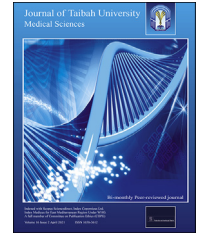




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Original Article

## Autonomy, accountability, and competition: The privatisation of the Saudi health care system



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### المخلص

**أهداف البحث:** تهدف هذه الدراسة إلى فهم تصور منسوبي القطاع الصحي والإداري لخصخصة القطاع الصحي في المملكة العربية السعودية.

**طرق البحث:** استخدم الباحثون دراسة نوعية في أحد مستشفيات التجمع الصحي الأول في المنطقة الشرقية بالمملكة العربية السعودية. تم عقد مقابلات مع 21 شخصا من منسوبي القطاع الصحي والإداري. إضافة إلى ذلك تم تحليل وثائق ومستندات رسمية ذات صلة بخصخصة القطاع الصحي.

**النتائج:** كشف التحليل عن ثلاثة محاور رئيسية. المحور الأول ناقش التغييرات في هيكل الحوكمة مع زيادة استقلالية المستشفى عن الحكومة. أما المحور الثاني فقد عكس ضرورة تقديم مفهوم المساءلة في داخل المستشفيات. وصف المحور الأخير العلاقة التعاونية بين مستشفيات التجمع وكذلك العلاقة التنافسية مع القطاع الخاص.

**الاستنتاجات:** أشارت نتائج الدراسة إلى التضارب بين المفاهيم التي أدخلت حديثاً داخل نظام الرعاية الصحية السعودي مثل الاستقلالية والمساءلة. فهم هذه المفاهيم والتمييز بينها يعد أمراً ضرورياً لتنفيذ عملية الخصخصة. يناقش الباحثون أهمية النتائج في توجيه السياسات الصحية والدراسات البحثية ذات العلاقة. وبذلك تساهم الدراسة في توثيق تصور الجهات الفاعلة والرئيسة في القطاع الصحي لعملية خصخصة الرعاية الصحية في المملكة العربية السعودية.

**الكلمات المفتاحية:** المساءلة؛ إعادة تشكيل الرعاية الصحية؛ تصورات؛ الخصخصة؛ دراسة نوعية؛ المملكة العربية السعودية

### Abstract

**Objectives:** This study aims to explore the perceptions of different stakeholders about the privatisation of the Saudi health care system.

**Methods:** Using a qualitative case study design, we interviewed 21 administrators and clinical staff of a public hospital in the Eastern Province of the KSA and analysed all official documents relevant to this study. The analysis followed a thematic approach to provide an in-depth interpretation of the data.

**Results:** Our analysis generated three main themes. The first was pertinent to the changes in the governance structure, with gradually increased autonomy from the government. The second reflected the necessity to introduce accountability within hospitals. The third described the cooperative relationship among the E1-Cluster hospitals as well as its competitive relationship with the private sector.

**Conclusion:** Our study demonstrates the interplay between newly introduced concepts of autonomy and accountability within the Saudi health care system. The findings of this study and their implications for research, practice, and policy are elaborated. Such an understanding is essential to improve the implementation process of privatisation and to recognise new dynamics that are shaping the health care system. The study contributes to the current scarce literature on health care reforms in KSA by reporting perceptions and experiences of key stakeholders.

**Keywords:** Accountability; Health care reform; Perceptions; Privatisation; Qualitative study; KSA

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Privatisation has gained prevalence across several developed and developing countries.<sup>1</sup> It can take different forms, including privatising services provision and health care finance, or transferring ownership from public to private.<sup>2,3</sup> Early efforts to privatise health care systems started in developed countries; since then, developing countries have taken cues from them to privatise their health care systems.<sup>4,5</sup> International agencies, such as the World Bank, play a major role in supporting privatisation in low-income developing countries,<sup>5</sup> and countries in Europe<sup>2</sup>, Latin America<sup>6</sup> and Asia<sup>7,8</sup> have seen privatisation as the solution for overcoming the financially burdened, inefficient and unsatisfactory public health care systems. For example, in Latin America the calls for political liberalisation and the economic crises were the main triggers behind privatising the public health sector.<sup>6</sup> In China and Bangladesh, the inappropriate utilisation of scarce resources, the high cost of health care services and the inequality of health care provision were among the factors leading to privatisation.<sup>7,9</sup> Thus, governments have been behind these calls for privatisation, with aims to increase efficiency, improve quality of care, increase patients' choice and ensure equal access.<sup>4-7</sup>

Previous studies examining the financial impact of privatisation have shown positive impact in terms of efficiency and resource utilisation<sup>10-12</sup>; for example, the privatisation of hospitals in Germany resulted in increased efficiency, although it was achieved by a major reduction in non-clinical staff, which affected the quality of care.<sup>11,12</sup> Furthermore, previous studies reported the reduced revenues and increased monitoring and administrative costs accompanying privatisation.<sup>1,13</sup>

The extant literature also examined the impact of privatisation on access, quality of care and equity. Specifically, following the privatisation of primary health care in Croatia, primary health care centres offered appointments at precise times, honoured scheduled appointments and increased access to practitioners after working hours with an overall shorter waiting time.<sup>14</sup> Evidence from Canada also supports improved access after privatisation. In a national survey study, 74% of the 90 surveyed urologists perceived privatisation to increase access and reduce waiting times<sup>15</sup>; however, other studies have found limited or no impact of privatisation on access. The privatisation of health care systems in Europe raised the issue of unequal access to it given the increased cost-sharing,<sup>12,16</sup> and the privatisation of reproductive health services in Pakistan increased access only to selective services, which were of low quality and only available to part of the population.<sup>8</sup> Furthermore, in the systematic review documenting health privatisation in Bangladesh, Rahman<sup>7</sup> concluded that privatisation has failed to provide equity in health services provision and to improve quality.

Evidence on the impact of privatisation is often inconclusive and in some cases contradicting. The literature has shown disparities in the experiences of developing and developed countries having positive and limited impacts or even negative externalities of privatisation. The particularity of countries' socioeconomic, cultural, and political contexts can explain the documented disparity and inconsistency in experiences of privatisation processes. Thus, one cannot expect similar impacts or experiences of privatisation across different countries given the complexity and diversity of health care systems in terms of health care finance, service delivery and multiplicity of the involved actors. Indeed, the disparity in countries' experiences underlines the calls for country-specific examination of health care reforms.<sup>17</sup> This is critical within western contexts, especially given that much of the literature on privatisation takes a macro approach in examining health care privatisation. A growing body of literature now focuses on the experiences of non-western countries<sup>7-9</sup>; however, the experiences of Middle Eastern countries remain undocumented. Furthermore, due attention to stakeholders is necessary in health care reforms to understand how privatisation reforms unfold at micro-levels.<sup>18,19</sup>

Building on this, we examined privatisation in the context of the KSA. The Saudi Ministry of Health (MOH) is the main funder and provider of the public health care system, with an allocated budget of more than SR 75 billion (\$20 billion) for the 2019 fiscal year<sup>20</sup>; with a total of 284 hospitals and 2,390 primary healthcare centres, it provides 60% of health care services.<sup>21,22</sup> Other governmental agencies, such as the Ministry of Education, Ministry of Defense and Ministry of Interior as well as the private sector provide services through 47 and 163 hospitals, respectively.<sup>22</sup>

In 2016, the Saudi government launched the Vision-2030 to serve as a national roadmap for the economic development across all sectors based on three pillars: 'a vibrant society, a thriving economy, and an ambitious nation'.<sup>23</sup> The Vision-2030 introduced the Privatization Program, which aims to increase the participation of the private sector in several areas, including health. Within the health sector, the Privatization Program aims at reducing public expenditure, facilitating access to health care services, improving quality of care, and increasing efficiency.<sup>24</sup> To implement the Privatization Program, the MOH has been gradually establishing clusters in the country's different regions which are reflective of the regions' demographics, available facilities, and capacities. Each cluster is an independent, comprehensive, and integrated network of health care providers, and consulting bodies for each cluster manage and clinically govern their hospitals. They also hold clear and precise decision rights and duties, including resources allocation, salaries and employee evaluation.<sup>25</sup> The First Health Cluster in the Eastern Province (hereafter E1-Cluster) was among the first established clusters in the country, and it currently includes 10 hospitals and 95 primary healthcare centres.<sup>26</sup> The consulting body of the E1-Cluster includes appointed consultants, mainly from King Fahd Specialist Hospital – Dammam, which is one of the E1-Cluster's hospitals.<sup>27</sup>

The transformation of the Saudi health care system has resulted in a growing and recent interest in documenting the privatisation process through thematic analyses and systematic reviews.<sup>19,28–30</sup> These studies found that, at the macro-level, the Saudi government chose privatisation as a solution to address the fragmented, financially dependent, unsatisfactory and low-quality health care system.<sup>29,30</sup> The overwhelming dependence of the health care system on governmental funding is threatened by an unstable, oil-dependent national economy; thus, the government realised the need to privatise the health care system to reduce government expenditure and provide better health care services, especially with the emergence of new diseases, the growth of the Saudi population and the increase in the population's life expectancy.<sup>21,30,31</sup> By 2030, the population of KSA will reach 39.3 million, and life expectancy is projected to reach 76.6 years.<sup>31</sup> Therefore, health demands are expected to increase dramatically, placing a huge burden on the government,<sup>32</sup> which prompts the need for an accelerated shift towards privatising the Saudi health care system.<sup>29</sup>

While it is early to have solid and clear evidence on the impact of privatisation in KSA, several scholars have shared their concerns regarding potential negative consequences. At the micro-level, privatisation is expected to increase administrative costs, decrease accessibility and equity, and increase fees.<sup>33</sup> Hospitals adopting a profit-seeking behaviour along with increased out-of-pocket costs would accompany privatisation and would have implications on equitable access for the less advantaged and vulnerable population.<sup>19,21,33</sup> Thus, candid attention is required to eliminate the negative impacts of privatisation regarding increasing costs, profit-seeking behaviour and possible job loss.<sup>19</sup>

The aim of this study was to explore how different health care stakeholders perceived the privatisation of the Saudi health care system as part of the National Transformation Plan. To the best of our knowledge, this is the first empirical study that investigated the perceptions of both administrators and clinical staff towards privatising the Saudi health care system. It contributes to the scarce literature on health care privatisation in KSA, and it answers calls from previous studies concerning health care privatisation in KSA with further qualitative analysis, revealing stakeholders' experiences with privatisation.<sup>19,21</sup> The study's findings report an in-depth analysis and interpretation of stakeholders' perceptions instead of replicating the positive-negative dichotomy found in previous studies.<sup>34,35</sup> In fact, it provides an example of better understanding of privatisation in light of the varied positions of health care stakeholders (administrators vs. clinical staff) and understands the state of reform within the Saudi health care system. The study also illustrates how a macro-level policy trickles through the different levels of the health care system to shape the micro-level. Such findings have practical relevance to other clusters as well as to other sectors affected by the Privatization Program in KSA.

## Materials and Methods

The study used a qualitative case study design to explore how administrators and clinical staff perceived privatisation in a public hospital in KSA, namely the Dammam Medical Complex (DMC). DMC, which is part of the E1-Cluster, is

one of the oldest and largest hospitals in the Eastern Province. It was established in the early 1960s with a capacity of 400 beds and provides a wide scope of services.

## Participants

Maximum variation sampling was employed to purposefully identify a sample of participants representing the range of variation in the hospital.<sup>36</sup> We selected administrators and clinical staff representing the different departments of DMC. While the hospital provided the contact information of administrators and clinical staff, other participants were chosen through snowball sampling, in which participants named other potential employees to participate in the study.<sup>36</sup>

A total of 21 participants – 13 administrators and 8 clinical staff – were selected from 17 different departments, as shown in Table 1. Interviewed administrators included junior and senior staff with work experience ranging from five to 23 years. Interviewed clinical staff had experiences ranging from seven to 20 years. Data saturation was reached after 18 interviews in which no new themes were emerging.<sup>36</sup> Three additional interviews were conducted to ensure the achievement of data saturation.

## Data collection and analysis

We approached qualitative analysis as an iterative process that ensures congruence among the research aim, design, data collection and analysis.<sup>37</sup> Data collection methods included document analysis and semi-structured interviews. Analysed documents were publicly available through official websites and included the Saudi Vision-2030, the Privatization Program, the National Transformation Program (NTP), the Health Sector Transformation Strategy and official documents from the E1-Cluster. Semi-structured interviews were used to obtain in-depth information and understand how administrators and clinical staff perceived privatisation. All interviews were conducted in Arabic and/or English and guided by an interview protocol; they were also audio-recorded and transcribed immediately after.

The development of the interview protocol was informed by the relevant literature and the aims of the Privatization Program,<sup>24</sup> and it included questions about the participants' background, aim of privatisation, how privatisation affected participants' roles and the hospital's operations. The protocol's face and content validity were assessed<sup>38</sup> using expert review and by piloting it among three participants.<sup>39</sup> Experts included two academics who specialise in privatisation and qualitative research. Developing inquiry-driven interview questions that are aligned with the research aim, along with expert review and piloting, strengthened the protocol's reliability and, accordingly, data collection, analysis and the study's findings.<sup>40</sup>

Data collection started in February 2019 and was carried out into two stages that included 13 and eight participants, respectively. While sampling in the first stage was mainly based on maximum variation sampling, snowball sampling complemented it in the second stage. The two stages of data collection allowed for initial analysis after the first stage and identifying preliminary themes and areas for further

exploration and clarification in the second stage. Data were analysed inductively.<sup>39</sup> We individually analysed collected data and coded transcripts manually, by reading and categorising data into codes. First, the analysis was conducted separately for administrators and clinical staff; then, the developed themes were compared to identify relationships, similarities, or any variation between administrators and clinical staff. The document analysis supplemented the interviews' analysis. Finally, the developed themes were confirmed and finalised.

The study was approved by the Institutional Review Board (UGS-2018-03-276) after undergoing an ethics review, and participants' information remains anonymous to maintain confidentiality.

Data triangulation is the process of validating data by using different methods, sources, or types of data with the aim of ensuring the credibility of research findings.<sup>39</sup> To ensure the findings' credibility, we triangulated data through different data collection methods (interviews and document analysis) and different data sources (administrators and clinical staff). Additionally, having several researchers analyse the data minimised potential biases.

## Results

The analysis of interviews and documents found three main and interrelated themes (Figure 1): (1) reforming governance and introducing autonomy, (2) introducing accountability and (3) cooperation and competition.

### *Reforming governance and introducing autonomy*

The MOH approached privatisation by establishing health clusters in KSA's different regions, including the

Eastern Province. Based on the document analysis, the MOH will now have the role of monitoring and legislating, while giving the clusters the responsibility to provide medical services, operate and manage each cluster's hospitals. This change was an opportunity to overcome the current obstacles inherited in the governance structure. Participants communicated obstacles reflecting the long chain of command and bureaucracy – all leading to inefficient service provision and operations. The increased bureaucracy, ineffective and inefficient communication and inefficient operations resulted in a conflict between the hospital and the Directorate of Health Affairs. Thus, the change in governance increased autonomy, innovation, and authority. Participants gave examples of broadening their authority in regulating, managing, and recruiting. In explaining this perspective, one administrator reported:

With privatisation, the existing long chain of command will be shortened. It will be clearer and shorter, and operations will be faster [than before] and thus will improve the quality of work. We will have faster responses and better quality of services... The centralisation of operations that we used to have [before privatisation] was highly bureaucratic, time consuming and caused many issues... privatisation resolves all these issues.

Until recently, the Directorate of Health Affairs, representing the MOH, has been the responsible entity for governing health care in the Eastern Province. The establishment of the E1-Cluster led to confusion among participants since it was established at the level of the Directorate; having two active governing entities at the same level and time caused confusion about who was 'in charge'. The analysis of the E1-Cluster's document did not reveal clear description of the role of the cluster in relation to the Directorate and, indeed, did not make any reference to the latter. One administrator explained, '[N]ow there is a conflict between the Cluster and the Directorate. Both are making decisions and we do not know what to follow?!'. A clinical staff further explained: '[S]ome responsibilities are still under the Directorate's [jurisdiction] and others are under the cluster's? We are lost! No one knows who should do this and who should do that ... it is still unclear'.

### *Introducing accountability*

Since the MOH is the main provider and funder of health care, interviewed administrators perceived a burden on the government bearing the cost of health care provision to the population. This perception was facilitated by the low contribution of the private health care sector and the improper utilisation and waste of resources by public hospitals; thus, privatisation was necessary to 'reduce the waste of public money'. Throughout the interviews, administrators gave examples of wasted resources, such as ordering unnecessary equipment, materials, services and medications or the inefficient utilisation of them. An administrator explained: 'MOH is very generous in funding the hospital... but [the hospital] might buy some equipment that we do not need'.

With privatisation, the hospital will share the financial burden with the government by bearing the cost of

**Table 1: Sociodemographic background of study participants.**

|    | Gender | Department               | Position                  |
|----|--------|--------------------------|---------------------------|
| 1  | Male   | Human Resources          | Admin./senior             |
| 2  | Male   | Medical services         | Admin./senior             |
| 3  | Male   | Health insurance         | Admin./senior             |
| 4  | Male   | Training and development | Admin./senior             |
| 5  | Female | Patient relations        | Admin./senior             |
| 6  | Male   | Finance                  | Admin./junior             |
| 7  | Male   | Purchasing               | Admin./junior             |
| 8  | Male   | Infection control        | Admin./junior             |
| 9  | Female | Quality management       | Admin./junior             |
| 10 | Female | Health insurance         | Admin./junior             |
| 11 | Female | Health education         | Admin./junior             |
| 12 | Female | Quality management       | Admin./junior             |
| 13 | Female | Risk management          | Admin./junior             |
| 14 | Male   | Laboratory               | Clinical/Lab technologist |
| 15 | Female | Inpatient                | Clinical/Nurse            |
| 16 | Female | Inpatient                | Clinical/Nurse            |
| 17 | Female | Outpatient               | Clinical/Head nurse       |
| 18 | Male   | Pharmacy                 | Clinical/Pharmacist       |
| 19 | Male   | Outpatient               | Clinical/Dentist          |
| 20 | Male   | Outpatient               | Clinical/Physician        |
| 21 | Male   | Outpatient               | Clinical/Physician        |

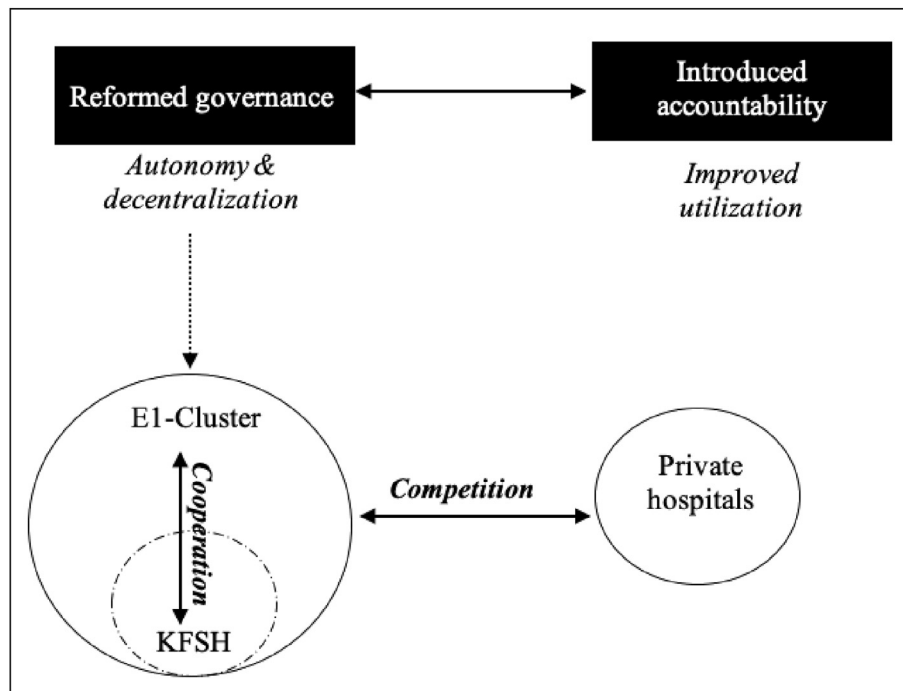


Figure 1: Participants' perceptions towards privatization.

operations, thus leading to better utilisation of resources and increased efficiency. Accordingly, privatisation introduced accountability by holding the hospital responsible for its expenditures. An administrator exemplified:

Many resources are wasted and are being improperly utilised, but privatisation will control and minimise this, because... the hospital will be responsible for its operation. The hospital would know and *value* the cost of the services provided. What is happening now is that we get everything for free and resources are being wasted because no one cares, and no one values them!

The 'generous' government funding has been met with waste and improper utilisation of resources without incurred consequences for the hospitals. Accordingly, administrators believed that privatisation introduces accountability: '[P]rivatisation does not forgive or tolerate any waste or mistakes'. The document analysis revealed the importance placed on transparency in order to instate and improve accountability and to hold hospitals accountable for received resources and their associated decision-making processes.

#### Cooperation and competition

Participants perceived a change in the nature of relationships or the introduction of new relationships with three different entities.

First, several administrators and clinical staff communicated that KFSH holds a reputable status with advanced systems, all reflecting a high-quality hospital. Thus, this status pressured the hospital to raise the bar of services and operations: 'KFSH is now our "fellow" ... for example, KFSH has a better system ... it is more advanced than us in

its operations ... so, this would force us to raise the quality at our hospital'.

As the consultant, KFSH was expected to ensure proper dissemination of information about privatisation among the E1-Cluster's hospitals. However, the mechanisms employed to disseminate information were deemed ineffective and unclear. Participants shared the different channels from which they received information about privatisation, which included talks/lectures, meetings, emails, social media and, in some cases, hearsays. Yet, interviewed participants remained unclear and confused about privatisation: '[W]e receive many circulars from the E1-Cluster, but they are unclear, and no one bothers to clarify them to us!'.

Second, participants perceived a supportive and cooperative relationship among the E1-Cluster's hospitals. They described the relationship, which was not activated prior to privatisation, as unifying organisation structures, operations, and internal policies. By operating as a coherent organisation, several participants referred to the E1-Cluster's hospitals as 'one organisation' – a relationship that allows for sharing human and materialistic resources. Throughout the interviews, participants gave examples of staff being rotated within the E1-Cluster's hospitals and covering for any vacancies or staff shortage.

Participants also reported an increased access accompanying privatisation. The cooperative relationship among the E1-Cluster's hospitals facilitates patients' transfer and referral processes. A clinical staff stated that 'there is an electronic system nowadays that connects all the E1-Cluster's hospitals, not like before [when we had to] wait to receive referrals through fax'. Having such a cooperative and supportive relationship enhanced the overall efficiency of the hospital.

Finally, given the analysed documents and interviews, privatisation created competition between the E1-Cluster's

hospitals and private hospitals, which motivated the hospital to provide a high-quality of care, attract more customers and ensure patients' satisfaction. The hospital will compete with the private sector by increasing its attractiveness to the public. As a result, private hospitals will reduce their costs to attract more patients: '[W]e will be competing with private hospitals, because the E1-Cluster [now] will provide all services to patients. The number of patients will decrease in private hospitals, [thus, private hospitals] will decrease their prices'. Participants further perceived a competitive advantage for public hospitals over private hospitals, which is the community's trust in them. They explained: '[T]here will be some sort of competition between us [public] and the private sector. Yet, we will have the precedence, because of our trustworthiness. The entire community trusts us!'

Given that competition did not exist between public and private hospitals, privatisation instated and stimulated competition to improve the quality of care.

## Discussion

This case study explored health care privatisation in KSA from the perspectives of administrators and clinical staff in a public hospital. It found that administrators and clinical staff perceived the change in governance and structure to empower the E1-Cluster by increasing its authority and reducing bureaucracy. This was facilitated by the held perception of better utilisation of resources and reduced waste – all reflecting characteristics of increased efficiency – among the E1-Cluster's hospitals. Participants also believed that privatisation creates competition between public and private hospitals.

The change in governance introduced a form of decentralisation that granted the E1-Cluster and hospitals a degree of autonomy that they lacked prior to privatisation. Indeed, the reformed governance enabled a cooperative relationship among hospitals of the E-Cluster (Figure 1). Such finding is consistent with previous studies that found privatisation to be accompanied by increased autonomy, less control and minimised government bureaucracy.<sup>41,42</sup> While decentralisation has been found to increase autonomy, enhance service provision and increase transparency, it has also been used to increase accountability. As illustrated in Figure 1, in our case, decentralisation was necessary to activate the monitoring role of the government and allow for introducing accountability. Accountability would be impossible without re-instating the monitoring role of the government; conversely, the redefinition of roles allowed for increased hospital autonomy, while holding hospitals accountable. Therefore, privatisation introduced an overlapping and dependable relationship between accountability and autonomy. Furthermore, our findings reflected a high degree of ambiguity surrounding the increased autonomy and introduced accountability, although previous studies contended that governments must determine degrees of demanded accountability and granted autonomy whenever privatisation is implemented.<sup>42</sup> The operationalisation of accountability and how it would be enforced as well as the level of autonomy accorded to the clusters and accordingly to hospitals remain vague.

Based on our findings, accountability is to accompany the newly autonomous and independent status of the E1-Cluster and the monitoring role of the government. While administrators in the study perceived accountability as necessary to address the waste of government resources, this perception was not shared by the clinical staff. Such findings can be interpreted by understanding the current work structure in the hospital, where a clear separation between administrators and clinical staff in terms of their operations is detected. Clinical staff are distanced from the administrative aspects and thus can be unaware of the extent of waste in resources and the importance of accountability as a form to address that waste.

The Saudi NTP acknowledges challenges associated with privatisation given that the 'insufficient preparation and execution of the privatisation process will ... increase the failure rates of the privatisation process or implements these processes in the wrong way'.<sup>24</sup> However, our findings clearly showed that implementation was undermined by conflicting governance structures and a lack of sufficient and clear communication. Having two active entities (E1-Cluster and the Directorate) operating at the same level with similar responsibilities confused stakeholders; thus, the lack of proper implementation highlights a gap between governmental communications and micro-level implementation.

Consistent with previous studies,<sup>43</sup> administrators and clinical staff perceived privatisation as an opportunity to activate the long-absent role of competition with the private sector. Such finding can be discussed in light of one the Vision's-2030 pillars, namely to improve economic enablers by supporting the growth of the private sector. The government is systematically encouraging the expansion of the private health sector, and such movement will change its landscape and dynamics between public and private hospitals. The strong belief of participants that they hold a competitive advantage over private hospitals was supported by a perceived legitimacy of public hospitals from the community. The perceived legitimacy can be explained by the fact that public health care sector was established, in the early 1920s – much earlier than the private sector.<sup>44</sup>

## Conclusion

The study findings indicated the interplay between newly introduced concepts of autonomy and accountability within the Saudi health care system. We discuss the study's findings and their implications for research, practice, and policy. Such understanding is essential to improve the implementation process of privatisation and to recognise the new dynamics shaping the health care system.

## Recommendations

The study's findings reflect primary experiences and perceptions of administrators and clinical staff about privatisation. The study focused on the variation between administrators' and clinical staff's perceptions and did not include other factors, such as nationality. Furthermore, the study's findings are based on one public hospital and cannot be generalised to other hospitals. However, providing contextual description contributed to the study's

transferability, making informed decisions on the applicability of the study's findings to other situations.<sup>36,39</sup>

The acknowledgement of such limitations highlights venues for future research, which would be essential to examine the impact of privatisation on several hospital and primary health care centres and on several health, social and financial indicators. Further examination of how accountability is operationalised and enforced in contexts where it was never implemented is also necessary. Additionally, it would be imperative to capture the perspectives of the private sector.

The study's findings have implications for policy, practice, and research. The lessons learned from this case study can be used to guide the coming stages of implementation and can be transferred to other hospitals that will be experiencing similar changes. By understanding how stakeholders perceive privatisation, policymakers will have the knowledge to inform further decisions. Finally, the findings reflect how different actors construct different meanings of the same reform. Thus, researchers are encouraged to identify differences among various groups of stakeholders and attempt to understand the underlying premises behind any identified differences.

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#### Conflict of interest

The authors have no conflict of interest to declare.

#### Ethical approval

This research was granted Ethical Approval # IRB-UGS-2018-03-276 dated 12th December 2018 from the Institutional Review Board, Imam Abdulrahman bin Faisal University – Dammam, KSA. Informed consent was obtained from all participants prior to data collection.

#### Authors' contributions

SM conceptualized the research idea, analyzed data, interpreted results, wrote, reviewed, edited, and submitted the manuscript. AA conceptualized the research idea, analyzed data, interpreted results, wrote, reviewed, and edited the manuscript. AA conducted the study, curated, and analyzed data. LA conducted the study, curated, and analyzed data. SB conducted the study, curated, and analyzed data. All authors have critically reviewed and approved the final draft and are responsible for the content and similarity index of the manuscript.

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