

Chapter 6

Barriers to Accessing Healthcare Services in Developing Nations: Reflective Lessons for the Gulf Cooperation Council Countries

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ABSTRACT

Patient satisfaction with the healthcare services is critical to addressing the barriers to accessing health-care. Many combined factors are responsible for the poor accessibilities to primary healthcare centers. Less availability of prescription drugs and less thoroughness of care are most frequently associated with high rates of patient dissatisfaction. The low satisfaction rates of patients need to be investigated further to promote prevention programs and increase utilization of healthcare services by patients. The purpose of this book chapter is to analyse the critical dimensions that influence patient satisfaction with primary healthcare services in six gulf countries.

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INTRODUCTION

Primary healthcare (PHC) services consist of healthcare services and activities that interface between the community and the healthcare system (WHO, 1978). Countries with stronger PHC have healthier populations (Starfield, Shi & Macinko, 2005), because PHC centers help in promoting, protecting and restoring the health of the local community (WHO, 1978). Through the evaluation of PHC centers, quality of primary healthcare services provided can be continuously improved. Evaluating PHC performance depends on two main domains: structural characteristics and practice features of the PHC center (Macinko, Startfield & Shi, 2003). Different stakeholders should be involved in the evaluation of PHC, which should include the patient population (WHO, 1978).

Involving patients by measuring their satisfaction with PHC services is one important dimension that can help in improving the performance and quality of healthcare services (Powell, 2001). PHC center's evaluation by measuring patient satisfaction can be used as a tool for learning and a reference for management and decision-making (Powell, 2001). More satisfied patients are more likely to engage in healthy behaviors by complying with treatment recommendations (Keegan & McGee, 2003).

Patient Satisfaction is a multifactorial-construct (Keegan & McGee, 2003). It reflects patients' evaluation of the quality of care they receive, compared with subjective standards (Crow et al., 2002). According to the literature, the main factors that influence the level of patient satisfaction are: patient characteristics and delivery features of the primary healthcare service provided. Patient characteristics are health status, expectations, socioeconomic and demographic characteristics. Delivery features are related to organization of care, patient-practitioner relationship, type and settings of services (e.g. primary care or hospital) (Crow et al., 2002).

In the literature, patient satisfaction is measured in a variety of dimensions (Fitzpatrick, 1991; Ware, Davies & Steward, 1977) that include: humaneness, informativeness, overall quality, bureaucracy, accessibility, availability of care, convenience, physical facilities, outcomes of care, continuity, cost and competency. Thiedke (2007) reported that demographic and socioeconomic factors impact patient satisfaction. Moreover, the effect of socio-demographic factors on the dimensions of patient satisfaction is not uniform (Ware, Davies & Steward, 1977). For example, younger patients tend to be less satisfied with the conduct of health care providers but more satisfied with access and outcomes of care (Ware, Davies & Steward, 1977).

Measuring patient satisfaction is not an easy task and can produce misleading results if psychometric characteristics of validity and reliability are not properly assessed (Keegan & McGee, 2003). Some of the negative assumptions about satisfaction surveys include: ill-considered answers, cognitive bias and uncovering general and extended dissatisfaction (Fitzpatrick, 1991). There is a wide scope of patient satisfaction questionnaires that differ in focus, size and details (Keegan & McGee, 2003).

In their study, Crow et al. (2002) identified that access, availability, information, and patient-physician communication were among the most important determinants of patient satisfaction. Long waiting times for appointments and restricted access to specialist care were among the causes of dissatisfaction. Patients who received health-promotion advice or preventive services were more satisfied than those who did not.

Research on patient satisfaction with primary healthcare services in the Arab world is scarce and more work is needed. Although literature on the satisfaction with primary healthcare services in the GCC is available; systematic reviews examining patient satisfaction with primary health care centers across the GCC are yet to be conducted. This chapter reviews literature related to patients' satisfaction with PHC centers across the Gulf Cooperation Council (GCC) countries. The work will provide policy makers, primary healthcare centers' administrators, and physicians with perspectives on patient satisfaction within the GCC region.

Studies from Saudi Arabia

Saeed et al. (1992) evaluated the level of satisfaction of attendees of Olaisha PHC center in Riyadh city. Non-citizens, patients with high education, and those who live nearby the PHC center were significantly more likely to utilize the PHC services than their counterparts. Suggestions to improve services were mostly related to laboratory services; enhancing the laboratory services (15%) by expanding scope of tests and extending the collection period of specimens. More than one-quarter of participants (28%) suggested improving parking space. This study was not comprehensive in its assessment of the PHC center, furthermore, this study had included participants as young as 12 years, who might have been influenced by their parents' perception of services.

In their study in Riyadh about PHC services, Mansour and Al-Osimy (1993) identified that patients' were most satisfied with humaneness and effectiveness of care while least satisfied with thoroughness and continuity of care. The study suggested that the structure of the facilities, levels of utilization and health education given by nurses are among areas to be considered for improvement of satisfaction. Two more articles reported the same results of this study, but they were expressed briefly as a part of the evaluation of the PHC system in Saudi Arabia (Al-Osimy, 1994).

Ali and Mahmoud (1993) have identified that the causes of dissatisfaction included: accessibility issues, waiting time and working hours. Still, the majority of participants (74.6% of satisfied and 61% of dissatisfied) reported that PHC centers were their first choice when they felt sick.

Al-Faris et al. (1996) had assessed patients' satisfaction with the services and staff of six PHC centers in Riyadh City. Overview-based satisfaction was not associated with gender or education level. The causes of dissatisfaction were diverse, including: over-crowded dental clinics, insufficient number of physicians and medications supply, receptionist services, difficulties in scheduling, appointments and waiting time. Doctors and nursing staff were criticized in some aspects relating to their communication skills. Participants also rated attributes of ideal physician according to their view.

Al-Qatari and Haran (1999) interviewed heads of households served by PHC centers in Qateef, Eastern Province of Saudi. Attitude, perceived outcomes and activities scored the highest satisfaction rate, while structure and confidentiality measures scored the lowest. A negative association was found between literacy and satisfaction. Females were more satisfied than males and age showed no association with any of the dimensions of satisfaction.

Makhdoom et al. (1997) assessed satisfaction in the Eastern province of Saudi Arabia in relation to seven aspects of PHC services including: humanness, informativeness, continuity of care and effectiveness of services. The majority of the participants were females and young patients. Satisfaction was high for humanness, accessibility, and effectiveness of services; but low for continuity, informativeness, and comprehensiveness of services. The young and the less literate patients showed a high overall satisfaction score. Regarding aspects of health services; a positive relationship was shown between satisfaction and female gender, old age, being married or having low income. Saudi citizens showed lower overall satisfaction score and were less satisfied with the aspects of care.

Occupation is another important socio-demographic variable affecting satisfaction. Employed participants were significantly more satisfied than the unemployed; and students were the most dissatisfied. Dental services showed high satisfaction levels (3.44 on a 5-point Likert scale). Low satisfaction scores were shown in relation to communication skills, laboratory services and some pharmacy services (Al-Doghaither & Saeed, 2000).

Alsharif and Al-Khaldi (2003) assessed tourists' satisfaction with services of PHC centers in Abha, south west of Saudi Arabia. They targeted the following domains: accessibility, staff attitude, availability of medications, consultation process and waiting time. Most of the study participants were males, married and approximately one-third of them were highly educated. 89% of the participants were satisfied with working hours, 87% with accessibility, 80% with consultation process and 77.2% with nursing care. Participants' suggestions to improve PHC center services included: demand for female physicians, more health-education materials, prescription drugs and extended working hours.

Alahmadi (2004) surveyed levels of satisfaction in five cities representing the five geographical regions in Saudi Arabia using a translated copy of Patient Satisfaction Questionnaire (PSQ). Mean satisfaction score was 3.9 out of 5. Females, older participants, those with low education or income and non-Saudis were significantly more satisfied than others. Participants from Riyadh showed the highest satisfaction scores while Dammam participants had the lowest scores. The above-mentioned socio-demographic variables were found to be predictors of satisfaction by a regression model.

Mahfouz et al. (2004) studied satisfaction among geriatric patients in Aseer region, south west of Saudi Arabia. The covered aspects of PHC evaluation in this study were: accessibility, continuity, thoroughness, humaneness and informativeness. The majority of participants (93%) was illiterate and had high overview-based satisfaction (79%). The main 3 reasons for dissatisfaction were: insufficient audiovisual means for health education (65.1%), long waiting time (46.4%) and insufficient specialty clinics (42.5%). Dentists and laboratory workers scored the lowest rates of satisfaction. Demographic factors did affect satisfaction in the investigated aspects.

Abdalla et al. (2005) found that patients were moderately satisfied in the 4 PHC centers evaluated in Hail, Saudi Arabia. The study showed negative significant association between physical distance to PHC center and patient satisfaction. Lowest satisfaction scores were for dental clinic, receptionists, laboratory and radiology services. Among the physicians' services; communication skills were the sole aspect that showed low satisfaction level. Participants with lower income or older age were significantly more satisfied, whereas gender, education and marital status were not related to satisfaction.

Al-Sakkak et al. (2008) used the General Practice Assessment Survey (GPAS) to assess 5 aspects of PHC centers. Enablement scored the highest level of satisfaction (70.6%) and the lowest level was for continuity of care (56.3%). Patient's average annual visit-frequency to PHC centers was inversely related to their satisfaction ($p=0.015$). No significant relationships reported between patients' satisfaction and their gender, occupation, marital status or average monthly income. Older participants and those with elementary or intermediate school education were most satisfied with services.

Salem (2010) investigated satisfaction of patients' in urban and rural PHC centers in Qassim region, Saudi Arabia. The World Health Organization (WHO) model sheet was used for assessing six dimensions of care (WHO, 2001). Elderly patients (60 years or more) in both setting were more satisfied as well as those who were illiterate. Satisfaction was significantly higher in urban centers in regard to: accessibility, technical competence of doctors and their thoroughness. On the other hand, patients in rural centres were more satisfied with courtesy of medical staff. Availability of prescribed drugs and patient education scored lowest in both settings.

Studies from other Gulf Countries

In Qatar, Abdal Kareem et al. (1996) conducted a study on patients' satisfaction in the country. They examined seven domains related to patient care and found that patients with lower income were significantly more satisfied with the quality of care. Younger patients were significantly more satisfied with the facilities physical environment of the PHC centers.

In 1998, Al-Doghaither et al. (2001) assessed the effect of socio-demographic variables on patients' satisfaction in Kuwait. General satisfaction with PHC centers' physicians, pharmacy, laboratory, radiology and dental services was studied. The overview-based satisfaction mean was moderate. Highest elements of satisfaction were for: availability of medicines and laboratory services, material, waiting time for x-rays and adequacy of dentists. Females, singles, elderly, unemployed, low income participants and people with low education reported higher levels of satisfaction.

Al-Eisa et al. (2005) identified that males were significantly more satisfied with the health services than females. Participants older than 50 years had higher satisfaction rates than younger participants ($p < 0.001$). Literacy played a key role where those that were not literate (haven't been to school) had a significantly higher satisfaction with all services of PHC centers. Occupation, marital status and nationality did not affect the overall satisfaction of patients. The physical environment of the facilities scored the lowest rates of satisfaction.

In Bahrain, Al-Shetti and Al-Sayyad (2006) found that gender had no association with satisfaction, while age was related inversely to satisfaction. Participants aged 20-39 years showed the least satisfaction level ($p=0.008$). Forty-nine percent of the participants were satisfied with PHC center services and 9.5% were not satisfied while the rest were borderline satisfied. Short consultation time, long waiting times and inadequate drug supply in pharmacy were the most common reasons for dissatisfaction. Physicians' examination, skills or communication were causes of dissatisfaction for 29-34.5% of patients.

In Kuwait, Bu-Alayyan et al. (2008) focused on particular services of the selected PHC centers including: accessibility, reception services, continuity of care, nursing services and physicians' communication skills. Majority of participants were 16-40 years old (65.9%) and females (52.7%). Overview-based satisfaction rate was relatively moderate (60.7%). It was highest among geriatric patients (67%) and those with university education or higher (66%). While most respondents were satisfied with reception services (58.7%), only (31%) were satisfied with nursing services.

Satisfaction with interpersonal and technical dimensions, accessibility, convenience, availability and overall satisfaction were evaluated in a study in Kuwait. Participants were relatively satisfied with the competency of physicians and their attitude (64.6% and 58% respectively), and the majority (89.1%) demanded specialty clinics. The accessibility issues of working hours and waiting time were among the causes of dissatisfaction (68.8% and 59.2% respectively). A negative association was found between satisfaction with PHC centers services and overall health status. It is, however, important to point out that the reported limitations of the study were that the questionnaire used in the local environment was not validated prior to conducting the study and there was reluctance of some patients to participate in the study (Alhashem, Alquraini & Chowdhury, 2011).

Albalushi et al. (2012) assessed patients' satisfaction in Oman using the Arabic version of Client Satisfaction Questionnaire (CS-42). Mean satisfaction scores (on 5-point Likert scale) were: humanness of staff (4.56), effectiveness of services (4.08), continuity (3.13) and accessibility to services (3.13). Comprehensiveness of care and health education availability showed the lowest mean satisfaction. Differences in between males and females in all aspects were not significant. One-third of participants visited PHC centers for preventive care services while the rest were seeking treatment services.

DISCUSSION

The mentioned studies varied in defining the terms of overview-based satisfaction and overall satisfaction, or had used them interchangeably. The summary measure of the overview satisfaction was more often reported than the detailed overall satisfaction. The overview-based satisfaction, which is based on a one-question general view of the services, was the indicator used in most studies. Literature shows that asking patients directly about their satisfaction with healthcare, or aspects of it usually results in high ratings of satisfaction (Crow et al., 2002). An indirect method to gauge satisfaction was suggested by asking patients to rate their experiences in different aspects of care; satisfaction then can be implied, to some extent, from answers (Crow et al., 2002).

We found that age, educational level and nationality had significant associations with satisfaction. Older patients were more satisfied than younger ones (Al-Faris, Khoja, FALOUDA & Saeed, 1996; Makhdoom, Elzuabair & Hanif, 1997; Al-Doghaither et al., 2001; Abdalla, Saeed, Magzoub & Reerink, 2005; Al-Eisa, Al-Mutar, Radwan, Al-Terkit & Al-Eisa, 2005; Bu-Alayyan et al., 2008; Al-Sakkak et al., 2008), this is consistent with other studies (Crow et al., 2002). This could be true for older cohort who would naturally get more respect from health care providers, or they might have lower expectations due to past experiences with healthcare systems (Crow et al., 2002). Also, elderly people are more frequent consumers of healthcare services, which might give them more chances to be influenced positively by the services provided (36).

Less educated patients (Abdal Kareem, Aday & Walker, 1996; Al-Qatari & Haran, 1999; Makhdoom, Elzubair, Hanif, 1997; Al-Doghaither et al., 2001; Al-Eisa et al., 2005, Al-Sakkak et al., 2008) were more satisfied than those with higher educational levels. Similar observations were noticed in a study conducted by Singh et al. (1999). GCC Citizens were generally less satisfied than non-citizens (Abdal Kareem et al., 1996; Al-Faris et al., 1996; Makhdoom, Elzubair, Hanif, 1997, Emadi et al., 2009) possibly due to higher expectations of citizens. Efforts to identify sources of dissatisfaction of citizens should be investigated in-depth, as they are the majority of patients served by PHC centers in their respective communities.

Most studies reported that gender (Mansour & Al-Osimy, 1993; Al-Faris et al., 1996; Mahfouz et al., 2004; Abdalla et al., 2005; Al-Sakkak et al., 2008; Emadi et al. 2009; Albalushi, Sohrabi & Kolahi, 2012) and marital status (Abdalla et al., 2005; Al-Eisa et al., 2005; Al-Sakkak et al., 2008; Emadi et al., 2008) were not significantly related to patients' satisfaction. Still, some authors reported higher satisfaction among females (Al-Qatari & Haran, 1999; Makhdoom, Elzubair & Hanif, 1997; Al-Doghaither et al., 2001) or males (Al-Eisa et al., 2005). This goes with many studies that either gave inconsistent results (Thiedke, 2007) or no association of gender to satisfaction (Crow et al., 2002).

Accessibility includes all the factors involved until medical care is received (Ware, Davies & Stewart, 1977). Working hours and waiting time were most commonly evaluated and are among the causes of dissatisfaction in many studies (Ali & Mahmoud, 1993; Al-Faris et al., 1996; Al-Qatari & Haran, 1999; Mahfouz et al., 2004; Bu-Alayyan et al., 2008; Alhashem, Alquraini & Chowdhury, 2011). Shortage of staff and/or facilities was suggested as possible reason for both (Mahfouz et al., 2004). International studies reported similar findings where accessibility issues provoked patients' dissatisfaction with primary care services (Hopton, Howie & Porter, 1993; Steven & Douglas 1988; Patro et al., 2008; Van Uden et al., 2005; Arain, Nicholl & Campbell, 2013).

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Provider workload was associated negatively with patients' perceived quality of care (Mohr, Benzer & Young, 2013). WHO recommends that it is important to address accessibility issues by properly balancing the ratio between populations expected to attend the health care facility and the number of health care staff (WHO, 1978). Recommendations to improve accessibility included increasing clinic capacity, empowering staff to handle more responsibilities and to upgrade appointment systems in the PHC centers (Al-Faris et al., 1996; Bu-Alayyan et al., 2008). Advances in technology and increasing numbers of staff recruited from local populations were possibly behind the differences in satisfaction with accessibility in later studies, after the year 2000.

Informativeness was behind dissatisfaction in several studies (Mansour & Al-Osimy, 1996; Al-Qatari & Haran, 1999; Makhdoom, Elzubair, Hanif, 1997; Al-Doghaither et al., 2001; Mahfouz et al., 2004; Al-Qatari & Haran, 2008; Emadi et al., 2009; Albalushi et al., 2012). Insufficient health education services and mediums were among the concerns expressed by patients. Literature shows that providing health information was associated positively with patients' satisfaction (Schauffler, Rodriguez & Milstein, 1996; Tung & Change, 2009). It is noteworthy that dissatisfaction with informativeness was mostly found in earlier studies, when health care facilities or personnel were viewed as the sole source of health-related information. Current health resources readily available to patients (i.e. internet) would empower patients and raise their expectations from healthcare systems.

Dissatisfaction with thoroughness was also noted in older studies, and absence or insufficient specialty clinics and staff members were expressed concerns. These concerns do affect continuity of care, which is a major determinant of effectiveness (Van Lerberghe, 2008). Moreover, decreased hospitalization rate was associated with continuity of care (Mainous & Gill, 1998). While providing specialty clinics might be out of the PHC scope; the increased life expectancy and increased prevalence of chronic diseases in populations should influence the expanding of PHCCs services to involve certain specialty clinics (Mahfouz et al., 2004; Van Lerberghe, 2008). Communication skills of physicians and nursing staff were criticized in some studies (Ali, 1992; Al-Faris et al., 1996; Saeed et al., 2001; Shetti & Sayyad, 2006; Alhashem, Alquraini & Chowdhury, 2011). These findings are important because satisfaction levels are influenced by functional quality of service provider rather than technical quality (Alrashdi, 2012). Higher rates of satisfaction were evident when patients perceived their physicians to be empathetic during consultations (Harrison, 1996). Al-Dogaither et al. suggested incorporating communication skills and psychological training for physicians following their undergraduate studies to sensitize them to patients' needs and satisfaction (Al-Dogaither et al., 2001).

Limitations of this review include the restricted inclusion of studies that investigated the correlation between satisfaction and socioeconomic and demographic characteristics only. Other individual factors that might affect satisfaction were beyond the scope of this review. Furthermore, the variability in the assessment methods and dimensions of care assessed between studies limited the comparison of satisfaction levels and factors causing dissatisfaction. Therefore, it is advised for future studies to follow a similar and thorough pattern of assessment, including all the main aspects of care. Level of agreement between studies was not strong and the long time span between studies (1987-2012) decreased comparability of results. In light of the studies included, it was found that age, educational level and nationality had a significant role in determining level of satisfaction with the services of PHCCs in the GCC countries. Level of overview satisfaction ranged from 60% to 99%. Most common dimensions of PHC services to cause dissatisfaction were: accessibility, thoroughness, informativeness, availability of drugs and continuity of care. Dental, laboratory and reception services had the highest rates of dissatisfaction compared to other services.

Generally, the reviewed studies showed a degree of heterogeneity in terms of patients included, aspects of care investigated and satisfaction results. In addition, the definition of the satisfaction measure (over-view or overall) was misused in some studies. The uneven distribution of studies from the Gulf countries and absence of studies from UAE; hinders the generalization of results to a scale larger than a single country at a time. Studies that used self-administered questionnaires might have a degree of selection bias, where illiterate patients were excluded from participation by the design of data collection tool.

CONCLUSION

Given the vast resources, healthcare in the GCC countries is developing rapidly. Health systems generally and PHC centers in particular deserve more work to be conducted as to understand to what degree are PHC systems capable of satisfying patients in their respective communities.

The crucial role of PHC in promoting health, preventing diseases and providing timely health care; makes it essential for countries to ensure quality of the services in PHCCs. Studies about patients' satisfaction have to be done on regular basis to guide decision making to the particular needs of communities. The role of PHC as a gatekeeper for secondary and tertiary care facilities would be enhanced if patients' perceive PHC services to be accessible, effective and satisfactory. Yet, High satisfaction rates should not be literally interpreted in isolation of all other factors that might affect satisfaction (Alrashdi, 2012). Future work should provide more studies on patient satisfaction with PHC centers in the Gulf countries, especially countries such as the UAE, which is in need of developing more patient satisfaction studies.

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KEY TERMS AND DEFINITIONS

Accessibility of Healthcare Services: Is the individual's perception of whether or not they can get the health care services they want in terms of utilization, eligibility and the probability of getting the needed services.

Developing Nations: Nations with an underdeveloped industrial base, and low Human Development Index (HDI) relative to other countries.

Gulf Cooperation Council (GCC): Is a political and economic alliance of six Middle Eastern countries; Saudi Arabia, Kuwait, the United Arab Emirates, Qatar, Bahrain, and Oman. The GCC was established in Riyadh, Saudi Arabia, in May 1981.

Healthcare Services: Healthcare services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services.

Patient Satisfaction: Is an important and commonly used indicator for measuring the quality in health care. Patient satisfaction affects clinical outcomes, patient retention, and medical malpractice claims.

Primary Health Care (PHC): The essential health care services that consist of health care activities that interface between the community and the healthcare system.