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Satisfaction and responsiveness with health-care services in Qatar—evidence from a survey

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ABSTRACT

Background: Satisfaction and responsiveness with health care are some of the main outcome variables of a health system. Although health outcomes have been studied in countries with different levels of economic development, there is limited information on the health provision/satisfaction/responsiveness nexus in countries where rapid transitions from middle to high-income status have occurred.
Methods: Using a 2012 survey conducted in Qatar (amongst both Qatari and non-Qatari respondents), we analysed satisfaction and responsiveness of health care. The sample consisted of 4083 respondents. We use logit analysis [as well as robustness checks involving ordered logit, ordered probit, ordinary least squares (OLS) and probit analysis] in order to estimate the determinants of satisfaction and responsiveness.
Results: Both, satisfaction and responsiveness rates were high. Gender, nationality and, to some extent, income and age were significant sociodemographic determinants of satisfaction, with non-Qataris and females, having higher levels of satisfaction. Cost, previous experience with the same health provider and provision of medical insurance for a particular health provider were the attributes significantly correlated with general satisfaction. The results are consistent when the analysis is applied to the correlates of responsiveness.
Conclusions: Sociodemographic factors explain the satisfaction with quality of health care in the state of Qatar (both from the general population point of view and from the patient point of view).

1. Introduction

Governments are increasingly cognizant of the fact that the stability of a health system is not assured without adequate satisfaction of the general public and of patients (users) [1–3]. In that respect, both, general population satisfaction with health-care system and its responsiveness to the legitimate needs of a country's citizens, residents and patients have been used as measures for health systems performance [2]. In other words, both terms have been used to measure the extent to which health systems, or their components, are successful in responding to the expectations of the general population or a subgroup of patients within a population [4]. The concept of responsiveness [developed by the World Health Organization (WHO)] is defined as aspects of the way individuals are treated and the environment in which they are treated during health system interactions. The concept covers a set of nonclinical and nonfinancial dimensions of quality of care that reflect

Abbreviations: GDP, gross domestic product; OLS, ordinary least squares; PPP, purchasing power parity.

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respect for human dignity and interpersonal aspects of the process [5–7]. The concept of satisfaction, on the other hand, revolves around factors and expectations that might fall outside of the remit of the health system and as such, it might be more dependent on expectations than responsiveness surveys: the lower the expectations, the higher the satisfaction with the actual system and vice versa. In addition, while the concept of responsiveness is close to the 'patient experience' surveys, and it focuses on an interaction of the respondent with the health-care system, the concept of general satisfaction is much broader in scope and does not necessarily focus on a 'recent' or direct interaction with the health-care system [4].

Both satisfaction and responsiveness play a significant role when measuring and assessing health outcomes and quality of care. Furthermore and going beyond, the direct nexus between satisfaction and health outcomes, it has been argued that being treated with respect is a right in its own [5]. In that respect, a significant body of literature has emerged focusing either on responsiveness [8,9] or satisfaction [10–13]. The studies focusing on responsiveness in particular, have documented that satisfied patients tend to adhere to recommended courses of treatment and to return for required follow-up visits [14]. Moreover, satisfied patients are more likely to develop a deeper and long-lasting relationship with their medical provider, leading to improved compliance, continuity of care and, ultimately, better health outcomes [14,15]. Some countries have explicitly undertaken reforms to make services patient centred and have implemented plans to monitor patient attitudes through surveys and focus groups [16,17]. At the same time, private insurance providers regularly measure patient satisfaction and patient experience as indicators of performance [18].

Satisfaction and responsiveness have not been widely studied in countries with the most rapidly growing and diverse populations. Some of the fastest population growth rates in the last decade have occurred in the countries of the Gulf Cooperation Council (GCC), mainly due to influx of migrant workers [19]. Aside from having the world's fastest growing population and second highest migrant population, the State of Qatar is also the only GCC country to have one of world's highest per capita wealth values (GDP per capita amounts to 127,562 USD, PPP) [19]. In addition, financial protection is high for all socioeconomic groups, with individual social health insurance contributions low and unchanged since 1996 (USD 14 for nationals, USD 27 for nonnationals per annum, respectively) [20], and out of pocket expenditure as a share of household expenditure lower than the OECD average (0.9% vs. 3% in 2013) [21,22]. This is because of high per capita government health expenditure, which in 2013 was higher than the OECD average (USD 3103 vs. USD 2627, PPP) [21,22]. Social health insurance was formally introduced in 1965, and entitled both nationals and nonnationals to a comprehensive package at public health facilities [23]. However, social insurance cover may be incomplete as enrolment is voluntary, and facility and workforce density has fluctuated or declined due to rapid population growth [24]. As such, the government expects to mandate social health insurance enrolment, abolish individual social health insurance contributions, and extend access to private providers, by the end of 2016, with nationals successfully enrolled between 2013 and 2014. The government also expects to open 73 new health facilities and 45 renovation facility projects between 2015 and 2022 [25].

1.1. Satisfaction with the Health system and Health System Responsiveness in the Gulf Cooperation Council Countries

In Qatar, most of the studies fall within the remit of responsiveness of the health-care system. There has not been any study that has looked at the general population satisfaction with the health-care system. Kareem et al. [26] examined six dimensions of responsiveness: availability of services, convenience of services, facilities, empathy of doctors, quality of care and continuity of care. Nationality (i.e. citizens vs noncitizens) and gender were found to be the most significant determinants of responsiveness. Mohammed et al. [27] analysed data on 80 patients who visited a diabetes clinic in Doha. They concluded that most respondents were satisfied with the quality of services provided, but would have liked to spend more time with their doctor. Similarly, Weber et al. [28] analysed the responsiveness of hospital care in one public hospital. It was found to be high, but gender, citizenship, level of education and number of visits to the doctor, were not found to be significant correlates of responsiveness.

Similarly, in the wider GCC context, most of the studies assess the responsiveness of the health-care services. The Kingdom of Saudi Arabia is the most researched Gulf Cooperation Council country when it comes to the responsiveness of health system. Almost all research conducted on the Kingdom of Saudi Arabia deals with the main socioeconomic and demographic correlates of responsiveness of health system. Level of education, gender and income status appeared to be the most important sociodemographic variables, while effectiveness, human aspects of care and waiting times were the most important attributes of responsiveness [29–36]. Similar studies in the United Arab Emirates (UAE) found that age was the most important demographic variable, while doctor's empathy was the most important attribute of health care [37]. Similarly, in Kuwait, gender, marital status, occupation and income level were the most important sociodemographic determinants of responsiveness [38–40].

Responsiveness has also been studied by a single survey instrument developed by the WHO [2] across some of the countries in the region [i.e. the World Health Survey in UAE (2002), Qatar (2006) and Kuwait (2013), as well as the WHO multicountry surveys on responsiveness (2000/2001)]. The results of the surveys augur very well for the responsiveness of the health systems of the countries in the region. For instance, according to 2013 WHS Kuwait [41], the overall responsiveness score for inpatient visits across all of the responsiveness dimensions was 76.9, while the responsiveness score for outpatient visits across all of the responsiveness dimensions was 72.9 (the responsiveness