Older Patients' Satisfaction with Home Health Care Services in Al-Baha Region, Saudi Arabia

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List of Abbreviations

A	The Abbreviation	Its Meaning
B	ADL	Activities of Daily Living
C	ANOVA	Analysis of Variance
D	CI	Colliers International
E	CDC	Centres for Disease Control
F	DSI	Department of Statistics and Information
G	ESCWA	Economic and Social Commission for Western Asia
H	GDP	Gross Domestic Product
I	HCCSI-R	Home Care Customer Satisfaction Instrument – Revised
J	HHC	Home Health Care
K	HIT	Health Information Technology
L	IADL	Instrumental Activities of Daily Living
M	MOH	Ministry of Health
N	NHS	National Health Service
O	NCQA	National Committee for Quality Assurance
P	PCMH	Patient Centred Medical Home
Q	PHC	Primary Health Care
R	PPC	Patient-Centred Care
S	RCS	Red Crescent Society
T	UN	United Nations
U	WHO	World Health Organization

II. Appendix

III. Definitions of Terms

The Key Term	Definition
Home Health Care	The emerging need to provide health care to the patients at their homes led to this new concept of HHC. Continuous patient care and communication with patients is provided through the services in the HHC system. The main aim of HHC services is to cater for the needs of the patient at his/her home while keeping patients in their familiar environment and amongst their family members.
Older people	**I**n this study, I decided to choose the age of older as individuals with 60 years of age and above, but there are many people who are living longer so this might need to be reviewed. This study will address older patients who are 60 years and above who have received HHC services.
Culture	"The entire world of human interaction and behaviour. Communication is the means by which culture is transmitted and preserved." (Giger & Davidhizar, 2002, p. 185)
Quality of service	**A** set of processes put in place to make sure that the health organizations provide a high quality of health service to the patients. A method used by an organisation that makes its services different from others, as determined by the personal organisation at all levels, is termed the quality of health services by Kotler and Armstrong (1994). When science and medical technology are applied so as to maximise benefits for public health without the increase of exposure to risk, then this is also termed quality of health services, as stated by Nakijima (1997).

Patient-centred care	1- A joint effort based on cooperation of professionals, doctors, patients, patients' families and others to achieve a comprehensive system in the field of health care, practising teamwork to exchange knowledge and work towards the common objectives of healing and recovery. 2- "A collaborative effort consisting of patients, patients' families, friends, the doctors and other health professionals…achieved through a comprehensive system of patient education where patients and the health care professionals collaborate as a team, share knowledge and work toward the common goals of optimum healing and recovery." (Grin, 1994).

IV. The publication, Conferences and Workshop

Publication:

1- Paper will publish at The Journal of Macro Trends in Health and Medicine, Paris France) on Jan, 2014. *Title: (Older patient satisfaction with Home health care Services in Al-Baha region, Saudi Arabia part 1? (Quantitative study).* (See Appendix).

Conferences:

1- Poster presented in the seventh Saudi Conference 2014 was held at Edinburgh International Conference Centre (EICC), United Kingdom.

Tile: (Overview of Home health care services in Saudi Arabia), (See Appendix)

2- Abstract of paper is accepted and presented as Oral presentation in France which will be in 19&20 of DEC, 2014 at: The Macro Trend Conferences, Paris 2014).

Title: (Are Elder Patients Satisfied with Home Medical Services in Al-Baha region, Saudi Arabia? (Quantitative study) (See Appendix)

3- Abstract of Poster is accepted and presented as poster at Saudi Students International Conference, London, UK which will be on 31 Jan - 1 Feb 2015.

(Title: (Case study on older Patients with Health Services which they received at homes in, Saudi Arabia. (Qualitative study) (See Appendix)

Workshop:

1- Certificate of Participation in Home Health Care workshop on 29-Sep-2013 in King Fahad Hospital, Saudi Arabia. (See Appendix).

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Abstract

In this study, I have presented the background of the current health services supported by the Saudi government and how these services work. Older patients' satisfaction and home health care are discussed, ageing population as well. Also, the theory of patient-centred care which is used in the Ministry of Health in Saudi Arabia is presented and reviewed in this thesis. To answer the research questions, hypothesis and meet the objectives, two main methods were used for this study, employing a cross-sectional survey and subsequent qualitative interviews. It included three major aspects regarding the pertaining topic of research, i.e. ageing, patients' satisfaction and home health care. These three areas are explored in consideration with educational level, gender and marital status of the employed participants. The Home Care Patient Satisfaction Instrument - Revised (HCCSI-R) was used. For this questionnaire, a response rate of 87% participants (n=410) was achieved. The findings of the quantitative part of this study showed that there is high contentment amongst patients about the Home Health Care (HHC) services being provided in Al-Baha region, Saudi Arabia. This is indicated in the findings, which reveal that 99.3% of respondents would recommend the service to other older people; while a mere 0.7% of people would not. The next part of this study has presented the in-depth qualitative interviews and analysed the results using the content analysis which revealed several overarching themes related to providers' perceptions of home health services. These topics reflect the common experiences of the group such as the Perceptions of HHC services as providing comprehensive medical care which serves to provide the effective care, reduce the burden on hospitals for the chronically ill, minimise the period of stay for patients, reduce rates of infection, improve psychological health of patients, and maintain patient dignity. In the end, keeping in view the variabilities of customs and religious conventions, recommendations are made to enhance the quality of services. Through the discussion with service providers and leaders in the Ministry of Health, it has been proposed pre-emptive action to improve the existing home health care services along with recommendations to further strengthen these services in the latter part of this study. With these findings, this study has recommended that Patients should be treated in compliance with their respective cultural arrangement to maintain their comfort level , also do further future research in this field to discuss any changes or developments or (opposite) in the services provided to patients, considering how much has been addressing the problems relating to the consent of the patients under the complicated environment such as Al Baha region with taking account that the culture is a central issues in this thesis and it could be an issue for similar researches globally. I believe that, this study is the newest and I am the first researcher on this topic until now in the Saudi context.

Chapter 1: Introduction

1.1 Introduction

This chapter provides an overview of the history of the progress of health care in Saudi Arabia with added emphasis on HHC services conducted through the Ministry of Health. It is a useful review because it indicates the need for continuous education and further training for health care providers. The chapter also highlights the challenges and opportunities that occur during the provision of HHC services because of the changing demographics of Saudi Arabia. The focus is on HHC level, and constraints applied. The size of health services provided to most individuals is increasing in most communities (MOH, 2010) For example; the French community obtains comprehensive health coverage, whether in the private or public sectors. The system may be incomplete or contains shortage; however, there are indicators on the significant increase in consumer satisfaction (Rodwin, 2003). Also, the UK Parliament has the responsibility to establish or support the development of health legislation, as stipulated in the updated Act (2006). According to this legislation, to provide and improve comprehensive health services for the public is a legal duty (Boyle, 2011). It is legally compulsory for any government to provide and develop the health care services for domestic populations. Hence, the Saudi Arabian government strongly emphasized on the development of health services in Saudi Arabia in which the Ministry of Health (MOH, 2010) considerably improved the quality and quantity of health services within the last few decades. Health services have been steadily improving, providing excellent quality of service and rehabilitation in a growing number of hospitals (MOH, 2010). There is increasing focus on the area of preventative medicine and nutrition for older people (MOH, 2010). The HHC service in Saudi Arabia now comes under the overall health care being offered to individuals in their homes (Mufti, 2000) This approach could encourage independence and a better quality of life for the patient (Mufti, 2000).The promotion of HHC programmes became prominent in the late 1980s because of the demand to reduce long-term hospital bed occupancy and for the provision of nursing and medical care to patients in their homes (Jamal, 2011). Following this demand is a call for the training of nurses and the continuing education of physicians to be integrated into the HHC services, which must respond to the growing need for

professional Health care workers in HHC field (William & Keenan, 1991).Currently, Some Saudi government-sponsored HHC programs in hospitals such as Hospital of ministry of defence, hospital of ministry of interior and a few private services are being offered in homes (Mufti, 2000).

1.2 Background

Policy development in Saudi Arabia has been given much attention in recent years, specifically, those policies relating to older people (MOH, 2010). Efforts have been made to deliver a quality health service and thus, increase the life expectancy of the Saudi Arabian people. National and international health policy considerations have increasingly considered the older person. According to a report by the World Health Organisation (WHO, 2011), the developed and developing countries are working to provide either the best or an adequate range of health care services, which will lead to a significant rise in older populations in the coming decades.

A range of medical activities and temporary health care services make up the HHC service that are provided by qualified medical teams in the Kingdom of Saudi Arabia, either at the patient's home or the hospital. These are aimed at preserving health and promoting healthy living. The length of hospital stays can be reduced through these services and will help people to avoid expensive hospital care, particularly for those at the end of their lives. The risk of infection is also reduced. The patient is made more comfortable, which satisfies both family and health care patient (New, 2013). More health care workers will be required in professional HHC services, so it is important to train people at the graduate and undergraduate level and to continue the education of professionals operating in the specified medical services. The issue of hospital bed occupancy was dealt with by the Saudi government in the late 1980s through the implementation of HHC programmes which would provide long-term medical and nursing services for the management of patients. Hospital based HHC programs were initiated in Saudi Arabia (MOH,2010). As motioned, there are some government-sponsored enterprise programs and some private hospitals are also carrying out HHC programs (MOH, 2010).

The government created the Green Crescent Hospital in Riyadh in the late 1980s as part of the emergency management program to assist older people; Saudi Arabia is trying to provide the available services as a basic right of its citizens (Mufti, 2000).But with the current development now in Saudi Arabia, it was necessary to develop new plans and strategy to improve the health system as well as HHC. A strategic plan has been designed by the Ministry of Health (MOH, 2010) which has benefited older people in accessing medical care facilities at home instead of going to the hospital, the HHC program was introduced (MOH, 2010). It is estimated the health care services which are provided by the HHC Department of Ministry of Health Saudi Arabia approximately 8,090 older patients including those with disability (MOH, 2012). HHC services should be provided to a home-bound patient and be declared medically necessary by a physician to qualify for the best HHC services. Moreover, this health service should be provided on a non-continuous and intermittent basis. Comparatively higher rates of HHC usage are seen for Medicare beneficiaries who have low-income levels, who are frail, and 60 years old and above (A.Same.el., 2016). It could be equitable and fairly open to debate because the health care services should be provided for everyone, not just for frail or poor people. Whatever their economic level, family level, education, ethnic, religious etc., this supported by the universal establishment of the human rights regarding to the health care services which stated "Universal Declaration of Human Rights recognizes the inherent dignity and the "equal rights of all members of the human family" (WHO,1948). This 'equality equal right' reflects the fact that the Saudi government is dedicating its efforts to providing HHC services to those who are really in need of it. In the past few decades, this dedication has considerably enhanced the health of the Saudi people. Nevertheless, there are many issues that could be detrimental to the health care system (MOH, 2011). These problems include the different roles of the Health Ministry, the variations in disease patterns, limited financial resources and the accelerating demand for HHC services (MOH, 2012). The past evolution and present framework of the health care system in Saudi Arabia, as well as its qualities, are discussed in this thesis. In the last few decades, the health services have developed and considerably improved in Saudi Arabia. In 1925, the very first public health department was set up in the Makkah region by the royal ruling of the King, Abdul Aziz. The purpose of the public health department was to

sponsor and provide free health care for people and pilgrims by developing numerous hospitals and dispensaries (MOH, 2010). The national income was inadequate to accomplish much progress in the health services even though the establishment of the department was an initial step for the provision of curative health services. "Most of the people still preferred traditional forms of medical treatment" (WHO, 2014). In 1950, the formation of the Ministry of Health in Saudi Arabia (MOH) was the next most significant step, under another royal edict the five-year strategy of development were initiated by the Saudi government after 20 years (Mufti, 2000).This strategy has been established to enhance the sectors of the country and included Saudi Health care system (Mufti, 2000). In Saudi Arabia, there has been no research into the feasibility of utilising HHC services by the experiences of older people and their contentment with the amount of care being received, while the Ministry of Health is looking for providers of HHC. This is due to lack of knowledge of such programs.

Moreover, being a culturally bound society, healthcare providers require introducing a system of care which may be in compliance with the social and cultural norms of Saudi social system. This would help to achieve better application of respective system as well as acceptance by the people (MOH, 2010). A culturally acceptable system would retain effective provision of intended services as well as will enhance patient satisfaction levels.

Despite the fact that older people and service providers confirm their stated experiences, their descriptions and degrees of contentment will vary in reality, so in this study it is evident that the views of older people should be heard as they are unique and reliable sources, with valuable information to share.

1.3 Statement of Research problem

The modern approach of the HHC service considers what other countries are doing and adopting a reflective awareness of how to advance and improve further. These approaches include use of qualified specialists and programs related to HHC. This has led to the need for research on the actual levels of patient satisfaction and beneficiaries of these health services in the country. It also includes identification of the challenges that prevent the improvement of the services provided in this area. In this study, the key issue is to determine the degree of satisfaction with the services offered through the HHC

system, the problem of this study lies in the lack of research in this area, and large obstacles that stand in front of evolution and divergence of views of older patients in the level of services, and the need to disclose ways to promote HHC in the Kingdom of Saudi Arabia.

1.4 Research aim

The aim of this research is to examine the level of satisfaction of older patients, in the context of factors such as accessibility, availability, and HHC service quality. In the light of this assessment, proactive procedures will also be suggested to improve the current HHC services in the Al-Baha region of Saudi Arabia.

1.5 Research Objectives

- To develop new knowledge regarding HHC services offered to older patients, specifically in the Al-Baha region of Saudi Arabia
- To study the features of patients obtaining HHC services in the Al-Baha region of Saudi Arabia; for example, age, gender, living arrangements.
- To provide suggestions to health care providers for the enhancement of the HHC services by considering the primary and secondary data.

1.6 Significance of the research

In Saudi Arabia, HHC services for older people were initiated in 2010 and are thus relatively new. Presently, there is sparse research regarding older people in Saudi Arabia, which implies a dearth of research on HHC services. This research examines the way HHC services are delivered and the obstacles which stand in the way of this delivery. The study aim outlines the present situation of the new HHC services being provided to older people in Saudi Arabia with a specific focus on the view of the patients. Indeed, this will aid health care providers in enhancing their HHC services and improving the current strategies at management level, serving in turn as a basis for further research in Saudi Arabia. Thus, the aim of this research is to identify the ideal method of quality care provision within good health services. This approach will be culturally sensitive to the religion and beliefs of by far the majority of people in Saudi Arabia. This aspect is

significant since the older population in Saudi Arabia are comparatively watchful of their religion and culture.

1.7 Research Question

1- **W**hat is the level of satisfaction of older patients with HHC services?

1.8 Sub Question

1.8.1 Do demographics and culture affected the level of satisfaction of older patients?

1.8.2 What are the views of older people of Home Health Care?

1.8.3 What do managers and policy makers think are the factors which enhance or limit Home Health care?

1.9 Hypothesis:

By convention, the hypotheses are stated negatively as 'null' hypothesis and it is only for the Quantitative part in this study. I decided to use this assumption, with the hope of proving the contrary, especially to increasing the controversy and argument for this study and increase the power of search to answer above questions because this study it is new in the Saudi context.

By inferential statistics as follows:

- There is no effect of the quality of HHC Service provided in Al-Baha Region, Saudi Arabia on older patients' satisfaction.
- There are no differences in the satisfaction level of older people with the HHC Services, which they received due to their Demographic Variables (gender, marital, Status, education and diagnosis).

In Karl Popper's book *Objective Knowledge* (1962) he argues that it be important to be openly sceptical of results and theory. Although many data support a theory, they will eventually be overturned by new data. Thus, the 'null' hypothesis has been used in this study. H0 symbolizes for the null hypothesis , for example, "there is no relationship between the withdrawals of one more of the variables" (Rosenthal Rosnow, 1991). It may

be that a null hypothesis is a key point from which to prove the negative results (Nickerson& Appelbaum, 2000).

1.10 Justification for the selection of Al-Baha region of Saudi Arabia

In Saudi Arabia, there is a shortage of health services in some regions (Al-Juhani and Kishk, 2006) Such as Al Baha region, which is located in southern Saudi Arabia? In this study, HHC services is a relatively new concept in Saudi Arabia, studies that analyse older patients' experiences and their level of contentment with health care services are few and far between. Concerning the provision of health care to locals in Al Baha community, it is not ideal to have non-Arabic-speaking nurses, due to language and cultural barriers. Further barriers include factors such as social conditions, customs, traditions, and standards of living. For these factors, Al Baha region is good environment and interesting for this study. These could be apparent in the contentment level of the patients. As a result, research in this field is required to reflect accurately the standard of contentment of HHC service users. I believed that there are also another reasons for the dearth of the studies, including most of these providers, nurses, and doctors at the HHC sector in Ministry of health are expatriates and are thus from different countries and backgrounds and or they are not attractive , so I did not find any study which will be supported in this field . Of course, there is some statistical information available in so far the demographics and the numbers of the older patients are concerned, but they are not studies. Sharm El Gilany and Al-Wehady (2010) state that this could be the reason for the weak communication link which exists between older patients and service providers.

1.11 Research Gap

In general, there is a dearth of studies that explore the experiences and satisfaction of older patients with HHC services in Saudi Arabia. Moreover, this kind of health care service is new to the Saudi context, as mentioned earlier. In the past, the focus of health activities was directed towards hospital-based services. Also, the majority of health professionals including doctors and nurses are expatriates, coming from countries other than Saudi Arabia, who have different cultures, some of which are not consistent with the culture, religion, language, etc. especially, Al Baha region. According to Aldossary in (2008), this diversity may result in a poor communication between older patients and

service providers. Thus, the current study addresses the gap in the available literature. It explores the current situation of HHC services for older patients in Saudi Arabia, with a particular focus on the patient's perspective. In conclusion, this research can assist authorities in formulating new, reliable strategies for HHC services that are based on the patients' requirements. Finally, it serves as a basis for future studies because this study is the first in this field in Saudi Arabia, especially in Al Baha region.

Chapter 2: Saudi Arabian Health System

2.1 Introduction

In this chapter of the study, the chronological development, and the existing health care system of Saudi Arabia is analysed. Health care is a priority in Saudi Arabia to ensure a healthy and productive population. One of the major objectives of (MOH) is to provide a quality and integrated Health care service to its citizens by adopting a PHC approach as a key health strategy. MOH plans to develop at least 2,000 PHC centres nationally, which promotes wellness and disease prevention, safe water and sanitation, proper nutrition, provision of maternal health and child care, immunization, and treatment of common diseases and injuries. The strategic plan of MOH intends to develop a health care system in Saudi Arabia that is focused on the needs of the patient, and recognises the importance of providing an integrated Health care system, with particular emphasis on the management of chronic diseases within a PHC context. Despite considerable progress and expansion in the provision of health care services, Saudi Arabia continues to encounter serious challenges that may affect the quality of health care services. To better understand the dynamics involved in Saudi health care system, this chapter examines and analyses the chronological development of the health care system. The next section provides a background of the Saudi health care system, followed by a discussion on the structure of the health care system. To suit the purpose of this study, the subsequent sections scrutinize the health care provided to older populations in Saudi Arabia, as well as the development of home health care services for older.

2.2 Background

In the past few years especially from 2010, there has been substantial improvement and expansion in the provision of health care services in Saudi Arabia. Saudi Arabia is one of the biggest Middle Eastern countries as it occupies a major portion of the Arabian Peninsula. It is situated in the external portion of South West Asia and is believed to be the most dominant nation in the Arabian Peninsula, Central Department of Statistics and Information (CDSI, 2009). One reason for this is the strategic aspect as the Kingdom links the two biggest continents, Asia, and Africa. About HHC services in Saudi Arabia, health care services for the ageing population are required on an urgent basis, particularly

the health services that are provided at their residence. This might therefore positively influence how subsequent studies in the domain of older care are implemented (MOH, 2010).There are several difficulties are still encountered by the Saudi health care system which means that new strategies and regulations need to be presented by the Saudi Ministry of Health (MOH), with other sectors effectively collaborating with the health care system (Almalki, 2011). The policies of the Saudi government are followed by the Saudi health care system which provides almost 60% of all the health care services to the 27 million residents and nationals. It was in 1925 that the foremost public health department was created in Mecca on the basis of a royal decree from King Abdulaziz (MOH, 2010). The responsibilities of this department included sponsoring and supervising free health care for the population and pilgrims by setting up several hospitals and dispensaries. Even though this first step was vital in the provision of health care services, the national income was inadequate to achieve substantial developments in this field. However, the health care system encounters several difficulties because of issues like lack of Saudi health professionals, multiple functions of the health ministry, lack of funds, varying disease patterns, excessive demand as services are provided free, lack of a national crisis management policy, inaccessibility of certain health care facilities, insufficient use of the capabilities of electronic health strategies and an absence of national health information system (WHO, 2001).

The services provided as per the strategy from 2010 to 2020 by the Ministry of Health in Saudi Arabia have been stated below:

1. The provisional services for primary health
2. Provisional services for health care across the treatment centres, specialized secondary centres and hospitals
3. Measures for health and vitality statistics and accordingly carrying out scientific research and studies and making their analysis for implementation
4. Incorporating necessary health strategy into the provision of health care
5. Arranging programs for generating workforce, with being collaborated with assistive authorities, in the area of health

6. Rules and regulations to prevent and restrict the proliferation of infectious diseases, epidemic ailments and quarantine and also monitoring the status
7. Controlling the licensing process in private health care centres and their employees and performance though monitoring and implementing necessary measures
8. Standardizing the level of quality in health care premise and supervising their proper application
9. Ensuing the ethical practice by the health care professionals and their consistent obligation to the rules and regulation to keep clean the profession
10. Focusing on the rules and policies to maintain the pharmaceutical and medical research and experiments
11. Diffusing the knowledge of fundamental health education at community level
12. Synergy and liaison among the international, regional and local health care organizations (MOH, 2010)

Hence, most of the residents were still dependent on traditional medicine and thus the occurrences of epidemic diseases amongst the residents and pilgrims remained high (Casalino, 2014). Setting up the MOH under another royal order in 1950 was the second major advance. The government launched the 5-year development plans twenty years later to enhance all sectors of the nation including the health care system. Following this step, there were significant advances in the health care system of Saudi Arabia (Mufti, 2000).

The health care sector of the nation deals with a fast-growing population and the greater demand these places on the health care sector. On the whole, the increasing of population is the real challenge for any government, especially in the delivery of health care.

The Saudi government acknowledges this situation, which is why it took several initiatives in recent times to promote the private sector to meet the deficiency and take advantage of this potentially profitable sector. The government essentially regulates the health care sector of Saudi Arabia through the Ministry of Health (MOH, 2010).

Moreover, there are several semi-public companies that particularly manage hospitals and medical services for their staff members. Furthermore, an important function is

performed by the private sector with respect to offering quality health care services in the country (Almalki, 2011).

The organisation of the Saudi health care system is such that it seeks to offer the most basic health care services to the entire population, with certain specialised treatment services being provided at particular private and public hospitals. A concise picture of the most important factors that influence the Saudi health care sectors is provided by the Colliers International Health care Overview (Colliers.I, 2015) as well as the future approach.

2.3 Structure of Health care Sector in Saudi Arabia

Several health care facilities are operational in the Saudi Arabian Kingdom at present which receive funds from the Ministry of Health (60%) and other government bodies (20%), including the Interior Ministry, Defence Ministry, Ministry of Higher Education (MOHE), the National Guard and the Red Crescent Society (RCS) (Health Statistical Book (HSB,2012).

Apart from the health services that the government provides, a substantial contribution is made by the private sector, particularly in cities and bigger towns.

There are 244 hospitals and 1,057 clinics that are managed by the private sector, which has also played a part in bringing advances to the health sector and in typical health indicators (HSB, 2012). In my view, these statistics clearly prove the development health services, along with other elements like better and extra available public learning, greater health knowledge in the society and improved life situations, have played a role in bringing substantial enhancements of the health indicators presented previously (see Figure 1).

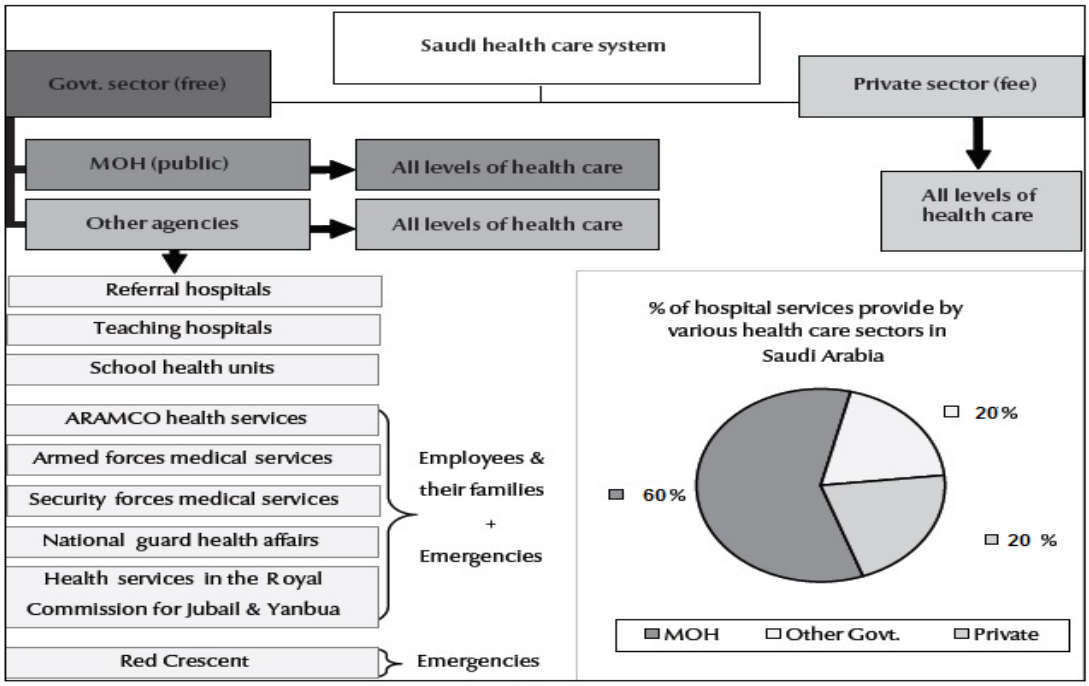

Figure 1. Health care system in Saudi Arabia

2.4 Current Health Care Services for Older People in Saudi Arabia

The Ministry of Health and the Ministry of Social Affairs are the two government ministries that offer health services to the aged population of Saudi Arabia. The Ministry of Health is seeking to develop a database of the older population by getting the in touch with them and meeting with them on a personal basis at their residences as well as the data from statistical department. In addition, it is aiming to offer a health services package that is curative as well as rehabilitative. It has also been suggested that more decisive HHC policies should be introduced so that greater effort is made to ensure that older patients get out of hospital and inpatient residential facilities, to be looked after under the HHC programme. Through this programme, the access of the older to health care services is addressed, while the government simultaneously tries to come up with solutions to any problems related to health care (MOH, 2010). Before the status quo is analysed, it is imperative to gain a complete understanding of the duties of patients and the roles of the bodies that play a major part in sustaining and rapidly implementing the policies and health laws of the Saudi Kingdom.

2.5 Ministry of Health (MOH)

MOH provides health services for everyone in Saudi Arabia including the older people through two sectors, namely the primary health care sector and the hospital care sector. The MOH has been defined and categorised into two broad demarcations.

2.5.1 Primary health care sector services

The Saudi government established the primary health care PHC sector in 1980, when health centres and maternal and child centres were integrated under the primary health care sector (MOH, 2008). PHC centres provide health services for all citizens, including older patients (MOH, 2010), and education and continuous training for workers in the health centres in various categories of public administration. Health centres as well as health departments in most cities of the Kingdom need to adopt this principle and work hard to meet the needs of the community (MOH, 2008). Ministry of health has created up to date around 2094 PHC centres, with the strongly recommendation and the planning to increase the numbers of PHC centres for the next years .The health indicators of PHC centres up to date in Table 1 below

Table 1: The Health Indicators for PHC Centres in Saudi Arabia

Facilities	Number
MOH Hospitals	249
Other Governmental Hospitals	39
Private Sector Hospitals	127
Total Number of Hospitals in KSA	34370
Beds in MOH Hospitals	10939
Beds in Private Sector Hospitals	12817
Total Number of Beds in KSA	58126
MOH Health Centres	2094
Private Collected Units	2021
Private Clinics	199
First Aid Centres	280
First Aid Ambulances	966

Source: Saudi statistical Book 2014.

The programmes and services offered in primary health care centres include maternal and child care, care for older people, breastfeeding programmes, and diarrhoeal disease control. The medical team that provides health services for the older comprises physicians, dentists, pharmacists, nurses, and social workers (MOH, 2010). The medical team assesses the health status of the older people as identified by nurses, provides clinical examination of them when needed, and arranges the plans for the patients to visit the PHC centres regularly (MOH, 2008). PHC service providers arrange a temporary visit for one or two times so if the patients still need more attention, the doctor will arrange for HHC registration and send referral report to HHC department of the nearest hospital within the area of responsibility of the centre, and provides health care.

2.5.2 Hospitals sector

MOH has expanded the provision of curative care at all levels and in all disciplines by established hospitals which serve and cover all regions in Saudi Arabia. Up to the present, the total number of hospitals is approximately 249 with a different number of the beds. See Table 2.

Table 2: The Health Indicators for Hospitals in Saudi Arabia

Facilities	Number
MOH Hospitals	249
Other Governmental Hospitals	39
Private Sector Hospitals	127
Total Number of Hospitals in KSA	34370
Beds in MOH Hospitals	10939
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MOH Health Centres	2094
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Private Clinics	199
First Aid Centres	280
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2.5.2 (A) Department of Home Health Care Service (HHC)

As mentioned previously, HHC services pertain to the medically-related services that are offered to patients at their homes instead of at a Health care facility like a hospital or primary health care centre (US Legal, 1999). In Saudi Arabia, HHC services are the medical services that are offered to particular groups of people by a team of health care experts who work in Ministry of health.

2.5.2 (B) Message and Values of HHC

The aim of HHC is to provide comprehensive health care for the patient at her or his home within the traditions of society, culture and religion. In late of 2010 the Saudi Arabia HHC services programme was established in hospitals and provides ongoing comprehensive health care for patients at their homes. Patients who qualify for this service need not stay in hospital (A.Sagheer, 2014). Health care is provided using trained health professionals, directly and in coordination with the doctor at the hospital. HHC services play a major role in the general services being offered to patients within the hospital (A.Sagheer, 2014). Many cases are targeted under this program, ranging from patients who suffer from chronic respiratory, heart, and kidney diseases to those with other cases. Also, patients who require critical care, such as those with long-term enteral feeding tubes, receive care for the intubation site to prevent contamination and infections.

2.6 HHC Objectives in Saudi Arabia

The Ministry of Health has made a commitment to the provision of health care at all levels and is aware of the importance of the health services accessible to those who need it. The ministry initiated the development of a domestic medicine program in late of 2010, which aims to deliver medical care in a broad sense to patients who meet the criteria and conditions in their places of residence.HHC services programme objectives encourage the families of older patients to participate in the process of health care, provide information and training on patient care and reduce the rate of transmission of infectious diseases that may occur during a stay in hospital (A.Sagheer, 2014). Also, the objectives of the HHC services programme include instilling the concepts of compassion and righteousness in families, and providing support and training for families and primary caregivers concerning the basic skills needed to care appropriately for older

relatives/patients. More attention is given to the patient when he/she is under the care of a family caregiver, which could help alleviate the suffering of the patient, making him/her feel comfortable, secure ,provide health care for patients in their homes and promote their feeling of safety in the vicinity of their families without the need to stay in hospital (A.Sagheer, 2014). if their condition is stable, and avoid infection that can occur during long stays in hospital, thus reducing the discomfort resulting from the visits of patients' relatives to hospitals and reduce the waste of funds provided from the government for the hospitals (A.Sagheer, 2014). I believe that the keenness working in the HHC department to provide the available services diligently and carefully and develop continuously to reach their efforts to achieve the satisfaction of the service user and the aspirations of the leadership to reach the desired goal.

2.7 Categories of Beneficiaries

HHC services are provided to a certain target group, which has been described by the Saudi Ministry of Health (See Table 3).

Table 3: HHC Categories

No	Categories of Beneficiaries of HHC
1	Post-op cases
2	Car accidents and head injuries.
3	Rehabilitation and physiotherapy
4	Bedsore patients
5	Diabetic food.
6	Palliative care & terminal illness cases
7	Psychiatric patients
8	Chronic diseases
9	Respiratory patients
10	Social services

2.8 Criteria for Accepting Patients

Criteria have been established by the Saudi (MOH,2010) for approving HHC services patients. MOH is also keen to know the cases that benefit from executing these standards. These include:

- *Patients from the beneficiary categories defined in the (HHC) service Programme.*
- *The physician has made referral to (HHC).*
- *Situations where the distance between the patient's home and the hospital is not more than 50 km and transportation time are not more than 30 minutes.*
- *Approval by the homeowner or the family responsible for the home visit by*

The older patients are categorised regarding health status (MOH, 2010). It may be necessary to reconsider this procedure on a regular basis, and this aspect will be addressed in the discussion chapter in this study, especially concerning future recommendations which are presented.

This study seeks to gain further knowledge about the satisfaction levels of the patients regarding these services and the degree to which the services fulfil their requirements. Even though introducing this kind of care system represents a huge achievement on offering services to the older in Saudi Arabia, it is imperative to investigate the program from the point of view of the patient.

This would allow for understanding its effects, the degree to which patients are contented with the services, and the extent to which they feel that they are being provided with quality services.

2.9 Ministry of Social Affairs in Saudi Arabia.

The Ministry of Social Affairs provides (MOSA) for the various needs of older people. Some of the health issues for this group include problems with sight and hearing, abnormalities in the endocrine glands, susceptibility to infections and chronic diseases (such as diabetes), anaemia, diseases of the digestive system, and psychological problems

associated with feelings of loneliness, anxiety about death, social deprivation and a sense of competence, as well as divorce, retirement and personal hygiene (MOSA, 2010).

Health care services provided to the aged population are as follows:

1. Comprehensive medical rehabilitation of physical disabilities, and stimulation of Blood circulation, muscles and joints, in collaboration with medical institutions and treatment.
2. Provision of social services to resolve the social problems and issues faced by older people.
3. Assistance intended to strengthen the network of social relations for older people and their families.

2.10 Conclusion

This chapter discussed the various aspects of the Saudi health care system. Like other developed and developing countries, the health care system has several challenges, such as the lack of Saudi health professionals, multiple functions of the health ministry, lack of funds, varying disease patterns, excessive demand for free services, lack of a national crisis management policy, inaccessibility of certain health care facilities, insufficient use of the capabilities of electronic health strategies, and an absence of national health information system. These challenges could inadvertently affect the quality of services provided to citizens, particularly to the older and their families. To move forward, this section identified some key issues that should be addressed.

One of the possible strategies to fully address the growing demand for quality health care is the development of HHC programmes for older people. HHC programmes encourage family members to participate actively in the care of their older family members in the comfort of their homes.

Chapter 3: Literature review

3.1 Introduction

In this chapter, I present a review of the previous studies which related to this study including those studies that deal with promoting the best available quality health care for older people in Saudi Arabia, ideal with cultural aspects that create satisfactory health care as well as the important role of governments and health policy-makers in creating highly satisfactory health care. Moreover, the perception of patients as the basis of satisfaction with HHC services has been presented. At the end of this chapter, the increasing number of the older population worldwide and aging population in Saudi Arabia producing challenges arising from this aging population are presented. In addition to that, the review also presents the views of patients about the available services to determine their level of satisfaction with them. This chapter begins by specifying the means and strategy of searching related literature and studies used in this study. It provides a list of the literature that is relevant for the study, as well as criteria for their inclusion and exclusion in the overall research. The literature or studies are grouped into specific themes that provide the framework for discussion, analyses, and arguments to validate claims in the study. The studies selected are those related and relevant to the topics considered in this study. The chapter concludes by discussing the increased number of old age people in the perspective of Saudi Arabia as well as that of the whole world. Moreover, it argues over the problems about the said generation owing to their increased number.

3.2 Literature Search Strategy

Description of the search strategy and searching process combined with the selecting criteria and sources are given in this part of the study. The study has been formulated based on the assessment of some evidence collected from selected research materials along with a detailed account of investigation on the principal studies (A. Brettle, 2007). Moreover, reliable data sources are searched by using particular keywords which allow carrying out a systematic research. It involved identifying, defining, refining and analysing the data obtained from relevant articles regarding the topic at hand (LoBiondo-

Wood and Haber, 2014).Therefore, accessible and reliable research works have been explored for the evaluation of this study as well as those contextual studies that really fit into the condition of Saudi models of patient centred care all across the ministry of health Saudi Arabia.As I mentioned previously, the study aims at assessing the satisfaction level among the aged patients regarding availability, HHC service quality and accessibility. All accessible and highly relevant materials that provide appropriate justified belief and knowledge scope are included in this part of the study. However, only those materials with knowledge that can be regarded as valid, reliable and relevant are considered and analysed. The foundations for choosing relevant materials or literature are usually anchored on the definition of knowledge, knowledge of people and the process, leading to justified beliefs. Research on pertinent materials is centred on the problems related to the generation and diffusion of knowledge, around some specifically inquisitive areas (LoBiondo-Wood and Haber, 2014). As mentioned earlier, this study intends to provide an insightful view into the Al Baha culture of Saudi community, as well as the actual services of health care being catered to the older patients by HHC providers in order to bring an overall enhancement to the HHC system in Saudi. Likewise, as mentioned earlier, this study aims to investigate the satisfaction of older people on the services they receive from HHC. In this regard, I selected PsycINFO, SCIENCE direct and PUBMED, CINAHL along with articles resulted from GOOGLE scholar search engine and the library of University of Salford for reviewing the literature. The official websites of Ministry of Health and Social Affairs Ministry of Saudi Arabia are also used as sources for this study.

Table 4: The databases used as sources in this study

Databases used in this research
1- The websites of Ministry of Health in Saudi Arabia. **2-** Library of University of Salford for reviewing the literature. **3-** Social Affairs Ministry of Saudi Arabia. **4-** ProQuest Nursing and Allied Health Science. **5-** American Psychology Association database (PsycINFO). **6-** Cumulative Index to Nursing and Allied Health Literature (CINAHL) **7-** National Centre for Biotechnology Information (PubMed). **8-** Google Scholar.

In the course of the search, each study has been examined on the basis of clear information and key terms in prior to be added into the literature review. I used keywords such as older patient, ageing, Saudi health, HHC, patient satisfaction and older patient. Each study employed for the research has been assessed as per the information and key terms previously added into the literature review. This indicates that the keywords and terms used in the study are attempted to be congruent to the respective research so that to enhance the effectiveness of this paper. The understanding of terms is also to be dwelled upon. The course of compiling the literature review yields to particular goals and objectives that utilize the literature in favour of the present study (LoBiondo-Wood and Haber, 2014). Reviewing the definition of HHC will benefit the research, which is contextual to the Saudi scenarios and the impact of education, language, culture, challenges and scopes of HHC upon HHC around Al Baha region of Saudi Arabia. The measuring process of the performance of HHC services along with accounting gaps between service providers and older patients has also been documented. It also provided assistance to the analyses of theories in relation to the recent studies for determining the useful data which initially fell short in HHC services. Finally, HHC is going to be appropriately defined though the literature review and the success and failure, anything can happen to the patient-centred care after being implemented into the health care system of Saudi Arabia (M.Damanhouri, 2011). Also, the horizon of the literature review should be wide with varied types of journals, articles having explicit relation to the

research question as well as extended reading of previous academic papers in various universities of developed and developing countries (M. Damanhouri, 2011). To sum it up, I have gone through all the literatures and any publication related to the health services in Saudi Arabia especially centred on aged patients (MOH, 2012). The search strategy of this study is designed though selecting the articles strongly contextual to Saudi Arabia. Therefore, international literature is reinforced by the search strategy in absence or lack of appropriate articles on Saudi context. It is quite necessary to attain a thorough understanding of the terms employed in the study. The compilation of the literature review is done whilst keeping in view the respective goals and objectives of the pertaining study (LoBiondo-Wood and Haber, 2014). The definition of HHC is essential to be considered during the course of literature review as it is quite relevant to the educational, linguistic and cultural aspects as well as the problems and opportunities regarding HHC within the context of Saudi environment particularly that of Al Baha region.

Moreover, the determining factors which tend to evaluate the performance of HHC services in addition to the inadequacies regarding accounting processes occurring between service providers and older patients, has also been examined. It also evaluates the existing theories within the perspective of the current research so that to identify the research gaps which previously existed to obstruct acquiring relevant data for HHC services.

Finally, the corresponding data will be employed to define HHC along with determining its success and failure, as after its implementation to health care system, the patient-centred care is likely to be influenced by any factor, particularly in Saudi Arabia (M.Damanhouri, 2011). Moreover, the literature review has been done employing different types of journals and articles which effectively address the research question and include a broad ranged study of different contextual arrangements of both developed and under developed countries (M.Damanhouri, 2011).

This literature review has been complied after thoroughly studying all the exiting literature and publications related to the health services in Saudi Arabia particularly based upon old age patients (MOH, 2012). The search strategy involves selecting such data

sources for examination which are increasingly related to the context of Saudi Arabia. In this regard, owing to the lack of suitable literature available in Saudi context and some international literature is employed.

Table 5: Initial Inclusion and Exclusion Criteria

	Inclusion criterion	**Exclusion criterion**
Article	Directly related to HHC, Aging, Saudi Health system and Health care.	Article not directly related to HHC and Health care.
Language	English and Arabic (Translated).	Other languages.
Nature of Reference Materials	Officially Published.	Not officially published.
Period	2000 up to 2014 (unless relevant from before).	Before 2000, except some important or relevant studies.
Studies	A mixed method of methodology approach.	Other unrelated studies

Main Keywords used in the study

Older Patient Satisfaction, Health care, Quality, HHC and Ageing.

3.3 Search Process

Independent searches have been employed to address some factors. Firstly, the study to evaluate the level of satisfaction of older patients regarding the HHC services in Al Baha region was based on three different perspectives i.e. HHC, Older patients and the level of satisfaction of patients who have had received HHC care. These three approaches were addressed and assessed in the light of related terms and keywords. A thorough understanding of the Health care within the context of Saudi culture was employed as a basis to develop the respective key terms and to interpret the HHC in the country. The study intended to identify the particular objectives and topics of research which will assist in representing the implementation of HHC services i.e. whether older patients are satisfied with the received serviced as well as what factors are responsible for impeding

the attainment of significant levels of satisfaction among patients. A large number of articles was selected for the purpose of research among which, 42 articles were chosen to be proceeded with for further evaluation. From these, 18 articles were considered as appropriate for use and providing the extent of information required by the particular themes of this study.

3.4 literature themes in this study

Table 6: The Summary of all included studies

	Review title & references	Country of origin & references	Purpose	Main Themes	Strengths	Limitations
1	Promoting quality home health care in the Southern Region of Saudi Arabia	Saudi Arabia Al-Modeer, Hassanien, and Jabloun (2013)	Highlighted the need to improve the quality, availability, and effectiveness of provision of health care, particularly home Health care service delivery, as the number of older people in Saudi Arabia is	Promoting high quality of health care for older people in Saudi Arabia	Highlighted the duty and responsibility of health authorities in promoting effective provision of health care services, i.e., those provided by home health care facilities	Did not consider the impact of cultural variables such as the psychology of Saudi older and the role of the family in Saudi society

			increasing			
2	Duty of health authorities to promote effective health care services, i.e., those provided by home health care facilities	Saudi Arabia Al Na'aim (2013)	Need to promote high quality and efficient home health services	Promoting high quality of health care for older people in Saudi Arabia	Used a thematic method, which incidentally was utilized in this study. At the same time, the study used a methodology based on the integration of the quantitative approaches	Did not consider the impact of cultural variables such as the psychology of Saudi older and the role of the family in Saudi society
3	Common cultural values and behaviours in Saudi Arabia giving importance to "affiliation and family,	Saudi Arabia Lipson and Meleis, (1983)	Need to recognize cultural values in promoting quality home health care	Promoting high quality of health care for older people in Saudi Arabia	Provided relevant facts on how cultural aspects affect older patients' view about home health care	A little bit old and was conducted about two decades ago

	culture, time and space orientations , interactiona l style, and attitudes toward health and illness.”					
4	Outline of the kind of health care that older patients should receive and the specific obstacles they faced	Saudi Arabia Al-Gwayer (2013)	Need to recognize the cultural values of older	Promoting high quality of health care for older people in Saudi Arabia	Study itself did shed some light on the axes of Gerontology	Did not specifically provide a precise description of the reality of the older people

5	Burden on the part of hospitals and patients can be reduced regarding money, effort, and mental state by incorporating various theories and methods in the delivery of home health care services	The United States of America Caffrey et al. (2011)	A need to develop the quality of home health care provision	Promoting high quality of health care	Understanding patient's satisfaction in general	Did not specifically delve into the issue of older patients satisfaction about HHC services
6	Objective of national estimates on the differences in the use of HHC among men and women	The United States of America Adrienne's, Jones, Harris-Kojetin,	The need to develop quality home health care	Promoting high quality of health care	The study also showed that the inter-relationship in the field of home care is significantly	Not much elaboration on the factors that affect the field of home care

	aged 65 years and above	and Valverde study (2012)			affected	
7	Mechanisms provided to older patients to increase the satisfaction of older patient health care services.	Middle Eastern Region Abyad (2006)	Pressing need for the provision of health care facilities, such as medical, psychiatric and rehabilitative services to alleviate problems on long-term debilitating conditions in old age	Important role of governments and health policy-makers in creating highly satisfactory health care	Understanding the role of governments in creating satisfactory health services	Limited to purely recommendatory perspectives
8	Specific variables that affect the satisfaction of older patients	United States Leff et al. (2006, p. 1357)	Understanding variables linked to older patients' perception	Perception of patients as basis of satisfaction on home health care services	Older' patients' perception shaped by age, sex, living condition, poverty status, co-morbid	No further explanations on other variables were made except those previously mentioned

					conditions, functional impairment, depression status, and cognitive function, affect their satisfaction to HHC.	
9	Causes of increasing number of older population worldwide	United States United Nations Population Division (2011).	Identifying the causes of increase in number of population	The increasing number of older population worldwide	Two leading reasons increase in number of older population: 1) Decline in fertility rate around the world; and 2) Multi-factorial and includes improvements to health services, educational status, and economic development	Discussion is limited to the same causes mentioned

10	Factors that contributed to increasing in number of older people in Saudi Arabia	United Nations – Switzerland According to Bloom, Boersch-Supan, McGee and Seike (2011)	Identifying the factors that contributed to the increase in number of older people in Saudi Arabia	The ageing population in Saudi Arabia	Factors this phenomenon in Saudi Arabia include improvements in health and living standards, quality of education, an unexpected reduction in the fertility rate, and fewer migrants	No attempt for further discussions on other factors
11	Challenges faced by Authorities with regards to ageing population in Saudi Arabia	England Bloom et al. (2011)	Search for ways to address the challenges arising from ageing population	Challenges Arising from an ageing population	Older people are not considered as liabilities or encumbrances to society	Limited to discussions outside Saudi Arabia
12	Specific variables that affect	United States	Understanding variables linked to	Perception of patients as basis of	Older' patients' perception	No further explanations on other

	the satisfaction of older patients	Leff et al. (2006, p. 1357)	older patients' perception	satisfaction on home health care services	shaped by age, sex, living condition, poverty status, co-morbid conditions, functional impairment, depression status, and cognitive function, affect their satisfaction to HHC.	variables were made except those previously mentioned

3.5 Promoting the quality of health care for older people in Saudi Arabia

A theme about the promotion of health care for older in Saudi Arabia should be included in this study as it is expected to enhance the satisfaction level among them. Studies about this theme were derived from research made in Saudi Arabia and other countries as well. Health care services tend to play a major role in lives of people in every society. These services not only include the availability and access to doctors, nurses, other Health care staff, medicines and treatment procedures but also the quality of the available services. Studies show that with the passage of time, the ratio of older age people is increasing across the world, presenting significant challenges for the Health care providers as older patients require more care and attention in their treatment than younger patients.

Along with facilitating the provision of respective services, the authorities are also subjected to ensure that the recipients of these services are satisfied with their scope and quality.

Moreover, it enhances the need to provide effective HHC services for those patients who are unable to come to the hospital for receiving their treatment. This section addresses the need to promote the quality of health care for older patients within the context of Saudi Arabia as well as Middle East Countries such as Saudi Arabia, Oman etc. where the number of older people has increased as a result of improvement in the provision of health care services, as well as the reduction of infectious diseases that cause early death, there is indeed a need to improve the quality, availability, and effectiveness of provision of health care, particularly HHC service provision (Suwaidi, Ward & Younis, 2013). Best available quality of HHC without doubt creates satisfaction among patients, particularly older patients, who are in need of this kind of service (Suwaidi, Ward & Younis, 2013). However, the forces that drive satisfaction among older people to choose HHC services are not based on the perception of patients, particularly older patients alone. Structural factors such as government intervention as well as family and cultural influence on decision to avail or not HHC services also play an important role in influencing the decision and hence satisfaction of older to HHC services provided to them by health professionals (Kouli et al., 2013).

A study by Al-Modeer, Hassanien, and Jabloun (2013) explored the importance attached to the reality of promoting quality HHC services provided in the Armed Forces Hospital of Southern Region of Saudi Arabia. The study showed that many older people attending HHC facilities in Saudi Arabia's southern region were suffering from many chronic disorders and that those people with co-morbidities need preventive, curative, and rehabilitative programs to improve the quality of life in HHC setting. Using descriptive analytical data to achieve its objectives, the study was conducted over a period of six months in 2011 by reviewing the medical records of 880 patients, aged above 60 years old. The assessment of the morbidity profile facilitated the intervention through HHC to improve health status and quality of life of older. Indeed, the significance of raising awareness on programs and design to improve health care services in the context of

cultural setup, on the part of health authorities, was one of the important themes in the study.

The study also emphasized the need to encourage such efforts, and highlighted the importance of welfare theories to enhance health services for the older in Saudi society. However, it did not examine the perceptions of the older patients on the health care provided to them. It also did not consider the culture of Saudi society as a variable that can have an impact and play an active role to change the results of the study. Nevertheless, the study is relevant for this current one because its statistical method served as guide or support for this thesis.

In a study by Al-Nuaim (2004), a thematic analysis approach was used to examine the responsibilities of society in the promotion and improvement of HHC services provision in Saudi Arabia. The study highlighted the duty of health authorities in promoting effective provision of health care services, i.e., those provided by HHC facilities. Various important results were deduced in the study, suggesting that older people should be protected from isolation and should receive health care with the cooperation of family members and volunteer members .The study likewise suggested that health care professionals should learn from the experiences of other developed countries, such as the European nations and the United States, and to explore other options to improve health care for the older. Al-Nuaim's study however is highly relevant since it used a thematic method, which incidentally was used in this study. At the same time, the study used a methodology based on the integration of the quantitative approaches (Hamadi, 2010).

Al-Modeer and Al-Nuaim did not consider the impact of cultural variables such as the psychology of Saudi older and the role of the family in Saudi society. The study likewise did not highlight how such information could be used to suggest ways of further improving the health care system in Saudi Arabia for the older, through description and analysis of the real data and literature collected and obtained.

Studies such as that of Lipson and Meleis, (1983), appropriately provided important facts about how cultural aspects affect whether older patients would view HHC provided to them satisfactorily or not. Although the study of Lipson and Meleis was conducted

approximately two decades ago, Middle Easterners' cultural perspective remained intact, making their study still relevant up to this present time.

Although Middle Easterners vary ethnically as indicated in the study, they permanently share a core of common values and behaviours that include their giving importance to "affiliation and family, culture , time and space orientations, interactional style, and attitudes toward health and illness" (Lipson & Meleis, 1983).

Hence, it is not difficult to see how adequate information by a patient's family, conflicting beliefs about planning ahead and differing patterns of communicating grave diagnoses or "bad news," all play an important role in influencing the satisfaction of older patients in the Middle East in general (Lipson & Meleis,1984).

Based on this study, it is essential to consider such cultural older patients, particularly Al Baha region, Saudi Arabian, to understand and improve the HHC services which provided to them. Hence, a Westerner or a non-Saudi health professional can adopt a personal approach and continuity of care, which are esteemed in the Saudi Arabian culture, to create a best quality and thus, highly satisfactory health services in home facilities, whether within Saudi Arabia.

In another study in Riyadh, Saudi Arabia which by (I.Juweir, 2013) who used the descriptive approach to explore the cultural aspect of "caring for the older between hope and reality". Part of the conclusion in this study is that the care of older people was a burden for families because of the complexity of relationships and high costs. I.Juweir recognized the obstacles that older people faced with regard to HHC, but his study, unlike Lipson and Meleis (1983), did not specifically provide a precise description of the reality of the older people, such as outlining the kind of health care that they should receive and the specific obstacles they might have faced. Nevertheless, the (I.Juweir's study itself did shed some light on the axes of gerontology, which were based on three aspects: (1) Biological aspect, to find a scientific explanation for the phenomenon of ageing; (2) Psychological, to examine the mental component of ageing, and (3) Social aspect, to explain the community's influence on ageing condition.

The study likewise acknowledged the fact that the Saudi government was making efforts to develop and improve health care facilities for older people. However, the development of the health services faced various challenges.

Caffrey et al. (2011) showed that there is a need to develop the quality of HHC provision. The study likewise suggested that the burden on the part of hospitals and patients can be reduced regarding money, effort, and mental state by incorporating various theories and methods in the delivery of HHC services. The study is useful with regards to understanding patient's satisfaction in general in Saudi Arabia context but did not specifically delve into the issue of older patients' satisfaction about HHC services.

The study of Caffrey et al. (2011) was rightfully placed within the context of different environments, society, and social conditions of America, but it did not focus on cultural and social variables and the family. The study remains very useful in the sense that it cited American experience as an experimental characteristic for a developed country like Saudi Arabia, scientifically and medically, in the field of HHC. Although Caffery's study developed a proposed model for the American setting, it can also be used to improve or give some recommendation to the programs of HHC in Saudi Arabia and other countries. The study likewise played a major role in predicting the desired results and presenting a proposal which will improve the level of HHC services in Al Baha region, Saudi Arabia, based on the American experience but in compliance with Saudi culture.

Adrienne's study (2012) presents the objective national estimates on the differences in the use of HHC among men and women aged 65 years and above based on the methods of data estimation from the National Survey 2007 Home care for the older person, conducted by the Centres for Disease Control and the National Centre for Health Statistics Prevention (CDC). The results showed that in the United States, men between the ages of 65 and 75 years used HHC at a lower rate than women. HHC patients were mainly women over the age of 80. Moreover, men were more likely to be married and receive HHC such as post-acute care. The women (65 years and older) who received HHC were less likely than males to receive wound care and physical therapy, and more liable to receive general care services.

Furthermore, in the 65 years and over the range, cancer was more prevalent among men whereas high blood pressure was more common among women.

One downside of this study was that a descriptive approach was used whereby the researchers just adopted a variable type in the extraction of results, which was less rigorous in determining the quality of HHC, the most substantial positive impact in the study is the limit of social requirements. Based on the above objectives and research questions, one of the aims was to investigate the availability of tools and quality of care services. In this respect, this study found that there was a positive relationship between the availability of tools and quality of services. The study could be important and is one of the most objective studies reviewed. The report includes an analysis of the availability of services (S.Aburoub, 2011). The study also showed that the inter-relationship in the field of home care is significantly affected.

It also evaluated communication between the beneficiaries and Health care services providers. Also, it considered the decisions of HHC programme leaders about the quality of development needed to take place regarding special considerations of cost, which can range from existing beneficiaries of spending on the related services to their perception of the quality of these services.

3.6 Important role of governments and health policy-makers in creating highly satisfactory health care.

It is important to include as a theme the role of government and health policy-makers in the creation of highly satisfactory health care because primarily they are at the forefront of undertaking this, and they carry on their shoulders the obligations to do it. World governments, including that of Saudi Arabia, are obliged by the international demand for effectively protecting the health and properly addressing the specific medical needs of patients, particular the older ones (WHO/EMR, 2003). Therefore, the government is responsible for formulating systems which may be a subject to function efficiently and facilitate quality services to the patients. In the same manner, the health policies including the insurance policies and medical grants offered to the patients also have a significant impact on the satisfaction level of patients.

In addition to providing subsidies and facilities for the patients, the government and policy makers may also be concerned about the satisfaction level of health service providers with respect to their jobs. This would have considerably a positive influence over the quality of services they are providing to the patients.

Abyad in 2006 was more specific about the important role of the Middle Eastern government in promoting high-quality HHC services for the older. According to the study, given the demographic shift in which the old age population is increasing at present times, the government, particularly, health policymakers should invest in social systems that would develop the financial capacity of the older to meet their financial needs to avail HHC services. In this case, policymakers should invest in social mechanisms that would encourage and facilitate longer working capacity, more savings, higher public pension, and enhanced health care programs for the older.

All these may take the form of any of the following: tax incentives, expanded housing options, increased employment opportunities, greater employment retention, or educational programs for the older (Abyad, 2006). Furthermore, the study claimed that there was a pressing need for the provision of health care facilities, such as medical, psychiatric and rehabilitative services for early diagnosis and treatment of illness, to alleviate problems that could lead to long-term debilitating conditions in old age (Abyad, 2006).

All such recommendatory perspectives indeed are just important considerations when understanding structural forces that create sources of satisfaction on the part of the older in availing HHC services. However, the structural forces that create satisfaction should also consider the attached mechanisms that would provide safety nets to absorb financially and health risks that older patients may encounter. One such mechanism is health insurance provided to older patients to avail health care services. In which case, the Patient Cantered Medical Home (PCMH), as explained by Kennedy et al in 2013 and Jackson et al in 2013, is an important model of health care system to consider. Satisfaction of older patients is derived from such mechanism. As such, health insurance mechanism emphasized the provision of patient-centred, coordinated, and readily accessible health care services to patient founded on quality and safety.

PCMH model is a patient-oriented type of health insurance mechanism used in health care, particularly HHC to provide comprehensive Health care services including prescription, for medical and dental findings, as well as wellness programs. Such structural component in the provision of health care services likewise respects the diversity and needs of its patients – Health care is standardized or tailor-fit to the need of the older patients.

Likewise, the health care mechanism uses modern technology, such as electronic medical records, in providing for the best or most appropriate team of health professionals to manage each of the health cases or problems of older patients.

3.7 Perception of patients as the basis of satisfaction on home health care services.

A theme on the perception of patients as basis of satisfaction has been included in this study because, as efficiently assumed in this study, the manner by which older patients view the delivery of home care services, i.e., convenience, availability, low-cost considerations, greater personal freedom, speaks well of their positive or negative satisfaction (Marak, 2016, Kouli et. al, 2013). A large number of old age patients are such that they are unable to reach the hospital or other health care service centres to receive their medical treatment. This inability to access the hospitals may be based on various factors including age, physical capacity, resident and economic status of the respective patient. Thus, to ensure the provision of necessary health care to such patients, they are offered the required medical facilities at their homes.

Studies have suggested that patients tend to have variable perceptions regarding the HHC services. The effectiveness of the facilitated services is very much dependent upon the attitude of patients towards the services. There are specific studies that deal essentially with how an older patient views HHC services provided to them as satisfactory. Leff et al in 2006 found that the satisfaction of older patients with regards to health care services provided through Hospital at Home scheme, as dependent variable, was affected mainly by independent variables on the part of the patients, which more specifically were identified as age, sex, whether they lived alone, poverty status, co-morbid conditions, functional impairment, depression status, and cognitive function.

Likewise, the satisfaction of older patients, as dependent variable, was shaped by separate independent variables on the part of the patients' family members, such as age, sex, relationship to patient, self-reported health status, functional status, and whether the family member provided activities of daily living (IADLs) and instrumental activities of daily living (IADLs) assistance to the patient. Bivariate analysis was used to compare the satisfaction in specific domains across patients, to develop a chi-square or Fisher exact test and to determine whether indeed satisfaction is influenced by the factors about both the patients and their family members (Leff et al., 2006). The results of the study showed that in general across patients, there is significant statistical relationship between the satisfaction of the older in the HHC services provided in Hospital at Home and the independent variables identified for specific domains except in the case of IADLs and IADLs. The results showed that ADLs and IADs, meaning financial assistance provided by family members to older patients did not significantly determine the satisfaction and decision of patients whether to choose HHC or not. The study is of Leff et al. (2006) is very much relevant to understanding and identifying the different factors that affect the satisfaction of older patients with regards to the services they receive from nursing home facilities. Likewise, the study is important particularly in distinguishing the factors readily identifiable with the older patients, i.e., those based directly on their perception, and those that are not, i.e. those that are identifiable with their family members. Kouli et al. (2013) conducted a similar study about variables directly identified with the perception of older patients.

They found that the level of patients' satisfaction was to a large extent highly affected by the behaviour, attitude and skills of the Health care professionals, as well as the facilities or environmental conditions in the nursing home. The results showed that approximately 70% of the respondent-patients indicated that they were very satisfied because of helpfulness, attentiveness to patients' concerns, and dependability of staff in times of needs, respect shown to patients, as well as knowledge of patients' health problems. The respondents' satisfaction, however, were less affected by the environmental aspects, such as the manner HHCservices being provided are organized, patient's ability to have choices with regards to their actions, schedule the delivery of care received and the consistency of the people who provide HHCservices (Kouli et. al, 2013).

This study is a real basis for claiming that indeed the attitude and behaviour, as well as in general the working relationship of staff, are important determinants on whether older patients are satisfied with the health care services being provided to them. The study is also helpful in distinguishing factors associated with nursing home professionals and environmental conditions or facilities including schedule of delivery of services, ability to have a control over their movement or actions within the assisted living facilities, and the psychological support they receive from health care professionals particularly in regard to difficulties they face as a result of their ailments. Likewise, it is important to note how the older patients also valued the way health care professionals treat and are very supportive of their families. In this case, it becomes an important determinant of the satisfaction of older to the health care services provided to them.

3.8 The increasing number of older population worldwide

A theme concerning the growing number of older population is important in this study because this shows why there indeed is a need to put attention to improving the health care services and hence ensuring satisfaction from their beneficiaries, particularly older patients. The human population across the world is currently experiencing an unexpected transformation on the proportion of people belonging to various age groups. In a survey presented in The Guardian, conducted by US census bureau, it has been shown that the global population or people 65 and over have outnumbered that of children under five. The report, An Ageing World: 2008, highlights a huge shift towards not just an ageing but an old population, with formidable consequences for rich and underdeveloped nations alike. The transformation carries with it challenges for families and policymakers, ranging from how to care for older people living alone to how to pay for unprecedented numbers of pensioners – more than 1 billion of them by 2040.

The population of the world is continually growing, which is leading to unfamiliar demographic transformations for various nations (Abyad, 2006; Al-Hazemi, 2005; Hafez, Bagchi, & Mahaini, 2000).

It is anticipated that there will be a greater number of older individuals, that a larger proportion of our populations will be older people, with longer and healthier life

expectancies, and that the number of people not working will continue to grow (Al-Hazemi, 2005). Some factors have caused an increase in the population of older worldwide (Bloom, Boersch-Supan, McGee, & Seike, 2011). One cause of growth in older population is the decline in fertility rate around the world, which is projected to fall to only 2.5 children per woman from 5 children during the 1950s (United Nations Population Division, 2011). Another cause of the increase in older populations worldwide is understood to be multi-factorial and includes improvements to health services, educational status, and economic development (Suwaidi, n.d.). All these showed that human society has considerably developed (Mansour, 1994). However, the rise in the number of aged people may cause new problems which can only be managed with HHC strategies that will better address the needs and requirements of an ever-aging population. Experts on the statistical study of the human population have realized for a long time that the global population is aging and that this aging is taking place at an extraordinary pace. Since the world entered the 21st century, aging populations are on the brink of becoming a major global phenomenon (Al-Hazemi, 2005; United Nations Population Division, 2013).

McMurdo (2000) suggested that older people are more active today than in the past, and the number of individuals over 60 years of age is increasing each year. By no later than 2025, it is estimated that the world's older population will reach 1.2 billion, and this number will increase further, to 1.9 billion, 25 years later World Population Prospects (WPP, 2003). Given that the ratio of the population of ageing people to the entire population was 5.8% in 2000, it was projected that this would increase to 8.7% by the year 2025 (WHO/EMR, 2003). The United Nations Population Division (2011) expected the number of people above 60 years of age would increase from 840 million in 2011 to over two billion at the end of 2050. These figures indicated that 11% of the total population today comprised older people, and this number will double by the year 2050 (United Nations Population Division, 2011).

Along with these foreseen and relentless increases in the aging population, another significant factor is the number and variety of technologies that defy the aging process (New, 2013). Despite the increasing aging population in both developed and developing

nations, the World Bank (2010) reported develop countries including transitional nations like Croatia and Bulgaria had the highest older population percentages (aged 60 years and upwards). By 2050, it is anticipated that this will change when some nations are included in the list while others will be taken out. There will be more aged people worldwide who will live longer and have better and healthier lives, but there will be fewer people belonging to the working age category. The following figure (2) shows the expected increase in the number of older in the years ahead.

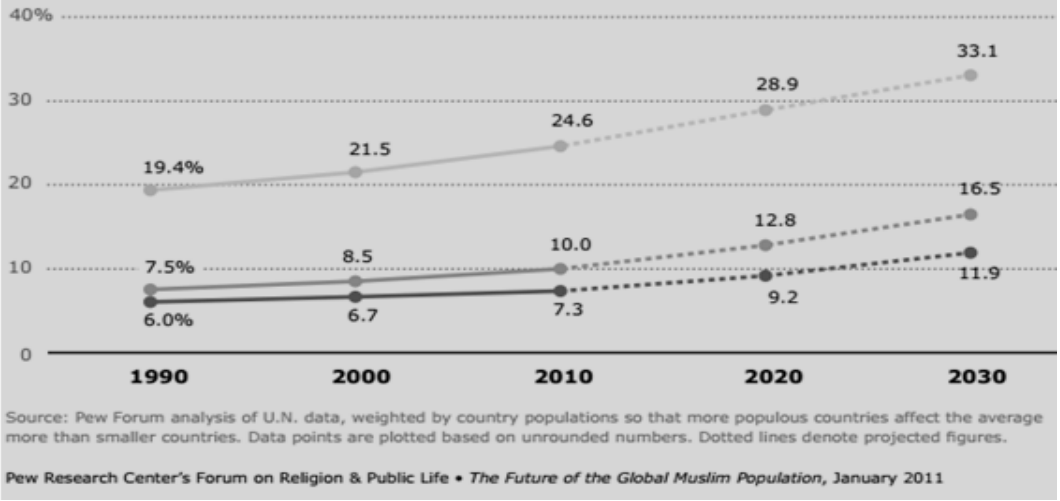


Figure 2: Average Annual Percent Growth of older Population in Developed and Developing Countries (World Health Organizations, 2011)

All these phenomena on demographics have attracted the attention of the world to the magnitude of the problems of providing health care for the older (Al-Doghether & Al-Megbil, 2004). Hence, a variety of methods are applied across the globe for setting policy priorities in the care of the aged, and examination of these policies is expected to shed light on the perceptions of the role that older people play in the family and society (MOH, 2010). Health care is also a significant consideration in the economic plans of many countries, including illness prevention and equality in access to health care, active participation on older people, and the full functionality of environments that support and care for them (MOH, 2010).

3.9 The ageing population in Saudi Arabia

A theme on the ageing population in Saudi Arabia is included in this part of the study because precisely, this research is about older patients' satisfaction with HHC services and hence, there is a need to discuss how demography is shifting towards increasing number of health care services recipients. As will be shown in the proceeding discussions, effectively it will be demonstrated that indeed ageing population is a common phenomenon in Saudi Arabia. The effects of an ageing population, who are still working, particularly in industrialised nations, are starting to be felt within the industry, commerce, economics, communities, and also within the family as a unit. Saudi Arabia is believed to be the most affluent of desert sovereign nations and is not currently going through the same challenges other countries face when it comes to an ageing population because its workforce is still vigorous and relatively young. However, ageing does appear to be a newly emerging issue for the country, and programs and agendas for dealing with demographic ageing are beginning to appear elsewhere amongst the Arab nations.

Similar to other nations' projections, the older population is estimated to rise to unprecedented proportions by 2050 and to be evident in Saudi Arabia's national statistics. As a result, there is a pressing need for demographic ageing to be addressed as a high priority by the Arab nations today and in the coming years (ESCWA, 2007). According to Bloom, Boersch-Supan, McGee and Seike (2011), the factors that have caused this phenomenon include improvements in health and living standards, quality of education, an unexpected reduction in the fertility rate, and fewer migrants. Even if at a slow pace, the ageing population in Saudi Arabia is evidently on the rise.

Despite this, the older people who have already retired from their occupations are still considered productive members of society and contributors to the economy's growth. Saudi Arabia has the youngest workforce among various countries. It has beaten the challenge of age since the older population is considered to have provided support to the country's national gross domestic product (GDP). Bloom et al. (2011) emphasise that older people who are still ambitious and active in the workforce in Saudi Arabia have provided economic benefits to the country as a whole.

The following figure (3) shows the distribution of older people in Saudi Arabia by region.

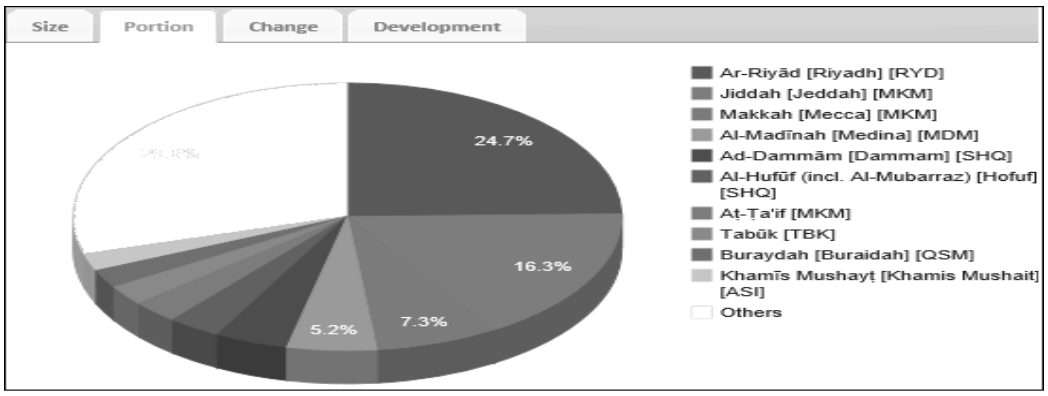


Figure 3: Distribution of older people in Saudi Arabia by region (World Health Organization, 2011)

The above figure shows the significant increase in the number of older people in Saudi society. The concentration is greatest in Riyadh, followed by Jeddah and Mecca, then Al-Medina, Dammam, Hofuf, Tabuk, Taif, and Briedh, Kahmis and finally the remaining areas, in which the proportions are equal. This underlines the need to continue the trend towards HHC services and to adopt the latest methods and theories which can be applied to achieve an ideal society.

Table 7: Saudi Arabia Population by Ageing 1950-2050

Year	0 – 4	5 – 14	15 – 64	65+
1980	18.5	25.9	52.6	3.0
1985	17.4	25.3	54.7	2.6
1990	16.8	25.7	54.8	2.7
1995	14.1	26.9	56.3	2.6
2000	13.9	24.5	58.1	3.5
2005	11.4	22.9	62.6	3.1
2010	11.1	19.6	66.3	3.0
2015	9.6	18.7	68.7	3.0
2020	8.4	17.3	70.3	4.1
2025	6.5	16.3	71.7	5.4
2030	5.3	13.9	73.6	7.2
2035	5.1	11.2	74.2	9.5
2040	5.4	9.90	72.6	12.1
2045	5.5	10.0	69.1	15.4
2050	5.4	10.5	65.7	18.4

While the total population increased by an estimated 2.8% annually, the given tables show that the number of aged people grows at a rate of 3.4% annually. Projections have placed the figure at nearly 2.5 million people by 2025 and about 5.9 million by 2050. This represents 6.6% and 13% respectively of the entire population. Based on demographic and socioeconomic indicators, from 1975 to 2004, the birth rate in Saudi Arabia declined from 45.9 to 26.5 while the death rate fell from 16.9 to 3.8 (Bloom, 2010). The 'World Population Ageing 1950-2050' report shows that the fertility rate declined from 7.3 children per woman to 5.5 in that period while the median age increased from 17.9 in 1975 to 18.4 in 2000 and 23.3 years in 2004. The old age index rose from 47.5% in the early nineties to 56.6% in 2004 (Bloom, 2010).

Life expectancy was 58.8 in 1975-1980 and improved to 72.2 in 2000-2005 (World Population Ageing 1975-2050). The number of people aged over 80 years old was 21.7% of the older population in 2007 (Bloom, 2010). Regarding socioeconomics, more women have access to education in the modern world as their presence in the workforce has grown, and the duties of a homemaker have changed. As a result, women have decided to marry later in life, and this has led to a lower fertility rate. Due to higher income levels, the tendency has been for older individuals to live on their own, depending on their income rather than on their male children. There has also been an increase in divorce rates. According to Arab News (2003), the Ministry of Justice disclosed in a statistical report that the average number of divorces in Saudi Arabia on a monthly basis in 2007 was 1,500 cases or 18,765 for the entire year. By contrast, in 2008, there were 1,980 cases monthly or a total of 24,428 for the year. This indicates a 5,663 increase in the number of cases from 2007 to 2008. With the growing number of divorce cases, it can be anticipated that there will also be a rise in the proportion of older individuals who live alone or are not married.

Males represent 50.4% and females 49.6% of the Saudi Arabian population; 20.5% of its older people are in the labour force; 25% of the labour forces are women and 75% are males (World Population Ageing 1975-2050).

The United Nations Population Division report for 2011, states that 34% of older women were homemakers while 26.01% were retired citizens.

According to Bloom et al. (2010), the low number of older living with family is an indication of a growing trend towards a nuclear family unit.

This trend is gradually doing away with the extended family, a development which unhelpfully affects the traditional family function as a care provider for its older members.

Five years ago, Riyadh, Makkah, and Eastern Saudi Arabia had the greatest number of older people, comprising 52.8% of the entire kingdom. This increase will affect housing, transportation, Health care, and social services in urban settings. Because of the scarcity of financial aid for poor people and job insecurity, some individuals who live in the city cannot provide for the needs of their ageing parents. In the city, maintaining the traditional family is not easy when compared to the situation in the rural setting. Many older people have to endure the loss of social connections and become isolated and lonely. In the city, older individuals can be found living by themselves, in homes far from where their adult children are living. Health services in Saudi Arabia are free but not sufficient to cover all the people who need them, such as the older population. There are private and public organisations which provide pensions to their workers.

According to the Saudi Public Pension Agency (2013), the number of individuals who have retired has increased greatly in recent years. Older individuals, particularly women who have no jobs, and self-employed male individuals like farmers, herders, and cab drivers, will have no pension when they retire. The majority of them are considered indigent. Those who receive financial help from the government, in the form of Social Security, are not receiving enough. However, a full and accurate evaluation of the level of income security and social well-being of the older people in Saudi Arabia (Bloom et al., 2011) would require more data. See the following table 8 which presents the rate of retirement persons in Saudi Arabia.

Table 8: Rate of retirement among individuals (Trading Economic site, 2015)

Unemployment Rate	5.7 percent	Jun/15	5.7	4.35 : 6.3	Quarterly
Unemployed Persons	646845	Jun/15	671630	437648 : 700035	Quarterly
Population	30.77 Million	Dec/14	29.99	4.04 : 30.77	Yearly
Employed Persons	11068 Thousands Pe	Dec/14	10635	6167 : 11068	Yearly
Retirement Age Men	62	Dec/15	62	60 : 62	Yearly
Retirement Age Women	55	Dec/15	55	55 : 55	Yearly
Prices	Last	Reference	Previous	Range	Frequency

3.10 Challenges arising from an aging population.

Since it was discussed in the preceding section about the phenomenon of an ageing population in Saudi Arabia, it is worthwhile including here also as a theme the challenges that would arise from such phenomenon. This and other related concerns are discussed below. The impacts of an aging population cannot be clearly foreseen. It does generate certain daunting and essentially new challenges, although none of these are insurmountable. These changes also result in the emergence of new opportunities because people now live longer and have healthier lifestyles, leading to more years in which they can generate income. They also have varying capabilities and needs. The solution lies in the ability to adapt to changes individually, organizationally, and socially. Governments and businesses have planned and implemented helpful responses to deal with the challenges.

Typically old-fashioned views concerning old age have been disregarded in recent years, and it has become imperative that older are not considered as liabilities or encumbrances to society (Szucs, 2001; WHO/Regional Office for Europe, 2001). Most Arab countries today have an increasingly aging population. At present, families are raising fewer children, and the ageing population is increasing in Saudi Arabia. The rising number of older individuals in the US has been brought about by the enormous number of persons who were born following the Second World War, and this situation has been mirrored in other parts of the world at varying times, resulting in the increased proportion of older

people, including Saudi Arabia. The effects of an aging population, who are still working, particularly in industrialized nations, are starting to be felt within the industry, commerce, economics, communities, and also within the family as a unit (Bloom et al., 2011). Saudi Arabia is believed to be the most affluent of desert sovereign nations and is not currently going through the same challenges other countries face when it comes to an aging population because its workforce is still vigorous and relatively young. However, ageing does appear to be a newly emerging issue for the country, and programs and agendas for dealing with demographic aging are beginning to appear elsewhere among the Arab nations. Similar to other nations' projections, the older population in Saudi Arabia is estimated to rise to unprecedented proportions by 2050. Even if at a slow pace, the aging population in Saudi Arabia is evidently on the rise. As a result, there is a pressing need to address demographic aging as a high priority by the Arab nations today and in the coming years (ESCWA, 2007).

Older people who have retired from their occupations are still considered productive members of society and contributors to the economy's growth. Saudi Arabia has the youngest workforce in various other Arab countries. It has beaten the challenge of age because the older population contributed to the country's national gross domestic product (GDP). Bloom et al. (2011) emphasized that older people who are still ambitious and active in the workforce in Saudi Arabia have provided economic benefits to the country as a whole. As the number of older increases in Saudi society, the concentration is greatest in Riyadh, followed by Jeddah and Mecca, Al-Medina, Dammam, Hofuf, Tabuk, Taif, and Briedh, Kahmis, and finally the remaining areas, in which the proportions are equal (Bloom et al., 2011). This situation underlined the need to continue the trend towards HHC services and to adopt the latest methods and theories which can be applied to achieve an ideal society.

The 'World Population Ageing 1950-2050' report showed that the fertility rate declined from 7.3 children per woman to 5.5 in that period, whereas the median age increased from 17.9 in 1975 to 18.4 in 2000 and 23.3 years in 2004 (Bloom et al., 2011). The old age index rose from 47.5% in the early 1990s to 56.6% in 2004 (Bloom et al., 2011).

Life expectancy was 58.8 in 1975-1980 and improved to 72.2 in 2000-2005 (World Population Ageing 1975-2050). The number of people aged over 80 years old was 21.7% of the older population in 2007 (Bloom et al., 2011). Owing to an increase in the access to educational facilities women have become more independent and usually resist early age marriages or motherhood. As the age of women tends to grow it causes a decrease in fertility rate. Moreover, the rates of divorce elevate as well. This consequently increases the proportion of older individuals in the society. Also, the United Nations Population Division report for 2011 stated that 34% of older women were homemakers and 26.01% were retirees. According to Bloom et al. (2011), the low number of older people living with family is an indication of a growing trend toward a nuclear family unit. This trend is gradually eliminating the extended family, a development which unhelpfully affects the traditional family function as a care provider for its older members. Five years ago, Riyadh, Makkah, and Eastern Saudi Arabia had the greatest number of older, comprising 52.8% of the entire kingdom. This increase will affect housing, transportation, Health care, and social services in urban settings. Some individuals who live in the city cannot provide for the needs of their ageing parents because of the scarcity of financial aid for poor people and job insecurity.

In the city, maintaining the traditional family is difficult when compared to the situation in the rural setting. Many older people have to endure the loss of social connections and become isolated and lonely. Hence, older individuals in the city lived alone and in homes far from where their adult children lived. Health services in Saudi Arabia are free but not sufficient to cover all the people who need them, such as the older population. There are private and public organizations which provide pensions to their workers. According to the Saudi Public Pension (S.Pension., 2013), the number of individuals who have retired has increased greatly in recent years. Older individuals, particularly women who have no jobs, and male self-employed individuals like farmers, herders, and cab drivers, will have no pension when they retire. The majority of them are considered indigent. Those who receive financial help from the government, in the form of Social Security, are not receiving enough.

However, a full and accurate evaluation of the level of income security and social well-being of the older people in Saudi Arabia would require more data (Bloom et al., 2011).

3.11 Patient satisfaction

3.11.1 Background

Patient satisfaction is defined as

> *The level to which a person considers health care service or the way it is rendered by the supplier, to be applicable, variable, or favourable* (Davies, 2005).

Satisfaction is measured regarding the patient's psychological well-being after obtaining services from Health care institutions; it is the extent to which patients' experiences at these establishments have been favourable and enjoyable, and have sustained their expectations (Stewart, 2003). Depending on the condition of care and services, satisfaction is developing and changeable (Meredith & Wood, 1996). It is necessary for patients to be satisfied with the health care services provided to them. The people associated with the health care system, such as nurses, state that there are six major factors involved in determining the standard of health care. These guarantee the effectiveness, efficiency, and adequacy of the health care system. The factors are safety, effectiveness, family-cent redness, efficiency, equality and timeliness (Barnet, 2013). Patients need to be kept from injury during provision of the health care services. Second, the services provided must benefit the patients, and the correct treatment must be given at the right time. Third, family-centeredness refers to respect and a proper response to the patient's preferences (in some cultures it may mean that the family's wishes are put before the patient's, but more commonly it will mean that the patient's and family's wishes will be put first; that is, before those of the health care professionals). Fourth, complementary to effectiveness, is the reduction of waiting time and other unnecessary delays for those who need care, as well as for those who are to deliver help. Fifth: avoidance of waste in supplies, energy, ideas, and equipment. Finally, equality refers to non-discrimination between patients, based on gender, ethnicity or race, geographic location or place of origin, and socioeconomic status (Barnet, 2012). In 1948, the rights of a patient to health care were published according to the 'Universal Declaration of Human Rights (United Nation, 1984). In principle, all members of a family now have guaranteed equal rights to health care facilities and services. Every individual has a basic right to adequate health services, and the satisfaction of the patients with the medical

services that they are receiving determines the level of performance of the health care system in a hospital, as well as the willingness of the staff of the hospital and the health care professionals to provide quality Health care service to their patients. In relation to these studies, Richard Stalin, a researcher and Assistant Professor of Business Administration at the Faculty of Vicia observed that:

> *'if you want to identify the quality of health services provided by the hospital you should be looking for a level of satisfaction among patients towards services and medical care; this is the best indicator of quality'* (Capilla.R, 2012).

3.11.2 Patient satisfaction is increased

Health professionals with a patient-centred interaction process rank highest regarding the quality of the relationship between the health service providers and patients, and in terms of patient satisfaction (Weng, et.al, 2011). Preparing health care providers through instruction and application of patient-centeredness heightens patient satisfaction with the care provided (Jacobs, et, al, 2005). Improved adherence to recommended treatment studies conducted over half a century indicated a 19% higher risk of patient non-adherence to instructions due to inadequate communication by health care providers, as compared to those whose doctors communicated well. Improving the skills and knowledge of doctors, with regard to communication, leads to notable and considerable increase in adherence to treatment recommendations (Jacobs, et, al, 2005).

3.11.3 Studies of conducted patient satisfaction

Patient satisfaction refers to the level of fulfilment and contention that the recipients of particular health care service. The services may not only be judged using the quality of treatment, medicines or other assistance regarding the therapy but also the attitude and behaviour of service provider on their approach towards the patients as well as their loyalty towards their job. Provided that if patients and care providers tend to be in a positive relation with each other, it significantly impacts the quality of results expected from the treatment. In the following, a literature review of various studies conducted to measure the factors affecting patient satisfaction has been presented. It discusses the existing studies and their respective results to develop an understanding regarding the

pertaining purpose of this research. A study in 1974 in Los Angeles measured the relationship between the levels of services provided, according to indicators of efficiency and justice for workers and citizens in the city, and the degree of satisfaction of citizens. The report concluded that the relationship between these two variables was weak while the results of the study showed that there was a significant effect of demographic factors on the degree of satisfaction with the services provided. Lawrence conducted a study in 1975 in which he addressed the factors and variables affecting the patient assessment of the level of service on one hand, and the characteristics of the institution providing the service on the other. He included 1739 patients of medical centres. The study found that the variables of age, satisfaction, social continuity and the nature of the medical service provided were the most important factors affecting the assessment of the patient's service while the variables of gender, marital status, and educational level had a lower impact on the patients regarding the services provided. Doering (1983) clarified the factors that affect the satisfaction of patients. His study demonstrated that the link between satisfaction with general inpatient care and satisfaction with health services was less than expected, based on some studies. However, there is a relationship between general satisfaction and satisfaction with nursing care. Additionally, age and income level had an impact on the services provided to patients. In 2000, O'Sullivan used several variables in his research which were shown to have a bearing on the patient’s satisfaction, including those related to the adequacy of the surrounding environment, cleanliness, and nursing care. Following this, Merkel’s study in 1984 was based on the level of patients’ satisfaction with medical services provided, to determine the real relationship between the dissatisfaction and the physician’s failure to realise the extent of the patient's satisfaction. The study showed that the technical progress of medicine regarding the negative role of the patient had a clear impact on the ability of the physician to assess the reaction of the patient regarding satisfaction with the medical service provided.

Most studies of inpatients and outpatients are more concentrated in countries like the USA, where the elements of profit and competition play an important role in the continuity, growth and improvement of these institutions and services (Mustafa, 2013).

In the UK, however, profit may not be a major determinant as their National Health Service is based on a government welfare system. Developing countries are trying to

follow in the footsteps of developed countries, where they are working to provide integrated services to the hospitals and give added priority to their development plans. In the UK, there is further evidence of commitment to improvement. In conjunction with the Health and Social Welfare law, there are also significant incentives for the development of health care businesses (BBC, Milton, 2014). Health Minister Anne Milton said 'This is good news for NHS patients who will get better services at the local hospital as a result of the work the NHS is doing abroad and the extra investment (BBC, Milton,2014). So, the deployment of high quality health services to all provinces in Saudi Arabia is the main objective to meet patients' needs (MOH, 2011). It is important to study health services especially for health planning processes at the domestic and regional level. Despite the age of the following studies, they are still relevant in that they can provide a level of historical accuracy and completeness to supplement current research. Mansour and Al-Osimy (1993) conducted a study in three Ministry of Health Primary Health Care Centres, in Riyadh City. The method consisted of personal interview of 100 patients per centre from November 1 to December 11, 1989. The patients were chosen systematically to measure their satisfaction with the services provided; they had been served by the centre for a period of at least six months. The data were systematically analysed by computer (SPSS). One-way analysis of variance (ANOVA), cross tabulations, and a qualitative analysis were applied to one open-ended question. The specific objectives of the study were to assess the patients' satisfaction level with different aspects of Primary Health Care services, to determine strategies for improvement as perceived by the patients, and to identify effects on the patients' satisfaction level of certain independent variables. The results showed that the patients in the three centres were moderately satisfied with the effectiveness and humanitarian aspects of care and less pleased with the care centres' systems about such matters as waiting time, posters, appointments, health education, adequacy of staff, and equipment. The major recommendations of this study for the Ministry of Health were to plan and implement national health manpower development programs and develop more Primary Health Care centres to avoid overcrowding in the existing ones. The strength of this study is in its systematic selection of respondents and use of instruments that were evaluated by experts regarding wording,

relevance to the purpose of the study, comprehensiveness, appropriate length of schedule, sequence of the schedule and scoring system.

Banakhar, Al-Khafee, Shibily, Al-Amri, and Faigah Al conducted a study of services at the Al-Bajad Primary Health Care Centre in Jeddah City. They used the questionnaire method on 2006; questioning 27 respondents (ages from 20 to 60 years old) that were randomly selected with the goal of assessing the satisfaction levels of patients and determining strategies for improvement. The questionnaire covered nursing services, medical services, and general services that were analysed by the SPSS software. The results showed a low level of satisfaction with the facility, as it was overcrowded and suffered from a lack of communication systems for appointments, lack of medical personnel compared to the high number of patients, poor listening skills and services on the part of nurses, and poor laboratory technology. It also appeared that the respondents wanted home nursing services. The authors recommended the improvement of services, increased manpower, education of patients about drug use, education of nurses about dealing with patients, improvement of laboratory equipment with licensed personnel to conduct the tests, and improved communication systems. While the study was not in-depth, it somehow exposed the reality in the health centre, being overcrowded with few health workers and poor facilities. It also pointed out one particular issue, which was the accountability of the government for providing quality health care to its people by improving services, upgrading equipment and equipping the centre with more licensed laboratory workers and medical personnel. The study, however, should have included in its recommendations the need of patients for native Saudi nurses with whom they could comfortably communicate without any language barrier.

(Al-Juhani and Kishk, 2006) conducted a study in a hospital in Al-Medina, Saudi Arabia. The satisfaction levels were recorded for the in-patient and out-patient clinics. It was found that the professionals working there were satisfied with their work and this made them perform better. The doctors were satisfied with their jobs and gave greater attention to the patients, which caused the satisfaction level amongst the patients to increase as well. The services of the hospital greatly depended on upon the satisfaction standards of the nurses.

The strategies developed for the primary health care clinics (PHC) must consider the factors which caused dissatisfaction amongst doctors and nurses so that these problems for professional staff at the health centres can be removed and the patients can receive better health care services. Ninety-one point three percent of the patients who were surveyed were satisfied with the medical services which were provided; they were also happy to recommend the hospital to family members and friends. Eighty-nine point sixty-two percent of them were satisfied with the providers of the health care services and 87.3% were satisfied with the nursing services and the hospital environment. Eighty points fifty-seven percent of the outpatients were satisfied with the treatment they had received in the health care centres. Ninety-nine point five percent of the patients surveyed were Saudis and 26.5% of them were receiving treatment which was being paid for by the government of Saudi Arabia. The purpose of the study was to determine the job satisfaction level at the primary health centres and how the doctors and nurses responded to their patients at Al-Medina, Al-Munawwara. The study also aimed to examine the connection between the personal qualities of the medical health care professionals at the health care facilities and the level of their satisfaction with their jobs.

The method selected for the research was a descriptive cross-sectional epidemiological approach, using a questionnaire given to the doctors and the nurses working at the primary health care centres (PHC). Traynor and Wade (1993) had introduced a multi-dimensional job scale which was changed for the objectives of this study and then employed in the research. The sample selected for the research contained 445 health care professionals. Twenty-three point six percent of these professionals were physicians and 76.4% of them were nurses. Most of them were not satisfied with their jobs, and this level of dissatisfaction can be seen in the statistics which were collected. Sixty-seven point one percent of the nurses and 52.4% of the doctors were not satisfied with their jobs. The physicians were mostly dissatisfied with the professional opportunities available to them, the level of patient care and the financial compensation they were receiving. The study also examined the connection between demographics, job qualities and the level of job satisfaction. The results of the study showed that the older, non-Saudi, specialist, male physicians were not very dissatisfied with their jobs as compared to the other doctors working in the health care centres. However, the older, non-Saudi, specialist, female

physicians were much more dissatisfied with their jobs than the other doctors working with them. This was shown by the mean scores for job dissatisfaction which were recorded during the study. A decrease in the burden of work for the nurses and the availability of greater promotion opportunities for physicians and nurses working in the primary health care centres were recommended by the study. The research recommended that the hospital follows up on the different concerns of the patients and the members of their families, and that treatment needed to be continued without any hindrances. The performance of the hospitals could be improved in areas like nutrition, patients' re-evaluation, reduction of waiting lists and more use of technology in the clinics. The patients needed to feel satisfied with the service they received, and it was necessary for medical staff to respect their privacy and dignity. The study at the hospital is carried out every 6 months by the Office of Quality Assurance so that the concerns of patients and their family members over issues such as the level of health care being provided, medical services, and therapeutic services can be dealt with, and a certain standard of health care provision can be maintained and also improved over time (Al Juhani & Kishk, 2006).

3.11.4 The opinions of the patients about communication and their treatment

A patient's knowledge of his/her condition and confidence in the attending physician are major indicators of whether a patient will decide to consult and be treated by a different doctor. The trust of patients and adherence to care relationships with doctors are related to adherence to recommended treatments (Safran, Montgomery, Chang, Murphy & Safran, 2001). A demographic change began a few decades ago especially in Saudi Arabia caused by the increased proportion of older people within the demographics. The unique needs of the older population included weakness in the ability of organs and systems to perform their vital functions properly (M.AlGabbani, 2010). Regardless of the scientific reasons for the ageing process, there are special needs for the care of the older population, such as medical and nursing care, psychological care, and social care which work in conjunction with the demographic change in modern societies (Soldo, Manton, 1985). In the traditional way of life, older people living with large families received most of their care from family members, especially concerning the requirements of everyday personal lives. Some families were dependent on maids to provide assistance and care for

the older, which arguably increases the sense of isolation and neglect within the community (Bianchi, 2000).

3.12 Summary

It should be clear from the preceding that the demographic transition in Saudi Arabia is leading to the spread of population aging in Saudi Arabia. Population aging is a global phenomenon sweeping the whole world and to a lesser extent developing countries, but there was agreement that all countries of the world will suffer this phenomenon in a big way in the future as reported by the WHO. Owing to an increase in the average age of the population as well as a decrease in the birth rates, the population is seemingly experiencing a rise in ages. This may have both positive and negative impacts on the macro level; however, adverse effects of various subsequent phenomenons are inevitable in the longer run. Hence, it is imperative that the developing nations, like Saudi Arabia, start to think of ways to face up to these concerns and maximise the opportunities that an older population may bring. The Saudi government can do much to address the changes in a country which have an ageing population. Also, there are some modifications necessary to choose from: for example, rising the retirement age. Financial support to health cares for many countries ineffective systems, in particular for places where the overall healthcare system. Accordingly, HHC consists of a wide range of health and social services which are provided in the home, and include nursing, therapy, prevention and education of patients and their families to help the patients and the bedridden older and disabled to perform their activities in their homes. HHC contributes to raise the morale of older patients due to the presence of their families, as well as to the change in location of their treatment from the hospital to the home.

Chapter 4 Theory

4.1 Patient-Centred Care Theory

This section examines the patient-centred care concept, the basics of the theory and its application in the ministry of health in Saudi Arabia to achieve the necessary outcomes and standard of home care. It also discusses the facts related to the application of the theory in the country, the challenges that the implementation process is facing and the difficulties of the medical professionals who try to raise the level of HHC. I am aware that there's another theory which related to person problem and primary health care such as person care theory and it may be suitable to use it but as I mentioned that ministry of health in Saudi Arabia used patient centred care theory so for this reason I decided to work on this point including a brief about the strength and weaknesses of patient centred care theory and definitions and so on as well.

Patient-Centred Care theory is highly complicated and has four major dimensions:

- understanding the illness of the patient,
- understanding the personal meaning of the disease,
- the division of decision-making and responsibility between the hospital staff and the patients,
- the development of the relationship between doctors and patients

Its main aim is to focus treatment and care on the patient, or person, rather than just their medical condition (MOH, 2010). These dimensions have a positive impact on personal feelings and thoughts of the patients to contribute and to achieve the objectives of this theory. It could be argued that the granting freedom to the patients and involve them in the treatment and health plans which offered to them will improve the level of performance for professionals (Froyd, Cain, 2014).

(Froyd, Cain, 2014). Presented a set of criticisms of this therapeutic method which can be proving the above concept such as: -

1. *Firstly, the treatment based on the patients distinguished in their ability to take responsibility.*

2. *The treatment is limited to sit down with the patient and retrieve thoughts and feelings and attitudes about the current situation.*
3. *The focus is on the patients through immersion in the same plan which can be applied to solve problems.*
4. *Uses the skills of the social worker rather than trends process. The respective skills of the social worker are given more importance than the process being in trend.*
5. *The theory implies that improved relationships between the health professionals and the patients lead to better patient satisfaction and more efficient health care (Higgs, nd).*

It is essential to understand the patient's illness so that health can be effectively promoted. The perception of the disease by the patient should be understood by the health care professionals and dealt with by them. The different professionals treating the patient should coordinate effectively with each other so that the patient can be helped to recover as soon as possible. The relationship between the health professionals and the patient should be a strong one, and the patient should come to trust the health professionals. This forms the basis of a patient-centred health care system. The relationships developed between the patients and the health professionals and other medical professionals help the patient to be satisfied with the services that he/she is receiving. Another approach to person-centred care is that provided by Tom Kitwood in which highlights the importance of the patient rather than the disease process itself. He had presented this approach with respect to people having dementia. Kitwood argued that people with dementia do not lose their personhood, but rather can be maintained through relationships with other people. Thus, Kitwood defines personhood as 'a standing or a status that is bestowed on one human being, by another in the context of relationship and social being' (Kitwood, 1997). Within person-centred care therefore, the personal and social identity of a person with disease arises out of what is said and done with them. Moreover, Kitwood adopts a moral and transpersonal position in which personhood as transcendent, sacred and unique; and that patient with an ethical status that offers them absolute value resulting in an obligation 'to treat each other with deep respect' (Kitwood, 1997).

The literature published in the previous decade has shown that health care services in Saudi Arabia have evolved. These services have been present in Europe and other developed countries. Combinations of different terms were used. These terms include patient-centeredness, health professional-patient relationship, communication, patient involvement, HHC, patient-centred home care, patient satisfaction and older patient satisfaction. The reports of reputable institutions such as the NCQA and the Commonwealth Fund were used in the literature review of the study (Washington, D.C.US, 2005). The health care program in Saudi Arabia places emphasis on the care of patients. It began seven years ago, and efforts were made to implement it in Al-Madinah Almunaorh and the Western regions, with the help of the national charity for the health care centres; other such centres were established in the rest of the country (Caffery, 2011). The system aims to provide proper health care to patients in their homes and to improve the levels of security and confidence of the family members of patients. This helps the patients to recover in a better way both physically and mentally.

The patients do not have to travel to the hospital and so can avoid the infections that they might acquire there. The Ministry of Health guides patients and their family members in using the health services at home, as this reduces cost, lessens the burden on the hospitals, and prevents unnecessary admission of ageing patients who have chronic illnesses (Seavey, 2010). Patient-centred care (PCC) is described as 'treating the patient as a unique individual' (Redman, 2004). It is a standard of practice that demonstrates respect for the patient, as a person (Webster, J, 2011). It is very much about considering the patient's point of view and circumstances in the decision-making process and goes well beyond simply setting goals with the patient (Webster, J, 2011).

Patient-centeredness also refers to a style of doctor–patient encounter characterized by responsiveness to patient needs and preferences, using the patient's informed wishes to guide activity, interaction, and information-giving, and shared decision-making (Safran et al, 2005). It is a way of viewing health and illness that affects a person's general well-being and an attempt to empower the patient by expanding his or her role in their health care. Making the patient more informed, and providing reassurance, support, comfort, acceptance, legitimacy and confidence are the basic functions of PCC (Stanghellini & Fulford, 2013). Brendan McCormack describes person centeredness as a practical

approach developed through the formation and fostering of relationships between all care providers, older people and other significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enables by cultures of empowerment that fosters continuous approach to practice development (McCormack, B. & McCance, Tanya, 2010).

Note: "similar idea; specifically the term patient-centred care which has been used in American nursing since the 1970s" (McCance, Tanya & McCormack, B. Dewing, Jan., 2011).

The impact of the goals of PCC has a direct logical link with promoting healing and reducing injury and suffering (Nelson and Gordon, 2006). The underlying philosophy of PCC is that the carer needs to understand the patient as a person rather than as a cluster of diseases (Epstein, 2000). PCC delivers care to the patient through a range of activities including consideration of the patient's beliefs and values, engagement, having a sympathetic presence, and providing for physical and emotional needs (McCormack and McCane, 2010). Working with patients' beliefs and values strengthens one of the important principles of PCC. This is closely related to share decision-making and facilitating patient participation through giving information and integrating newly formed perspectives into care activities (Stewart, 2001). PCC assumes that the patients are qualified to decide their needs and expectations that they can make decisions and choices about what they need and want (Lutz and Bowers, 2000). The provision of PCC is to educate patients of appropriate health advice so that they can make informed decisions. (Coulter, 2009) defines PCC as: "Health care that meets and responds to patients' wants, needs and preferences and where patients are autonomous and able to decide for themselves."

4.2 Patient-Centred Care in the home

There are a growing recognition and acceptance of the need to embrace patient-centred care (PCC) approaches in the delivery of health care. Governments across the world (National Health Service 2005, US Department of Health and Human Services 2008, Australian Commission on Safety and Quality in Health care 2010together with international organizations (World Health Organisation 2000), patient and health policy organizations (Picker Institute 2004, NRC Picker 2008, Kings Fund 2011, Health

Foundation 2011), and lobby groups International Alliance of Patients' Organisations (I.A.P.O, 2007).are all emphasizing the need for health care to be more explicitly centred on the needs of the individual patient.Quality and Safety agencies (Australian Commission on Safety and Quality in Health care 2009) and Health care reform initiatives (Department of Health 2008) all prioritize the philosophy and practice of PCC as being the core of new and efficient models of care delivery. While none would argue with the overarching philosophy, there is less agreement on how to make PCC a reality in everyday clinical practice or indeed how it is defined (I.A.P.O, 2007).

A discussion study published by the Australian Commission on Safety and Quality in Health care (A.C.S.Q.H.C, 2010) identified several dimensions to be addressed. These included policy-level recommendations and organizational-level actions for service executives and managers. The document did not explicitly outline what Health care professionals were expected to do to provide PCC. Running through this paper and many of the high-level policy documents are the implicit assumption that different stakeholders (patients, policy makers, professionals in particular doctors and nurses) all agree on the core elements of what constitutes PCC despite the fact there is no globally accepted definition (I.A.P.O, 2007). Core elements such as respecting patient choice and efficient communication feature in most descriptions, whether they are derived from patient groups, medical or nursing investigations, or high-level policy activities. However, what is less clear is what different weight groups put on various elements of PCC.

Despite the fact there are some literature reviews on PCC, both reviewing the generic concepts (Mead and Bower 2000), few have explicitly addressed the possibility that different stakeholders could and would view PCC in various ways. For example, Mead and Bower (2000) deliberately excluded nursing literature on PCC in developing their conceptual framework and in a subsequent study (Mead & Bower 2002) reviewing the impact of PCC on patient outcomes acknowledged that 'although patient-centeredness is an important concept in relation to other disciplines there may be substantial differences in meaning. Also, the different clinical conditions under which different professionals work (e.g. length of consultation, types of problems seen) means that the results found for one professional group may not generalize to another'. Subsequently, Gillespie et al. (2004) confirmed this view in a UK survey where they attributed different groups'

inability to appreciate and accept others' views of the importance of PCC as one of the main reasons for the failure to operationalize the concept at the level of patient care.

They found that different (health care) groups tended to focus on the various aspects, reflecting their professional roles and interests. This was both at the individual clinical encounter level, through the various levels of management to high-level policy activity.

This study has reported on a two-stage narrative review and synthesis of the seminal and emerging literature on PCC as it is described, defined, and operationalized by different stakeholders within the acute Health care setting. The objective was to identify whether there are common, core elements of PCC across the various disciplines of Health care policy, medicine, and nursing and if so what are they. The rationale for undertaking this review was to inform a wider study that was exploring how a PCC approach could influence service redesign and models of care delivery in the acute care setting, in particular for older people (Zeitz, Kitson, Gibb, Bagley, Chester, Davy. Shanks, 2011).

The National Committee for Quality Assurance (NCQA) describes the Patient-centred Medical Home (PCMH) model as an instrument for evaluating the performance of medical health care facilities. Patient-centred care provides better results while keeping the patients as the major focus of the efforts of the doctors and the health care system (Almalki, Fitzgerald & Clark, 2011). NCQA states that medical home care is based on the relationship between the patients and the doctors, who provide coordinated care instead of episodic care on a long-term basis. At a single site, medical health care is provided by doctors and their team. Quality health care is ensured, and other experts are also involved in the provision of standard medical services.

The level of medical care is high in the system based on the Patient-Centred Medical Home (PCMH) model and the services provided are very effective because the system mainly focuses on the satisfaction of the patients (NCQA, 2005). The PCMH aims to provide health care facilities for both young and old patients (Collaborative patient-centred primary care). The main focus is on the patients and the treatment they receive. The model has six aims for improving the system and ten rules for changing the state of health care in the Kingdom of Saudi Arabia. (The Health care Quality Book, 2008).

4.2.1 The six aims which focus on the actual delivery of care:

Table 9: Aims of Care delivery for older patients (The Health care Quality Book, 2008)

NO	The care delivery for older patients
1	Safe: preventing patients from becoming injured.
2	Effective: evidence-based services provided to those who need them.
3	Patient-centred: treating patients with respect and explaining to them the treatment that is being planned.
4	Timely: minimising delays which could have adverse effects for patients.
5	Efficient: reducing the wastage of medical equipment, supplies, and concepts.
6	Equitable: equal care for all patients being treated without any bias.

4.2.2 Rules which address the necessary change within the health care system:

1- The relationship between the patients and the doctors and nursing is long-term, and the patients deserve to receive adequate health care whenever they are in need of it.

2- Every patient needs individual attention, and the treatment of each patient should be according to his or her medical needs.

3- The patient needs to be informed about the treatment being given to him or her and should be given the power to make decisions relating to the treatment.

4- Patients should be provided with easy access to the data related to their medical condition and the treatment they are receiving.

5- The treatment given to patients should be based on sufficient medical evidence.

6- The health care system should avoid causing any harm to the patient.

7- The necessary medical information should be available to patients and their family members.

8- The needs of the patient should be determined beforehand, instead of responding to the patient's needs after a medical emergency has occurred.

9- Precious resources and patients' time should not be wasted.

10- The different medical professionals providing medical services should coordinate efficiently and exchange information so that the patient may receive proper treatment. (IOM, 2001).

The standards are given by the National Committee for Quality Assurance NCQA state exactly what the patient-centred health care system tries to achieve the Joint Principles of the guidebook for the PCMH are described below:

Every patient has a trust-based relationship with a personal physician who provides complete and continuous health care to the patient. The aim is to establish a solid relationship between Health professionals and patients so that the confidence of the patients can be earned (Giarelli, 2012). At the practice stage, the personal physician is the head of a professional team which provides effective health care to the patients. This pre-doctoral leader survey was developed and tested using cognitive interviews with pre-doctoral faculty members at a non-participating school and we revised the instrument based on feedback about the clarity of questions and the accuracy of information collected. The second instrument was a PCMH Practice Survey, which we designed to be self-administered by the lead physician at each suitable clerkship site. The aim is to promote usage of a team of professional experts to the doctors so that the different needs of the individual patients can be met (Romeo, 2010). The personal physicians provide the patients with the necessary health care, and they are also responsible for making sure that the other health care professionals are involved so that all the different medical needs of the patients (acute, chronic and preventive) are met (Roberts, 2006). Various health care professionals are involved in the treatment of the patients, and an efficient health care system ensures that the medical professionals are properly coordinated. This is done by promoting the use of information technology, diseases registries, and health information exchanges. The patients are provided with health care in an efficient manner which accommodates cultural and linguistic sensitivities (Wang, 2010). Any health care system needs to have a certain standard, and it must ensure that the patients are treated safely; injuries must be avoided during the treatment. The system can work efficiently by using information technology and online communication and the necessary support to provide for the sharing of data with the different doctors involved in the treatment of patients and their family members. The physicians are responsible for the improvement processes and

must take part of the certification programs that are offered (Al-Husban, 2009). The exchange of information can also be by telephone or through web portals on the Internet (Roberts, 2006). The patient-centred medical homes provide patients with standard medical services with experts who are responsible for regularly monitoring the patient's health and giving each one the necessary and proper treatment (Backer, 2009).

4.3 Key attributes of patient-centred care

Effective treatment of the patients can only be guaranteed if the patients themselves are also responsible for their care. A health care system which focuses on the patients provides various opportunities for them to form a partnership with the Health care staff. Different designs have been created for providing patients with effective Health care services, and many have several features in common. The three top models which determine how the patient-centred health care system works are described in this section.

4.4 Commonwealth dimensions

The Picker-Commonwealth Program for Patient-centred Care was the first to come up with the term 'patient-centred care'. The program was later named as The Picker Institute (Al-Modeer, 2013). Focus groups were held by this program, and telephone interviews were conducted with patients at the national level. The Picker survey tools were used to examine the views of patients according to the eight dimensions which will be discussed (Al-Modeer, 2013). The patient-centred values and the medical needs of the patients have to be respected, and the patients should know about the decisions that they can make. Every patient needs to be treated with dignity and receive individual attention. The patients' reach and ability to avail themselves of medical facilities is judged by a number of measures, including the time they have to wait to consult a physician in a hospital, the time it takes for a patient to be linked to an available hospital bed when required, and the time it would take and the convenience of the process for walk-in patients to consult a physician.

4.5 Institutes for the Family-Centred Care Model

During the establishment of the Institute in Saudi Arabia for Family-Centred Care in 1992, it was envisioned that this would be an all-encompassing development which

would bring significant changes and positive improvements in the lives of patients admitted there. The Institute would improve the lives of the patients and their families by providing them with access to health, education and social services and it was therefore expected that a close partnership between the Institute and the various stakeholders would be beneficial to everybody, including the patients, their families and the medical community (Al-Modeer, 2013). With the main objectives of the Institute set out below it was stressed that the patient should be provided with adequate dignity and respect, taking into account cultural aspects, ideas and religious beliefs which must be fully accommodated and respected. All information related to the patients would be shared with them and their families in a way that would be beneficial for all. Patients and their accompanying family members would be provided with timely health and status information which would be used to make appropriate decisions for the betterment of everybody. Patients' and their families' involvement would be encouraged so that a free flow of information would enable the best decisions to be taken, benefiting all parties. The Institute would collaborate with the patients and their families towards providing optimum service standards. It was envisioned that the health care professionals and the Institute's management would work with the patients in all respects, contributing to aspects of policy and program development, its implementation, periodic reviews, program design, steps in professional development of the staff and in maintaining consistent standards of patient care (Al-Modeer, 2013).

4.6 Planetree Model

Planetree, founded in 1978, was established with the intention that the Institute would strive to bring about significant and major improvements in the way medical care and nursing was administered, and would incorporate aspects to remedy and soothe the ailments affecting the body, mind, and spirit of the patient, while also providing the best value for money packages possible. It was intended to be a place that could fuse the best healing processes of Western medicinal practices with those of the other types of medical practice (Al-Modeer, 2013), as per the following nine aspects of the patient-centric model: All actions of the medical faculty would be dictated, keeping the patient in perspective at all times. Hence, the staff would go out of their way to exhibit care and

kindness in their dealings, making the patients feel that the officials were in mental harmony with their patients. Policies include: Keeping the patient community aware of their rights and expectations from the staff and educating them on this to the greatest extent reasonably possible. Involving the family, friends and well-wishers accompanying the patients, in the healing process enables them to contribute spiritually. Closely observing that the dietary requirements of the patients are being met and fulfilled at all times. Fulfilling the spiritual requirements of the patient to the greatest extent possible so that this too contributes to the patient's healing process.

Providing regular massages and ensuring human contact with the patient. Making use of opportunities offered by arts, music, and visual arts as a part of the healing process. While continuing to focus on the conventional healing methodologies and dimensions, make sure that alternative and unconventional aspects are incorporated as well, provided that being beneficial to the healing process. Incorporating soothing features of architecture and design in the patient's healing process.

4.7 Synthesis of key attributes

Multiple concepts and models of patient-centric care exist, and they all have certain underlying aspects in common, albeit with a few necessary additions and deletions. In 2004, Carol Cronin, a consultant associated with the National Health Council in the US, made a review of the various models in circulation and going through the literature of nine of these models concluded that there were overall around 45 specifics involved (Shaller, 2007). Below is a list of six of these details, which were determined to be common to at least three of the theories debated and analysed:

4.7.1 The six elements of the definitions or descriptions of the Patient-Centric Care models

1. *Education and the transmission of know-how were prerequisites.*
2. *Family and friends contributed significantly to the patient's mental welfare.*
3. *All efforts needed to be in synchronisation and coordination.*
4. *While medical aspects were taken care of, other extraneous factors too had to be heeded.*

5. *The patient's personal preferences and choices had to be taken into consideration.*
6. *Information and knowledge had to flow freely.*

Considering the breadth and multitude of theories regarding patient-centric care, there is clearly no shortage of the multiple aspects which could be debated. However, perhaps what is of interest here is that at least half a dozen attributes seem to be common when comparing all the theories and the interviews and discussions with health care managers. In this respect, at least five aspects appeared to be prerequisites for these theories:

4.7.2 Basic features of the theory of Patient-Centred Care

1. *Regard and care for the principles, needs and requirements of individual patients had to be kept in perspective (Charmel & Frampton, 2008).*
2. *The patient had the right to be informed about the course of treatment determined for the ailment, and each step initiated by the medical professional had to be conveyed to the patient beforehand (Charmel & Frampton, 2008).*
3. *The patient should have the right to gain access to all the services of health care and preventive medical care required to lead a long and healthy life (Wolf et al., 2008).*
4. *The patient's psychological needs and requirements had to be perceived and understood as the complete healing process (Epstein, 2005).*
5. *The patient had the right to gain access to and be provided with a correct and genuine representation of the options available to him or her while exploring options for treating and healing the person's ailments (National Asthma Council Australia, 2007).*

Considering the above elements, it may be substantial for current research to investigate older patients' satisfaction with HHC about patient-centred care theory in Saudi Arabia. A report by Shaller (2007) indicated that patient-centred care had, in 2007, turned into a major goal for the health system in the literature is unfortunately dominated by a medical model based IOM definition. However, feedback obtained from encounters with patients implied that the system was not yet in line with the concept. From conversations with the heads of patient-centred institutions and programs, five major factors were identified as

key to the attainment of patient-centred care. One was the commitment of the leadership of the organisation. Others were a well-planned vision comprehensively and continuously related to all organizational affiliates; patient, as well as family, involvement; a workplace that was supportive and compassionate to all its employees; and effective information technology (Shaller, 2007). In the clinical setting, patient-centred care refers to the way the health care provider and patient communicate. It is the behavioural know-how of the health professionals which enables them to modify care according to the exact needs and condition of the patient and not the other way around (National Diabetes Education Program, 2007). It enables health care providers to devise means of assimilating the perspectives of their patients into clinical discussions by inquiring about, giving encouragement on, and acknowledging the opinions of the patient about his or her treatment and illness (Vanish & Tiewtranon, 2004). It appears that the focus of the patient-centred consultation in the clinical setting is the collaboration of the patient, families, and clinicians, in recognising the treatment and life objectives of the patient.

4.8 Better health outcomes

Patients suffering from such chronic and life-threatening diseases as diabetes and cancer had to be provided with adequate care and a quality of life to the greatest extent possible so that the pain was lessened and reduced to the maximum degree (Dibbelt, 2009; Hojat, 2011; Mack, 2010). It was also observed that where cancer patients had honest and free discussions with their physicians, the cost of medical care was considerably reduced in the later and terminal stages of the progression of the ailment. On a corresponding note, doctors who could talk freely and comfortably with their patients were able to glean greater information and data on the patient's health status. Hence, it could be rightly concluded that every stakeholder ideally needs to put in an appropriate share of effort to make the initiative successful.

4.9 Lower costs to health care services

Among outpatient facilities, health care providers who obtain the highest ratings regarding patient-centred communication incur lower expenses in the diagnostic examination, with certain health outcomes, compared to those who have the lowest ratings (Epstein, 2005). Patient satisfaction in Saudi Arabia, along with communication

upon discharge, is related to notably lower re-admissions, resulting in lower expenses for treatment of heart ailments and pneumonia (Boulding, others). There were notably reduced costs for health care services in the course of the final treatment of patients with severe cancer who had end-of-life discussions with their doctors. Increased expenses related to the deficient quality of life for dying patients were found in Huskamp, Nilsson, Maciejewski, Earle, Block and Prigerson (Zhang, B, et.al, 2009). Hence the importance of providing the highest quality of HHC service in Saudi Arabia. The improvement of the HHC service depends on the availability of funds and services. The quality of the delivered HHC service must also be excellent since a poor quality of service will lead to many patients being admitted back into the hospital (Katz, 1972). The Ministry of Health in Saudi Arabia plans to implement HHC services within the framework of its budget. It is no secret that a good quality of HHC could be delivered in a way which meets all the many needs of the patient without the need for hospital admission, based on the type of condition (MOH, 2011). The implementation of HHC services for older patients who are admitted for long-term stays in the hospital will contribute to reducing the outgoings of hospital budgets (Corwin, 2005).

4.10 Benefits of patient-centred care

The available evidence on the relationship between patients' health and patient-centred care may not yet be extensive. Nevertheless, there are still implications of favourable overall health outcomes for the patient. According to Bauman (2015) the patient-centred method results in patient satisfaction, compliance with task instructions, less anxiety, improved quality of life and physician satisfaction. Efficiency is also an outcome, leading to fewer diagnostic examinations and reduction in additional medical appointment recommendations. (Wolf, 2008) asserts that consideration of the perception of the patient was related to increased satisfaction, improved conformity with treatment, and the care continuum. There is growing evidence that physician who concentrates on the patient as well can obtain more precise and specific data. They were able to initiate more successful physician-patient relationships (Platt Et al, 2001). From a report by Lau (2002), it was apparent that shared understanding results in immediate diagnosis and agreed alternatives for treatment. According to Lau (2002) 'patient centred care immensely affects the

patients' perception, satisfaction level, and quality of care provided to them. The health care sector has to steer clear of incentives for reducing treatment and avoid over-treatment'. All citizens may have a need for medical home services; however, not all places in Saudi Arabia are ready for the necessary modifications. It will take lots of conviction and effort by all interested parties to make this program workable.

4.11 Patient-Centred Care Theory and Home Health care

Concepts enabling patients to be taken care of in their homes, instead of being institutionalised and sent to hospitals for long durations, were supposed to bring about marked improvements in the ways of dispensing care for the sick (National Committee for Quality Assurance, 2008). The concept was introduced as a model of health care for those requiring it (National Committee for Quality Assurance, 2008). Thus, patient-centric care is a dimension of care where the patient is the focus of efforts on the part of both the professional and the people taking care of the situation at home. Towards this end, multiple surveys were initiated, but the one conducted by Wolf, Lehman, and others, (2008) is commendable in that it tried to quantify the patient's satisfaction, including satisfaction with this model of care. For the purpose of the study, two groups were created, one provided with patient-centric care, the other provided with normal nursing facilities and standards. The results observed were certainly mixed. However, proponents of the theory have been vocal on the multiple benefits perceived regarding improving the quality of care, reducing inadvertent medical mistakes and helping to counteract any perceptions of racial discrimination in the dispensing of medical care. In turn, these aspects contributed to add a political dimension to the study, and as of 2009, four different legislative measures have been proposed towards increasing and promoting patient-centric care efforts (Andrews & Toubman, 2009). Practical implementation of all the recommendations in the model could significantly alter the way health care functions are currently made available, with households themselves increasingly taking on the onus of care for the patient. The model foresees some advantages for the patient in that the entire focus of the medical community would shift, to be directed towards the ultimate advantage of the patient, whose requirements would take precedence over any and all other aspects of the industry.

4.12 Factors that Contribute to Successful Implementation of Patient-Centred Care

The text in the preceding section has attempted to demonstrate the benefits of patient-centric health care and its gradual acceptance in the global scenario and Saudi Arabia. Multiple factors affecting the course of this experiment include:

4.12.1 Leadership:

As per experience and current theories and literature, the mindset and the commitment of the top management and the uppermost hierarchy in the health care industry must determine the actual success of this initiative. Hence, for the ultimate and long-term success of any such project, it is imperative that the industry leaders be all on board.

To quote an observer who was interviewed during the study, 'There is no chance to succeed without it and maybe not even with it' (Al-Modeer, 2013). The organisational leadership inevitably decides on setting the culture, and this has been supported by the likes of noted organisational theorist Edgar Schein, who is of the opinion:

'The leadership of an organization would determine the prevalent culture, and can both make, and break the social set ups in organizations. It is hard to study and evaluate either of the two in isolation and is best that they are evaluated in plurality' (Shaller, 2007).

4.12.2 A Strategic Vision Clearly Communicated.

A committed leadership would be best able to decide on the course of action most suitable for achieving the goals and tasks in the most optimum manner. Experts are of the almost unanimous opinion that the organisational mission statement needs to reflect the organisation's commitment towards patient-centric care if its management and leadership are truly committed to taking such a path and such an initiative. This would then become part of the everyday work routine of lower-level employees (Shaller, 2007). It is equally important to note that hospitals and institutions alone cannot be patient-centric, without the complete cooperation of family members who would ultimately provide the long-term care the patient would require. Thus, of the multiple levels of patient-centric care, the patient's family and social circles are perhaps the set of people who would be in closest contact with the patient and therefore need to be brought onboard with the concepts of this theory. On the second level, the clinical staffs that provide professional advice for the patient would need to be educated regarding the concepts of this theory. On the next,

third, level, the commitment of the organisational leadership would determine the success or failure of the initiative. The organisational leadership can take the necessary steps to enable the family and the social circle of the patient to be a part of the process, and can impart the necessary training and sensitisation to the patient's requirements. A format for this process could be the formation of family advisory councils as a medium enabling the education of families on the intricacies and specifics of this theory. At the final, fourth level, continuous feedback from the patients themselves and their families would go towards further refining and improve the system, in turn providing guidelines for the regulatory authorities and the law makes bodies draft, and if necessary to legislate, provisions for ensuring continued long-term sustainability of the initiatives undertaken in this regard (Al-Modeer, 2013).

4.12.3 Supportive Work Environment:

To roll out a successful patient-centric program, the people responsible for ensuring the continued success of the initiative should, most importantly, be given due regard and respect for the efforts they are expected to make. Thus, if we want professional employees to care for their patients, the workforce too needs to be taken care of in the same manner and should be shown the same regard expected of them (Shameloo, 2012).

4.12.4 Systematic Measurement and Feedback:

To ensure that any new initiative is successfully concluded as per the required standards, continuous and periodic feedback on the performance of the initiative is of vital importance, as reflected in the maxim 'you cannot manage what you cannot measure.' Initiatives to gather feedback on the status of the system being implemented could take multiple forms, including the 'balanced scorecard' concept proposed by Kate Goonan, which would measure and collect feedback on multiple aspects of care disbursement, including such factors as patient experiences and complaints. Correspondingly, 'patient loyalty' exercises would determine how many patients signed on to a program again after their first experience. There is also the 'walk through' concept whereby employees play the role of patients and experience the level of service provided to patients (Shaller, 2007). Family advisory councils are yet another valuable avenue for generating true feedback from patients and their caretakers. Hence, irrespective of the scale of the

initiative, from redesigning the reception area of the hospital to such small-scale initiatives as adding signs in hospital corridors, it is vital to obtain continuous feedback on how the process could be further improved. Continuous, cyclical measurement of the input and its corresponding effects is also known as PDSA, or 'plan, do, study, and act.'
Peter Coughlan is correct in advising that it is critical for the feedback received to be immediate and close to real-time so that the necessary corrective actions can be taken at the earliest stage in case any discrepancy is observed (Sulaiman, 2009).

4.12.5 Quality of the Built Environment:

The working environment provided by the institution for implementing the patient-centric initiative is a primary factor in determining its success, as depicted by Planetree's specific and continued emphasis on providing an aesthetically pleasing environment in which employees and patients can interact.

4.12.6 Planetree Parameters of Health Facility Design

1. *Ensuring that the patient's attendants are relaxed and feel welcome.*
2. *Motivate patients to provide their feedback on their perceptions of what would make them comfortable.*
3. *Give individual patients a sense of personalised attention to their requirements.*
4. *Motivate employees to be cognizant of patient requirements.*
5. *Seamlessly align aesthetic beauty in the workplace.*
6. *Ensure that information flows without any hindrance. (Shaller, 2007).*

Planetree is an organisation which aims to provide affordable education and information opportunities to underprivileged sections of society; it promotes patient-centric health care options. It is a trendsetter in the community, striving to provide accessible means of human development and progress. Since its inception in 1978, its implementation of the various models at diverse locales has led to marked improvements in the quality of life for millions of people.
Starting in 2000, the Centre for Health care Design has overseen the Pebble Project as an initiative geared towards proving that changed physical environments can have a corresponding effect on patient welfare, and that aspect of the patient's family

involvement also determines how well the patient responds to other stimuli (Murshed, 2012). The organisation perceives that caring for others is a natural human trait. Towards this end, they conduct periodic demonstrations on how households can themselves care for terminally ill patients and how organisational cultures can promote a patient-centric environment, going on to prove how social support is conducive to healthier living.

The organisation encourages families to participate in the care and well-being of patients and arranges for family members to be together with patients in otherwise restricted environments. The Care Partner Program is a means of increasing family participation in the care of the sick, with illness being perceived as a learning opportunity. The organisation allows members to view patient records through the Open Chart program, and also arranges for family members to make entries in the Patient Progress Notes.

The Self-Medication aspect of their activities encourages keeping medicines at the patient's bedside.A variety of year-round activities promotes the firm's perspectives, with educational material made widely available to the public by the organisation. The Planetree Health Resource Centres offer free educational sessions and programs for the community, promoting patient-centric approaches. Realising how much the physical environment affects the quality of care provided, each of the premises of the organisation is aesthetically designed to deliver a pleasant feeling. Efforts have been made to create a seamless architectural design and to promote unhindered human interaction. Ample space is incorporated into the designs to provide for both group activities and private spaces. Libraries, kitchens, lounges, activity rooms, chapels, gardens and a host of other facilities are incorporated in every Planetree building.

4.12.7 Supportive Technology:

Each Planetree facility promotes seamless and unhindered communication opportunities across a variety of media. Considering how important communication is to the success of all patient-centric approaches, the organisation wants to take every opportunity to demonstrate this aspect to visitors.

Aspects of Health Information Technology (HIT) are widely utilised, including basic e-mails to more of the sophisticated media, as well as specific web portals offering access to patient records. Correspondingly, the cost factor varies in implementing all these varied technologies (Shaller, 2007).

4.12.8 Cultural Competence

The social system of Saudi Arabia is deeply bound to cultural and normative values. This clearly shows in the views as well as practice of native citizens. People's decisions and consequent actions are considerably influenced by the cultural system they had been living into. The impact of culture is present in every walk of life in Saudi Arabia, which also includes health care system. People significantly uphold their cultural values while accepting healthcare services. This contributes towards developing a culturally competent system of patient centred care so as to provide effective services to the patients.

Cultural competence involves implementing the procedures of patient-centred care so as to be in compliance with their background (Matthews and Kostelis, 2011). This model employs various communication skills such as exploration, empathy, and other techniques to obtain better understanding of patients' needs, values, and preferences. Various other skills are included as well which are considered as facilitating the cross-cultural interactions (Lowhorn, 2007). To ensure the provision of effective medical care, thus, requires a combination of scientific knowledge, along with communication skills which may facilitate in understanding the needs of the individual patient and thus, cater to their feelings and concerns with sensitivity and compassion (Al-Modeer, 2013). Patient-centeredness and cultural-competence aim to improve health care quality, however, they emphasize on different aspects of it. The patient-centeredness movement majorly aims at creating an individualized approach to quality, to comply with the increased focus on process measures and performance benchmarks with a focus on personal relationships and service provision (Al-Modeer, 2013). As such, patient-centeredness aims to elevate quality for all patients. Moreover, the cultural competence movement aims at balancing quality, improving equity, and reducing disparities by specifically improving care for people of all backgrounds and cultures (Abyad, 2006). The implementation of HHC is significantly influenced by these factors since if health care providers will be competent enough to understand the cultural backgrounds of patients' various actions and decisions, it would become easier for them to treat them as per their particular social systems. This would definitely help in developing an effective healthcare system. As home health care systems is specifically intended to provide healthcare services to older patients, the service providers must understand the cultural

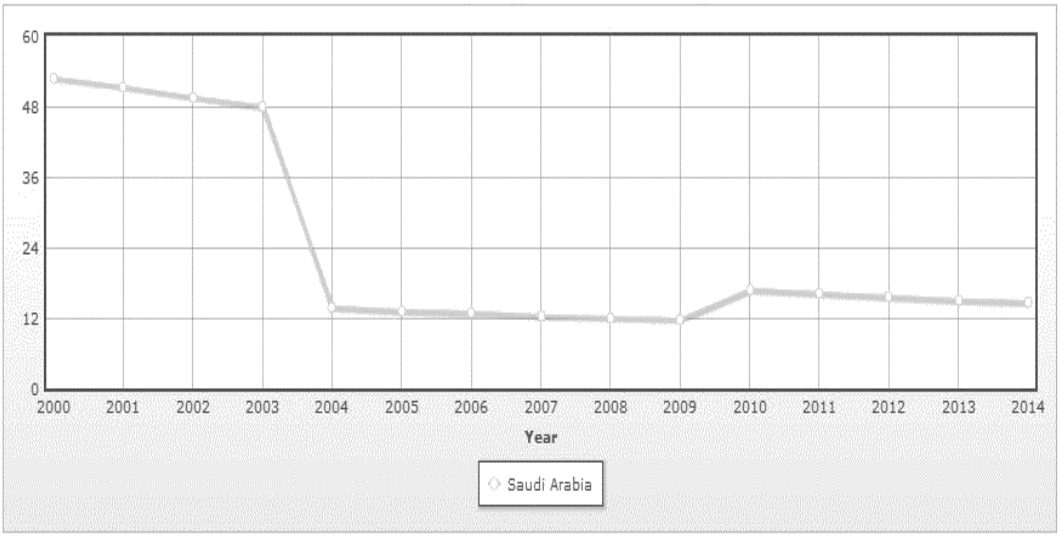
setting of Saudi society regarding them. Elders are expected to be respected and looked upon for decision making in the family as well as social groups (Dixon, 2009). As for healthcare, there are certain practices which prevail as cultural habits among Saudi people, especially amongst the older generation. Older people in Saudi Arabia may subscribe to folk remedies and beliefs regarding their ailments. They have firm beliefs about the evil eye. Similarly, on noticing certain symptoms, people may employ home remedies instead of seeking medical advice. In some cases, this step aggravates the issue by the time it reaches the doctor. Moreover, in Arab culture, patient is supposed to be kept unaware of their ailment if something serious prevails. Family members especially ask the care providers to not share any news to patient unless it is a good one regarding their disease. This does not let the patient become mentally prepared for the worst, and hence affects their will power to support the medical care (Thomas, 2016). Moreover, older patients are usually observed to be in a habit of taking medicines only till the time their symptoms exist, but once the symptoms subside, they may discontinue their prescribed drugs. In Arab tradition, family members are obligated to visit and bring gifts to hospitalized elderly persons, and therefore, may not wish to adhere to visitation restrictions in the hospital. Thus, it is quite a challenge for healthcare providers to make them understand the hospital decorum (Thomas, 2016). Modesty is considered to be upheld among the conversations of every nature, thus, even in conversations with doctor, people may get embarrassed by personal questions, especially if the doctor is of the opposite gender. Being a gender segregated society, people even in their older age resist from being treated by healthcare providers of opposite gender (Dixon, 2009). These are some of the most commonly practiced cultural norms regarding the field of healthcare in the Arab society. The healthcare providers must acknowledge these practices and understand their backgrounds so as to design their strategy for the provision of care to patients effectively. Considering the present situation, majority of care providers in Saudi Arabia comprise of expatriates (MOH, 2011). Thus, they must be trained as such that they may be fully able to understand the culture and practices of the region and thus devise their actions accordingly. One of the major challenges for care providers is to be able to communicate with patients in their native language while maintaining the similar standards of respect in conversation as expected by Arabs. As for elder patients, they may

be quite resistant towards a person who cannot communicate in their language. Moreover, understanding the social values is of due importance as well (Abyad, 2006). By employing these measures, the health care provider will be able to offer effective healthcare services which may be in the best regards of the patients.

4.13 Patient-Centred Care and Patient Satisfaction in Saudi Arabia

The Saudi Arabian health care sector has matured much over the past four decades. Infant mortality has decreased from 52.9 in 2000 to 47.94 cases per 1,000 live births as of 2003 and increased from 13.7 in 2004 to 11.57 2009, etc. Mortality rates for children under 5 have decreased to 20 per 1000 between 2009 and 2014 from the high of 250 per 1000 (Statistical book of the ministry of health 2014).

Below is the figure indicating the number of deaths of infants with one-year ages per 1,000 live births in Saudi Arabia.



Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Saudi Arabia	52.9	51.25	49.59	47.94	13.7	13.24	12.81	12.41	11.94	11.57	16.73	16.16	15.61	15.08	14.58

Figure 4: Deaths of Infants at One Year per 1,000 Live Births in Saudi Arabia

Source: World Bank online, 2015

All this has been possible due to extensive government support, as demonstrated by Royal Order No. 66/a on 13/4/2011 allocating 16 billion Saudi Riyals for the construction of five medical facilities across the country by the Ministry of Health (Al-Modeer, 2013). The Saudi health model follows the principles of patient safety, emphasising service standards and ensuring patient satisfaction. Correspondingly, the population has access to the best Health care facilities at very affordable cost to themselves (Al-Hazmi, 2005).

A 2011 study by the Institute of Public Administration in Riyadh found that almost 70% of the population have been fully satisfied with health care standards, with Ministry of Health facilities being voted the best by nearly 73.4% of respondents. Correspondingly, over 68.4% respondents were satisfied with out-patient facilities in the government health facilities, while 69.8% agreed with the state of affairs in the Emergency departments of the nation's hospitals (Al-Modeer, 2013). A study by (Albawardi, 2013) the Ministry of Health has begun to focus on patient-centric approaches to a certain extent by taking a few tentative steps in that direction, placing emphasis on the patient's consent before taking major decisions affecting the patient. This study analysed patient satisfaction in Saudi hospitals and observed that age was a factor in this respect. Patients 60 years and older indicated a 78% satisfaction level with the current standards offered at the hospitals, but this decreased to 68% amongst people between the age of 20 and 30 years. Only 27% of married respondents were unhappy with the range and standard of services offered, but around 68% of unmarried respondents said they would like things to improve (Albawardi, 2013).The study also observed that 79% of respondents agreed that health professionals are human beings while 78% agreed that the institutions maintained their privacy. A further 76% of respondents acknowledged that the doctors were competent in the sense of being able to make effective identification of ailments to the satisfaction of the patients, and the same percentage of respondents agreed that they had no issues about communicating with doctors, finding them attentive to the patients during visits and being able to understand clearly the patient in verbal communication between medical staff and patients (Albawardi, 2013).Fifty-five percent of respondents complained of excessively long waiting periods for getting an appointment to see a consultant (Albawardi, 2013). In general, the results were positive, and of course, serious steps are required to improve the services provided. Consequently, there is certainly a chance to

meet the needs of patients through the Ministry of Health (Albawardi, 2013). The study made a few cursory recommendations, such as improvements in the process of providing medications after physician visits, and more walk-in day care centres which must meet the latest medical needs. In line with patient-centric approaches, adequate, continuous and proper feedback would have to be obtained from the people accessing the system, so as to have more thorough input on all the potential areas of improvement in the country.

4.14 Strengths of the Application of Patient-Centred Care Theory in Saudi Arabia

Patient-centric approaches call for two elementary bifurcations of the type of care provided to patients (Patient-Centred Quality Care Collaborative, 2007). They comprise the setting up and aligning of the physical and organisational infrastructure for the initiative, and then ensuring that the same conditions continue to be maintained consistently in the long term. Hence, registries, health data exchanges, and communication aspects all need to be adequately covered (Patient-Centred Quality Care Collaborative, 2007). Correspondingly, besides the availability of the required infrastructure, it is equally necessary to ensure that it is adequately maintained and made available when required over time. Otherwise, huge investments could fall into disuse; entirely defeat the purpose of the initiative. Recognising the importance of providing HHC services, the Ministry of Health in Saudi Arabia offers these health care services, called Home medical care, for citizens, to provide health care and services for older patients in their homes without the need to take them to or keep them for extended periods of time in public hospitals (MOH, 2010). One of the main economic objectives of the HHC program is to reduce the cost of providing health care services in public hospitals, particularly those cases which filled the group of public hospitals without medical justification (MOH, 2010). It is thus possible to provide to the patient at home the same service that he would receive in the hospital (MOH, 2010). Also, one of the goals of HHC is to speed up the healing process. In fact, the opportunity to remain at home when receiving treatment and health care will make the patient feel comfortable and safe. Thus, the above application is not only beneficial as a HHC program but is also integral to the management of health resources in economic terms. Currently, HHC services provided by the Ministry of Health cover more than 80 hospitals in different

regions in Saudi Arabia, and the number of patients who receive HHC services in Saudi Arabia has risen to thousands of beneficiaries over the last three years (MOH 2014).The following table shows the number of hospitals was provided the HHC services in all regions in Saudi Arabia. Health experts and leaders in Saudi Arabia expect to see an increase in the number of older patients eligible to receive services from the HHC program in the next few years, caused by an increase in the ageing population and plan to establish the HHC department in All public hospitals and focus on the indicate of the statistical number of those aged 60 years and above will increase between 2005 and 2030 (MOH 2014).

Table 10: HHC Beneficiaries Aged 60 Years and Above (2005-30)

No of Beneficiaries	No of Cases (end of 2015)	No of Manpower	No of Hospitals	Region
7168	3572	228	25	Riyadh
3456	1552	82	7	Makkah
2222	1880	79	6	Jeddah
2360	1307	57	4	Taif
3465	2022	158	15	Madinah
3056	1275	123	18	Qassem
4340	2663	139	13	Eastern
2542	1491	31	8	AL-Ahsa
1042	414	32	5	Hafr-Albaten
5054	1728	135	21	Aseer
412	201	30	4	Besha
1823	692	47	10	Tabouk
1377	841	62	8	Hail
778	545	59	8	Northern
2296	1282	103	17	Jazan
1572	669	48	8	Najran
766	991	43	3	Al-Baha
794	584	25	4	Al-jouf
508	345	15	3	Quarayyat
45031	-	-	-	Total

Source: Statistical book of ministry of health 2014

4.15 Weaknesses of the Application of Patient-Centred Care Theory in Saudi Arabia

The Saudi perspective on patient-centric care has a few shortcomings, including the need to improve the decision-making process (Devoe, Wallace, Pandhi, Solotaroff & Fryer, 2008). So, while the prevalent system may have adequate infrastructure for providing the required level of service and care for the patient, unfortunately, adequate data storage, and recall systems need to be introduced in order to make the required information available more efficiently to both the physician and the patients when needed, thus enabling appropriate timely decisions to be made (Devoe, 2008). Also, a lack of planning could be observed at times on the part of both patients and health care professionals and staff, which again ultimately affects the quality of service available to the stakeholders utilising the system (Safran, 2007).

4.16 Conclusion

Studies in the field provide input on the theories of patient-centred care, although the Saudi Arabian health sector still has to mature and develop significantly to be able to grasp the concept in its entirety. However, the system has seen tremendous development in a space of just four decades, with almost all key indicators exhibiting significant and marked improvements. Organisation such as Australia has been observed to have exceeded global standards in the level and quality of service they provide, although this should hold true for the health care system as a whole. Such an outcome would make possible and promote a nationwide patient-centric health care system.

Chapter 5 Methodology

5.1 Introduction

This chapter describes the ethical considerations and research methods employed in this study. The purpose, objectives and the problem are provided along with a rationale for undertaking the research. The data collected for the pilot and main studies and analysis are included, as well as a description of the independent and dependent variables. Further measurements were used to analyse the other factors including means, standard deviations, and F-test. In this study, the analysis of quantitative data was performed using SPSS software. Content analysis was used to evaluate the qualitative data that was extracted from the patients and leaders in this study.

5.2 Ethical considerations

In their book 'Research Ethics in the Real World' Tony Long and Martin Johnson provided that there are three broad positions from where to view the design and execution of research. The most influential of all is that of codes of human rights. They are significant as they have explicit criteria that they must be met and can add a margin of safety for inexperienced researchers. The second one is the consequential approach which is least admitted to directly benefit the society. However, considering the importance of individual autonomy and respect for persons, this is the pre-eminent model of decision making in both health care and health and social care research. The third one is relational or care approach which is has developed with respect to the consciousness towards the women and other oppressed groups. This is most popular in qualitative research (Long & Johnson, 2007). Concisely, the social context in which the research is being designed, planned or approved seeks significant importance. Issues of occupational socialization, professional power, social class, gender, race and culture each has a strong influence on the values that we bring to the research and that our participants hold. Moreover, personal and professional integrity and holding key values are central to defensible approaches to research, even when all might not agree equally with the justifications (Long & Johnson, 2007).

The Research Ethics Committee at the University of Salford approved this study. Permission was also obtained from the Health Affairs Department in the Al-Baha region of Saudi Arabia. The participants were selected on a free basis, and their personal information will be kept anonymous and confidential. The concept of informed consent was used in this study, which gave the participants the right to take part in this study or not. For the purpose of clarity, it has been explained to participants that I will not use any data or information except for scientific research purposes. In some studies, participants in many cases have not known about the health or social aspects of the studies in which they have been involved. This implies that studies should use a consent form (Lewis and Ritchie, 2003). The participants were given the option to leave the study if they felt uncomfortable at any time without to present the reasons. Questionnaires were sealed in individual envelopes after the participants had filled them in and the participants' names will not be mentioned in any report or publication related to this study. Markle et al. (2011) stated that disclosure of data, such as full names, should not be asked of participants if they are not to be used in the study. To be suitable for achieving the desired objectives of the study, the interviews were conducted at the homes of the participants. As an additional measure, the participants' homes were visited in daylight and pairs, and no dwelling was entered if it appeared to be in any way suspicious. Personal copies of the data collected were made. Pseudonyms or descriptions were used to represent the data, thus preserving the participants' anonymity, while still making the data easily recognisable. To ensure confidentiality, the study material was kept at my home for safety, and a password was applied to all recorded computer data. The data will be stored for a period of time in the form of questionnaires and codes, after which they will be statistically analysed to extract results. When in use, these data will be kept under strict control.

5.3 Statement of the problem

The modern approach of the HHC service relies on taking into account what other countries are doing and adopting a reflective awareness of how to advance and improve further in this field. These approaches include the use of qualified specialists and programs related to HHC. This project has led to the need for research on the actual

levels of patient satisfaction and benefits of these health services in the country. It also involves identification of the challenges that hinder the improvement of the services provided in this area. In this study, the key issue is to determine the degree of satisfaction with the services offered through the HHC system in Saudi Arabia.

5.4 Research Method

A two-method approach was deployed for this study as it allows for the ideal utilisation of quantitative and qualitative techniques for data collection. This is supported by Creswell (2004), who contends that the close analysis of interview and survey data will undoubtedly lead to a detailed insight into the older patients' level of satisfaction with the HHC service in the Al-Baha region. The survey element of the study is based on an available sample of 410 older patients who use the HHC services in the Al-Baha region of Saudi Arabia. It comprises a cross-sectional survey. For the collection of the survey data a questionnaire designed by Westra et al. (1995) entitled the 'Home Care Patient Satisfaction Instrument - Revised (HCCSI-R)' was used. For this questionnaire, a response rate of 87% participants (n=410) was achieved. The analysis of data was used. For this questionnaire, a response rate of 87% participants (n=410) was achieved. Data analysis included both descriptive and inferential statistical methods. Firstly data on categorical variables like demographics (gender, education, and marital status) are presented using frequency distributions and pie charts. Data on quantitative interval scale variables like satisfaction level scores for different satisfaction items and overall satisfaction are summarized using measures of central tendency and dispersion including mean, standard deviation, minimum and maximum. Test for significance of the difference in ways across two groups like testing the satisfaction score across gender (with male and female categories) is done using independent samples t test, and this test assumes equality of variances across two groups. This is tested using Levene's test for equality of variances. If the equality of variance assumption is satisfied, then the standard variance version of independent samples t-test is used. Otherwise, unequal variances version of the independent samples t-test is used. Test for mean satisfaction score across three or more groups like across marital status or education levels is done using single factor analysis of variance (ANOVA) F test. This test assumes homogeneity of variance of the difference

across groups. This homogeneity of variance assumption is tested using Levene's test. Under any violation of homogeneity of variance assumption, Brown – Forsythe corrected robust test for equality of means is used. Post-hoc comparison of pair wise means is made using Tukey's procedure to adjust for the inflation of type I error probability. Under unequal variances, Games-Howell corrections for post hoc comparisons are used. All the statistical tests are performed at 0.05 level of significance. The data analysis was carried out using IBM SPSS 19.0 version**.**

5.5 Philosophy of using various Methods

There are many methods contain various philosophies. On the basis of their inclinations, they can be arranged into three categories, which are: philosophies about the two main paradigms methods along with their functionalities, secondly, the philosophies discussing structures of other paradigms through which tow methods practice is investigated, and philosophies in relation to belief in multiple methods around their "complementary" nature. Since the tow methods reflect both the quantitative and qualitative techniques, we identify that they reveal both a quantitative positivist approach and a qualitative interpretive approach. Therefore, hypothetically speaking, the benefits of both paradigms can influence the research. As far as this study is concerned, certain advantages can be observed, when we take into account these two main paradigms besides their subsequent transformations. If we talk about the positivist research approach, it has several benefits. In positivist research, the researcher is concerned with gaining empirical and objective knowledge using scientific methods of enquiry. Methods associated with this paradigm include experiments and surveys aimed at collecting quantitative data. Analysis methods using statistical procedure are employed, and conclusions drawn may be used to provide evidence to support or negate the hypotheses generated at the start of the research process; in other words to use deduction instead of induction. The major focus is on measurement, whether this be of scientific quantities e.g. time or speed through experimental activities, or of attitudes, behaviours and opinions through surveys and questionnaires ("Research Observatory, UWE", 2016).The nature of the methods, within this approach, is structured and analysis of the resultant data is generally achieved through the use of rigorous statistical technique. The huge and substantial amounts of

numeric data can be generated and efficiently manipulated to address the research question through the use of survey studies (Ingleby, 2013).To prioritize multiple themes for this study, this preparation is essential to understand having the learning needs and their assessment, and eventually, we can come up with a successful educational project (Bastable, 2006). Besides the specific nature of findings, the focus on goals and scientific research is another benefit of using a positivist approach (Ingleby, 2013). As a result, the generalizability and possible publication of the study findings can be enhanced to a greater extent. Interpretivism, also known as interpretivist involves researchers to interpret elements of the study, thus interpretivism integrates human interest into a study. Accordingly, "interpretive researchers assume that access to reality (given or socially constructed) is only through social constructions such as language, consciousness, shared meanings, and instruments" (Myers, 2008, p.38). Development of interpretivist philosophy is based on the critique of positivism in social sciences. Interpretivism is associated with the philosophical position of idealism, and is used to group together diverse approaches, including social constructionism, phenomenology and hermeneutics; approaches that reject the objectivist view that meaning resides within the world independently of consciousness" (Collins, 2010, p.38). Moreover, interpretivism studies usually focus on meaning and may employ multiple methods in order to reflect different aspects of the issue. Development of interpretivist philosophy is based on the critique of positivism in social sciences. Interpretivism is associated with the philosophical position of idealism, and is used to group together diverse approaches, including social constructionism, phenomenology and hermeneutics; approaches that reject the objectivist view that meaning resides within the world independently of consciousness" (Collins, 2010, p.38). Moreover, interpretivism studies usually focus on meaning and may employ multiple methods in order to reflect different aspects of the issue. In general interpretivist approach is based on the following beliefs:

1. Relativist ontology. This approach perceives reality as intersubjective that is based on meanings and understandings on social and experiential levels.

2. Transactional or subjectivist epistemology. According to this approach people cannot be separated from their knowledge, therefore there is a clear link between the

researcher and research subject ("Interpretivism (interpretivist) - Research Methodology", 2016).The basic differences between positivism and interpretivism are illustrated by Mansfeld (2009) in the following manner:

Assumptions	**Positivism**	**Interpretivism**
Nature of reality	Objective, tangible, single	Socially constructed, multiple
Goal of research	Explanation, strong prediction	Understanding, weak prediction
Focus of interest	What is general, average and representative	What is specific, unique, and deviant
Knowledge generated	Laws Absolute (time, context, and value free)	Meanings Relative (time, context, culture, value bound)
Subject/Researcher relationship	Rigid separation	Interactive, cooperative, participative
Desired information	How many people think and do a specific thing, or have a specific problem	What some people think and do, what kind of problems they are confronted with, and how they deal with them

Since the processes and principles of education, health and practice are almost the same; positivist research has the capability to create generalizable knowledge across different populations (Belk, 2007). Furthermore, the researcher is enabled effectively to discover the problems under investigation, if he/she is following the positivist approach (Ingleby, 2013). Consequently, the researcher gains an insight into the types of variables, which can influence the problems under investigation. Furthermore, during the measurement of the satisfaction of older patients with HHC services in this study, the issues which they faced may be taken into account while using more precise measurement tools for this research. Subsequently, assisting the researcher in explaining social problems and the

development of methods to measure the worth of related social practices are the expected benefits of a positivist approach (Stoneham, 2005). Service providers in HHC can learn how to improve the effective of procedures besides learning the ways to deal with HHC services and culture-related older patients in Al Baha region, Saudi Arabia. We can say that the researcher has to set up a totally artificial situation if he/she desires to control all the variables; else the truth has to be accepted by the researcher that all the variables cannot be held constant together. Therefore, to guarantee that the identified cause and effect are correct is not possible (Garrick & Rhodes, 2000). So, it has been used the combining a qualitative/ interpretive paradigm with a quantitative/ positivist paradigm is an essential action / element for this study. It also gains, ability to statistically explore scientific data by integrating these paradigms and, at the same time, the complex emotional and psychosocial factors influencing on the culture issues too. Consequently, this study has to consider tow various Methods approaches owing to the likely benefits. Apart from the key challenges encountered by mixed method researchers besides different paradigms' frameworks, there are also some of the features, such as, praxis, pragmatism, publication and proficiency, which are among the key areas for capacity-building. Also, a set of core beliefs surrounds this type of philosophical assumption over various methods. Moreover, those assumptions are known as the world view. For this reason, a world view composed of beliefs and assumptions about knowledge is included in this study the methods brought by the researchers (Creswell and Clark, 2011). The researcher by methodological rules is supposed that data integration is often formulated to all appearances. It is not formulated about any notional facts regarding the nature of the subject area. Regarding the exploitation and application of methods designs, data analysis and techniques, making well-versed choices is the challenge encountered by the researchers, and therefore, a comprehensive understanding of the research methodologies, literature, and data integration must be possessed by various Methods (Cameron, 2011). Beliefs of various methods and their benefits come under the other type. According to Andrew and Halcomb (2009), quantitative and qualitative methods can be employed to deliver the "complementary" knowledge.Creswell and Clark (2004) express that a more general picture, which can be expressed in numbers is offered by the quantitative data.This is an important requirement of this study since the researchers should clearly

identify the aims that are represented by older patient's needs, cultural challenges, and barriers, so that the researchers would prioritize them. Meanwhile, the comprehensive understanding of the objectives would be offered by the qualitative data, which is needed to manipulate and effectively utilize the findings, so that better recommendations for HHC services can be established.It is comprehended that knowledge, skills, and barriers can be clearly identified through the questionnaire technique while the real world problems are emphasized in the qualitative interview besides gaining an insight with them regarding the implementation of health education.Therefore, Creswell and Clark (2011) state that by following a process of elaboration and clarification of required learning needs and by switching from one method to another is a critical component for collecting "complementary" information.There are some advantages of this approach, for instance, offering a clear understanding of multifarious research questions and making the best use of the research findings (Creswell, Clark, and Nykiel, 2007). While evaluating the data by human choice, the shortcomings of both the qualitative and quantitative approaches which can be covered by their integration, and the benefits of each method can then be exploited by the researcher in the evaluation of human behaviour (Johnson and Christensen, 2011). On the other hand, various methods approach are reportedly criticized by some literature (Hesse-Biber, 2010).

5.6 Research Design and Instrument

The various methods approach was deployed for this study as it allows for the ideal utilisation of quantitative and qualitative techniques for data collection. The study design comprises of conducting a survey to obtain a quantitative insight into older patients' level of satisfaction with the HHC service in the Al-Baha region, followed by in-depth interviews designed in the finding obtained from survey. For this study, I did not find any available instruments to measure older patients' satisfaction with HHC in Saudi Arabia. It was decided to find an instrument suited to Saudi culture, traditions, and religion. For a collection of the survey data, a questionnaire developed by Westra, (1995) entitled the 'Home Care Patient Satisfaction Instrument - Revised (HCCSI-R)', was used. Previously, Westra and others had reported that 'No reliable and valid instrument to

measure patient satisfaction in HHC was found; however, three instruments reviewed provided a foundation for the development of the HCCSI' (Westra, 1995). Westra found three suitable instruments for development, and those used for measuring patient satisfaction with home care are: the Outpatient Satisfaction with Health Care Questionnaire (OSQ-37) by Hays and colleagues (Hays, 1990); the Patient Satisfaction Instrument (PSI) developed by Risser (1975) and modified by Hinshaw and Atwood (1982); and the Patient Satisfaction Survey (CSS) (Reeder & Chen, 1990). Westra used the review of literature and suggestions by expert nurses who were part of a HHC team to develop the HCCSI (Westra, 1995). I got the approval to use this survey from Westra (See Appendix). This survey element of the study is based on the available sample of 410 older patients who received HHC services in the Al-Baha region, Saudi Arabia. It comprises a cross-sectional survey and semi-structured interviews which were obtained to determine the level of contentment amongst older patients in the Al-Baha region. The HCCSI-R provides an overall patient satisfaction score and subscale scores for 5 common services, all on a scale of 0-100. It was more prominent in other study and suited research such as that conducted by Hamadi in Saudi Arabia (2010). This questionnaire is related and suited to the field of the present study. HCCSI-R is the first measure developed on the basis of the views of older consumers that also meets standard psychometric criteria (Westra, 1995). The HCCSI-R provides a consumer-based indicator of quality and can be used to examine changes in satisfaction over time and differences among providers or within a single agency (Westra, 1995). The questionnaire and interview questions were translated into Arabic and back to English. I then checked the translation, and kept this for help in considering the meaning of the data that were collected. For the qualitative part, the semi-structured interviews were conducted with open-ended questions. These interviews were held during the regular visits with HHC providers. Free and in-depth questions were raised during these interviews with older patients. This procedure was also followed with the HHC leaders.

5.6 Sample and Data Collection

5.6.1 First stage

The first stage of data collection has involved circulating the survey questionnaire. In addition, quantitative data were analysed and the most significant outcomes were determined. A confidence level of 95% is also used as well as a margin of error of 5% to find out the sample size. I have followed Raosoft Sample Size Calculator (Raosoft, Inc, 2004) to use 50%, which gives the largest sample size. According to Pallant (2007), the sample size is related to the test of the power of this sample in this research. Thus, it has been used the multivariate analysis for different independent variables such as Gender, Marital status, education level. Logically, the recommended sample for this research was likely to be n = 212. (Raosoft, Inc, 2004). Taking into response rate and recording error, the sample was further increased by 10 to n =222 (See Appendix). **But** to ensure the highest response rate possible, as the Saudi community in Al Baha region are not entirely familiar with health research. As I am from this area and I spent most my life there, I believe that this community are not familiar to present them opinion and provide negative feedback to government services! It could be related to the religion and respectful to the government. All 410 samples were included in this study. Therefore, the total population sampling was appropriate for the sample in this study because the total population sample is a technique involving a certain set of knowledge and experience in a specific subject (Creswell, 2006).

5.6.2 Second Stage

In stage two, the qualitative interviews of patients, consent to participate was obtained from a purposive sample of 15 older patients who received HHC services in the Al-Baha region, Saudi Arabia. The selection was made on the basis of information relevant to the main issues being investigated and is usually less than 30 cases (Lowhorn, 2007).

It has been stated that the suitable and available sample, which can yield what information I need from the person who is ready to give the answer, can be defined as the purposive sample in qualitative research (Dolores &Tongco, 2007). It is advantageous to choose the samples that are ready to attend the study and can help the researcher to get the best available information (Kristie & Lisa 2008). The researcher easily identifies the

important things and therefore can find individuals who can provide the information because they have relevant experience (Bernard, 2002; Lewis and Sheppard, 2006). The sampling was directed notably through the key informant technique (Bernard, 2002; Garcia, 2006). This is an anthropological method that uses rich information sources, as the total population of potential key informants was limited (Martin, 1998). That is, qualitative information will allow for finding out any relevant information that could be vital for the study and would not be covered by other survey instruments. In addition, it tries to offer clarification and understanding of complicated psychosocial problems (Marshall, 1996) and to ensure the greatest transferability of outcomes. For this purpose, people from different socio-demographic backgrounds were selected. During the interviews, notes were taken and memoranda, recording comments on tone and body language and face expression. The interview was recorded by digital recorder after obtaining permission from the participants (Martin, 1998). Obtaining in-depth answers from the older patients was challenging because the older people in this region were not familiar with researchers. The limitations of this study are related to nature, culture, religion and so on. Hence, more discussions about the culture in Al Baha region will be included in the final chapter.

5.6.3 Third Stage

In the third stage, purposive samples of the HHC leaders were selected for individual discussion. Here the Systematic Sample was used in the selection of those to be interviewed. These leaders gave in-depth explanations for the most significant findings which I obtained. This strategy allowed me to put forward comprehensive and efficient recommendations (Martin, 1998), as well as to improve HHC services in the Al-Baha region, Saudi Arabia. Purposive sampling refers to a non-representative subset for explaining a particular purpose and providing justification for the research, keeping in view the practicalities (Teddlie and Tashakkori, 2009). The selection is made on the basis of information relevant to the main issues that are being investigated and normally consists of less than 30 cases (Teddlie and Tashakkori, 2009). The interview was undertaken with the 5 Leaders of HHC services.

Chapter 6 Findings

6.1 Introduction

This chapter includes presenting the results obtained through various steps carried out in the research process. It presents the findings gathered through data analysis was done on pilot study as well as the actual research. Firstly, I started with a pilot study with small samples, to test the tools because i translated to Arabic and check if there are any issues. Simple Arabic words which were used with older patients are important. I mean that the used of slang words it will be Comfortable and suitable to get the best answer especially from the older patients who are from complicated culture such as in Al Baha region. Then, the main quantitative data were analysed using SPSS for this study. As I mentioned earlier, the tool can be regarded as valid because it has been utilized in another study in the health field and my use of this tool was approved by correspondence with the first author. Descriptive statistics have been presented through percentages, frequencies, subscale and total scores, and means. For the main quantitative data, statistical tests were carried out, based on the variables and dimensions that have been determined, including ANOVA sample F and T-tests, and regressions (Creswell & Plano Clark, 2011).

The final part of the findings covers the qualitative data in which I present the outcomes of interviews with the 15 older patients and 5 leaders of HHC services in Al Baha region. ‘Content analysis was used in this study in which individual summaries place emphasis on the context and particular features of the main aspects of the program under investigation. Field notes and general observation in this study has identified similarities between numerous statements, and determined orientations, trends. Data can be categorised regarding recurring themes which seem appropriate to the evaluation questions to validate the hypotheses if any (Gilbert, 2010). I aimed to avoid the risk of hasty conclusions by using a content analysis, in which individual summaries highlight the context and the specific characteristics of the essential elements of the satisfaction of older patients with HHC programme.

6.2 Pilot Study

6.2.1 Introduction

The objective of the pilot study was to test the tools which would be used in the main study and to observe each stage of the process. To gain a preliminary understanding of the study, the small data were extracted for the pilot study are analysed for testing. This knowledge also allows the researcher to develop a subsequent study with which to collect information in more detail (Walliman, 2006). So the use of the pilot study is in line with the earlier statement that the objective of this study was to discover information about the level of satisfaction of HHC services being provided in Al Baha region, Saudi Arabia. The questionnaire helped to collect the responses of the patient's participants regarding the actual and frequently changing needs, and created the idea of self-evaluation in the participants (Davis & Sutton, 2004). Also the small findings are presented to ensure the readiness of this questionnaire.

6.2.2 Definition of Pilot Study

A pilot study is a bit like the actual study, but I described it as only to test the tools. With the knowledge that the validity and reliability of this questionnaire have been achieved in advance by Westra and has also been tested in an internal study of one of the specialists in the Saudi Ministry of Health (Hamadi 0.2010). It can also incorporate particular pre-testing of the research methods such as questionnaires or interview schedules (De Vos, 2002). A Likert Questions-style questionnaire is employed in this research to evaluate the extent of satisfaction felt by the aged in Saudi Arabia on the availability and quality of care of HHC services by taking into account their experiences. Likert questions invite the patients/ participants in the study to agree with specific statements, such as in the current questionnaire (Satisfied, Very Satisfied ..., etc.) (Outsource Marketing, 2014).

6.2.3 The value of a pilot study

As stated, it is apparent that in the on-going research it was important to carry out a pilot study to test the tools and to ensure that the full-length research did not end up wasting time, effort and money. It has been stated by Welman and Kruger (1999) that many beginning researchers are disappointed when they learn that the research processes are only valid under ideal conditions and not in the practical research setting where their

study is carried out. This is one of the major reasons why a pilot study is required. Also, a pilot study is performed for the reasons given below (Welman and Kruger, 1999). It is essential to discover the shortcomings that can be inherent in the measurement processes, including the application technique, effort, time, interaction with study sample, etc., when dealing with the different research variables. These advantages of a pilot study are relevant for the present study, which makes use of two distinct measurement techniques: exploratory measurement, and collection of information through the use of interviews and a questionnaire. Welman and Kruger (1999) also observed that the non-verbal behaviour of respondents in the pilot study might provide vital information regarding any awkwardness or uncomfortable situation that they faced with respect to the subject or wording of questionnaire items. Jonathan (2002) states that there are other benefits of carrying out a pilot study, including the following:

- It can provide warning of those areas that can be detrimental to the actual research project.
- It suggests the situations in which the research guidelines might not be adhered.
- It helps the researcher to recognise the practical issues about the research process.
- It ascertains whether the suggested techniques or tools are irrelevant or too complex.

6.2.4 Goal of Pilot Study

The objective of the pilot study is linked to the aims of the research project it is going to be a part of. However, in general, a pilot study aims to give information that can play a part in the success of the entire research process.

6.2.5 Selection of Group Members for Pilot Study

The criteria set for selection for the pilot study were identical to those for the actual study. The following paragraphs briefly discuss the criteria that are especially used for application to the present study. This chapter discusses the final selection criteria more extensively (Selection of the small samples).The key criteria followed when choosing the participants of the pilot study are given below:

o Gender o Marital status o Educational level

The small sample of the pilot study was selected from the main samples of this study. A total of 10 questionnaires were distributed for analysis to test the tools. The number of male participants in the pilot study was 7 (70%), and the number of females 3 (30%).

Table 11 shows the distribution of the pilot study sample regarding the variables, indicating that 70% of people who received HHC were married, and 30% widowed; there are no divorced or single cases. The differences in the small sample were between those who received primary education, and others. The table shows that high-school graduates are a lesser category of participants in the survey. Also, in this pilot study participants were patients suffering from diseases of the chest and heart.

Table 11: Distribution of Samples and Results of Pilot Study

Demo. Variable	**Frequency**	**Percentage (%)**
Total number of participants	10	100%
Gender		
	Frequency	**Percentage (%)**
Male	7	70%
Female	3	30%
Marital status		
	Frequency	**Percentage (%)**
Single	0	0%
Married	7	70%
Divorced	0	0%
Widower	3	30%
Educational level		
	Frequency	**Percentage (%)**
Uneducated	0	0%
Primary	6	60%
Secondary	2	20%
Other	2	20%
Total	10	100%

The pilot study has used for test the tools as mentioned; small modifications commensurate the goals and objectives of the current study were made to the original questionnaire following the pilot study. SPSS ver.19 has been used to analyse the small sample of quantitative data gathered. The test of the tools via the data analysis summarising the results in statistical form, providing the means and the ranges of the data collected, was the major objective of the pilot study. I found it suitable for the main study, especially with older patients in the Al-Baha region in Saudi Arabia. It allowed me to determine the statistical significance of the figures involved in the study. For instance, the data collected from the questionnaires can be evaluated statistically by calculating the mean, median, range and standard deviation (Eysenck, 2004). But not with a small sample here. This process is carried out by responding to the questions that have been put forward for the purpose of studying a particular phenomenon by using statistical programs or software like SPSS. The results of the analysis of the answers to the survey questions to identify the degree to which patients are satisfied with the HHC services. The study extracted arithmetic averages, standard deviations, percentages and grades from the questionnaire, and orders descending from the arithmetic mean. Of course the sample of the pilot study is very small, but it is imperative to meet the criteria of the processors of how to work with the pilot study (Cress well, 2006). See in the appendix the tables of arithmetic averages and standard deviations of the standard questionnaire.

6.2.6 The outcome of the pilot study

The pilot study produced results that gave good indications as follows:

1- The selected variables address all aspects of the study.

2- The procedures applied in the pilot study are suited to the analysis of the same goals in the main study.

6.3 Conclusion of pilot study

For the pilot study, the description, tow methods, usefulness and application of a model study were discussed. The instrument was found to be suited to this research, and it was concluded that such a study would be quite useful. A few tables, figures, and graphics are presented the small sample of the quantitative method in the Appendix.

6.4 Main Findings of the research study

In this section, it is noted that the results of this study have been obtained. Data analysis collected includes both descriptive and inferential statistical methods. Firstly data on categorical variables like demographics (gender, education, and marital status) are presented using frequency distributions and pie charts. Data on quantitative interval scale variables are summarized using measures of central tendency and dispersion including mean, standard deviation, minimum and maximum quantitative interval scale variables are summarized using measures of central tendency and dispersion including mean, standard deviation, minimum and maximum. Test for significance of the difference in ways across two groups like testing the satisfaction score across gender (with male and female categories) is done using independent samples t-test and this test assumes equality of variances across two groups. This was tested using Levene's test for equality of variances and If the equality of variance assumption is satisfied, then the similar variance version of independent samples t-test is used. Otherwise, unequal variances version of the independent samples t-test is used. Test for mean satisfaction score across three or more groups like across marital status or education levels is done using single factor analysis of variance (ANOVA) F test. Levene's test is employed to test the assumed homogeneity of variance across groups. Under any violation of homogeneity of variance assumption, Brown – Forsythe corrected robust test for equality of means is used. Post-hoc comparison of pairwise means is made using Tukey's procedure to adjust for the inflation of type I error probability. Under unequal variances, Games – Howell corrections for post hoc comparisons are used. All the statistical tests are performed at 0.05 level of significance. The data analysis is carried out using IBM SPSS 19.0 version.

6.4.1 Sample Profile and Demographics of the participants

Information on the participants' demographic profile is presented in Table 12, 2.5% of the sample respondents were married. Only 4.4% were single, and 4.1% were divorced. Also, 28.5% of the sample was widowers. Figure 1 gives the pie chart of the distribution of marital status. The sample had 61.6% females and 38.4% males Sample reported 44.7% of respondents with no education, 24.1% with primary education, 21.9% with secondary education and the remaining 9.3% with other educational level.

Table 12: Demographic Profile of Respondents

Variable	Frequency (%)
Gender	
Male	157 (38.4)
Female	252 (61.6)
Education Level	
Uneducated	182 (44.7)
Primary	98 (24.1)
Secondary	89 (21.9)
Other	38 (9.3)
Marital Status	
Single	18 (4.4)
Married	258 (62.9)
Divorced	17 (4.1)
Widower	117 (28.5)

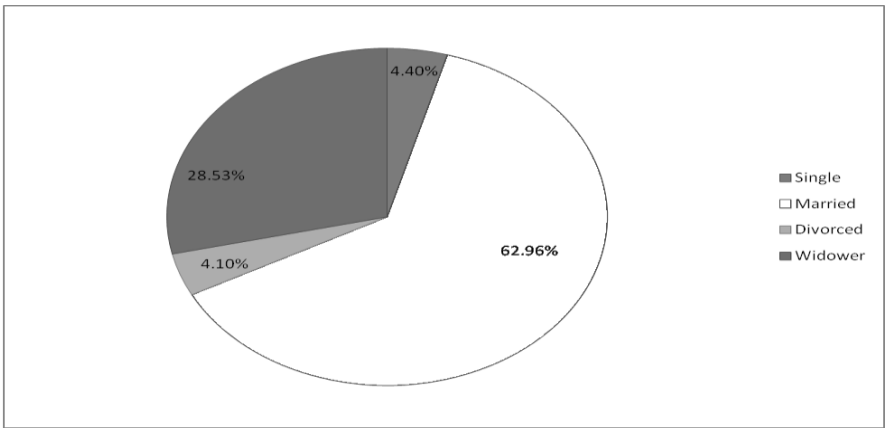


Figure 5: Pie Chart Distribution of Marital Status

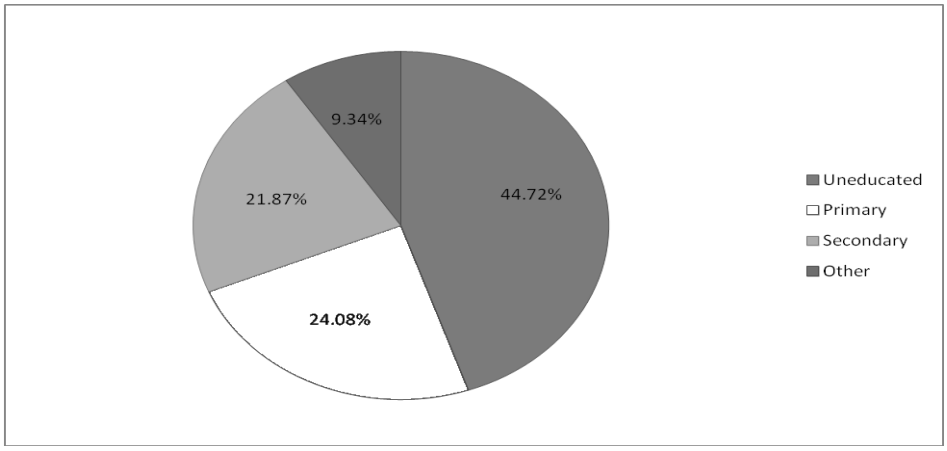


Figure 6: Pie Chart Distribution of Education Level

Response to Satisfaction Scale Items

Table 13 gives the frequency distribution of responses and also descriptive statistics for each question asked under satisfaction on different elements of services. Mean and Standard deviation are reported to summarize the response to each question. On a scale of 1 to 5, the average satisfaction score ranged from 1 to 3.954. Statement 1 reported the highest mean response score of 3.954 with statements 13, 14 and 15 reporting the least mean score of 1.00.

Table 13: Frequency Distribution of Response to each Satisfaction Questionnaire Item

Statement	VD	DS	U	SA	VSA	Total	Mean	SD
How satisfied are you with the cooperation of the HHC providers?	67 (16.3)	12 (2.9)	33 (8.0	59 (14.4)	239 (58.3)	410 (100.0)	3.954	1.502
How satisfied are you with the HHC team attention to your concerns?	46 (11.2)	66 (16.1)	24 (5.9)	135 (32.9)	139 (33.9)	410 (100.0)	3.622	1.383
How satisfied are	77	14	56	82	181	410	3.673	1.518

you with the dependability and loyalty of the HHC providers?	(18.8)	(3.4)	(13.7)	(20.0)	(44.1)	(100.0)		
How satisfied are you with the respect shown to you by the HHC providers?	65 (15.9)	52 (12.7)	26 (6.3)	105 (25.6)	162 (39.5	410 (100.0)	3.602	1.497
How satisfied are you with the HHC providers acquaintance of your health problems?	51 (12.4)	20 (4.9)	41 (10.0)	133 (32.4)	165 (40.2)	410 (100.0)	3.832	1.339
How satisfied are you with having choices and options about your home care?	51 (12.4)	20 (4.9)	37 (9.0)	159 (38.8)	143 (34.9)	410 (100.0)	3.788	1.309
How satisfied are you with how safe you felt when HHC was provided?	60 (14.6)	21 (5.1)	28 (6.8)	141 (34.4)	160 (39.0)	410 (100.0)	3.781	1.392
How satisfied are you with knowing who to contact if you had a problem?	48 (11.7)	49 (12.0)	35 (8.5)	113 (27.6)	165 (40.2)	410 (100.0)	3.727	1.396
How satisfied are you with the ability of the HHC providers to meet your needs?	73 (17.8)	25 (6.1)	19 (4.6)	125 (30.5)	168 (40.1)	410 (100.0)	3.707	1.491

How satisfied are you with the home health care team response and reaction to your concerns?	47 (11.5)	47 (11.5)	27 (6.6)	131 (32.0)	158 (38.5)	410 (100.0)	3.746	1.372
How satisfied are you with your ability to schedule home visits at the right time for you?	49 (12.0)	60 (14.6)	16 (3.9)	146 (35.6)	139 (33.9)	410 (100.0)	3.649	1.386
How satisfied are you with having the same people consistently?	92 (22.4)	16 (3.9)	11 (2.7)	123 (30.0)	168 (41.0)	410 (100.0)	3.632	1.576
Do you consider that the level of HHC provided by the best you have, and fit with your expectations?	410 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	410 (100.0)	1.000	0.000
What is the possibility to recommend to others and relatives to take advantage of HHC services?	410 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	410 (100.0)	1.000	0.000
How satisfied are focusing primarily on the patient to provide HHC	410 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	410 (100.0)	1.000	0.000

services?	

VD=Very Dissatisfied, DS = Dissatisfied, N = Neutral, SA=Satisfied, VSA=Very Satisfied, SD = Standard deviation.

Note: Value in parenthesis represents percentage to the total

Testing the Effect of Gender on Average Satisfaction Score

This section tests the effect of gender on average satisfaction score. Essentially, the significance of the difference in mean satisfaction score for male and female respondents is tested using independent samples t-test. Table 14 represents the descriptive statistics for mean satisfaction score for males and females representing the average satisfaction across all the items asked under satisfaction scale. This is essentially done to compare whether there is a significant difference in average satisfaction score between male and female respondents. Male respondents report a means satisfaction score of M = 3.729 (SD = 0.348). Females report mean satisfaction score of M = 2.8402 (SD = 1.19). Figure 4 gives the box plot of the distribution of average satisfaction score for males and females. Box plot reports more consistent and less variable response from males with a higher mean score compared to females. Results of the Levene's test for equality of variances reports p-value <.001 and indicates that the null hypothesis of no significant difference in variances must be rejected at .05 level of significance (F = 506.587, p = <.0001). This result means that the assumption of equal variances across male and female respondents is not satisfied, and therefore, unequal variances version of independent samples t test must be used to test the difference in means for males and females. Results of the independent samples t-test indicate that the null hypothesis of no significant difference in mean satisfaction score between males and females must be rejected at .05 level of significance (t (315.16) = 11.097, p = <.001). This means that there is a significant difference in mean satisfaction score between males and females. 95% confidence interval for the difference in mean satisfaction score between males and females is (0.696, 1.080). These results precisely indicate that male respondents are statistically significantly more satisfied on an average compared to females.

Table 14: Descriptive Statistics of Satisfaction Score for Males and Females

Gender	N	Mean	Std. Deviation	p-value
Male	157	3.7287	.348	0.05
Female	252	2.8402	1.19	0.05

Figure 7: Box Plot of Satisfaction Score for Males and Females

Testing the Effect of Marital Status on Average Satisfaction Level

Table 15 reports descriptive statistics for average satisfaction score according to the respondents' marital status for different marital status categories. Single factor ANOVA is used to test the significance of the effect of marital status on average satisfaction level. Respondents who were single reported mean satisfaction score of M = 3.885 (SD = 0.288). Those who were married reported mean score of M = 2.085 (SD = 0.999). People who were divorced reported mean score of M = 1.490 (SD = 1.101). Those who are

widowers reported a mean score of M = 3.529 (SD = 0.928). ANOVA F test assumes homogeneity or equality of variances across groups. Results of the Levene's test for homogeneity of variances indicate that variances are not equal across groups (F (3, 406) = 10.516, p = <.001).

Therefore, Welch's corrected version of ANOVA F test is used. Results of this F-test indicates that the null hypothesis of no significant effect of marital status on satisfaction must be rejected at .05 level of significance (F (3, 54.689) = 42.219, p = <.001). This means that mean satisfaction score is not same across different marital status categories. Marital status has a statistically significant effect on satisfaction. To assess the significance of the difference in pairs of groups so that the direction of the effect can be assessed, post hoc comparisons are performed. Table 16 gives the post –hoc comparisons across different pairs of groups using Tukey's procedure of adjusting for inflation of probability of committing type I error. Games – Howell correction for unequal variances is also reported. Figure 8 gives the means plot of mean satisfaction score for different marital status categories. Since the homogeneity of variance assumption is violated, Games – Howell version of post –hoc comparisons is used to interpret the significance of the pairwise comparisons.

Results of the post hoc comparisons indicate that divorced people are least satisfied with the HHC reporting with the least satisfaction score of M = 1.490, significantly less than all other categories. Individuals who are single, report the highest level of satisfaction (M = 3.885) considerably higher than all other categories. Widower's report the second highest level of satisfaction (M = 3.529) significantly higher than married and divorced but significantly lesser than single. This is followed by married people reporting the significantly higher level of satisfaction than divorced people but considerably less than widowers and single people. These results indicate that regarding descending order of level of satisfaction across marital status categories, single people report the highest followed by a widower, married and then the least satisfaction reported by divorced people.

Table 15: Mean Satisfaction Score according to for Marital Status

Marital status	N	Mean	Std. Deviation	95% CI for Mean		Minimum	Maximum
				Lower Bound	Upper Bound		
Single	18	3.885	.288	3.741	4.028	3.40	4.20
Married	258	3.085	.999	2.962	3.207	1.00	4.20
Divorced	17	1.490	1.101	.924	2.056	1.00	4.20
Widower	117	3.529	.928	3.359	3.699	1.00	4.20
Total	410	3.180	1.051	3.078	3.282	1.00	4.20

Table 16: Post hoc Comparisons test for Satisfaction across Marital Status Categories

Test	(I) Marital Status	(J) Marital Status	Difference (I-J)	P	95% CI	
Tukey	Single	Married	.800*	.004	.193	1.406
		Divorced	2.394*	.000	1.55	3.236
		Widower	.355	.464	-.274	.985
	Married	Single	-.800*	.004	-1.406	-.193
		Divorced	1.59*	.000	.971	2.21
		Widower	-.444*	.000	-.721	-.167
	Divorced	Single	-2.394*	.000	-3.235	-1.553
		Married	-1.594*	.000	-2.217	-.971
		Widower	-2.039*	.000	-2.685	-1.393
	Widower	Single	-.355	.464	-.985	.274
		Married	.444*	.000	.167	.721
		Divorced	2.039*	.000	1.393	2.685
Games-Howell	Single	Married	.800*	.000	.556	1.044
		Divorced	2.394*	.000	1.616	3.173
		Widower	.3558*	.009	.0689	.642
	Married	Single	-.800*	.000	-1.044	-.556
		Divorced	1.594*	.000	.819	2.370
		Widower	-.444*	.000	-.718	-.170

	Divorced	Single	-2.394*	.000	-3.173	-1.616
		Married	-1.594*	.000	-2.370	-.819
		Widower	-2.039*	.000	-2.826	-1.252
	Widower	Single	-.35584*	.009	-.642	-.068
		Married	.44433*	.000	.170	.718
		Divorced	2.03915*	.000	1.252	2.826

*significant at .05 level **significant at.01 level

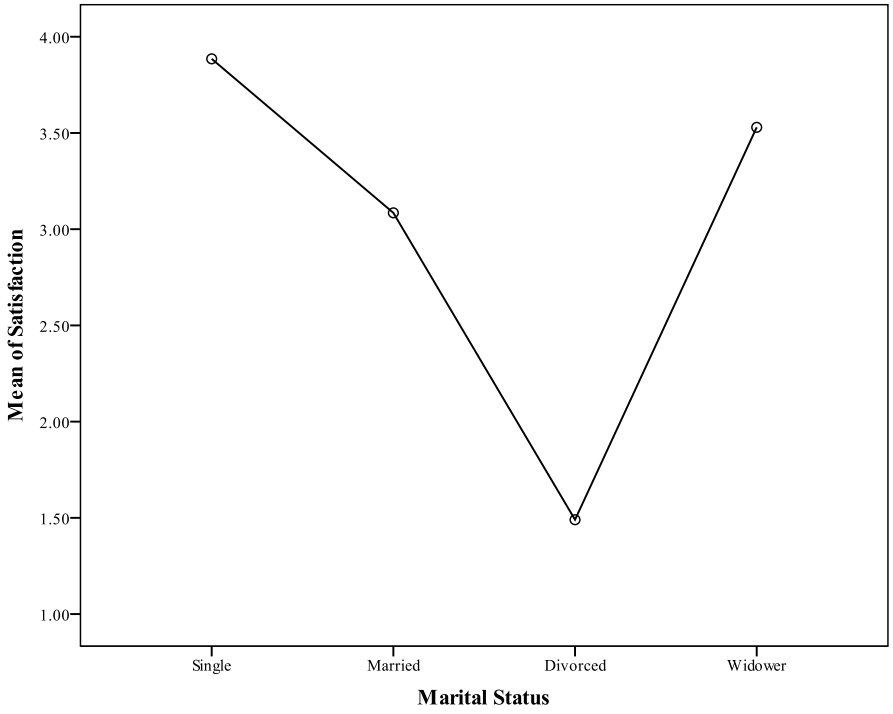


Figure 8: Means plot of Satisfaction Score for Marital Status

Testing the effect of Education Level on Average Satisfaction Level

Table 17 reports descriptive statistics for average satisfaction score for different education level categories. Single factor ANOVA is used to test the significance of the effect of educational attainment on average satisfaction level. Respondents who were uneducated reported mean satisfaction score of M = 3.31 (SD = 1.057). Those who had

primary level education, average score of M = 3.493 (SD = 1.179). People who had other education levels reported mean score of M = 2.831 (SD = 1.081). ANOVA F test assumes homogeneity or equality of variances across groups. Results of the Levene's test for homogeneity of variances indicate that variances are not equal across groups (F (3, 403) = 19.39, p = <.001). Therefore, Welch's corrected version of ANOVA F test is used. Results of this F-test indicates that the null hypothesis of no significant effect of marital status on satisfaction must be rejected at .05 level of significance (F (3, 204.73) = 12.281, p = <.001).

This demonstrates/signifies that mean satisfaction scores are not same across different education level categories. Education level has a significant effect on satisfaction.

Results of the post hoc comparisons indicate that people who are uneducated or had primary level education report no significant difference in satisfaction level among themselves while they both report significantly higher satisfaction level compared to both secondary level and other education level categories. Secondary level and other level of education do not report significant difference among them. These results report a summary that uneducated and primary level education report significantly higher level of satisfaction compared to secondary level and other education levels. Table 18 gives the post –hoc comparisons across different pairs of groups using Tukey's procedure of adjusting for inflation of probability of committing type I error. Games – Howell correction for unequal variances is also reported. Figure 6 gives the means plot of mean satisfaction score for different education level categories. Since the homogeneity of variance assumption is violated, Games – Howell version of post –hoc comparisons is used to interpret the significance of the pairwise comparisons.

Table 17: Descriptive Statistics of satisfaction Score for Education Level

Education level	N	Mean	Std. Deviation	Std. Error	95% CI for Mean		Min	Max
					Lower Bound	Upper Bound		
Uneducated	182	3.310	1.057	.078	3.156	3.465	1.00	4.20
Primary	98	3.493	.6700	.067	3.359	3.628	1.93	4.20

Secondary	89	2.696	1.179	.125	2.448	2.945	1.00	4.20
Other	38	2.831	1.081	.175	2.476	3.187	1.00	4.20
Total	407	3.175	1.052	.052	3.073	3.278	1.00	4.20

Table 18: Post hoc Comparisons test for Satisfaction across Education Level Categories

	(I) Education	(J) Education	Difference (I-J)	P	95% CI	
Tukey HSD	Uneducated	Primary	-.183	.471	-.509	.143
		Secondary	.613*	.000	.276	.951
		Other	.479*	.041	.014	.944
	Primary	Uneducated	.183	.471	-.143	.509
		Secondary	.797*	.000	.415	1.179
		Other	.662*	.004	.164	1.160
	Secondary	Uneducated	-.613*	.000	-.951	-.276
		Primary	-.797*	.000	-1.179	-.415
		Other	-.134	.901	-.640	.370
	Other	Uneducated	-.479*	.041	-.944	-.014
		Primary	-.662*	.004	-1.160	-.164
		Secondary	.134	.901	-.370	.640
Games-Howell	Uneducated	Primary	-.183	.290	-.450	.084
		Secondary	.613*	.000	.230	.997
		Other	.479	.073	-.030	.988
	Primary	Uneducated	.183	.290	-.084	.450
		Secondary	.797*	.000	.427	1.167
		Other	.662*	.005	.161	1.162
	Secondary	Uneducated	-.613*	.000	-.997	-.230
		Primary	-.797*	.000	-1.167	-.427
		Other	-.134	.923	-.701	.431
	Other	Uneducated	-.479	.073	-.9888	.030
		Primary	-.662*	.005	-1.1627	-.161
		Secondary	.13495	.923	-.4311	.701

*significant at .05 level **significant at.01 level

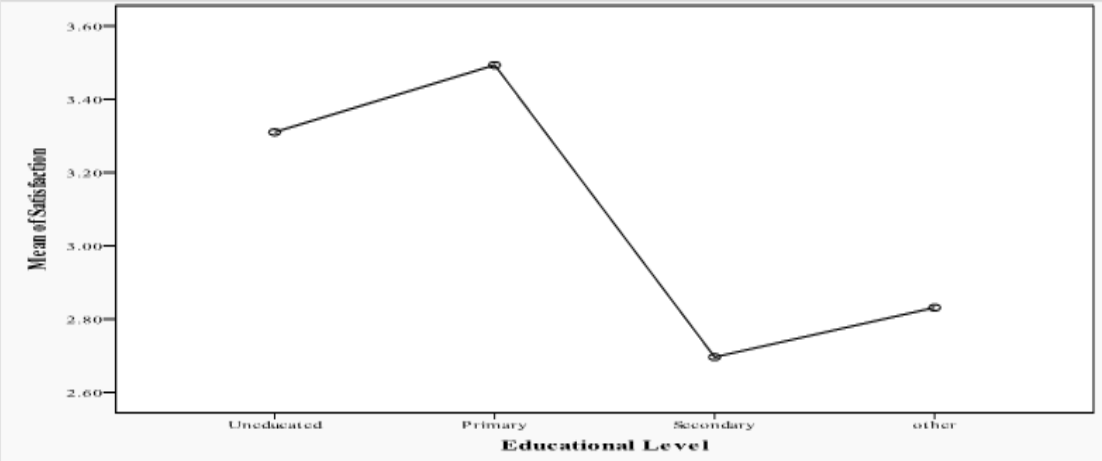


Figure 9: Means Plot of Satisfaction Score for Education level

Testing the Effect of Gender on Overall Satisfaction with Meeting Needs

Table 19 reports descriptive statistics for overall satisfaction with ability of HHC team to meet their needs and overall satisfaction with services in general for males and females. Independent samples t-test is used to test whether there is any significant difference in overall satisfaction between males and females regarding overall satisfaction. On overall satisfaction in meeting their needs, males reported a mean satisfaction score of M = 2.579 (SD = 1.468) while females reported mean satisfaction score of M = 2.051 (SD = 1.363). Levene's test indicated that variances of the overall satisfaction are not same across male and female groups. Therefore, unequal variances version of independent samples t tests us used. Results of this independent samples t-test indicate that the null hypothesis of no significant difference must be rejected at .05 level of significance (t (312.52) = 3.65, p = <.001). This means that there is a significant difference in overall satisfaction in meeting their needs between males and females. 95% confidence interval for the difference in overall satisfaction in meeting their needs is (0.247, 0.808). This precisely means that males report a higher level of overall satisfaction in meeting their need for the HHC team compared to females. Males are significantly more satisfied than females.

With respect to overall satisfaction with services, males reported a mean satisfaction score of M = 4.369 (SD = 0.736) while females reported mean satisfaction score of M = 4.440 (SD = 0.940). Levene's test indicated that variances of the overall satisfaction are not same across male and female groups. Therefore, unequal variances version of independent samples t tests us used. Results of this independent samples t-test indicate that the null hypothesis of no significant difference cannot be rejected at .05 level of significance (t (386.31) = 0.851, p = .395). This means that there is no significant difference in overall satisfaction in meeting their needs between males and females. This precisely means that gender of the person does not affect the overall satisfaction level on all the services in general.

Table 19: Descriptive Statistics of Overall Satisfaction for Males and Females

	Gender	N	Mean	Std. Deviation
Satisfaction with meeting needs	Male	157	2.579	1.468
	Female	252	2.051	1.363
Satisfaction with health care services in general	Male	157	4.369	.7363
	Female	252	4.440	.940

Testing the Effect of Marital Status on Overall Satisfaction with Meeting Needs

Table 20 reports descriptive statistics for overall satisfaction for meeting their needs for different marital status categories. Single factor ANOVA is used to test the significance of the effect of marital status on average satisfaction level. Respondents who were single reported mean overall satisfaction score of M = 2.111 (SD = 1.45). Those who were married reported average score of M = 2.457 (SD = 1.441). People who were divorced reported mean score of M = 1.176 (SD = 0.727). Those who are widowers reported a mean score of M = 2.000 (SD = 1.364). ANOVA F test assumes homogeneity or equality of variances across groups. Results of the Levene's test for homogeneity of variances indicate that variances are not equal across groups (F (3, 406) = 48.434, p = <.001). Therefore Brown - Forsythe's corrected version of ANOVA F test is used. Results of this F-test indicates that the null hypothesis of no significant effect of marital status on

satisfaction must be rejected at .05 level of significance (F (3, 78.54) = 8.29, p = <.001). This means that mean overall satisfaction score is not same across different marital status categories. Marital status has a significant effect on overall satisfaction on ability of the HHC team to meet their needs. Table 10 gives the post –hoc comparisons across different pairs of groups using Tukey's procedure of adjusting for inflation of probability of committing type I error. Games – Howell correction for unequal variances is also reported. Figure 10 gives the means plot of overall mean satisfaction score for different marital status categories. Since the homogeneity of variance assumption is violated, Games – Howell version of post –hoc comparisons is used to interpret the significance of the pairwise comparisons. Results of the post hoc comparisons indicate that single, married and divorced people do not report significant difference among them and are significantly more satisfied than people who are divorced. The overall difference in overall satisfaction in meeting the needs is attributed to significantly less satisfaction level among divorcees compared to other marital status categories.

Table 20: Descriptive Statistics for Overall Satisfaction with Meeting Needs Marital Status Categories

				95% CI for Mean			
				Lower	Upper		
	N	**Mean**	**Std. Deviation**	Bound	Bound	**Minimum**	**Maximum**
Single	18	2.111	1.450	1.389	2.832	1.00	4.00
Married	258	2.457	1.441	2.280	2.634	1.00	4.00
Divorced	17	1.176	.727	.802	1.550	1.00	4.00
Widower	117	2.000	1.364	1.750	2.249	1.00	4.00
Total	410	2.258	1.426	2.120	2.397	1.00	4.00

Table 21: Post hoc Comparisons test for Overall Satisfaction with Meeting Needs across Marital Status

	(I) Marital Status	(J) Marital Status	Difference (I-J)	P	95% CI Lower Bound	Upper Bound
Tukey HSD	Single	Married	-.346	.740	-1.22	.533
		Divorced	.934	.199	-.285	2.154
		Widower	.111	.989	-.802	1.024
	Married	Single	.346	.740	-.533	1.225
		Divorced	1.280*	.002	.377	2.184
		Widower	.457*	.019	.055	.859
	Divorced	Single	-.934	.199	-2.154	.285
		Married	-1.280*	.002	-2.184	-.377
		Widower	-.823	.107	-1.760	.113
	Widower	Single	-.111	.989	-1.024	.802
		Married	-.457*	.019	-.859	-.055
		Divorced	.823	.107	-.113	1.760
Games-Howell	Single	Married	-.346	.763	-1.338	.645
		Divorced	.934	.097	-.122	1.992
		Widower	.111	.990	-.901	1.123
	Married	Single	.346	.763	-.645	1.338
		Divorced	1.28*	.000	.736	1.825
		Widower	.457*	.018	.056	.858
	Divorced	Single	-.934	.097	-1.99	.122
		Married	-1.280*	.000	-1.825	-.736
		Widower	-.823*	.003	-1.408	-.238
	Widower	Single	-.111	.990	-1.123	.901
		Married	-.457*	.018	-.858	-.056
		Divorced	.823*	.003	.238	1.408

**significant at .05 level **significant at.01 level*

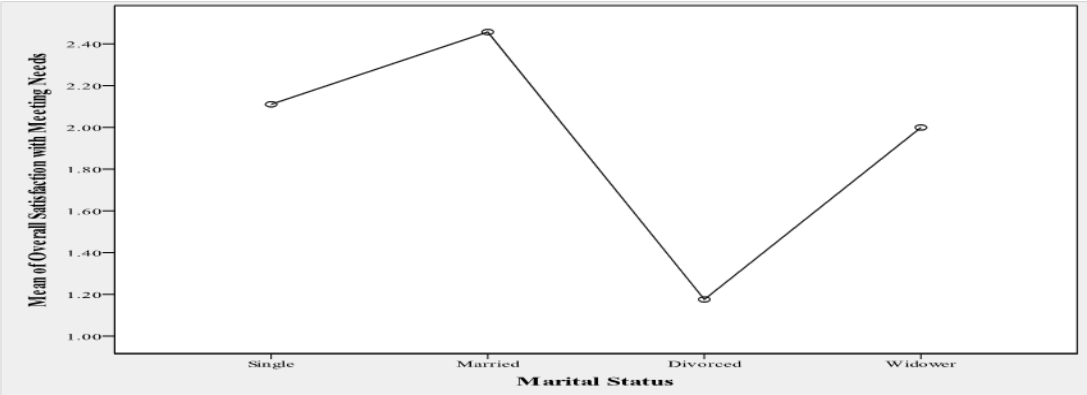


Figure 10: Means Plot of Overall Satisfaction with meeting needs Score for Marital Status

Testing the Effect of Marital Status on Overall Service Satisfaction

Table 22 reports descriptive statistics for overall satisfaction for services in general, for different marital status categories. Single factor ANOVA is used to test the significance of the effect of marital status on average satisfaction level.

Respondents who were single reported mean overall service satisfaction score of M = 4.555 (SD = 0.983). Those who were married reported average score of M = 4.345 (SD = 0.954). People who were divorced reported mean score of M = 5.000 (SD = 0.000). Those who are widowers reported a mean score of M = 4.461 (SD = 0.65). Results of this F-test indicates that the null hypothesis of no significant effect of marital status on satisfaction must be rejected at .05 level of significance (F (3, 406) = 3.472, p = .016). This means that mean overall service satisfaction score is not same across different marital status categories. Marital status has a significant effect on overall service satisfaction. Table 23 gives the post –hoc comparisons across different pairs of groups using Tukey's procedure of adjusting for inflation of probability of committing type I error. Games – Howell correction for unequal variances is also reported. Figure 11 gives the means plot of overall mean satisfaction score for different marital status categories. Results of the post hoc comparisons indicate that single, married and divorced people do not report significant difference among them and are significantly more satisfied than people who are divorced. The overall difference in overall satisfaction in meeting the needs is attributed to considerably less satisfaction level among divorcees compared to another marital status.

Table 22: Descriptive Statistics for Overall Satisfaction across Marital Status Categories

	N	Mean	Std. Deviation	95% CI Lower bound	Upper bound	Min	Max
Single	18	4.555	.983	4.066	5.044	1.00	5.00
Married	258	4.345	.954	4.227	4.462	1.00	5.00
Divorced	17	5.000	.000	5.000	5.000	5.00	5.00
Widower	117	4.461	.650	4.342	4.580	3.00	5.00
Total	410	4.414	.867	4.330	4.498	1.00	5.00

Table 23: Post hoc Comparisons test for Overall Satisfaction across Marital Status

	(I) Marital Status	(J) Marital Status	Difference (I-J)	P	95% CI Lower Bound	Upper Bound
Tukey HSD	Single	Married	.210	.746	-.329	.751
		Divorced	-.444	.421	-1.194	.305
		Widower	.094	.973	-.467	.655
	Married	Single	-.210	.746	-.751	.329
		Divorced	-.655*	.013	-1.210	-.099
		Widower	-.116	.616	-.363	.130
	Divorced	Single	.444	.421	-.305	1.194
		Married	.655*	.013	.099	1.210
		Widower	.538	.076	-.036	1.113
	Widower	Single	-.094	.973	-.655	.467
		Married	.116	.616	-.130	.363
		Divorced	-.538	.076	-1.113	.036
Games-Howell	Single	Married	.210	.815	-.461	.882
		Divorced	-.444	.258	-1.103	.214
		Widower	.094	.979	-.578	.766
	Married	Single	-.210	.815	-.882	.461

		Divorced	-.655*	.000	-.808	-.501
		Widower	-.116	.514	-.335	.101
	Divorced	Single	.444	.258	-.214	1.103
		Married	.655*	.000	.501	.808
		Widower	.538*	.000	.381	.695
	Widower	Single	-.094	.979	-.766	.578
		Married	.116	.514	-.101	.335
		Divorced	-.538*	.000	-.695	-.381

*significant at .05 level **significant at.01 level

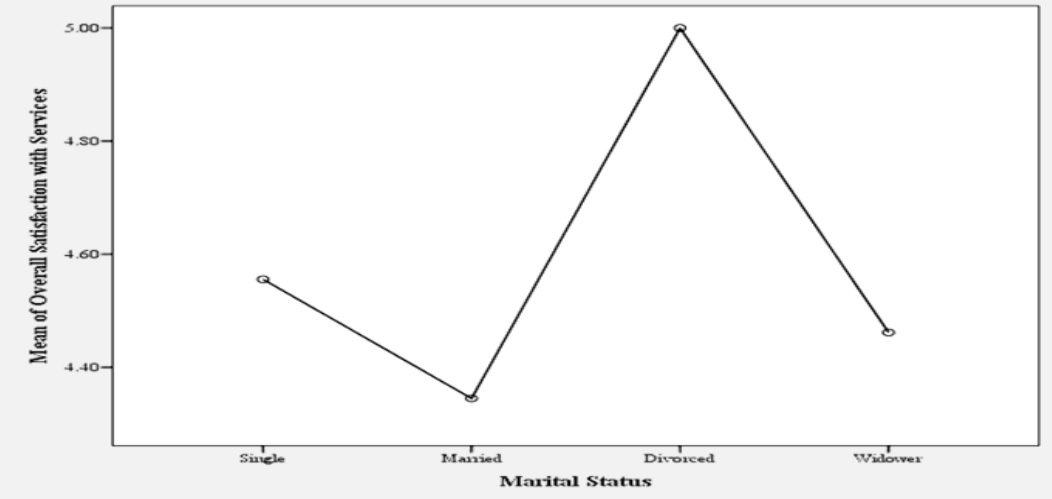


Figure 11: Means Plot of Overall Satisfaction with Services for Marital Status

Testing the effect of Education Level on Overall Satisfaction with Meeting Needs

Table 24 reports descriptive statistics for overall satisfaction in meeting their needs for different education level categories. Single factor ANOVA is used to test the significance of the effect of education level on average satisfaction level. Respondents who were uneducated reported mean satisfaction score of M = 2.137 (SD = 1.425).

Those who had primary level education, report a mean score of M = 2.714 (SD = 1.347).

Those who had secondary level education, report mean score of M = 1.853 (SD = 1.344).

People who had other education levels reported mean score of M = 2.684 (SD = 1.49). ANOVA F test assumes homogeneity or equality of variances across groups. Results of the Levene's test for homogeneity of variances indicate that variances are not equal across groups (F (3, 403) = 4.962, p = <.001). Therefore Brown - Forsythe's corrected version of ANOVA F test is used. Results of this F-test indicates that the null hypothesis of no significant effect of marital status on satisfaction must be rejected at .05 level of significance (F (3, 221.127) = 7.502, p = <.001). This means that mean satisfaction score is not same across different education level categories. Education level has a significant effect on overall satisfaction with meeting their needs. Table 25 gives the post –hoc comparisons across different pairs of groups using Tukey's procedure of adjusting for inflation of probability of committing type I error. Games – Howell correction for unequal variances is also reported. Figure 12 gives the means plot of mean satisfaction score for different education level categories.

Since the homogeneity of variance assumption is violated, Games – Howell version of post –hoc comparisons is used to interpret the significance of the pairwise comparisons. Results of the post hoc comparisons indicate that people who are uneducated or educated at secondary level report significantly lesser mean score compared to primary and other education levels.

Table 24: Descriptive Statistics for Overall Satisfaction with meeting needs Services for Education level

			Std.	95% CI	
	N	**Mean**	**Deviation**	**Lower Bound**	**Upper Bound**
Uneducated	182	2.137	1.425	1.928	2.345
Primary	98	2.714	1.347	2.444	2.984
Secondary	89	1.853	1.344	1.570	2.137
Other	38	2.684	1.490	2.194	3.174
Total	407	2.265	1.429	2.126	2.404

Table 25:

Post hoc Comparisons test for Overall Satisfaction with meeting needs across Education Levels

	(I) Education	(J) Education	Difference (I - J)	P	95% CI	
Tukey	Uneducated	Primary	-.576*	.006	-1.028	-.125
		Secondary	.283	.397	-.182	.749
		Other	-.546	.126	-1.189	.095
	Primary	Uneducated	.576*	.006	.125	1.028
		Secondary	.860*	.000	.333	1.387
		Other	.030	.999	-.657	.718
	Secondary	Uneducated	-.283	.397	-.749	.182
		Primary	-.860*	.000	-1.387	-.333
		Other	-.830*	.012	-1.527	-.132
	Other	Uneducated	.546	.126	-.095	1.189
		Primary	-.030	.999	-.718	.657
		Secondary	.830*	.012	.132	1.527
Games-Howell	Uneducated	Primary	-.576*	.005	-1.023	-.130
		Secondary	.283	.382	-.176	.743
		Other	-.546	.176	-1.24	.153
	Primary	Uneducated	.576*	.005	.130	1.023
		Secondary	.860*	.000	.349	1.371
		Other	.030	1.000	-.702	.762
	Secondary	Uneducated	-.283	.382	-.743	.176
		Primary	-.860*	.000	-1.371	-.349
		Other	-.830*	.022	-1.570	-.089
	Other	Uneducated	.546	.176	-.153	1.247
		Primary	-.030	1.000	-.762	.702
		Secondary	.830*	.022	.089	1.570

*significant at .05 level **significant at.01 level

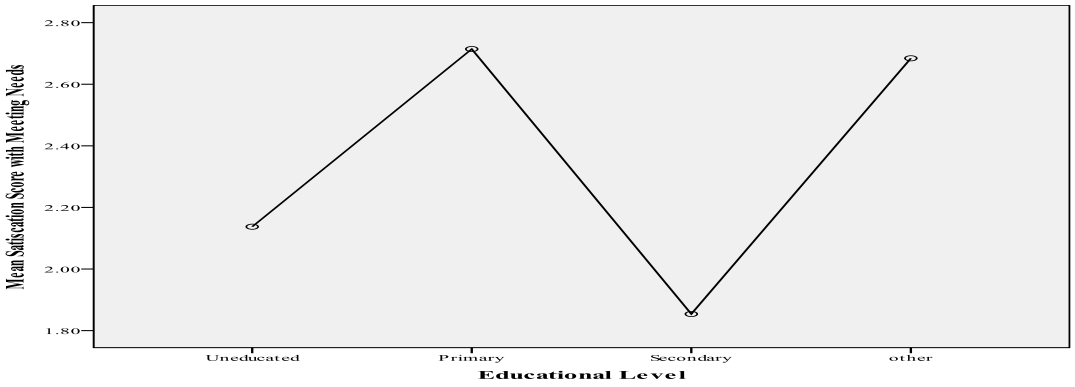


Figure 12: Means plot of Overall Satisfaction with meeting needs for Education Level

Testing the effect of Education Level on Overall Service Satisfaction

Table 26 illustrates descriptive statistics for overall service satisfaction towards different categories of education levels. Single factor ANOVA is used to test the significance of the effect of education level on average satisfaction level. Respondents who were uneducated, reported mean satisfaction score of M = 4.467 (SD = 0.812). Those who had primary level education, report a mean score of M = 4.000 (SD = 1.005). Those who had secondary level education, report mean score of M = 4.662 (SD = 0.638). People who had other education levels reported mean score of M = 4.657 (SD = 0.847). ANOVA F test assumes homogeneity or equality of variances across groups. Results of the Levene's test for homogeneity of variances indicate that variances are not equal across groups (F (3, 403) = 2.39, p = <.05). Therefore Brown - Forsythe's corrected version of ANOVA F test is used. Results of this F-test indicates that the null hypothesis of no significant effect of marital status on satisfaction must be rejected at .05 level of significance (F (3, 227.54) = 11.94, p = <.001). This means that mean overall service satisfaction score is not same across different education level categories. Education level has a significant effect on overall service satisfaction. Table 27 gives the post –hoc comparisons across different pairs of groups using Tukey's procedure of adjusting for inflation of probability of committing type I error. Games – Howell correction for unequal variances is also reported. Figure 13 gives the means plot of mean satisfaction score for different education level categories. Since the homogeneity of variance assumption is violated,

Games – Howell version of post –hoc comparisons is used to interpret the significance of the pairwise comparisons. Results of the post hoc comparisons indicate that people who educated at primary level report significantly lower mean score compared to all other education level categories.

Table 26: Descriptive Statistics for Overall Satisfaction with Services for Education level

				95% CI	
	N	Mean	Std. Deviation	Lower Bound	Upper Bound
Uneducated	182	4.467	.8118	4.348	4.585
Primary	98	4.000	1.0051	3.798	4.201
Secondary	89	4.662	.6386	4.528	4.797
Other	38	4.657	.8471	4.379	4.936
Total	407	4.415	.8664	4.330	4.499

Table 27: Post hoc Comparisons test for Overall Satisfaction with Services across Education Levels

	(I) Education	(J) Education	Difference (I - J)	P	95% CI	
Tukey HSD	Uneducated	Primary	.467*	.000	.197	.736
		Secondary	-.195	.266	-.473	.082
		Other	-.190	.573	-.574	.192
	Primary	Uneducated	-.467*	.000	-.736	-.197
		Secondary	-.662*	.000	-.977	-.348
		Other	-.657*	.000	-1.062	-.247
	Secondary	Uneducated	.195	.266	-.082	.473
		Primary	.662*	.000	.348	.977
		Other	.005	1.000	-.411	.421
	Other	Uneducated	.190	.573	-.192	.574
		Primary	.657*	.000	.247	1.068
		Secondary	-.003	1.000	-.421	.411
Games-Howell	Uneducated	Primary	.467*	.001	.160	.773
		Secondary	-.195	.137	-.430	.038
		Other	-.190	.584	-.589	.207
	Primary	Uneducated	-.467*	.001	-.773	-.160
		Secondary	-.662*	.000	-.979	-.346

	Other	-.657*	.001	-1.106	-.209
Secondary	Uneducated	.195	.137	-.038	.430
	Primary	.662*	.000	.346	.979
	Other	.005	1.000	-.400	.410
Other	Uneducated	.190	.584	-.207	.589
	Primary	.657*	.001	.209	1.106
	Secondary	-.005	1.000	-.410	.400

*significant at .05 level **significant at.01 level

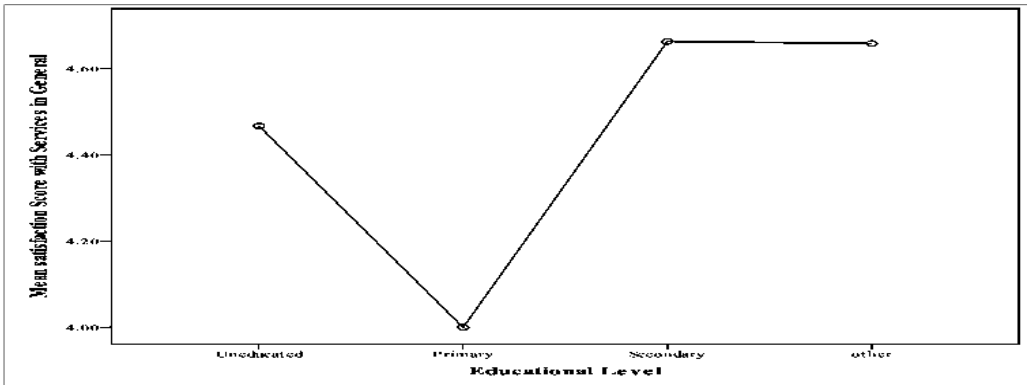


Figure 13: Means plot of overall Satisfaction with Services for Education level

Testing the Effect of Gender on Willingness to Recommend

Table 27 refers to cross table of gender and willingness of the respondent to recommend the team to others. All the males strongly recommend the team to other while 99.2% of females recommend the team to others. There is small difference in the proportion of males and females recommending the team to their people. Chi-square test for independence of attributes is used to test the significance of the association between gender and willingness to recommend. Results of the Chi-square test indicates that the null hypothesis of no significant association cannot be rejected at .05 level of significance (χ^2 (1) = 1.252, p = .263). This means that gender and willingness to recommend the team are not associated.

Table 28: Cross Table of Gender and Recommendation of Home Care

	Recommendation		
	Do not recommend	**Recommend strongly**	**Total**
Male	0	157	157
	.0%	100.0%	100.0%
Female	2	250	252
	.8%	99.2%	100.0%
Total	2	407	409
	.5%	99.5%	100.0%

Note: Percentages refer to percentage of the cell frequency to the row totals

Testing the Effect of Marital Status on Willingness to Recommend

Table 29 refers to cross table of marital status and willingness of the respondent to recommend the team to others. More than 95.0% of all people in all the marital status categories expressed willingness to recommend the team. Chi-square test for independence of attributes is used to test the significance of the association between gender and willingness to recommend. Results of the Chi-square test indicates that the null hypothesis of no significant association cannot be rejected at .05 level of significance (χ^2 (3) = 1.184, p = .757). This means that marital status and willingness to recommend the team are not associated.

Table 29: Cross Table of Marital Status and Recommendation of Home Care

	Recommendation		
	Do not recommend	**Recommend strongly**	**Total**
Single	0	18	18
	.0%	100.0%	100.0%
Married	2	256	258
	.8%	99.2%	100.0%
Divorced	0	17	17
	.0%	100.0%	100.0%
Widower	0	117	117
	.0%	100.0%	100.0%
Total	2	408	410

	Recommendation		
	Do not recommend	Recommend strongly	Total
Single	0	18	18
	.0%	100.0%	100.0%
Married	2	256	258
	.8%	99.2%	100.0%
Divorced	0	17	17
	.0%	100.0%	100.0%
Widower	0	117	117
	.0%	100.0%	100.0%
Total	2	408	410
	.5%	99.5%	100.0%

Note: Percentages refer to percentage of the cell frequency to the row totals

Testing the effect of Education Level on Willingness to Recommend

Table 30 refers to cross table of education level and willingness of the respondent to recommend the team to others. More than 95.0% of people in all the education level categories expressed willingness to recommend the team. Chi-square test for independence of attributes is used to test the significance of the association between gender and willingness to recommend. Results of the Chi-square test indicates that the null hypothesis of no significant association cannot be rejected at .05 level of significance (χ^2 (3) = 1.201, p = .703). This means that education level and willingness to recommend the team are not associated.

Table 30: Cross Table of Education Level and Recommendation of Home Care

	Recommendation		
	Do not recommend	Recommend strongly	Total
Uneducated	1	181	182
	.5%	99.5%	100.0%
Primary	1	97	98
	1.0%	99.0%	100.0%
Secondary	0	89	89
	.0%	100.0%	100.0%

Other	0	38	38
	.0%	100.0%	100.0%
Total	2	405	407
	.5%	99.5%	100.0%

Note: Percentages refer to percentage of the cell frequency to the row totals

6.5 Summary of Quantitative results.

The aim of HHC providers is to offer high quality and safe care in a manner that respects the sovereignty of the patient and takes into account the personal characteristics of the home and family of each patient and also, to assess the significance of the effect of gender, education level and marital status on the satisfaction score related to HHC providers and whether these demographic variables are significantly associated with the willingness of the patients to recommend the HHCteam to others. Data collected on a random sample of 410 respondents were analysed using descriptive and inferential statistical methods. Results of the analysis indicated that gender has a significant effect on satisfaction level. Precisely, males were found to be significantly more satisfied compared to females. Marital status also reported significant effect with people who were single reported the highest satisfaction followed by a widower, married and then the least satisfaction reported by divorced people. Also, regarding education level, uneducated and primary level education report the significantly higher level of satisfaction compared to secondary level and other education levels. On overall satisfaction, it was found that gender of the person does not affect the overall satisfaction level on all the services in general. Divorcees reported significantly less satisfaction level compared to all other marital status categories regarding overall satisfaction level on all the services in general. People who are uneducated or educated at secondary level report significantly lesser overall satisfaction level with services in general compared to individuals who have primary and other education levels. Interestingly, gender, education level and marital status reported no significant association with willingness to recommend the team to others. To conclude, gender, education, and marital status report the significant effect on satisfaction level with HHC team while they report no significant effect on willingness to recommend the HHC providers to others. (More explanation will be provided in the Discussion chapter).

6.6 Main Findings and Analysis of qualitative data

The analysis of qualitative data from interviews was noted in the current study may identify similarities between numerous statements, and can determine orientations, trends, and tendencies. Data can be categorised regarding recurring themes which seem appropriate. I have used content analysis to avoid the risk of hasty conclusions and highlight the context and characteristics of the essential elements of the program being evaluated. An advantage of qualitative research is the ability to explore further information, ideas, opinions and attitudes which can help to answer the questions 6.6.2 Understanding Saudi Culture. This section will consider the society and culture in Saudi Arabia. Islam is the dominant religion in Saudi Arabia and also governs its people's political, legal, personal and economic lives. Friday and Saturday are the two governmental weekend days in Saudi Arabia and hence almost all companies are closed on these two days. Furthermore, during 'Ramadan' (the holy month) all Muslims fast in Saudi Arabia from dawn to dusk during which the permitted working hours are 6 hours per day. In general, friends, relatives and families gather on different days of the week to celebrate various moments, especially in Ramadan when the festivities continue into the night. In the Al-Baha region, family values are crucial due to Saudi culture, within which they form the basis of social relations and structures in the country. Therefore, family values are related to any social means within Saudi Arabia and among its people.

In Saudi Arabia, families are related through the conventions of naming, the social cultures and traditions, and even the social relations between nuclear and extended families. Moreover, people in Saudi respect the family means and take on themselves the responsibilities towards their families. Also, families in Saudi Arabia seemed mostly to be large and extended rather than nuclear, since there are strong relations within families. These strong relations between Saudi families create the means of cooperation and solidarity between individuals in the family.

The strong relationship between families in the culture of Al Baha and the nature of this culture, religion and Loyalty to the government may go some way to explaining the reason for the relatively uncritical opinions which I was able to obtain from the older patients I interviewed.

Thus, there has emerged an unwillingness by the older people to express a clear opinion or criticism of services, when they see that the government and the departments of hospitals offer them everything that can be provided, such as HHC service, and criticism might seem dishonest or disloyal to those in charge of the care and the government. Interpretation of the traditional family culture in the Al-Baha region, Saudi Arabia, is just an example of comparison between various cultures that differ from one country to another or from one society to another, even if those communities are from the same country. However, these differences in culture and tradition are among the key aspects of humanity that must be taken into account among personal or family features, even if the service provider is from the same country.

6.6.1 The cultural differences in home health care

Understanding of cultural differences is one of the main requirements for meeting safety and efficiency standards in the HHC service, saefety and efficiency being among the major needs in the field of international health. The understanding of different cultures is needed to select the most suitable approaches for various societies. HHC is one of the international industries that operate in a multicultural environment; therefore, the selection of any approach has to fit all the cultures included, since a certain approach can be considered appropriate for one culture but unacceptable for another. The selected approaches in HHC have to take into account many parameters of cultural difference to achieve proportionality between the context of the approach and the included cultures. The most important cultural parameters that have to be taken into account in HHC are customs, behaviours, languages, beliefs, attitudes, and values. Moreover, those parameters have to be assessed about different perspectives.

6.6.2 The Impact of Cultural Gaps

Recent research has been conducted on the human factors of HHC in government hospitals, mostly in Western Europe and North America. Many variables have been analysed to measure the human factors such as knowledge, attitudes, and skills of the patients' participants who provide the service, and to make decisions regarding their abilities. I have noticed that cultural differences lead to the emergence of many differences in attitude, behaviours and knowledge between members of the same team.

The huge growth of international health services in almost all countries has clearly increased the interaction between different cultures, especially between doctors and hospital managers, where this activity is considered the most suitable area of contact between different cultures. To cope with this contact through radical solutions, preparation of the staff of HHC services is required, through some training courses in the field of communication and delivery of health services about different cultures. These training courses for HHC employees will give them a multicultural background that qualifies them to deal with people of any culture, as well as respect for them. This means that the training courses will effectively enhance communication between different cultures. Moreover, the training sessions give employees of HHC the ability to understand the views and attitudes of other cultures to minimise problems arising from misunderstanding. Also, the HHC staff can make the right decisions to suit different cultures, which also reduces problems of misunderstanding.

6.6.3 Overcoming the Barriers of Cultural Differences

To overcome the barriers which stem from the differences in cultural background, many procedures have to be followed when dealing with a person of a different culture. All these procedures give the HHC staff the opportunity to understand the other person correctly, without misunderstanding. For example, the language difference is one of the significant cultural differences between people in the HHC environment and the solution to this problem is considered to be achieved by the standardisation of language. However, any staff member in the HHC environment has to be mindful and understanding of the barriers posed by cultural differences. Finally, it appears that the training courses and awareness campaigns in the community health field provide the most efficient way to facing the cultural differences, habits and misconceptions that create barriers, by establishing a multicultural background in the HHC environment between the staff members and diverse people; also, it decreases misunderstandings by developing open-minded patients and staff who can understand different cultures.

6.7 Qualitative Data Analysis Method

Interviews and document reviews as data collection methods are more common in evaluations of the views of the population and patients.

Interviews and semi-structured interviews yield high-quality data as in the current study. In semi-structured interviews, the evaluation objectives guide the discussion. Overall, interviews uncover the in-depth feelings and views of respondents and allow for organization of the data into areas of similarity and presentation of a variety of facts, while shedding light on the motivations of people that can be built upon to improve practice. These are the qualities sought through the qualitative analysis in this study. I met all the interviewees on a one-to-one basis so that they would feel free to express controversial ideas, offering privacy to support honesty, openness, and reduce feelings of coercion, if present; so I thought it best to interview them individually. This procedure allows for the comparison of different views on the subject of study, which is especially useful when exploring personal subjects. In the next following pages I am going to use (The Educational Research Book 6th edition, by John W.Creswell, 2003) as a guide for the procedures of the Qualitative data analysis.

6.7.1 Overview of the Procedures:

1. Select the desired goals in conducted interviews and listen carefully and in a concentrated manner.

2. Apply coding and classification of each part of the information provided in the interview, according to the coding model that built for the study.

3. Compare the responses of the study sample to interview questions according to the selected classification and coding system.

4. View the results of the analysis of the interviews and discuss it regarding the desired objectives.

5. Calculate the agreement by procedures before clarifying and interpreting the results.

In this part of my study, the chosen method of observation will be to register all that is seen and heard in interviews. These observations can be physical accounts of activities, processes, and discussions, and can be characterised by the following:

1- When performance monitoring data indicate that the results are not being achieved as planned, when there are suspected problems with implementation, but problems are not understood. The direct observation can help to determine whether the operation is executed poorly or required input does not exist.
2- When you need to assess the details of the activity, for example if the tasks are being implemented by the standards required;
3- When you need an inventory of physical facilities and inputs, but that list is not available from existing sources.

In this study, I have observed an event (i.e., the interview participant during the interview) in its natural setting, the only difference being that a note will be made of it. I have used a mixture of observations, assessments, and conclusions to assist leaders or decision makers to obtain adequate, accurate, timely, and usable information on the topic of study.

Sampling, interviews, and observation are the usually common methods used in evaluation, as is the case in this study. The following is the qualitative analysis based upon a total of 15 interviews with sample patients' participants using the method of content analysis.

6.8 Description of Interview Sample

The qualitative sample consisted of a total of 15 patients' participants who were received HHC services in Al Baha region, Saudi Arabia after having a lengthy hospital stay due to chronic illness. Participant diagnoses included a variety of combinations of heart disease, hypertension, diabetes, cancer, and chronic joint/bone pain or disorders.

6.9 Content Analysis of Interviews

Qualitative content analysis is used to analyse text data with a focus on the content and contextual meaning within the written data obtained from verbal responses, open-ended surveys, interviews, focus groups, observations, and other print media (Hsieh & Shannon, 2005). Content analysis requires analysis through multiple document data sources to develop a thorough comprehension of the various texts comprising the research. A hermeneutic perspective to the content analysis provides the human perspective in

understanding the knowledge transfer within distributed groups utilizing a virtual network model.

Hermeneutics, the study of interpretation theory, can be defined as either the art of interpretation or the theory and practice of interpretation. Content analysis has been defined as "A research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005).Therefore, content analysis is used to determine whether there are certain concepts (themes) present in texts or written documents (Neuendorf, 2002). The purpose of determining themes and concepts within documentation or texts is to enable the investigator to quantify and analyse the data such that inferences about the written text can be made. To conduct a content analysis of the interview text obtained for this research, the data were coded into manageable categories on different levels, which included breaking the textual data down into key components, words, sentences or themes (Neuendorf, 2002). Neuman (2006) stated, "The researcher locates themes and assigns initial codes in a first attempt to condense the mass of data into categories". These themes or key components were then examined using relational analysis to determine whether there are any relationships between the responses of the subjects. The data analysis also included manifest coding, which is "coding the visible, surface content in a text" (Neuman, 2006, p. 325). Manifest coding includes counting the number of occurrences of words or phrases (Neuman, 2006).

6.10 Patient Interviews

Table 31 provides an overview of the thematic categories revealed in the data and the key themes described by the 15 patient participants.

Table 31: Thematic Categories and Key Themes from Patient Interviews

Thematic Category	Key Theme Revealed
Inpatient hospital experiences	Lack of information received on HHC services and risks of long-terms hospitalization. Difficult communications with hospital staff due to language differences

Thematic Category	Key Theme Revealed
	Psychological distress due to separation from family
	Boredom
HHC experiences	
Sub-category: Feelings about moving from hospital to HHC setting	Feel good about HHC services and in particular with the provider (doctor) visits.
	Understanding the benefit of being home with family to patient psychological well-being
	Better for family
	More comfortable at home
Sub-category: HHC services received	Services that encompass checking vital signs and blood chemistry, counselling, physiotherapy, provider visits, and treatments
	Comfortable, kind service that offers opportunities for better communication with the patient
Sub-category: Difficulties experienced	Difficulty in communication when do not know Arabic or customs
	Irregularity of services
	Difficulties getting to hospital for tests, possible use of ambulance to provide additional services
Perceived benefits of HHC	Being home with one's family/ Psychological benefits
	Not being bored in hospital
	Not having to wait a long time for doctor
	Medical team visits home; difficult getting to hospital
Suggested improvements	More frequent provider visits and longer session times for visits
	Train foreign nurses in Arabic language and culture
	Train family for crisis and first aid
	Increase awareness of program and risks of lengthy hospital stays
Comparing hospital and HHC	Hospital was perceived to provide more services, more

Thematic Category	Key Theme Revealed
	often, and with high quality
	Home care services offered benefits of enhanced communication through the use of family members if necessary compared to difficult communication with providers at hospital
	Elimination of boredom, being alone, and long waits for provider services with HHC
	Difficulty connecting or communicating with HHC providers due to short visits.
	Potential issues with providers failing to demonstrate respect for cultural or religious customs.

6.11 Inpatient Hospital Experiences

The first thematic category revealed from the analysis of the interview content was developed from participant responses detailing their inpatient experiences. Common themes included (a) not receiving information on HHC services, (b) a general lack of communication of the risks of being in the hospital for extended periods of time, (c) distress from being away from one's family, (d) difficult communication with hospital staff due to language differences, and (e) complaints of boredom in the hospital and being sad or upset at being away from family. Table 32 illustrates the common responses and the frequency of each response among the fifteen interviews patient participants.

Table 32: In Hospital Experiences

Response	Number of patients' participants to offer this response
Did not receive information on HHC services	15
Lack of communication of risks of being in hospital for a long time	15
Difficult communications with hospital staff	13

due to language differences	
Boredom (with no one to talk to – links with language differences)	13
Upset being away from family or being alone	10

Three of the common themes were related to communication. Patients' participants noted difficult communications with nursing staff and providers at the hospital, which was primarily due to language differences with the staff, who did not speak Arabic. For example, Participant 1 reported:

> *"All nurses here are not Saudi; I mean they did not speak Arabic, so I can't talk to them. I tried to understand them, but it was difficult. I did not get anything. They cannot talk Arabic, so I can't understand them."*

Participant 14 similarly described this communication issue:

> *"Communicating with nurses at the hospital is difficult because they are not proficient Arabic and they did not know our customs and traditions."*

These language differences also contributed to three other negative experiences: boredom and lack of information received on the risks of long-term hospital stays and information on HHC services. As a critical communication-related issue, while at the hospital, all 15 of the patients' participants reportedly did not receive information on the risks of long-term hospital stays, nor on HHC services, but some patint participants acknowledged that this lack of information often stemmed from the language differences. For example, patients' participants 12 and 14 explained that they were not told of any risks to staying in the hospital for a long time:

> *"[The hospital providers] did not tell me any risks of keeping in the hospital, or importance and benefits of HHC care services."* (Participant 12)

> *"[They] did not tell me. I don't know if there is any risks for being in the hospital, I just felt bored and I need very much to go back home. "*(Participant 14)

Another communication-related problem described in the interview data was the lack of discussion and information given about the HHC option.

Patients' participants 3, 12, and 13 discussed this deficiency in communication of services:

> *"No, they did not describe or send any information about HHC before we left the hospital." (Participant 3)*

> *"They told me I was suitable now to move to my home, and they would send the doctors and nurses to my home. Without clarification of the mechanism of action of the program for HHC." (Participant 12)*

> *"They told me I was ready to go home and they complete the treatment by send my doctor to my home. Without explain the mechanism or the definition the action of the program." (Participant 13)*

Another common theme within the interview data found in this study was patient complaints of boredom while at the hospital, which for some was related to the lack of communication abilities due to language differences. Patients' participants commonly noted not being able to find anyone to talk to. For example:

> *"I felt bored at the hospital and no one wants to talk to me; the nurses don't talk Arabic." (Participant 10).*

This boredom was also tied to missing one's family, which, of course, is another social component and related definition to the six common basic aspects of patient-centric care (i.e., that family and friends contribute significantly to the patient's mental welfare), as described by Al-Helwagi (2006). Participant 13 described both missing the family and feeling bored.

> *"I felt bored. I could not find anyone who wished to talk to me. I missed and my children and also my home where I will be comfortable*."

Also, the patients' participants ' inpatient hospital experiences were often emotionally difficult, as the participant reported being upset or distressed due to separation from family, despite family visitations. Again, the evidence pointed to missing common aspects of patient-centred care theory, such as the need to perceive and understand the patient's psychological needs and requirements to support the complete healing process (Epstein, 2005),

Participant 1 described:

"I felt very sad and upset when I was in the hospital away from my family. ... They were with me [visiting at the hospital], but they can't be [there] all day and night, they have work and have other things to do."

This was echoed by the interview with Participant 12, who stated,

> "*I missed my home ... and my children, especially my grandchildren*" and Participant 2, who stated, "*I felt sad. No one visited me. I did not want to stay in hospital. I missed my home ... and my grandchildren; I didn't see anyone in the hospital."*

Overall, the key themes revealed from the analysis related to the thematic category of inpatient hospital experiences included psychological distress due to separation from family, and challenging communications with hospital staff due to language differences, which supported a lack of information received from HHC services and long-term admission risks. These deficiencies demonstrate serious threats to the delivery of patient-centric care, which from the literature demonstrates six specific common elements of education and transmission of information and know-how, acknowledgement and support for family and friends contributing significantly to the patient's mental welfare, efforts at synchronization and coordination of care, consideration for extraneous factors, understanding and considering patient preferences and choices, and providing the availability of information, knowledge, and understanding to flow freely (Al-Helwagi, 2006), as well basic features of patient-centred theory of (a) regard and care for the principles, needs and requirements of individual patients had to be kept in perspective

(Gasquet et al., 2005); (b) the patient right to be informed about the course of treatment determined for the ailment, and each step initiated by the medical professional had to be conveyed to the patient beforehand (Charmel & Frampton, 2008); (c) the patient right to gain access to all the services of health care and preventive medical care required to lead a long and healthy life (Wolf et al., 2008); (d) perception and understanding of the patient's psychological needs and requirements for the complete healing process (Epstein, 2005); and (e) the patient had the right to gain access to and be provided with a correct and genuine representation of the options available to him or her while exploring options for treating and healing the person's ailments (National Asthma Council Australia, 2007).

6.12 Home health care experience

Several facets of the HHC experience were discussed by the patient participants, who included the patients' feelings about moving from the hospital to the home environment, the HHC services received, and the difficulties experienced with HHC. These common thematic sub-categories were all related to the primary thematic category of HHC experience and are, therefore, presented individually with themes discussed in each subcategory.

6.13 Feelings about moving from hospital to home environment.

As a subtheme of HHC experiences, several themes were identified related to the patients' feelings of moving from the hospital to the home environment. Most of the patients' participants noted feeling "good" and comfortable with HHC, acknowledging the benefit to the family and their psychological health (13 of 15 patient participants). Nine patients' participants also discussed being physically more comfortable at home, compared to the hospital, but also perhaps having concern for the level of treatment that would be received (4 patient participants). Table 33 illustrates the common themes and associated frequency of mention among the patient participants. The findings support the importance of achieving patient-centred care regarding addressing and providing for patient comfort, decision-making, psychological well-being, social support of family and friends, and general communications. The health care program in Saudi Arabia seeks to place emphasis on the care of patients, providing proper health care in the patients'

homes and improving the level of security and confidence of the family members of the patients. These aspects support patient recovery, both physically and mentally.

Table 33: Feelings about Moving from Hospital to Home

Response	Number of patients' participants to offer this response
Feel good/comfortable with HHC	12
Understood better psychologically to be with family	13
More comfortable at home	9
Better for family	6
Don't think will have the same level of treatment at home compared to hospital	4
Feel happy	4
Can communicate with family	2

Over half of the patients' participants commonly described feeling good about the move to HHC and understanding the benefit of being at home with family, which supported psychological health. Participant 1 noted, *"I know that psychologically I will be much better."*

Participant 1 also described being comfortable with HHC with the doctor coming every week. However, the participant was concerned that the same level of care and services would not be available through HHC services.

"I don't think I will have the same treatment at home like in the hospital."

Similarly, the following patients' participants also described this sense of psychological well-being in being home to complete the treatment.

> *"I felt comfortable; it is good for me, between my families. And I can see my doctor in my house, and it's good too that the completion of treatment will be at home. I can see my grandchildren and my children any time I want not only for*

few hours a day. I can speak to them instead of being alone in the hospital, which Is much better." 12

"I feel in better shape and it is good for me, I'm between my family. It is good that the treatment completion will be at home and I see my grandchildren and my children at any time, and I think it always speaks to me and makes me feel better, and the doctors and nurses can visit me at home give me the treatment." 12

"I have felt very happy to go home because I will be near my family, we can talk, I am not alone at least. This is more comfortable than the hospital." (Participant 12)

Another theme was that home was felt to be more comfortable compared to the hospital. Participant 12 stated,

"*I am comfortable more now, at my home, instead the hospital treatment*."

Participant 13 also described being more comfortable at home, stated,

"*I know I will be comfortable more than being in the hospital. And I am veryhappy to be at my home again."*

Therefore e, key themes to this thematic category included (a) understanding the benefit of being home with family to patient psychological well-being; and (b) sense of comfort, both in being home and with HHC services and in particular with provider (doctor) visits.

According to the literature reviewed, the HHCsystem serves to provide proper health care to patients in their own homes, to improve the levels of security and confidence of the family members of patients, and to help the patients to recover in a better way both physically and mentally (National Committee for Quality Assurance, 2008).

The findings of this qualitative analysis support these assumptions in that patients' participants discussed the psychological benefits in particular of being home for this specific population in Saudi Arabia. In line with patient-centric approaches, adequate, continuous and proper feedback would have to be obtained from the people accessing the system, so as to have more thorough input on all the potential areas of improvement (Al Bwardi & Al-Megren, 2013).

6.14 Home health care services received.

The third thematic subtheme of popular response content under the thematic category of HHC experiences was defined by the HHC services received. Patients' participants described various services that were received, which included checking vital signs, treatment given, checking blood chemistry, physiotherapy provided, counselling, and skin ointments/treatments.

Table 34 provides the different services mentioned by patients' participants and the associated frequency.

Table 34: Services Received

Response	Number of patients' participants to offer this response
Checking vital signs	15
Treatment given	11
Checking blood chemistry	13
Counselling (by physician or other provider)	9
Physiotherapy or rehab	9
Skin ointments or treatment	4
Special diet or nutrition education	3

According to the participant interviews, the home health services received included checking vital signs and blood chemistry, provider visits, treatments, physiotherapy, skin ointments and treatments, and special dietary instructions or nutrition education.

The following examples demonstrate the some of the most common services received:

> *"They check the blood pressure, blood sugar and pulse. They give treatment and counselling by physicians. … The provider comes to me every 2 weeks [and] gave me treatment."* (Participant 1)
>
> *"I receive from HHC team a Supervision of the special diet program, checking blood pressure, blood sugar, and give physicians' treatment. Sometimes they give*

me some physiotherapy for my muscles and my joints. Also I get some ointments for my skin" (Participant 14)

Overall, the participant felt the HHC providers were kind and it was comfortable to see the providers. Participant 1 reported, "*In general they are very kind... I feel comfortable to see them."*

6.15 Difficulties experienced.

A final thematic subcategory related to the HHC experiences of patients' participants was defined by difficulties experienced with HHC. The key common themes included (a) irregularity of services and the need for increased visits and time at each visit; (b) the difficulty in communication when the provider did not speak Arabic. (c) Difficulties getting to the hospital for tests, x-rays, etc., which was felt to possibly be remedied by the use of ambulances for these services; and (d) HHC did not provide the quality of care expected. Table 35 provides the responses and frequency of these replies.

Table 35: Difficulties Experienced

Response	Number of patients' participants to offer this response
Irregularity of services and need for increased number visits and time given at each visit	13
Difficult communication when do not speak Arabic or know customs	12
Difficult to get to hospital for tests; maybe use ambulance	12
Home care not at level expected	4

The most commonly noted difficulty was the irregularity of services and the need for increased number of services and the amount of time of each visit. For example:

"I think irregular visits and nurses are unable to connect and communicate with me, and time of the visit is short. … We need to increase the number of visits, and the time of each visit. Moreover, that the team will be more cooperative in the program." (Participant 12)

Another commonly noted difficulty with HHC services was the difficulty with communication and not knowing the customs, similar to what was reported at the hospital.

This was explained by Participant 13, who described as an example:

"I faced the same problem in the hospital which is to communicate with the care team is difficult, and they don't know our traditions and customs also." (Participant 13)

Patients' participants 12 and 14 also described communication issues with HHC providers. Participant 14 stated, "*I think the language is the most difficulty I have*." Participant 12 also explained:

"Medical care, the level was not [what] I expected, maybe because communication with team-based care home is difficult because they are not proficient in Arabic and know our customs and traditions, so I can't contact with them". (Participant 12)

Another difficulty, noted by 12 patient participants, included getting to the hospital for additional testing when needed. These patients' participants felt that perhaps the use of an ambulance for such visits might be possible or even an ambulance equipped to handle such testing. Participant 9 explained:

"Sometimes I need to conduct laboratory tests, and I must go to the hospital, I hope I can take the tests at home, without going to the hospital. May be if they have an equipped ambulance they can conduct the tests. ... Perhaps they have already an ambulance to take the patients to the hospital with the team to provide such services." (Participant 9).

From these subcategories under HHC experiences, the themes revealed from the analysis of the 15 interviews highlight (a) services that encompass checking vital signs and blood chemistry, provider visits, and treatments; (b) comfortable, kind service that offers opportunities for better communication with the patient; (c) psychological and health benefits of being home with one's family; and (d) continued difficulties with communication due to language/cultural differences.

6.16 Perceived Benefits of Home Health Services

From the interview data, the perceived benefits of HHC were described, forming another thematic category of data. Common responses within the 15 interviews included (a) being with family, (b) relief from boredom of the hospital, (c) not having to wait extended periods of time for the doctor, (d) psychological benefits of being at home, (e) not having to go to the hospital, as this was difficult, and (e) the ability to better understand HHC providers. The table 36 provides the different common responses and associated frequencies within this thematic subcategory.

Table 36: Perceived Benefit of Home Health Services

Response	Number of patients' participants to offer this response
Being with family	12
Not having to be bored at the hospital	7
Not having long wait to see doctor; doctor comes to you	6
Psychological benefits of being at home	5
Not having to go to hospital (medical team visits home); difficult getting to hospital	3
Can understand home health providers better	2

The essential perceived benefit of HHC is the ability to be with family.

> Participant 1 reported, *"The most benefit is that I am here with my family."* Being with one's family provides support and social contact to support positive gains.

Participant 14 similarly commented:

> *"I am also delighted to be comfortable with my son and my grandchildren. I can spend more time now with my family*." (Participant 14)

An additional benefit of HHC services was the importance of communication and the

ability of HHC workers to more efficiently provide this communication. Patients' participants 1 and 14 explained the importance of this communication.

For Participant 1, the communication was critical, as this participant did not learn to read.

> *"I cannot read because I did not learn before, I mean I need them to repeat the explanation of how to use my medication." (*Participant 1)

The communication with providers was described as better within the HHC setting, for many because of the availability of family to assist in the communications process, particularly in situations of language differences.

Patients' participants 7, 10, and 14 noted, for example:

> *"I can understand them by asking anyone from my family to help me." (Participant 7)*

> *"Also they do not speak Arabic, especially the nurses. But in my home, the providers are very friendly and I can understand them by asking anyone from my family to help me" (Participant 10)*

> *"It is hard to understand most of them; they do not speak Arabic, especially the nurses. But in my home, the providers are very friendly and I can understand them by asking anyone from my family to help me." (Participant 14)*

Other benefits were perceived as not having the difficulties of getting to the hospital, not being bored at the hospital, and not having to wait for long times for the doctor. These were issues at the hospital that seemed to be better using HHC services.

The following are the interview text illustrates these themes:

"It is too difficult to go to the hospital, sometimes I can't find anyone who can take me to the hospital. And I feel bored when I go to there. I am also comfortable with my son and my grandchildren." (Participant 13)

"I don't have to wait a long time to see the doctor's. The doctor's come to visit me and give the treatment." (Participant 12) *"I suppose, but I prefer HHC because no need to wait a long time* to see the *doctor, which is happened when I go to the hospital."* (Participant 14)

From the literature reviewed, these findings support the key concepts of patient centred care. Because patients avoid having to travel to or be admitted to the hospital, patients maintain a decreased risk for infections that might be acquired there (Patient-Centred Quality Care Collaborative, 2007). The Ministry of Health claims to guide patients and their family members in using the health services at home, as this reduces cost, lessens the burden on the hospitals, and prevents unnecessary admission of ageing patients who have chronic illnesses (Seavey, 2010). Certainly, greater understanding between health care provider and patient supports the efforts and benefits of HHC (Al Bwardi & Al-Megren, 2013). The Ministry of Health guides patients and their family members in using the health services at home, as this reduces cost, lessens the burden on the hospitals, and prevents unnecessary admission of ageing patients who have chronic illnesses (Seavey, 2010).

6.17 Perceived Changes Needed to Support Improved Home Health Care

The participant interview data revealed several recommendations offered by the patients' participants that would support improvements in the HHC services. Common response themes included (a) an increase in the number of visits and the time for each session/visit, (b) providing training to the providers in Arabic language and culture, (c) providing training to family members to handle crises and home first aid. Table 37 illustrates the variety of responses and the associated frequencies of the responses. One participant aptly noted the need to increase awareness of the services offered and the risks of long-term hospital care.

Table 37: Recommended Changes to Improve Home Health Care

Response	Number of patients' participants to offer this response
Increased number visits and time with each session	13
Train foreign nurses in Arabic language and culture	12
Should train family to deal with crises and home first aid and complications	7
Need to increase awareness of the program and risks of being in hospital long time	5
More physical therapy and rehab	2
Medication comes to home	1

The patient interview participants discussed that they would like HHC services to provide more frequent visits from the medical team and other services, such as delivery of medication at the time of the provider visits.

The following examples support this theme:

> *"I liked the visits of the medical team at home many times, not just every 2 weeks. And it will be better to bring the medication to me in the home. ... I think it's ok for now, but [it's] not enough [that] they come every 2 weeks. ... It [getting medication] is difficult for me, and it is too far from here to the hospital. My son is busy and sometimes I have to wait couple of days to receive my medication. They came from hospital, so why they did not help me during the visiting time."* (Participant 1)

> *"[They] should consider increasing the number of meetings and the allocation of time*. (Participant 13) *[They] should consider increasing the number of meetings and the allocation of time, especially with regard to physical therapy and rehabilitation. And Increase the number of sessions and the time of each session."* (Participant 14)

In addition to a call for more frequent and longer visits with providers, patients' participants also commonly felt the need for training, both for the nursing and provider staff as well as for the patient and the patient's family.

Twelve patients' participants felt there is a need to train nurses and care providers in Arabic and the culture and customs.

According to Bliss (2004) and Sharm et al. (2001), diversity may result in poor communication between patients (particularly older patients) and service providers. For example, Patients' participants 6 and 13 stated:

> *"But I request for the increase the number of visits and time, and to train the nurses the Arabic language, and some of our traditions. Because they will come to our houses and stay for a period of time, this requires them to understand some of the important points in our communities." (Participant 6)*

> "*They must train Arabic to get the best benefits from the program…I request the organizers at this program to train foreign nurses for Arabic language and our customs and traditions*" (Participant 13)

Other patients' participants felt that the family of the patient also needed training in emergency care and the use of specialized machinery or equipment that is crucial to their care. For example, Participant 12 stated:

> *So they should be training for family members to deal with attitudes and health crises that have been exposed to while in the home and first aid necessary to prevent any complications in the future. ... it is important to the education and training of disabled older HHC work; use some simple machines in the rehabilitation and emergency aid, however. And provide my home with some simple equipment, safety and training family members to use them and train them to do the necessary first aid in emergency situations.* (Participant 12)

Lastly, the patients' participants called for an increased awareness. The provision of PCC is to educate patients of appropriate health advice so that they can make informed decisions. Coulter (2002a) defined PCC as: "Health care that meets and responds to patients' wants, needs and preferences and where patients are autonomous and able to decide for themselves.

> "Participant 13 discussed: *They must increase the awareness for this programme; people must know what is the purpose of the program, or the risks of being in the hospital for long time.*

The literature highlighted that patient-centeredness also reflects on the doctor–patient encounter characterized by responsiveness to patient needs and preferences (Safran et al, 2005). Within a patient-centred approach, the patient is empowered by expanding his or her role in their own health care. Supporting the patient in become more informed, and providing reassurance, support, comfort, acceptance, legitimacy and confidence are the basic functions of PCC (Fulford et al., 1996). The impact of the goals of PCC has a direct logical link with promoting healing and reducing injury and suffering (Nelson & Gordon, 2006). Although there is no globally accepted definition of PCC (International Alliance of Patients' Organisations 2007), the core elements of respect for the patient, his or her values and choices, and effective communication feature in most descriptions of PCC and the findings of this qualitative portion of the study support these elements.

6.18 Comparing hospital and home health care

Finally, interview data provided participant responses to comparisons made between hospital and HHC. The patients' participants discussed comparisons between providers, hospital and home care. The findings revealed themes related to hospital providers, such as problems with difficulties communicating with hospital providers, boredom in the hospital, and having to wait for services, but more services provided and high quality of services offered at the hospital. These themes were compared with those of the HHC providers, which included friendly and easy to understand (enhanced communication) providers in HHC, enhanced understanding, particularly with the assistance of family members, noted professionalism of nurses and a high level of comfort with providers in the home; however, patients' participants also described persistent issues with providers failing to demonstrate respect for cultural or religious customs and failing to connect and communicate during short visits.

Table 38: Comparison of Hospital Providers and HHC Providers

Response	Number of patients' participants to offer this response
Hospital providers	
Difficult communicating with hospital providers (Don't speak Arabic)	8
Boredom at hospital	6
Took long time to receive services	6
More services or provided services more often	3
High quality services and treatment	2
Home providers	
Home providers are very friendly	12
Can understand the home providers, especially with assistance from family	11
Nurses are professional and am comfortable with them	3
Do not have to go to hospital to get treatment	2
Sometimes fail to respect culture or customs of house	1
Need for female doctor	1
Difficult to connect and communicate with short visit	1

In describing hospital providers and staff, Participant 1 highlighted the availability of more services at the hospital, but also having problems with communication due to language differences, and boredom at the hospital. Noting the additional services, but also the time needed to see the doctor, this participant stated:

> *"In the hospital, the provider's gave me more services; I got my service, but I need to wait a long time to see the doctors."*

At the same time, communication was difficult due to language differences, as noted previously. The first participant described:

> *"I can't contact and communicate with them and it is boring. ... [I] still cannot understand most of them. They do not speak Arabic, especially the nurses." (Participant 1)*

This was supported by participant 14, who stated, "It is hard to understand most of them; they do not speak Arabic, especially the nurses."

In contrast, HHC providers were considered to be very friendly and easy to understand with the availability of family to assist in understanding the nurse or provider. Participant 14 explained:

> *"I mean that I need the nurse to come to me. She is very friendly and she can understand what I need. In fact I feel Comfortable when I see her. She can reassure me also* (Participant 14)

Participant 1 also explained how the communication can be assisted by family members or others, stating, *"I can understand them by asking anyone from my family to help me."*

However, two problems were noted as well. First, sometimes home health workers failed to respect cultural differences and customs of the family. This is a key factor, as these home providers must enter the house and stay to provide treatment.

> *The nurses (females) some time did not respect our culture and customs, because they enter to our houses and stay sometimes for long time and didn't wear Islamic uniform for women. (Participant 1)*

One of these cultural differences is the need for a female nurse for a female patient. The participant explained,

> "*Also it is better to see female doctor because my son always objection on this*."

Overall themes for this thematic category highlighted (a) although the hospital was

perceived to provide more services, the HHC services offered benefits of enhanced communication through the use of family members if necessary; and (b) potential issues with providers failing to demonstrate respect for cultural or religious customs. These findings support the need for better patient-centred care practices that can be perhaps focused on patient needs through appropriately addressing cultural and or religious customs in order to truly meet the basic elements of patient centred care, with a focus on the patient's well-being and specific needs (Al-Helwagi, 2006; Epstein, 2005; Gasquet et al., 2005) in order to achieve the benefits of the model in terms of patient satisfaction, compliance, and continuity of care (Bauman, 2003; Lau, 2002; Wolf, 2008).

6.19 Qualitative Patient Interview Summary

Overall, the content analysis of the interview data revealed several overarching themes related to patient extended hospitalization and the use of home health services. These themes reflect the common experiences of the group as a whole. The following themes were revealed from the content analysis of the interviews.

- Inpatient experiences of psychological distress and boredom, as well as communication issues due largely to language and cultural differences, which also result in a perceived lack of information on the risks of extended hospital stays and the benefits and use of HHC services.
- Patient positive attitudes toward the shift from hospital to HHC due to perceptions of quality and ease of services and benefits of comfort and companionship at home.
- Home health experiences with multiple services provided in the comfort of the home and by kind, professional providers offering enhanced communications with patients, although some remaining communication gaps due to language and cultural differences.
- Perceived benefits of being home with family, psychological benefits associated with the increased socialization, elimination of issues of boredom, and solutions to long wait times and difficulties in getting to the hospital.
- Suggested improvements of more frequent visits with longer session times per visit, Arabic language and cultural training for foreign nurses, training for family

members to provide crisis and first aid training, and increased awareness of program and risks of lengthy hospital stays.

Comparisons revealing more service availability and quality at the hospital, but better communication with home care, despite some issues surrounding communication and cultural differences.

6.20 Service providers Interviews

A total of five interviews were conducted with home health services leadership. These interview patients' participants provided content data related to several thematic categories and themes evident within these categories. Table 39 provides an overview of the thematic categories revealed in the data obtained from the leaders and the key themes described by these five patients' participants

Table 39: Thematic Categories and Key Themes from Leadership Interviews

Thematic Category	Key Theme Revealed
Perception of HHC	Provides medical services to older patients, those with chronic illness, or patients needing constant nursing Controls repeat hospitalizations Improved Psychological health for patients Maintains patient dignity Provides care to supplement and support family care Provides cost effective care Reduces burden on hospitals for chronically ill Reduces period of stay Reduces risk of infection
Services Provided	Assessment, treatment, and follow-up Prescribing and dispensing medications Providing nursing care and comprehensive health care Patient and family education
HHC coverage and	Coverage currently 70-75%

obstacles to providing care	Obstacles of difficulty reaching patients, financial burden, and lack of personnel Solutions in establishing sub-centres, hiring non-Saudi staff, use of volunteers
Perceptions of HHC workers	Believe in objectives of HHC Qualified, and experienced Humanitarian
Lack of Explanation/understanding of patient rights	Respect for older patients and right for care Lack due to nature of Saudi society and culture Lack due to newness of program
Patient Satisfaction	General satisfaction of patients Inability to increase visitation, as requested by patients, due to low personnel, difficulty reaching patients, and financial burden Need for medication administration Need for Provision of medical equipment Need for transportation assistance
Solutions for communication issues	Having at least one member of team fluent in Arabic Hiring foreign personnel who are fluent in Arabic Use of family members to assist communication Need for additional education and training
Recommendations for improvement	Build strategies for HHC continuously Education community members of rights and needs Engage family members in services to assist patients with information Coordination with other sectors of ministry to support objectives Improve quality of HHC services through feedback from older patients to policy makers

	Increase financial budget for HHC department in region
	Provide medical devices as needed
	Repeat this study
	Revise policy or rules of HHC
	Send update to HHC leaders on issues
	support providers and aids to the success of HHC objectives

6.21 Perception of Home Health Care and Benefits

The leadership patients' participants (five in total) offered their perceptions of HHC and the benefits of providing this care to patients. Key common responses highlighted themes of (a) providing medical services and nursing to patients with chronic disease, older patients, and those needing constant nursing care; (b) controls repeat hospitalizations and ER visits for this population of patients; (c) improves the psychological situation for patients, offering a sense of security and comfort to patients by being with family; (d) provides care and education to supplement and support family care; (e) maintains patient dignity; (f) provides cost effective care; (g) reduces the burden on hospitals to car for chronically ill; (h) reduces period of stay in hospital for patients; and (I) reduces rates of infection. In general, the HHC was described as:

> *A program that provides HHC services which provided to patients in need the medical care and constant nursing as well as patients who require hospitalization repeatedly for short periods, or their frequent visits to the emergency department and primary clinics and this segment of the patients are the ones who make up the brunt of Hospitals. (Leader participant 2) It is one of the programs offered by the Saudi Ministry of Health; this program provides medical services and nursing care for patients who are unable to get out of the hospital, but they still need health care. (Leader participant 3)*
>
> *It is a new program which aims to provide health care services to older patients at their homes and strengthen their sense of confidence in the vicinity with their families without having to be present in the hospital. (Leader participant 4)*

Table 40 illustrates the variety of responses shared by the leadership patients' participants related to their perceptions of HHC.

Table 40: Leadership Perceptions of HHC and Benefits

Response	Number of patients' participants to offer this response
Provides medical services and nursing to patients with chronic disease, older, or Need constant nursing	5
Controls repeat hospitalizations and ER visits	5
Improved psychological situation; offers sense of security and comfort to patients by being with family	5
Provides care to supplement and support family care	5
aintains patient dignity	4
Provides cost effective care	4
Reduces burden on hospitals to care for chronically ill	4
Reduces period of stay in hospital	4
Reduces rates of infection	4
Help patients regain strength	1
Help those in need of medical equipment	1

The leadership noted certain benefits of HHC, when describing their perceptions of the program. For one, it was felt to control repeat hospitalizations and ER visits, improve patient psychological well-being, and provide increased awareness and educational support to family and patient. This was noted by leader participant 4, who stated several of these benefits:

> *We help patients regain their strength better respects (physical – psychological-rehabilitation), and reducing the admission of patients in hospitals and contribute to spreading awareness of health and guidance to the patient and his family through the medical team during the service.* (Leader participant 4)

Leader participant 5 specifically noted the decrease in hospitalizations and ER visits, with a focus on the older population, stating,

> "*The program provides comprehensive health care services to control the entry of repeated hospitalizations for older patients and the reduction of frequent visits to the emergency department*."

Leader participant 3 also highlighted the older population of patients, while describing the benefit of controlling spending, offering a cost effective option to care for this population.

> *After the patient is out of the hospital, [it offers] the optimal control of spending for the operation of hospitals, [while] working to improve the social and psychological situation, and medical, for the older patient*. (Leader participant 3)

As another example, Leader participant 4 offered insight into several of these benefits:

> *The provision of these services in the home contributes to reducing the need for the introduction of the patients in the hospital who suffer from chronic diseases and the need for constant care, as well as to preserve the dignity and privacy of patients, and to provide effective care in terms of cost*. (Leader participant 4)

This reduces the burden on the hospitals to provide care.

> *The hospitals and specialized units involved in the diagnosis and treatment cannot afford the survival of patients with chronic disease for long periods, especially the older [patients] and for that high cost of nursing in hospitals. Despite all provided by society or the state of services for the older, the family remains the primary incubator for the older, which can be no alternative to his physical and psychological health, social and economic reasons*. (Leader participant 1)

Another benefit is the control of infection and the length of stay in the hospital. According to the patient participants,

> "*It works to fight infection; internal patients in the hospital are more susceptible to various kinds of infections"* (Leader participant 2), and

"*These services include infection control, because inpatients in the hospital are more susceptible to various kinds of infections"* (Leader participant 4). Participant Leader 2 and 5 similarly noted, "*The reduction of the period of stay in the hospital,*" among other benefits.

These perceived benefits align with claims made by the Ministry of Health, supporting that HHC reduces cost, lessens the burden on the hospitals, and prevents unnecessary admission of ageing patients who have chronic illnesses (Seavey, 2010). Leader perceptions of HHC as providing comprehensive medical care to patients in their homes, helping patients to recover both physically and mentally was supported by the patient perceptions in this current study and by the literature (National Committee for Quality Assurance, 2008). Both patients and leadership discussed the psychological benefits in particular of HHC for this population in Saudi Arabia.

6.22 Home Health Care Leaders

Leadership patients' participants described the services provided through HHC. The commonly cited services included (a) assessment, treatment, and follow-up; (b) prescribing and dispensing of medication; (c) providing nursing care and comprehensive Health care services; and (d) providing patient and family education. Table 41 offers the services mentioned by the providers who discussed the specific services offered by the HHC service.

Table 41: Services Provided

Response	Number of patients' participants to offer this response
Assessment, treatment, follow-up	4
Prescribing and dispensing medication	3
Providing nursing care	3
Comprehensive Health care services	2
Patient and family education	2
Infection and bed sore control	1
Medical consultations through single team of Health care providers	1
Medical equipment	1

Nutrition program	1
Physical therapy	1

As examples of the leadership responses, most leaders described multiple services offered or noted the services to be "comprehensive." Leader participant 2 noted,

> "*The program provides comprehensive health care services.*" The following example is given to demonstrate the perceptions of the leadership as to the services provided by the HHC.
>
> *Includes medical care for patients in their homes to include assessment, treatment, and follow-up. Repeat prescribing and dispensing. ... Provides nursing care*. (Leader participant 3)

Also noted by patients' participants was the prescribing and administration of medication, which was noted by patients' participants 2, 3, and 5, who described "*repeat prescribing and dispensing*."

6.23 Home Health Care providers and Obstacles to Providing Care

The leadership patients' participants described the current coverage as providing care for about 70-75% of the area. This includes a range of no more than 50 KM for HHC services. To improve the coverage for HHC, patients' participants suggested three primary solutions, which included the establishment of sub-centres, hiring non Saudi staff who will accept lower pay, and the use of volunteers. Also noted was the need for a larger budget. Table 42 offers these solutions, as noted by patient participants.

Table 42: Solution for Greater Coverage and/or Meeting HHC Objectives

Response	**Number of patients' participants to offer this response**
Establish sub-centres	5

Need for private funding	4
Would be burden for ministry of health	5
Non-Saudi staff, lower pay	4
Use of volunteers	4
Bigger budget	1

Leader participant 1 described:

> *The solution here maybe lays in three points...the first is recruitment of the non-Saudi such as who from another Arabic country if any because they accept low income, and the second is to open the door to volunteers in this region, and the third is the plan to establish the sub-centres in the region.*

When discussing the need for sub-centres, patients' participants acknowledged that these centres would be a financial burden for the ministry of health (mentioned by all five patient participants).

Therefore, it was suggested that private funding could serve to support this need.

> *Yes, it will be a great burden, especially with the current financial allocations, so there should be contributions from the private investors and the business sector for the development of these services in the Al Baha region*. (Leader participant 2)

Obstacles to providing HHC services, as commonly noted by the patients' participants , included difficulty in reaching patients (geographically in terms of distance and terrain), financial limitations and burden, lack of personnel. These three obstacles were frequently mentioned together by the patient participants.

> *Frankly, the biggest obstacles are the lack of manpower and personnel, financial burden, then the difficulty of reaching (the patients).* (Leader participant 1)

> *Because this is one of the biggest obstacles we face in this region as well as the subject of reducing the cost and expenses is one of the major obstacles in terms of finding solutions that achieve the objectives of HHC program, was also added to*

the roads, especially mountainous regions and hard roads and most of the workers refused to go and spend these tasks without the extra money. (Leader participant 3)

Also mentioned were communication issues, cultural and religious limitations, lack of resources, and the need for training and education for staff and patients.

Yes, unfortunately, the biggest problem that we face in this area, particularly the ladies, as the religious, cultural, and social beliefs in the courtyard are in control of the actions and decisions, and the low wages for caregivers working in this field. ... I mean, the nature of society in the Al Baha region, the cultural and social aspects of tribal control somewhat dramatically (affect?) the nature of the work. (Leader participant 4)

Table 43 illustrates the frequency of the participant responses and the variety of the responses with regard to the perceived obstacles to providing HHC.

Table 43: Obstacles

Response	Number of patients' participants to offer this response
Difficulty reaching patients	5
Financial burden	5
Lack of personnel	4
Communication issues	1
Cultural and religious limitations	1
Lack of resources	1
Need for training and education for staff and patients	1

Specific to the sample population, the experiences of challenges associated with physically reaching the patients, whether due to distance, terrain, or other variables was

noted by all the leader patient participants, but not noted by the patients' participants in this study. Financial burden and lack of personnel are related, as leaders discussed difficulties obtaining personnel willing to meet the physical challenges of reaching the patients without extra pay of mention were communication issues, discussed later in this analysis, as well as cultural and religious limitations. Certainly, greater understanding between health care provider and patient through enhanced communication supports the efforts and benefits of HHC (Al Bwardi & Al-Megren, 2013).

6.24 Perceptions of Home Health Workers

Home health care workers were believed to have strong conviction and belief in the HHC objectives, to be very qualified and experienced in their work, and have a humanitarian motivation. All five patients' participants believed the HHC workers believe in their objectives and were highly qualified and experienced.

> Leader participant 5 noted the workers are "*selected and nominated by their superiors; they have a great desire and free choice without any pressure*." Participant 1 described in detail:
>
> *We pick and choose the team member carefully, where they have previous experience and a desire to develop their skills. [We] must provide specific conditions and standards in who will provide these services; for example, you must have experience and awareness are enough in such a region, and have a humanitarian motivation and a noble goal, and that the nomination managers, doctors, and defined social class scientific conscious, and to pass the tests and the period experimental work successfully*. (Leader participant 1

Table 44: Perceptions of Home Health Workers

Response	Number of patients' participants to offer this response
Believe in objectives	5
Qualified and experienced	5
Must have humanitarian motivation	2

6.25 Lack of Explanation of and Patient Understanding of Patient Rights

In the interviews with HHC leaders, the lack of explanation of and patient understanding of patient rights that was noted among the patient interviews was discussed. Although all five leaders interviewed expressed their respect for older patients and their right for care, the leadership offered their explanation for the apparent lack of awareness of patient rights and care options found among the patient sample. Findings indicated that this was felt to be due to the nature of Saudi society and culture, the newness of the HHC program, and the older age of the population.

The following examples demonstrate the participant responses related to this thematic category in terms of the nature of Saudi society. Participant 2 noted:

> *The nature of Saudi society is characterized by loyalty to the government, respect the laws, and this is due to many reasons such as religion and customs. It could be some patients are afraid to make any comments he might think that we will take any action against them such as higher services to them, but this is not true*. (Leader participant 2)

> *I think the nature of Saudi society and culture play a big role in this matter, especially since the target group are the older*. (Leader participant 4)

Another response was the newness of the program, as noted by participant 5:

> *This program is still new and we need a lot of seminars and awareness and guidance for everyone to recognize what it is and strive to spread of culture and awareness.*

Table 45: Patient Rights

Response	Number of patients' participants to offer this response
Respect for older patients and right for care	5
Lack of explanation of patient rights	5
Due to nature of Saudi society and culture	5
Newness of program	4

Due to older population	2

The lacks of explanation of patient rights to HHC services as well as the risks associated with long term hospital admission were noted by the patient interviewees in this present study. As noted in that discussion, these deficiencies represent a serious threat to the delivery of patient-centric care through the lack of education and transmission of information and patient rights of access to health care and preventative medical care, and regard for the needs and requirements of individual patients, including psychological needs and requirements for the complete healing process (Al-Helwagi, 2006; Charmel & Frampton, 2008; Epstein, 2005; Gasquet et al., 2005; Wolf et al., 2008). As noted in the patient interview section and reiterated here, the lack of information and communication with regard to the HHC program evidences that the patient-centred approach was not being successfully utilized. Within patient-centred care, the patient has the right to gain access to and be provided with a correct and true representation of the options available to him or her while exploring options for treating and healing the person's ailments (National Asthma Council Australia, 2007).

6.26 Patient Satisfaction

In general, the leadership felt the patients demonstrate satisfaction with HHC (as noted by all five patients' participants). Critical areas of patient care that seem to negatively affect patient satisfaction included the inability to meet patient desire for increased visitation of medical team, medication administration, provision of medical equipment, and assistance with transportation needs to hospital.

The general satisfaction was noted by all five patient participants. For example, leader participant 2 stated, "*I see that there is a sizeable proportion of satisfaction*."

Table offers the full variety of responses related to this thematic category along with the frequency of each response type.

Table 46: Patient Satisfaction

Response	Number of patients' participants to offer this response
Patients demonstrating satisfaction	5

Inability to meet patient desire for increased visits	5
Cannot meet due to low personnel and difficulty reaching patients	4
Difficulty reaching	2
Financial burden	1
Increase in number visits is the responsibility of doctor	1
Medication	5
Believe patients get their medications with help of family	5
Need for ability to dispense medication	3
Provision of medical equipment or other needs	5
Assistance comes from social affairs	5
Good proposal to coordinate with Ministry of development affairs	4
Trying to provide	4
Transportation to hospital if needed	5
Arranged transport to hospital if needed depending on patient condition or status	5
Cannot use ambulance because not under MOH	5
Suggested transport car will be considered	5
Patients without transportation must rely on family	4
Possible cooperation with other ministry like social, to support patient transport needs	1

Factors felt to affect satisfaction included the inability to meet the patient desire for increased visits, medication assistance, medical equipment availability, and transportation to the hospital, if needed.

Perhaps critical were the patient desire for increased visits and the inability of the HHC team to accommodate this request due to the previously noted obstacles of low staff, limited financial resources, and difficulty getting to the patients due to geography and terrain.

Participant 1 noted:

For increasing the number of visits, which represents the major problem and

> *demand the most of the patients, it is closely linked to the problems and constraints of the physical burden and the low number of labour and rugged roads.*

Transportation depends on the patient's status, and the cooperation and availability of family.

> *This is dependent on how is the patient's status...We are looking for the cooperation and understanding from the patients in this regard, maybe they will get assistance from their families*. (Leader participant 1)

According to Barnet (2012), six major factors are involved in determining the standard of health care from which satisfaction is gained, which include safety, effectiveness, family-centeredness, efficiency, equality, and timeliness. In terms of safety, patients must be kept from injury during provision of health care services. In addition, the services provided must benefit the patient (effectiveness) and must be delivered in a timely fashion and at the correct time (timeliness). The term family-centeredness refers to respect and proper response to the patient and family preferences, highlighting the importance of a patient-centred model. Efficiency is seen in the reduction of waiting time and delays, as well as the avoidance of wasted time, supplies, and equipment. Lastly, equality refers to non-discrimination, including geographic location (Barnet, 2012). The reported perceptions of patient satisfaction offered by the leadership in this study support these factors, as patients' participants suggested factors affecting patient satisfaction to be related to the inability to meet the patients' desire for increased visitation (impacted by financial resources, ability to geographically reach the patients, and availability of staff), provision of medication and medical equipment, and availability of transportation to hospital as needed. However, leader patients' participants generally felt patients were satisfied with HHC services, which aligned with prior research by Karlsson et al. (2003), who suggested that older people under HHC were more satisfied than those who were in the health care facilities. However, the authors noted the limitation that older patients in their homes were generally healthier than those in the health care facilities.

6.27 Solutions for Communication Issues

The patients' participants agreed upon several solutions for communication issues, which were primarily related to foreign HHC workers who are not fluent in Arabic and/or do not understand cultural and religious practices. All five patients' participants mentioned (a) that at least one person on the care team should speak fluent Arabic, (b) the hiring of foreign/non-Saudi workers from other Arabic countries (i.e., who are fluent in Arabic themselves), (c) the use of family members to help with communications, and (d) the need for additional training and education for both workers and families. Participant 2 noted, "*I think to resolve this issue, we can add one person at least in the care team is fluent in Arabic language*." For some patients' participants (three of the five), this one team member could come from other Arab countries. *These patients' participants described, "very nice to be foreign workers from Arab countries and this will ease the burden and solve the problem radically*" (Participant 1). The patients' participants also noted the need for a family member to help the patient understand, "*Here say that it must be a family member with the patient to understand things and connect to the patient*." Table provides an in-depth look at the responses related to the communication issues between patients and team members, particularly among the foreign staff. Training and education was another option.

> *There is a solution through foreign employment training and mastery of the Arabic language, but it will be very expensive, as I mentioned earlier or maintain the presence of Arabic-speaking one in every medical team of caregivers at least, that's enough.*

Table 47: Leadership Solutions for Communications Issues

Response	Number of patients' participants to offer this response
At least one person on team speaks Arabic	5
Hiring foreign workers/non-Saudi personnel fluent in Arabic/from Arabic countries	5
Use of family members to help with communications	5
Need for additional training and education	5

Need appropriate training and education for workers; working with older patients and culture; traditions	5
Need experience and awareness of region	3
Patient and family education	2

The importance of addressing communication issues in HHC services is critical. Prior research has suggested that patient adherence was affected by doctors who had training and experience in communication skills (Zolneirek & Kimatteo, 2009). Patients demonstrate higher confidence in doctors and improved quality of relationships with health care providers with enhanced communications (Zolneirek & Kimatteo, 2009). Also, patient-centred care is related to the degree of confidence patients have in their medical health providers (Gasquet et al., 2005). Although the HHC has the primary role in promoting patient comfort and recovery (Bergquist, 2005), the family role is critical in providing a broad range of services for the patient, including medication, physical therapy, personal care, meals, physical advancement, and psychological support (Byrne, 2009; Ramundo, 1995). As such, family engagement and education are critical to the success of HHC. Thus, the solutions offered by leadership align with the need for communication, family engagement, and education, as well as training and education for medical staff.

6.28 Recommendations for Improvement

The final thematic category among this participant group of leaders was defined by recommendations for improvement.Within this category, all five of the patients' participants agreed upon the following recommendations for improvement of the HHC.

- Increase the financial budget for home health department in Al Baha region.
- The provision of support the providers and aids to the success of HHC objectives.
- Educate the community members of all their rights and their needs especially when the patients are under HHC services.
- Train the health care staff to learn the use of local language (Arabic) as it will enable effective communication between service provider and patients.
- Provide the most and available medical devices if needs.

- Improve the quality of HHC services by sending the feedback from the older patients to policy makers in the future.
- -Engage the family member in this services by giving them useful information regarding HHC so they can assist the patients.
- Get the help from other sectors of another ministry to support the patients and HHC objectives.
- Send the update to HHC leaders by providing the new details or any issues that maybe affect or break the word.
- Revise the policy or rules of HHC and build future strategies for HHC continuously.
- Repeat this study in the future to find any differences especially for the new benefit of HHC.

In line with the patient-centric approach, adequate, continuous feedback from the variety of stakeholders is critical to providing thorough input on all the potential areas of improvement (Al Bwardi & Al-Megren, 2013).

6.29 Qualitative Leader Interview Summary

As with the patient interviews, the content analysis of the leader interview data revealed several overarching themes related to leadership perceptions of HHC services. These themes reflect the common experiences of the group as a whole. The following themes were revealed from the content analysis of the leader interviews.

- Perceptions of HHC as providing comprehensive medical care, education, and services to older, chronically ill patients, which serves to control repeat hospitalizations, provide more cost-effective care, reduce the burden on hospitals for the chronically ill, reduce the period of stay for patients, reduce rates of infection, improve psychological health of patients, maintain patient dignity, and generally provide care to supplement and support family care.
- The HHC program was perceived to cover roughly 70-75% of the region, with coverage affected by obstacles of physically reaching the patients (through often difficult terrain or distances), financial burden, and lack of personnel. Perceived solutions to limited coverage included establishing sub-centres, hiring non-Saudi staff, and the use of volunteers.

- HHC workers were described as well qualified and experienced staff, with humanitarian goals and a belief in the objectives of HHC.
- Despite a lack of explanation/understanding of patient rights (as reported by patients), leadership described a respect for older patients and the good for care, acknowledging that this limitation may be due to the newness of the program and or the nature of Saudi society and culture in which religion and customs support loyalty and respect for the government and laws.
- Proposed solutions for communication issues stemming from language differences of (a) having at least one member of the medical team fluent in Arabic, (b) hiring foreign personnel who are fluent in Arabic, (c) using family members to assist in communication, and (d) additional education and training.
- Overall recommendations for improvement in HHC of: continuously building strategies for HHC, community education of rights and needs, engagement of family, coordination with other sectors of ministry, improved quality of services through feedback from patients and policy makers, increase the financial budget for HHC in region, provision of medical devices, revision of policy and rules of HHC, update HHC leadership, support providers and aids, and repeating the current study.

6.30 Integration of Findings

Examining the data from both patient findings and leaders, several commonalities and differences are noted. Patient interviews provided insight into patient attitudes toward HHC and the experience of changing from the inpatient hospital setting to the home care setting. Patients demonstrated positive attitudes related to this shift, which was supported by perceptions of high-quality care, ease of services, and benefits associated with HHC, specifically the comfort and companionship of home and family. Patients also felt that although the hospital environment offered more services, the HHC provided better communication with medical staff, given the existing communication and cultural differences noted in both the hospital and HHC settings. This limitation on communications (primarily due to language and cultural difference) was felt by patients to be the main reason for the lack of information on the risks of extended hospital stays

and the benefits and use of HHC services. Leader's interviews highlighted the ability of the HHC program to serve roughly 75% of the region. Obstacles to providing HHC to patients including reaching the patients, financial limitations, and lack of personnel. To address these barriers, leaders in this study suggested the establishment of sub-centres, the hiring of non-Saudi staff willing to work for lesser pay, and the use of volunteers.

In describing HHC, both patients and leaders supported the provision of comprehensive care in the home. Leadership noted that these services support cost-effective care while reducing the burden on hospitals, as well as limiting repeat hospitalizations, infections, and period of stay for this population of chronically ill patients. Both leaders and patients described the HHC workers as competent, kind, and supportive of the HHC objectives. Communication issues, largely based on language differences between Saudi patients and non-Saudi staff, were noted by patients to contribute likely to the reported lack of information received from the HHC program as well as the risks of extended hospitalization and the benefits of HHC. Leader patients' participants noted that despite the lack of explanation and understanding of patient rights for care and availability of HHC services, older patients are respected and have the right to care. Acknowledging this limitation, leaders reported possible contributing factors to this knowledge gap of the newness of the HHC program and the nature of Saudi society. Saudi culture was seen as stemming from religion and social customs that support loyalty and respect for government laws.

Table 48 provides a comparison between patient interview thematic findings and leaders thematic findings. Finally, both leader and patients' participants were asked to detail their recommendations for improvement of the HHC program. Similar responses highlighted education and training for staff on Saudi culture and the Arabic language, engagement and education of patient families, and increased awareness of the HHC program. Finally, the leaders and patients suggested the following combined recommendations, some of which align with the existing literature and research.

Table 48: Comparisons between Patient Interview Findings and Leader Findings

	Patient Interview Findings	Leaders Findings
Attitude toward HHC, coverage of HHC, obstacles, and suggested solutions to impediments to providing HHC	Patient, positive attitudes toward the shift from hospital to HHC due to perceptions of quality of care, ease of services, and benefits of comfort and companionship at home Comparisons revealing more service availability and quality at the hospital, but better communication with home care, despite some issues surrounding communication and cultural differences	HHC program was perceived to cover roughly 70-75% of the region, with coverage affected by obstacles of physically reaching the patients (through often difficult terrain or distances), financial burden, and lack of personnel. Perceived solutions to limited coverage included establishing sub-centres, hiring non-Saudi staff, and the use of volunteers
Experiences and perceptions of HHC, HHC services and staff, and hospital services, obstacles to care	Home health experiences with multiple services provided in the comfort of the home and by kind, professional providers offering enhanced communications with patients, although some remaining communication gaps due to language and cultural differences Perceived benefits of being home with family,	Perceptions of HHC as providing comprehensive me dical care, education, and services to older, chronically ill patients, which serves to control repeat hospitalizations, provide more cost-effective care, reduce the burden on hospitals for the chronically ill, minimise the period of stay for patients, reduce rates of infection, improve psychological health of patients, maintain patient dignity, and generally provide care

	psychological benefits associated with the increased socialization, elimination of issues of boredom, and solutions to long wait times and difficulties in getting to the hospital. Inpatient hospital experiences of psychological distress and boredom, as well as communication issues due in large part to language and cultural differences, which also result in a perceived lack of information on the risks of extended hospital stays and the benefits and use of HHC services	to supplement and support family care HHC workers were described as well qualified and experienced staff, with humanitarian goals and a belief in the objectives of HHC Despite a lack of explanation/understanding of patient rights and HHC services available (as reported by patients), leadership described a respect for older patients and the right for care, acknowledging that this limitation may be due to the newness of the program and or the nature of Saudi society and culture in which religion and customs support loyalty and respect for the government and laws

Recommendations for improvement	Suggested improvements of more frequent visits with longer session times per visit, Arabic language and cultural training for foreign nurses, training for family members to provide crisis and first aid training, and increased awareness of program and risks of lengthy hospital stays	Proposed solutions for communication issues stemming from language differences of (a) having at least one member of the medical team fluent in Arabic, (b) hiring foreign personnel who are fluent in Arabic, (c) using family members to assist in communication, and (d) additional education and training. Overall recommendations for improvement in HHC of: continuously building strategies for HHC, community education of rights and needs, engagement of family, coordination with other sectors of ministry, improved quality of services through feedback from patients and policy makers, increase the financial budget for HHC in region, provision of medical devices, revision of policy and rules of HHC, update HHC leadership, support providers and aids, and repeating the current study

Chapter 7: Discussion

7.1 Introduction

Health 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. These services are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, staff, equipment, and drugs are combined to allow the delivery of health interventions (WHO, 2013). According to WHO regarding the human rights to get the health services, most countries around the world have established a legislations and as a legal duty to provide and improve comprehensive health services for public (Boyle, 2011). Considering the case of Saudi Arabia on its health system, being a developing country, the government is still struggling to ensure the provision of adequate health care services to people and thus increasing the life expectancy of Saudi people. The respective policies are specifically emphasized upon older people for they require more care and attention in their treatment than the younger ones. Thus, national and international health policy considerations have increasingly considered the older person. According to a report by the World Health Organisation (WHO, 2011), the developed and developing countries are working to provide either the best or an adequate range of health care services, which will lead to a significant rise in older populations in the coming decades. A range of therapeutic activities and temporary health care services make up the HHC services that are provided by qualified medical teams in the Kingdom of Saudi Arabia, either at the patient's home or the hospital. These are aimed at preserving health and promoting healthy living. In the last few decades, owing to the efforts of Ministry of Health, the development of health services in Saudi Arabia has seen much improvement in the quality and quantity of health services (MOH, 2010). Health services have been steadily improving, providing a good quality of service and rehabilitation in a growing number of hospitals (Strategy of MOH, 2010). There is increasing focus on the area of preventative medicine and nutrition for older people (MOH, 2010).

The HHC service in Saudi Arabia now comes under the overall health care being offered to individuals in their homes. This could encourage independence and a better quality of life for the patient (Mufti, 2000).

The promotion of HHC programmes became important in the late 1980s when demand for a reduction in long-term hospital bed occupancy and provision of nursing and medical care to patients in their homes arose (Jamal, 2011)This was followed by a call for the training of nurses and the continuing education of physicians to be integrated into the HHC services, which must respond to the growing need for professional health care workers in the field of HHC (William, Keenan, 1991). Currently, in the Al-Baha region, there are three government-sponsored HHC programs in hospitals and a few private services being offered in homes (Mufti, 2000). Nevertheless, there are many issues that could be detrimental to the health care system (MOH, 2011). These issues include the different roles of the Health Ministry, the variations in disease patterns, limited financial resources and the accelerating demand for HHC services (MOH, 2012). In this study, the major aim was to determine the degree of satisfaction with the services offered through the HHC system. Being a relatively newer concept to the country, there is a lack of significant research in this particular area. Thus, the current study was aimed at filling the research gap and investigate the factors which tend to influence the level of satisfaction of old age patients towards the HHC services provided by the Saudi system. To strengthen our understanding over the concept as well as to evaluate the existing information about it, a thorough literature review had been conducted on the three major themes i.e.

1- Ageing population

2- Patient satisfaction

3- Home health care

Further, a mixed method approach was employed to collect an insight to the current situation regarding the phenomenon in Saudi Arabia. It included in-depth interviews and an extensive survey to determine the views of patients regarding the services they are receiving and insight from five leaders who are responsible for HHC programme.

The results obtained from these were analysed and discussed. In the light of this assessment, proactive procedures will also be suggested to improve the current HHC services in the Al-Baha region of Saudi Arabia. The survey element of the study is based on an available sample of 410 older patients who use the HHC services in the Al-Baha region of Saudi Arabia. It comprises a cross-sectional survey.

For the collection of the survey data, a questionnaire designed by Westra et al. (1995) entitled the 'Home Care Patient Satisfaction Instrument - Revised (HCCSI-R)' was used. Data analysis included both descriptive and inferential statistical methods. Firstly, data on categorical variables like demographics (gender, education, and marital status) are presented using frequency distributions and pie charts. Data on quantitative interval scale variables like satisfaction level scores for different satisfaction items and overall satisfaction are summarized using measures of central tendency and dispersion including mean, standard deviation, minimum and maximum. Moreover, in the qualitative interviews of patients, consent to participate was obtained from a purposive sample of 15 older patients who received HHC services in the Al-Baha region, Saudi Arabia. The selection was made by information relevant to the main issues being investigated and is usually less than 30 cases (Lowhorn, 2007). That is, qualitative information will allow for finding out any relevant information that could be vital for the study and would not be covered by other survey instruments. Also, it tries to offer clarification and understanding of complicated psychosocial problems (Marshall, 1996) and to ensure the greatest transferability of outcomes. For this purpose, people from different socio-demographic backgrounds were selected. During the interviews, notes have been taken and documented, recording comments on tone, body language and face expression. In the next section, the tested hypotheses have been presented in the light of obtained results. Further, the implications for further research are discussed.

7.2 Review and Discussion of Main Conclusions of the Study

7.2.1 Quantitative results

It is important to consider these findings from the perspective of the common Saudi cultural arrangement in which women are subjected to certain limitations and are expected to have lesser social exposure. In this regard, the dissatisfaction of females with the quality and nature of services requires the concerned authorities to emphasize designing and managing the services as such to comply with the social environment of the recipients so as to ensure effective care to them.

Women in Saudi culture are expected to remain in a gender secluded environment in which they usually do not interact with the opposite gender. On the health care systems, it must be ensured that more female staff may be employed as health care service providers so that women may feel at ease during their treatment. It must be noted that the mentioned situation is unique to certain areas, though it has a general impact overall. The results showing married people being dissatisfied with the HHC services in comparison to single people stress upon the need to develop family-based plans and health care structures. Having a family to look after people and provide them with best facilities and care is always the foremost priority of caretakers or guardians. Thus, if the government and private authorities focuses on providing family oriented plans, health insurance policies and health care structures which may serve the whole family, it will enhance the satisfaction of married people. Moreover, educated people are reported as being more dissatisfied with the services than the uneducated ones. This may be because former category is more aware of their health conditions and the potential treatments. They are likely to be dissatisfied if being handled with negligence and carelessness. In addition to that, educated people are more concerned with the behaviour and attitude of service providers towards themselves or their patients. Thus, it is required to employ such staff who are loyal and considerate to their responsibilities as well as are effectively equipped with particular skills to satisfy the patients. About future studies, the new research should aim to investigate and describe the factors causing dissatisfaction among various categories of recipients of health care services. Researchers should attempt to conduct subject-specific studies which may be focused on a particular class of the population and on their demographics. Moreover, new policies may be designed, and improved health care structures may be developed, keeping in view the results of these studies so as to exclude the apprehensions of patients and enhance their satisfaction with the system. The authorities may develop a formal system to assess the opinion of the recipients of the health care services to make improvements in the existing structures accordingly. About overall satisfaction level to the services received by the population, the respondents showed considerable satisfaction with the services, i.e. mean value is 3.954

7.2.2 Qualitative results

As qualitative method of data collection, in-depth interviews were conducted with patients as well as health services leaders.

Interviews with Patients

With regard to in-depth interviews, the key issue identified by patients was that of language differences between patients and service providers at the hospital, a majority of whom are expatriates. This gives rise to some communication-related problems, including inability to effectively communicate with the staff, lack of knowledge regarding the HHC, thus risk to a longer stay at the hospital and psychological distress from being away from home. These deficiencies demonstrate serious threats to the delivery of patient-centric care. Literature demonstrates six specific elements which are:

- education and transmission of information and know-how,
- acknowledgement and support for family and friends contributing significantly to the patient's mental welfare,
- efforts at synchronization and coordination of care,
- consideration of extraneous factors,
- understanding and considering patient preferences and choices, and
- providing the availability of information, knowledge, and understanding to flow freely (Al-Helwagi, 2006).

Secondly, regarding HHC experience, patients discussed their feelings about moving from the hospital to the home environment, the home care services received, and the difficulties faced with HHC. In this regard, patients showed that they feel secure for being at home, as they are closer to their family as well as in a familiar environment. According to the literature reviewed, the home care system serves to provide proper health care to patients in their own homes, to improve the levels of security and confidence of the family members of patients, and to help the patients recover in a better way, both physically and mentally (National Committee for Quality Assurance, 2008). The findings of this qualitative analysis support these assumptions in that patients

participants discussed the psychological benefits, particularly about being home for this specific population in Saudi Arabia. In line with patient-centric approaches, adequate, continuous and proper feedback would have to be obtained from the people accessing the system, so as to have more thorough input on all the potential areas of improvement (Al Bwardi & Al-Megren, 2013). This requires the concerned authorities to emphasise more upon developing and improving HHC systems so that to ensure the provision of health care services to patients while retaining their comfort level. Further, the third theme was regarding the description of services received by patients in HHC services. According to the participant interviews, the services provided by HHC included checking vital signs and blood chemistry, provider visits, treatments, physiotherapy, skin ointments and treatments, and special dietary instructions or nutrition education. On the basis of these interviews, the problems faced by patients while receiving services from HHC were majorly comprised of:

a) the irregularity of services and the need for increased visits and time at each visit
b) the difficulty in communicating when the provider did not speak Arabic
c) Difficulties getting to the hospital for tests, x-rays, etc., which was felt to be possibly remedied by the use of ambulances for these services
d) HHC did not provide the quality of care expected

Future research can be based on collecting people's opinion regarding the particular services they have been receiving and as per their perceptions, make improvements in the quality as well as the number of services offered to the patients.

The next theme was to suggest for potential improvements in the HHC services. The patients' responses can be summarised as:

a) an increase in the number of visits and the time for each session/visit
b) providing training to the providers in Arabic language and culture
c) providing training to family members to handle crises and home first aid

It was highlighted in the literature that patient-centeredness also reflects on the doctor–patient encounter characterized by responsiveness to patient needs and preferences

(Safran et al., 2005). Within a patient-centred approach, the patient is empowered by expanding his or her role in their health care. Supporting the patient in become more informed, and providing reassurance, support, comfort, acceptance, legitimacy and confidence are the basic functions of PCC (Fulford et al., 1996). The impact of the goals of PCC has a direct logical link with promoting healing and reducing injury and suffering (Nelson & Gordon, 2006). Although there is no globally accepted definition of PCC (International Alliance of Patients' Organisations 2007), the core elements of respect for the patient, his or her values, and choices, and effective communication feature in most descriptions of PCC and the findings of this qualitative portion of the study support these elements. Lastly, the final theme for the patients' interviews was to draw a comparison between hospital-based health care services and HHC services. Overall topics for this thematic category highlighted that although the hospital was perceived to provide more services, the HHC services offered benefits of enhanced communication through the use of family members if necessary; potential issues with providers failing to demonstrate respect for cultural or religious customs. These findings support the need for better patient-centred care practices. These can be focused on patient needs through appropriately addressing cultural and/or religious customs so as to meet truly the basic elements of patient-centred care, with a focus on the patient's well-being and specific needs (Al-Helwagi, 2006; Epstein, 2005; Gasquet et al., 2005). This will help to achieve the benefits of the model regarding patient satisfaction, compliance, and continuity of care (Bauman, 2003; Lau, 2002; Wolf, 2008).

Interviews with Health Services Leaders

Moreover, five interviews were conducted with home health services leadership. The patient leadership participants offered their perceptions of HHC and the benefits of providing this care to patients. Key common responses highlighted themes of:

a) providing medical services and nursing to patients with chronic disease, older patients, and those needing constant nursing care
b) controls repeat hospitalizations and ER visits for this population of patients

c) improves the psychological situation for patients, offering a sense of security and comfort to patients by being with family
d) provides care and education to supplement and support family care
e) maintains patient dignity
f) provides cost-effective care
g) reduces the burden on hospitals to the car for chronically ill
h) reduces the period of stay in the hospital for patients
i) reduces rates of infection

These perceived benefits align with claims made by the Ministry of Health (Seavey, 2010). Leader perceptions of HHC as providing comprehensive medical care to patients in their homes, helping patients to recover both physically and mentally, was supported by the patient perceptions in this current study and by the literature (National Committee for Quality Assurance, 2008). Leadership patients' participants described the services provided through HHC.

The commonly cited services included:

a) assessment, treatment, and follow-up;
b) prescribing and dispensing of medication;
c) providing nursing care and comprehensive health care services; and
d) Providing patient and family education.

The leadership patients' participants described the current coverage as providing care for about 70-75% of the area. This includes a range of no more than 50 KM for HHC services. To improve the coverage for HHC, patients' participants suggested three primary solutions, which included the establishment of sub-centres, hiring non-Saudi staff who will accept lower pay and the use of volunteers. The need for a larger budget was also stressed. Regarding HHC service providers, the leadership patients' participants showed significantly positive perception providing that they be well equipped in their particular field of operations. They are reported to be selected by skills and proficiencies; hence, the ones who are currently serving in the field are the best ones among their peers.

However, to further enhance their abilities, the participants suggested developing training programs and taking significant measures to help them learn more about their job, particularly to be able to overcome the pertaining issues and barriers to the provision of health care services. In the interviews with HHC leaders, the lack of explanation of and patient understanding of patient rights that was noted among the patient interviews was discussed. Findings indicated that this was felt to be due to the nature of Saudi society and culture, the newness of the HHC program, and the older age of the population. The lacks of explanation of patient rights to HHC services, as well as the risks associated with long-term hospital admission, were noted by the patient interviewees in this present study. As pointed out in that discussion, these deficiencies represent a significant threat to the delivery of patient-centric care through the lack of education and transmission of information and patient rights of access to health care and preventative medical care, and regard for the needs and requirements of individual patients, including psychological needs and requirements for the complete healing process (Al-Helwagi, 2006; Charmel & Frampton, 2008; Epstein, 2005; Gasquet et al., 2005; Wolf et al., 2008). As noted in the patient interview section and reiterated here, the lack of information and communication concerning the HHC program provides evidence that the patient-centred approach was not being successfully utilized. Within patient-centred care, the patient has the right to gain access to and be provided with a correct and genuine representation of the options available to him or her while exploring options for treating and healing the person's ailments (National Asthma Council Australia, 2007). The reviewed literature showed that six major factors are involved in determining the standard of health care from which satisfaction is gained, which include safety, effectiveness, family-centeredness, efficiency, equality, and timeliness (Barnet, 2012). This provides that patients must be kept from injury during provision of health care services. Also, the services rendered must benefit the patient (effectiveness) and must be delivered in a timely fashion and at the correct time (timeliness). The term family-centeredness refers to respect and proper response to the patient and family preferences, highlighting the importance of a patient-centred model. Efficiency is seen in the reduction of waiting time and delays, as well as the avoidance of wasted time, supplies, and equipment.

Lastly, equality refers to non-discrimination, including geographic location (Barnet, 2012). Moreover, this complies with the patient-centred care theory as well.

The patients' participants agreed upon several solutions for communication issues, which were primarily linked to foreign HHC workers, who were not fluent in Arabic and/or did not understand cultural and religious practices. All five patients' participants mentioned that

a) at least one person on the care team should speak fluent Arabic,
b) the hiring of foreign/non-Saudi workers from other Arabic countries (i.e., who are fluent in Arabic themselves),
c) the use of family members to help with communications, and
d) the need for additional training and education for both workers and families

The leadership participants suggested the following recommendations for improvement in HHC of continuously building strategies for HHC, community education of rights and needs, engagement of family, coordination with other sectors of ministry, improved quality of services through feedback from patients and policy makers, increased financial budget for HHC in region, provision of medical devices, revision of policy and rules of HHC, up to date HHC leadership, support providers and aids, and repeating the current study.

7.5 Summary

To sum all, it can be asserted that the pertaining study highlighted a number of useful areas regarding the application of HHC services in the Saudi society with regard to the cultural as well as organisational limitations. The research instruments were targeted to obtain opinion of both patients i.e. the receivers of already offered services as well as of the service providers .This helped in connecting the perception of both sides involved, so as to devise a new system which may address the requirements of an effective healthcare system. The findings are indicative to the needs for future search especially in another different theories which maybe Highlight on the understanding the cultures differences .Thus, it has been provided that as HHC services are targeted to serve older population more than the rest, the respective staff must be understanding towards the fact that older

generation usually take more time to adapt to new systems than youngsters, thus they must be treated with patience and care so that they may not get annoyed with the course of action and refrain from getting their treatments. Thus, the health care staff may be given considerable training to understand the societal, cultural and religious aspects of the respective patients. This would allow them to offer care and assistance to patients in compliance with their social practices. This would consequently enhance patients' satisfaction, as well as the quality of HHC services.

Chapter 8: Conclusion

Ensuring the provision of healthcare services to people is among the foremost responsibilities of the concerned authorities in any country. In Saudi Arabia, the concept of Home Health Care (HHC) was introduced in the late 1980s when demand for a reduction in long-term hospital bed occupancy and provision of nursing and medical care to patients in their homes arose (Jamal, 2011). This was followed by a call for the training of nurses and the continuing education of physicians to be integrated into the HHC services, which must respond to the growing need for professional Health care workers in the field of HHC (William, Keenan, 1991). Currently, in the Al-Baha region, there are three government-sponsored HHC programs in hospitals and a few private services being offered in homes (Mufti, 2000). This study was aimed at filling the research gap and investigates the factors which tend to influence the level of satisfaction of old age patients towards the HHC services provided by the Saudi system, which still are considered as rather a non-conventional practice in the region. Mixed method approach was employed to study the pertaining field using both qualitative as well as quantitative methods of data collection. As per the responses, it was obtained that level of satisfaction with respect to the quality of healthcare services being offered in the region, is higher among the males in comparison to females. In the similar manner, well-educated populaces seemed dissatisfied with the level of care being provided by healthcare authorities. The former case indicates towards the lack of cultural competence of healthcare systems in the region. Saudi Arabia is predominantly a region where gender differences exist considerably in all fields of life. Thus, dissatisfaction of women towards the existing system shows that the system is being unable to cater to the female population as per their cultural settings and values. This raises the need for improvement in the system in this regard, i.e. to make the home health care system as more culturally competent. In the second case, it can be deduced that having entered an era of advanced awareness and availability of information, people are now aware and insightful of systems and procedures. Moreover, exposure to external world makes them aware about the workability of various processes in the other parts of the world. This drives them to compare their persisting situations with that being practiced elsewhere. As a result,

whenever systems show any limitation or do not work as per the standards, there is a drastic impact upon the level of satisfaction with the respective system. Thus, this stresses upon the authorities to make the HHC systems effective enough to meet the international standards so as to offer health care services to their fullest potentials.

The qualitative design of the study was aimed at obtaining the opinion of both patients as well as HHC leadership regarding the following themes:

- Inpatient hospital experience
- Home health care experiences
- Perceived benefits of HHC
- Suggested improvements
- Comparing hospital and HHC

On the first theme, the key issue identified by patients was that of language differences between patients and service providers at the hospital, a majority of whom are expatriates. This gives rise to some communication-related problems. This includes an inability to effective communication with the staff, lack of knowledge regarding the HHC, thus risk to a longer stay at the hospital and psychological distress from being away from home. These deficiencies demonstrate serious threats to the delivery of patient-centric care. Secondly, regarding HHC experience, patients discussed their feelings about moving from the hospital to the home environment, the home care services received, and the difficulties faced with HHC. In this regard, patients showed that they feel secure at home as they are closer to their family as well as in a familiar environment. According to the literature reviewed, the home care system serves to provide proper health care to patients in their own homes, to improve the levels of security and confidence of the family members of patients, and to help the patients recover in a better way, both physically and mentally. Further, the third theme was regarding the description of services received by patients in HHC services. According to the participant interviews, the HHC included checking vital signs and blood chemistry, provider visits, treatments, physiotherapy, skin ointments and treatments, and special dietary instructions or nutrition education.

The common responses regarding the perceived benefits of HHC services include:

a) relief from the boredom of the hospital,
b) not having to wait long periods of time for the doctor,
c) psychological benefits of being at home,
d) not having to go to the hospital, as this was difficult,
e) the ability to better understand HHC providers, and
f) Being with family.

The next theme was to suggest for potential improvements in the HHC services. The patients' responses can be summarised as:

a) an increase in the number of visits and the time for each session/visit,
b) providing training to the providers in Arabic language and culture, and
c) Providing training to family members to handle crises and home first aid.

Lastly, the final theme for the patients' interviews was drawing a comparison between hospital-based health care services and HHC services. Overall topics for this thematic category highlighted that although the hospital was perceived to provide more services, the HHC services offered benefits of enhanced communication through the use of family members if necessary; while there were potential issues with providers failing to demonstrate respect for cultural or religious customs. These findings support the need for better patient-centred care practices. These can focus on patient needs through appropriately addressing cultural and/or religious customs so as to meet truly the basic elements of patient-centred care, with a focus on the patient's well-being and specific needs (Al-Helwagi, 2006; Epstein, 2005; Gasquet et al., 2005). This will help to achieve the benefits of the model regarding patient satisfaction, compliance, and continuity of care (Bauman, 2003; Lau, 2002; Wolf, 2008).

Interviews were conducted with leadership of HHC, and were based upon the following themes of discussion:

- Perception of HHC
- Services provided

- HHC coverage and obstacles to providing care
- Perception of HHC workers
- Lack of information to patients' rights
- Patient satisfaction
- Solutions for communication issues
- Recommendations for improvement

In general, the leadership felt that the patients demonstrate satisfaction with the HHC. Critical areas of patient care that seem to affect patient satisfaction negatively included:

- the inability to meet the patient desire for increased visitation of the medical team,
- medication administration,
- provision of medical equipment, and
- assistance with transportation needs to hospital

The reviewed literature asserted that six major factors are involved in determining the standard of health care from which satisfaction is gained, which include safety, effectiveness, family-centeredness, efficiency, equality, and timeliness (Barnet, 2012). This provides that patients must be kept from injury during provision of health care services. Also, the services rendered must benefit the patient (effectiveness) and must be delivered in a timely fashion and at the correct time (timeliness). The term family-centeredness refers to respect and proper response to the patient and family preferences, highlighting the importance of a patient-centred model. Efficiency is seen in the reduction of waiting time and delays, as well as the avoidance of wasted time, supplies, and equipment. Lastly, equality refers to non-discrimination, including due to geographic location (Barnet, 2012). Moreover, this complies with the patient-centred care theory as well.The leadership participants suggested for the following recommendations for improvement in the HHC: continuously building strategies for the HHC, community education of rights and needs, engagement of family, coordination with other sectors of ministry, improved quality of services through feedback from patients and policy makers, increase in the financial budget for HHC in region, provision of medical devices, revision of policy and rules of HHC, updating the HHC leadership, support providers and aids,

and repeating the current study.In Saudi Arabia, HHC services for older people were initiated in 2010 and are thus, relatively new. Presently, there is sparse research regarding older people in Saudi Arabia, which implies a dearth of research on HHC services. This research examines the way HHC services are delivered and the obstacles which stand in the way of this delivery. The study outlines the present situation of the new HHC services being provided to older people in Saudi Arabia, with a specific focus on the view of the patients. Indeed, this will aid health care providers in enhancing their HHC services and improving the current strategies at management level, serving in turn as a basis for further research in Saudi Arabia. Thus, the aim of this research is to identify the ideal method of quality care provision within better health services. This approach will be culturally sensitive to the religion and beliefs of by far the majority of people in Saudi Arabia. This aspect is significant for the older population in Saudi Arabia who are comparatively watchful of their religion and culture.

8.1 Limitations

This study was conducted with a limited population and sample size, as well as the characteristics of the selected participants, because the study is newest in Al Baha region in Saudi Arabia, especially in this field including the nature and culture in Al Baha region. This has limited the generalizability of results to be implicated on a broader level in a future study. Moreover, it was unfamiliar for the respondents who made it quite difficult to obtain their responses, clearly owning to the difference in culture, religion, and ethnographic characteristics. However, regardless of facing these limitations, this study was conducted in the best possible manner and was intended to explore all the relevant fields so as to obtain significant knowledge. This information can serve as the foundation for further studies in future as the respective area has not been subjected to academic research yet.

8.2 Concluding Remarks and Recommendations

This study was aimed at investigating the currently employed health care services supported by the Saudi government and private organisations in Saudi Arabia regarding their functionality and effectiveness. Ageing population and patients' satisfaction with

HHC are discussed in this regard. The theory of patient-centred care within the perspective of its application to the health system by the Ministry of Health in Saudi Arabia is also reviewed. The findings of the quantitative part of this study showed that there is high contentment amongst patients concerning the HHC services being provided in Al-Baha. This is indicated in the findings which reveal that 99.3% of respondents would recommend the service to other older people, while a mere 0.7% of people would not. Further, the results of qualitative interviews revealed several overarching themes related to providers' perceptions of home health services. These topics reflect the common experiences of the group, such as the Perceptions of HHC services, as providing comprehensive medical care which serves to provide the effective care, reduce the burden on hospitals for the chronically ill, minimise the period of stay for patients, reduce rates of infection, improve psychological health of patients, and maintain patient dignity. The study is significantly appropriate to be employed in the practical field as it encompasses analytical data obtained through methodological procedures, the results of which are supported by theoretical evidence. It may serve as the foundation for future studies as by far, this is likely to be the first one in the respective field.

8.3 Recommendations for future research

The following recommendations are offered for related studies in the area of HHC services on older people;

- The research may be employed with a larger population and broader sample sizes so as to attain a more generalized perspective.
- Patient satisfaction is impacted by some factors. In future research, the researchers may study each of these factors individually to obtain a more thorough insight into the subject at hand.
- Owing to the subjective nature of the topic, as well as being a sensitive matter, more focus may be given to the in-depth qualitative studies so as to collect detailed data.
- Studies may be conducted to access the functioning of the different departments of HHC services along with specific dimensions of the fields so as to identify the pertaining deficiencies in the system.

8.4 Recommendations for service providers

- Keeping in view the universality of the area of health care service, the service providers may be trained as per the presumptions of patient-centred care theory, and other theory which related to Culture Care so that they may be able to perform effectively when in practice also for future strategy.Patient feedback should frequently be collected to improve the existing structures.
- Patients should be treated in compliance with their respective cultural arrangement to maintain their comfort level.

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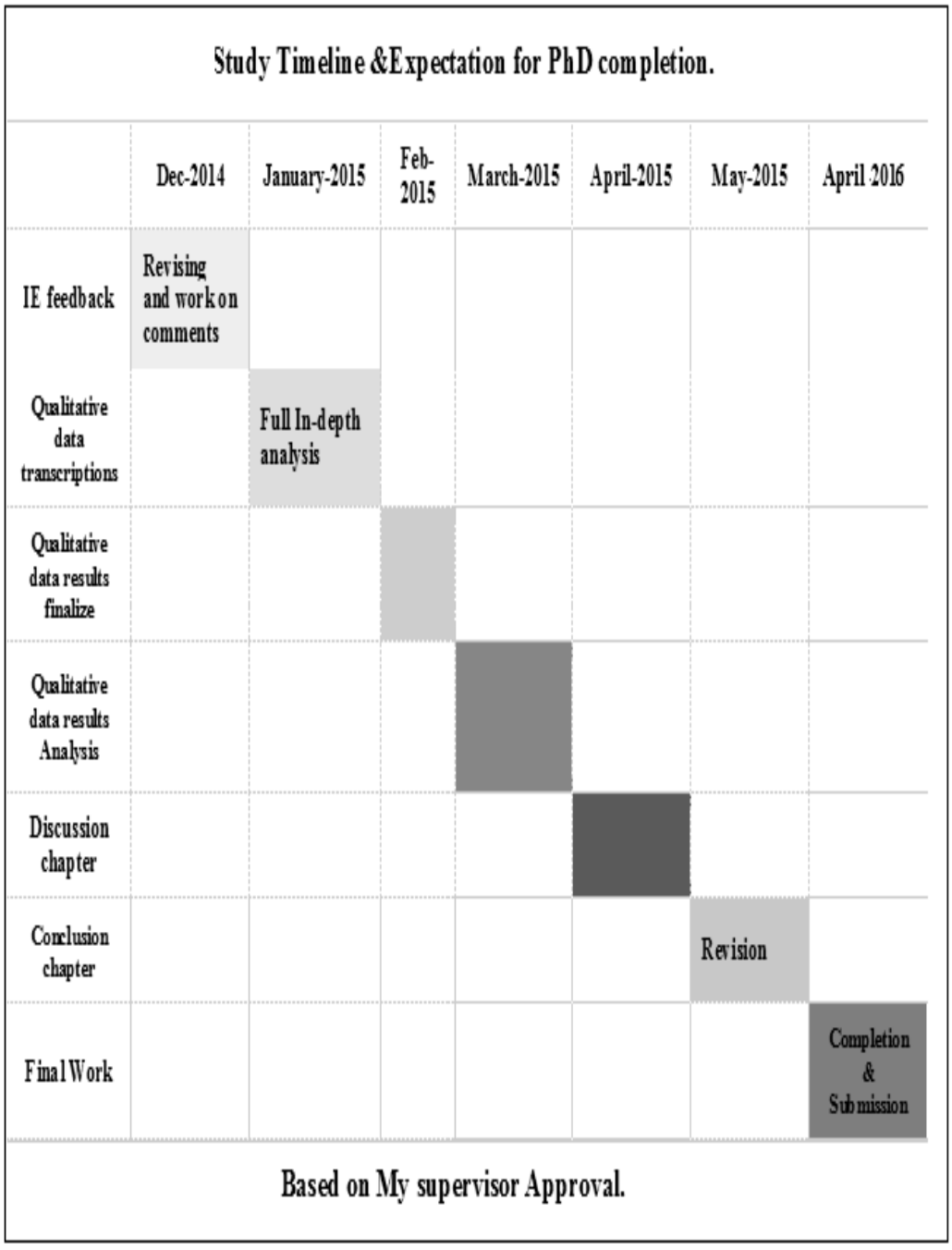
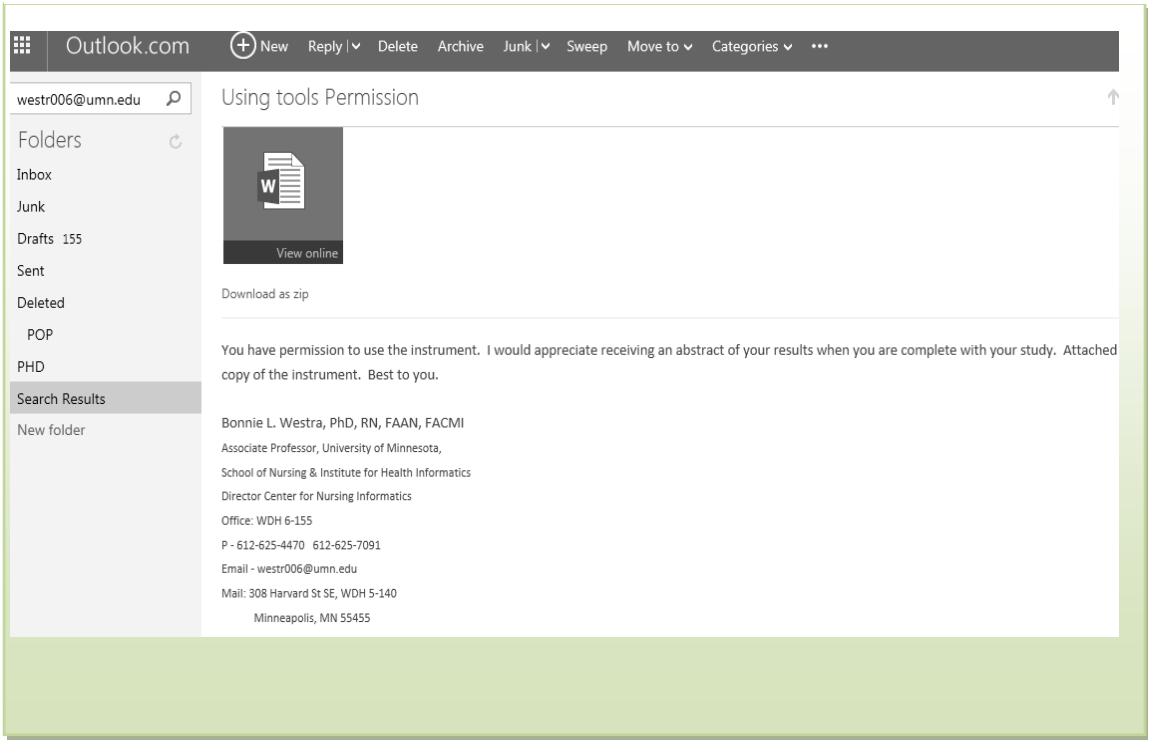
Appendix

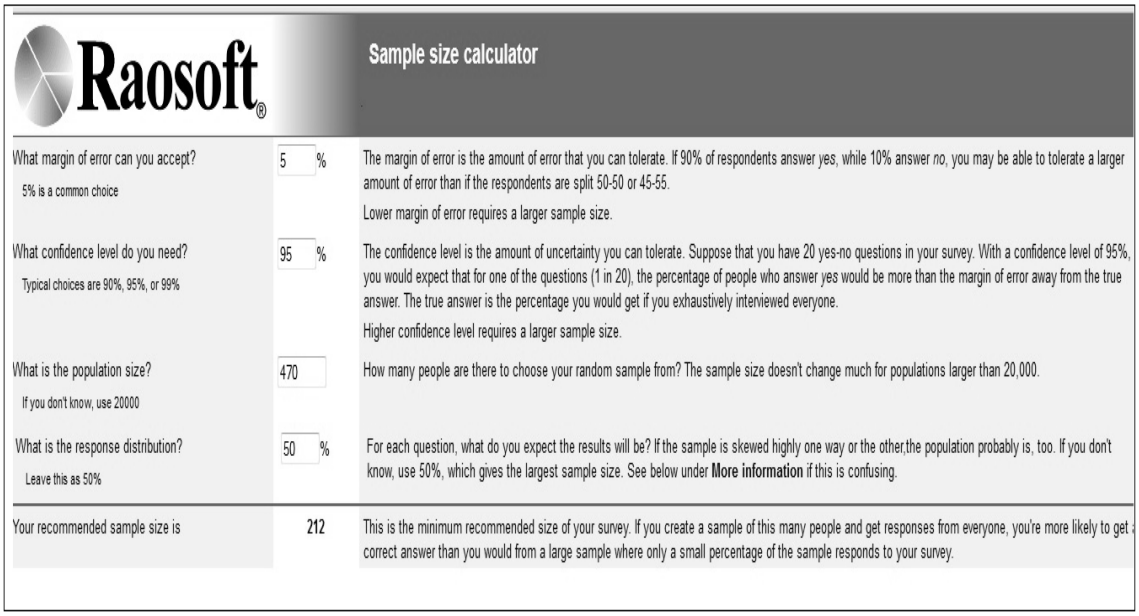
A. Study Timeline & Expectation Date



B. Permission to use the Survey



C. Sample size Calculation



D. Ethics Approval from Salford University

University of Salford MANCHESTER

Research, Innovation and Academic Engagement Ethical Approval Panel

College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU

T +44(0)161 295 7016
r.shuttleworth@salford.ac.uk

www.salford.ac.uk/

6 August 2013

Dear Soltan,

RE: ETHICS APPLICATION HSCR13/23 – Older patient satisfactions with home health care services in Albaha region, Saudi Arabia

Based on the information you provided, I am pleased to inform you that application HSCR13/23 has now been approved.

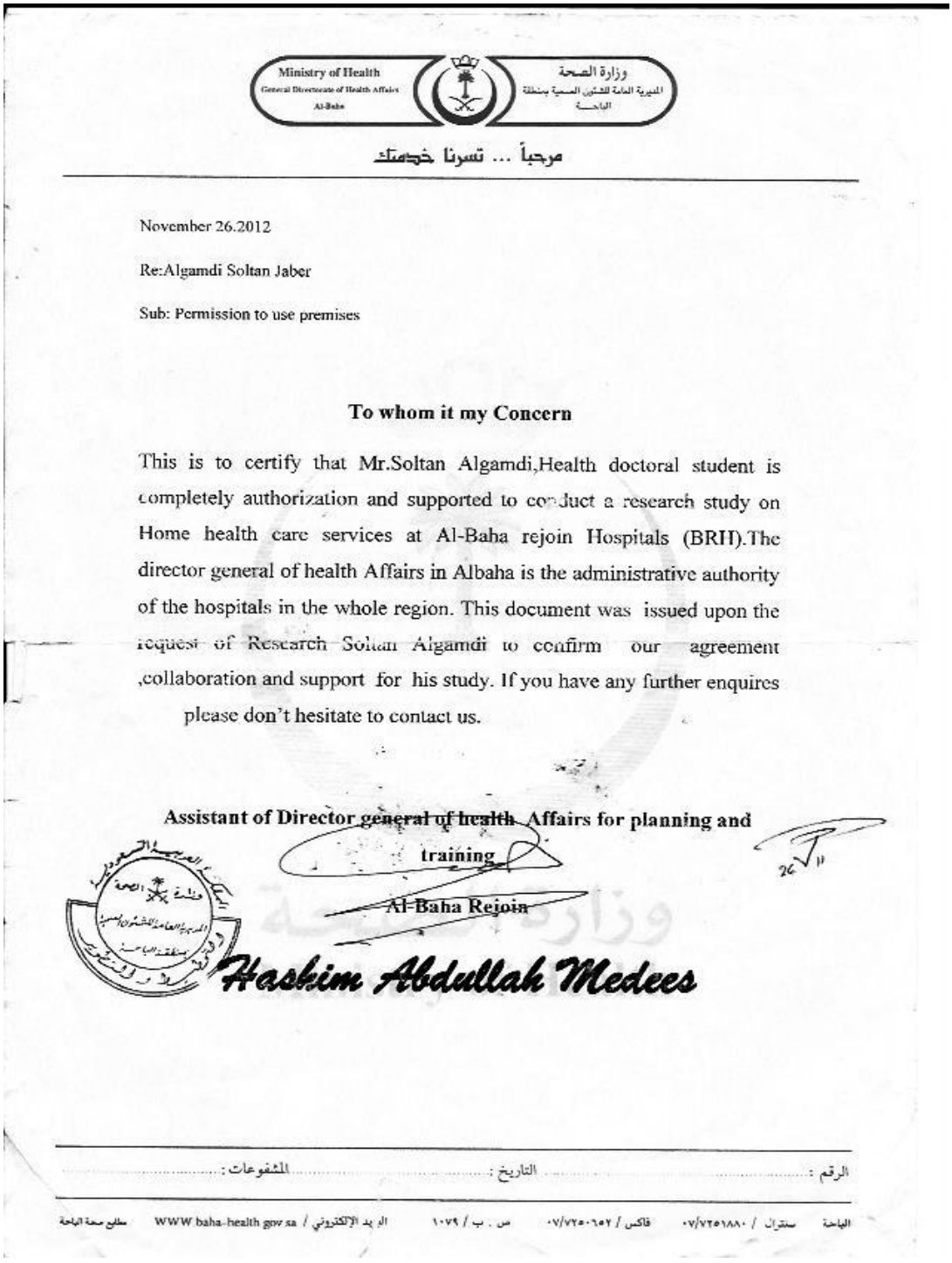
If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

E. Permission approval of Ministry of health in Albaha sector



Ministry of Health
General Directorate of Health Affairs
Al-Baha

وزارة الصحة
المديرية العامة للشئون الصحية بمنطقة
الباحة

مرحباً ... تسرنا خدمتك

November 26.2012

Re:Algamdi Soltan Jaber

Sub: Permission to use premises

To whom it my Concern

This is to certify that Mr.Soltan Algamdi,Health doctoral student is completely authorization and supported to conduct a research study on Home health care services at Al-Baha rejoin Hospitals (BRH).The director general of health Affairs in Albaha is the administrative authority of the hospitals in the whole region. This document was issued upon the request of Research Soltan Algamdi to confirm our agreement ,collaboration and support for his study. If you have any further enquires please don't hesitate to contact us.

Assistant of Director general of health Affairs for planning and training

Al-Baha Rejoin

Hashim Abdullah Medees

الرقم : ..... التاريخ : ..... المشفوعات : .....

الباحة سنترال / ٠٧/٧٢٥١٨٨٠ فاكس / ٠٧/٧٢٥٠٦٥٢ ص . ب / ١٠٧٩ البريد الإلكتروني / WWW baha-health gov sa مطبع صحة الباحة

F. Approval from Research committee, Albaha hospitals

M.O.H
General Directorate Of Health Affairs Al-Baha
Subjective Operating program
King Fahad Hospital At Al-Baha

وزارة الصحة
Ministry of Health

وزارة الصحة
المديرية العامة للشئون الصحية بمنطقة الباحة
برنامج التشغيل الذاتي بمستشفى الملك فهد
بالباحة

مرحباً . . . تسرنا خدمتك

Research Committee

Subject : Approval of Research Proposal

The Research and Ethical Committee had given approval to conduct the Research of :

"Elderly Patient Satisfaction with Home Health Care in Al Baha"

1. This approval is valid for 6 months starting ***1 November 2013***. The research will be monitored by the Research Committee all during this period and at its end.
2. The Main Investigator (***Mr. Soltan Jaber Al Ghamdi***) has to arrange with the Home Health Care office for the distribution and collection of the data sheet.

Dr. Ali Saeed Dammas
Chairman, Research & Ethical Committee
Director, Academic Affairs & Training Center

الرقم : ..... التاريخ : ..... المرفقات : .....

P.O.box 204 ص . ب FAX (07)7251732 فاكس TEL (07)7254000 تلفون

G. The Questionnaire which used in This Study and Interveiw questions

HCCSI – R

Home Care Client Satisfaction Instrument

After each question, please circle one answer, which best represents how satisfied you are with that issue.

1. How satisfied are you with the helpfulness of the office staff?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

2. How satisfied are you with the staff's attention to your concerns?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

3. How satisfied are you with the dependability of the staff?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

4. How satisfied are you with the respect shown to you by the staff?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

5. How satisfied are you with the staff's knowledge of your health problems?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

6. How satisfied are you with having choices about your care?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

7. How satisfied are you with how safe you felt when care was provided?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

8. How satisfied are you with knowing who to contact if you had a problem?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

9. How satisfied are you with the ability of the agency to meet your needs?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

(2)

10. How satisfied are you with the staff's response to your concerns?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

11. How satisfied are you with being able to schedule care at the times you wanted?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

12. How satisfied are you with having the same people consistently?

Very Satisfied Satisfied Uncertain Dissatisfied Very Dissatisfied

13. Please circle a number from 1 to 10 that best represents how satisfied you were with the agency's ability to meet your expectations for care.

Very Satisfied 1 2 3 4 5 6 7 8 9 10 Very Dissatisfied

14. Please circle a number from 1 to 10 that best represents how satisfied you were with your overall care.

Very Satisfied 1 2 3 4 5 6 7 8 9 10 Very Dissatisfied

15. Please circle how likely are you to recommend to others the home care agency with 1= Definitely would not recommend and 10= Absolutely would recommend it.

Would not recommend 1 2 3 4 5 6 7 8 9 10 Absolutely would recommend

Do you have any other comments about the care your received?

Thank you for completing this questionnaire. Your opinion is important to us in evaluating the quality of care provided.

Westra, B.L., Cullen, L., Brody, D., Jump, P., Geanon, L., & Milad, E. (1995). Development of the home care client satisfaction instrument. Public Health Nursing, 12(6), 393-399.

Interview Questions

Individual Meeting:

Date: March-2014

Location: Al-baha rejoin

Length: [00:00:00]

Interviewee:

Interviewer: Soltan

Transcriber:

I = interviewer question. P = response.

I: Salam (Hi) and thank you for participating in this interview.

I: OK, before we begin the interview itself, I'd like to confirm that you have agreed and approved the informed consent form, that you understand that your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at anytime.

I: Do you have questions before we proceed?

I: As I said, this interview is going to be used to improve home health care services which you received from service providers. Rest assured that I will not use your name unless you would like me to.

I: So, this is the first interview I've done. I am really asking people who've received home health care services to say a bit about being on home health services. So could I just ask you, to begin with, where you were before you started to get health services at home?

I: could you tell me, any prevention of (.....) do you have?

I: Sorry to hear this. Could you tell me what happened after you were admitted to ….?

I: May I ask why you were upset?

I: Is there nurses and others from social health department in the Hospital that they talk to you?

I: Okay, why you needed to be discharged from hospital to go to home ?

I: What did you feel when they moved you from hospital to your home?

I: Did you receive any information about home health care services before you were discharged from hospital, such as what is HHC and what was the reason for discharging you?

I: Did they tell you, what were the risks of keeping you in hospital for a long time?

I: Did you know it is good to keep you at home to save you from any infection?

I: Do you know that it is good to keep you close to your family instead of in hospital?

I: What sorts of home health care services do you receive?

I: Are there any another services or benefits that you receive when the providers come to your home?

I: Can you tell me what you like most about home health care services?

I: Can you tell me why you want ……..

I: what do you like most about the providers from the home health care department? Or is there a big difference between the providers in hospital and Providers at home? Is that the same question to you?

I: You are free, and have a right, to say what you think. I guarantee this.

I: Is there any another difficulty?

I: why you did not study reading before ☺ ? Just joking

I: What are your comments on the regularity f these services? Are there enough?

I: Is there any problem with other providers?

I: I will discuss your comment with HHC providers but could you tell me what you think about if you need more medical examination such as X- rays or test labor something extra?

I: I don't know but it is very interesting point ……., I will discuss this with them.

I: Is there anything else that you would like to add?

I: Well, thanks for taking the time to talk with me today. I really appreciate it.

H. Conference 1

I. Conference 2

The MacroTrend
Conferences, Paris 2014

The Journal of MacroTrends in Health and Medicine

Damir Tokic
MacroJournals Editor-in-Chief and Conference Chair
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Roquebrune Cap Martin
06190 France
+33 (0)6 01671877
tokicd@macrojournals.com

October 6, 2014

Soltan Jaber Algamdi
University of Salford
Manchester, UK
Abstract: Elderly Patients satisfaction with Home Health Care Program in Saudi Arabia

Subject: Letter of acceptance (invitation)

Dear Soltan Jaber Algamdi,

Your article/abstract has been peer-reviewed and accepted for an oral presentation (or poster if requested) at **the MacroTrend Conference on Health and Medicine: Paris 2014**, which will be held on December 19-20, 2014 in Paris, France.

The conference venue is: ESPACE VOCATION PARIS HAUSSMAN SAINT-LAZARE 92, rue Saint-Lazare 75009 Paris. Publishing opportunity for full papers: *The Journal of MacroTrends in Health and Medicine*. All abstracts will be published in the conference proceedings. The conference registration fees are $450 ($370 students and $250 for each attending co-author). Please visit our payment site for more info: http://www.macrojournals.com/payments. Also, please visit the conference webpage for more info about the venue area for booking a hotel, and important dates/deadlines: http://www.macrojournals.com/paris/health_and_medicine

We welcome you to the conference and looking forward to your intellectual contribution.

Best regards,

Dr. Damir Tokic

J. HHC Workshop

الطب المنزلي
Home Medical

General Directorate of Health Affairs, Al-Baha

Baljurashi General Hospital

وزارة الصحة
Ministry of Health

Certificate of Participation

This is to cerlify that

SOLTAN JABER ALGAMDI

Has successfully participated in

Home Health Care Workshop

On 29 September 2013 / 23 Dhu-alqadah 1434

Date issued: 30 Sept. 2013

Mr. Abdulhamid Abdullah Al Ghamdi

Head of Home Medical Program

King Fahad Hospital, Al-Baha Saudi Arabia

K. Translating Accreditation

Office For Translation

مكتب
هاشم عبدالرحمن محمد زمخشري
للترجمة

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إشهـــاد

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المدير العام

هاشم عبدالرحمن زمخشري

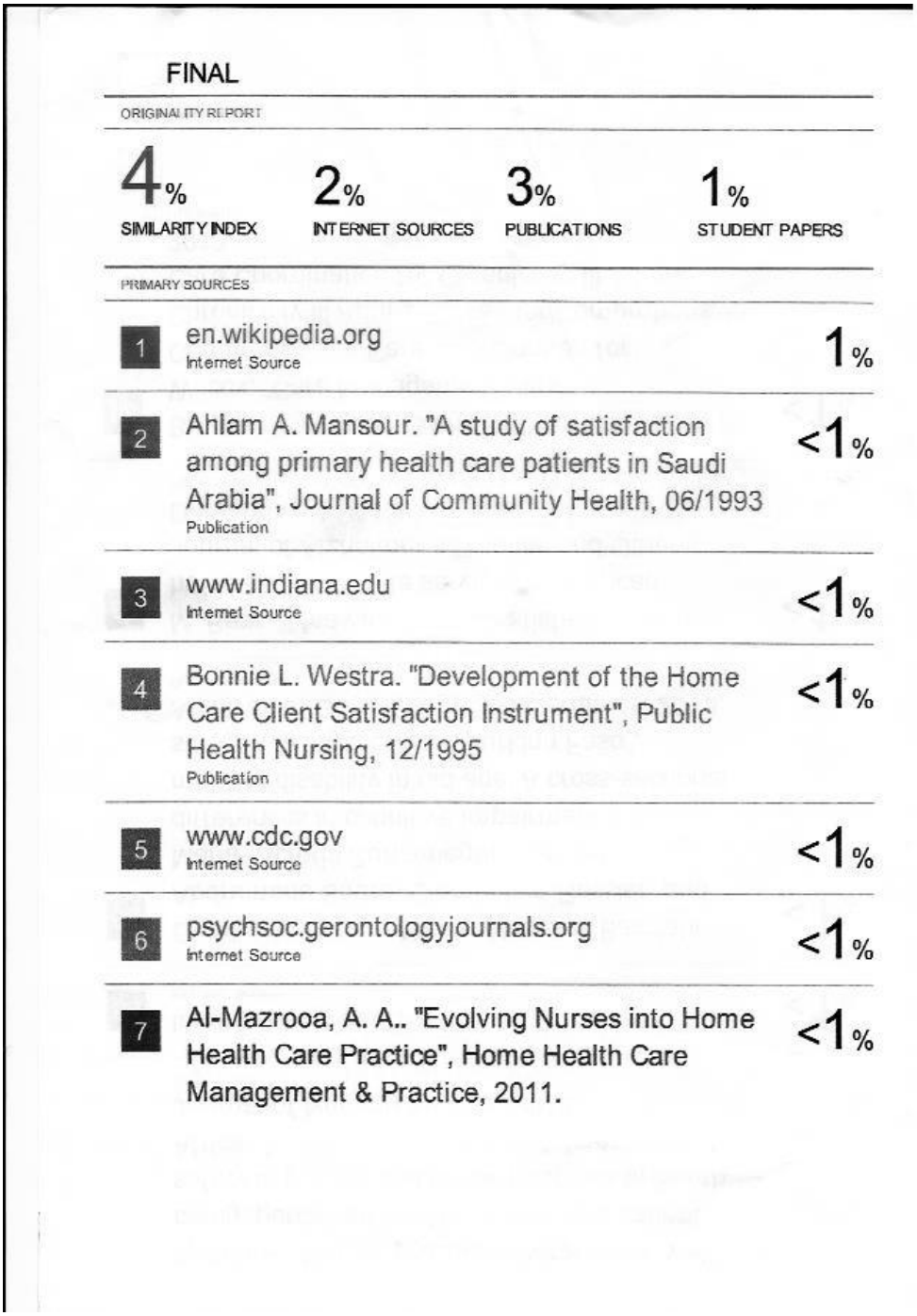
إدارة الاختبارات والقبول

JEDDAH

SAUD H. ESHMAWI

جدة – الشرفية – طريق المدينة – ٦٥٧٤٤٤٣ فاكس : ٦٥٢١٦٠٣ – غرفة تجارية : ٧٦٩٤٤

L. Plagiarism



FINAL

ORIGINALITY REPORT

4%	2%	3%	1%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

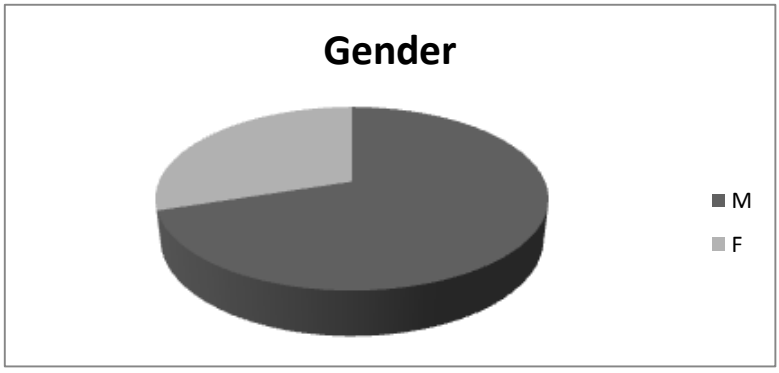
PRIMARY SOURCES

1	en.wikipedia.org Internet Source	1%
2	Ahlam A. Mansour. "A study of satisfaction among primary health care patients in Saudi Arabia", Journal of Community Health, 06/1993 Publication	<1%
3	www.indiana.edu Internet Source	<1%
4	Bonnie L. Westra. "Development of the Home Care Client Satisfaction Instrument", Public Health Nursing, 12/1995 Publication	<1%
5	www.cdc.gov Internet Source	<1%
6	psychsoc.gerontologyjournals.org Internet Source	<1%
7	Al-Mazrooa, A. A.. "Evolving Nurses into Home Health Care Practice", Home Health Care Management & Practice, 2011.	<1%

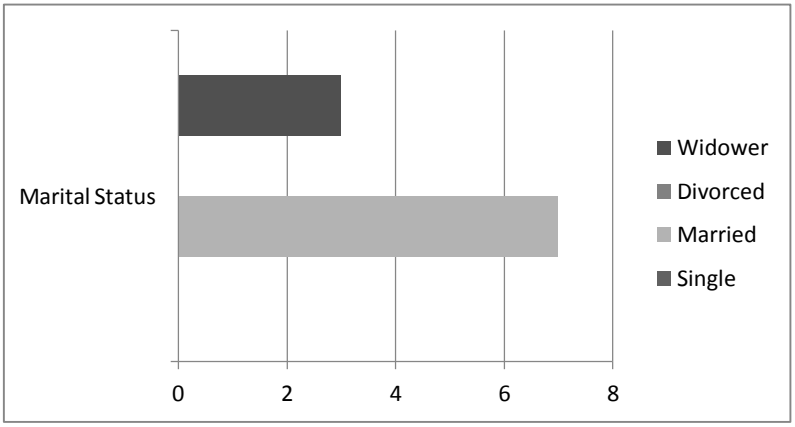
M. The demographic variables of the pilot study questionnaire participants

Demo. Variable	Frequency	Percentage (%)
Total number of participants	10	100%
Gender		
	Frequency	**Percentage (%)**
Male	7	70%
Female	3	30%
Marital status		
	Frequency	**Percentage (%)**
Single	0	0%
Married	7	70%
Divorced	0	0%
Widower	3	30%
Educational level		
	Frequency	**Percentage (%)**
Uneducated	0	0%
Primary	6	60%
Secondary	2	20%
Other	2	20%
Total	10	100%

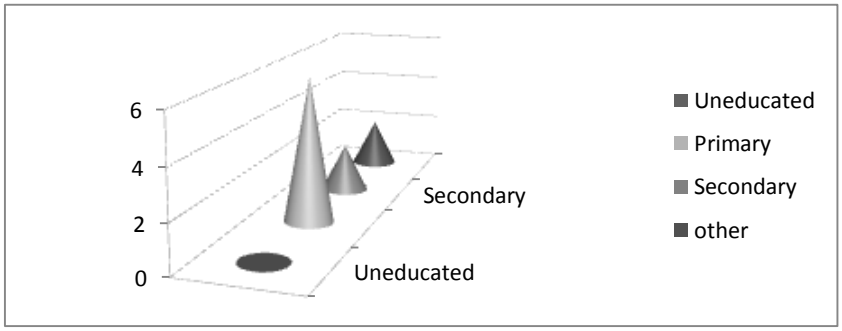
N. Sample survey distribution based on demographic variables (Gender)



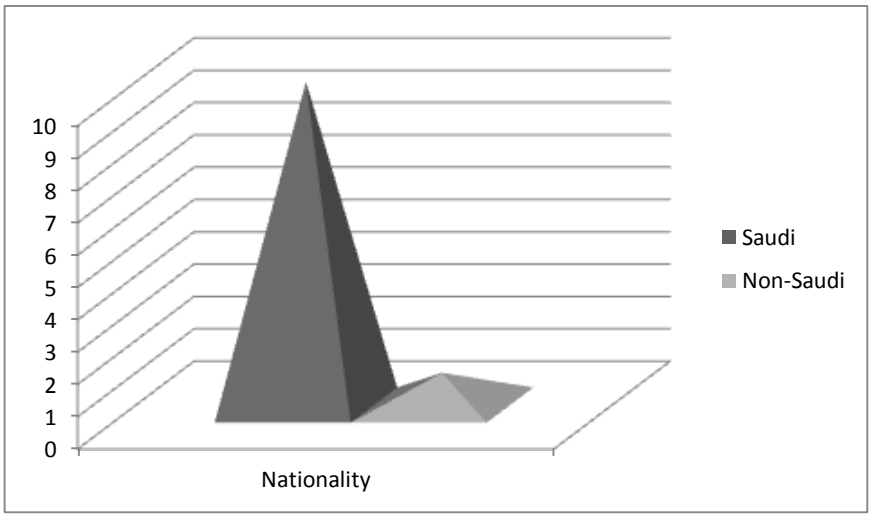
O. Sample survey distribution based on demographic variables (Marital Status)



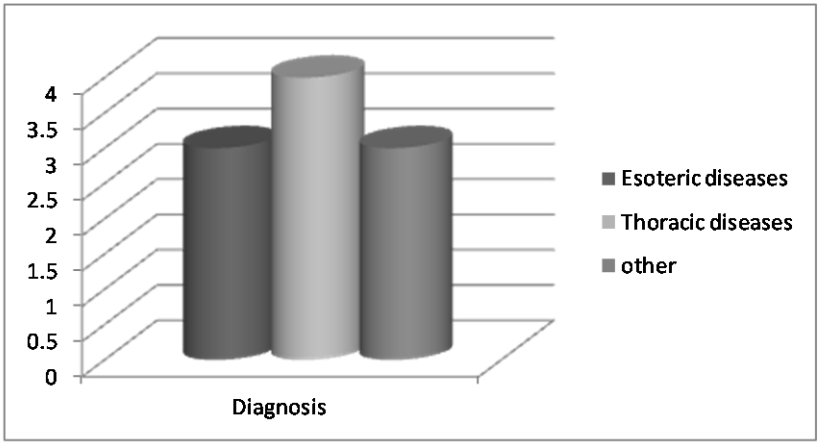
P. Sample survey distribution based on demographic variables (Educational Level)



Q. Sample survey distribution based on demographic variables (Nationality)



R. Sample survey distribution based on demographic variables (Diagnosis)



S. Arithmetic averages and standard deviations, of standard questionnaire in descending order according to the arithmetic mean

Rank	No.	Paragraph	Mean	Deviation	Level
		Level of Satisfaction			
1	11	How satisfied are you with your ability to schedule home visits at the right time for you?	4.5	1.8	Very big
2	7	How satisfied are you with how safe you felt when home care was provided?	4.3	1.4	Very big
3	13	Do you consider that the level of home health care provided was the best available and met and fit with your expectations?	4.3	1.4	Very big
4	12	How satisfied are you with having the same people consistently?	4.1	1.2	Very big
5	5	How satisfied are you with the home health care team's acquaintance with your health problems?	3.8	1.20	Big
6	4	How satisfied are you with the respect shown to you by the home health care team?	3.7	1.8	Very big
7	3	How satisfied are you with the dependability and loyalty of the home health care team?	3.5	1.1	Very big

8	14	What is the probability that you will recommend that others and relatives to take advantage of home health care services?	3.5	1.6	Big
9	1	How satisfied are you with the cooperation of the home health care providers?	3.4	1.3	Big
10	9	How satisfied are you with the ability of the home health care providers to meet your needs?	3.4	1.2	Big
11	10	How satisfied are you with the home health care team's responses and reactions to your concerns?	3.4	1.2	Big
12	15	How satisfied are you that the home health care team is focusing primarily on the patient to provide home health care services?	3.4	1.2	Big
13	8	How satisfied are you that you know who to contact if you have a problem?	3.3	2.1	Middle
14	2	How satisfied are you with the home health care team's attention to your concerns?	3.2	1.2	Middle
15	6	How satisfied are you with having choices and options concerning your home care?	3.2	1.6	Middle
16	16	How satisfied are you with the ability of the home health care providers to meet your needs?	3.2	1.6	Middle
17	17	How satisfied are you with home health care services in general?	2.8	0.89	Middle
Total			**-----**	**----**	**Big**

T. The level of patients' satisfaction with their home health care based on the gender variable

	Variable	**Mean**	**Deviation**	**T**	**Sig**
Level of Satisfaction	Male	**2.5**	**1.0**	**1.05**	**0.15**
	Female	**3.1**	**0.71**		

U. The level of patients' satisfaction with home health care based on the Marital Status

variable

	Variable	Mean	Deviation	T	Sig
Level of Satisfaction	**Single**	**3.1**	**0.9**	**-3.92**	**0.87**
	Married	**3.5**	**4.0**		
	Divorced	**3.4**	**0.8**		
	Widower	**4**	**0.7**		

V. The level of patients' satisfaction with home health care based on the Educational Level variable

	Variable	Mean	Deviation	T	Sig
Level of Satisfaction	Uneducated	2.5	1	1.02	0.13
	Primary	3.2	1.9		
	Secondary	2.3	1.6		
	Other	3.8	1.1		

W. The level of patients' satisfaction with HHC based on the Nationality variable

	Variable	Mean	Deviation	T	Sig
Level of Satisfaction	Saudi	**3.1**	**1.2**	**1.8**	**0.34**
	Non-Saudi	**---**	**---**		

X. The level of patients' satisfaction with HHC based on the Diagnosis variable

	Variable	Mean	Deviation	T	Sig
Level of Satisfaction	Chest diseases	3.1	1.2	1.2	0.09
	Thoracic diseases	2.5	1.00		
	Other	3.8	1.1		

Y. Measure sincerity of the internal consistency of questionnaire themes

No.	Correlation	No.	Correlation
Level of satisfaction (total correlation: 0.90)			
1	0.62*	9	0.63*
2	0.69*	10	0.60*
3	0.85*	11	0.67*
4	0.66*	12	0.97*
5	0.74*	13	0.70*
6	0.77*	14	0.65*
7	0.60*	15	0.56*
8	0.65*		
Problems facing the HHC (Total Correlation: 0.90)			
		16	0.77*
		17	0.80*

Z. Cronbach's alpha for the study variables

Dimension	Number of items	Cronbach's Alpha
Level of satisfaction	1-15	0.901
Problems facing the HHC	16-17	0.909
All variables	1-17	0.971