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A Study Of Change Process Factors In Determining Individual Readiness For Change: A Case Of Healthcare Reforms In Khyber Pakhtunkhwa, Pakistan

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Abstract

This study intends to investigate the change process factors in relation to readiness for change during the healthcare reforms. It theorizes readiness for change as multidimensional and considers the cognitive, emotional, and intentional dimensions. This is crucial for creating a rich and holistic understanding of readiness for change. An exploratory sequential mixed method has been used to explore the change process factors and then test its connection with all the three dimensions of readiness for change. Data has been collected from four medical teaching institutes in Khyber Pakhtunkhwa, Pakistan in which healthcare reforms had been implemented. Fifteen in-depth semi-structured interviews were carried out with the healthcare staff followed by 390 survey questionnaires. Qualitative findings reveal process factors that are not previously known in the literature. This includes transforming and threatening organizational philosophy and pervious policies, mismatch of change and existing organizational resources and practices, and fear of creating a coercive work environment. The quantitative part of the study reveals the varying impact of identified process factors on individual cognitive, emotional, and intentional readiness for change. This study contributes to our current understanding of change process considering it as contextual, and by appreciating and embracing the multidimensional aspect of readiness for change, particularly the emotional and intentional dimensions. It also introduces additional change process factors to the current literature.

Keywords: readiness for change, process factors, cognitive, affective, intentional, healthcare reforms.

I Introduction

Healthcare organizations face repeated challenges in relation to change management for effective change (Vaishnavi, Suresh, & Dutta, 2019). The contemporary healthcare environment has become highly complex and dynamic with swift and frequent changes that often have unrealistic and challenging timeframes (Beasley, Grace, & Horstmanshof, 2021). Research on change in public sector reveals that the insights are either drawn from the information on private sector or it has been

studied as administrative reforms with an increased focus on organizational perspective (Stewart & Kringas, 2003; Hemme et al., 2018). This study intends to address the employees' perspective about the change, the micro level changes involved therein, contextual dynamics of the change and the context itself, and other change dynamics.

One of the critical factors that influence employees' perspective and compliance to change is the readiness for change (Soumyaja, Kamalanabhan & Bhattacharyya, 2011; McKay, Kuntz, & Näswall, 2013). Readiness for change is important to understand since it largely contributes to change effectiveness. It refers to the extent to which an individual[s] is [are] willing to accept, embrace or resist the change (Wang, Olivier & Chen, 2020). It signifies the positive attitude towards change (Holt, Armenakis, Harris & Field, 2007; Bouckenooghe, 2009). Despite considerable research on readiness for change due to its significance for successful change, there are certain limitations that need to be addressed. First and foremost, research on readiness for change, including the healthcare sector, has been largely de-contextualized and is considered static. Previous research has investigated readiness for change in a specific moment and as a static phenomenon during the change process; whereas both change and readiness for change are dynamic, emergent, and processual (Jansen, 2000; Steven, 2013; Mladenova, 2022). Secondly, readiness for change has three dimensions: cognitive (i.e., individual's belief regarding change to be beneficial), emotional (i.e., feeling of individuals toward change initiative), and intentional (i.e., personal intent towards change) (Szabla, 2007; Nikolaou et al., 2007; Smollan & Sayeszablars, 2009). Among the three dimensions, the cognitive dimension has been a matter of great interest to the researchers and has been classified as a main precursor for readiness for change (e.g., McKay, Kuntz, & Näswall, 2013; Saleh, Khodor, Alameddine, & Baroud, 2016; Banjongprasert, 2017; Iqbal & Asrar-ul-Haq, 2018). The emotional and intentional dimensions are seldom studied in the change management literature perhaps due to overwhelming rational view of managing change (George & Jones, 2001; Kiefer, 2005; Rafferty et al., 2013; Costello & Arghode, 2020). Neglecting the emotional and intentional aspects of readiness for change comprehends a very limited conceptualization of the change process. Hence, this study defines readiness for change as tridimensional concept by considering all the three components of readiness for change i.e., cognitive, emotional, and intentional.

Also, current literature suggests four major antecedants of individual[s]' readiness for change, which include change content, change process, change context, and individual[s]' traits (Weiner, 2009; Jack Walker, Armenakis, & Bernerth, 2007; Sawitri & Wahyuni, 2018; Wang, Olivier, & Chen, 2020). The change content describes the change object and includes alteration in policies, procedures, technology, organizational structure, and so forth. The change process describes the way[s] change is introduced and executed. It involves communication, training, and other management practices that facilitates the change implementation. The change context means the situation[s] in which a change happens. It encompasses the internal culture, climate, and other organizational dynamics. Finally, the individual[s]' traits narrate the personal traits of individuals that may affect their involvement in the change process, such as, personality, beliefs, and experiences. Among these factors, the change process factors have a highly transient character and deals with the way change is actually implemented (Bouckenooghe et al., 2009), which significantly affects the way individuals respond to change. Also, there is a tendency of the researchers to decontextualise process

factors while investigating its relationship with readiness for change. Since process factors are highly contextual in nature, generalizability can be problematic (Choi & Ruona, 2011; Shah, Irani and Sharif, 2017; Andrew, 2017; Schneider, Oppel, & Winter, 2021). This study, therefore, expands our theoretical and empirical understanding regarding the process factors in creating readiness for change during public healthcare reforms, which are conceptualized as a radical change process, and by considering readiness for change as multidimensional.

2 Literature review

Studies exploring individual readiness for change initially started to emerge in the domains of psychology and medicine, focusing on the cessation of harmful behaviors (Choi, 2011; Choui & Rouana, 2011). In this context, readiness for change is about one's need for change and his/her capacity to accept and embrace change (Choi, 2011). In the management literature, readiness of individual for change is typically related with individuals' understanding of the necessity for change and their perception of the organization's capacity to effectively carry out the change (Gärtner, 2013). The process of readiness for change has its origin in Lewin's model of change which is one of the oldest change management models. Lewin (1951) has proposed three stages to bring change: unfreezing, changing, and refreezing. Unfreezing is required to help employees discard their previous attitude and behavior, then the change occurs, and it is refrozen to institutionalize the change (Robbins et al., 2013). The primary issue to consider about successful change management is how change agents can unfreeze the present condition, or rather, how they can enhance employees' readiness to undergo change (Bakari, Hunjra, & Niazi, 2017). This highlights the importance of implementing an effective "unfreezing process" prior to introducing a change to minimize resistance toward change (Backer, 1995).

Later, Holt et al. (2007) relabeled the three stages of Lewin's Change model in accordance with readiness for change. Unfreezing is about creating readiness for change, adoption is the change itself, and institutionalization is refreezing the change. At "unfreezing" stage, individuals and organizations need to "unfreeze" their existing mindset, attitudes, and behaviors to be open to embrace and adopt the proposed change. By "unfreezing," individuals and organizations are encouraged to critically assess and challenge their current state, including any resistance or reluctance to change. The importance of developing readiness for change takes precedence on other stages because the latter two stages cannot occur successfully without achieving readiness for change (Al-Maamari et al., 2018). Similarly, other popular and commonly used change models as presented in Table 1 highlights readiness for change as an important step/stage in the change process.

Table 1 Readiness for change identified/embedded in various steps of the change models

Lewin's Change Management Model (1951)	**Tichy & Devanna model of change (1987)**	**Judson's Change Model (1991)**	**Kanter's Ten Commandments for Change (1992)**	**Kotter's 8-Step Model (1996)**	**Schein's Three-Stage Model of Change (1996)**	**Galpin's Change Model (1996)**	**Anderson & Anderson model of change (2001)**	**Luecke's Seven Steps (2003)**
Step1: Unfreezing Readiness for change is created through: • Sensitizing break down and evaluate existing belief, norms, and values. • Communicate the necessity for change.	Step 1: Recognizing the need for revitalization.	Step 1: Assessing the organization and planning the change.	Step 1: Analyse needs for organizational change.	**Step 1: Creating a sense of urgency:** • Identifying and addressing critical issues, potential crises, or significant opportunities through open discussions and proactive actions.	**Step1: Creating the motivation to change:** • Effectively conveying the rationale for change. • Generating a feeling or perception of survival anxiety that outweighs learning anxiety. • Establishing psychological safety	**Step 1: Establishing the need to change:** • Conveying the rationale behind the change. • Developing support for the change initiative.	**Step1: Preparing to Lead the Change Initiative:** • Inspiring and motivating employees to embrace change initiatives.	**Step 1: Drive enthusiasm and dedication by involving all stakeholders in identifying and solving business problems collaboratively.** • Creating a sense of urgency. • Creating the need and value for change through quality

					through supportive measures during the change process.			communication.
Step 2: change	**Step 2: Mobilize dedication to change:** • Encouraging a sense of immediacy and dedication towards change. • Clear communication of change rationale and necessity. • Stakeholder engagement and buy-in building for	**Step2: Communicating the change:** • Communicate the need for change and vision of change. • Communicate how change will be beneficial. • Communicate how change will be implemented.	Step 2: Separate from the past	Step 2: Forming a powerful guiding coalition.	Step 2: Change	**Step 2: Creating and promoting a vision for change:** • Communicate the new vision.	**Step2: Defining the Organizational Vision, Commitment and strengthening the Capabilities** • Constructing a robust and compelling case for change. • Seeking employee involvement and participation in the process.	**Step 2: Developing a vision and strategy** • Develop change mission through communication, participation, and involvement.

	effective change.							
Step 3: Refreezing	Step 3: Execute the change	Step 3: Obtaining buy-in for new behaviours	**Step 3: Instilling a feeling of urgency:** • Establishing a compelling rationale for change. • Generating urgency and emphasizing the significance of change.	Step 3: Creating a vision.	Step 3: Internalizing the change.	Step 3: Diagnose/Analyze the Current Situation.	Step 3: Determine the Design Requirements by Assessing the Situation.	Step 3: Identify the leadership
	Step 4: Consolidate the change.	Step 4: Integration of change.	Step 4: Establishing a unified vision and direction	**Step 4: Communicating the vision:** • Utilizing various communication channels to effectively convey the		Step 4: Generate Recommendations.	Step 4: Design the desired state.	Step 4: Emphasize short-term outcomes, not just actions.

				new vision and strategies. • Demonstrating new behaviours through the guiding coalition as an example.				
		Step 5: Commitment to change.	Step 5: Create a strong leadership role.	**Step 5: Enabling others to act upon the vision:** • Promoting a culture of risk-taking and encouraging new and innovative ideas, process, and procedures.		Step 5: Detail Recommendations.	Step 5: Analysis of the Impact.	Step 5: Catalyzing change at the edges and permitting organic diffusion to other units, without hierarchical imposition.
			Step 6: Line up political sponsor.	Step 6: Formulating plans and achieving		Step 6: Pilot test recommendations	Step 6: Planning	Step 6: Establishing formal policies,

				short-term wins to build momentum and demonstrate progress towards the change initiatives.				systems, and structures to institutionalize the success and sustainability of the change.
			Step 7: Develop implementation plans.	Step 7: Build on change.		Step 7: Prepare Recommendations for Rollout.	Step 7: Change implementation.	Step 7: Continuously monitoring and adjusting strategies in response to challenges and issues that arise during the change process.
			Step 8: Develop supporting structures.	Step 8: Institutionalizing new approaches.		Step 8: Rollout changes.	Step 8: Celebrating and institutionalizing change.	
			Step 8: Create a plan, communicate, and			Step 9: Measure, reinforce, and refine changes	Step 9: Learning & correct course	

			involve individuals: • Communicate change vision, process, and benefits to stakeholders. • Involving employees in the change process and decision-making to promote ownership, engagement.					
			Step 10: Reinforce and institutionalize change.					

The readiness of employees for change is shaped by a range of factors that are broadly classified into individual and structural levels (Choi & Ruona, 2011; Saragih et al., 2013); personal and organizational levels or psychological and structural dimensions (Rusly, Corner, & Sun, 2012). The individual factors relate to the attributes of individuals embracing the change (Holt & Vardaman, 2013) while structural dimensions pertain to the circumstances surrounding the change and the degree to which they facilitate or hinder change implementation (Holt & Vardaman, 2013, p. 51). The personal level encompasses motivation, competency, and individual personality traits (Holt & Vardaman, 2013) and the organizational level includes resources, environment, culture, and financial resources (Taylor & Wright, 2004). Similarly, the psychological dimension pertains to an individual or collective beliefs, attitudes, and behavior/intentions toward change (Weiner, 2009; Holt & Vardaman, 2013). Irrespective of the classification of the factors that influence readiness for change either based on levels or dimensions, both have a complementary role to build readiness for change.

In healthcare, there has been a general concern of determining individual readiness for change due to radical and incremental healthcare reforms across the globe. The emphasis has been on creating organizational readiness for change and less on individual readiness for change (e.g. Nuño-Solinís, 2018; Al-Hussami et al., 2018; Vaishnavi et al., 2019; Weiner, Amick, & Lee, 2008). Organizational readiness pertains to the level of commitment and efficacy demonstrated by members of an organization to implement organizational change (Weiner, Lewis & Linnan, 2009) On the other hand, individual readiness for change pertains to their beliefs, attitudes, and intentions regarding the need for change and the organizational capability and capacity to effectively carry out the change (Armenakis et al., 1993).

Several studies have been conducted to find out various factors that influence individual/ employee's readiness for change (e.g., Tsaousis, Vakola, & Nikolaou, 2003; Rafferty & Simons, 2006; Khammarnia, Ravangard, & Asadi, 2014; Oreg, Vakola, & Armenakis, 2011; Samaranayake & Takemura, 2017). Among these factors, process factors deals with a way how a specific change is actually implemented and is critical in making or breaking individual's readiness for change (Bouckenooghe et al., 2014). Thus, process factors refer to the specific tactics or techniques employed by change agents to carry out organizational changes (Holt, Armenakis, Harris and Field, 2007). Importantly, the tendency of current research to decontextualize factors of readiness for change has prompted researchers to keep on investigating the already explored factors in different contexts. The common process factors that have been discussed so far includes quality of change communication, employees participation in the change process, change process planning and reasons for change (Soumyaja, Kamalanabhan & Bhattacharyya, 2011; McKay, Kuntz & Näswall, 2013; Banjongprasert, 2017; Haqq & Natsir, 2019), lack of strategic planning and implementation (Napier, Amborski, & Pesek, 2017; Shea et al., 2014), and exclusion from the change process (Bouckenooghe, et al., 2009). Further, individuals' response to readiness for change is unique as it is based on personality attributes, work experiences, habits, culture, mental process, context, and logical disposition of employees (Cummings & Worley, 2005), which is largely ignored.

Even within the healthcare, research on readiness for change reveals that it has either focused on conceptualization and designing the instruments that could measure organizational readiness for

change (Weiner, Amick & Lee, 2008; Helfrich, Li, Sharp, & Sales, 2009) or has reviewed the existing instruments to determine if they are applicable in the healthcare (e.g., Gagnon et al., 2014; Pomare et al., 2020). These studies reveal that only a few instruments have been validated specifically in the healthcare setting to assess change. Hence, there is a need for more research to validate existing instruments and develop new ones in this specific context, as intended in this study.

3 Healthcare reforms in the Khyber Pakhtunkhwa

The healthcare reforms, known as the MTI Act, was introduced in 2015 in the Khyber Pakhtunkhwa province of Pakistan. It aimed to bring managerialism in the public medical teaching hospitals that later expanded to the Punjab province. The Act restructured the governance structure and processes of the public teaching hospitals by introducing a board of governors appointed by the government, which are now responsible for decision making and management of the hospitals. The board of governors can form several committees for prompt and effective decision making. This includes the executive committee, finance committee, and recruitment committee, apart from several other committees that the board of governors are empowered to create. Thus, the reforms aimed to decentralize decision making and transfer power to the board of governors, provide financial autonomy to hospitals, introduce structural changes, revising human resource policies and practices (Ahmad, 2017). The reforms required changes in work timings, encouraging doctors to have their private clinics in the hospitals, introduced a performance management system, and created options for contract-based hiring. Thus, the MTI reforms aimed to solve the long-standing problems of lack of accountability, managerial inefficiencies, government ineffectiveness, lack of quality and quality control measures, weak rules and regulations, and corruption in the public teaching hospitals that had compromised the quality of public health (Javaid, 2016; Ahmad, 2017).

4 Methodology

This study adopts an exploratory sequential mixed methods approach to explore the change process factors in readiness for change during the healthcare reforms, and to test its relationship with the three dimensions of individual readiness for change (i.e., cognitive, emotional, and intentional). Hence, this study has been conducted in two phases, which are discussed below:

4.1 Qualitative Phase:

In the first phase, qualitative research has been conducted to find out the change process factors in relation to readiness for change. Data has been collected from fifteen respondents through in depth semi structured interviews from four public teaching hospitals in the Khyber Pakhtunkhwa, Pakistan that had implemented the MTI reforms. The interviews lasted between twenty to thirty-five minutes. Snowball sampling technique was used to select and seek access to the sample for the study due to the reluctancy of participants to participate in the study (Parker, Scott & Geddes, 2019). Informed consent was taken from the research participants before conducting interviews. Fictitious names have been assigned to protect the confidentiality of the research participants. Prior permission was taken from respondents before recording the interviews. They were then immediately transcribed with the help of Express Scribe.

Data has been analyzed through reflexive thematic analysis. This involves identifying, analyzing, and reporting patterns in the dataset (Braun & Clarke, 2006). This helps to extract meaning from the data and to grasp the pattern and the relationships, which helps to gain deeper insight into a complex phenomenon. The coding

process was carried out through NVIVO 12, which assisted in data management and data analysis. The analysis revealed the findings that are presented in Figure 1.

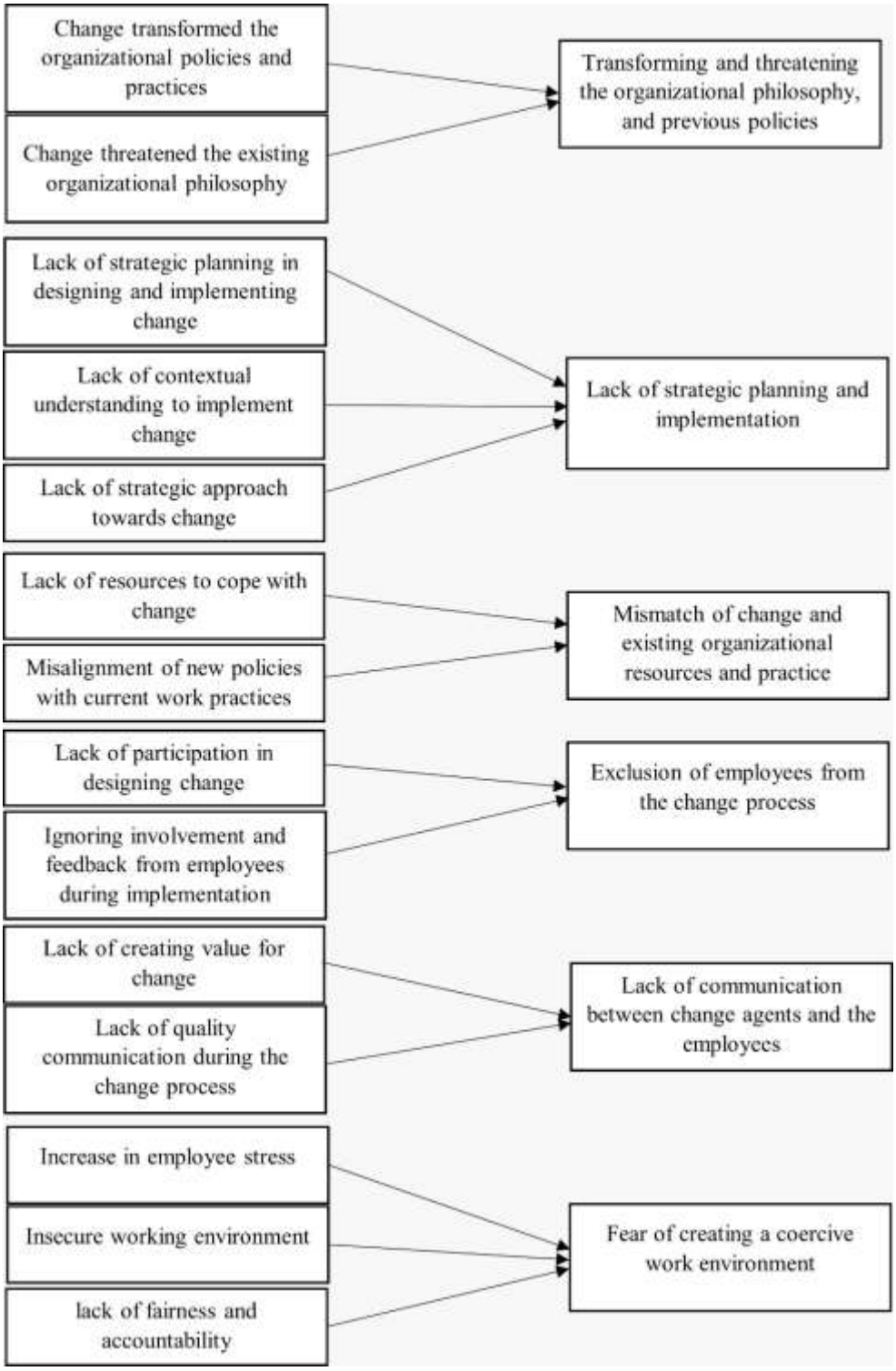

Fig. 1 Process factors identified in the qualitative phase

4.2 Quantitative Phase:

In the second phase, quantitative research was used to examine the connection between change process factors and individual readiness for change. A survey questionnaire was designed based on the qualitative data analysis that was conducted in the qualitative phase of the study. A large pool of questions was accumulated based on the lower and higher order codes representing the items for the theme measurement. Content validity of the questionnaire was established through Delphi technique (Jones & Hunter, 1995) and face validity was confirmed through a pool of reviewers from the research participants (Umanath & Coane, 2020). This resulted in the omission of questions that were measuring more than one item.

A 5-point Likert scale was used to scale the responses of the participants. Allen and Seaman (2007) suggest that this scale is easily understood by the respondents and has good psychometric properties. The questionnaires were distributed among 390 staff from the four hospitals under study based on random sampling technique. The analysis of the data was carried out through Smart PLS.

5 Qualitative Findings

5.1 Transforming and threatening the organizational philosophy and previous policies

The healthcare employees felt threatened that the reforms would transform and affect the organizational philosophy of providing free healthcare to the public. They were concerned that the public hospitals were moving towards privatization since they had to generate their own revenue.

> "MTI suggests that the hospital will generate its own revenues and will spend on their operations. They want to make this not-for-profit organization a business which earns money for its own operations" (Doctor).

Previous reforms had created certain policies and practices which had internalized. Although the MTI reforms had some similarity with the previous changes, but it was mainly radical in bringing structural and processual changes. Prior to change, the hospitals had well established policies and procedures regarding every aspect of the job, but MTI system fail to adopt those well-established policies.

> "MTI has no specific policy for terminating an employee and the management can terminate you even for one mistake without following any procedure. Previously there was a proper procedure for terminating an employee and the management had to follow that procedure" (Technician).

Respondents believed that the several aspects of reforms were not completely implemented. They were concerned that the reforms were not fully functional and had also destroyed the previous policies along with the organizational philosophy of public care.

5.2 Lack of strategic planning and implementation

Respondents felt that there was a lack of strategic planning during the MTI reforms. It lacked a strategic approach since the organizations were unable to prioritize areas where change was needed. This was attributed to the lack of initial work to assess the needs of stakeholders and the organization. The government's approval of the reforms without detailed planning was also criticized, resulting in unclear goals and objectives.

> "They have not set their priorities till now; they do

> not know what is important for the hospital and for its revenue generation. If they have their own collection center and laboratories in various areas, they will have more patients in terms of diagnosis and prognosis" (Doctor).

Respondents criticized the MTI system as being unsuitable for Pakistan since it was taken from the UK healthcare system without considering the differences in context and challenges. They also felt that the MTI reforms did not address the needs of employees, patients, and the organization.

> "People are mentally disturbed because this is a foreign-imported system which does not cater for the problems of the employees here" (Doctor).

Further, this change also lacks clear and effective strategies for implementation of the change process. This made the respondents assume that the change agents are directionless, and the reforms will create resistance and will ultimately fail.

> "Looking at the current situation where they have no strategy for its successful implementation, they are going blindly to implement these reforms. It looks like it will collapse" (Paramedic).

Hence, respondents believed MTI reforms were unsustainable due to lack of strategic planning and would revert like previous reforms.

5.3 Mismatch of change and existing organizational resources and practice

A fit between change and the current organizational resources and practices is required for effective change. However, employees faced challenges such as increase in workload, difficulties in accessing free medications for patients and treatment with Sehat card (health insurance card), accommodating patients from private practice, lack of availability of expert staff, and so forth.

> "They claim that free medicines are available but there are not apart from few and the process to get free medications needs time. The Sehat insaf card that they have introduced, also has problems. Sometimes, the link is down, and sometimes the card is not activated. I personally have facilitated many patients availing Sehat card facility and I always found problems with it". (Doctor).

The flow of patients has increased because of the introduction of IBPs (Institute Based practices) which means that the doctors should hold their private practice in the hospitals instead of their own private clinics. The employees found it difficult to properly serve and accommodate all patients of the private practice due to lack of beds.

> "Also, with the introduction of IBP we are now receiving more patients. KTH has an inflow of four to five

> thousand patients a day. It was difficult for us to accommodate and serve them because we do not have enough staff and beds and now after IBP it has become more difficult" (Nurse).

Thus, the lack of fitness between the organization resources and practices with change creates problems for employees to meet the requirements of the change thereby affecting readiness for change.

5.4 Exclusion from the change process

Respondents felt ignored and not involved in the designing and implementation of the change, particularly doctors and senior staff who wanted to be involved.

> "Unfortunately, in the designing of the MTI reforms the doctors were completely sidelined. No local doctors were involved, only those who were from abroad were involved" (Doctor).

Respondents felt that doctors who had designed the MTI reforms, having returned from abroad, were out of touch with the contextual problems and stakeholder needs, leading to the local staff feeling undermined and creating resistance to change.

> "Why bring reforms from the West. We have very capable people who can design a far superior system by taking into account all the ground realities here. They will have knowledge of the local problems and they will be able to communicate with the concerned parties and will then incorporate their suggestions and address their reservations" (Paramedic).

Due to lack of involvement and participation, the hospital staff were unclear about their responsibilities and accountabilities.

> "Employees need a clear policy like these are the conditions, doctors will be responsible for these things, and the rest will be their responsibilities" (Doctor).

This shows that the lack of participation in change creates confusions. They felt neglected and their feedback was ignored during change implementation.

5.5 Lack of communication between change agents and the employees

The MTI change program lacked communication between the hospital management and the employees since it failed to provide proper justification for the reforms. The reforms were radically introduced to which the respondents did not agree.

> "They first should have laid the foundation for change, communicated, and created its need. You cannot introduce a change suddenly" (Doctor).

The uncertainty fueled by the lack of communication lost the confidence of the employees in the reforms.

> "The lack of communication between the parties also creates lack of confidence" (Paramedic).

Hence, the employees refused to change their practice and accept change.

> "Change initiators do not consider changing our minds regarding the benefits and the need for change. It is very important, that's why we are not changing the ways we used to have before MTI" (Doctor).

This implies that the change agents were unable to create value for change by demonstrating the way it would affect employees. Hence, the readiness for change was adversely affected.

5.6 Fear of creating a coercive work environment

Respondents revealed that MTI reforms created a coercive work environment and fears of political influence in the performance-based system that was required for the extension of contracts, and partiality of independent monitoring units. Such apprehensions created fear of losing jobs.

> "The senior system has been banished and performance-based system is introduced but I am telling it is also going to be political. Independent monitory units will favor and report good performance of those who are politically strong and as a result a person who is not good will get promotion and contract extensions and the more intelligent and deserving candidates will be terminated and thus suffer" (Doctor).

One of the responded report sexual harassments since was asked for sexual favors in return for the extension of her contract. This created a lack of a secure and a safe work environment.

> "Recently a nurse whose contract expired was trying for the extension for the contract. But the people she contacted ask her for sexual favors in return for extension. Tell me who will work in such an unsecure and unsafe environment" (Nurse).

Employees believe that the present unsafe working environment in the change process will become more unsuitable and riskier as the change progresses, making them more vulnerable to exploitation, which is why they were reluctant to accept the change.

6 Quantitative results

Descriptive results of the study show that the employees lack cognitive readiness (M=3.56), emotional readiness (M= 3.50) and intentional readiness (M=3.52) for change. It further reveals that there is a lack of communication between change agents and the employees (M= 3.09), employees are excluded from the change process (M= 3.58), and there is a lack of strategic planning and implementation (M= 3.55) is present as the value shows. Further, the mismatch of change with existing organizational resources and practices (M= 3.73) and the change process transforming and threatening the organizational philosophy and policies (M= 3.58) is evident from the mean values. Finally, the change has resulted in the creation of a coercive work environment (M= 3.59). All the data was normally distributed.

Reliability and validity are crucial components of any research study that utilizes measurement tools (Pallant, 2016). Reliability pertains to the stability and consistency of the measurement

tools used to collect data, ensuring that they produce consistent results. Thus, reliability "refers to the accuracy of the results" (Jordan & Hoefer, 2001, p. 53) Validity indicates the accuracy and appropriateness of the measurement tools in measuring what they are intended to measure (Mohajan, 2017). Both reliability and validity demonstrate rigor and ensure the credibility, trustworthiness, and usefulness of research findings. Hence, the data collected, and the measurement tools are both considered to be trustworthy. The reliability and the validity of the study is presented in Table 2.

Table 2 Reliability and validity of the study

	Cronbach's Alpha	rho_A	Composite Reliability	Average Variance Extracted (AVE)
Transforming and threatening the organizational philosophy and policies	0.748	0.743	0.859	0.672
Lack of strategic planning and implementation	0.863	0.870	0.908	0.714
Mismatch of change and existing organizational resources and practice	0.913	0.918	0.906	0.833
Exclusion from the change process	0.803	0.815	0.869	0.625
Lack of communication between the change agents and the employees	0.853	0.885	0.893	0.627
Fear of creating a coercive work environment	0.737	0.762	0.883	0.790
Cognitive readiness for change	0.792	0.791	0.858	0.547
Emotional readiness for change	0.791	0.811	0.857	0.547
Intentional readiness for change	0.796	0.803	0.828	0.553

The results showed that all the indicators are reliable because their composite reliability value and Cronbach's alpha value was above the threshold value of 0.70. As the AVE values of all the constructs are above 0.50, the measurement has showed the convergent validity of the scale. In relation to discrimination validity, strong cross loading of measures of transforming and threatening the organizational philosophy and policies (ICF1 0.872, ICF2 0.697, ICF3 0.877), lack of strategic planning and implementation (LPP1 0.890, LPP2 0.918, LPP3 0.860, LPP4 0.693), mismatch of change and existing organizational resources and practices (OPF1 0.999, OPF2 0.817), exclusion from the change process (PIC1 0.762, PIC2 0.794, PIC3 0.798, PIC4 0.806), lack of communication between change agents and the employees (QCC1 0.778, QCC2 0.838, QCC3 0.839, QCC4 0.661, QCC5 0.829), and fear of creating a coercive work environment (UWEC1 0.914, UWEC2 0.862) have been found out. The measures have no

strong cross loading of above 0.50 with other unrelated constructs. Further, the relationship between the variables is shown in Table 3.

Table 3 Path coefficient and T-statistics of variables

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
ICF➡CRC	0.125	0.126	0.040	3.101	**0.002**
ICF➡ERC	0.089	0.092	0.046	2.017	**0.050**
ICF➡IRC	0.066	0.064	0.049	1.349	**0.178**
LPP➡CRC	0.161	0.153	0.039	4.179	**0.000**
LPP➡ERC	0.011	0.017	0.049	0.230	**0.819**
LPP➡IRC	0.089	0.091	0.056	1.584	**0.114**
OPF➡CRC	0.003	0.010	0.032	0.093	**0.926**
OPF➡ERC	0.037	0.048	0.035	1.065	**0.287**
OPF➡IRC	0.031	0.036	0.039	0.790	**0.430**
PIC➡CRC	0.177	0.177	0.035	5.017	**0.000**
PIC➡ERC	0.085	0.083	0.037	2.326	**0.020**
PIC➡IRC	0.015	0.018	0.043	0.353	**0.724**
QCC➡CRC	0.042	0.038	0.034	1.221	**0.223**
QCC➡ERC	0.160	0.161	0.045	3.560	**0.000**
QCC➡IRC	0.004	0.005	0.045	0.094	**0.925**
UWEC➡CRC	0.074	0.072	0.034	2.194	**0.029**
UWEC➡ERC	0.004	0.002	0.040	0.109	**0.913**
UWEC➡IRC	0.237	0.233	0.038	6.163	**0.000**

Note: CRC (Lack of Cognitive readiness for change), ERC (Lack of Emotional readiness for change), IRC (Lack of Intentional readiness for change), ICF (Transforming and threatening the organizational philosophy, and previous policies), LPP (Lack of strategic planning and implementation), OPF (Mismatch of change and organizational process), PIC (Exclusion from the change process), QCC (Lack of communication between change agents and the employees), UWEC (Fear of creating a coercive work environment)

Table 3 shows that transforming and threatening the organizational philosophy and previous policies (β= 0.125, t= 3.101, p= 0.002), lack of strategic planning and implementation (β= 0.161, t= 4.179, p= 0.000), exclusion from the change process (β= 0.177, t= 5.017, p= 0.000), and fear of creating a coercive work environment (β= 0.029, t= 2.194, p= 0.029) have positive and significant influence on individual's lack of cognitive readiness for change. Transforming and threatening the organizational philosophy and previous policies (β= 0.089, t= 2.017, p= 0.050), Exclusion from the change process (β= 0.085, t= 2.326, p= 0.020), and lack of communication between change agents and the employees (β= 0.160, t= 3.560, p= 0.000) have positive and significant influence on individual's lack of emotional readiness for change. Fear of creating a coercive work environment (β= 0.237, t= 6.163, p= 0.000) has positive and significant influence on individual's lack of intentional readiness for change.

7 Discussion and conclusion

Unlike previous research that treats readiness for change as a unidimensional, this study investigates readiness for change as a multidimensional concept as it explores the change process factors of readiness for change and its relationship with individual's cognitive, emotional, and intentional willingness for change. In this way, it contributes to our understanding of the emotional and intentional dimensions as well. Also, it defines readiness for change as contextual and, therefore, determines the process factors in the specific context of public health reforms in the Khyber Pakhtunkhwa, Pakistan. The choice of sequential mixed methods approach has been particularly helpful in finding new process factors in context and then testing its relationship with individual readiness for change. This includes transforming and threatening organizational philosophy and pervious policies, mismatch of change and existing organizational resources and practices and fear of creating a coercive work environment in addition to previously known process factors, that is, lack of strategic planning and implementation (Napier, Amborski, & Pesek, 2017; Shea, Jacobs, Esserman, Bruce & Weiner, 2014), exclusion from the change process (Bouckenooghe, et al., 2009), and lack of communication between the change agents and the employees (Haqq and Natsir, 2019). This study, therefore, reveals that contextualizing readiness for change can reveal process factors for change that are not previously known.

Also, the quantitative part of this study reveals that all the three dimensions of readiness for change are crucial in creating a holistic and in depth understanding for creating readiness for change. Emphasis on cognitive elements as done in the previous research can only provide an incomplete understanding of readiness for change. Several process factors found in this study have influenced all the three dimensions of readiness for change with varying degrees.

In this study, employees were resistant to change as they perceived that the organizational philosophy was being threatened by the MTI reforms since they assumed that public teaching hospitals were being privatized. This is aligned with the earlier literature that suggests that resistance to change is often due to a perceived

threat to the organizational culture and previous policies (Balogun & Johnson, 2004; Ford, Ford, & D'Amelio, 2008). Employees often resist change when they feel that the change process will disrupt their work environment, existing policies, or values. Quantitative results show that transforming and threatening organizational philosophy and pervious policies had a significant negative impact on individual cognitive and emotional willingness/readiness for change.

Further, respondents found difficulty in coping with change due to limitations in current organizational resources and the practices. This created a mismatch of change and existing organizational resources and practices which further created lack of readiness for change. Similarly, lack of strategic planning and implementing the change process along with exclusion from the change process and lack of communication negatively influenced readiness for change. Exclusion from the change process reflects that there was a lack of participation of employees in the change proves. These findings are slightly different from Bouckenooghe et al. (2009) where they had observed strong influence of participation on all the three dimensions of change readiness whereas this study suggests that it is strongly tied with individual cognitive and affective dimensions and has no significant impact on intentional change readiness.

The mixed methods show that there was lack of quality of change communication in the change process that affected employees' emotional readiness for change. This is supported by previous research conducted by Haqq and Natsir (2019) that shows that employees' emotional readiness for change decreases when they perceive low quality of communication reagrding the change process. Hence, employees are less likely to be emotionally prepared to deal with the change. Respondents also complained that the change created room for creating a coercive work environment. Individuals feared exploitation, which led to increased intention of turnover. Vakola and Nikolaou (2005) also found negative impact of work environment on attitudes toward change as they examined the effect of work environment on attitudes toward change in the context of a large Greek public sector organization undergoing a major restructuring process. Thus, this study concludes that process factors are crucial in creating readiness for change and should be contextualized. Further, readiness for change should be treated as multidimensional since the unidimensional view only gives a narrow view of the change process.

In future, the content, context, and individual factors along with process factors of individual readiness to change should be studied in context and should take into account all the dimensions of readiness for change to provide a comprehensive understanding of change. An in depth qualitative research would be required in future to explore additional factors of change. Practically, this study helps the change agents to understand the process factors that affect the cognitive, emotional, and intentional dimensions. This study suggests that individuals experience change in unique ways, which prompts them to either accept or resist change (Beasley et al., 2021). Therefore, change agents should take proactive measures "to influence beliefs, attitudes, and intentions" to minimize resistance to change (Rusly et al., 2014) and to achieve the desired outcomes of change (Madsen et al., 2006; Weiner, Amick, & Lee, 2008). In this way, managers will be able to address the relevant dimension to increase readiness for change. Hence, "one fit all" philosophy seems dysfunctional due to variation in context to deal with while strategizing for individual readiness for change.

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