).

“The research component is a bigger challenge, we just don’t have proper research infrastructure. In the whole of Abu Dhabi, I don’t know who owns research funding and it is quite unfortunate because the will to spend the money is there, but I don’t know where to go to get money for research. We have valid research opportunities but don’t seem to be able to secure funding to conduct this research, so we have to sneak money out of our operating budget to fund what little research we do. We are not huge in clinical research trials, we do some but it is not enough. The ground is so fertile for all those research opportunities and the government wants to spend the money, but the mechanism to apply does not seem to exist, and nobody seems to own the mandate of creating that mechanism” (SEHA 1).

Such comments were also cascaded to SEHA corporate office and hospitals where informants felt that centralised system steered by KPIs is not the necessarily the ideal place for an adhocracy culture. Comments such as ‘we are definitely not adhocracy’ were consistent almost across all informants.

6.2.5 Conclusion

The obvious dominance of hierarchy and market cultures was clear across HAAD, SEHA, and the public hospitals studied. Driven by the desire to have clear systems and processes to support the aggressive reform initiatives in the sector and the heavy emphasis on managing and measuring performance as a way to ensure strategic objectives were met,
hierarchy and market cultures overshadowed the clan and adhocracy cultures across the public healthcare system.

An interesting finding in the assessment of clan culture is the divergent visions of this culture between Emirati and non-Emirati. The former, assessing culture from their perspective indicated the existence of a supportive, nurturing organisational culture. Such views were contrasted with the views of the majority of expatriate staff who indicated that low job security, and lack of promotion and learning and development opportunities as factors leading to low staff engagement. Finally, the development of an adhocracy culture seemed to be restricted by the bureaucratic, performance-oriented nature of the organisations.

6.3 Preferred Organisational Cultures

When informants were asked which types of preferred organisational culture would foster better performance in their opinion, clan culture was strongly preferred, with the vast majority of participants expressing that they would like to see more elements of a clan culture in their organisation. The second preferred organisational type is adhocracy. Almost two third of the participants highlighted the need for an organisational culture that fosters innovation, and encourages new ideas and out of the box thinking. Additionally, recognizing the importance of external focus and performance measurement, more than half of the informants indicated the need to maintain certain aspects of market culture in the preferred organisation, albeit with less measurement fixation and a stronger emphasis on people. Finally, informants indicated a desire for a decreased focus on hierarchy culture as a mean to increase accountability and achieve the desired cultural changes.

6.3.1 Higher Emphasis on Clan Culture

If there is one thing that all participants Emirati and non-Emirati across all organisations agree on, it is the need to have more focus on people, to develop a sustainable, motivated human capital that can support the implementation of the ambitious reforms of the healthcare system in the emirate of Abu Dhabi. Even though as discussed in the analysis of current organisational culture, some Emirati participants felt that there are obvious elements of clan culture in their organisation, they also seem to agree there is a need to foster a more cohesive, supportive culture where staff work together as a team and thrive in a supportive environment. Words such as focus on people, engagement, cohesiveness, and trust appear in almost all the interviews. The following statement by one of the hospital
executives summarises the emphasis on people: “Our ability to recruit, retain, and develop top talent is crucial to our existence and growth” (HOSP 1).

Informants agree that far too much emphasis have been placed on building the right infrastructure and investing in buildings, equipment, and technology. In order to address the growing challenges of the sector, emphasis should be shifted to building the right human capital: “People, this is the real challenge is the healthcare sector; investing in more buildings and more equipment will not necessarily improve healthcare outcomes, it is fundamentally addressing the human capital challenge, and providing a good working environment where people strive to provide better services to the community” (HAAD 6).

“It is a very building oriented strategy. We will have enough hospital beds once we finish our construction process to take us beyond 2030. So it is not about the beds, it is about the people, getting the right people on the bus” (SEHA 2)

Building the human capital was seen as building the ‘soft infrastructure’ which is equally, if not more important than the ‘hard infrastructure’: “We need to focus on people and how to build human capital, how to have the ‘soft infrastructure’ of healthcare” (SEHA 6).

The criteria for success in the preferred culture can be summarised in one word ‘cohesiveness’. Bringing people together around common values was thought promote a healthier culture as indicated in the following statement:

“Just having cohesiveness and participation is a huge thing” (HAAD 7)

“We need to focus on universal truth, on common vision, common values, and respect for all irrespective of nationality or ethnicity. We need to focus on what we have in common rather than what differentiates us in order to arrive at a common cohesive culture that fosters better performance” (HOSP 1).

Having cohesiveness is thought to promote staff engagement which in turn will have positive effect and performance. Having engaged staff is seen as the foundation for building a better organisation where a culture of innovation can be fostered. Only then can organisations start moving to an adhocracy culture, the second preferred cultural type. The following statements illustrate this idea:

“Engagement and trust is a must, it is a priority. People should share the same vision and values. This is a prerequisite before talking about giving people room for innovation. There is huge potential for innovation in the growing healthcare sector, but we need to
build the right foundation first and this can only be achieved through trust and engagement” (HOSP 2).

“In order to be successful, we have to value people and we have to be innovative. Those will be the values that will get us to the next generation” (SEHA 2).

6.3.2 Accentuation of Adhocracy Culture

After clan, adhocracy culture appears to be the second preferred culture with more than half the informants indicating that the presence of certain aspects of an adhocracy culture in their organisation would lead to improved performance. Informants stressed the existence of immense potential for innovation is a relatively fertile ground that characterises the healthcare sector in Abu Dhabi. One of the primary expressions of innovation in the healthcare sector is the research and development both in clinical and non-clinical fields. This appeared to be chronically lacking in view of lack of funding mechanisms and adequate research infrastructure. The statements below clearly indicate the value of research and innovation in delivering best in class healthcare services:

“I think striving to deliver world class healthcare would not be complete if we only focus on service, we needed to focus on education as well as research to contribute to new knowledge generation” (SEHA 6)

“You need creativity, because if you have creativity you can always go back and re-engineer your processes” (HAAD 5).

Informants also indicated the importance of building a healthcare research infrastructure as a mean to attract and retain qualified physicians as indicated in the statements below:

“Medical research opportunities is one of the top strategic priorities for SEHA, it is of course important to retain top physicians” (HOSP 1).

“Having a solid research infrastructure and research facilities would allow us to recruit and retain the best physicians” (HOSP 2).

However, even in a fertile system with great potential for interesting medical discoveries, and ample financial resources, building a research infrastructure cannot be achieved overnight. Informants indicated the need for a long term healthcare research vision, coupled with the right infrastructure and funding mechanisms, in addition to building more teaching hospitals and implementing appropriate incentive plans to foster research and innovation in the sector.
6.3.3 Sustaining Market Culture

Around half of the informants agree that maintaining a market culture with emphasis on performance is very important in order to ensure achievement of strategic objectives. When asked about the preferred organisational culture that would foster better performance, one informant indicated: “...it is Market, in my opinion external focus is important, measuring and reporting results are the keys to success. We need to have clearer objectives and expectations” (HAAD 3).

A robust PMS was seen by some informants as essential to ensure transparency and foster accountability to drive performance improvement. Informants believed that measuring and reporting performance indicators not only help in benchmarking with other organisations, but could potentially improve the public perception of the health system as indicated in the following statement: “I think we need to focus more on performance because we need to change people’s perception and mentality when it comes to public hospitals” (SEHA 4).

However not all informants believe that the dominance of market culture at SEHA is necessarily the best culture that would lead to performance improvement. Some informants recognised that a measurement fixation could become counterproductive, and indicated that performance data should be used to drive performance improvement and that people should not be fixated with measurement per-se: “If KPIs and performance measures are used solely for the purposes of reporting and accreditation, then they will be become a burden for a small group of people. We should not measure for the sake of measuring” (SEHA 6).

Finally, informants indicated that a reductionist, data driven view of performance would potentially hide the real challenges affecting performance improvement. The following statements elucidate this idea:

“We are spending a lot of time on performance currently, we need to gradually shift our focus on people, and then we can focus on innovation” (SEHA 5).

“By focusing too much on performance, we do not always understand personal relationships and cultural differences” (HAAD 5).

6.3.4 Diminishing Emphasis on Hierarchy Culture

Informants acknowledged the need to have systems, policies and procedures especially in a highly regulated healthcare environment where they are dealing with human lives. But some of them realise that having rigid systems is not necessarily the solution to all
situations: “Processes and policies are meant to define common practices. But in some cases you need exceptions; you need to think out of the box to provide appropriate solutions in certain situation” (HAAD 5).

Informants also indicated that the prevailing hierarchical organisational structure prevented the formation of cross functional teams that were thought to be essential in reaching organisational objectives and addressing the sector challenges. The following statements illustrate this challenge:

“A hierarchical, bureaucratic organisational culture is not the ideal place to support an immature system with ever evolving requirements. We need a structure that would facilitate adapting our systems and procedures to the requirements of the market” (HAAD 8).

“Most KPI are cross cutting across different sectors and divisions. We need to identify cross functional teams that can work across many sectors/divisions and identify improvement opportunities to processes” (HAAD 3).

Moreover, informants acknowledged that micromanagement of hospitals is counterproductive. They also expressed the strong need to change hospitals’ perception of SEHA corporate office as a “police and controller” (SEHA 4) in order to build an integrated system. One way to achieve that is through some form of decentralisation, and delegation of authority in order to ensure smoother running operations, and most importantly to build accountability and ownership in hospitals:

“I do believe that we have to benefit from being part of one system, but at the same time, we should not micromanage hospitals so as we prevent innovation. We have to leave more room for decentralisation which would create more efficiency. At the same we need some form of standardization and quality metrics to eliminate unnecessary, unjustified variations” (SEHA 6).

In turn, hospital executives indicated the need for more decentralisation and delegation of authority to hospitals to create that culture of accountability across the system: “The key to performance improvement is to have more accountability and decentralise decision making” (HOSP 1).

6.3.5 Conclusion

When assessing the preferred organisational culture that is considered best for performance improvement, all informants with no exception stressed on the importance of human
capital, and creating a cohesive culture. This indicates a strong desire to create a clan
culture that would help addressing the most important challenge that the healthcare sector
in Abu Dhabi is facing that is ‘people’.

Informants also stressed on the need for innovation and to build a strong and sustainable
research infrastructure indicating the preference for stronger presence of adhocracy culture.
With respect to market culture, there is recognition of the importance of being externally
focused and measuring performance; however informants indicated their desire for less
measurement fixation. Finally, hierarchy culture seemed to be pulling back all three
organisations and is seen as creating obstacles in achieving their objectives. Less
micromanagement, more participation from hospitals and physicians, decentralization, and
adapting some policies and procedures to serve organisational purposes, rather than
creating additional red tape seem to be the way to create a culture that would promote
excellence in healthcare regulation and healthcare delivery.

6.4 Challenges Facing the Public Healthcare Sector in Abu
Dhabi

As the research unfolded, emergent themes became apparent. These were related to the
wider reforms processes being encountered by the health care system. A number of those
themes especially those related to human capital are directly related to the research
objectives and support the analysis of clan culture. However, other themes grouped under
organisational and systemic challenges appear to be more independent of the stated
research objectives, they were nevertheless very important in the minds of the respondents.
Those challenges are associated with the health system reform and managing patients’
expectations. Issues such as tension and role ambiguity between the regulator and the
operator, under-developed primary care, service line rationalisation, wait time, and
managing service level expectation of the Emirati community surfaced from the analysis.
Those emerging themes are discussed in the sections below.

6.4.1 Human Capital Challenges

The first and most important challenge relates to human capital and talent management.
This challenge was obvious in the discussion of clan culture above, and is further stressed
by the informants in the following quote: “The human capital issue has a huge ripple effect
on all aspects of healthcare delivery. Employee morale and engagement are low, this in
turn increases turnover which leads to massive increase recruitment costs” (HAAD 6).
Challenges related to workforce and human capital in the healthcare sector are not necessarily specific to Abu Dhabi and the UAE. According to Mourshed (2008), the GCC countries are unable to produce sufficient number of clinical staff to provide care for their growing population (Mourshed et al., 2008). Governments thus rely heavily on foreign workers to fill demand gaps. With over 82% foreign physicians and 96% foreign nurses, the UAE has the highest percentage of foreign medical workforce among GCC countries (Mourshed et al., 2008). Integrating such a diverse workforce in the workplace and ensuring its retention and continuity are among the most important challenges that governments are facing. Internationally, a recent report issued by the Global Health Workforce Alliance and World Health Organisation, ‘A universal truth: no health without a workforce’ (Campbell et al., 2013) called for a paradigm shift in the discussion around the health workforce. The continued shortage of healthcare workers in many countries, the recognition of the centrality of health workers in translating and implementing the vision of health coverage for all into reality, and the importance of creating an enabling environment where health workers are motivated, were among the main themes stressed in this report.

Attraction and retention of physicians and staff, and attracting Emirati to the healthcare sector were cited amongst the most important challenges that the healthcare sector in Abu Dhabi is facing. Those issues are discussed in detail in this section.

**Attraction and retention of Staff**

Turnover of medical staff including physicians and nurses remains one of the most challenging aspects of healthcare delivery in Abu Dhabi. Physicians’ turnover is believed to be in the range of 15-17%. Nurses’ turnover is even higher; some SEHA statistics indicate a turnover rate as high as 30% in one hospital. This means that some hospitals need to replace their entire nursing staff every 3 to 4 years. The cost associated with recruiting qualified medical staff in Abu Dhabi are very high. SEHA estimates recruitment costs to be in excess of $25,000 per physician. Moreover, healthcare professionals are recruited from over 50 countries which renders licensing procedures complicated and time consuming. Licensing of physicians can take up to nine months in some cases.

The high turnover of medical professional is cited by informants as a very serious concern affecting the stability of the system: “*To build a good healthcare system, you need stability, you need stable staff. With high turnover, some of your programmes might be jeopardized*” (HAAD 9).
The consistently low engagement scores specifically among physicians and allied health professionals seem to be the strongest indicator of staff discontent leading to high turnover and low retention. One informant attributed the challenges faced by the sector to the disengaged workforce: “Most of the healthcare system deficiencies we are seeing nowadays are related to low staff engagement” (SEHA 1)

SEHA employee engagement report for 2013 indicated an overall engagement score of 52 percent across SEHA. This score is considered low compared to the average for GCC providers and global healthcare providers both rated at 59%. A detailed analysis of the scores reveal that engagement scores for physicians at 43% and allied health professional at 51% are even below SEHA’s overall average. Public hospital generally have lower engagement scores compared to SEHA corporate office. Around 60% of the hospitals (5 out of 9) had engagement scores lower than the overall average, with some hospitals, including large ones reporting engagement scores as low as 40%. The four major areas driving the low engagement scores as reported by the participants in the survey were recognition, career opportunities, pay, and people/HR practices (SEHA employee engagement report, 2013). Those findings resonate with the observations compiled from the interviews in the current study. Indeed those challenges were clearly highlighted in the informants’ assessment of clan and hierarchy cultures in their organisations.

Recognition appeared to be a very important factor in addressing the retention challenges as indicated in the following statements:

“We need to focus on people, HR needs to put a retention plan in place. Money is not everything, people need recognition. They also need transparent, periodic communication that would drive accountability” (HAAD 4)

“We need to recognise key staff within the hospital and develop recognition programmes as a mean to retain personnel” (HOSP 2)

The issue with recognition appears to be fundamentally related to the way medical professionals are generally treated. Hospitals’ management seem to agree with this and recognise that dis-engaged medical personnel will have an impact on medical services provided by the hospital and patients’ experience as illustrated by one of the informants: “we treat our physicians, nurses, and medical professionals as normal workers. We do not recognise that they are our most important assets without whom the healthcare system won’t even function” (SEHA 2).
According to informants, recognition could be achieved by providing staff with both monetary rewards like compensation and benefits, as well as non-monetary rewards such as a supportive working environment and providing opportunities for growth and promotion. In Abu Dhabi’s healthcare sector, challenges in both monetary and non-monetary reward systems appear to be contributing to the low staff engagement which in turn leads to high turnover rates.

**Staff Compensation**

SEHA engagement survey showed that ‘pay’ and staff compensation were considered important factors in staff engagement. In fact, over 40% of the staff indicated that they do not feel fairly paid compared to the contribution they make to their organisation (SEHA engagement survey, 2013). Two main factors seem to explain the staff compensation challenges in Abu Dhabi, competition from both local and regional healthcare providers, and overly centralised compensation structure.

The issue of staff compensation appears to be a particular challenge in hospitals where demand for qualified physicians and nurses in an under-supplied market is soaring, and competition from the private sector and neighboring countries is very high. Informants expressed concerns that the growing private healthcare providers in Abu Dhabi are pitching their best physicians and nurses by offering them higher salaries and better benefits. The following statement by one of the hospitals directors illustrates this challenge:

“Current salary levels offered to physicians, nurses, and certain level of staff are not competitive compared to salaries offered by the private sector and neighboring GCC countries especially Qatar and Saudi Arabia. Salaries offered by private hospitals are sometimes twice or thrice compared to those offered by SEHA hospitals, and when that is the case it is very difficult to retain physicians. The same applies to sub-specialty nurses who are very high in demand and limited in supply, here too we find big pay inequities”.

(HOSP 3)

Informants also indicated the presence of internal competition especially from SEHA corporate office where better pay and less hours seem to attract some staff and physicians to take administrative jobs at the corporate office: “We also have internal competition; we are losing staff to SEHA corporate office over higher pay, benefits and better working conditions. We lost 25 staff to SEHA last year” (HOSP 3).
Besides local and regional competition for talent, a centralised, rigid, and unresponsive compensation system seems to hinder the recruitment and retention of top talent across the healthcare system in Abu Dhabi. Informants indicated that lack of funding for salary raises especially at hospital level further affects staff retention as indicated in the following statements:

“SEHA has frozen salaries increases for the past two years. The ad-hoc increases we had to give on a case by case basis were financed from salary savings. Lack of funding for salaries increases in a big obstacle toward retaining staff and physicians and also attracting new physicians needed to address increasing population demands for health services” (HOSP 3).

“Some staff did not receive a pay raise for as much as three years and this has a negative impact on motivation and performance. We are trying to address inequities in compensation as well. We are currently looking at around 80 cases where staff compensation is not at par with their fellow workers” (HOSP 1)

Informants also indicated that such centralised compensation system with apparently excessive power and control exercised by the corporate office was hindering hospitals from recognizing their top performers: “Staff are not aware of the budget constraints imposed by SEHA but they do not understand them. If we cannot motivate staff and recognise them, this will impact performance in the long run, and we will lose our best employees” (HOSP 5)

Those statements reveal important challenges in the pay scale and the overall compensation policy adopted in the public healthcare sector in general, and in the hospitals in particular. The root cause of this challenge seems to be the centralized pay system imposed by SEHA. This system appears to give little or no flexibility to hospitals to adapt compensation packages to attract and retain the best staff and physicians, or to give performance based bonuses to their staff. Moreover, the dispersed nature of healthcare delivery in the Emirate of Abu Dhabi where a number of health centres and hospitals are located in remote locations with low population density calls for a more flexible compensation structure to incentivize staff and medical professional to work in such remote locations.

Moreover, focusing on replacement of physicians and nurses as a way to address challenges relating to high turnover was critisised by many informants as being too costly and too disruptive to the system. Informants indicated the need for a more proactive
approach including developing a robust retention strategy as indicated in the statements below:

“Retaining staff is a huge challenge especially with the growing demand for healthcare professionals, thus the need for a clearly articulated retention strategy” (HOSP 2)

“We are putting all our eggs on recruitment, none on retention” (SEHA 8)

What is apparent is that issues relating to lower retention rates, and low employee engagement are more deeply rooted in the system, and a quick fix strategy would simply not be sufficient. Moreover, ad-hoc pay increases might help in addressing certain cases in the short run, but will not solve the systemic problems of compensation and pay structure. The way to address the pay challenge is to formulate a long term compensation strategy that is transparent, fair, flexible, and responsive to the market in order to provide competitive pay packages that would help in attracting and retaining top talent: “So far we have adopted a reactive HR strategy, addressing issues with quick-fix solutions. However, we need to be more pro-active and look at a comprehensive long term staff benefit strategy to attract and retain top talent. We need a long term strategy to decide where we need to focus and where we need to invest more resources” (HOSP 1).

**Emiratisation in the healthcare sector**

Nationalisation of the workforce remains one of the top challenges of the healthcare sector in Abu Dhabi. As indicated earlier, with less than 12% of physicians and 1% of nurses, the percentage of Emirati healthcare professionals across the sector is very low. According to informants this factor threatens the sustainability of the sector as indicated in the statement below:

“The healthcare systems in the UAE and in Abu Dhabi, share more or less the same challenges faced by healthcare across the world; quality of care, raising costs and loss subsidies, access, and shortage in medical staff. But one challenge that is often overlooked in the context of healthcare delivery in Abu Dhabi is how would the government be able to sustain a sector that is more than 90% dependent on expatriate staff” (HAAD 6).

The Emiratisation challenges and the factors that explain the low number of the Emirati in healthcare field including the education system, socio-cultural factors, and attractiveness of the medical profession to Emirati graduates have been addressed in Chapter 4. This section focuses on the perceived implications of Emiratisation challenges as analysed through the informants’ interviews. Essentially informants indicated that Emiratisation cannot be
addressed in isolation of the bigger human capital challenges as both aspects are very much related. Treating Emiratisation as a separate issue in fact leading to the accentuation of the problem and creating further divides between the Emirati and expatriate groups and negatively impacting staff engagement and job security. Those issues were clearly highlighted in the assessment of clan culture, indicating that cultural assessment explains to a large extent the prevailing human capital challenges.

One Emirati informant expressed his concerns about the misuse of the term ‘Emiratisation’. He believes that although this a very important national priority, misusing or misinterpreting the term Emiratisation might have potential negative impacts both on nationals and on expatriates by limiting real advancement opportunities for Emirati staff and creating a feeling of insecurity for expatriate staff: “Expatriate staff feel that Emiratisation poses threat that impacts their job security, as a result we might lose very good talent needed to build this sector. Some UAE nationals on the other hand, consider Emiratisation as a granted right for hiring and promotion which can sometimes happen on basis other than meritocracy and required competencies. In a sector like healthcare, we still need expats to fill the growing demands of a growing population; the expertise they provide is vital to the advancement of the healthcare sector. Leadership should always bare this in mind and act accordingly” (HOSP 3).

Other informants at HAAD and SEHA corporate office shared the same views as well as indicated in the statements below:

“Our work culture is overshadowed by Emiratisation, this is creating insecurity and uncertainty amongst expats” (SEHA 8)

“Balancing between the competing needs of Emiratisation agenda and perceptions of Meritocracy is a very important issue, often un-discussed” (HAAD 3).

Emiratisation efforts largely focused on meeting targets and quotas for Emirati personnel as a percentage of total workforce. Although such efforts helped in increasing Emirati staff especially in administrative functions, informants indicated that development of national workforce should focus on building real competencies for a sustainable skills development rather than just meeting quotas and targets: “Development of nationals is a top priority for SEHA and hospitals. We have probably six different ways of measuring national workforce, however the issue is not meeting those quotas, it is about proper development of nationals and giving them the right opportunities to develop in different areas of the hospital. The ultimate goal should be real development rather than just numbers and
quotas” (HOSP 1). In order to create real advancement and learning opportunities for UAE nationals, informants also indicated that there are clear needs to implement plans for training, development, and succession planning which appeared to be lacking in all organisations.

Whereas Emiratisation remains a national priority, it is widely believed that there no quick, easy fixes to address this challenge especially in a growing healthcare sector that has depended and continues to depend on a larger number of expatriates. The factors that support a longer term vision for a sustainable workforce include building an education infrastructure, promoting the medical profession as an attractive, prestigious career option for UAE nationals, and investing in the expatriate workforce to ensure their long term employment. The sustainability and stability of the healthcare workforce are vital prerequisites to realise the ambitious vision on an improved healthcare sector in Abu Dhabi.

6.4.2 Structural Challenges

In addition to the human capital challenges, the review of qualitative data revealed a number of structural and systemic challenges that affect the performance of the sector. According to informants, the scope and pace of reforms in the sector could well be a contributing factor behind those structural and systemic challenges. Sweeping changes implemented within short timeframes did not allow room for the organisations and the people to test those changes, address their implication on structures and systems, and assess their impact on the quality of care provided. It was a case of huge reforms being made too quickly and often too soon as indicated in the following statements:

“*The pace of reform is simply huge, an across the board reform that would usually take place decades, is taking place in Abu Dhabi in a matter of years*” (HOSP 1)

“*Here we have a dynamic and ever changing strategy. We might be consolidating certain services, discontinuing others, people might be forced to move to other hospitals and that creates a sense of instability in the system and among healthcare professionals*” (HAAD 9).

Tensions between the regulator and the operator and role ambiguity seem to indicate the extent of the structural challenges in Abu Dhabi health system.
Tensions and role ambiguity between HAAD and SEHA

One of the major issues facing the healthcare sector in Abu Dhabi is the apparent tensions between HAAD as the regulator and SEHA as the operator of the public hospitals. These tensions resulted in role ambiguity and conflicts, which in turn negatively affected the performance of the public healthcare sector.

According to informants, the root cause of the problem is that HAAD and SEHA initially started out as a single entity, GAHS as indicated in Chapter 4. When the government decided to split healthcare regulation from healthcare operations in 2007, many of GAHS staff moved to SEHA. The split was challenging especially for people who were in charge of both regulation and operations, it was difficult for some managers to understand the clear scope of responsibilities between HAAD and SEHA as illustrated in the following statement:

“In 2007 when they split SEHA as an operator from HAAD, people thought we will not have to deal with operational issues anymore. But we are also responsible, whatever happens in the community and hospitals is our responsibility, though SEHA would say it is not our responsibility. We are facing some issues regarding authority and responsibility between HAAD and SEHA who is doing what, who is responsible for what” (HAAD 2).

The restructuring and segregation of healthcare regulation from healthcare delivery which what was intended to create complementary roles with clear segregation of duties seems to have resulted instead with conflicts in certain areas. This raised questions by some informants as to whether HAAD and SEHA were really working together to achieve the common vision of improving healthcare services in the Emirate. SEHA was regarded as a delivery focused, KPI driven entity; whereas HAAD saw itself as the ultimate authority responsible for protecting public interest, and in charge of the performance of the sector as a whole. The following statement indicates this disagreement:

“It appeared like two monsters were trying to get this position as regulator. SEHA wants to do their own way that helps their revenues and their expectations, and HAAD wants to achieve the overall objective of improving the healthcare system and achieving the instructions of government” (SEHA 2).

The lack of clarity in the roles of HAAD and SEHA led in turn to role ambiguity. Throughout the interviews, it was apparent that role ambiguity was a leading cause of frustration among most of the informants. Although Law No. (1) of 2007 regarding the
formation of HAAD, and Emiri Decree No. 10 of 2007 regarding the formation of SEHA, indicated the roles of both entities, informants indicated that some clauses in those laws were rather vague. This led to different interpretations that meant unclear duties and mandates: “There are of course in HAAD constitutional laws, but there is ambiguity in interpreting those rules. Battles are real, and this is affecting our operations. Healthcare is about people, about reputation, not continuous debates as to who does what, and who is responsible for what. There are clear guidelines to govern such relationships but no clear segregation of duties and tasks” (HAAD 3).

Although certain aspects such as licensing seemed clear from a regulatory perspective, other aspects especially those impacting healthcare delivery seemed much more ambiguous. For example, one informant indicated that the delivery of tertiary care, which from a purely financial standpoint might seem not feasible, is very essential from a comprehensive care delivery perspective. The role ambiguity between HAAD and SEHA led to a place where it is not clear who can mandate tertiary care and how. The following statement illustrates this issue:

“It is clear that HAAD is the regulator, but what is unclear is what does regulate means. What can HAAD regulate within SEHA is a question. For example when it comes to licensing healthcare professionals, it is clear that this is HAAD’s responsibility. But in other areas, it is grey. Types of services offered by SEHA is an example. This ambiguity could affect performance. Government has expectations of the healthcare sector; if certain aspects are not clear from SEHA’s perspective, it creates an issue, and a question of who is ultimately responsible should come from the government” (HAAD 9).

6.4.3 Systemic Challenges
The systemic challenges identified during the data analysis included sub-standard primary care, service line rationalization, and wait time management. Those are analysed in the section below.

Sub-standard primary care and lack of ‘Gatekeeping System’

In spite of sweeping reform initiatives implemented by the Abu Dhabi government to modernise and address challenges in its healthcare system and in spite of heavy investments in this sector, primary care remains underdeveloped and lagging behind compared to secondary care. According to informants at HAAD, the main challenges regarding primary care are linked to the fragmented nature of care delivery and the lack of
an integrated continuum of care for patients that addresses their care need from ‘cradle to grave’. Lack of proper primary care across the emirate is thought to be one of the contributing factors to over-utilisation of medical services, over-crowding of hospitals, and increase in IPC cases; factors that lead to raising costs across the system. According to informants, many factors contribute to the underperformance of the primary care. Those factors include low patient trust, low perceived quality of care, and weak referral system.

Low patients’ trust appears to be high on the list of factors affecting performance of primary care: “Trust in the system is low. Patients do not believe in primary care, they prefer to go directly to specialists and consultants which command much higher cost; number of patients-doctors encounters per patient increase, raising insurance premiums and cost subsidies. But that is not all, UAE nationals who still do not trust the local healthcare system, choose to go abroad to get medical treatment, commanding an even higher bill for International Patient Care (IPC)” (HAAD 6).

A number of informants indicated that the reasons that patients, especially Emirati, do not go to primary care are mostly cultural. Primarily patients believe that a general practitioner (GP) or registered nurse would not be able to assess their health problems, including the minor ones, as well as a specialist physician could. However, the root cause of this issue appears to be more related to competencies and service level rather than purely ‘cultural’ as indicated in the following statement:

“The reason why it is cultural that people do not go to primary care is that we put the least qualified physicians in primary care centres. They are the GPs. Patients are sceptical about quality of care in Ambulatory Health Services (AHS), so they go directly to hospitals with very little coordination from hospitals which leads to overcrowding and increase in wait time” (SEHA 2).

Quality of physicians and nurses in primary care units appears to be the main cause of lack of patients’ trust in primary care. But that is not all, weak communication between physician and patient appears to be another factor. Weak communication is mainly due to very low numbers of Emirati physicians and nurses as discussed in the section above. Expatriate medical professionals often working in primary care units often come from culturally diverse backgrounds and do not speak the same language as their patients: “Proper diagnosis in the starting point in care delivery; communication between GP and patient is key. If the language is broken and cultural barriers exist, communication is broken, and service will be impacted” (HAAD 6).
The weaknesses in primary care and the lack of referral system are thought to lead to over-jamming of services in hospitals leading to an increase in wait time and in turn to an increase in demand for specialist physicians. An informant described the situation as follows:

“The system is jammed with unnecessary appointments that might not be needed in the first place. We do not necessarily need two more brain surgeons to reduce the queue; we need more qualified primary and family physicians” (SEHA 1).

Informants also indicated the importance of building a good primary care system to act as a gate keeper for secondary and tertiary care: “We need to have a system in place to refer patients from primary care to specialists. You can’t gate keep the services if you do not have a strong primary care and referral system. You can’t make sure that there are enough specialists to treat people, if you do not have good referral system. So you need to hire good primary physicians to do referrals so you can track patients’ movement” (HAAD 7).

Finally, most informants agreed on the need to recreate the primary system in Abu Dhabi with quality, access to care, and coordinated care as its main pillars. The following statement indicates the importance of building a robust primary care: “If we don’t get our act together in terms of creating a really robust primary care system and recruiting good primary care physicians, then we have little chance of improving the healthcare system in Abu Dhabi” (SEHA 1).

**Volume based competencies and service line rationalization**

The study found a consensus among informants that a fragmented health delivery system has largely contributed to the lower perceived quality of medical services. The nature of the system led to the creation of centres for specialised care (e.g. cardiac surgery) in a number of hospitals sometimes within close physical proximity without paying attention to creating critical mass of instances. That physicians perform low volumes of procedures may have led to a decrease in the quality of care in the long run, inhibiting the building of volume-based competencies. The following example cited by one of the informants illustrates this idea:

“For example if you look at something like knee replacement in the US, on average one physician that is specialised in knee replacement will probably do at least 200 cases a year. When we looked at the numbers across SEHA, we did only 126 patients across 5 hospitals last year. Those procedures were performed by 15 different physicians. If we look
at post-operations events such as infections, we had a fairly high rates of infection. So it is very clear that if we put the work in one hospital, then we can improve quality” (SEHA 2).

Another factor that is thought to lead to lower volume based competencies is that constitutionally, all physicians, except Emirati are not allowed to perform procedures expect in the hospitals they are recruited for, and cannot work in other public hospital or private hospitals. “Strict rules prohibit physicians from working across hospitals and between public and private hospitals which is common practice in many countries. This limits the exposure of physicians and their experience and ability to progress in the field (i.e. if a physician only performs 3 to 4 operations per week, it is very different to when they perform 15-20 operations a week)” (HAAD 6).

One way to address the system inefficiencies, build competence, and improve quality is service line rationalisation as indicated in the following statement:

“It is critically important to integrate services across the organisation also called service rationalisation. It is also important to integrate organisation into a continuum of services from primary care, hospital care, to post-hospital care. We started focusing on core delivery, we transitioned from horizontal integration to vertical integration. Service line leads to service rationalisation, it not only improve quality, it also creates care paths and standards around care delivery, but also it makes sure we have the right physicians, right number of physicians and also ramp around the notion of primary care which was lost around in the shadow” (SEHA 2).

Wait time management and overcrowding of public hospitals

From patients’ perspective, hospital buildings and wait time are thought to be the most visible factors in the assessment of healthcare system. Managing wait time is thought to improve patient satisfaction: “We need to improve trust in the healthcare system and increase patients’ satisfaction. This is also related to the waiting time. In my opinion, if we fix the waiting time, this will increase patients’ satisfaction” (HAAD 2).

In Abu Dhabi healthcare system, wait time appears to be a growing challenge especially with the growing demand for health services after opening access of public hospitals to non-national as well as national population following the reforms in 2008. A hospital executive indicated:

“We need to be able to keep up with the growth in demand for services. Patients’ volumes are up by 25-40% while growth in staff and physicians is only 5%. In Emergency treatment
growth is 19% while increase in doctors is only 1%. In some cases staff and physicians have to do 40 to 60 overtime hours per month” (HOSP 1).

However, notwithstanding increase in patient volume that would impact wait time; the challenges in wait time in Abu Dhabi healthcare system appear to be more of systemic nature. The main factors that are thought to impact wait time are sub-standard primary care system discussed in the section above, over-utilisation of medical services by Thiqa patients, and service level expectation of Emirati patients.

As discussed in Chapter 4, Thiqa policy holders appear to be making up to four times as many in-patients and out-patients claims compared to the basic and enhanced policyholders. Although the exact reasons for the over-utilisation are yet to be analysed, it appears that they might be due to lower cultural health awareness, coupled with very high instances of non-communicable life-style related diseases such as Type 2 diabetes, and cardiovascular diseases necessitating continuous care.

Another factor that is thought to explain the high wait time is related to the service level expectation of Emirati patients. For instance the target wait time in emergency rooms is 30 minutes. This appears to be aggressive even in comparison with international standards as indicated by one informant: “Service expectation of UAE nationals is totally off-chart, and maintaining the same level of service and performance targets for nationals as well as basic insurance holders (blue collar workers) is simply not realistic and unsustainable economically and resource wise. One way to address this challenge is to look at two tiered delivery system, one off-chart system for nationals and a second system for everybody else. The first system would address the expectations of the Emirati patients, whereas the second system would have more realistic and achievable performance expectations” (HOSP 1).

Finally, combined, the factors relating to wait time discussed above seem to indicate a measurement fixation as opposed to a more holistic approach of improving the quality of care as indicated in the statement below:

“We tend to be totally fixated on timeliness at the expense of quality of care. We have systemic issues regarding wait time targets and service expectation for national Thiqa holders, but in reality quality is the real challenge. We should the focus on quality of care in order to improve services and reduce the number of patients being treated abroad” (HOSP 1).
6.4.4 Conclusion

The analysis of qualitative data has revealed a number of challenges in the public healthcare sector in Abu Dhabi, some of which are related to the prevailing organisational culture, that are affecting the performance of the sector as a whole. Those challenges are divided into two categories, human capital challenges, and structural and systemic challenges.

Regarding human capital, the majority of the informants agreed that creating a sustainable, motivated workforce that can cope with the ever increasing demands of a growing and aging population with high risk of non-communicable diseases holds the keys to realising the government vision of providing best care for its population. However, the analysis revealed a number of important challenges including high turnover of physicians and staff, inadequate staff compensation, and low numbers of Emirati in the healthcare sector. In a sector heavily reliant on expatriate staff and physicians, those challenges potentially threaten the sustainability of the sector if they remain unaddressed. The prevailing organisational culture characterised with a bureaucratic, centralized rigid system especially in HR practices, coupled with divergent visions of clan culture between the Emirati and expatriate staff appear to explain a large extent the prevailing challenges in human capital.

The second set of challenges indicate structural issues including tensions and role ambiguity between HAAD and SEHA. Those challenges are thought to inhibit the implementation of cross functional teams and collaboration between divisions and sectors that would foster performance improvement. Systemic challenges including lack of an integrated continuum of care characterised by sub-standard primary care, and lack of service line rationalisation seem to affect patients’ trust and satisfaction in the healthcare system. High wait time, a major cause of dissatisfaction amongst patients, appears to be the result of many factors including increased demand, over-utilisation, and aggressive service level expectations from the Emirati population.
Chapter 7- Empirical Findings: Quantitative Data

7.1 Introduction

This chapter presents research findings from the analysis of quantitative data collected through the on-line survey conducted across the operator of public health facilities (SEHA) and public hospitals. The analysis provided in this chapter attempts to answer the two research questions relating to the assessment of current and preferred organisational culture across the different constituents of the public healthcare sector in Abu Dhabi. In addition, the analysis answers the two secondary research questions as to whether those cultural assessments differ based on the organisational affiliation, nationality of participants, and other demographic factors.

The chapter commences with a justification of the rationale behind the proposed nationality clusters used in the quantitative analysis followed by a description of the analytical approach taken as well as the analytical procedures chosen. Subsequently, the key characteristics of the respondents who took part in the questionnaire survey are described. The text then moves on to a presentation of the research findings. Those findings are presented in three major parts; the first section portrays the overall cultural profile of public healthcare culture. It depicts the current culture as well as the preferred culture which reflects respondents’ perceptions of what cultural types would improve performance. A comparison between the current and preferred cultures is presented to illuminate potential divergences and the wish for change. The following section includes comparisons of current and preferred cultural values based on organisational affiliation. In the final section, the comparison of current and preferred cultural values and in how far those perceptions are shaped by nationality clusters is analysed. A brief conclusion closes the chapter.

7.2 Nationality Distribution

Based on the analysis of pilot study and the interviews conducted, nationality distribution was found to be an important demographic factor. A review of literature indicated that nationality influences beliefs about organisations and management (Klein et al., 2009). Laurent (1983) studied how managers from different countries perceived their organisations. Results of his study indicated that nationality has three times more influence
on shaping managerial assumptions than any other demographic factors such as age, education, function, etc. Similarly, Trompenaars (1993) found that culture of origin or nationality has the highest influence on work related values, followed by industry and religion (Laurent, 1983, Trompenaars and Hampden-Turner, 1993) as quoted in (Klein et al., 2009).

As indicated in Chapter 4, the UAE population has a unique demographic and ethnic composition reflected with less than 12 percent UAE national population, and 88 percent expatriates from over 180 different nationalities. Such demographic diversity is clearly present in the workplace. The sample participants of the survey included 30 distinct nationalities reflecting the diversity of the working population. In order to facilitate the data analysis, the researcher decided to group participants based on nationality clusters. The clustering of nationalities was based on the Global Leadership and Organisational Behavior Effectiveness (GLOBE) grouping of societal cultures into 10 cultural clusters (House et al., 2004). The Middle-Eastern cluster of GLOBE included Egypt, Kuwait, Morocco, Turkey, and Qatar only. However a recent extension of the Globe study by (Mensah and Chen, 2013) analysed data on demographics of the individual countries not included in the original Globe study based on five main variables ethnicity, religion, official languages, world region, and native languages. The analysis expanded the Middle-Eastern cluster to include countries such as UAE, Lebanon, Saudi Arabia and other Arab countries. The grouping of the sample participants based on nationality resulted into four distinct clusters Anglo, Middle East, Southeast Asia, and Latin Europe as indicated in Table 16 below.

**Table 16 - Nationality clusters based on GLOBE**

<table>
<thead>
<tr>
<th>Cluster Name</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo</td>
<td>Australia, England, New Zealand, South Africa, USA, Canada</td>
</tr>
<tr>
<td>Middle East</td>
<td>UAE*, Bahrain*, Jordan*, Lebanon*, Palestine*, Syria*</td>
</tr>
<tr>
<td>Southeast Asia</td>
<td>Pakistan*, India, Bangladesh*, Malaysia &amp; Philippines</td>
</tr>
<tr>
<td>Latin Europe</td>
<td>France</td>
</tr>
</tbody>
</table>

* Countries marked with * are not included in the original Globe Clusters (House et al., 2004), however a recent extension of the Globe study by (Mensah and Chen, 2013) included those countries in the clusters above

Participants in the Latin European cluster amounted to two only; further investigations revealed that they are from Arab origins. They were therefore included in the Middle East Cluster.
7.2.1 Sub-Clusters within the Middle East Cluster

In Chapter 2, the diversity of the Arab World and the Middle East region in terms of demographic, ethnic, economic and political characteristics was highlighted. Kabasakal et al., (2012) posit that while countries in the Middle-Eastern cluster countries have commonalities in their societal cultural norms they also have differing socioeconomic, demographic and ethnic dynamics that may also differentiate their cultural norms and leadership attributes (Kabasakal et al., 2012). Kabasakal and Bodur (2007) noted that in Middle-Eastern countries, strong in-group ties and networks of interdependent relationships are both practiced and valued. Inspired mainly by Islamic traditions, common cultural practices in those countries include high power distance and high in-group collectivism. However their analysis also showed that there are notable differences among the different countries represented in the cluster. For example, while decisiveness marks the most effective leadership quality in Turkey, humane leadership is see as the most effective attributes in Qatar (Kabasakal and Bodur, 2007). Kabasakal et al., (2012) used cluster analysis to investigate the dispersion in terms of leadership prototypes among the seven MENA countries represented in the Globe study, which include in addition to the five countries indicated above, Iran and Israel. Their analysis indicated that the MENA region can be identified by four sub-clusters exhibiting slightly different leadership and cultural characteristics. Sub-cluster 1 includes Iran, Egypt and Kuwait; sub-cluster 2 includes Israel and Turkey, sub-cluster 3 includes Qatar, and finally sub-cluster 4 includes Morocco. In Qatar, which is part of sub-cluster 3, ‘humane leadership’ was found to contribute most to outstanding leadership. However, unlike other MENA sub-clusters, Decisive, performance oriented leadership was found to be a negative attribute in Qatar (Kabasakal et al., 2012).

Informed by the analysis of qualitative data gathered from the interviews which indicated that UAE nationals have different perceptions of organisational culture compared to the other nationality clusters, and by the review of literature above, the researcher decided to isolate the UAE nationals from the Middle East Cluster. The UAE nationals group was therefore considered as a separate cluster in the quantitative data analysis. The four resulting nationality groups included Anglo, Middle East, Southeast Asia, and UAE as indicated in Table 18.

7.3 Quantitative Data Analysis

The quantitative data collected through the on-line OCAI survey was first extracted from the proprietary database, described in Chapter Five, into excel and subsequently imported
into SPSS version 22. SPSS was used for the main inferential analyses of statistically significant differences. While descriptive statistics such as means and percentages were computed across all items in the questionnaire, inferential analyses using General Linear Modelling (GLM) and regression analysis were carried out in order to provide a deeper level of understanding that could not be acquired through descriptive statistics. Such analysis was essential to verify initial hypotheses which were particularly crucial in answering the core research questions. To ensure high level of clarity, the results of the analysis are presented in condensed form. Only the important findings directly related to the research questions, including the comparison of cultural assessment across different organisational affiliation and nationality clusters are presented in the text. Although the dependent variables (cultural evaluation) were statistically non-normally distributed, the reported findings stem from parametric analyses rather than non-parametric tests, for four reasons. Firstly, the overall shape of the dependent variables resembles a normal distribution and initial non-parametric test of the data give the same results as parametric tests. Secondly, several studies have shown that parametric tests (such as GLM or t-test) are highly robust against violations of the normality assumption with respect to the Type I error (Rasch and Guiard, 2004, Bolker et al., 2009). Thirdly, parametric tests are often easier to understand and thus allow a better understanding to which extent qualitative and quantitative findings align. Lastly, parametric tests allow for more complex analyses models necessary for the present data.

The results are presented both in tables and diagrams. Emphasis was placed on providing clear illustration of current and preferred organisational culture profiles focusing on nature of change or shift in cultural perception between current and preferred culture, in addition to different views of cultural profiles across different organisational affiliations and nationality clusters. The hypothesis tested in the analysis were mainly derived from the results of the qualitative analysis described in Chapter Six. The examination of different nationalities’ cultural evaluations is focused the comparison between Expatriates and UAE nationals, as this comparison emerged to be worth of further investigation from the qualitative results. Table 17 provides a summary of the different statistical and analytical techniques used to answer the research questions. The analysis of the quantitative data in terms of demographic characteristics including gender, age and education levels did not reveal any major differences from the findings of the overall cultural profile. The respondents in various demographic groups appeared to share a common view of their culture. Given the research focus of this work, the limited sample size and thus statistical
power, as well as the lack of effect of those demographic variables, those were left out in the following presentation of the findings.
<table>
<thead>
<tr>
<th>Test nb.</th>
<th>Research approach</th>
<th>Research objective</th>
<th>Hypotheses</th>
<th>Analyses procedure</th>
<th>Statistic/Applied Test</th>
<th>Main Finding</th>
<th>Result Overview</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Descriptive</td>
<td>Examining key characteristics of survey respondents</td>
<td></td>
<td>Univariate analyses</td>
<td>frequencies and percentages, box-plots</td>
<td>Respondents represent only a subsample of the types of employees and organisations working in the health care sector in terms of their demographic and professional profile</td>
<td>-Table 18</td>
<td>Main sample characteristics of the respondents do not allow generalization of the findings to entire health sector</td>
</tr>
<tr>
<td>2</td>
<td>Descriptive</td>
<td>Examining the parametrical properties of the cultural profiles as preconditions for subsequent application of the appropriate inferential approach</td>
<td></td>
<td>Univariate analyses; multivariate parametric and non-parametric analyses</td>
<td>Histograms, Shapiro-Wilk-test of normality, kurtosis and skewness, Box-Cox transformation, Friedman ANOVA and Wilcoxon-signed rank test, General linear model for repeated measures</td>
<td>Dependent variables are statistically not normally distributed mainly due to kurtosis, yet follow in overall shape a normal-distribution; hence, non-parametric analyses and parametric analyses give similar results</td>
<td>-Table 19</td>
<td>For easier understanding to which extent qualitative and quantitative findings align, parametric results are presented given that they are similar to the results of the non-parametric tests, but allow for more complex analyses models</td>
</tr>
<tr>
<td>3</td>
<td>Descriptive &amp; inferential</td>
<td>What are the current dominant types of organisational culture across the constituents of the public healthcare</td>
<td><strong>H1</strong>: There is a difference to which degree respondents perceive %average</td>
<td>Variance analyses: Comparison of the mean percentages</td>
<td>Mean percentages, paired-sample t-test (Bonferroni-corrected), General Linear Model for repeated measures</td>
<td><strong>H1 supported</strong> current dominant cultures are hierarchy and market types</td>
<td>-Table 20</td>
<td>Triangulates with qualitative interviews</td>
</tr>
</tbody>
</table>

**Table 17**: Overview of analytical approach, statistical methods, and key findings
<table>
<thead>
<tr>
<th>Test nb.</th>
<th>Research approach</th>
<th>Research objective</th>
<th>Hypotheses</th>
<th>Analyses procedure</th>
<th>Statistic/Applied Test</th>
<th>Main Finding</th>
<th>Result Overview</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Descriptive &amp; inferential</td>
<td>What are the preferred dominant types of organisational culture across the three constituents of public healthcare sector in Abu Dhabi?</td>
<td>H2: There is a difference in the extent of preferred organisational culture related to the favored degree of variance analyses: (same as test 3)</td>
<td>an ascribed percentage to a particular type of current organisational culture across the different organisational culture types; test if potential differences in mean percentages across cultures are statistically meaningful with current organisational culture (4: clan, adhocracy, hierarchy, market) as within subject factor, first-order simple effects</td>
<td>Mean percentages, paired-sample t-test (Bonferroni-corrected); General Linear Model for repeated measures with preferred organisational culture as within</td>
<td>H2 supported, respondents wish for a clan dominated culture with equal amount of the other types.</td>
<td>-Table 22 -Figure 18 -Table 23</td>
<td>Triangulates with qualitative interviews</td>
</tr>
<tr>
<td>Test nb.</td>
<td>Research approach</td>
<td>Research objective</td>
<td>Hypotheses</td>
<td>Analyses procedure</td>
<td>Statistic/Applied Test</td>
<td>Main Finding</td>
<td>Result Overview</td>
<td>Remarks</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>--------------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>-----------------------</td>
<td>--------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>5</td>
<td>Inferential</td>
<td>Is there a divergence of current and preferred organisational culture? Do respondents wish for a change in organisational culture?</td>
<td>H3: There is a difference between current cultural assessment at (T1) and the preferred cultural assessment (T2) across all four cultural types</td>
<td>Multivariate analyses: test whether there is a statistically significant difference between participants' mean evaluation in percentages of the current culture and</td>
<td>General linear model for repeated measures with time (2: now, preferred) and organisational culture (4: clan, adhocracy, hierarchy, market) as within subject factors; First-order simple effects, contrast analyses, linear regression analyses with categorical dummies</td>
<td>H3 supported, significant 2-way interaction effect of organisational culture * time</td>
<td>-Table 24 -Figure 19 -Table 25 -Figure 20</td>
<td></td>
</tr>
<tr>
<td>Test nb.</td>
<td>Research approach</td>
<td>Research objective</td>
<td>Hypotheses</td>
<td>Analyses procedure</td>
<td>Statistic/Applied Test</td>
<td>Main Finding</td>
<td>Result Overview</td>
<td>Remarks</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
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<td>-------------------</td>
<td>-------------------</td>
<td>--------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>6</td>
<td>Descriptive &amp; inferential</td>
<td>Does the evaluation of the current and preferred cultural profile differ based on organisational affiliation (i.e. corporate office and public hospitals)?</td>
<td><strong>H1.1:</strong> Operator and hospitals differ in their current culture evaluation</td>
<td>Variance analysis (same as test 3)</td>
<td>Mean percentages, paired-sample t-test (Bonferroni-corrected); General Linear Model for repeated measures with current and preferred organisational culture and organisational affiliation between-subject factor</td>
<td><strong>H1.1</strong> partially supported, corporate office reports a lower degree of hierarchy compared to the hospitals currently.</td>
<td>- Table 26 - Figure 21</td>
<td>- Table 27 - Figure 22</td>
</tr>
<tr>
<td>Test nb.</td>
<td>Research approach</td>
<td>Research objective</td>
<td>Hypotheses</td>
<td>Analyses procedure</td>
<td>Statistic/Applied Test</td>
<td>Main Finding</td>
<td>Result Overview</td>
<td>Remarks</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| 7       | Inferential       | Is there a 
divergence 
of current and 
preferred 
organisational culture based 
on organisational affiliation | **H3.1:** There is a difference in the evaluation of the operator compared to the hospitals for cultural scores between current assessment (T1) and preferred assessment (T2) | Multivariate analyses (same as test 5) | General linear model for repeated measures with time and organisational culture and organisational affiliation as between-subject factors | **H3.1. not supported,** significant 2-way interaction of culture*organisational affiliation instead of 3-way interaction time*culture*organisational affiliation. | -Table 28  
-Figure 23  
-Table 29  
-Figure 24 |       |
| 8       | Descriptive & Inferential | Does a respondents' nationality influence their evaluation of the current and preferred cultural profile? | **H1.2:** Nationality affects current culture evaluation. 
**H2.2:** Nationality affects preferred culture type | Variance analyses (same as test 3) | Mean percentages, paired-sample t-test (Bonferroni-corrected); General Linear Model for repeated measures with current and preferred organisational culture and nationality between-subject factor | **H1.2 supported,** the Anglo expats evaluation deviates for all 4 culture types from the evaluation of the UAE nationals. 
**H2.2 supported:** Anglo expats compared to UAE nationals prefer a | -Table 30  
-Figure 25  
-Table 31  
-Figure 26 | Triangulates with qualitative interviews |
<table>
<thead>
<tr>
<th>Test nb.</th>
<th>Research approach</th>
<th>Research objective</th>
<th>Hypotheses</th>
<th>Analyses procedure</th>
<th>Statistic/Applied Test</th>
<th>Main Finding</th>
<th>Result Overview</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Inferential</td>
<td>Is there a divergence of current and preferred organisational culture based on <em>nationality clusters</em>?</td>
<td>H3.2: Nationality cluster has a statistically significant effect on cultural evaluation scores at (T1) and (T2)</td>
<td>Multivariate analyses (same as test 5)</td>
<td>General linear model for repeated measures with time and organisational culture and <em>nationality</em> as between-subject factors.</td>
<td>H3.2 supported; significant three-way interaction of organisational culture<em>time</em>nationality cluster</td>
<td>Table 32 - Figure 27 - Figure 28</td>
<td></td>
</tr>
</tbody>
</table>
7.4 Respondents’ Main Characteristics

As indicated in Chapter Five, the on-line survey was distributed to a sample of 491 participants across SEHA and public hospitals. Survey results are summarized in Table 15, 114 responses were received resulting in a gross response rate of 23%. 14 out of the 114 responses could not be used due to non-complete information resulting in a net response rate of 20%.

Key-characteristics of the survey respondents are presented below. Table 18 summarises demographic attributes, and Table 19 professional characteristics. There is fairly equal gender distribution in the sample with male representing 56% and female 44%. People aged between 30 and 44 represent the largest group (47%), half as many are either in the youngest age group 19 to 29 years (22%), or in the older group 45 to 59 years (25%). Only 5% of the respondents were above 60 years old. In terms of education levels, almost half of the respondents (49%) had post-graduate degree, followed by 32% with a bachelor degree. A small proportion (13%) had either high school or college diploma, whereas only 6% held a doctorate degree. A third of the respondents are UAE nationals, followed by 29% from Anglo countries, 24% from the Middle East, and 14% from South Asia.

Overall, 40% of the respondents work in public hospitals, and 53% work in SEHA corporate office. In terms of organisational tenure, more than third of the respondents (35%) have been working with their organisations between two to five years, followed by less than one year (19%), between one and two years (17%). Around 28% of the respondents have been with their organisation for more than 6 years. Most respondents to the survey (62%) are in middle or senior management positions, a smaller percentage (26%) are in senior officer position or equivalent and only 8% in coordinator/officer position. In terms of professional affiliation, administrators represented the largest number of respondents (42%), whereas physicians and nurses represented a much smaller percentage at 7% and 1% respectively.
### Table 18 - Demographic characteristic of the survey respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>55</td>
<td>56.10%</td>
</tr>
<tr>
<td>Female</td>
<td>43</td>
<td>43.90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 19 – 29</td>
<td>22</td>
<td>22.4%</td>
</tr>
<tr>
<td>Between 30 - 44</td>
<td>46</td>
<td>46.9%</td>
</tr>
<tr>
<td>Between 45 - 59</td>
<td>25</td>
<td>25.5%</td>
</tr>
<tr>
<td>60 plus</td>
<td>5</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td>5</td>
<td>5.1%</td>
</tr>
<tr>
<td>College/Diploma</td>
<td>8</td>
<td>8.2%</td>
</tr>
<tr>
<td>Associate or bachelor</td>
<td>31</td>
<td>31.6%</td>
</tr>
<tr>
<td>Post-graduate or Master</td>
<td>48</td>
<td>49%</td>
</tr>
<tr>
<td>PhD or doctorate</td>
<td>6</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglo</td>
<td>29</td>
<td>29.6%</td>
</tr>
<tr>
<td>South-Asian</td>
<td>14</td>
<td>14.3%</td>
</tr>
<tr>
<td>Middle-Eastern</td>
<td>24</td>
<td>24.5%</td>
</tr>
<tr>
<td>UAE</td>
<td>31</td>
<td>31.6%</td>
</tr>
</tbody>
</table>

\[N = 98\]
Table 19 - Professional characteristic of the survey respondents

<table>
<thead>
<tr>
<th>Organisational affiliation</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>52</td>
<td>53.10%</td>
</tr>
<tr>
<td>Operator SEHA</td>
<td>39</td>
<td>39.80%</td>
</tr>
<tr>
<td>Missing response</td>
<td>7</td>
<td>7.10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinator/ officer</td>
<td>8</td>
<td>8.2%</td>
</tr>
<tr>
<td>Coordinator/ senior manager</td>
<td>26</td>
<td>26.5%</td>
</tr>
<tr>
<td>Middle Management</td>
<td>35</td>
<td>35.7%</td>
</tr>
<tr>
<td>Senior Management</td>
<td>27</td>
<td>27.6%</td>
</tr>
<tr>
<td>Missing response</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organisational tenure</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 10 years</td>
<td>16</td>
<td>16.6%</td>
</tr>
<tr>
<td>Between 6-10 years</td>
<td>12</td>
<td>12.2%</td>
</tr>
<tr>
<td>Between 2-5 years</td>
<td>34</td>
<td>34.7%</td>
</tr>
<tr>
<td>Between 1-2 years</td>
<td>17</td>
<td>17.3%</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>19</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Affiliation</th>
<th>Frequency</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Physicians</td>
<td>7</td>
<td>7.1%</td>
</tr>
<tr>
<td>Administrative</td>
<td>41</td>
<td>41.8%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6.1%</td>
</tr>
<tr>
<td>Missing response</td>
<td>55</td>
<td>43.9%</td>
</tr>
</tbody>
</table>

N = 98

7.5 Cultural Profile of Public Healthcare Organisations

7.5.1 Overall Current Cultural Profile

This section seeks to identify the current dominant types of organisational culture in public healthcare in Abu Dhabi. Findings from the quantitative data in Table 20 indicate that participants perceived their current organisation culture to be largely dominated by hierarchy (M= 29.45, SD = 9.53) and market cultures, (M= 28.43, SD = 7.48). The results from a paired-sample t-test (Bonferroni-corrected) reveal that both types are statistically the same, and as such, equally predominant in the organisational culture, t(97)= -.79, p < .05. The organisational culture is to a much lesser extent constituted of the clan culture (M=22.41, SD=7.77), and to the least degree by adhocracy (M=19.40, SD=6.23); all mean values of these cultural types are statistically different from each other (Table 20), ps < .001. Table 20 contains the ranking of the cultural types according to their organisational predominance starting from the most dominant types.
Table 20 - Average current cultural profiles across the public health sector

<table>
<thead>
<tr>
<th>Rank</th>
<th>Type</th>
<th>Mean (%)</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hierarchy</td>
<td>29.45</td>
<td>9.53</td>
</tr>
<tr>
<td>1</td>
<td>Market</td>
<td>28.43</td>
<td>7.48</td>
</tr>
<tr>
<td>2</td>
<td>Clan</td>
<td>22.41</td>
<td>7.77</td>
</tr>
<tr>
<td>3</td>
<td>Adhocracy</td>
<td>19.40</td>
<td>6.23</td>
</tr>
</tbody>
</table>

N = 98

Table 21 - Mean difference comparison across current cultural profiles

<table>
<thead>
<tr>
<th>Culture type</th>
<th>Mean-Differences (%)</th>
<th>Std. Deviation</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan vs. Adhocracy</td>
<td>3.01</td>
<td>8.25</td>
<td>3.61*</td>
</tr>
<tr>
<td>Clan vs. Market</td>
<td>-6.02</td>
<td>13.33</td>
<td>-4.47*</td>
</tr>
<tr>
<td>Clan vs. Hierarchy</td>
<td>-7.04</td>
<td>15.39</td>
<td>-4.53*</td>
</tr>
<tr>
<td>Adhocracy vs Market</td>
<td>-9.03</td>
<td>11.06</td>
<td>-8.08*</td>
</tr>
<tr>
<td>Adhocracy vs. Hierarchy</td>
<td>-10.05</td>
<td>14.44</td>
<td>-6.89*</td>
</tr>
<tr>
<td>Market vs Hierarchy</td>
<td>-1.02</td>
<td>12.87</td>
<td>-0.79</td>
</tr>
</tbody>
</table>

*p < .05

Figure 17 – Average current cultural profiles across the public health sector

Note: Scores represent average percentage score of cultural assessment based on ipsative scale evaluation

7.5.2 Overall Preferred Cultural Profile

The distribution of respondents’ scores for preferred cultural profile revealed one clear finding, emphasizing the wish of an organisational atmosphere dominated by a clan

1 Cultural assessment scores using ipastive scales represent the average assessment of each of the four cultural types based on the six dimensions indicated in OCAI as explained in section 5.6.4. This scale applies to all figures in this chapter.
culture. Respondents rated the other three cultural types, hierarchy, adhocracy, and market culture as preferred constituents of the organisational culture in the health care sector with an almost similar rating of 24% (Table 22). By far the highest score denotes the clan culture with 29% (SD=8.20), marking its prescriptively assigned importance. Paired-sample t-test (Bonferroni-corrected) revealed this cultural type is clearly outstanding, and statistically higher than all the other scores for the remaining cultures (see Table 23, row 1 to 3); whereas the market, adhocracy, and hierarchy scores are statistically the same (Table 23, row 4 to 6). Thus respondents wish for a clan dominated culture with equal amount of the other types. Moreover, it can be observed that the range of average score across all cultural types became narrower compared to the current cultural profile from 24 to 29 for the preferred profile and 19 to 29 for the current profile scores. This may point towards a smaller gap between the four cultural types in the preferred cultural assessment compared to the current one, potentially representing a preference for a change towards a more balanced culture.

Table 22 - Average preferred cultural profiles

<table>
<thead>
<tr>
<th>Rank</th>
<th>Type</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clan</td>
<td>28.91</td>
<td>8.20</td>
</tr>
<tr>
<td>2</td>
<td>Market</td>
<td>24.15</td>
<td>8.33</td>
</tr>
<tr>
<td>2</td>
<td>Adhocracy</td>
<td>23.93</td>
<td>5.66</td>
</tr>
<tr>
<td>2</td>
<td>Hierarchy</td>
<td>23.91</td>
<td>6.90</td>
</tr>
</tbody>
</table>

$N = 98$

Figure 18 - Average preferred cultural profiles
Table 23 - Mean difference comparison across preferred cultural profiles

<table>
<thead>
<tr>
<th>Culture type</th>
<th>Mean-Difference</th>
<th>Std. Deviation</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan vs. Adhocracy</td>
<td>4.09</td>
<td>9.72</td>
<td>4.17*</td>
</tr>
<tr>
<td>Clan vs. Market</td>
<td>3.87</td>
<td>15.18</td>
<td>2.52</td>
</tr>
<tr>
<td>Clan vs. Hierarchy</td>
<td>4.11</td>
<td>12.65</td>
<td>3.22*</td>
</tr>
<tr>
<td>Adhocracy vs Market</td>
<td>-0.23</td>
<td>11.56</td>
<td>-0.19</td>
</tr>
<tr>
<td>Adhocracy vs. Hierarchy</td>
<td>0.02</td>
<td>10.80</td>
<td>0.02</td>
</tr>
<tr>
<td>Market vs Hierarchy</td>
<td>0.24</td>
<td>11.39</td>
<td>0.21</td>
</tr>
</tbody>
</table>

*p < .05

Note: rows marked in dark colour represent statistically significant variances, rows marked in light colour are not statistically significant variance, but have large enough variance to indicate potential trends.

These statistically significant differences between current and preferred cultures scores shown in Table 23 require further statistical testing to confirm that indeed a change from current to preferred cultural profiles is present. Given that this suspected difference is one of the core findings of the qualitative research, the next section examines the difference between current and preferred cultures.

7.5.3 Overall Difference between Current and Preferred Cultures

The previous findings from the separate analyses of the current cultural profile and the preferred cultural profile need to be examined in a temporal context to enable identifying a statistically confirmed change in cultural profile evaluations. In order to assess the difference between the current cultural profiles (Time 1) and their preferred cultural profile (Time 2), the time component (2 levels: time 1, time 2) in addition to the cultural profiles (4 levels: clan, adhocracy, market, hierarchy) were modelled into one repeated measures GLM with time and culture both as within-subjects factors.

From the above described model, a significant main effect of culture emerged $F_{\text{Greenhouse-Geisser}}(2.53, 245.76) = 10.92, p = .001, \eta^2 = .10$; while no main effect of time was detected, $F_{\text{Greenhouse-Geisser}}(1, 97) = 2.02, p = .16, \eta^2 = .02$. This means overall the culture type assessed explains 10% of the variance in the average evaluation percentage observed. In other words, which culture type respondents evaluated contributed to a degree of 10% to different scores in percentages the respondents assigned to the dominance of a particular cultural type overall, independent of their evaluation of current vs. preferred cultures (e.g. time 1 and time 2). Moreover, the lack of a main effect of time means that current and preferred cultural profiles per se do not change the average evaluation scores. Said differently, just the fact that a repeated measurement occurred and respondents were asked to evaluate twice - the current profile and their preferred profile - did not independently of the cultural type judged, lead to different scores.
The next observation is the expected discrepancy between the current organisational culture and the preferred organisational culture, apparent from the qualitative analyses. As predicted, a significant 2-way interaction effect of time and culture type was found, F\text{Greenhouse-Geisser} (2.22, 215.51) = 27.49, \( p = .001 \), \( \eta^2 = .22 \). Thus, a difference of the cultural type assessed, current compared to preferred, emerged. This difference is furthermore sizeable, as it explains 22% of the variance in the overall mean percentages observed. Where the exact differences are, is further elucidated by decomposing the interaction to its first-order simple effects. First the discrepancy between a particular culture type evaluation at time 1 (current) and time 2 (preferred) are displayed in Table 24. Since all simple effects (Bonferroni-corrected) are significant at \( p < .05 \), each and every cultural type evaluated deviates from the respondents’ preferred degree. As such, the wish for a change between the current organisational culture in the health care sector and the desired organisational culture is statistically supported, illustrated in Figure 19.

### Table 24 - Mean difference between current and preferred cultural profiles

<table>
<thead>
<tr>
<th>Culture type</th>
<th>Current (Mean in %)</th>
<th>Preferred (Mean in %)</th>
<th>Mean-Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan</td>
<td>22.41</td>
<td>28.02</td>
<td>5.61*</td>
</tr>
<tr>
<td>Adhocracy</td>
<td>19.40</td>
<td>23.93</td>
<td>4.52*</td>
</tr>
<tr>
<td>Market</td>
<td>28.43</td>
<td>24.15</td>
<td>-4.28*</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>29.45</td>
<td>23.91</td>
<td>-5.55*</td>
</tr>
</tbody>
</table>
*\( p < .05 \)

### Figure 19 - Discrepancy between current and preferred cultural profiles

Furthermore, within-subject contrast analyses reveal a noteworthy pattern, visualized in Figure 20 and statistically confirmed in Table 25. Regarding the significant contrast of the clan culture and adhocracy culture, it can be stated that respondents wish for an increase in
the clan/market culture to the same extent, yet the respondents wish that the clan culture remains more dominant than the adhocracy culture. The desired change for the hierarchy and market cultures are statistically insignificant and therefore similar. In other words, respondents desire a decrease from the current hierarchy/market culture to a lower level of hierarchy/market in the preferred culture in the same degree.

Table 25 - Results of within-subject contrast Aanalyses

<table>
<thead>
<tr>
<th></th>
<th>Df</th>
<th>Error df</th>
<th>F-value</th>
<th>p-value</th>
<th>Eta-squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>time * profile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred vs current Clan vs Adhocracy</td>
<td>1</td>
<td>94</td>
<td>28.19</td>
<td>.000</td>
<td>.23</td>
</tr>
<tr>
<td>Adhocracy vs Market</td>
<td>1</td>
<td>94</td>
<td>47.79</td>
<td>.000</td>
<td>.34</td>
</tr>
<tr>
<td>Market vs Hierarchy</td>
<td>1</td>
<td>94</td>
<td>.05</td>
<td>.82</td>
<td>.00</td>
</tr>
</tbody>
</table>

P<.05

Figure 20 - Interaction effect of time and culture evaluated

7.6 Cultural Profile of Public Healthcare Organisations Based On Organisational Affiliation

7.6.1 Current Cultural Profile by Organisational Affiliation

In this section, the focus is to analyse whether the previously identified distribution of cultural profiles is independent of the organisational affiliation, or is different for the
corporate office (SEHA) and public hospitals. As indicated in Chapter Five, in view of the low response rate from individual hospitals, the researcher was unable to conduct an analysis of cultural profiles at individual hospital level and compare it to the corporate office cultural profile. Instead, data was analyzed by comparing average cultural scores for all hospital staff to the average score for all SEHA corporate office staff.

Only a marginal significant interaction between cultural evaluations and organisational affiliation was found, $F_{Greenhouse-Geisser}(2.3, 205.33) = 2.27, p < .1, \eta^2 = .03$ utilising a repeated measures GLM with culture as within subject-factor and organisational affiliation as between-subjects factor. Table 26 and Figure 21 show the average scores for the cultural types for the corporate office (SEHA) and the hospitals. The analysis of cultural profiles in terms of organisational affiliation did reveal higher scores for hierarchy culture when assessed by hospital staff compared to average scores recorded by corporate office. This is supported by decomposing the interaction looking at the parameter estimates for the organisational affiliation on the cultural types, $t(89) = 2.23, p < .05, B = 4.42, \eta^2 = .05$; all other $ps > .35$.

Table 26 - Average current cultural profiles based on organisational affiliation

<table>
<thead>
<tr>
<th>Cultural type</th>
<th>Affiliation</th>
<th>Mean (%)</th>
<th>St. Dev.</th>
<th>Mean Difference</th>
<th>t-value</th>
<th>Eta squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan</td>
<td>Corporate office</td>
<td>22.68</td>
<td>7.61</td>
<td>-1.28</td>
<td>0.80</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Hospitals</td>
<td>21.39</td>
<td>7.46</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhocracy</td>
<td>Corporate office</td>
<td>19.55</td>
<td>6.15</td>
<td>-1.04</td>
<td>0.77</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Hospitals</td>
<td>18.5</td>
<td>6.59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Market</td>
<td>Corporate office</td>
<td>29.43</td>
<td>7.52</td>
<td>-1.53</td>
<td>0.95</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Hospitals</td>
<td>27.9</td>
<td>7.76</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hierarchy</td>
<td>Corporate office</td>
<td>27.77</td>
<td>7.79</td>
<td>4.43</td>
<td>-2.23*</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>Hospitals</td>
<td>32.2</td>
<td>11.13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*N = 91, *p < .05
7.6.2 Preferred Cultural Profile by Organisational Affiliation

A GLM for repeated measurements with the cultural profile as within-subjects factor and organisational affiliation as between-subjects factor was run. Mirroring the results from the current cultural analyses, Table 27 and Figure 22 show that the interaction of organisational affiliation and assigned profile scores is only marginally significant. \( F(\text{Greenhouse-Geisser}) (2.34, 208.64) = 2.24, p = .10, \eta^2 = .03. \) Respondents from the corporate office reported to prefer a lower hierarchy culture (M= 22.45, SD = 5.43) than people from the hospitals (M = 25.59, SD = 8.18). No differences on clan, adhocracy, or market cultures arose from splitting the interaction looking at the parameter estimates for the organisational affiliation by cultural types, t(89) = -2.2, p < .05, B = -3.41, \eta^2 = .05; all other ps > .11. Yet, two trends can be noted, which approach a statistical more liberal significance level of p = .10. Firstly, hospital respondents prefer a lower level of adhocracy than those from the corporate office. t(89) = 1.62, p = .11, B = 1.95, \eta^2 = .03. Secondly, hospitals favor lower levels of a market culture compared to the corporate office, t(89) = 1.42, p = .16, B = 2.56, \eta^2 = .02. However, the influence of organisational affiliation on cultural profiles needs to be seen in the context of current and preferred cultural types as detailed in the following section.
7.6.3 Overall Differences between Current and Preferred Cultural Profiles by Organisational Affiliation

Having previously established a difference in cultural assessments between current and preferred cultural types, a potential moderation effect of respondents’ organisational affiliation is tested in the following section. Extending the above used repeated measure GLM with cultural evaluation and time as within-subject factors by organisational affiliation as between-subject factors reveals the following: the assumed 3-way interaction of culture*time*organisation affiliation was not significant, $F_{\text{Greenhouse-Geisser}} (2.19, 194.09) = .62, p = .55, \eta^2 = .01$. Instead, a two-way interaction effect of organisational affiliation and culture type was obtained, $F(2.54, 226.29) = 3.37, p < .05, \eta^2 = .04$. This indicates that respondents’ organisational affiliation and the culture type judged (clan, adhocracy, market, hierarchy) determine the score allocated to a particular culture, regardless of the time point of cultural evaluation (current vs preferred). In other words, depending on
hospital or corporate office affiliation, a particular culture type is overall assessed differently. How exactly, is illustrated in Table 28 and Figure 23. Hospitals generally assign higher hierarchy scores than the corporate office as the mean-difference is significant at $p < .05$; all other ps are $>.11$.

Table 28 - Comparison of the mean differences in cultural types based on organisational affiliation

<table>
<thead>
<tr>
<th>Cultural comparison</th>
<th>Mean-Difference in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate office</td>
<td></td>
</tr>
<tr>
<td>Clan vs. Adhocracy</td>
<td>2.91*</td>
</tr>
<tr>
<td>Clan vs. Market</td>
<td>-2.38</td>
</tr>
<tr>
<td>Clan vs. Hierarchy</td>
<td>-0.07</td>
</tr>
<tr>
<td>Adhocracy vs Market</td>
<td>-5.29*</td>
</tr>
<tr>
<td>Adhocracy vs. Hierarchy</td>
<td>-2.97*</td>
</tr>
<tr>
<td>Market vs Hierarchy</td>
<td>2.31</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Clan vs. Adhocracy</td>
<td>4.44*</td>
</tr>
<tr>
<td>Clan vs. Market</td>
<td>-0.29</td>
</tr>
<tr>
<td>Clan vs. Hierarchy</td>
<td>-3.81*</td>
</tr>
<tr>
<td>Adhocracy vs Market</td>
<td>-4.74*</td>
</tr>
<tr>
<td>Adhocracy vs. Hierarchy</td>
<td>-8.25*</td>
</tr>
<tr>
<td>Market vs Hierarchy</td>
<td>-3.52*</td>
</tr>
</tbody>
</table>

*p < .05

Figure 23 - Comparison of the mean differences in cultural types based on organisational affiliation

As the results above indicated that the main differences of cultural assessment based on organisational affiliation is primarily in hierarchy culture, the focus is the question whether hospitals and corporate office differ in their assessment of current and preferred hierarchy culture prevailing in their organisation. An ANOVA predicting current and preferred hierarchy scores showed a significant main effect of organisational affiliation $F(1,89) = 7.60, p < .01, \eta^2 = .08$. Contrast analyses revealed that both hospitals and the corporate
office wish for a lower degree of hierarchy compared to their current level (see Figure 24 and Table 29); all ps < .001; whereby hospitals’ hierarchy culture is at a higher level to begin with and remains higher in the preferred rating compared to the corporate office, ps < .05.

**Figure 24 - Difference between current and preferred hierarchy score across organisational affiliation**

![Figure 24](image)

**Table 29 - Difference between current and preferred hierarchy score across organisational affiliation**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Hierarchy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate office</td>
<td>27.77</td>
<td>25.70***</td>
</tr>
<tr>
<td>Hospital</td>
<td>32.20</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred Hierarchy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate office</td>
<td>22.45</td>
<td>2.12***</td>
</tr>
<tr>
<td>Hospital</td>
<td>25.59</td>
<td>2.08***</td>
</tr>
</tbody>
</table>

***p < .001

7.7 Cultural Profile of Public Healthcare Organisations Based on Nationality Clusters

7.7.1 Current Cultural Profile by Nationality Cluster

The assessment as to whether respondents’ nationality influences their evaluation of the current cultural profile is considered by testing the effect of nationality clusters on the distribution of the cultural profile. The findings of repeated measures GLM with culture (4 levels: clan, adhocracy, market, hierarchy) as within subject-factor and nationality (4 categories: Anglo, South-Asian, Middle-East, UAE) as between-subjects factor revealed a
clear interaction effect of a respondents’ nationality and their assessment of the cultural profile, $F_{\text{Greenhouse-Geisser}} (7.09, 219.51) = 3.54, p = .001, \eta^2 = .10$. Most prominent is the discrepancy of the perception of the Anglo expatriates in reference to the UAE nationals across the judgment for all cultural types. Their views about the current extent of a particular culture type in the health care sector is fundamentally different from the perception of the UAE nationals. As shown in Table 30 and Figure 25, Anglo expatriates see a much lower degree of the clan type ($M = 18.87, SD = 8.3$) in their current organisational culture compared to the UAE nationals ($M = 25.8, SD = 8.43$), $t(94) = -3.63, B = -6.92, p < .001, \eta^2 = .12$. This also holds true for their lower evaluations of adhocracy ($M = 15.93, SD = 7$) related to UAE nationals ($M = 19.61, SD = 5.13$), $t(94) = -2.47, B = -3.68, p < .05, \eta^2 = .06$. However, this pattern is reversed for the market and hierarchy cultures, they are evaluated as currently being higher and representing the two equally dominant cultural types by the Anglo expatriates. They report hierarchy to be dominating one third of the organisational culture ($M = 33.34, SD = 12.39$) while UAE nationals indicate a lower degree ($M = 28.16, SD = 8.55$), $t(94) = 2.15, B = 5.18, p < .05, \eta^2 = .05$. Similarly, adhocracy is anchored at $M = 31.34, SD = 9.23$ by Anglo expatriates and $M = 26.44, SD = 6.17$ by UAE nationals, $t(94) = 2.59, B = 4.90, p = .01, \eta^2 = .07$. Apart from these statistically validated differences in cultural evaluation, one noteworthy trend occurred, pointing towards a divergence in the judgment of the clan culture between people from the Middle-East and UAE nationals. Middle-Eastern nationals indicate a lower presence of the clan culture ($M = 22.1, SD = 5.96$) in the health care sector than Emiratis ($M = 25.8, SD = 8.43$), $t(94) = -1.84, B = 3.69, p = .07, \eta^2 = .04$. 
<table>
<thead>
<tr>
<th>Current culture</th>
<th>Nationality</th>
<th>Mean</th>
<th>St. Dev.</th>
<th>Mean Diff UAE</th>
<th>t-value</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan</td>
<td>Anglo</td>
<td>18.87</td>
<td>8.3</td>
<td>-6.92</td>
<td>-3.63***</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>South-Asian</td>
<td>22.77</td>
<td>4.37</td>
<td>-3.02</td>
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</tr>
<tr>
<td></td>
<td>Middle-East</td>
<td>22.1</td>
<td>5.96</td>
<td>-3.69</td>
<td>-1.84</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>UAE</td>
<td>25.8</td>
<td>8.43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhoercy</td>
<td>Anglo</td>
<td>15.93</td>
<td>7</td>
<td>-3.68</td>
<td>-2.47*</td>
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</tr>
<tr>
<td></td>
<td>South-Asian</td>
<td>23.51</td>
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<td>0.05</td>
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<td>5.16</td>
<td>1.32</td>
<td>0.84</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>UAE</td>
<td>19.61</td>
<td>5.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Market</td>
<td>Anglo</td>
<td>31.34</td>
<td>9.23</td>
<td>4.90</td>
<td>2.59**</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
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<td>6.99</td>
<td>0.83</td>
<td>0.33</td>
<td>0.00</td>
</tr>
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<td>1.73</td>
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</tr>
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<td>6.17</td>
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<tr>
<td>Hierarchy</td>
<td>Anglo</td>
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<td>12.39</td>
<td>5.18</td>
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<td>0.05</td>
</tr>
<tr>
<td></td>
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<tr>
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<td>0.00</td>
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<tr>
<td></td>
<td>UAE</td>
<td>28.16</td>
<td>8.55</td>
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<td></td>
</tr>
</tbody>
</table>
7.7.2 Preferred Cultural Profile by Nationality Cluster

The analyses from the preferred cultural profile parallel those of the current one, running a repeated measures GLM with cultural profile (4 levels: clan, adhocracy, market, hierarchy) as within-subject factor and nationality (4 categories: Anglo, South-Asian, Middle-East, UAE) as between-subjects factor. A significant 2-way interaction was obtained, $F_{\text{Greenhouse-Geisser}} (7.16, 224.28) = 2.03, p < .05, \eta^2 = .06$. Follow-up analyses parade the special view of the Anglo expatriates related to their judgment of the preferred clan culture. As shown in Table 31 and Figure 26, Anglo expatriates wish for a sizable higher degree of the clan culture in the public healthcare organisations ($M = 31.61, SD = 9.71$) compared to the UAE nationals ($M = 27.45, SD = 7.64$), $t(94) = 2.03, p < .05, B = 4.16, \eta^2 = .04$. Another finding pertains the South-Asian expatriate group ($M = 27.15, SD = 5.81$) who prefer a higher degree of adhocracy compared to UAE nationals ($M = 23.08, SD = 5.77$), $t(94) = 2.27, B = 4.07, \eta^2 = .05$. Two trends though not statistically are worth noting. The first one shows that Anglo expatriates wish for less hierarchy ($M = 21.41, SD = 6.31$) than the UAE nationals ($M = 24.10, SD = 8.23$), $t(94) = -1.54, p = .13, B = -2.69, \eta^2 = .03$. The second trend again concerns South-Asians ($M = 21.49, SD = 6.75$) preferring a smaller proportion of market culture than UAE nationals, ($M = 25.37, SD = 7.69$), $t(94) = -1.45, p = .15, B = -3.88, \eta^2 = .02$. However, in how far the trends hold and turn into convincing findings needs to be seen in the context of current and preferred culture, this analysis is considered in detail in the following section.
<table>
<thead>
<tr>
<th>Current culture</th>
<th>Nationality</th>
<th>Mean</th>
<th>St. Dev.</th>
<th>Mean Diff UAE</th>
<th>t-value</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clan</td>
<td>Anglo</td>
<td>31.61</td>
<td>9.71</td>
<td>4.16</td>
<td>2.03*</td>
<td>0.04</td>
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<tr>
<td></td>
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<td>-0.75</td>
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</tr>
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<td>7.64</td>
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</tr>
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<td>5.81</td>
<td>4.07</td>
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<td>0.05</td>
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<td>0.11</td>
<td>0.07</td>
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<tr>
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<td>UAE</td>
<td>23.08</td>
<td>5.77</td>
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</tr>
<tr>
<td>Market</td>
<td>Anglo</td>
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<td>8.74</td>
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<td>0.01</td>
</tr>
<tr>
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<td>21.49</td>
<td>6.75</td>
<td>-3.88</td>
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<tr>
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<td>0.01</td>
<td>0.00</td>
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<tr>
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<td>7.69</td>
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<td>Anglo</td>
<td>21.41</td>
<td>6.31</td>
<td>-2.69</td>
<td>-1.54</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>South-Asian</td>
<td>25.77</td>
<td>7.64</td>
<td>1.67</td>
<td>0.77</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Middle-East</td>
<td>25.58</td>
<td>4.23</td>
<td>1.48</td>
<td>0.80</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>UAE</td>
<td>24.10</td>
<td>8.23</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05*
7.7.3 Differences in Cultural Assessment between Different Nationality Clusters

Since the overall analyses in the previous section found a clear desire for cultural change, the question can be asked, if this wish for change is tied to a respondent’s nationality. The analysis revealed the predicted three-way interaction of evaluated culture, time (current and preferred), and nationality, $F_{\text{Greenhouse-Geisser}} (7.17, 224.65) = 5.63, p < .001, \eta^2 = .15$. A three-way interaction in this context means that the previously described 2-way interaction of time and cultural evaluation is different for different nationalities, i.e., the degree of the desired change is different across cultures and across nationalities. Therefore, the $p$ results concerning the differences between nationalities and their current and desired cultural evaluation in previous sections are now subsumed and confirmed by one comprehensive model. Since the impact of nationality cluster on the cultural assessment was seen as one of the most significant findings of the current study, and in view of the small sample size, the analysis of data using regression tests was conducted to confirm the initial findings of impact of nationality clusters on cultural assessment highlighted in the sections 7.7.1 and 7.7.2.

Instead of using a complex contrast matrix to decompose the 3-way interaction, another way to look at the differences for cultural change by nationality is to utilise regression analyses. Predicted is the desired change by comparing the effect of different nationalities focusing on the UAE versus the Anglo expatriates. Since the differences in cultural scores at time 1 (current) and time 2 (preferred) of the four cultural types are represented by a slope, this slope
can be explained when nationality is entered into the regression model coded as categorical dummies. The findings are presented in Table 32. The results reveal that the slope for the change in clan culture for the Anglo expatriates is significantly steeper than for the UAE nationals, $R^2 = .20$, $F(3, 96) = 8.10$, $p < .001$. As the beta-coefficient is positive it means that Anglo expatriates request a change towards a clan culture to a much higher degree than the UAE nationals, while both UAE nationals and Anglo expatriates both wish for an increased clan culture. The other nationalities’ slopes do not significantly differ from the UAE. Regarding the adhocracy change, the same pattern holds true, $R^2 = .10$, $F(3, 96) = 3.37$, $p < .05$. The change in market culture is desired to a higher degree for Anglo expatriates than for UAE nationals, whereby both wish for less market culture, $R^2 = .07$, $F(3, 96) = 2.66$, $p = .05$. No other effect is observed. Finally, in terms of hierarchy, no significant result is obtained, $R^2 = .06$, $F(3, 96) = 2.10$, $p = .11$. Yet, there is a trend for Anglo expatriates to desire much less hierarchy than UAE nationals, despite both wanting a decrease in hierarchy – but this effect is not significant. To summarise, the Anglo expatriates show an almost polarized view of organisational culture compared to the UAE nationals and their wish for change is more pronounced compared to the UAE nationals (Figures 27 and 28).

**Figure 27 - Current and preferred cultural profiles of UAE Nationals**
Figure 28 - Current and preferred cultural profiles of Anglo expatriates

![Cultural Profiles Diagram]

Table 32 - Degree of desired change across cultural types and nationalities with the UAE cluster as comparison standard

<table>
<thead>
<tr>
<th>Regression model</th>
<th>B</th>
<th>St. Error</th>
<th>Beta</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slope for change in clan culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle-East</td>
<td>1.99</td>
<td>2.46</td>
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</tr>
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<td>South-Asian</td>
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<td>2.95</td>
<td>0.04</td>
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<td>0.70</td>
</tr>
<tr>
<td>Anglo</td>
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<td>2.35</td>
<td>0.49</td>
<td>4.54</td>
<td>0.00***</td>
</tr>
<tr>
<td>Slope for change in adhocracy culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle-East</td>
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<td>1.84</td>
<td>-0.08</td>
<td>-0.68</td>
<td>0.50</td>
</tr>
<tr>
<td>South-Asian</td>
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<td>0.01</td>
<td>0.08</td>
<td>0.94</td>
</tr>
<tr>
<td>Anglo</td>
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<td>1.75</td>
<td>0.27</td>
<td>2.39</td>
<td>0.02*</td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Middle-East</td>
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<td>-0.06</td>
<td>-0.55</td>
<td>0.58</td>
</tr>
<tr>
<td>South-Asian</td>
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<td>3.27</td>
<td>-0.16</td>
<td>-1.44</td>
<td>0.15</td>
</tr>
<tr>
<td>Anglo</td>
<td>-6.86</td>
<td>2.60</td>
<td>-0.30</td>
<td>-2.64</td>
<td>0.01*</td>
</tr>
<tr>
<td>Slope for change in hierarchy culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle-East</td>
<td>-2.27</td>
<td>3.79</td>
<td>-0.07</td>
<td>-0.60</td>
<td>0.55</td>
</tr>
<tr>
<td>South-Asian</td>
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<td>4.55</td>
<td>0.14</td>
<td>1.27</td>
<td>0.21</td>
</tr>
<tr>
<td>Anglo</td>
<td>-5.28</td>
<td>3.62</td>
<td>-0.17</td>
<td>-1.46</td>
<td>0.15</td>
</tr>
</tbody>
</table>

***p < .001, *p < .05. Note, the comparison category are the UAE nationals.
7.8 Conclusion

The chapter contains presentations of the empirical results acquired from the analysis of the quantitative data gathered from the on-line OCAI survey to answer the two core and two secondary research questions. Prior to reporting the findings, explanations behind the nationality clusters used in the data analysis which are based on GLOBE grouping of societal cultures were discussed. Following that, demographic details of the participants who took part in the questionnaire survey, in addition to the organisational affiliation were provided. The analysis of the quantitative data revealed the presence of a hybrid cultural profile in which hierarchy and market based values dominate. Importantly, the analysis revealed that when assessing current organisational culture, there were significant difference between clan and adhocracy cultures; however, there was no significant difference between hierarchy and market cultures suggesting that both hierarchy and market culture exist together. Regarding preferred culture assessment, the analysis indicated significant difference between participants’ evaluation of the clan culture compared to the other three cultural types, indicating the emphasis of participants on fostering a culture based on trust and collaboration.

Finally, using a three-way repeated measures analysis, nationality of the participants was found to have a statistically significant effect of their assessment of both current and preferred cultures. A regression analysis comparing the UAE cluster’s cultural assessment to the other nationality clusters revealed notable difference with the Anglo cluster. When assessing the current culture of their organisation, UAE nationals evaluate clan and adhocracy cultures significantly higher than the Anglo cluster, and market culture at significantly lower than the this cluster. With respect to preferred culture, the Anglo cluster assesses clan culture higher than the UAE cluster.

The next chapter triangulates the findings from the qualitative analysis of interviews and the quantitative analysis of surveys to draw a picture of the current and preferred organisational cultures in Abu Dhabi healthcare sector across its different constituents and nationality clusters.
Chapter 8- Discussion and Findings

8.1. Introduction
In this chapter, the results of the qualitative and quantitative studies was combined and compared in order to interpret, evaluate, and discuss the findings of the current investigation in relation to the research questions presented in Chapter 1. Furthermore, the chapter contains a range of discussions of the critical issues around the empirical findings in the context of the existing literature. The chapter commences by providing an evaluation of the public healthcare reform in Abu Dhabi by comparing the distinctive patterns of those reform initiatives to other health system reforms documented in the academic literature, particularly that of NHS in the UK. The chapter also summarises the challenges facing the public healthcare sector in Abu Dhabi locating those challenges within both the universal and contextual factors affecting health systems reforms. This is followed by an assessment of the current and preferred organisational cultural profiles across the different constituents of the public healthcare sector in Abu Dhabi. The discussion subsequently moves on to analyse the different factors that could potentially account for the variation in cultural values among different organisations and nationality clusters. As a final point, the chapter includes evaluations of the strengths of the methodological approach and limitations of the current research.

8.2. Assessment of Health System Reform and Challenges

8.2.1 Abu Dhabi Health System
Focusing on Rothgang et al.’s classification of healthcare systems discussed in Chapter Two, the Abu Dhabi health system appears to be a hybrid model between National Health Service and Private Healthcare System. Such hybrid models are not unusual in health systems; Böhm et al. (2013) posit that in many countries such as Germany and the US, the population is covered through different sub-schemes. Those schemes exist in parallel leading to vertically segregated health systems. The hybrid model in Abu Dhabi is due to a combination of factors including population ethnicity and healthcare financing models discussed in Chapters 4 and 5. The Abu Dhabi population is divided into UAE nationals representing around 20% of the population, and expatriates representing the remaining 80%. The financing and service provision of those two segments of the population have dictated a hybrid health system model.
When it comes to the UAE national population, the system in Abu Dhabi resembles the National Health Service model in many aspects. The system provides universal free access to healthcare to all UAE nationals through the ‘Thiqa’ scheme. In terms of financing, though there is no direct taxation in Abu Dhabi, the government fully finances the health system through direct subsidies derived from oil revenues in what can be considered redistribution of wealth (Davidson, 2009). Such allocations are typical of rentier states characterised by generous social allocations (Alhadhrami, 2013). Health services are provided through a network of public hospitals and Ambulatory Health Service (AHS) units providing primary care. In addition, when medical services required are not available in the country, the government provides full assistance to its citizens to seek care abroad through the International Patient Care (IPC) programme. With respect to regulation, HAAD, the government regulatory authority fully regulates the health system in Abu Dhabi including licensing and accreditation of medical facilities and healthcare professionals for both public and private hospitals.

On the other hand, when it comes to the expatriate population, the system in Abu Dhabi acts more like a Private Health System. Elements of a Private Health System are especially apparent in the financing and provision of health services. Health insurance for all expatriates was made mandatory through the health insurance bill of 2005. This scheme is largely financed by employers with a smaller portion of out-of-pocket financing. The low-wage labourers of the expatriate population are covered through the ‘Basic’ scheme. This scheme is partially subsidised by the Abu Dhabi government who absorbs losses exceeding or not covered by the contractual coverage, especially in the case of work related accidents. Service provision is provided by private, for profit hospitals that provide around 40% of the hospital bed capacity in Abu Dhabi, in addition to a smaller number of private clinics. Until recently, expatriates were able to seek medical services in public hospitals depending on their medical insurance coverage. However, in 2014, and in an attempt to address the capacity issues and wait time in some public hospitals, access to a number of public hospitals in Abu Dhabi was restricted to UAE nationals only. This move was also thought to indirectly encourage private sector investment in the healthcare sector in order to address the growing demand of the population. The impact of this policy change is yet to be seen, but it could potentially lead to a more accentuated vertical segmentation of the Abu Dhabi health system.

However, despite the vertical segmentation of Abu Dhabi health system based on Emirati and Expatriate population groups, regulation remains highly centralized in the public sector. The
absence of societal actors and any form of physicians associations that could play a role in the regulation of the healthcare sector accentuates the dominance of the state in Abu Dhabi in the regulation of the health system. Following the sector reform, the Abu Dhabi health system converged into a hybrid system combining elements of both state controlled and regulated services, and private sector led financing and delivery. This conversion to hybrid system is in line with trends observed in OECD countries (Rothgang et al., 2010, Böhm et al., 2013), where pressures to reform health system have driven states to move from monochromatic to more blended systems.

8.2.2 Health system reform and reform trajectory

The reform trajectory of the public healthcare care in Abu Dhabi portrayed in Chapter 5, illustrates a case of sweeping reforms on all aspects of health systems including financing, service provision, and regulation. The objectives of those reforms were originally driven by the desire to modernize the public sector in order to drive a sustainable economic and social development (GSEC, 2009). Such reforms have also re-invented the way public healthcare organisations in Abu Dhabi are organized and managed in an attempt to improve health outcomes, ensure access, raise quality, increase efficiency and accountability, and introduce a new element of transparency to public services. Those reform objectives are largely identical to universal drivers for any health system reforms identified by Tenbensel et al., (2012).

A strong, centralized regime facilitated the implementation of the healthcare reform initiative with little if no political resistance from those affected by the reform. Wilsford (1994) argues that institutional structures characterised by centralised regimes with weaker presence of civil and professional societies are more conducive to big-bang reform than others; Abu Dhabi falls in this category. Such a rash of reform and modernization is to be expected of a young growing economy. Such reforms patterns can be observed in similar high-income countries with rapid social and economic development across the region such as Qatar and Kuwait. The scarcity of academic literature and scholarly evaluations of health system reforms in the Arab world as indicated in Chapter 2 posed a challenge for the researcher in attempting to locate the pattern and consequences of reforms in Abu Dhabi within the context of reforms in the Arab world and other GCC countries. Therefore in an attempt to locate the public healthcare reform in Abu Dhabi within the global context of health system reforms, the following section discusses the differences and similarities between the antecedents and consequences to the UK’s NHS restructuring and those of Abu Dhabi’s.
Politt (2007) draws a picture of the rapid, repeated restructuring of the UK public services taking the National Health Service (NHS). Politt’s analysis provides a framework that includes both the antecedents and consequences of the health system reforms. The analysis shows far reaching reform patterns in the NHS starting in 1980s, starting with Thatcher’s *Working for Patient* white paper of 1989 that transformed hospitals into Trusts leading to the formation Primary Care Trusts under New Labour (Politt, 2007). Politt (2007) indicated the presence of similar patterns of sweeping reforms in other sectors in the UK public administration including education, and in other states such as Australia and New Zealand.

Politt (2007) cited five different factors that are thought to explain the UK’s distinctive pattern of restructuring. The first two are contextual factors; the high political priority of certain policy changes, education and healthcare being the top candidates for increased political attention; and the ease of organisational reform in the UK driven mainly by constitutional structures. The three other factors are driven by agents, e.g. politicians, executives, and managers who have different vested interest in the reforms. According to Politt (2007: 537), politicians in Britain used restructuring and reforms to reinforce their ‘high modernist ideology’ project by New Labour. The second factor is fixation with measuring and managing performance as a way to impress the public and give citizens the indication that targets set by the government are being met. Finally, Politt (2007: 541) indicates the raise of management reform community, a phenomena whereby business consultants and managers are hired to fix organisations, and where there is growing belief that “better management” almost always provides the solutions to problems.

Looking at the political, constitutional, and socio-economic structure of Abu Dhabi government detailed in Chapter Four, the contextual factors explaining the ability to implement sweeping reforms bear certain similarities to the factors indicated in the UK context. The ease of organisational reform, facilitated by the constitutional monarchy, appears to be a common factor. The political motives for policy changes in the healthcare sector in Abu Dhabi seem to be a direct reflection of the rentier sates’ social contract (Davidson, 2009, Alhadhrami, 2013). Regarding the agent driven factors, there are striking similarities with the UK factors. First, the agencification of change actors through the creation of ‘Abu Dhabi Government Restructuring Committee’ (ADGRC), an entity charged with the design and implementation of the reform initiatives across government entities in line with the Emirate’s 2030 Economic Vision largely resembles the modernization ideology of the New Labour
Government. Second, the implementation of an elaborate PMS across all government entities, the introduction of Performance Contracts, and an almost obsessive focus of measuring performance and meeting targets resonates with the effect of Public Service Agreements (PSAs) and targets in UK public administration. Finally, the proliferation of the ‘management reform community’ through the restructuring of all government entities led by a team of young, ambitious professionals backed up by an array of international consulting firms mirrors the ‘managerialist’ trend observed in the UK public administration (Pollitt, 2007). However in spite of prima facie resemblance to this managerialist trend, the Abu Dhabi experience had noted differences. In the UK, management experts were largely hired to facilitate the wave of change in an otherwise mature, well established system, and as Politt (2205) suggests as a tool used by politicians to show changes and accomplishments in the short term. In comparison, Abu Dhabi, a young emirate with scare human capital, which built its first hospital less than fifty years back, had limited choices but to hire foreign management experts and consultants to implement reforms. Arguably, the only way to institutionalize the reforms in a vital sector such as healthcare was for the government to hire the best expertise it could afford, and to import best practices from developing nations.

8.2.3 Consequences of the Reform

The preceding section indicated notable similarities between the public healthcare reform in Abu Dhabi and NHS reforms. Those similarities reinforce the idea that Abu Dhabi government imported best practices from around the world and implemented them in the hope of improving the performance of its health sector. Analysing the impact of such reforms is beyond the scope of this study, which is exploratory in nature and attempts to understand the context in which public health systems in Abu Dhabi operate, and the nature and scale of healthcare reform initiatives in Abu Dhabi. Nevertheless, the empirical findings of this study highlighted in Chapter Six revealed a number of important systemic, organisational, and human capital challenges that can largely be attributed to the health system reforms. In the following section, some of the observed consequences of reforms in Abu Dhabi are discussed in comparison to Politt (2007) NHS reform evaluation. Those include the rate of change, lack of comprehensive evaluation, transition costs, and impact on staff morale and engagement.

A clear pattern that can be observed is the speed in implementing certain policy decisions that could have certain far reaching impacts of the health system and patients. A recent example is
the decision to limit access to certain public hospitals to Emirati (Thiqa) policyholders in an attempt to address the access and wait time issues. Such change was almost implemented overnight; the majority of patients arguably only knew about this policy change when their appointments were cancelled (Bell, 2014b). But was the potential impact of such a change in a developing health system where the private sector is yet to catch up with the increasing demand health services from primary to tertiary care evaluated before new the policy was implemented? It is difficult to tell, but judging from the speed the change was implemented, probably not. Politt (2007: 538) posits that this rate of change makes it impossible to find out which organisational designs work well and which do not. “Rapid parallel and sequential changes in organisational structures and processes mean that ‘results’, in so far as these are measured, cannot be attributed to any particular element in the overall package of reforms”. Experienced practitioners indicate that a period of two to five years is usually needed in order to assess the impact of organisational and clinical changes and to measure the magnitude of change, and learning outcomes (Pollitt, 2007). However in many cases, change is so rapid, and is followed by yet another change that makes it impossible to evaluate the impact of the reform. Moreover, according to Politt, it is all too easy sometimes to mask the challenges or even failure of certain projects by launching new reforms that give the impression of a constant ‘reinventing’ of the system.

The lack of convincing evaluations of reforms can be clearly observed in Abu Dhabi. The analysis of health system reform revealed a number of cases that illustrate this trend. For example, the service line rationalization and clinical integration project was prematurely aborted two years after its launch before the full potential of the original design could be properly assessed. Similar examples can also be found in other sectors such as education where in 2008, international providers were contracted through Private Public Partnership (PPP) agreements to manage public schools in Abu Dhabi. After an expansion of the project to cover more than 40% of public schools in Abu Dhabi in the first two years, operational, contractual, and budgetary challenges led to its abrupt termination within less than five years from its inception. The real impact of this project was never empirically documented. A striking observation is that whereas government is willing to invest substantial funds and resources to design and implement new reform initiatives, almost negligible funds are earmarked to the evaluation and assessment of those initiatives. Arguably, without objective evaluations, governments will find it difficult to explain to citizens and the civil society
whether programmes are making a difference beyond the superficial measurable outputs, to results and impacts (Morra Imas and Rist, 2009, Talbot, 2010).

A second consequence of the reform according to Politt (2007) is that rapid change inevitably brings substantial transition costs. Transition costs expand from new buildings, to new systems and new processes, but what is often overlooked is the impact of re-organisation on new and existing staff. As discussed in Chapter Six, evidence of consistently low staff engagement across all public hospitals and high turnover of physicians and nurses indicate the far reaching impact of re-organisation on staff morale and staff motivation. The large scale engagement surveys performed by SEHA and HAAD over the past three years indicated clear trends of consistently low and even decreasing staff engagement. Anecdotal evidence suggests that in 2014, SEHA lost over 600 physicians (over 12% of total physicians) to private hospitals and other neighbouring countries. Many factors could be attributed to such low engagement and high turnover, including as discussed in Chapter Six, pay scale, lack of professional development opportunities, and low job security. It is difficult to establish clear links between the policy changes, successive re-organisations and their impact on staff engagement. In other words, one can hardly attribute the low engagement to specific aspects of reforms, however what is clear from the analysis is that the combined effect of those quick, successive transformations created a culture with a heavy, bureaucratic structure focused on achieving targets at the expense of creating a nurturing, enabling environment where staff are motivated to contribute to the overall success of the health sector in the Emirate.

Having analysed the reform in Abu Dhabi healthcare sector in the context of existing literature on reform in the NHS, the next section summarises the cultural profiles of Abu Dhabi health sector organisation based on the analysis of qualitative and quantitative data.

8.3. Dominant Organisational Culture in Public Healthcare System in Abu Dhabi

8.3.1 Hierarchy and Market Cultures

The analysis of qualitative data in Chapter Six suggests the prevalence of hierarchy culture within the public healthcare system. Hierarchy culture appears to be dominant in all organisations studied including the regulator, the operator, and public hospitals. All three organisations appear to be driven by rules and regulations, and governed by bureaucratic,
command and control management style. Likewise the results derived from the analysis of quantitative data confirm that participants perceived their current organisation culture to be largely inclined to hierarchy. Demographic factors including, gender, age, education level, and seniority do not seem to have any significant impact on the respondents’ current scores of hierarchy culture.

A number of factors explain the dominance of hierarchy culture in public healthcare organisations in Abu Dhabi. The first factor relates to the nature of public sector organisations which have strong tendency to be hierarchical in configuration. Indeed hierarchy cultures are seen to largely reflect the traditional theoretical model of public administration which heavily relies on formal rules and regulations and control processes (Zammuto and Krakower, 1999). Such characteristics also comply with the Weber’s legal rational model of rule enforcing hierarchical bureaucracies (Weber et al., 1948), and indicate the organisations’ ‘obsession with control’ conceptualised by Mintzberg (1979) as a key attribute of public sector organisations. Furthermore, empirical research on organisational culture in public sector organisations in different settings including Australia (Parker and Bradley, 2000), Thailand (Jingjit, 2008), Libya (Twati and Gammack, 2006) and Saudi Arabia (Al-Otaibi, 2010) suggest the dominance of hierarchical cultures.

The second factor that explains the prevalence of hierarchical culture is the impact of national culture. Klein and Radnell (2009) found a significant impact of Arab national culture on organisational culture in the UAE (Klein et al., 2009). Indeed the UAE national culture is characterised on Hofstede dimensions as collectivist with high power distance and high uncertainty avoidance (Hofstede, 2001). These types of characteristics are typically associated with hierarchy cultures. Hofstede (1991) and Van Muijen and Koopman (1994) argue that in countries where power distance and uncertainty avoidance index are high, the hierarchy model characterised by centralised bureaucracies and standardised rules and regulations is typically prevalent. Furthermore Tayeb (1988: 76) posits that the collectivist characteristics of Arab societies are reflected in organisations characterised by “hierarchical and centralised structures, with paternalistic, authoritarian management style”.

A third factor that enforces the dominance of hierarchical culture in Abu Dhabi is associated with the increase in hierarchical controls and bureaucratic rules associated with health system reforms that took place between 1999 and 2012 as indicated in Chapter Four. Such phenomenon can also be observed in other studies. For example Jacobs et al., (2013) noted
that in the NHS, the development of clinical guidelines, the introduction of professional protocols and the implementation of national standards of care led to increase in hierarchy cultures.

In addition to hierarchy cultures, the findings of the previous chapters suggest that a market or rational culture was predominant in public healthcare organisations in Abu Dhabi. The analysis of quantitative data revealed that the average results of both cultural types are markedly close. Furthermore, the analysis indicated no significant difference in the assessment of hierarchy and market cultures suggesting that both hierarchy and market cultures are tightly linked together. Qualitative data obtained from the interviews revealed that market culture was predominant in the three types of organisations studied. Identical results were obtained when quantitative data was analysed both in terms of aggregate score and in terms of different organisations. In healthcare contexts, market or rational culture promotes achieving a competitive advantage, and is characterised by goal oriented leadership, bonded by control and an emphasis on achieving objectives (Brazil et al., 2010, Jacobs et al., 2013a, Carlstrom and Olsson, 2014). In Abu Dhabi, such goal orientation was driven by public sector and health system reforms at a national level. As indicated in Chapter 5, government reforms attempted to implement pro-market driven initiatives that were thought to enhance competition and improve performance. Those reforms also placed heavy emphasis on measuring and managing performance as a way to implement policy changes and steer performance in the desired direction. Though, at first glance, a market culture is counter-intuitive with the vision of public sector organisations dominated by hierarchical bureaucracies, the presence of such goal-oriented cultures is not uncommon in other health systems. Jacobs et al., (2013) noted an increase in rational culture in NHS trusts following the implementation of pro-market policies and explicit economic incentives geared for increased competitiveness and financial independence of hospitals.

The findings of this study indicated a dominance of hierarchy and market cultures in public healthcare organisations in Abu Dhabi. Such findings mirror findings of earlier studies in other public healthcare systems including Turkey (Seren and Baykal, 2007) and Estonia (Saame et al., 2011). The scarcity of similar empirical studies in public healthcare in the GCC and Arab World did not allow for proper comparison of findings with similar socio-economic contexts; however, an earlier study by Al Khalifa and Aspinal (2001) provided an interesting comparison. In this study, the authors used CVF to investigate the organisational culture of
industries in Qatar which largely shares common socioeconomic and cultural characteristics with the UAE. The results indicated that hierarchical and rational (market) cultures were largely dominant in Qatari industries. The authors posit that the dominance of such cultures is a result of the governmental and control cultures in the region that “tend to emphasize measurement and documentation with the intention of bringing stability and control” (Al-Khalifa and Aspinwall, 2001: 426).

But the question remains what does it mean to have an organisational culture largely dominated by rules and regulation in public healthcare context? Will such cultures facilitate the implementation of health system reform and would they lead to performance improvement and better health outcomes? Although answering such questions in the context of Abu Dhabi is outside the scope of the current investigation, earlier studies seem to indicate that hierarchy and market cultures may be less flexible and could encounter resistance in implementing policy changes. For example, Carlstrom and Olsson (2014) found that in Swedish hospitals, cultures characterised by planning, routines and goal setting appeared to increase change-resistant behaviour, which could be an obstacle in introducing new care models. But resistance to change is not all, health systems dominated by hierarchy and market culture also appear to be negatively associated with a number of performance indicators including employees’ job satisfaction and perceived effectiveness (Brazil et al., 2010), and patient safety (Hartmann et al., 2009). Moreover, Saame et al., (2011) found that outcome oriented, rational cultures tend to be associated with lower patient satisfaction. The authors argue that the excessive focus on economic value could overshadow the cohesion and interpersonal relationships with patients which in turn lead to lower patient satisfaction. Finally, Mannion and Goddard (2001) found that while the raise of measurement culture in NHS promoted some constructive changes, it also led to unintended consequences. Among those unintended consequences are measurement focus which can come at the expense of quality improvement in other areas, ‘gaming’ or misrepresentation of data, and focus on short term targets that help ratings in league tables rather than long term, lasting improvements.

**8.3.2 Clan and Adhocracy Cultures**

The findings of the current study indicate that in comparison to the hierarchy and market cultures, clan and adhocracy models were perceived to exist to a remarkably lesser extent in public health sector organisations in Abu Dhabi. The examination of qualitative data indicated lower prevalence of clan and adhocracy cultures across the organisations studies. Similarly,
lower scores for both cultures were obtained from the analysis of the quantitative data, with slightly lower scores for adhocracy culture compared to clan culture.

Clan or human relation culture in healthcare contexts denotes trust and belongingness and emphasis on teamwork, cohesiveness and participation as a mean to improve human resource development (Brazil et al., 2010, Johansson et al., 2014). Analysis of qualitative data indicated whilst there was overall agreement among informants regarding the assessment of hierarchy and market cultures in their organisations, only a third of informants indicated the presence of clan culture. Similar results were obtained when analysing quantitative data where clan culture acquired lower aggregate mean score compared to hierarchy and market cultures. However, those results need to be carefully interpreted as further analysis of qualitative and quantitative data indicated that although average scores for clan culture were relatively low, significant variations existed between nationality clusters, those results are discussed in more details in section 8.5.2.

Notwithstanding variations in clan cultural assessment based in nationality clusters, the low presence of clan culture seems to explain some of the challenges that the public healthcare system in Abu Dhabi is facing as indicated in Chapter 6. Those challenges include varying success in implementing reform initiatives, consistently low employee engagement, and high physician and staff turnover. Empirical studies in healthcare settings indicate the centrality of clan culture in implementing health system reforms. McWilliam and Ward-Griffin (2006) posit that ‘top down’ approaches to change and reform initiatives are often faced with resistance from medical staff. Healthcare systems that exhibit clan (human relations) cultures focused on flexibility, cohesion and trust provide a group dynamic that is more prepared to implement and sustain change which is necessary to respond to the rapidly changing environment (Carlstrom and Olsson, 2014, Saame et al., 2011). Moreover, such clan cultures with their emphasis on interpersonal relationships, communication and teamwork could help hospitals to provide improved health care services that respond better to the patients’ needs and promote a patients’ safety culture (Saame et al., 2011).

The adhocracy model was also not highly perceived in the organisations investigated. According to Carlstrom and Olsson (2014), adhocracy or open system culture in healthcare contexts refers to the readiness to achieve growth and development and the ability and openness to run experiments and projects. The analysis of the qualitative data indicated that informants rarely mentioned elements associated with an adhocracy culture. Similarly, the
quantitative results reveal that the adhocracy culture acquired the lowest score among the four cultural types. Although a small number of informants indicated elements of adhocracy culture especially as they relate to their perceived ability to steer and shape reform initiatives, the vast majority agreed that a hierarchical culture with a high degree of command and control and a strong emphasis on meeting performance targets, is hardly the place that fosters innovation and new ideas. The low occurrence of adhocracy culture is consistent with the public choice theory with argues that public sector organisations tend to lack the motivation that drives innovation (Borins, 2002). Another way to explain lower emphasis on encouraging development, innovation and creativity in public healthcare organisations in Abu Dhabi is the potential impact of national culture which favours hierarchy and rule conformity. This finding is consistent with Al Otaibi (2010) who found that in Saudi Arabia, national culture shapes public management which in turn is described as highly hierarchical culture dominated by rules and regulations. Finally, informants also indicated that the lower emphasis on adhocracy culture tends to inhibit important development in clinical and non-clinical research which is seen as chronically lacking in Abu Dhabi health system. Such finding resonates with Davies et al., (2007) and Jacobs et al., (2013) who found that in the UK, NHS Trusts with adhocracy or developmental cultures tend to have higher research activity and usually enjoy higher star ratings.

8.4. Preferred Organisational Culture

Analysis of qualitative data revealed a desired cultural shift by most informants when assessing their preferred culture. Such a shift can be summarised by a higher emphasis on clan and adhocracy cultures and a lower emphasis on hierarchy and market culture. Those results were also confirmed through the analysis of quantitative data which revealed a statistically significant variance in cultural assessment between current and preferred cultures across all four cultural types. Such variances seem to hold true across organisational affiliation and nationality clusters.

8.4.1 Higher emphasis on clan and adhocracy cultures

When assessing their preferred culture, most informants indicated a desire to see a shift towards a more clan oriented culture which emphasises cohesion and participation. The analysis of quantitative data confirmed those findings. Those results seem to be consistent across all organisations studied. In addition, unlike differences observed in assessment of current clan culture based on nationality clusters as indicated in section 8.5.2, quantitative
analysis revealed that nationality does not seem to have any significant effect on participants’ assessment of their preferred organisational culture. The emphasis on clan culture as a preferred culture is not unusual given that human capital was identified as one of the most important challenges facing the public healthcare sector in Abu Dhabi as indicated in Chapter Six. Indeed, informants stressed the need to increase focus on people in order to develop a sustainable and motivated workforce that can support the implementation of health system reform in Abu Dhabi. This finding is consistent with earlier studies that indicate that clan or human relations culture in healthcare contexts is usually positively correlated with different dimensions of performance improvement. Those performance dimensions include reduction in medical error (Stock et al., 2007), quality improvement (Shortell et al., 2000), and job satisfaction.

In addition to clan culture, analysis of qualitative data indicated a desire to see a higher emphasis on adhocracy culture. Those results were confirmed by the analysis of quantitative data where adhocracy culture received the second highest mean score after clan culture. The emphasis on adhocracy culture seems to be driven by the desire to create a culture where research and innovation can be fostered. Moreover, previous studies indicated that healthcare organisations with higher emphasis on adhocracy cultures seem to foster organisational commitment (Lok et al., 2011), and have lower wait time and clinical negligence expenses compared to other cultures (Jacobs et al., 2013a).

The results of this study confirm the presence of two opposing or competing cultural dimensions clan/adhocracy vs. hierarchy/market. The indication that a higher emphasis on developing clan and adhocracy cultures as preferred organisational cultures that are thought to lead to performance improvement in Abu Dhabi health system compared to lower emphasis on hierarchy and market culture is consistent with prior empirical studies in healthcare settings. Alharbi et al., (2012) and Carlstrom and Olsson (2014) found that Human Relation(Clan)/Open System (Adhocracy) culture has been shown to facilitate change processes, while the opposite culture, Relational Goal (Market)/Internal Process (Hierarchy) counteracts change by stability, control and routines. Similarly, Shortell et al. (1995) found that group and developmental culture was positively associated with quality improvement programme implementation in hospitals. Quinn and Spreitzer (1991) used CVF to study the relationship between culture and individual affective outcomes. Their research found that cultural profiles described by an emphasis on both group and developmental cultures were
generally associated with high levels of satisfaction with work, promotion, supervision, and work-life balance.

Overall, the preferred organisational culture seems to move to a more balanced culture where all four culture types co-exist albeit with slightly higher emphasis on clan culture compared to the other three cultures. This finding resonates with Jacobs et al., (2013) who found that in NHS, there is an observed move to more blended culture over time with a single dominant culture becoming less prominent. Although interestingly in NHS, the shift seems to be depicted in lower emphasis on clan culture and more emphasis on rational or market culture which can be explained by a starting point of higher assessment of clan culture in NHS compared to Abu Dhabi.

8.4.2 Lower emphasis on hierarchy and market cultures

Analysis of both quantitative and qualitative data indicates a desired lower emphasis on hierarchy culture. Informants indicated that rigid policies and procedures and over-centralisation seem to affect performance and hinder the implementation of reform initiatives. Moreover, the micromanagement of hospitals and limited delegation of authority across the board seem to also have a negative impact on performance. Such findings concur with previous organisational studies in the Arab world which indicated problems of over-centralisation of power and controls (Jabbra and Dwivedi, 2004, Al-Yahya, 2009) and lack of sustainable and meaningful modes of empowerment and representation in most state institutions (Al-Yahya and Vengroff, 2004). Moreover, previous work on Arab organisations suggested that decision making is characterised by the duality of both consultation in decision making and directive management (Muna, 1980). In that context, managers tend to adopt an authoritarian management style, and although subordinates expect to be consulted in decision making, they also look for the leader to make the final decisions on his/her own (Tayeb, 1988). However, in recent years, there appears to be a slight shift in such traditional management model in the Arab world towards a more participative management style. This shift seems to be the result of globalization and formation of global networks coupled with a more educated and informed workforce. A recent study by Al Yahya (2009) indicated an increased preference of public managers in Saudi Arabia towards a more participative management style that goes beyond traditional consultation.
8.5. Variations in cultural assessment among different groups

8.5.1 Potential divergence based on organisational affiliation

Results of qualitative analysis revealed some subtle variations in cultural assessment based on organisational affiliation. Such results were confirmed in the quantitative data analysis with the exception of the assessment of hierarchy culture. Analysis of survey results revealed that hospitals ranked hierarchy culture as slightly more dominant compared to the corporate office. One way to explain the higher dominance of hierarchy culture in hospitals compared to corporate office is the presence of an overly centralised governance system and the perceived ‘micromanagement’ of hospitals by SEHA corporate office. Another explanation could be linked to the nature of the medical profession which exhibit certain forms of hierarchical relationships between the different professional groups (e.g between physicians, nurses, and other medical technicians).

The analysis did not reveal significant variations in assessment of clan culture between hospital staff and corporate office staff. This finding is somewhat inconsistent with prior literature which indicates that clan culture appears to be more dominant in particular hospital sub-cultures including nurses, technicians and to some extent physicians (Gerowitz et al., 1996, Davies et al., 2007, Lok et al., 2011, Carlstrom and Olsson, 2014). There are three ways to explain such variations, first is the low number of responses received from participants belonging to the nursing or physicians sub-groups which represented only 20% of the total responses received from hospital staff. The second factor could be attributed to the prevailing hierarchy culture in hospitals emphasised by micromanagement and excessive use of power from corporate office which tend to largely inhibit the development of clan cultures in hospitals. The third factor is related to the demographic mix of hospital staff. As indicated in Chapter 4, the public health system in Abu Dhabi relies heavily on expatriate staff especially in the medical field. Those staff come from very different cultural backgrounds and education systems, therefore creating a clan culture based on cohesiveness and participation could be especially challenging.

8.5.2 Emerging links between nationality cluster and cultural assessment

Interestingly, the analysis of qualitative data indicated a difference in the assessment of clan culture between the different nationality groups particularly the UAE nationals compared to other expatriate groups. The expatriates in turn are not a ‘homogenous collective’ group and...
exhibit significant differences based on their nationality, skills, and hierarchy (Al Ariss, 2014). As explained in Chapter 7, technically UAE nationals belong to the Middle East cluster according to Globe classification (Mensah and Chen, 2013). However, literature indicates the presence of important variations between the different nationalities included in this cluster. The analysis of qualitative data revealed such variations. In fact, the majority of UAE national informants indicated a higher prevalence of clan culture compared to their expatriate co-workers. Those results were confirmed by the analysis of quantitative data where nationality cluster was found to have a statistically significant effect on cultural assessment; in addition, differences in assessment of clan culture where found between the UAE cluster and other nationality clusters particularly Western expatriates. The higher assessment of clan culture of the UAE cluster compared to other nationality clusters could be partially attributed to the collectivist nature of Arab national culture (Hofstede, 1980, Tayeb, 1988). Emiratis in general are very proud of their national identity, they have strong group affiliation and respect to their leaders. Earlier studies found that collectivist cultures, with their emphasis of in-group relationships tend to exhibit more clan oriented cultures (Al-Otaibi, 2010, Jingjit, 2008). The second factor that could explain such higher assessment of clan culture by UAE nationals is related to the nature of the social contract as explained in Chapter 3. In fact, UAE nationals especially those working in the public sector see themselves in a privileged situation with preferential HR treatment (Al Ariss, 2014), job security, higher opportunities for advancement and promotion, and very generous allocations of salary and numerous benefits which all contribute to an elevated social status. Davidson (2009) posits that the nature of allocative society in Abu Dhabi and the resulting social contract created a sense of contentment and gratitude towards the leadership. Therefore the UAE nationals’ higher assessment of clan culture could well be a reflection of their social contract. Those findings are consistent with Alhadhrami (2013) who observed that UAE nationals’ perceptions of managerial competencies are quite different from those of other nationality clusters including the Arab expatriates. He attributed such differences to the nature of UAE’s rentier sate and the higher job security that UAE nationals enjoy (Alhadhrami, 2013).

The analysis of quantitative data indicated that other expatriate groups, mainly the Anglo cluster, tend to give lower score in their assessment of the current clan culture compared to the UAE cluster. A number of factors could help explain such discrepancies. First and foremost, as indicated in Chapter Four, prior research found evidence that the UAE labour market is
highly segmented based on sectors (public versus private) and types of workers (nationals versus non-nationals) (Abdalla et al., 2010). Such segmentation could help explain different cultural assessment among different nationality clusters. Nationalization of the workforce or Emiratisation is another factor. Prior studies indicate that Emiritazation policies seem not only to struggle in achieving their objectives of increasing Emirati in the UAE workforce, but have also generated resentment and distrust between Emirati staff and the expatriate counterparts (Davidson, 2009, Al Ariss, 2014). Brickson (2000) argues that other unintended consequences of quota driven nationalization policies in a demographically diverse workforce is the reinforcement of sub-group identities which has negative impact on the relationship between expatriates and nationals (Brickson, 2000). By examining the local (UAE nationals) perceptions towards their expatriate counterparts in the UAE, Al Ariss (2014) noted that UAE nationals feeling as minority in their own country, perceived their expatriate co-workers, especially the skilled ones as a threat to their career progression since they do not necessarily transfer knowledge and expertise to them. In turn the expatriates feel threatened by UAE nationals and see them as competitors who prevent them from accessing top management positions. This leads to a double threat situation that creates an environment of hostility and unhealthy competition. On one hand, expatriates staff are not keen to pass their knowledge to their Emirati colleagues for fear of loosing their job and being replaced in the future. On the other hand, Emirati perceive skilled expatriates as a need, but also as a threat to the employment of the national workforce. Moreover, in view of the numerous privileges given to Emirati as a result of Emiratisation policies, the latter feel stereotyped by the expatriate co-workers as being less productive and taking their employment for granted (Al Ariss, 2014). Consistent with Al Ariss’ study, the analysis of the data from informant interviews revealed that instead of trying to cooperate with each and work as a team in order to achieve organisational objectives, Emirati and expatriates staff continue to feel threatened by each others’ roles. Those peculiar group dynamics appear to have a direct impact on participants’ perception of clan culture in their organisation. Factors such as lack of recognition, lower job security, limited opportunities for advancement, and discriminative HR policies discussed in Chapter Six, appear to largely be the result of the group dynamics discussed above, and to contribute to the lower assessment of clan culture by expatriate groups.
8.6. Strength of methodological approach and limitation of the research

8.6.1 Strength of methodological approach

The findings of the current research can be viewed as having a high degree of validity given the rigour of the methodological approach, which relied upon a combination of both quantitative and qualitative techniques. The research benefited from the qualitative data acquired from the semi-structured interviews. Two notable strengths were noted from this method of inquiry. First the interviews were conducted in the three entities of the Abu Dhabi health care system that is the regulator (HAAD), the operator (SEHA), and three public hospitals. By doing so, rich narratives of organisational culture in those entities were uncovered. In addition, the researcher was able to analyse difference and/or similarities in cultural profiles across the entire health system. The second strength is that the less restrictive nature of this method of inquiry allowed the researcher to address several issues that were not necessarily part of the CVF, including systemic, organisational, and human capital factors. Those were seen by informants as critical in understanding the challenges facing the health sector as whole.

In addition, the quantitative analysis of the on-line OCAI survey, allowed the researcher to triangulate the finding from the qualitative analysis and to perform a more detailed inquiry across a number of demographic and organisational variables. This allowed systematic comparisons across organisations and groups of respondents from different nationality clusters. What is striking, is that in spite of the relatively small sample size of 491 managers from hospitals and corporate office, and the low response rate of around 20%, the researcher found almost perfectly triangulated results between the qualitative and quantitative analysis. Similar studies using CVF conducted in healthcare sector in Saudi Arabia (Al-Otaibi, 2010) found significant discrepancies between the survey results and the results obtained from the analysis of qualitative data. The researcher believes that the use of Ipsative scale in the survey as opposed to the Likert scale used by Al-Otaibi (2010), forced respondents to make choices regarding the cultural assessment of their organisation which improved the validity of the responses. Overall, the findings acquired through the combination of methods appear to have effectively validated, complemented and extended one another.
8.6.2 Limitations of the research

The results and recommendations from this study would be premature before careful consideration of its limitations. The first and most obvious limitation is this research is the use of key informants. The study assessed culture by exploring the views of senior managers and executives of the organisations studied. Although previous studies indicated that senior managers are the best individuals in an organisation to assess an organisational culture given their influence and their agenda setting power (Cameron and Freeman, 1991, Davies et al., 2007, Jacobs et al., 2013a), this approach cannot capture all important cultural aspects of the organisations especially the specificities relating to the sub-cultures that might exist within different professional groups. According to Cameron and Freeman (1991), the most effective method in assessing culture would be best accomplished by surveying all members of an organisation.

The second limitation is relating to the response rate. With a 20% response rate, the non-response bias could be considered as a possible constraint. Those who decided not to participate in the survey might exhibit different views of organisational culture in their respective organisations. Therefore the results might not be representative of all organisational settings and all public hospitals.

In addition, given the nature of this study and the limited financial and time resources available, the feasibility and cost-benefit of empirical work were taken into consideration in the research design. Although the researcher attempted to cover the three constituents of the public health system in Abu Dhabi, the representation of public hospitals was weaker compared to the regulator and operator organisations. A small number of interviews were conducted with executives from three public hospitals; in addition an average of four survey responses per hospitals was obtained. This sample was considered too small and not representative enough to allow for individual assessment and comparison of cultural profiles between hospitals, or between different professional groups. Therefore individual variations in organisational culture that might exist within and between hospitals could not be captured in this current study.

8.7. Conclusion

The chapter revealed the hybrid nature of the Abu Dhabi health system combining elements of both National Health Service, and Private Healthcare System. The system reflects vertical
segmentation in the delivery and financing dimensions based on population groups (UAE nationals and expatriates). Regulation remains highly centralized in the public sector. The analysis also indicated the distinctive patterns of reform in the Abu Dhabi health system facilitated by a highly centralised regime with weak presence of civil societies. The speed of implementing policy changes coupled with a lack of comprehensive evaluations, obscured in many cases the impact of the reforms. One of the most tangible consequences appears to be the effect on healthcare personnel which is reflected in low staff engagement and high turnover.

With respect to the assessment of organisational culture, the analysis of both qualitative and quantitative data revealed that the prevailing cultural model of the Abu Dhabi public sector organisations was concurrently governed by hierarchy and market cultures. Three distinct factors seem to contribute this prevailing cultural direction. First is the nature of public sector organisations which have strong tendency to be hierarchical in configuration. The second factor is the impact of the Arab national culture with its high power distance and uncertainty avoidance which typically leads to centralised bureaucracies and standardised rules and regulations. Finally, the nature of health system reform seems to also have an impact on the cultural assessment within the organisations studied. The reform in Abu Dhabi health system has largely steered those organisations to become more bureaucratic while at the same time introducing market elements with heavy emphasis on measuring and managing performance. The analysis also indicated that the presence of clan and adhocracy models was relatively limited. The limited presence of those cultures could be attributed to the preoccupation with measurement and documentation in order to bring forward control and stability. This environment is thought to have a negative impact on group dynamics and to reduce the drive for innovation. Interesting variations in assessment of clan culture were found between UAE nationals and other nationality clusters. Those variations are largely explained by the national culture, the labour market segmentation, and the nature of the social contract prevailing in Abu Dhabi.

With respect to preferred culture, analysis of data revealed a desired cultural shift by most informants manifested by a higher emphasis on clan and adhocracy cultures and a lower emphasis on hierarchy and market culture. Those results confirm the presence of two opposing or competing cultural dimensions clan/adhocracy vs. hierarchy/market. The higher assessment of clan culture as a preferred culture appears to be a reflection of the desire of the informants
to address the human capital challenges present in the Abu Dhabi healthcare sector. Moreover, the higher assessment of adhocracy culture indicates the desired drive for external focus and fostering innovation. Such desired cultural shift is consistent with prior empirical studies in healthcare settings, and appears to be a step in creating a culture conducive of performance improvement.

Finally, given the rigour of the methodological approach, the research findings could be viewed as having a high degree of validity. The data collection and analysis, which relied upon both quantitative and qualitative methods, was employed as a mean of both triangulation and complementarity. Nevertheless, findings need to be assessed in the light of certain limitations of the research methodology.
Chapter 9 - Conclusion and Policy Implications

9.1 Introduction

The current research focused on two main areas; understanding the health system reform in Abu Dhabi, and analyzing the organisational culture of public healthcare organisations in the Emirate. This chapter draws together the conclusions and key arguments that reflect the significance of this study. In the first section, the principal results of the empirical investigation are recapitulated in terms of contextual factors impacting the public healthcare sector in Abu Dhabi. In addition, the results of the cultural assessment including the current and preferred cultural models and the desired cultural shift are summarised. This is followed by a discussion of the key theoretical and methodological contributions of the study. Additionally, the chapter includes practical contributions of the findings that are likely to benefit policy makers regarding challenges relating to the systemic transformation of public healthcare organisations. Lastly, opportunities for further research are discussed, including the prospective replication of the research in other GCC and Arab countries and the possibility of examining the impact of national culture as a related philosophical issue.

9.2 Summary of Key Findings

9.2.1 Contextual factors impacting the public healthcare sector in Abu Dhabi

The study emphasised the complex nature of health systems driven by a multitude of stakeholders operating within a very public and politically driven environment. Demographic changes and advancements in medical technology pushed governments to implement reform initiatives that would enable them to contain the increasing costs while at the same time ensuring access and delivery of quality healthcare services, and improving the health status of their growing population. Institutional, political and socioeconomic contexts have a direct impact on how reforms are implemented and shape the way healthcare professionals respond to those changes (Dickinson and Mannion, 2012). As such, understanding those unique contextual factors is important in order to unpack the distinctive challenges involved with those reforms.
Abu Dhabi’s oil wealth allowed it to enjoy a strong, stable economy with healthy GDP growth. Generous social allocations to all citizens have always been a distinctive feature of the social system in Abu Dhabi with free education, healthcare, housing, and significant employment and business advantages provided to all national citizens. Such allocations are considered the primary way through which oil wealth is distributed among citizens in what is known as ‘social contract’. Another distinctive feature of Abu Dhabi and the UAE, is the over-reliance on foreign workers to support and sustain its economic growth. The ‘laissez faire’ labour policies facilitated the influx of ‘guest workers’. This has led to a unique population mix and a demographic imbalance where UAE nationals represent less than 20% of the total population, and the other 80% is constituted of workers and professional expatriates from over 180 different nationalities.

Attempts to reform the Abu Dhabi healthcare systems started in early 2000s in order to improve access and quality of care, and address raising costs. Those NPM reforms were characterised by decentralization, agencification, privatization, and public choice (Simonet, 2011). However despite noticeable improvement in healthcare regulation and provision in the Emirate, the Abu Dhabi health system still faces a number of systemic, organisational, and human capital challenges that might jeopardize the progress made if they remain unaddressed. The heavy reliance on expatriate health professionals coming from diverse systems and cultures, coupled with the very small number of Emirati in the medical profession create unique set of challenges in the workplace. National culture, Emiratisation policies, the ‘social contract’, labour and emigration policies, and labour market segmentation appear to be some of the unique contextual factors that explain those challenges.

9.2.2 Current cultural model in the Abu Dhabi healthcare organisations

A hybrid model of hierarchical and market cultures

The findings of this study indicated a dominance of hierarchy and market cultures in public healthcare organisations in Abu Dhabi. The bureaucratic cultural attributes were manifested in various aspects of organisational life. Informants seem to agree that formal rules and regulations are essential to ensure compliance with health regulations and to protect public interests. Centralised, rigid processes coupled with a command and control mentality were apparent in all organisations. Public hospitals in particular seem to be suffering from the micromanagement mentality imposed by the regulator and operator agencies. On the other
hand, market culture was manifested though the focus on stakeholders’ expectations and meeting performance targets. KPIs were seen as a way to steer organisational performance.

Three distinct factors seem to contribute to this prevailing cultural direction. First is the nature of public sector organisations which have strong tendency to be hierarchical in configuration. The second factor is the impact of the Arab national culture with its high power distance and uncertainty avoidance which typically leads to centralised bureaucracies and standardised rules and regulations. Finally, the nature of health system reform seems to also have an impact on the cultural assessment within the organisations studied. The reform in Abu Dhabi health system have largely steered those organisations to become more bureaucratic while at the same time introducing market elements with heavy emphasis on measuring and managing performance.

**Limited presence of clan and adhocracy cultures**

The analysis also indicated that the presence of clan and adhocracy models was relatively limited. The limited presence of those cultures could be attributed to the preoccupation with measurement and documentation in order to bring forward control and stability. This environment is thought to have a negative impact on group dynamics and to reduce the drive for innovation. The narrow presence of clan culture is translated into low staff engagement and high turnover. Moreover, informants indicated their frustration with the limited promotion and professional development opportunities and what is seen as discriminative human resources policies. However the analysis of both qualitative and quantitative data revealed an interesting finding; the differing, almost polarised assessments of clan culture between UAE nationals and other expatriate staff.

**9.2.3 Preferred Cultural Model: a move towards a more balanced, blended cultural approach**

Results of this study revealed a desired cultural shift by most informants when assessing their preferred culture. Such shift is reflected by a higher emphasis on clan and adhocracy cultures and a lower emphasis on hierarchy and market culture. Those results confirm the presence of two opposing or competing cultural dimensions clan/adhocracy vs. hierarchy/market. Findings indicated a strong preference for creating a clan culture with higher emphasis on building a cohesive and sustainable human capital. Emphasis on adhocracy culture was exemplified through the wish to build a strong research and development infrastructure to foster innovation
in the sector. On the other hand, results indicated a desired lower emphasis on hierarchy culture which was seen as too rigid and negatively impacting on performance. The lower emphasis on market culture was apparent in the desire for a less measurement fixation.

Finally, it was observed that the range of average cultural score across all four cultural types became narrower in the assessment of preferred culture compared to the assessment of the current culture. This shift represents an apparent preference towards a more balanced culture.

9.2.4 Cultural Profile in Different Organisations

No significant differences were observed in cultural assessment based on organisational affiliation. The cultural profile for the regulator, the operator, and public hospitals appear to be fairly similar. The co-domination of the hierarchy and market cultures was found to be shared across the organisations studied, whereas clan and adhocracy cultures were less dominant. One notable observation was that hospitals ranked hierarchy culture slightly higher than the operator reflecting the presence of an overly centralised governance system and the perceived ‘micromanagement’ of hospitals by the corporate office.

9.2.5 Cultural Profile Based on Different Nationality Clusters

One interesting finding of this study is the difference in the assessment of clan culture between the different nationality clusters particularly the UAE nationals compared to other expatriate groups. Given the diverse mosaic of the UAE population, nationality was perceived to be an important factor in cultural assessment. Clustering of data by nationality was based on GLOBE (House et al., 2004) grouping of societal cultures. Although the UAE is typically part of the Middle-Eastern cluster, literature indicated the presence of important variations between the different nationalities included in this cluster. As such the analysis isolated the UAE nationals from other nationality clusters. Findings revealed that UAE nationals assessed clan culture to a higher degree compared to their expatriate co-workers, particularly those in the Anglo cluster. Such differences could be attributed to the collectivist nature of the Arab national culture, in addition to the nature of the ‘social contract’ with its inherent benefits and privileges to the UAE national population. Moreover, the labour market segmentation in the UAE and its implications in the workplace could explain such variations in cultural assessment.
9.3 Research Contribution

9.3.1 Theoretical Contribution

The current thesis managed to make a concrete theoretical contribution by filling a significant gap in literature on two important contemporary topics; health system reforms and organisational studies in public healthcare in GCC countries and in Abu Dhabi in particular. The main contribution of this research is that it complements our understanding of organisational culture in healthcare as a broader concept linked not only to organisational settings which in most cases consist of hospitals (Davies et al., 2007, Hann et al., 2007, Gerowitz et al., 1996, Saame et al., 2011, Stock et al., 2007, Carlstrom and Olsson, 2014), or to national culture (Al-Otaibi, 2010, Al-Yahya, 2009), but also as a construct tightly connected to the wider contextual factors. According to Mark (2006), core values and assumptions in healthcare settings are shaped by contextual factors which include socioeconomic and political environment. Those contextual factors also include the type of prevailing health systems including regulation, delivery, and financing. Therefore by studying the contextual factors that shaped the health system reforms in Abu Dhabi, this study enriched our understanding of the organisational culture in a unique context such as Abu Dhabi and helped to fill a gap in the literature of healthcare management in the UAE.

In particular, having applied CVF to examine organisational culture in an Arab, GCC context, the current thesis has made a contribution to certain aspects of organisational management in the healthcare sector. The thesis provides new knowledge on cultural profile of public healthcare organisations. In fact, the study reveals that in public healthcare sector in Abu Dhabi, hierarchy and market culture exist concurrently, and in almost the same strength. This finding is considered a departure from typical profiles one would expect in public sector contexts, where bureaucratic models tend to dominate. The presence of a market, rational culture in Abu Dhabi appears to be a direct result of public sector reform where pro-market policies were implemented with greater emphasis on measuring performance. Moreover, the study contributed to another interesting finding regarding clan culture, which is largely considered the ideal organisational culture in healthcare contexts. Indeed conflicting, almost polarized assessments of clan culture were identified between different nationality clusters. Those differences appear to be not only driven by differences in national cultures, but are also due to the divergent HR practices between UAE nationals and their expatriate coworkers.
9.3.2 Methodological Contribution

The current research has also provided a contribution in terms of the methodology which was derived from the application of the CVF to examine the organisational culture in public healthcare organisations in Abu Dhabi. A review of previous empirical studies indicated that this framework has never been employed to investigate organisational culture in such a context. CVF has been used extensively in healthcare and non-healthcare sectors; however the majority of the studies using CVF are found in western contexts. Those contexts are arguably significantly different from an Arab context characterised by being multicultural and multinational as a result of high dependence of expatriate workforce. The framework has been used on a very limited scale in organisational studies in the Arab world (Al-Khalifa and Aspinwall, 2001, Twati and Gammack, 2006, Al-Otaibi, 2010), also to the best of the researcher’s knowledge, only a couple of studies used CVF in the context of UAE, both those studies were in the construction sector (Jaeger and Adair, 2013, Alyousif et al., 2010). Therefore, by adopting the CVF in the current study, the model was empirically tested for further clarification and validation. The suitability of the application of the framework in Abu Dhabi was established through the consistency of the research findings compared to other studies in healthcare context in different national settings.

A second contribution to research methods is the validation of the appropriateness of using ipsative scale as opposed to Likert scale for the measurement of organisational culture using OCAI based surveys. As discussed in 8.6.1, one of the major strength of the research methods employed in this study is the use of ipsative measurement scale. This scale encouraged participants to make choices regarding their assessment of the current and preferred organisational culture which led to statistically validated differences between those choices. Those differences were also triangulated through the qualitative data analysis.

A final contribution to methods stemmed from the recognition of the central role of nationality cluster as an important demographic factor in the analysis of organisational culture especially in culturally diverse context such as the UAE. Previous investigations of organisational culture focused on demographic factors such as age, gender, and organisational tenure (Jingjit, 2008, Saame et al., 2011, Aktaş et al., 2011), and on organisational subcultures created as a result of professional affiliation in healthcare contexts (Carlstrom and Olsson, 2014, Lok et al., 2011). The current study expands our understanding on the applicability of CVF in Arab contexts.
characterised by a mix of different cultures and nationalities by empirically establishing the importance of nationality clusters in the assessment of organisational culture.

9.4 Practical Implications

Notwithstanding the importance of the theoretical and methodological rigour, the practical implications of the study, its ability to address real problem, and its applicability in the context being studied are equally important. Raadschelders (2011) posits that the quality of research in social sciences and public administration is not only evaluated in terms of theoretical rigor, methodological sophistication, and empirical evidence, but also in terms of usable knowledge that involves civil servants, executive, and policymakers. In order for research in this field to be relevant in untangling the wicked practical problems, research must “grow out of actual social tensions, needs, and ‘troubles’ . . . Any problem of scientific inquiry that does not grow out of actual (or ‘practical’) social conditions is fictitious” (Dewey, 1938: 499).

Findings of the current study have crucial implications: leaders in healthcare policy need to be sensitive to the culture of their organisation before implementing structural change in the healthcare system. Some structures initially designed to improve quality of care may become counterproductive if they are not aligned with the organisational culture. For example in Abu Dhabi, the implementation of PMS and performance culture led to the development of market culture with measurement fixation. Studying organisational culture provides an understanding as to why certain reform initiatives fail while others may succeed. Moreover, identifying the type of culture dominant in organisations and employees’ attitude to change can help decision makers and managers to develop appropriate strategies for implementation of reform initiatives (Weber and Manning, 2001) and to ensure that structural changes are aligned with the organisational culture of the practice (Brazil et al., 2010).

Answers to salient challenges- Human Capital

This study provides some answers to two central practical challenges that Abu Dhabi public health system is facing; (1) explaining the consistently low employee engagement across the sector and (2) investigating the reasons behind the high physicians and staff turnover. The answers are clearly not just in addressing the pay and compensation structure. This study revealed that the challenges are more deeply rooted than management probably realizes. They stem from fundamental inequities in HR policies that need to be addressed in order to create a fair and transparent treatment of all employees. One way to address those challenges is to
focus on building a sustainable human capital. The centrality of building an engaged and motivated workforce in order to improve healthcare for the population continues to be emphasized by governments, WHO, scholars, and practitioners alike (Campbell et al., 2013, McDermott and Keating, 2013, Department of Health, 2013, Institute of Medicine, 2012, Dickinson and Mannion, 2012, Mintzberg, 2012). A recent report from The Best Places to Work indicated that engaged workforce in healthcare sector have contributed to lower turnover rate leading to direct and indirect cost savings and higher patient satisfaction. A high-functioning, positive workplace starts with having a good work culture where employees feel valued and recognised for their efforts paired with a healthy work-life balance and ongoing learning and career advancement opportunities (Herman, 2014).

In a multicultural system heavily dependent of expatriate health workforce such as Abu Dhabi, building a sustainable human capital where physicians, nurses, and staff from all nationalities thrive in an enabling and supportive environment seems to hold the keys not only for the successful implementation of health system reforms but also for a lasting improvement in health outcomes for the population. In order to achieve a high functioning, positive workplace, policy makers and managers need to be cognizant of the intricacies of managing a culturally diverse workforce. To do so they need to understand the implications of this diversity in the workplace, within and between different professional groups (e.g physicians, nurses, and administrators). How this diversity equally impacts physician-patient relationship also needs to be analysed. Moreover, with respect to the relationship between the UAE nationals and their expatriate co-workers, it is crucial to understand and address the gaps and tensions between those two groups in order to promote cohesiveness and teamwork in the workplace. Managers could also replicate the factors that lead to the success of the clan culture in the UAE national group to the entire organisation.

Policies designed to promote Emiratisation in the healthcare sector need to be strengthened, and developed around the right incentives, education systems, and residency programmes. Finally, managers need to develop a fair and competitive compensation structure and to address the existing gaps in the HR policies to ensure that they are not only fair and transparent but also responsive to the needs of the different professional and nationality groups.
Organisational and Systemic challenges

The study also revealed a number of organisational and systemic changes that affect the health system in Abu Dhabi. Role ambiguity and tensions between the different players in the system including the regulator, operator, and public hospitals appears to be the result of unclear mandates and often conflicting duties and authorities. Those factors need to be addressed to ensure better accountability for achieving outcomes.

Systemic challenges appear mainly to be the result of sub-standard primary care in the Emirate. The implications of the lack of well-developed primary care to act as a gatekeeping system are many: they include overcrowding of hospitals, high wait time, and high costs. Another important challenge revealed by this study is the dispersed nature of healthcare service provision in Abu Dhabi’s public hospitals inhibiting the building of volume based competencies, an essential factor in ensuring higher quality of care in the long run. Regulators and policy makers need to craft appropriate policies and reform initiatives to address those challenges.

9.5 Future Research Recommendations

Organisational studies in the Arab countries appear to be severely under-represented in the academic literature. Despite sharing commonalities in societal cultural norms, countries in the Arab world and the Middle East region differ in terms of demographic, ethnic, economic and political characteristics. As indicated earlier, cultural assessment is shaped by contextual factors within which organisations operate, therefore the results of the current study could be context specific. As such, an interesting potential for future research could be a replication of a comparable empirical investigation in other Arab nations both in the GCC and outside the GCC. Comparative analysis could also be then performed to explore differences and similarities in cultural assessment between different contextual settings.

The current study used CVF as a key research framework for data collection and data analysis. Analysis of the current and preferred organisational culture were performed on the different constituents of the healthcare sector, however as indicated in earlier studies, differences in cultural assessment could be found between different organisational settings (e.g. different hospitals), different units or sub-cultures, and different professional groups. Therefore the current study could be expanded to include such level of analysis.
In terms of healthcare reform, the exploratory phase of this study could be further developed to investigate the consequences of rapid changes in health system especially in terms on quality of care, costs, employee morale, and other performance indicators.

Finally, the UAE work environment, as a unit of analysis, had several interesting characteristics. Moore et al. (2010: 8) posit that the United Arab Emirates has a “confused cultural identity”. On one hand, the country is very keen to uphold and retain its cultural heritage, but on the other hand, this is believed to be conflicting with its process of modern development. As such, future research can explore the impact of Arab national culture and the UAE’s unique cultural identity on organisational culture.

9.6 Concluding Remarks

This research provides an important contribution to better understand the nature and type of organisational culture in healthcare sector in a developing, multicultural context such as Abu Dhabi which might be quite different than the western contexts widely researched in the academic literature. In such context, management and organisational development and cultural change may be different in view of the complexity of societal structure and the eclectic population mix. Abu Dhabi represents a particular case in point with a unique demographic mix where UAE nationals constitute less than 20% of the total population and expatriates from over 180 nationalities are represented in the society and the workplace.

The study drew rich explanations of the context and history of health system development in Abu Dhabi in an attempt to provide deeper explanations about the organisational culture and the forces that shape the prevailing cultures in public healthcare organisations. The mix of qualitative and quantitative methods used in this study allowed a deeper dive into the organisational culture of the different constituents forming the public health system in Abu Dhabi including the regulator, the operator, and public hospitals to uncover the complex web of relationships and the cultural differences within those organisations. This study also aimed to understand how the multicultural environment and the existence of different nationality clusters shape the culture of those organisations.

The thesis attempted to move the debate on organisational culture in healthcare from a prescriptive and normative narrative to an empirical one. Abu Dhabi health sector has been bombarded by hundreds of consultants’ reports prescribing packaged solutions to the enduring problems in public healthcare in the Emirate. In many cases, those prescribed solutions were
imported from mature, developed health systems, with the idea that implementing best practices would make an impactful reform. Reality is that whilst this approach worked in certain major policy drivers such as the health insurance bill; in other cases, the pace of implementation of reform initiatives was so rapid that not enough time was allowed to assess the readiness of local hospitals and organisations to implement the change and ensure buy in from major players.

The study analysed the unique institutional, political and socioeconomic factors that shape the context of the public healthcare sector in Abu Dhabi. National culture, Emiratisation policies, ‘social contract’, labour and emigration policies, and labour market segmentation were identified as defining contextual factors that informed the subsequent analysis of organisational culture in the different constituents of the healthcare sector. The key finding of the research was the discovery that those organisations were governed by a hybrid cultural model distinctly typified by the co-domination of hierarchy and market culture, emphasizing rigid controls combined with external focus and a clear performance orientation. The presence of clan and adhocracy cultures was relatively limited with interesting variations in the assessment of clan culture between UAE nationals and other nationality clusters. Those variations are largely explained by the unique contextual factors described above. When assessing the preferred culture, the study revealed a desired cultural shift reflected through a higher emphasis on clan and adhocracy cultures and a lower emphasis on hierarchy and market culture. Those results confirm the presence of two opposing or competing cultural dimensions clan/adhocracy vs. hierarchy/market.

Finally, the study of organisational culture in healthcare contexts is fascinating and complex at the same time. This thesis provided an interesting theoretical contribution in terms of studying organisational culture in diverse multicultural environments, where expatriate ‘guest workers’ dominate the workforce. In that context, the study found that it is not enough to assess organisational culture at an aggregate level. Indeed important variations in cultural assessment can be found based on nationality clusters; those variations explain many of the tensions and challenges that exist within those organisations. From a practical standpoint, the analysis of organisational culture in public healthcare organisations in Abu Dhabi helped to explain the root cause of some of the salient challenges that the sector is facing. It reinforced the idea that implementing reforms in the healthcare sector cannot be achieved through structural and
policy changes alone, rather an understanding of the forces that define culture within those organisations is necessary for those reforms to be successful.
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Appendix 1- Interview questions guide

I- Demographic information
   a. Title:
   b. Education Level:
   c. Number of years in the role:

II- General questions:
1. What is your role within HAAD?
2. How would you describe the experience of working here?
3. What makes this organisation feel different or unique?

III- Organisational Culture Questions: (Explain briefly the CVF and the resulting four cultural types. The researcher provides the interviewee a brief description about each of the cultural types; Hierarchy, Clan, Adhocracy, and Market)

1. (Dominant Characteristics and organisational glue) How would you describe your organisation?
2. (Leadership and Management of Employees) How would you describe the management style/Leadership in your organisation?
3. (Strategic Emphasis and criteria for success) How does your organisation define success?
4. In your opinion, what is the desired culture that would help HAAD in achieving its mission and strategic objectives?
   a. Internally focused vs. externally focused
   b. Flexibility vs. control

III- IV- Performance Management Questions:
1. What are the most important measures or indicators from the point of view of your sector? And what, in your opinion, are the most important measures at organisational level?
2. Have there been any significant recent changes in the way in which performance is thought about here?
3. What are the main external influences on how well the organisation performs?

IV- V- Additional Questions:
1. In your opinion, what are the greatest challenges that HAAD is facing in achieving its mission and strategic objectives?
2. If you given the opportunity to change three things in this Organisation, what would they be, and why?
3. What are the challenges and issues you are facing concerning Emiratisation? Are you satisfied with the progress HAAD is making to meet its Emiratisation targets?
Appendix 2- Interview cover letter

SEHA is taking part in an academic research initiative led by Ms. Nada Messaikheh; a researcher/Doctoral candidate from the University of Manchester, UK. This research initiative is approved by the Chairman, it is entitled: “Analysis of Organisational Culture and Performance in Public Health Care Sector in Abu Dhabi”. The Objectives of the research is to understand how organisational culture influences performance across the three constituents of public Healthcare sector in Abu Dhabi (Regulator, Operator, and Public Hospitals).

The research will be conducted in two phases: The first phase will entail semi-structured interviews with the leadership of SEHA, each interview will take around one hour. The second phase will consist of an on-line survey administered to SEHA personnel.

As a member of our senior management team, we would like to request your support in participating in a one hour one on one interview with Ms. Nada. If this time is not convenient please let me know so I may reschedule this meeting.

The research initiative is subject to the Confidentiality and Ethics Guidelines of both SEHA and the University of Manchester. The attached presentation gives some highlights about the research and its scope.

Please let me know if you have any questions or concerns.
Appendix 3- Covering Email for Survey

Dear,

You have been selected to take part in this survey to examine the ‘Organisational Culture’ in SEHA Hospitals. This survey is part of an academic research initiative entitled “Analysis of Organisational Culture and Performance in Public Health Care Sector in Abu Dhabi” that SEHA is taking part of.

The survey can be completed in either Arabic or English languages and can be accessed via this link: http://www.nmessaikeh.com/. You can click on GO TO SURVEY! from anywhere in the site, you will be prompted to create a username (your email address) and password and complete the sign-up information. You will then receive a confirmation email enabling you to access the survey. The survey itself will take around 15 minutes; detailed instructions on the purpose of the survey and scoring criteria are available under Instructions tab.

The survey is composed of six questions where each question has two scenarios: The “Now” scenario and the “Preferred” scenario. Each scenario has four alternatives A, B, C and D. You simply have to rate each statement of the alternatives A, B, C, and D over 100 points and the sum of the total points should be 100. Your rating shall depend on how similar the description is to your firm. Please note that 100 would indicate ‘very similar’ or ‘perfectly describes your organisation’ and zero would indicate ‘not at all similar’ or ‘does not describe your organisation at all’. The total points for each question in each scenario must equal to 100.

The results of your individual cultural assessment will be shared with you through email should you so wish. Your participation in this survey is completely voluntary; all information you provide will be strictly confidential and will only be used for academic research purposes. The research initiative is subject to the Confidentiality and Ethics Guidelines of both SEHA and the University of Manchester.

If you have any questions or experience any technical issues, please direct your queries to Ms. Nada Messaikeh at nada.messaikeh@hotmail.com.

Thank you for taking part, Best Regards,
Appendix 4-Survey Covering Letter

Welcome and thank you for taking the time to fill out this survey. I am currently undertaking my Doctorate in Business Administration (DBA) at the University of Manchester. Through this project, I aim to gain a deeper understanding of the relationship between Organisational Culture and Organisational Performance in Public Sector entities; It is hoped that the research findings will help shedding light on the important yet under-researched topic of organisational culture in the Arab world and the UAE, and provide useful suggestions and recommendations that might help addressing the salient issue of performance in public sector organisations.

Confidentiality is 100% guaranteed so there is no need to write down your name if you do not wish. Only people directly involved in this project (myself and my supervisors Professor Colin Talbot and Doctor Richard Common) will have access to the questionnaires. The results of this survey will be purely used for academic purposes in the context of the study referred to above.

I am hugely grateful that you are participating in this study. The questionnaire itself will take around 15 minutes to complete. More detailed information about the purpose of this instrument and instructions on how to respond to the questions are provided below.

In completing the questionnaire, you will be providing a picture of the fundamental assumptions on which your organisation operates and the values that characterise it. There is no right or wrong answer for the items included in the questionnaire just as there is no right or wrong culture. Every Organisation will most likely be described by a different set of responses.

Lastly, if you are interested in knowing more about this research or would like to be informed of the results, please do not hesitate to contact me at my email address: nada.jammoul@postgrad.manchester.ac.uk or nada.messaikeh@hotmail.com, I will be more than happy to try my best to answer any queries.

Many thanks in advance for your time and contribution.

Kind regards,
Appendix 5-The Organisational Culture Assessment Survey

PART A- DEMOGRAPHIC DATA

1) Username: The user selects a username to be able to login.
2) Password: The user sets a password for this account information.
3) Name: Optional field.

4) Gender: (Male or Female) Mandatory field
   a) Male
   b) Female

5) Age: user will have values to choose from (age groups) as follows: (Mandatory Field)
   a) Between 19 and 29
   b) Between 30 and 44
   c) Between 45 and 59
   d) 60 and above

6) Nationality: the user selects his current nationality from a list of values the countries. (Mandatory Field)

7) Education: Users will have values to choose from the following values: (Mandatory Field)
   a) High School
   b) College/Diploma
   c) Associate or Bachelor Degree
   d) Postgraduate or Masters Degree
   e) Doctorate/PhD

8) Organisation: Users have to indicate their organisation, e.g., HAAD, SEHA, or Public Hospital from a drop down list (Mandatory Field)

9) Position: Users indicate their position in their organisation from a list of values tailored to each organisation. This list displays different values according to the organisational selected (Mandatory Field)
   a) For HAAD it is list of 9 options from clerical to chief executive based on position
   b) For SEHA, it is a cluster of three positions mirroring ranks used (C1 to C10), typically assigned to specialists/middle managers, and senior managers
   c) For Hospitals it is a list of three options as follows:
      i) Senior Management
      ii) Middle Management/Physician/Chair
iii) Staff/Resident/Intern

10) Organisational Tenure: Users will have the following values to choose from:
    (Mandatory Field)
    a) Less than one year
    b) Between one year and two years
    c) Between two years and five years
    d) Between six years and ten years
    e) Above ten years

11) Professional Group: (Mandatory Field when users choose hospital as ‘organisation’)
    a) Physicians
    b) Nurses and Paramedical
    c) Technicians
    d) Staff
    e) Others
PART B-CULTURAL ASSESSMENT SURVEY

1-Dominant Characteristics: The organisation is a very:

<table>
<thead>
<tr>
<th></th>
<th>Now</th>
<th>Preferred</th>
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<tbody>
<tr>
<td>A- Personal place - It is like an extended family. People seem to share a lot of themselves.</td>
<td></td>
<td></td>
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<tr>
<td>B- Dynamic and entrepreneurial place - People are willing to take initiatives and risks.</td>
<td></td>
<td></td>
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<tr>
<td>C- Results oriented - A major concern is with getting the job done and achieving results. People are very objective oriented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D- Controlled and structured place - Formal policies and procedures govern what people do.</td>
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<tr>
<td>Total</td>
<td>100</td>
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2- Organisational Leadership: The leadership in the organisation is generally considered to exemplify:

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<tbody>
<tr>
<td>A- Mentoring, facilitating, or nurturing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B- Entrepreneurship, innovation, or risk taking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C- Results-oriented, focus mostly on achievements and meeting targets.</td>
<td></td>
<td></td>
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<tr>
<td>D- Coordinating, organizing or flawless, smooth-running efficiency.</td>
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3-Management of employees: The management style in the organisation is characterised by:

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<tr>
<td>A-</td>
<td>Teamwork, consensus, and participation.</td>
<td></td>
</tr>
<tr>
<td>B-</td>
<td>Innovation, freedom to make decisions, and uniqueness.</td>
<td></td>
</tr>
<tr>
<td>C-</td>
<td>Individual and collective target achievement.</td>
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<tr>
<td>D-</td>
<td>Security of employment, conformity, predictability, and stability in relationships.</td>
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4-Organisation Glue: The glue holds the organisation together is:

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<tbody>
<tr>
<td>A-</td>
<td>Loyalty and mutual trust between organisation and employees. Commitment to this Organisation is very high.</td>
<td></td>
</tr>
<tr>
<td>B-</td>
<td>Commitment to innovation and development- There is an emphasis on being on the cutting edge.</td>
<td></td>
</tr>
<tr>
<td>C-</td>
<td>Emphasis on achievement and goal accomplishment.</td>
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<td>D-</td>
<td>Formal rules and policies- Maintaining a smoothly run organisation is very important.</td>
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**5-Strategic emphasis:** The organisation emphasizes:

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<td>A-</td>
<td>Human development – High trust, openness, and participation.</td>
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<tr>
<td>B-</td>
<td>Acquiring new resources and creating new challenges - Trying new things and prospecting for opportunities are valued.</td>
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<tr>
<td>C-</td>
<td>Competitive actions and achievements - Hitting stretch targets and winning are dominant.</td>
<td></td>
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<tr>
<td>D-</td>
<td>Permanence and stability - Efficiency, control, and smooth operations are important.</td>
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**6-Criteria of Success:** The organisation defines success on the basis of:

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<tr>
<td>A-</td>
<td>The development of human resources, teamwork, employee commitment, and concern for people.</td>
<td></td>
</tr>
<tr>
<td>B-</td>
<td>Innovative developments of the organisation and the ability to respond to external changes.</td>
<td></td>
</tr>
<tr>
<td>C-</td>
<td>Achieving the specified targets, and outpacing other organisations in the same levels.</td>
<td></td>
</tr>
<tr>
<td>D-</td>
<td>Efficiency - Dependable public service, smooth operations, and control of costs are critical.</td>
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Appendix 6- Survey cover letter and OCAI survey in Arabic

أود أن أرحب بكم و أشكركم على الوقت الذي ستستخدمونه لتعبئة استبياناتي! أقوم حالياً بدراسة الدكتوراة في مجال إدارة الأعمال في جامعة مانشستر وأحاول، من خلال هذا المشروع، أن أكتسب فهماً أعمق لطبيعة العلاقة بين الثقافة المؤسسية والأداء المؤسسي في مؤسسات القطاع الحكومي. و يركز اهتمامي على التعرف على طبيعة الثقافة المؤسسية التي تؤدي إلى تحسين الأداء.

السرية مضمونة بنسبة 100% و لذلك لا يتوجب عليكم كتابة اسمكم إن لم ترغبوا في ذلك. لن يتمكن أحد من الاطلاع على الاستبيانات سوى الناس ذوي العلاقة بالمشروع (أنا و المشرفين على رسالتي و هما بروفسور كولين تالبوت و د. ريتشارد كومون). ستستخدم نتائج الاستبيان لأغراض أكاديمية محضة و في إطار الدراسة المشار إليها أعلاه.

إني ممتنة جداً لمشاركتكم في هذه الدراسة. ستتمكنون من تعبئة الاستبيان خلال حوالي 15 دقيقة و ستجدون أدناه معلومات مفصلة حول الأداة المستخدمة و التعليمات الخاصة بفما الإجابة على الأسئلة.

من خلال تعبئة الاستبيان ستعطونا صورة حول الفرضيات الرئيسية التي تعمل على أساسها مؤسسكم و كذلك حول القيم التي تميزها. ليس هناك إجابات صحيحة أو خاطئة بخصوص البنود الواردة في الاستبيان كما ليس هناك ثقافة مؤسسية صحيحة أو خاطئة. على الأغلب سيتم وصف كل شركة عبر مجموعة مختلفة من الإجابات.

و أخيراً، إن كنت مهتمين بمعارف تعليمelcome على الدراسة أو بالإطلاع على النتائج النهائية، يرجى ألا تترددوا في مراسلتي على البريد الإلكتروني nada.messaikeh@hotmail.com , nada.jammoul@postgrad.manchester.ac.uk . أعدكم بأن أبذل قصارى جهدي للإجابة عن استفساراتكم.

شكرًا على وقتكم و مساعدتكم.

ندى ميسكيه
"إن تقييم الأداء هو دافع رئيسي لتعزيز كفاءة الحكومة وتحسين إدارة الخدمة العامة" (تصميم عملية إدارة الأداء – المجلس التنفيذي لإمارة أبوظبي، يناير 2006).

دراسة: إدارة الأداء في القطاع الحكومي

تأثير الفنون المؤسسية: دراسة تجريبية في حكومة أبوظبي

سياق الدراسة:
يشمل سياق الدراسة مؤسسات القطاع الحكومي في حكومة أبوظبي. ما دعاني لاختيار حكومة أبوظبي لإجراء دراستي التجريبية حولها هو أهمية الإصلاح الذي طرأ على القطاع الحكومي خلال السنوات الخمس الأخيرة. بالنسبة لموضوع إدارة الأداء بشكل خاص، تعتبر عملية تقييم الأداء المتبعة في مؤسسات القطاع الحكومي منظمة تنظيمية عامة على مستوى أي دولة عربية. و من ناحية أخرى يعتبر البحث الأكاديمي في مجال الفنون المؤسسية وإدارة الأداء في العالم العربي محدودًا، لذلك فإن هناك حاجة لإجراء هذا البحث في السياق الخاص بدولة الإمارات العربية المتحدة، مما يكمن في هذا الحاجة لدراسة الأداء في هذه الفلقة.

أ渲染ي أن يُقدم هذا البحث منظورًا جديداً حول نظام إدارة الأداء في حكومة أبوظبي و أن أشارك بتواضع في وضع البناء المعروف حول الموضوع في دولة الإمارات العربية المتحدة بشكل عام و في العالم العربي بشكل خاص.

ما هي الفنون المؤسسية؟
إن الفنون المؤسسية هي مجموعة المعتقدات والسلوكيات التي تحدد كيفية تفاعل الموظفين مع بعضهم البعض في مؤسسة ما و كذلك كيفية قيامهم بأعمالهم. ليس هناك تعريفًا محددًا لفهم الفنون المؤسسية لأنها ضمنية وعادة ما تتطور مع الوقت من خلال السمات التراكمية للموظفين في المؤسسة.

تتشكل الفنون المؤسسية من قيم المؤسسة ورؤيتها ومبادئها ولغة العمل فيها و أنظمتها ورموزها وقواعد القواعد التي تندرج في أروقتها، كما أنها تعكس في جوانب المبادئ وتفاصيل العمل في المؤسسة. و من ناحية أخرى، الفنون المؤسسية يمكن أن تكون في مجالات العمل وضوابط الموظف في المؤسسة وشرائح العمل الأخرى من العملية.

لماذا ندرس الفنون المؤسسية؟
يدرك معظم الخبراء المراقبين أن الفنون المؤسسية لها تأثير قوي على الأداء وفعالية المؤسسات. و كامرون و كويين، (2011) يشير الفنون المؤسسية مهمة لأنها العامل الوحيد الذي يمكن أن يكون محددًا لتحفيز الأداء المؤسسي.

الأداة: "هيكيل القيم التنافسية"
"هيكيل القيم التنافسية" (Competing Values Framework) يعد هيكيل القيم التنافسية واحدًا من أبرز النماذج الذي يُستخدم في تحليل الأداء وكيفية تعزيزه. يُستخدم هذا النموذج لتحديد كيفية التعامل مع الأفعال الإدارية وتحديد الأهداف والقيم التنافسية لرؤية الأداء المؤسسي.

المزيد من المعلومات الخاصة باستكمال الاستبيان
يهدف نموذج الفنون المؤسسية إلى التعرف على الطريق الذي ترى فيه مؤسستك الآن (سيناريو "الآن") و كذلك الطريق الذي ترغب أن تكون عليه مؤسستك في المستقبل (سيناريو "المفضل"). للأغراض الإدارية، يتم تقسيم قيم المؤسسة في أربعة أقسام: "أ", "ب", "ج", و "د". إذا كنت تعتقد أن الجزء "أ" صديق للجهل، و أن الجزء "ب" صديق للجهل، و أن الجزء "ج" صديق للجهل، و أن الجزء "د" ليس شبيهًا بما على الإطلاق، فقد تكون أرضاً عامة لفهم الفنون المؤسسية إذا كنت ترغب في تعزيز الأداء المؤسسي.

إذا كنت ترغب في تعزيز الأداء المؤسسي، فقد تكون أرضاً عامة لفهم الفنون المؤسسية إذا كنت ترغب في تعزيز الأداء المؤسسي.

بالنهاية، نتمنى أن يُقدم هذا البحث منظورًا جديداً حول نظام إدارة الأداء في حكومة أبوظبي و أن أشارك بتواضع في وضع البناء المعروف حول الموضوع في دولة الإمارات العربية المتحدة بشكل عام و في العالم العربي بشكل خاص.
1. الخصائص المهنية: تعتبر المؤسسة و بوضوح:

<table>
<thead>
<tr>
<th>المفضل</th>
<th>الآن</th>
<th>المجموع</th>
</tr>
</thead>
<tbody>
<tr>
<td>مكاناً ذا طابع شخصي – يسودها الجو العائلي. يشارك الناس بعضهم البعض في كثير من الأمور.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>مكاناً حيوي و مشجعاً على ريادة الأعمال – إن الناس على استعداد لأخذ المبادرة و خوض المخاطر.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>التركيز على النتائج – يعتبر إنجاز العمل أمراً رئيضاً. يتمتع الناس بروح المناقشة و التوجه نحو الإنجاز.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>مكاناً يُتم بالالتزام والتنظيم – تحكم السياسات والإجراءات المؤسسية ما يقوم به الناس.</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

2. القيادة المؤسسية: بشكل عام تعتبر القيادة في المؤسسة مثالاً للتالي:

<table>
<thead>
<tr>
<th>المفضل</th>
<th>الآن</th>
<th>المجموع</th>
</tr>
</thead>
<tbody>
<tr>
<td>التوجيه، تيسر العمل، أو الإرشاد.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>ريادة الأعمال، الابتكار، أو خوض المخاطر.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>التركيز على الجدية و النتائج و تحقيق الأهداف.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>التنسيق، التنظيم و الفعالية.</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

3. إدارة الموظفين: يتصف أساليب الإدارة في المؤسسة بالتالي:

<table>
<thead>
<tr>
<th>المفضل</th>
<th>الآن</th>
<th>المجموع</th>
</tr>
</thead>
<tbody>
<tr>
<td>روح الفريق و الإجماع على الرأي و المشاركة.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>الابتكار و الحرية في اتخاذ القرار و التميز في العمل.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>تحقيق الأهداف على المستوى الفردي و الجماعي.</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>الأمان الوظيفي و الالتزام بقواعد العمل و القدرة على التنبؤ في الفترات الحرجة و استقرار العلاقات.</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
4. الرابط المؤسسي: إن الرابط الذي يربط المؤسسة هو:

<table>
<thead>
<tr>
<th>المفضل</th>
<th>الآن</th>
</tr>
</thead>
<tbody>
<tr>
<td>أ. الولاء والثقة المتبادلة. يعتبر الالتزام نحو المؤسسة أمرًا مهماً للفرد.</td>
<td></td>
</tr>
<tr>
<td>ب. الالتزام بالإبتكار والتطوير. هناك دافع مشترك لوضع المؤسسة في الطليعة.</td>
<td></td>
</tr>
<tr>
<td>ج. التأكد على تحقيق الإنجازات والأهداف.</td>
<td></td>
</tr>
<tr>
<td>د. القواعد والسياسات المؤسسية. إن سلامة العمل على مستوى المؤسسة يعتبر أمرًا أساسيًا.</td>
<td></td>
</tr>
<tr>
<td>المجموع</td>
<td>100</td>
</tr>
</tbody>
</table>

5. التوجه الاستراتيجي: تنجز المؤسسة نحو:

<table>
<thead>
<tr>
<th>المفضل</th>
<th>الآن</th>
</tr>
</thead>
<tbody>
<tr>
<td>أ. تطوير الطاقات البشرية - الثقة العالية والشفافية والمشاركة.</td>
<td></td>
</tr>
<tr>
<td>ب. خلق تحديات وأكتساب موارد جديدة - إن محاولة الأشياء الجديدة و استشراف الفرص يقين التقدير.</td>
<td></td>
</tr>
<tr>
<td>ج. التنافسية والإنجاز - إن تحقيق الأهداف طويلة المدى و الفوز يعتبران عاملان مهيمنان.</td>
<td></td>
</tr>
<tr>
<td>د. الاستمرارية والاستقرار - تعتبر الفعالية والالتزام بالسياسات والإجراءات و سلاسة العمليات أمرًا مهمًا.</td>
<td></td>
</tr>
<tr>
<td>المجموع</td>
<td>100</td>
</tr>
</tbody>
</table>

6. معايير النجاح: يقوم تعريف النجاح في المؤسسة على أساس:

<table>
<thead>
<tr>
<th>المفضل</th>
<th>الآن</th>
</tr>
</thead>
<tbody>
<tr>
<td>أ. تطوير الموارد البشرية والإهتمام بها والعمل بروح الفريق والالتزام الموظف.</td>
<td></td>
</tr>
<tr>
<td>ب. التطورات المتكررة في المؤسسة والقدرة على الاستجابة للتغييرات الخارجية.</td>
<td></td>
</tr>
<tr>
<td>ج. تحقيق الأهداف المحددة والتقدم على المؤسسات التي تقع في ذات المستوى.</td>
<td></td>
</tr>
<tr>
<td>د. الفعالية - تعتبر العوامل التالية مهمة: خدمة عامة فعالة يعتمد عليها؛ إجراءات سلسة و واضحة؛ السيطرة على التكلفة.</td>
<td></td>
</tr>
<tr>
<td>المجموع</td>
<td>100</td>
</tr>
</tbody>
</table>