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Performance Management Of Primary Health Care Centres (PHCCs) For Providing Comprehensive Health Care Service To The Elderly In Saudi Arabia

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Abstract:
Care for the elderly has always drawn the attention of policy makers in all countries and Saudi Arabia is not an exception in this regards. While there are budgetary allocations for the health care of the elderly, there is a need to understand whether the concerns of the Primary Health Care Centers are addressed. The elderly, which is established by some experts as "Risk Group" need special attention in the quality and dispensing method of health services provided to them. It is remarkable that this age group (the elderly) and other groups tend to receive health services in the advanced health facilities (specialized hospitals) or in the second row of health services (public hospitals). They rarely go to the services of the first row (primary health care centers), although in practice they do not need more than services of primary health care centers, which causes wasting of more health resources at the time the countries are suffering from high cost of health services. The present study is focusing on identifying the factors for providing comprehensive service to the elderly in PHCCs in the Assir region of the Kingdom of Saudi Arabia and to determine the most influencing factors for providing comprehensive service to the elderly at primary health care centres there. Hypotheses are also framed to cross check the importance of the factors identified. Data are collected from physicians and medical directors working in PHCCs in the Assir Region or KSA. Statistical tests like chronbach's alpha, KMO Bartletts test, Factor Analysis, Cross tabs and Chi-Square tests are conducted using SPSS 21.0 to identify the influencing factors and to test the hypotheses. Results are discussed and suggestions are given to the policy makers to improve the performance of the PHCCs in the Assir Region of KSA.

Key words*: Primary Health Care; Comprehensive Care; The Elderly Group*

1.Introduction

It is a well known fact that the structure of the population in the world has changed very drastically during this century. Perhaps the most important change has occurred in mortality rate, particularly among the elderly population. It is estimated that, currently, people live about 20 years longer-on average- than they did at the beginning of this century. This is due to the fact that advances in the field of medicine have achieved great improvements in the treatment of many diseases associated with old age. For this reason, a great deal of attention has been given to health care for the elderly in health care planning and delivery all over the world. For instance, elderly persons receive a large share of health services expenditures that do younger individuals in the USA.

The health care system should respond to social change in order to meet people's expectations as well as to set and implement efficient health care plans, both in terms of the types of services needed, their mode of delivery, and the staff required to deliver them.

Aging is a natural process that leads to a gradual deterioration of body functions. The elderly person is more susceptible to diseases such as bronchitis, heart disease, diabetes, tumours etc. In addition to that, the senses and mental abilities get weaker, and a drastic change in personality takes place. The elderly person grows more suspicious, introverted, and more concerned about his health. Also, the elderly are more likely to experience episodes of depression and melancholy. Elderly persons usually fear the loss of the ability to walk, dress, bathe or perform any of the other activities essential for independent living declining physical and mental capacities signal marked deterioration in the quality of life.

The elderly are not a homogeneous group, but represent a spectrum of individuals ranging from those who are fit and able to lead an independent life to those with multiple medical, functional and social problems. The needs of the elderly who become unwell and require hospital admission, therefore, will vary greatly and depend both on the nature of their illness and on their previous state of health. This fact has very important implications for the type of services needed by the elderly and the appropriate means of delivering such services.

Although many facts about the elderly are more or less universal, countries differ in varying degrees regarding their health policies towards the elderly. These differences could be attributed to economic, social or cultured factors. In the Kingdom of Saudi Arabia, which is the focus of the present research, the type of cultural setting and the type of family relations, as well as the economic stability make the Saudi society rather unique, particularly regarding the issue of care for the elderly. None of the models or policies adopted abroad can be applied completely in the Saudi setting. The socio-cultural factors unique to the Saudi society have to be taken into consideration.

The field of health services in the Kingdom of Saudi Arabia has witnessed a tremendous development both in terms of quality and quantity. Health care for the elderly has been part and parcel of the health care plans in the Kingdom, but in practical terms, this category of the population received less attention in the sense that there are no special programs for the care of the elderly.

Thus, despite the great deal of attention that has been given to health care in the Kingdom of Saudi Arabia, there is much left to be done regarding the channeling of such services and the coordination of efforts among the various sectors and levels of health care within the health care system. The present study is concerned with the role that is being played and that can be played by Primary Health Care Centers (PHCCs) in the delivery of comprehensive care for the elderly in the Kingdom of Saudi Arabia.

As far as the religious and social aspect is concerned, our religion urged the need to care for the elderly whether from the Muslim family or non- Muslims. This is commensurate with the social aspects. The majority in the Islamic and Arab societies prefer this group live with them at home or in the vicinity so they look after them almost every day. Therefore, to preserve the optimal use of resources, the establishment of primary health care centres in all villages and towns can play this role.

In Saudi Arabia the census and other population statistics, the elderly are often placed under the age group '45 or more. However, the retirement age is 60. In general, "elderly" has been defined as a chronological age of 65 years old or older, while those from 65 to 75 years old are referred to as "early elderly" and those over 75 years old as "late elderly"[1]. However, the evidence on which this definition is based is unknown. According to the World Health Organization (WHO), elderly people are those aged over 65 years. The definition of "elderly" is always changing over the time[2]. The lack of a standard use of an agreed cutoff age in all studies and other differences in methods made comparisons between studies difficult[3].

Elderly patients are consistently high users of health care services[4]. Utilization is defined as obtaining the health care provided by the health care services in the form of health care contact[5]. Previous research shows that the elderly patient's decision to use the health care services is the result of a complex interaction of several factors. These factors may relate to the elderly person's health status[6, 7], perceived health status[8], availability of health resources[9], and the accessibility to health facilities[10, 11].

In an attempt to explain the phenomenon, many studies attempt to identify the factors associated with utilization of health services. These factors include socio-demographic characteristics[12, 13], medical factors (physical illness) and psychiatric disorder[14], Organizational factors, accessibility to health care facilities[15], availability of health facilities and resources[16], geographical factors[17], and satisfaction with care[18].

There are three sets of factors: (1) predisposing factors such as age, gender, race/ethnic group and social status; (2) enabling factors include conditions that facilitate or inhibit the use of health services such as insurance coverage, income, distance to the health centre; availability of regular source of care and, (3) need or health status variables which may include perceived need and urgency, level of distress and presence of psychiatric co-morbidity[19].

The utilization of health care by the elderly people is influenced by a variety of factors. An important starting point for designing proper provision of health care for the elderly is to understand factors which determine the utilization of health services by this group of population. In the present study 9 factors are initially identified to study which among them are the most influencing factors.

2.The Objectives Of The Study

- To identify the factors providing comprehensive service to the elderly in PHCCs.
- To determine the influencing factors for providing comprehensive service to the elderly at primary health care centers.
- To study the degree of importance of the factors as perceived by physicians and medical directors.

3.Hypotheses

- $H_0$1: Regarding importance of visiting specialist for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.
- $H_0$2: Regarding importance of Additional Technical Staff for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.
- $H_0$3: Regarding importance of Hospital PHCC Service Coordinator for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.
- $H_0$4: Regarding importance of Citizen PHCC Relations Committee for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.

4.Study Design

Following are operational definitions of the key terms of the study:

- Primary Health Care: The type of health services provided through PHCCs as regulated and described by the Ministry of Health in the Kingdom of Saudi Arabia.

- Comprehensive Care: The type of care that would include not only the somatic aspect of the individual, but the psychological, mental and social aspects as well.
- The Elderly Group: Since there is no standard or agreed definition in the literature on what constitutes "elderly", for the purpose of this study an elderly person is taken to refer to a man or woman beyond 60 years of age.

The study is conducted on Primary Health Care Centers in Assir Region, Kingdom of Saudi Arabia. The sample involves an opinion survey of 354 physicians and medical directors currently working in the PHCCs, and focuses on the role PHCCs currently play in the care for the elderly, and the way they can be improved in order to provide an efficient and comprehensive care for such group.
After careful evaluation of the discussion with physicians and medical directors in PHCCs in Assir Region of KSA, nine items are identified for seeking the opinion is taken, from the physicians and medical directors, on the degree of importance of each of the nine items (listed under data analysis) in providing comprehensive service to the elderly at PHCCs.

5.Statistics

Data analysis is carried out by using cronbach's alpha, item statistics, KMO and Bartlett's test followed by factor analysis which includes total variance, scree plot, component matrix and rotated component matrix using principle component analysis as extraction method. Cross tabs and Chi-square test is being conducted to test the hypotheses.

6.Results

6.1.Reliability, Item Statistics And Scale Statistics

Cronbach's alpha has been run for to check the reliability of the survey questionnaire. The overall alpha for the all items is 0.883, which is very high and indicates strong internal consistency among the given items in the questionnaire (View Table 1). On a 5 point scale from very important to unimportant, the respondents rated visiting specialist at 4.38, additional technical staff at 4.68, social workers 4.5, sports and social activities 3.82, additional building facilities and equipment at 4.21, hospital PHCC service coordinator at 4.18, citizen PHCC relations committee at 4.12, health support council at 4.19 and others at 3.59. The mean rate given by the respondents for all the 9 items considered for the purpose of the study is 4.196. (view table 2:Item Statistics and Table 3: Scale Statistics)

6.2.Factor Analysis

Before proceeding for factor analysis, the researcher tested the eligibility of the data by checking KMO- Bartlett's test which is a measure of sampling adequacy. The KMO value is 0.779 >0.5. Bartlett's Test of Sphericity indicates a measure of the multivariate normality of set of variables (Sig. value is less than 0.05) which indicates multivariate normality and hence the data are acceptable for factor analysis.(View Table 4: KMO and Bartlett's Test)
The final list of influencing factors is identified after calculating the total variance (View Table 5), Scree Plot, Component Matrix (View Table 6), Rotated Component Matrix (View Table 7). Rotation of factors helps in the better interpretation of factors. Since the first factor in the ROTATED COMPONENT MATRIX is heavily loaded with the Visiting Specialist and Additional Technical Staff with factor loading Values of 0.852 and 0.824 respectively, these are the highest for the first factor. Hence the renamed first influencing factor for providing comprehensive health care to the elderly is visiting specialists supported by additional staff. The second factor is heavily loaded with Hospital- PHCC service Coordinator (0.905) and Citizen- PHCC Relations Committee (0.803). Hence the renamed second influencing factor for providing comprehensive health care to the elderly is PHCC Service coordinator and Citizen-PHCC Relations Committee.

Factor Name	Factor loading value	Renamed Influencing Factor
Visiting Specialists	0.852	Visiting Specialists Supported by Additional Technical Staff.
Additional Technical Staff	0.824	
PHCC service Coordinator	0.905	PHCC Service Coordinator and Citizen-PHCC Relations Committee.
Citizen-PHCC Relations Committee	0.803	

Table 8: The Final List Influencing Of Factors

7.Tests Of Hypotheses

In order to understand the difference in the perception of physicians and medical directors on the above influencing factors, the hypotheses framed after performing the factor analysis are tested and the results presented below.

Null hypotheses on	Sig. value	Result	Strength of Association	%Strongly Agree/ Agree
$H_0$1: Importance of visiting Specialist.	0.537	Accepted	0.078	88.2
$H_0$2: Importance of Additional Technical Staff	0.639	Accepted	0.069	91.6
$H_0$3: Importance of Hospital PHCC Service coordinator	0.478	Accepted	0.100	91.8
$H_0$4: Importance of Citizen PHCC Relations Committee	0.259	Accepted	0.122	86.5

*Table 21: Consolidated Results Of Hypotheses Testing**

** View Tables 9 To 20*

8.Discussion

The cronbach's alpha value is 0.883 indicates the internal consistency among the items in the questionnaire. From the above consolidated table of tests of hypotheses it may concluded that there is no significant difference in the perception of physicians and medical directors regarding the importance of all the four influencing factors- Visiting Specialist, Additional Technical Staff, Hospital PHCC Service Coordinator and Citizen-PHCC Relations Committee for providing comprehensive service to the elderly at the PHCC. Further, it may also be noted that above 88.2%, 91.6%, 91.8%, 86.5% of physicians and medical directors strongly agreed/ agreed that the four influencing factors are important.

From the results of factor analysis, crosstabs and tests of hypotheses, it may be inferred that the PHCC can provide better comprehensive service to the elderly of Assir Region of Saudi Arabia if the policy makers focus on the influencing factors. The PHCCs may invite more visiting specialists depending on the requirements of the elderly. Additional technical staff must also be provided to provide timely service to the elderly. Further, the PHCC service coordinator and the citizen-PHCC relations committee may work together to identify the needs of the elderly and coordinate the facilities to provide comprehensive service to the elderly.

The results of this empirical study indicate that the health authorities in Saudi Arabia may recognize these needs of the elderly visiting PHCCs in the Assir Region of the Kingdom of Saudi Arabia. The results showed that elderly patients are making an increasing use of the health resources and this should prompt policy makers to propose health plans to cope with such an increase.

9.Limitations And Conclusion

The limitation of this study is that the results reported are based on the data provided by the physicians and medical directors. Data if collected from the elderly would have given further insights into needs of the elderly. The study could have focused on PHCC wise requirements of the elderly and accordingly type of visiting specialists may be determined accordingly. Future research may focus on these aspects. The study was conducted on a sample from Assir Region of the Kingdom of Saudi Arabia and hence the scope can be extended to the other regions and cities of KSA.

10.References

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11.Appendix - Tables

I. RELIABILITY STATISTICS, ITEM STATISTICS AND SCALE STATISTICS

Cronbach's Alpha	N of Items
.883	9

Table 1: Reliability Statistics

	Mean	Std. Deviation	N
1Visiting Specialist	4.38	.739	34
2 Additional Technical Staff	4.68	.535	34
3 Social workers	4.50	.663	34
4 Sports and Social Activities	3.82	.904	34
5 Additional Building facilities and Equipments	4.21	.845	34
6 Hospital PHCC service Coordinator	4.18	.716	34
7 Citizeen PHCC Relations Committee	4.12	.729	34
8 Helath Support council in District or Region	4.29	.579	34
9 Others.	3.59	1.579	34

Table 2: Item Statistics

Mean	Variance	Std. Deviation	N of Items
37.76	30.973	5.565	9

Table 3: Scale Statistics

II. FACTOR ANALYSIS

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.779
Bartlett's Test of Sphericity	Approx. Chi-Square	186.115
	df	36
	Sig.	.000

Table 4: KMO And Bartlett's Test

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.260	58.443	58.443	5.260	58.443	58.443	3.311	36.794	36.794
2	1.065	11.838	70.281	1.065	11.838	70.281	3.014	33.487	70.281
3	.720	8.004	78.285						
4	.610	6.781	85.066						
5	.398	4.423	89.489						
6	.392	4.359	93.848						
7	.312	3.470	97.318						
8	.143	1.584	98.901						
9	.099	1.099	100.000						
Extraction Method: Principal Component Analysis.									

Table 5: Total Variance Explained

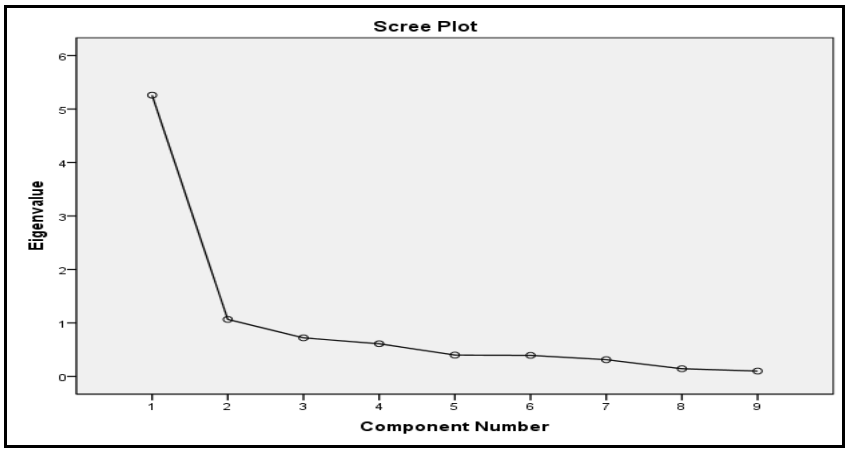

Figure 1

	Component	
	1	2
1. Visiting Specialist	.751	.443
2. Additional Technical Staff	.688	.470
3. Social workers	.837	.190
4. Sports and Social Activities	.694	-.406
5. Additional Building facilities and Equipments	.873	-.046
6. Hospital PHCC service Coordinator	.812	-.480
7. Citizeen PHCC Relations Committee	.727	-.420
8. Helath Support council in District or Region	.761	.151
9. Other if any	.715	.122
Extraction Method: Principal Component Analysis.		
a. 2 components extracted		

Table 6: Component Matrix[a]

	Component	
	1	2
1. Visiting Specialist	.852	.188
2. Additional Technical Staff	.824	.125
3. Social workers	.742	.431
4. Sports and Social Activities	.231	.770
5. Additional Building facilities and Equipments	.607	.629
6. Hospital - PHCC service Coordinator	.267	.905
7. Citizen - PHCC Relations Committee	.245	.803
8. Helath Support council in District or Region	.660	.408
9. Other if any	.606	.397
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.		
a. Rotation converged in 3 iterations.		

Table 7: Rotated Component Matrix[a]

III TESTS OF HYPOTHESES

$H_0$1: Regarding importance of visiting specialist for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.

			Visiting Specialist				Total
			Disagree	Neutral	Agree	Strongly Agree	
Position	MEDICAL	Count	0	3	18	22	43
		% within Position	.0%	7.0%	41.9%	51.2%	100.0%
	PHYSICI	Count	6	33	104	169	312
		% within Position	1.9%	10.6%	33.3%	54.2%	100.0%
Total		Count	6	36	122	191	355
		% within Position	1.7%	10.1%	34.4%	53.8%	100.0%

Table 9 : Crosstab

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.173[a]	3	.537
Likelihood Ratio	2.903	3	.407
N of Valid Cases	355		

Table 10 : Chi-Square Tests

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is .73.

From the above table chi square is not significant (sig. value is greater than 0.05), null hypothesis $H_0$1 is accepted.

		Value	Approx. Sig.
Nominal by Nominal	Phi	.078	.537
	Cramer's V	.078	.537
N of Valid Cases		355	

Table 11: Symmetric Measures

The Strength of association between designation and visiting Specialists is 0.078

$H_0$2: Regarding importance of Additional Technical Staff for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.

			Additional Technical Staff				Total
			Disagree	Neutral	Agree	Strongly Agree	
Position	MEDICAL	Count	0	2	17	24	43
		% within Position	.0%	4.7%	39.5%	55.8%	100.0%
	PHYSICI	Count	2	26	99	184	311
		% within Position	.6%	8.4%	31.8%	59.2%	100.0%
Total		Count	2	28	116	208	354
		% within.Position	.6%	7.9%	32.8%	58.8%	100.0%

Table 12 : Crosstab

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.690[a]	3	.639
Likelihood Ratio	1.995	3	.573
N of Valid Cases	354		

Table 13 : Chi-Square Tests

A. 3 Cells (37.5%) Have Expected Count Less Than 5. The Minimum Expected Count Is .24.

From the above table chi square is not significant (sig. value is greater than 0.05), null hypothesis $H_0$2 is accepted.

		Value	Approx. Sig.
Nominal by Nominal	Phi	.069	.639
	Cramer's V	.069	.639
N of Valid Cases		354	

Table 14: Symmetric Measures

The Strength of association between designation and additional technical staff is 0.069

$H_0$3: Regarding importance of Hospital PHCC Service Coordinator for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.

			Hospital PHCC service Coordinator					Total
			Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Position	MEDICAL	Count	0	0	1	15	27	43
		% within Position	.0%	.0%	2.3%	34.9%	62.8%	100.0%
	PHYSICI	Count	1	5	22	125	157	310
		% within Position	.3%	1.6%	7.1%	40.3%	50.6%	100.0%
Total		Count	1	5	23	140	184	353
		% within Position	.3%	1.4%	6.5%	39.7%	52.1%	100.0%

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.502[a]	4	.478
Likelihood Ratio	4.562	4	.335
N of Valid Cases	353		

a. 5 cells (50.0%) have expected count less than 5.
b. The minimum expected count is .12.

Table 16: Chi-Square Tests

From the above table chi square is not significant (sig. value is greater than 0.05), null hypothesis $H_0$3 is accepted.

		Value	Approx. Sig.
Nominal by Nominal	Phi	.100	.478
	Cramer's V	.100	.478
N of Valid Cases		353	

Table 17: Symmetric Measures

The strength of association between designation and hospital PHCC service coordinator is 0.100

$H_0$4: Regarding importance of Citizen PHCC Relations Committee for providing comprehensive service to the elderly at the PHCC, there is no significant difference in the perception of physicians and medical directors.

			Citizeen PHCC Relations Committee					Total
			Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	
Position	MEDICAL	Count	0	0	1	20	22	43
		% within Position	.0%	.0%	2.3%	46.5%	51.2%	100.0 %
	PHYSICI	Count	4	3	40	128	137	312
		% within Position	1.3%	1.0%	12.8%	41.0%	43.9%	100.0 %
Total		Count	4	3	41	148	159	355
		% within Position	1.1%	.8%	11.5%	41.7%	44.8%	100.0 %

Table 18: Crosstab

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.285[a]	4	.259
Likelihood Ratio	7.647	4	.105
N of Valid Cases	355		

Table 19: Chi-Square Tests

A. 5 Cells (50.0%) Have Expected Count Less Than 5. The Minimum Expected Count Is .36.

From the above table chi square is not significant (sig. value is greater than 0.05), null hypothesis $H_0$4 is accepted.

		Value	Approx. Sig.
Nominal by Nominal	Phi	.122	.259
	Cramer's V	.122	.259
N of Valid Cases		355	

Table 20: Symmetric Measures

The Strength Of Association Between Designation And Citizeen Phcc Relations Committee Is 0.122.