

Responsiveness of the Private Health Sector: Views of Insured Versus Uninsured Patients

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Abstract. The Saudi health system is going through a transitional phase, which requires careful consideration of the available alternative strategies. System responsiveness is one of the means to assess the performance of the healthcare system as a whole or on the level of subfields. The purpose of the current study was to measure the responsiveness of the private sector in the Saudi health system through seven dimensions; prompt attention, dignity, communication, autonomy, confidentiality, choice, and quality of amenities. The objectives were to measure, within the health insurance status context, private health sector's users' experience and their perceived importance of seven responsiveness dimensions. The study instrument was designed based on the 2002 World Health Survey; Health System Responsiveness. Six hundred and one patients participated of whom 76% were insured and mostly working in the private sector. Both experience and perceived importance of the seven responsiveness dimensions of private healthcare sector's users were of a moderate level with no significant difference between insured and uninsured individuals. The study concluded that careful training of health professionals on the non-therapeutic aspects of healthcare was needed within the private sector to prepare professionals to handle the responsibilities of delivering and financing healthcare. A survey at the population level is required to validate the current findings; including a thorough implementation analysis on health insurance.

1- Introduction

Globally, tremendous efforts have been made to assess the performance of healthcare systems aiming to improve human health and quality of life (Fillipo, 2003; Murray & Frenk, 2000; World Health Organization, 2000). Developed health systems have worked on the issue from different angles while less developed systems are still focusing on healthcare delivery to assess the performance with little attention given to the patients' experience with health services, which is a major determinant of health outcomes (Ali, Nikoloski, & Reka, 2015). Individuals may have experience with healthcare in several forms of interaction within health systems: inpatient care, ambulatory care, other than delivery of personal care such as insurance claims, or a combination of the three forms of interaction (Fillipo, 2003).

Health related activities have two aspects: therapeutic and non-therapeutic aspects that affect the experience of the receipt of healthcare. The non-therapeutic aspects of health related activities were introduced, in 2000, by the World Health

Organization (WHO) as the responsiveness of health systems (Fillipo, 2003). Within responsiveness, patient experience represented by the interpersonal relation between the practitioner and the patient was broadened to cover the interaction between the health system and the population it serves (Houweling, Kunst, & Mackenbach, 2001). Responsiveness is defined as aspects related to the way in which individuals are treated and the environment in which they are treated (Fillipo, 2003), it focuses on 'actual' experiences with less dependency than the satisfaction measurements on needs and expectations (Busse, Valentine, Lessof, & Prasad, n.d.; Fillipo, 2003). Eight dimensions were identified by WHO that most comprehensively captured responsiveness (Fillipo, 2003; World Health Organization, 2005): prompt attention, dignity, communication, autonomy, confidentiality, choice, quality of amenities, and access to social support.

In literature, the WHO responsiveness concept has been applied to compare health systems (Grol et al., 2000; Robone, Rice, & Smith, 2011; Saltman,

Busse, & Figueras, 2004; Sirven, Santos-Eggimann, & Spagnoli, 2012), or to assess subfields among health systems (Bramesfeld, Wedegärtner, Elgeti, & Bisson, 2007; Liabsuetrakul, Petmanee, Sanguanchua, & Oumudee, 2012; Mohammed, Bermejo, Souares, Sauerborn, & Dong, 2013; Röttger et al., 2015; Röttger, Blümel, Fuchs, & Busse, 2014); either application has contributed valuable information indicating the suitability of the responsiveness domains in measuring patient experience with healthcare systems. Similar to other healthcare systems in developed and underdeveloped countries, the healthcare system in Saudi Arabia is facing growing challenges and much effort has been carried out to deal with the obstacles and to improve the system (Almasabi, 2013). Measuring responsiveness of this system will give insight into its performance from the actual experience of its direct users, the patients, to enhance improvement efforts. Despite the Saudi health system being a comprehensive one that covers all citizens (Almasabi, 2013), a recent study (Alrashed, 2017) has found that access to healthcare was not as convenient as expected, which requires attention since the level of accessibility to a health system is a direct indicator of its responsiveness- the prompt attention dimension. Communication and dignity as dimensions of responsiveness should also be of concern due to shortages of Saudi health professionals (Almalki, Fitzgerald, & Clark, 2011; Almasabi, 2013). Around 57 percent of health professionals in the Saudi health system are non-Saudis, 59% of these are in the private sector (Ministry of Health, Kingdom of Saudi Arabia, 2014); healthcare is provided by multinational health personnel which affects the communication process with service users and might contradict cultural norms of users during physical exams, for example. Additionally, health regulations dictate that female patients are to be represented by male guardians to give permission for major surgeries, which means less autonomy for female patients.

Health insurance was first introduced in Saudi Arabia in 2003, as the Cooperative Health Insurance scheme (Khaliq, 2012); with great resistance from society because of the perceived religious prohibitions against the concept of insurance, while interested parties believed that it would improve access to healthcare by: leading to more regulations and utilization review, lessening the financial burden of governmental health expenditures and creating new jobs in the healthcare sector (Alnaif, 2006; Mufti, 2002). Other analysts thought that it would reduce access to care and raise costs. The National

Health Service model in Saudi Arabia, which is similar to the UK-health system, is transforming into a free market US-style system, in which employment-based insurance will be the mechanism of financing with the majority of the services provided within the private sector (Khaliq, 2012). Cooperative Health Insurance was planned to be launched through two phases; the first phase started in 2006 (Khaliq, 2012) which required, in three stages, all employers in the private sector to purchase health insurance for their employees, Saudi and non-Saudi alike, as well as their dependents. The second phase required, dependent on the success of the first phase, extending the mandatory insurance coverage to all employees in the public sector (Alnaif, 2006).

Based on the Regulation of the Cooperative Health Insurance Law (2010), the following categories were dictated as subjects to mandatory health insurance: non-Saudi employees in the non-government sector, non-Saudi residents in the Kingdom who do not work in the public or the private sectors, and Saudi employees in the non-government sector (Cooperative Health Insurance Council, 2010). Implementing Cooperative Health Insurance was delayed by many challenges, and besides, the progress of the first phase has been slower than anticipated (Aldosari, Ibrahim, Manab, & Islam, 2014; Khaliq, 2012).

In light of the weakness symptoms in Saudi healthcare, an assessment from the position of the care recipient is intended and the target should be the private sector for two reasons: first, in the literature, evaluation of healthcare performance was mostly limited to the public sector in the Saudi health system (Khaliq, 2012). Second, mandatory health insurance was recently enacted within the private sector, as the first phase, and measuring its association with performance level is important to enlighten the implementation of the second phase in the public sector.

Although several studies have been conducted to measure the responsiveness of the healthcare system, some of these studies evaluated system responsiveness at a global level (Robone et al., 2011; Sirven et al., 2012); other studies evaluated system responsiveness at country level (Ali et al., 2015; Bramesfeld et al., 2007; Liabsuetrakul et al., 2012; Mohammed et al., 2013; Röttger et al., 2015, 2014); while few studies evaluated system responsiveness at the facility level (Bazzaz, Taghvae, Salehi, Bakhtiari, & Shaye, 2015; Yakob & Ncama, 2017). No similar study has been conducted to evaluate responsiveness of the system

at country or hospital level in either the public or the private sector in Saudi Arabia. The current study was conducted to investigate the differences between insured and uninsured participants' experiences, and their views about the importance of seven responsiveness' dimensions (prompt attention, dignity, communication, autonomy, confidentiality, choice, and quality of facilities), when receiving health services within the private sector in the Saudi health system.

2-Methodology

An inferential cross-sectional design was adapted to satisfy the purpose of the study. The private sector of the healthcare market was targeted to locate healthcare users; the inclusion criteria included patients with at least one year's active medical chart in a private hospital, who can read or understand Arabic, and who have been resident in Saudi Arabia for at least twelve months prior to the data collection period. Data was collected from five private hospitals in Riyadh, Saudi Arabia. According to the statistics of the Saudi Ministry of Health, there were 34 private hospitals in Riyadh city at the time of study; ten hospitals were accredited by Central Board for Accreditation of Healthcare Institutions CBAHI (Ministry of Health, Kingdom of Saudi Arabia, 2014). The researcher contacted all accredited hospitals with a request for participation in this study, out of which five hospitals accepted the request of including their patients in the study. For this study, the researcher used a convenient sampling approach, which was the most appropriate sampling procedure to recruit participants for this study. Since it was difficult to obtain a list of participants from hospitals, participants were approached at the outpatient department of hospitals with a requisition of participation. There were about 52000 outpatient visits (General Authority for Statistics, Saudi Arabia, 2017). Accordingly, the researcher calculated the average number of visits to be roughly 1500 outpatient visits per private hospital; and calculated the sample size to be 352 ("Sample Size Calculator by Raosoft, Inc.," n.d.). 650 questionnaires were distributed between April 26 and May 26 2017, 601 patients accepted the invitation and participated in the study by completing the questionnaire form; hence the response rate for the study was 92%. A consent statement was attached to the questionnaire, stating that participation was voluntary, they could withdraw at any time, their confidentiality would be maintained through data collection and analysis, and their data would be used for research purposes only.

The study instrument was a self-administered questionnaire generated from the 2002 World Health Survey; B-Individual Questionnaire: "section 7. Health System Responsiveness" (World Health Organization, 2002). It included three parts: the first part was to describe the participants' demography, health insurance status and the use of healthcare services. The second part was to measure the responsiveness of healthcare institutions through seven dimensions adapted from the 2000-2001 World Health Organization Multi-country Survey Study on Health and Health System's Responsiveness (MCSS) (World Health Organization, 2000, 2005). The responsiveness dimensions represent the non-therapeutic aspects of health related activities that are expected to affect the patients' experience of healthcare; they included two items; prompt attention (convenient travel and short waiting times), three items; dignity (respectful treatment and communication), three items; communication (clarity of communication), two items; autonomy (involvement in decision making; respect for the right to make informed choices), two items; confidentiality (confidentiality of personal information), two items; choice (choice of healthcare provider), and two items; quality of amenities (quality of basic amenities, surroundings). The eighth dimension of responsiveness, access to social support, was eliminated because the study focused on the outpatient experience.

The third part of the questionnaire was dedicated to rate the importance of the seven dimensions perceived by the users of healthcare with two items utilized to rate each dimension. Five-level likert scales were used to measure both the participants' experience and the importance of the responsiveness dimensions; scales were coded from one (very high) to five (very low). The 16 items selected to measure the experience and the 14 items selected to rate the importance of the responsiveness dimensions were translated into the Arabic language and reviewed by a professional for translation accuracy. The content validity of the instrument was reviewed by three academicians. Finally, the instrument's reliability was measured by conducting a pilot study with 26 participants; Cronbach's Alpha = 88%. The detailed recorded reliability for each of the study's seven dimensions, *prompt attention, dignity, communication, autonomy, confidentiality, choice, and quality of amenities* were as follows: 60%, 77%, 65%, 53%, 74%, 69%, and 83%, respectively.

The Statistical Package for the Social Sciences (IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.), was used to analyze the

collected data. Descriptive statistics were used to describe study participants and their utilization of healthcare. Pearson's chi-square test was conducted to test for the association between health insurance status and socio-demographic correlates. Additionally, Mann-Whitney U test was performed to compare insured and uninsured participants' experiences with the care provided, and their views about the importance of seven responsiveness dimensions within the private health sector. The significance level was set at ≤ 0.05 .

3- Results

Table 1 describes the study participants; their demography correlates were tested in relation to their health insurance status. Three quarters of the participants were insured and mostly working in the private sector. Among the uninsured participants, the number of Saudis was significantly higher than the non-Saudis ($p=.018$). The participants also differed significantly based on their education level ($p=.001$); the less educated individuals were more likely to not have health insurance. Employment status was another factor associated with insurance status ($p<001$); almost half of the government employed individuals were uninsured while only 15% of the private sector employed individuals did not have health insurance and less than one quarter of the self employed and the unemployed did not have health insurance. Out of the 218 insured parents (79% of the participating parents), 71% have their children covered by their health insurance plan.

Testing demography in relation to hospital visits indicated that female patients tended to have less

visits than male patients ($p=.017$), younger users had less visits ($p<001$), having a chronic health condition was associated with more hospital visits ($p<001$), Saudi users tended to visit hospitals more than non-Saudi ($p=.001$), married individuals were the least likely to visit a hospital, while divorced or widowed individuals were the most ($p<.001$), although parents were more likely to visit hospitals than non-parents ($p<.001$).

Table 2 shows participants' (total, insured, and uninsured) experience with healthcare services provided within the private health sector. Regarding all participants' experience, the highest score's mean was 3.22 (SD=1.3) for the communication dimension, the middle score's mean was 3.14 (SD=1.4) for the dignity dimension, and the lowest score's mean was 3.07 (SD=1.25) for the choice dimension. Looking at insured participants' experience, the highest score's mean was 3.21 (SD=1.45) for the confidentiality dimension, the middle score's mean was 3.16 (SD=1.44) for the dignity dimension, and the lowest score's mean was 3.07 (SD=1.24) for the prompt attention dimension. Concerning uninsured participants' experience, the highest score's mean was 3.28 (SD=1.23) for the communication dimension, the middle score's mean was 3.11 (SD=1.18) for the autonomy dimension, and the lowest score's mean was 2.99 (SD=1.19) for the choice attention dimension. Additionally, results showed that there were no significant differences between insured and uninsured participants in relation to their experience with the services provided within the private sector.

Table (1) Study participants' socio-demographic characteristics stratified by health insurance status

	Total N=601		Insured* n=457 (76.0%)		Uninsured n=144 (24.0%)		P- value**
Gender							.213
Male	188	31.3%	149	79.3%	39	20.7%	
Female	413	68.7%	308	74.6%	105	25.4%	
Age							.173
< 25	165	27.5%	130	78.8%	35	21.2%	
26-34	255	42.4%	196	76.9%	59	23.1%	
35-44	79	13.1%	60	75.9%	19	24.1%	
45-54	72	12.0%	46	63.9%	26	36.1%	
55-64	21	3.5%	17	81.0%	4	19.0%	
64 >	9	1.5%	8	88.9%	1	11.1%	
Nationality							.018
Saudi	266	44.3%	190	71.4%	76	28.6%	
Non-Saudi	335	55.7%	267	79.7%	68	20.3%	
Marital Status							.867
Single	296	49.3%	223	75.3%	73	24.7%	
Married	255	42.4%	194	76.1%	61	23.9%	
Divorced/Separated	38	6.3%	31	81.6%	7	18.4%	

	Total N=601		Insured* n=457 (76.0%)		Uninsured n=144 (24.0%)		P- value**
Widowed	12	2.0%	9	75.0%	3	25.0%	
Having children***							.119
Yes	276	45.9%	218	79.0%	58	21.0%	
No	325	54.1%	239	73.5%	86	26.5%	
Have chronic condition?							.381
Yes	124	20.6%	98	79.0%	26	21.0%	
No	477	79.4%	359	75.3%	118	24.7%	
Hospital visits							.308
Many	55	9.2%	46	83.6%	9	16.4%	
Moderate	256	42.6%	196	76.6%	60	23.4%	
Few	290	48.3%	215	74.1%	75	25.9%	
Education							.001
Have no schooling	43	7.2%	28	65.1%	15	34.9%	
High school or less	120	20.0%	80	66.7%	40	33.3%	
Diploma	190	31.6%	151	79.5%	39	20.5%	
Bachelor degree	216	35.9%	167	77.3%	49	22.7%	
Higher education degree	32	5.3%	31	96.9%	1	3.1%	
Employment							.000
Government employee	125	20.8%	65	52.0%	60	48.0%	
Private employee	323	53.7%	274	84.8%	49	15.2%	
Self-employed	37	6.2%	29	78.4%	8	21.6%	
Non-employed	116	19.3%	89	76.7%	27	23.3%	
Monthly income							0.248
Less than 3000	100	16.6%	73	37.0%	27	27.0%	
3000-5999	150	25.0%	114	76.0%	36	24.0%	
6000-8999	107	17.8%	80	74.8%	27	25.2%	
9000-12000	175	29.1%	130	74.3%	45	25.7%	
More than 12000	69	11.5%	60	87.0%	9	13.0%	

* Health insurance classes percentages: A (45.3%), B (41.4%), C (11.4%), and Don't know (1.9 %).

** Chi square tests

*** Children covered by insurance was 154 (70.6%)

Table (2) Experience with health care services provided within the private health sector: insured versus uninsured participants

Dimensions of experience with Healthcare services	Total N=601		Insured n=457 (76.0%)		Uninsured n=144 (24.0%)		U**	P-value
	Mean*	SD	Mean*	SD	Mean*	SD		
Prompt attention	3.09	1.21	3.07	1.24	3.13	1.10	31262.50	0.68
Dignity	3.14	1.40	3.16	1.44	3.08	1.29	31977.50	0.61
Communication	3.22	1.30	3.20	1.32	3.28	1.23	32181.00	0.69
Autonomy	3.17	1.32	3.18	1.36	3.11	1.18	31088.50	0.32
Confidentiality	3.20	1.43	3.21	1.45	3.16	1.36	32191.00	0.69
Choice	3.07	1.25	3.09	1.27	2.99	1.19	31257.00	0.36
Quality of amenities	3.07	1.29	3.08	1.32	3.03	1.19	32127.00	0.67
Overall Experience	3.14	1.24	3.15	1.27	3.12	1.13	32022.50	0.63

* Items scored from 1 (very low) to 5 (very high)

**Mann-Whitney U test (p<0.05)

Table 3 shows participants' (total, insured, and uninsured) views about the importance of the seven

responsiveness dimensions in relation to the healthcare services provided within the private health sector. Regarding all participants' views about the importance of the responsiveness dimensions, the highest score's mean was 3.20 (SD=1.36) for the autonomy dimension, the middle score's mean was 3.15 (SD=1.41) for the communication dimension, and the lowest score's mean was 3.09 (SD=1.38) for the prompt attention dimension. Looking at insured participants' views about the importance of responsiveness dimensions, the highest score's mean was 3.21 (SD=1.35) for the autonomy dimension, the middle score's mean was 3.16 (SD=1.49) for the confidentiality dimension, and the lowest score's

mean was 3.07 (SD=1.38) for the prompt attention dimension. Concerning uninsured participants' views about the importance of responsiveness dimensions, the highest score's mean was 3.23 (SD=1.46) for the dignity dimension, the middle score's mean was 3.13 (SD=1.47) for the quality of amenities dimension, and the lowest score's mean was 3.07 (SD=1.39) for the communication dimension. Additionally, results showed that there were no significant differences, between insured and uninsured participants' views, about the importance of the seven responsiveness dimensions in relation to healthcare services provided within the private health sector.

Table (3) Importance of seven responsiveness' dimensions within the private health sector: insured versus uninsured participants' views

Dimensions of experience with Healthcare services	Total N=601		Insured n=457 (76.0%)		Uninsured n=144 (24.0%)		U**	P-value
	Mean*	SD	Mean*	SD	Mean*	SD		
Prompt attention	3.09	1.38	3.07	1.38	3.14	1.38	31920.50	0.58
Dignity	3.18	1.45	3.17	1.46	3.23	1.46	32178.50	0.69
Communication	3.15	1.41	3.18	1.42	3.07	1.39	31101.00	0.32
Autonomy	3.20	1.36	3.21	1.35	3.15	1.42	32303.00	0.74
Confidentiality	3.17	1.47	3.16	1.49	3.17	1.42	32840.50	0.97
Choice	3.13	1.39	3.13	1.37	3.12	1.45	32799.00	0.95
Quality of amenities	3.10	1.46	3.09	1.45	3.13	1.47	32206.50	0.70
Overall importance	3.15	1.32	3.15	1.32	3.14	1.32	32613.00	0.87

* Items scored from 1 (very low) to 5 (very high)

**Mann-Whitney U test ($p < 0.05$)

4-Discussion

This study was conducted with the intention of finding the difference between insured and uninsured participants' experiences with the care provided, and their views about the importance of seven responsiveness' dimensions within the private health sector.

The study showed that insured and uninsured participants had a similar experience when receiving healthcare within the private sector. Participants thought the level of their experience was a little above average; with their experience with communication at the best level and their experience with choice of healthcare provider at the lowest level, which is similar to the finding of a previous study (Yakob & Ncama, 2017). Additionally, these support one study's findings that suggested that the

recent transition in the Saudi health system has been headed to a free market system leading to better quality of care but with decreased access and increased cost (Khaliq, 2012), and uncorroborated with some previous studies suggesting health insurance application as a mean for improving the quality of healthcare (Almalki et al., 2011; Alnaif, 2006).

In general, private service provision is expected to increase patients' choice, whereas, through the current participants' experience, choice was reported as the least responsive dimension. This contradicts with the assumption of a previous study that expansion of non-public sector provision may serve to improve responsiveness (Robone et al., 2011).

Both insured and uninsured participants had similar views about the importance of seven responsiveness dimensions in relation to the healthcare services

provided within the private health sector. Participants considered that the level of importance of responsiveness dimensions, in relation to the healthcare services provided within the private health sector, was a little above average; with their views being that the autonomy dimension was the most important and the prompt attention dimension was the least important.

Responses relating to the seven dimensions of health system responsiveness indicated a weakness that was translated through the users' actual views. None of the responsiveness dimensions or even their measurement items scored more than a moderate level of experience, which contradicts a recent study conducted in a neighboring country, Qatar, that reported a high responsiveness rate (Ali et al., 2015). Another study comparing academic to non-academic hospitals found that the responsiveness score was the highest in the private hospitals (Bazzaz et al., 2015). Supporting previous findings (Almalki et al., 2011; Alnaif, 2006; Alrashed, 2017), the participating patients face delays and access problems, yet they reported prompt attention as the least important dimension in receiving healthcare while their priority was, in support of previous findings (Mohammed et al., 2013), the issue of good communications which was, although the best experience reported, of a moderate level. The composition of the multinational health providers in the Saudi health system (92.3% of health professionals in the private sector are non-Saudis) (Ministry of Health, Kingdom of Saudi Arabia, 2014) would be a major factor affecting the quality of communication. The same applied to patients dignity as the different background and cultures are expected to contradict with interpersonal relationships (Gabbott & Hogg, 2001; Institute of Medicine, 2003; Saha, Komaromy, Koepsell, & Bindman, 1999).

Knowing that autonomy and dignity were reported by the current participants as the first and the third most important dimensions, respectively, serious planning of health personnel should be a priority, with careful consideration of current recruitment and on-job training; a recommendation that has been proposed since 2008 (Jannadi, Alshammari, Khan, & Hussain, 2008).

Although the Regulation of the Cooperative Health Insurance Law, approved in 2014, dictated that all employees, Saudi and non-Saudi, in the non-government sector are subject to mandatory health insurance (Cooperative Health Insurance Council, 2010), 49 (15%) of the research participants from that category were uninsured; 17 (36%) were Saudi employees and 32 (65%) were non-Saudis.

Moreover, similarly low figures were reported in regard to the non-Saudis who do not work, being subject to mandatory health insurance (Cooperative Health Insurance Council, 2010), in that 12 (44%) of the unemployed participants who did not have health insurance were non-Saudis, indicating an employment-based insurance. Such implementation flaws in cooperative health insurance were justified earlier by Khaliq as attributed to weak infrastructure, rising insurance premiums, and insurance fraud (Khaliq, 2012).

In conclusion, the findings of this study suggest that having health insurance by no means will, as expected, positively affect the experience of the private health sector's users. Additionally, although weakness symptoms of the Saudi healthcare system are apparent, the experience of private healthcare sector users were lower than anticipated. In general, the non-therapeutic aspects of health-related activities were thought of as elements that distinguish the private sector from the public sector, where the latter, supposedly, were always associated with better non-therapeutic aspects.

Therefore, the health system is in a critical position, especially if the current findings were supported by a representative random sample at the population level. The adopted strategy to deal with challenges in healthcare has been to shift the role of providing and financing care to the private sector, but if the private sector continues at this level of performance on the non-therapeutic aspects then the quality of the healthcare services provided to the population is expected to encounter serious problems.

Careful training of health professionals on the non-therapeutic aspects of healthcare to increase the responsiveness of the private sector and healthcare in Saudi Arabia in general is crucial at this stage. Nonetheless, thorough analysis of the implementation of health insurance and the endorsement of its regulations are major determinants of its success.

Lack of the randomness of the sampling procedure and small sampling size might affect the generalizability of this study. Research should be conducted to investigate the associations between socio-demographic factors and responsiveness among the Saudi population.

References

- Aldosari, M., Ibrahim, Y., Manab, N. A., & Islam, R. (2014). Foreign Workers Satisfaction with Cooperative Health Insurance in Saudi Arabia, *8*(9), 101–108.
- Ali, F. M. H., Nikoloski, Z., & Reka, H. (2015). Satisfaction and responsiveness with health-care

- services in Qatar—evidence from a survey. *Health Policy*, 119(11), 1499–1505. <https://doi.org/10.1016/j.healthpol.2015.09.012>
- Almalki, M., Fitzgerald, G., & Clark, M. (2011). Health care system in Saudi Arabia: an overview. *Eastern Mediterranean Health Journal*, 17(10), 784–793. <https://doi.org/10.26719/2011.17.10.784>
- Almasabi, M. H. (2013). An overview of health system in Saudi Arabia. *Research Journal of Medical Sciences*, 7(3), 70–74.
- Alnaif, M. S. (2006). Physicians' perception of health insurance in Saudi Arabia. *Saudi Medical Journal*, 27(5), 693–699.
- Alrashed, A. M. (2017). Illustration of informal caregiving within Saudi society: demography, scope of care and enabling arrangements. *Scandinavian Journal of Caring Sciences*, 31(2), 263–272. <https://doi.org/10.1111/scs.12339>
- Bazzaz, M. M., Taghvae, M. R. E., Salehi, M., Bakhtiari, M., & Shaye, Z. A. (2015). Health System's Responsiveness of Inpatients: Hospitals of Iran. *Global Journal of Health Science*, 7(7), 106–113. <https://doi.org/10.5539/gjhs.v7n7p106>
- Bramesfeld, A., Wedegärtner, F., Elgeti, H., & Bisson, S. (2007). How does mental health care perform in respect to service users' expectations? Evaluating inpatient and outpatient care in Germany with the WHO responsiveness concept. *BMC Health Services Research*, 7(99), 1–12. <https://doi.org/10.1186/1472-6963-7-99>
- Busse, R., Valentine, N., Lessof, S., & Prasad, A. (n.d.). Chapter 8. Being responsive to citizens' expectations: The role of health services in responsiveness and satisfaction (p. 27).
- Cooperative Health Insurance Council. (2010). Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended). Retrieved August 5, 2018, from http://gulfmigration.eu/database/legal_module/Saudi%20Arabi/National%20Legal%20Framework/Rights%20and%20Obligations/3.2%20Implementing%20Regulations%20of%20CHIL_EN.pdf
- Fillipo, P. D. (2003). *Health Systems Performance Assessment: Debates, Methods and Empiricism*. World Health Organization.
- Gabbott, M., & Hogg, G. (2001). The Role of Non-verbal Communication in Service Encounters: A Conceptual Framework. *Journal of Marketing Management*, 17(1–2), 5–26. <https://doi.org/10.1362/0267257012571401>
- General Authority for Statistics, Saudi Arabia. (2017, April 18). Chapter 04 | Health [Text]. Retrieved July 16, 2018, from <https://www.stats.gov.sa/en/868>
- Grol, R., Wensing, M., Mainz, J., Jung, H. P., Ferreira, P., Hearnshaw, H., ... Szecsenyi, J. (2000). Patients in Europe evaluate general practice care: an international comparison. *The British Journal of General Practice*, 50(460), 882–887.
- Houweling, T. A., Kunst, A. E., & Mackenbach, J. P. (2001). World Health Report 2000: inequality index and socioeconomic inequalities in mortality. *The Lancet*, 357(9269), 1671–1672. [https://doi.org/10.1016/S0140-6736\(00\)04829-7](https://doi.org/10.1016/S0140-6736(00)04829-7)
- Institute of Medicine. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (with CD)*. Washington, D.C.: National Academies Press. <https://doi.org/10.17226/12875>
- Jannadi, B., Alshammari, H., Khan, A., & Hussain, R. (2008). Current Structure and Future Challenges for the Healthcare System in Saudi Arabia. *Asia Pacific Journal of Health Management*, 3(1), 43.
- Khaliq, A. (2012). The Saudi Healthcare System: A View from the Minaret. *World Health & Population*, 13(3), 52–64. <https://doi.org/10.12927/whp.2012.22875>
- Liabsuetrakul, T., Petmanee, P., Sanguanchua, S., & Oumudee, N. (2012). Health system responsiveness for delivery care in Southern Thailand. *International Journal for Quality in Health Care*, 24(2), 169–175. <https://doi.org/10.1093/intqhc/mzr085>
- Ministry of Health, Kingdom of Saudi Arabia. (2014). *Health Statistics Year Book: 2014*. Ministry of Health, Kingdom of Saudi Arabia.
- Mohammed, S., Bermejo, J. L., Souares, A., Sauerborn, R., & Dong, H. (2013). Assessing responsiveness of health care services within a health insurance scheme in Nigeria: users' perspectives. *BMC Health Services Research*, 13(502), 1–13. <https://doi.org/10.1186/1472-6963-13-502>
- Mufti, M. H. S. (2002). *Healthcare Development Strategies in the Kingdom of Saudi Arabia* (1st ed.). Boston: Kluwer Academic Publishers. <https://doi.org/10.1007/b112322>
- Murray, C. J. L., & Frenk, J. (2000). A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*, 78(6), 15.
- Robone, S., Rice, N., & Smith, P. C. (2011). Health Systems' Responsiveness and Its Characteristics: A Cross-Country Comparative Analysis. *Health*

- Services Research*, 46(6 Pt 2), 2079–2100.
<https://doi.org/10.1111/j.1475-6773.2011.01291.x>
- Röttger, J., Blümel, M., Engel, S., Grenz-Farenholtz, B., Fuchs, S., Linder, R., ... Busse, R. (2015). Exploring Health System Responsiveness in Ambulatory Care and Disease Management and its Relation to Other Dimensions of Health System Performance (RAC) – Study Design and Methodology. *International Journal of Health Policy and Management*, 4(7), 431–437.
<https://doi.org/10.15171/ijhpm.2015.97>
- Röttger, J., Blümel, M., Fuchs, S., & Busse, R. (2014). Assessing the responsiveness of chronic disease care - Is the World Health Organization's concept of health system responsiveness applicable? *Social Science & Medicine*, 113(2), 87–94.
<https://doi.org/10.1016/j.socscimed.2014.05.009>
- Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care. *Archives of Internal Medicine*, 159(9), 997–1004.
<https://doi.org/10.1001/archinte.159.9.997>
- Saltman, R. B., Busse, R., & Figueras, J. (Eds.). (2004). *Social health insurance systems in Western Europe* (1st ed.). Maidenhead: Open Univ. Press.
- Sample Size Calculator by Raosoft, Inc. (n.d.). Retrieved July 16, 2018, from <http://www.raosoft.com/samplesize.html>
- Sirven, N., Santos-Eggimann, B., & Spagnoli, J. (2012). Comparability of Health Care Responsiveness in Europe. *Social Indicators Research*, 105(2), 255–271.
- World Health Organization. (2000). *Health systems: improving performance* (p. 206). Geneva, Switzerland: World Health Organization.
- World Health Organization. (2002). WORLD HEALTH SURVEY 2002: B – Individual Questionnaire [World Health Organization, Evidence and Information for Policy]. Retrieved July 18, 2018, from <http://www.who.int/healthinfo/survey/whslongindividuala.pdf>
- World Health Organization. (2005). MCSS_Analytical_Guidelines.pdf. World Health Organization. Retrieved from http://www.who.int/responsiveness/papers/MCS_S_Analytical_Guidelines.pdf?ua=1
- Yakob, B., & Ncama, B. P. (2017). Measuring health system responsiveness at facility level in Ethiopia: performance, correlates and implications. *BMC Health Services Research*, 17(1). <https://doi.org/10.1186/s12913-017-2224-1>
- Yakob, B., & Ncama, B. P. (2017). Measuring health system responsiveness at facility level in Ethiopia: performance, correlates and implications. *BMC Health Services Research*, 17(1). <https://doi.org/10.1186/s12913-017-2224-1>

استجابة القطاع الصحي الخاص: آراء المرضى المؤمن عليهم مقابل غير المؤمن عليهم

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الكلمات المفتاحية: استجابة النظام الصحي، النظام الصحي السعودي، التأمين الصحي التعاوني، تجربة المرضى، القطاع الصحي الخاص.

ملخص البحث. يمر النظام الصحي السعودي بمرحلة انتقالية تتطلب دراسة متأنية للاستراتيجيات البديلة المتاحة. استجابة النظام هي واحدة من الوسائل المستخدمة لتقييم أداء نظام الرعاية الصحية ككل أو على مستوى الحقل الفرعية. الهدف من الدراسة الحالية هو قياس مدى استجابة القطاع الخاص في النظام الصحي السعودي باستخدام سبعة محاور: الاهتمام الفوري، والكرامة، والتواصل، والحكم الذاتي، والسرية، والاختيار، ونوعية وسائل الراحة. و لتحقيق هدف الدراسة فقد تم قياس تجربة المرضى من خلال الحالة التأمينية لهم بالإضافة الى تحديد أهمية محاور الاستجابة من وجهة نظرهم. وقد صممت أداة الدراسة استناداً إلى الدراسة الاستقصائية للصحة العالمية لعام ٢٠٠٢؛ "استجابة النظام الصحي". شارك في الدراسة ٦٠١ مريض؛ ٧٦٪ منهم مؤمنون ومعظمهم يعملون في القطاع الخاص. وكانت كل من التجربة والأهمية المتوقعة لأبعاد الاستجابة السبعة لمستخدمي قطاع الرعاية الصحية الخاص من المستوى المتوسط، مع عدم وجود فرق كبير بين المؤمن عليه وغير المؤمن عليهم. وخلصت الدراسة إلى أن التدريب الدقيق للمهنيين الصحيين على الجوانب غير العلاجية للرعاية الصحية في القطاع الخاص لإعدادهم للتعامل مع مسؤوليات تقديم وتمويل الرعاية الصحية أمر مهم. هناك حاجة لمسح على مستوى السكان للتحقق من صحة النتائج الحالية، وذلك من خلال القيام بتحليل شامل لعملية تطبيق التأمين الصحي.