



Review

Factors influence and impact of the implementation of quality of care in Saudi Arabia

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Abstract

Quality of care has seen influenced by political, global, economic, and social factors. In Saudi Arabia, these factors play a vital role to implement quality of care in Saudi hospitals. The political factor comes from the decision makers such as Ministry of Health since the regulations in health system are influenced by government. For global factor, qualified people from different countries and World Health Organization play an important role in terms of quality standards. Good finance resources will result in implementing quality of care. The social factor is seen when health organizations meet the expectations of the society. The implantation of quality of care is one of the significant reforms in health. This reform occurs due to the interrelationships between political, global, economic and social factors.

Keywords: Saudi Arabia, Quality of care, Political, Globalization, Economic, and Social.

INTRODUCTION

Since the 1980s, Total Quality Management (TQM) has been the significant theme for a large number of health care organizations. Total quality management aims to improve the quality of care. The Institute of Medicine defines quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Campbell, Roland, and Buetow, 2000). There are four factors that affect total quality management. These factors are political, global, economic and social influences.

Political Structure and Influences Impacting on Quality in the Health Sector within Saudi Arabia

Healthcare in Saudi Arabia is the duty of the Ministry of Health (MOH), which offers specialized as well as general services, through health organizations, for all citizens. The MOH has a very simple strategy, which is to offer free health services so that all residents of Saudi Arabia can take advantage of these services (Farsy, 1990:269).

Quality assurance is identified as a key principle in achieving the goals set by this strategy, as acknowledged by 2009 by King Abdullah Bin Abdulaziz Al-Saud: "*Saudi Arabia cannot achieve global competitiveness unless*

quality becomes the basic standard for all it provides for the world, with excellence derived from the teachings of Islam", He also claimed that quality had become "*the most important grounding for the Kingdom to achieve international recognition with the products and services that reflect the country and its people's potential*" (King Abdullah, 2009).

In addition, every resident of Saudi Arabia, as well as non-Saudis who work in the public sector or for the government in Saudi Arabia, has the right to free healthcare. The MOH is the key provider of healthcare services and its duties includes planning and provision of 60% of health services at different levels (primary, secondary, and tertiary). Around 20% of the provision is offered by other government organizations, and the remaining 20% of healthcare services is provided by the private sector. Saudi and expatriate residents expect that the government will provide them with the best possible quality of healthcare (MOH, 2011).

There are four key areas that the MOH focuses on in order to offer complete healthcare services to the residents of Saudi Arabia. Firstly, it prioritises preventive healthcare. There is also a referral system for those patients who require any special form of treatment or care. In addition, MOH recognizes the need for increasing in-service training, specifically amongst the Saudi workers. Finally, enhanced efficiency of administra-

tion and health related research has been seen as important for improved quality in healthcare (Farsy, 1990:270).

Healthcare units such as KFSHandRC and KKEH were among the first to practice TQM, and they were thriving, so the Ministry of Health decided to implement TQM in all the healthcare units in the country during the 1990s. Consequently in 1990, the Saudi Ministry of Health and the US based Hospital Administration Development (HOSAD) initiated a project which aimed to assist the Ministry of Health in developing a complete Quality Assurance Programme (Al-Abdul Gader, 1999:34). This project was not successful because of lack of specific criteria set for hospitals of Ministry of Health. Furthermore, there was no culture of quality in the hospitals, so the project was not supported by the organizational structure. There was also an absence of a General Directorate in the Ministry of Health so no one had ultimate responsibility for the application of quality standards. Later, in 2000, the Ministry of Health, introduced a General Directorate of Quality Assurance (Minister Memo No. 1523/11 of July 1 2000) (Naiaz, 2005: 69).

There have been a number of advancements in the field of quality in healthcare units of Saudi Arabia since 2000. The first advancement was under the management of the Prince of Makkah who introduced the Makkah Regional Quality Programme (MRQP). Its purpose was to enhance the quality of health services in the areas of Makkah by using a regional quality standard in private as well as public hospitals. High quality organizations and strategies such as JCAHO, ARAMCO and the Canadian Standard, were studied before formulating the standards for MRQP. In 2003, MRQP's first version was published and applied in the hospitals of Makkah (Albejaidi, 2010).

Ministerial Ruling 144187/11 introduced the Central Board for Accreditation of Healthcare Institutions (CBAHI) in 2005. This showed how essential quality in healthcare units was for political leaders. The chief aim of this ruling was to enhance healthcare quality and safety. It also aimed to assist the public and private health services in their official recognition systems (CBAHI). As a result, many healthcare units came together to establish the CBAHI standards. The professional teams included personnel from Security Forces Healthcare Services, Saudi ARAMCO, and the Saudi Commission for Health Specialties, the Saudi Armed Forces healthcare services, National Guard Healthcare Services, the Ministry of Health, KFSHandRC as well as private organizations. In 2006, the manual, the CBAHI standard, was verified. A total of 21 hospitals, were recognized by CBAHI in 2010, as a result of successful efforts to apply quality standards in the hospitals of Ministry of Health (Al-Hayder, 2010).

Globalization Factors Impacting on Quality in Health Sector within Saudi Arabia

The healthcare sector in Saudi Arabia has been affected by globalisation in a number of ways. For instance, there has been:

- a rise in the need for high technology;
- a rise in the need of professional expatriates because there are insufficient numbers of qualified Saudi Arabian medical personnel (Walston, Al-Harbi, and Al-Omar, 2008);
- changing policies in Saudi Arabia because of globalization as well as its membership of the World Bank and World Trade Organization;
- a rise in the need of high quality of care; and
- hospital accreditation (Shin, 1995).

The health services in Saudi Arabia depend upon not only the Saudi residents but also Health experts that come from other countries. In 2010, the percentage of Saudi physicians, nurses and allied health personnel was 21.6, 48.8 and 87.1, respectively (MOH, 2011). Differences in backgrounds of medical personnel as well as the different ways that they have been educated can have major impacts on the quality of services in Saudi Arabian hospitals. Even though English is the language spoken in most of the hospitals, language diversity creates certain barriers in communication between the medical practitioners and the patients, and between the medical personnel themselves.

As the two sacred cities of Islam are present in Saudi Arabia, the quality of healthcare systems is very much affected during the pilgrim season (Hajj). Every year, nearly two million pilgrims come to Saudi Arabia. According to statistics, in 2010, 2.79 million pilgrims came to the holy cities, 64.5% of whom came from other countries (MOH, 2011). Conducting an occasion in which millions of people come together needs detailed planning by organizations to ensure that there are sufficient transportation service, and accommodation as well as healthcare facilities. The healthcare service demands during Hajj include providing treatment for chronic and acute illnesses as well as parasitic and infectious conditions. It is estimated that around 20,000 associated and clinical staff are needed to provide care to the pilgrims throughout the Hajj season (Jannadi, Alshammari, Khan, and Hussain, 2008). Immunisation and chemo-prophylaxis are the two types of preventive treatments that are offered (Almalki, Fitzgerald, and Clark, 2011). In 2005, 2,902 pilgrims were vaccinated against meningococcal meningitis while prophylactic treatments were provided to 305,625 pilgrims.

Those who are responsible for managing healthcare services in Saudi Arabia have contingency plans on a large-scale and considerable resources are invested every year to offer services of healthcare to the pilgrims, 24 hours each day, so the chances of injuries can be lessened. Regardless of these efforts, statistics show that

during the 2010 Hajj season, there were 1,044 deaths (MOH, 2011). Consequently the Saudi Arabia government and authorities need to continue to improve safe and effective health services.

Economic factors impacting on quality in the health sector within Saudi Arabia

In the 1960s, there were few hospitals in Saudi Arabia. The economy of Saudi Arabia was struggling to meet the expectations of the population regarding health outcomes. However, in the 1980s, the Saudi economy witnessed a major turnaround, and this has impacted positively on health services. In 1973, Saudi Arabia prospered as a result of the oil embargo and this wealth was extended to many aspects of life, including health services (WHO, 2006). As a result of this newfound investment, mortality and morbidity rates reduced. For example, in 1987, Diphtheria, Polio, Measles and BCG vaccines provided protection for 89%, 89%, 77% and 93%, respectively of infants and children. In 1983, healthy drinking water and sanitary services were available to 93 per cent and 86 per cent of the population respectively. In 1987, available statistics show that 93 per cent of the population were covered by health services. There was also a decrease in the incidence of communicable diseases. In addition, there was an overall reduction in infant mortality and an increase in life expectancy at birth due to higher socio-economic development and better health care (Farsy, 1990).

It is important to highlight that there is connection between budgetary allocation to the Saudi health sector and quality of health services. Financing health services in Saudi Arabia is closely linked to state revenues and this is a shortcoming because the government, which is the major financier of health services, runs a welfare-based health policy (Al-Yousuf, Akerelle, and Al-Mazrou, 2002). For example, a significant change in oil revenues would negatively impact on health services because there is no financial shock absorber, as employers and employees do not contribute to any insurance fund. There is therefore a clear need to apply quality management to control the high cost of health care in order to face future challenges in the health system (Jannadi et al., 2008).

Although free and universal health care for all Saudis has legal backing in the constitution, new trends are gradually emerging in health policy. This is due to the economic pressure on the government. For example, there are increasing costs of providing health care and dealing with common non-communicable disease (cardio-vascular disease, diabetes, cancer) in addition to the high incidence of road traffic accidents (WHO, 2006). Dealing with these health issues are fundamental financial problems that Ministry of Health is finding difficult to cope with. The outcome of this socio-economic pressure is a

shift in health policy. Specifically, there is a commitment to applying principles of quality as a strategy for reducing cost.

Social context and factors impacting on quality in the health sector within Saudi Arabia

Saudi Arabia produces 5 year plans which set the national agenda for development in all areas of Saudi life, including economic, social, education, and health policy. The most recent plan, the "Ninth Plan", which is the 2010-2014 strategy, priorities two social agenda: continued improvement of living standards (quality of life) and the development of the national labour force. Clearly the government is interested in developing the productive and creative capabilities of all Saudi citizens (MOEP, 2010).

The Plan also places special emphasis on developing and meeting the challenges that Saudi Arabia faces, key among which are the dependence on expatriate workers and the emergence of structural unemployment, especially among the youth. These challenges require action through social and health development sectors such as social affairs, health, culture, information, and youth affairs. The Ninth Development Plan aims at spending around SR273.9 billion on social and health development, which constitutes about 19% of the Plan's total allocations for development sectors (MOEP, 2010).

This plan also places great emphasis on implementing quality assurance programs and is aimed at:

1. Achieving the best possible health standard by improving the general health condition of population.
2. Providing integrated, comprehensive health care to the whole population, ensuring easy access to these services and providing them in a fair and proper way at reasonable cost.
3. Enhancing the parallel and complementary role of the private sector to the government's role in financing, operating and providing health services.
4. Ensuring balanced geographic distribution of health services and ensuring easy access to these services (MOEP, 2010).

One of the major health issues in Saudi Arabia is smoking. According to MOH, in 2009, the percentage of smokers among adult males was 24%. Anti-smoking clinics were established in the different parts of the country by the MOH to help and support smokers who are willing to quit (MOH, 2010). To protect the society from the 'smoking epidemic', the Ministry of Health also established a Tobacco Control Program in 2002. This program aims to help smokers quit, and to protect the non-smokers especially children from "second-hand" smoke. The program also encourages research, training and rehabilitation

in its fight against smoking (Bassiony, 2009).

Interrelationship between these factors

Historically, concepts of quality have existed for thousands of years, since the Ancient Greek era. However, over the last century, companies and organizations based in Japan and USA, have formalised principles of quality to establish standards and framework which can be applied in health systems to ensure a better "product" (a better quality of health provision). These standards are now used worldwide, including in Saudi Arabia's health system.

At a very basic level, political, global, economic and social factors work together to drive implementation of total quality management strategies. The Industrial Revolution, for example, enabled the use of quality standards to increase productivity and reduce costs. Clearly, TQM is an economic imperative, often directed by politicians and bureaucrats (in the case of public organizations) or CEO's (private organizations). Global organizations such as the World Health Organization also provide governance, and therefore standards, for health systems. There is also a globally mobile workforce, so that organizations can benefit from qualified people from other countries. Thus, the quality of health care improves, as does the quality of life throughout society.

For example, in Saudi Arabia, revenues have skyrocketed as a result of oil sales in the last 40 years. This increase has led to significant rises in the Ministry of Health's budget. Policy makers have needed to develop a strategy that can improve health services. In 2005, policy makers in MOH decided to establish CBAHI and developed processes to improve the quality of health care. Highly qualified people from other countries were needed to ensure that the program achieved its objectives. At the same time, the program also aims to meet rising societal expectations. Interestingly, those expectations are now driving the presence of thousands of Saudi Arabia health personnel in overseas universities. This relates to current policy which aims to increase living standards and improving the capacity of Saudi Arabians to participate more fully in their own workforce and community.

CONCLUSION

It can be clearly seen that total quality management has been influenced by political, global, economic and social factors. Political factors affect total quality management since the role and regulations in health systems are influenced by agenda established by government and management. Global factors also affect total quality management since organizations such as the World Health Organization plays a crucial role around the world

in terms health standards. Economic factors, as good financial resources can result in implementing total quality management. The social factors encourage health organizations to meet the change and the increasing of population to meet the society expectations.

One of the significant reforms in health globally has been the implementation of Total Quality management (TQM). This has occurred because there are interrelationships between political, global, economic and social factors which reforming health systems.

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