INFLUENCE OF NATIONAL CULTURE ON THE SOCIAL CONSTRUCTION OF HEALTH CARE QUALITY

by

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First and foremost, I would like to express my sincere gratitude to my thesis supervisor Dr Carole Doherty for her continuous support, guidance, and motivation throughout my PhD study. Carole is my academic ‘mom’. Without her, without her nurturing and encouragement, I might not have been able to finish my PhD successfully. I have learned (or perhaps inherited) a lot from Carole, including the constructivist lens through which I see much of the world today.

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Abstract

The purpose of this study is to examine how national culture influences the social constructions of health care quality in the Kuwaiti primary care. Kuwait has a well-developed primary care system, offering a wide range of services in practices distributed throughout the nation, throughout the day, and on a walk-in basis. Despite its extended hours, relative comprehensiveness and affordability, the primary care service in Kuwait appears to be poorly received by the public. This study employed a qualitative research methodology to investigate how the elements of the Kuwaiti national culture shape the social constructions of health care quality. The study proposal was reviewed by the research ethics committees of the University of Surrey and KIMS, and a favourable ethical opinion was obtained. Participant information sheet were given to potential participants and consent obtained before data collection. Semi-structured interviews were conducted with 42 participants from various stakeholder groups. Data analysis identified three themes that represent the experiences of the various stakeholders’ relating to their social constructions of health care quality in primary care: (1) meanings of health, (2) attitudes towards primary care service, and (3) access to primary care. Within the identified themes, a number of sub-themes were identified, including: (a) the meaning of health, (b) responsibility for one’s health, (c) tensions in doctor-patient communication, (d) doctors feeling ‘undervalued’, (e) gender issues, (f) cultural suitability of primary care, (g) primary care work environment, (h) disproportionate distribution, (i) waiting times, and (j) institutional discrimination. The study found that the high-power distance element of national culture impacts the social constructions of health care quality. Perceptions of power differentials across social groups seem to contribute considerably to the social construction of health care quality. The contribution of this study is towards the body of knowledge on the cultural competence of health care provision in high-power distance cultures.

Keywords: health care quality • cultural competence • primary care
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Chapter 1

Introduction

1.1. Introduction

This thesis explores how culture influences the social construction of health care quality. Health care quality and national culture are used as theoretical constructs to add to our understanding of how the various and, often, competing stakeholders’ perspectives of health care quality interact with parts of the cultural system to influence both how health care quality is constructed and the enactment of health care policy objectives in primary care in Kuwait.

There is, now, growing interest in health care quality (Schuster et al., 1998; Kizer, 2001; Marshall & Campbell, 2002; Seddon & Buchanan, 2004; Boaden, 2006; McIver, 2006; Buttell et al., 2008). This interest stems from a number of factors. First, there is evidence that the quality of health care is suboptimal (Schuster et al., 1998; McGlynn et al., 2003; Øvretveit, 2009). Second, it is now known that the long-term costs of providing suboptimal quality outweigh the operating costs of providing high quality health care (Cutler & McClellan, 2001; Seddon & Buchanan, 2004; Buttell et al., 2008; Øvretveit, 2009). Third, there have been several high-profile scandals and failures in a number of health care systems around the world, including the Kuwaiti system (Marshall & Campbell, 2002; Seddon & Buchanan, 2004; McIver, 2006; Buttell et al., 2008). Fourth, there are increasing public demands for greater accountability and better health care services. These demands are further backed by governments, politicians, and the media (Marshall & Campbell, 2002) and are considered by many writers to be a part of a bigger picture.
comprising economic and social changes. They are often linked to the wider movement and culture of consumerism (Marshall & Campbell, 2002; McIver, 2006).

In the same manner, interest in primary health care has been increasing. The importance of primary care is increasingly recognised in health care systems around the world (World Health Organization, 2003; 2008). This growing global interest in primary care is not surprising and is due to the multiple benefits associated with this level of health care. Studies have consistently shown that strong primary care is associated with better health outcomes and lower total costs of health care (Franks & Fiscella, 1998; Starfield & Shi, 2002; Starfield et al., 2005; Beasley et al., 2007; Starfield & Shi, 2007; Stange & Ferrer, 2009). The multiple benefits of primary care continue to attract the attention of health care providers and policy makers. With the increasing pressures and rising costs of health care, there is a growing need to shift the focus to primary care and to intensify research on primary health care quality.

1.2. Health Care Quality

Due to its unique characteristics, health care quality has been studied as a separate concept from service quality. A brief look at the published literature shows that the concept—health care quality—has been defined in various ways (Donabedian, 1980; Øvretveit, 1992; Campbell et al., 2000). Proposing a generally applicable, all-encompassing definition of health care quality is a particularly difficult task, in part because the interests of the key stakeholders involved in health care quality are often competing. An examination of the literature show that the conception of health care quality has moved, over time, from a solely technical subject to a multifaceted issue, that now seeks to satisfy not only health care professionals, but all stakeholders involved (Donabedian, 1988; Øvretveit, 1992; McGlynn, 1997; Camilleri & O'Callaghan, 1998).
Increasingly, health care quality has been evaluated through the use of indicators, based on health care standards and practice guidelines, developed through reviewing the literature. In addition, health care quality has been assessed by monitoring health outcomes (Salzer et al., 1997).

In general, many empirical studies have demonstrated that various health care attributes are significantly associated with better outcomes (Hartz et al., 1989; Needleman et al., 2002). In contrast, very little has been written about the relationship between health care quality and culture. It is known from the literature that conceptions of health and health care are influenced by cultural factors (Eisenberg, 1977; Helman, 1981; Mishler, 1981; Morgan et al., 1985; Wildes, 1999; Burr, 2003; Yadavendu & Kumar, 2009) but the mechanisms of how culture affects health care quality have not been explicitly explained in the literature. Research into how culture affects the social construction of health care quality is therefore needed to further our understanding of health care quality and ways to improve it.

1.3. The Kuwaiti Case

Kuwait is a small, oil-rich country in the Middle East. The total population in Kuwait is estimated at 3.6 million, of whom Kuwaiti nationals constitute less than a third (Central Statistical Bureau, 2012). Kuwait has a distinct and independent identity from its neighbours. The people in Kuwait are strongly influenced by the country’s culture. Kuwaitis share a strong sense of their cultural identity (Crystal, 1992; O'Shea, 2000; Al-Suwaihel, 2009).

The primary care service in Kuwait is well developed, offering a wide range of services including general practice, pharmacies, medical laboratory, and dental services. All primary care practices in Kuwait are walk-in centres, providing their services on a drop-in basis. The system is
government-funded: Kuwaiti citizens can use all services for free; zero out-of-pocket payment is the rule in all primary care centres. Non-citizen residents, on the other hand, pay nominal fees (the equivalent of £2) for the use of primary care services. These fees cover the entire medical encounter including, if necessary, the use of diagnostic services—for example, medical laboratory, radiology—and therapeutic services—like pharmacy and physical therapy (World Health Organization, 2006; Al Sharafi, 2009; Kieft et al., 2012).

Primary care centres in Kuwait are a doctor-led service, and the doctors have a gatekeeper role to secondary and tertiary care (Benson, 2006). Primary care services are offered in Kuwait in two loci: in-centre consultations and home visits (World Health Organization, 2006).

However, despite the extended working hours, relative affordability, and relative comprehensiveness of primary care services in Kuwait, the pressures on the primary care service are progressively growing. Being in such an important position within the Kuwaiti health care system, primary care has received particularly strong comments and harsh criticism from politicians and the media alike. Hence, many public demands have been made for improved primary care services. Patients and the general public often complain about poor quality of care in primary care facilities. Politicians are constantly demanding the establishment of new primary care facilities within easier reach for residential neighbourhoods, opening new supporting medical services in existing facilities like radiology and laboratory services, and extending working hours in primary care facilities (Al Sharafi, 2009; Kieft et al., 2012).

These demands take place within a context of instability at the level of the ministry. There have been several high-profile scandals and failures in the Kuwaiti health care system in
the last few years. From 2006 to 2014, twelve ministers have replaced each other in the cabinet of health, each averaging approximately eight months. Undoubtedly, media coverage has also played a vital role in drawing public attention to the health care situation and driving interest in health care quality (Marshall & Campbell, 2002; McIver, 2006; Buttell et al., 2008).

Over the years, the Kuwaiti Ministry of Health has responded to many of these demands. An accreditation programme aimed primarily at improving health care quality in primary and secondary care settings was recently launched nationwide. However, the demands and criticisms made by the public do not seem to have changed despite the ministry’s quality improvement efforts (Al-Shammari, 2008; Al Sharafi, 2009; al-Rajhi, 2011; Abdullah, 2012; Kieft et al., 2012).

1.4. Research Aims and Objectives

The main aim of this thesis is to examine how the Kuwaiti national culture influences the social construction of health care quality in primary care. The objectives of this thesis are as follows:

1. To examine how the various stakeholders define health care quality in the Kuwaiti primary care service
2. To explore the similarities and tensions between the various stakeholders’ constructions of health care quality
3. To investigate how the Kuwaiti national culture influences the various definitions and perceptions of health care quality

The thesis aims to make a three-fold contribution. First, it aims to add to our understanding of the role of national culture in the social construction of health care quality. By comparing and contrasting the various stakeholders’ perceptions of health care quality, it aims to add to our understanding of how culture influences the stakeholders’ perceptions and conceptualisations of health care quality within a primary care setting. Second, it aims to
contribute to the currently lacking empirical evidence on how health care quality is constructed in the Kuwaiti primary care sector. Third, it aims to add to policy recommendations on health care quality in the Kuwaiti primary care service which can be useful for purposes of primary care service design and planning.

This thesis adopts a social constructivist approach to examine the influences of national culture on health care quality. Social constructivism rejects the positivist perspective of a reality existing ‘out there’ independent of the researcher. Instead, it assumes that there is no single objective reality but multiple dynamic ‘realities’, internally constructed based on how we experience the world. Knowledge under this approach is socially constructed, and, thus context- and time-dependent.

1.5. Structure of the Dissertation

The chapters of this dissertation are organised as follows. Chapter 2 examines how the concept of quality has evolved before ‘health care quality’ has been established as a separate construct that is conceptually distinct from service quality. The chapter will look at the early development of ‘quality’ and the subsequent emergence of service quality as a distinct field of study.

Chapter 3 explores health care quality, which is the theoretical framework for this thesis, by reviewing the literature on the topic. It begins by highlighting the growing interest in health care quality across health care systems. Then, it discusses the concept of health and argues that it is a socially constructed phenomenon. The chapter also argues that the health care industry, itself, is characterised by a number of factors that contribute to the uniqueness of the health care service from other services.
Given the social construction of health, health care, and health care quality, studying the implications of cultural factors on perceptions of health care quality is important and directly relevant to the topic of this dissertation. The concept of culture is explored in Chapter 4, which also examines how culture is related to health care quality. In addition, the chapter provides an overview of the culture of Kuwait.

In Chapter 5, the research methodology used in this study will be explained. The chapter will first present the research aims and questions. The philosophical stance underpinning this study is then discussed. The research design and methodology are then presented and the methods of data collection and analysis described. The measures taken to ensure the study is methodologically sound and ethical are then described.

The findings of this study will be presented in the following three chapters. Chapter 6 will present findings relating to the study participants’ beliefs and perceptions about the concept of health and the individual’s responsibility for their own health. Then, Chapter 7 will present the findings of the study relating to participants’ perceptions and attitudes towards the primary care service. In the next chapter, Chapter 8, findings relating to participants’ experiences and perceptions of health care quality will be presented—with specific attention given to the cultural factors that influence these experiences and the ways in which they do so.

Discussion of the findings and the main results of the research are summed up in Chapter 9, followed by recommendations for research, management, and policy.
1.6. Chapter Summary

This chapter gave a brief introduction and overview of the research problem and rationale for the study. The aims and objectives of the thesis were described. The layout of this thesis was also presented.

The next chapter, Chapter 2, goes on to explain the concept of quality and how it has evolved before health care quality has been established as a separate field in the literature, distinct from service quality. The chapter introduces the reader to quality before delving into the details of health care quality, which is discussed in Chapter 3.
Chapter 2

Quality in the Service Sector

2.1. Introduction

The objective of this chapter is to examine how the concept of quality has evolved before health care quality has been established in the literature as a separate construct that is conceptually distinct from service quality. This introductory chapter will, first, look at the early development of ‘quality’ in the manufacturing sector. Then, it will examine how the concept of quality has evolved in the service sector as ‘service quality’, highlighting the unique characteristics that distinguish services from physical goods. A number of issues central to service quality will be highlighted, including user-centeredness; the subjective nature of the concept; and its relationship with user satisfaction. The chapter will, then, look at how service quality is judged, exploring the different models and theories on the matter.

2.2. The Evolution of Quality

The concept of quality has been developed and pioneered in the manufacturing sector (Parasuraman et al., 1985; Deming, 1986; Harvey, 1996; Al-Assaf, 2001; Boaden, 2006). Driven by competition for limited resources, many manufacturing firms have started to adopt and apply methods of quality improvement. Soon after the implementation, manufacturers started to realise the benefits of quality. Contrary to the belief held at the time (Deming, 1986), they have come to believe that high quality improves productivity. High quality reduces the costs associated with errors, delays, and repetition. As well, it attracts more potential buyers given the higher-quality, lower-priced goods (Garvin, 1983; Deming, 1986). Within the manufacturing sector, the quality
movement flourished and became a top priority for most firms (Boaden, 2006). Quality was, then, seen as the uniformity resulting from adhering to established guidelines (Juran, 1951; Crosby, 1979); it was variously defined as conformance to requirements, conformance to specifications, and fitness for use (Reeves & Bednar, 1994). Apparently, all of these definitions placed a great emphasis upon technical issues like reducing error and variation (Shewhart, 1931; Juran, 1951; Crosby, 1979; Garvin, 1983; Deming, 1986).

As the service sector grew during the second half of the twentieth century, it became obvious that many of the older definitions of quality (for example, conformance to requirements) failed to tackle the unique characteristics of services (Reeves & Bednar, 1994). Services are activities that do not directly generate a physical product during the transaction between users and providers (Collier, 1987). They have also been described as intangible products involving a performance or an effort that cannot be possessed (Berry, 1980). That is, services have been defined in different ways, but there is an agreement, however, that they share certain characteristics that distinguish them from goods. For example, Zeithaml and her colleagues (Zeithaml, 1981; Parasuraman et al., 1985; Zeithaml et al., 1985; 1990) have identified four characteristics of services that contribute to their distinctiveness from goods. Namely, they are intangibility, heterogeneity, inseparability, and perishability. These characteristics are also strongly expressed in the health care service sector, which in addition is characterised by a number of unique features that distinguish from other services (see Chapter 3).

Unlike goods, most services are intangible: they cannot be seen, felt, or tasted in the same manner in which goods can be sensed. In many cases, services cannot be displayed or demonstrated because they are performances rather than objects. Being performances, the potential exists for high heterogeneity and variation across providers, consumers, locations, and
time. Services cannot be standardised as easily as goods. Rather, they need to be customised to fit every user. Unlike manufacturing which seeks uniformity, service delivery, in general, requires a high degree of customisation. Also, because services are often performed by humans, they are prone to variability. That is, service performances may vary across employees from the same provider and even within the same employee. The presence of the human factor makes consistent service delivery difficult (Parasuraman et al., 1985; Zeithaml et al., 1985).

In addition, the concurrent production and consumption characterise many services. In contrast to goods, which are produced, sold, and then consumed, services are first sold, then produced and consumed simultaneously. Thus, production and consumption of services cannot be separated. Due to this inseparability, services users frequently participate in the production of service, thereby affecting service performance. That is, in many services, the service performance depends on both how well the provider performs and how well the user performs (Zeithaml, 1981). Furthermore, services are perishable. They cannot be stored or inventoried once produced (Parasuraman et al., 1985; Zeithaml et al., 1985).

2.3. Service Quality

These characteristics of services, together with failure of traditional manufacturing definitions to address quality in the service sector, have made it increasingly important to develop a definition for service quality as a distinct construct from product quality. A number of definitions have been proposed taking into account the unique features of services. For example, one definition of service quality is the extent to which a service meets or exceeds its users’ expectations (Parasuraman et al., 1985). Compared to older definitions, this definition reflects a radical change in focus which has shifted from the provider to the user. Implied in this change is a
diversion of thinking from the then dominant paradigm of provider-defined quality to one being primarily driven by the user. This approach to quality has been criticised by Deming (1986) who thought that quality means more than just attracting users, although he recognised that user satisfaction is an integral component of service quality. This definition, even though heavily criticised, is considered to be the most pervasive definition of service quality currently in use (Reeves & Bednar, 1994; Clewes, 2003; Ayyildiz & Cengiz, 2007). It places a great emphasis on user satisfaction and convenience (Øvretveit, 2005), believing that services, after all, exist for the benefit of users (Gaster & Squires, 2003).

It is argued by some scholars that ‘only customers judge quality; all other judgments are essentially irrelevant’ (Zeithaml et al., 1990, p.16), and that quality ‘is what the customer says it is’ (Feigenbaum, 1991, p.828). In this sense, the construct of quality as defined by Parasuraman and his colleagues (1985) involves perceived quality—that is, the user’s judgment about the overall excellence or superiority of a product or service (Zeithaml, 1988). Perceived quality is different from objective quality (Parasuraman et al., 1988; Zeithaml, 1988). This dichotomy points out that at least some part of quality is subjective. That is, users’ perception of quality is likely to be biased by their individual value system, their past experiences, and the situation. This has been suggested in an earlier work by Shewhart (1931), who theorised that quality has two aspects: objective and subjective. The objective aspect refers to quality as a reality independent of our existence. It refers to quality that can be measured on a predetermined standard, and, in this sense, is closely related to many of the definitions used to describe quality in the manufacturing sector, like conformance to requirements and conformance to specifications (Zeithaml, 1988). On the other hand, the subjective aspect views quality as what we think, feel,
or sense as a result of the objective reality. This notion supports the idea that ‘quality’ is socially constructed and, therefore, is historically and culturally contingent (Burr, 2003).

2.3.1. Special Challenges to Service Quality

The unique characteristics of services, highlighted above, impose a number of challenges on service quality. Due to these characteristics, service quality is both more difficult to provide and more difficult to evaluate (Zeithaml, 1981; Lewis, 1989; Lovelock & Wirtz, 2004). For example, the heterogeneity inherent in many services makes consistent service delivery difficult across different employees in the same provider (Lewis, 1989; Lovelock & Wirtz, 2004). Service cannot be standardised; they are often personalised to meet every user’s needs. In periods of high demand, where less time is available to every individual user, services are more prone to variation.

In addition, being intangible performances rather than physical goods, services cannot be returned or replaced, even if deemed unsatisfactory by the user (Berry & Bendapudi, 2003; Lovelock & Wirtz, 2004). Moreover, one of the differentiating characteristics of many services is the extent to which the user participates in the process of service creation and delivery (Zeithaml, 1981; Lewis, 1989; Lovelock & Wirtz, 2004). In services, quality depends not only on the performance of the provider, but also on that of the user. That is, user participation will directly affect service performance and, consequently, service quality (Zeithaml, 1981; Lewis, 1989). This is particularly evident in high-contact services, such as health care (Lovelock & Wirtz, 2004). For example, a doctor’s accurate diagnosis requires, among other things, a full history and an extensive description of symptoms by the patient. That is, the service user must adequately perform his or her part of the service to ensure that a satisfactory service quality could be
achieved. In other words, both the health care user and the health care provider co-produce the health care service and consequently health care quality (Zeithaml, 1981).

Furthermore, because of the inseparability of production and consumption in most services, service quality occurs during service delivery. Service users observe the production process, in which they are involved, and evaluate service quality as they experience the service. In contrast, quality in the manufacturing sector is planned and engineered in the factory before it is delivered intact to the user. Quality control is easier in this case as failures and errors can be detected before they reach the user. Services do not have the benefit of a factory to separate production errors from the user and to serve as a buffer to absorb fluctuations in demand. Also, services are perishable: they cannot be stored; they have to be produced only upon demand and consumed simultaneously. Therefore, quality control is more difficult in services (Lovelock & Wirtz, 2004).

In addition, service quality is more difficult to evaluate than goods quality. Based on their ease of evaluation, all goods and services can be placed on a continuum ranging from ‘easiest to evaluate’ to ‘difficult to evaluate’. On this continuum, services tend to be anchored to the one end of the spectrum that is ‘difficult to evaluate’ and goods to the other end, ‘easy to evaluate’ (Zeithaml, 1981). It is proposed that services, compared to goods, have more experience attributes—which cannot be evaluated by the user before consumption—and credence attributes—which cannot be evaluated by the user even after consumption. For example, a patient cannot usually tell how an appendectomy has been performed, even well after the procedure. Services provided by professionals, like health care, are typically high in credence attributes.
Services typically possess few, if any, search attributes—qualities that can be evaluated by the user prior to consumption. In contrast, goods exhibit mainly search attributes, like colour and style, and are, as a result, easier to evaluate (Zeithaml, 1981). For instance, because of the inseparability of service production and consumption, the user cannot evaluate service quality before consumption (Lovelock & Wirtz, 2004). In fact, even after consumption, service quality is more difficult to evaluate than goods quality. Services contain fewer tangible clues than goods, limiting the tangible evidence available for the user to evaluate their quality (Parasuraman et al., 1985; Lovelock & Wirtz, 2004).

2.3.2. How Users Judge Service Quality

It is theorised that service users, in judging service quality, compare what they expect the service provider to offer with their perception of the service they receive (Parasuraman et al., 1985; Parasuraman et al., 1988; Øvretveit, 1992). Perceived service quality may therefore be defined as ‘the degree and direction of discrepancy between consumers’ perceptions and expectations’ (Parasuraman et al., 1988, p.17). In this regard, perceived service quality is very similar to user satisfaction. Both concepts derive from the expectancy-disconfirmation theory, which holds that utility—in this case, either perceived quality or user satisfaction—is a function of the size and direction of disconfirmation, which in turn is related to the user’s initial expectations (Oliver, 1993). They, both, may be defined in terms of the difference between an individual’s expectations of a service and their perceptions of the actual outcome of the service.

Even though the two concepts are closely related and may partially overlap, scholars have attempted to make distinctions between them. It is argued that perceived service quality is a global judgment or attitude relating to the superiority of a service, whereas user satisfaction is the
user’s evaluation of a specific service transaction, and hence is a less enduring judgment (Parasuraman et al., 1988). Thus, compared to satisfaction, which is transaction-specific, perceived service quality is a more stable evaluation held for a longer term (Bolton & Drew, 1991).

In addition, it has been pointed out that the construct expectation is used to mean different things in the literatures of service quality and user satisfaction. For example, in the user satisfaction literature, the user’s expectations are viewed as his or her predictions about a specific service transaction, whereas in service quality literature, expectations are generally viewed as the user’s wants and preferences regarding a service (Parasuraman et al., 1988; Zeithaml et al., 1993). However, both concepts—user satisfaction and perceived service quality—are related, in that satisfaction, with time, forms the individual’s perception of service quality. That is, repeated incidents of user satisfaction, especially when consistent, would eventually consolidate into what the user perceives to be service quality (Oliver, 1981).

Furthermore, it has been proposed that users assess the performance of service according to two standards or levels of expectations: desired service and adequate service (Zeithaml et al., 1993). The desired service standard refers to what the user desires or hopes to receive; it is a blend of what the user believes both ‘can’ and ‘should’ be done. On the other hand, the adequate service standard is the minimum level of service performance that the user will accept without being dissatisfied. It is assumed that although users hope to receive the level of service they desire, they understand that it is not always possible, and hence, they hold another, lower level expectation of what they consider acceptable.
The domain extending between the two levels—desired service and adequate service—is termed the zone of tolerance (Zeithaml et al., 1993). Service performances that fall in this zone are deemed acceptable by the user, since they fare better than the user’s minimum tolerable expectation. In a way, the user’s zone of tolerance represents the extent to which the user is willing to accept heterogeneity in service performance, which may be inevitable (Parasuraman et al., 1985). Users do not usually pay explicit attention to service performances within the zone of tolerance. In contrast, they would react—positively or negatively—to performances that fall outside this range. Service performances perceived by the user to fall below the adequate service level will cause dissatisfaction, whereas those that exceed the level of desired service will lead to surprise and satisfaction (Lovelock & Wirtz, 2004).

Research (Zeithaml et al., 1993) has shown that there is a considerable variation in different users’ zones of tolerance. In fact, even the same user’s zone of tolerance continually fluctuates up and down. Fluctuations in the individual user’s zone of tolerance of can be attributed to the changes in the user’s expectations of adequate service (Zeithaml et al., 1993), which are in turn influenced by factors such as competition, price, and other service attributes (Lovelock & Wirtz, 2004). The desired service standard, on the other hand, seems to move slowly in an upward direction in response to the user’s accumulative experience (Zeithaml et al., 1993; Lovelock & Wirtz, 2004).

In addition to comparing their expectations with the actual service performance, it is assumed that in judging service quality, service users tend to compare the service in question within a set of other services that serve the same general purpose (Zeithaml, 1988). Of note is that the set of services used in comparison appears to be evoked by the user, not the provider. In other words, users judge service quality depending on its relative superiority among other
services that are viewed by them as substitutes to the service under consideration (Zeithaml, 1988). Frequently, for non-professional services, the user’s evoked set of alternatives includes the user’s self-provision of the service. This may form a special challenge on service providers since they must compete with the user, which implies more individualised service and more personal attention than from the service provider (Zeithaml, 1981). The users’ expectations of acceptable service from a certain provider are continuously changing, as users constantly compare it with other services that they regard as competitors (Zeithaml et al., 1993).

It is widely recognised in the literature that, in the health care service for example, patients are not objective observers of their care any more than are health care professionals and providers. They participate in and co-create the service and its consequent quality. Their communication style, language proficiency, cognitive abilities, and education level all affect their role in the co-creation of the service, which together with their prior expectation of the service, affect their perception of service quality (Zeithaml, 1981; Lewis, 1989; Stange et al., 1998; Bethell et al., 2003; Lovelock & Wirtz, 2004).

In addition, because production and consumption of services often occurs simultaneously, often with a great extent of participation on the part of service users, the users’ judgments involve evaluations of the outcomes, as well as the processes of service. That is to say, users not only evaluate the consequences of the service, they, as well, evaluate the manner in which the service was delivered to them. They base their evaluations on expectations, which they hold about both, how the service is delivered and what the outcomes are (Parasuraman et al., 1985). This hypothesis is supported by Grönroos (1982), who suggested that there are two types of quality: technical quality, which refers to what the user actually receives from the service, and functional quality, which involves the manner in which the service is delivered. However, since
technical quality is defined primarily on the basis of accuracy in performing the technical processes of the service, knowledge about it—in many service industries—is not generally available to the consuming public. This is especially true in the health care service industry, where technical quality remains within the purview of health care professionals. Because service users often feel they are unable to accurately assess technical quality, especially in professional services, their perception of quality relies heavily on functional quality (Babakus & Mangold, 1992). There is now growing evidence to suggest that functional quality is the single most important variable in influencing users’ perception of quality (Zeithaml, 1988).

Although a full review of methods for measuring service quality is beyond the scope of this report, the report would benefit from a brief discussion of SERVQUAL, one of the most widely used instruments for measuring service quality. SERVQUAL was developed by Parasuraman and his colleagues (1985; 1988) to assess service quality from the user’s perspective. It is based on the expectancy-disconfirmation paradigm—another model developed by the same researchers (Zeithaml et al., 1990)—where SERVQUAL is a comparison between consumers’ expectations and their perception of the service they actually received (Parasuraman et al., 1988). The SERVQUAL instrument is founded on the view that the users’ assessment of service quality is paramount (Buttle, 1996).

SERVQUAL captures the multidimensionality of service quality by assessing five dimensions of the service experience from the user’s point of view (Parasuraman et al., 1988). The five dimensions are as follows: 1) tangibles, which include the physical facilities, equipment, and personnel; 2) reliability, which is the ability to perform the service dependably and accurately; 3) responsiveness, which is the willingness to help users and provide a prompt service; 4) empathy, which is the individualised attention and caring provided to the service
users; and 5) assurance, the service employees’ knowledge, courtesy, and ability to convey trust and confidence. Parasuraman and his colleagues (1985) had originally identified ten dimensions of service quality, which were then collapsed into the current five dimensions, after extensive empirical testing. In its final form, SERVQUAL contains 22 items with which the users’ expectations and perceptions can be measured (Parasuraman et al., 1988).

Parasuraman and his colleagues (1985; 1988; Zeithaml et al., 1988) argue that service organisations share many commonalities in service delivery process, both within and across the various service industries. They argue that these commonalities shared across service organisations permit service users to evaluate service quality using the same criteria, regardless of the type of service. They argue that the use of SERVQUAL is thus accepted across service industries (Parasuraman et al., 1988).

Furthermore, SERVQUAL is intended to measure the manner in which the service is delivered from the perspective of the user, that is, technical quality. It is not intended to measure the technical quality of the service, the knowledge of which in most cases is industry-specific (Parasuraman et al., 1988; Babakus & Mangold, 1992).

The SERVQUAL instrument has been extensively used in many services across various industries. Despite its wide usage, however, the appropriateness of the instrument for use across different types of services has been questioned (Babakus & Mangold, 1992; Buttle, 1996; Laws, 2004; Hui et al., 2011). Particularly in health care, the use of the expectation-disconfirmation model to define and measure service quality is a major departure from the traditional efforts to measure quality in health care where much weight is placed on technical quality (Babakus & Mangold, 1992).
In addition, SERVQUAL has been subjected to other theoretical and operational criticisms (Buttle, 1996; Soliman & Alzaid, 2002; Laws, 2004; Hui et al., 2011). The universality of the SERVQUAL’s dimensions across different types of services has been questioned (Babakus & Mangold, 1992; Buttle, 1996; Soliman & Alzaid, 2002; Hui et al., 2011). For example, Carman (1990) concluded that the five dimensions of SERVQUAL are not so generic and suggested different sets of dimensions for different services. It was argued that SERVQUAL lacks the capability of measuring user-perceived service quality generically across all service sectors and hence different sets of dimensions should be proposed to measure service quality in the various service industries (Carman, 1990; Soliman & Alzaid, 2002). Despite its criticism, SERVQUAL instrument has been applied to various service sectors and continues to be widely utilised to measure service quality (Buttle, 1996; Laws, 2004; Hui et al., 2011).

Moreover, because of the differing characteristics of goods and services, it is theorised that users employ different processes to evaluate quality in each sector (Zeithaml, 1981; Berry & Bendapudi, 2003). For example, it is hypothesised that users rely more on information from personal sources, like a friend’s word-of-mouth, than from non-personal sources, like mass advertising, when evaluating a service prior to use (Zeithaml, 1981).

While mass and selective media can effectively deliver information about search attributes, they are not suitable to communicate advice about experience attributes. Since experience and credence attributes dominate in services and users at best can discover only a few attributes before actually using the service, they may prefer to use personal sources of information, like word-of-mouth, which they may perceive to be more credible and less biased (Zeithaml, 1981). Being dominated by experience and credence attributes, services are more difficult to evaluate and are perceived by the user as higher risk transactions than goods. Also,
the inability to return or replace services adds to the user-perceived risk (Berry & Bendapudi, 2003; Lovelock & Wirtz, 2004). It is theorised that in situations with high perceived risk, such as health care, the user’s reliance on word-of-mouth is especially significant (Zeithaml, 1981).

2.4. Chapter Summary

The purpose of this chapter was to explore how the concept of service quality has been developed and has evolved. The chapter argued thus far that services are characterised by a number of unique features that make them distinct from physical goods—namely intangibility, heterogeneity, inseparability, and perishability. Service quality, therefore, has been studied as a separate entity from product quality. However, the unique characteristics of services—mentioned earlier—impose a number of challenges on service quality, which make it more difficult to provide and evaluate.

In addition, meeting or exceeding the service users’ expectations is a central component of service quality. That is, the user-perceived quality—which is based on the expectancy-disconfirmation model—is of paramount importance in the service sector. However, the use of expectancy-disconfirmation model alone for defining and evaluating quality in health care has been criticised.

In the next chapter, the concept of health care quality is explored.
Chapter 3

Quality in Health Care

3.1. Introduction

Over the past few decades, there has been an increasing focus on health care quality. This increasing emphasis has been driven by a number of factors including the rising public demand for greater accountability and better health care service. The public is demanding a true partnership between the users and providers of health care. These public demands are further backed by governments, politicians, and the media (Marshall et al., 2002). In addition, it is now recognised that the long-term costs of providing suboptimal quality outweigh the operating costs of delivering high quality health care (Cutler & McClellan, 2001). For these reasons, among others, interest in health care quality has been growing steadily in the past decades.

This chapter explores the concept of health care quality. The chapter will first highlight the growing interest in health care quality across health care systems. Then, the notions of health and illness will be discussed, together with the social construction of health and health care. The chapter will then argue that the health care industry is different from other industries in the service sector: a number of distinguishing characteristics of health care will be highlighted. Next, the concept of health care quality will be discussed in depth and the relevant literature reviewed. The related issues of health care quality multidimensionality, differing stakeholders’ perspectives, and health care quality assessment will be discussed.

Given that this study aims to explore the concept of health care quality in the primary care setting, a section of this chapter will be devoted to primary care.
3.2. Growing Interest in Health Care Quality

Perhaps, the best way to introduce health care quality is by highlighting the increasing awareness of health care quality. There is, now, growing interest in health care quality (Schuster et al., 1998; Al-Assaf, 2001; Kizer, 2001; Marshall & Campbell, 2002; Seddon & Buchanan, 2004; Boaden, 2006; McIver, 2006; Buttell et al., 2008). Whenever health care issues are discussed, three concepts keep coming up: quality, access, and cost (Al-Assaf, 2001). This growing interest in health care quality stems from a number of factors. First, there is evidence that the quality of health care is suboptimal. This can be demonstrated in a number of ways. The most direct way comes from studies that have directly measured the quality of health care in various settings. These studies have consistently found that there are large gaps between the level of care people should receive and the care they actually receive (Schuster et al., 1998; McGlynn et al., 2003; Øvretveit, 2009). However, deficits in health care quality can also be demonstrated by variations in health care practice and outcomes that are not attributable to differences in patients’ characteristics or preferences (Schuster et al., 1998). Another way to demonstrate the deficits in health care quality comes from studies that measured the rates of medical errors and adverse events. These studies have consistently shown that health care—which should promote and protect patient safety—has been a major cause of harm to patients (Vincent et al., 2001; Buttell et al., 2008; McDowell et al., 2010). While the deficits in health care quality are well established, studies have also suggested that there is much room for improvement in the quality of health care (Schuster et al., 1998; Kizer, 2001; Rubin et al., 2001).

The second factor behind this growing interest in health care quality is that it is now known that the long term costs of providing suboptimal quality outweigh the operating costs of providing high quality health care (Cutler & McClellan, 2001; Seddon & Buchanan, 2004;
Buttell et al., 2008; Øvretveit, 2009). The costs of health care are rising; and the costs of poor quality account for a great portion of the total health care costs (Savage & Williams, 2007; Øvretveit, 2009). Apparently, the costs of poor quality are not restricted to monetary or financial costs; the time and effort wasted by health care providers—that could have been put to better use—are examples of non-monetary costs of poor quality (Cutler & McClellan, 2001; Øvretveit, 2009). The long-term benefits of investing in high quality health care counterbalance the costs of treating diseases and complications that would have arisen otherwise (Cutler & McClellan, 2001). Furthermore, strong associations have been found between the level of patient-perceived quality and the subsequent health-related behaviour of the patient. Patient-perceived quality and satisfaction had already been established as a reliable method for predicting whether a patient seeks health care, complies with health care recommendations, and maintains a continuing relationship with a health care provider (Larsen & Rootman, 1976). Similar associations have been found between patient-perceived quality and satisfaction and health outcomes (McKinley & Roberts, 2001; Beach et al., 2006). Thus, the indirect costs of poor quality add further to the already high costs of health care. In addition, since publication by the Institute of Medicine of the report ‘To Err is Human’ (Kohn et al., 1999), which brought to public attention the extent of unnecessary harm caused to patients by medical errors, further interest in health care quality and patient safety has grown.

Third, there are increasing public demands for greater accountability and better health care services. These demands are further backed by governments, politicians, and the media (Marshall & Campbell, 2002) and are considered by many writers to be a part of a bigger picture comprising economic and social changes. They are often linked to the wider movement and culture of consumerism (Marshall & Campbell, 2002; McIver, 2006). A number of forces have
contributed to the rise of consumerism in health care, especially the demographic changes in populations, the increasing concerns about patient safety, and the relatively higher availability of medical knowledge (Kizer, 2001; George & Sanda, 2006). Associated with these economic and social changes are raised expectations of health care quality (Kizer, 2001; McIver, 2006). In addition, the implicit trust the public has always had in the medical body started to fall: a trend has emerged towards reduced professional power and autonomy (Daniels, 2000; Hogg & Williamson, 2001; Marshall & Campbell, 2002; Harrison, 2004; McIver, 2006). The recent high-profile failures and the increased media coverage have, certainly, intensified the situation (Marshall & Campbell, 2002; McIver, 2006). The stakeholders are now increasingly demanding greater transparency and more information about health care services. Politicians are demanding that the scarce resources are utilised in the public’s best interest. In addition, it has been argued that some patients wish for a greater role in their own health care and more involvement in decisions relating to service provision (Poulton, 1999; Kizer, 2001; Marshall & Campbell, 2002; Flynn, 2004; Seddon & Buchanan, 2004).

Fourth, there have been several high-profile scandals and failures in a number of health care systems around the world (Marshall & Campbell, 2002; Seddon & Buchanan, 2004; McIver, 2006; Buttell et al., 2008). Kuwait is no exception. In 2007, HE Sheikh Ahmed Al-Abdullah Al-Sabah, the then minister of health was interpellated for the chronically troubled Ministry of Health, and a vote of confidence was demanded. A few months later, after a fire that hit a general hospital, Dr Al-Mubarak, the next minister of health, resigned after chairing the cabinet for less than six months. In 2008, a number of Ministry of Health officials were investigated in light of irregularities that marred the requests for overseas treatment and cost more than £2.3m. In 2009, the chair of the department of surgery in a general hospital was summoned for interrogation after
allegations of high rate of medical errors. In the same year, a number of specialty hospitals used expired disinfectants in their operating rooms for several months. From 2006 to 2014, twelve ministers have replaced each other in the cabinet of health, each averaging approximately eight months. Undoubtedly, media coverage played a vital role in drawing public attention to the health care situation and driving interest in health care quality (Marshall & Campbell, 2002; McIver, 2006; Buttell et al., 2008).

All these factors have undoubtedly played an important role in the growing interest in health care quality. More research on the quality of health care is, thus, needed, particularly in understudied areas, such as primary care (Franks & Fiscella, 1998; Singh et al., 2007). Campbell (2002) notes that most research on health care quality focused on secondary and tertiary care settings. In addition, judging by the number and character of publications, health care quality in the Kuwaiti primary care is an understudied topic.

### 3.3. Conceptions of Health Care

Before attempting to define health care quality, it is useful first to define health care itself. Health care has been defined in different ways, and there are various conceptions in the literature of what constitutes proper health care (Donabedian, 1980; Campbell et al., 2000). It has been described as the actions taken by health care providers aimed at improving the well-being of health care users (Donabedian, 1980). However, “several formulations are both possible and legitimate” (Donabedian, 1988, p.1743) depending on one’s position within the health care system and the nature and extent of his or her responsibilities within the system. These formulations can be graphically represented by a series of concentric circles, layer upon layer, surrounding a central core; each layer represents a level of care (see Figure 1).
Figure 1: Levels at which health care quality may be assessed; adapted from Donabedian (1988)

The central core (number 1) in Figure 1 represents the care provided by health care professionals, which can be divided into two parts: clinical care and interpersonal care. This central core is immediately surrounded by a circle (number 2) that represents the amenities of care, the desirable attributes of the setting through which care is delivered. Amenities of care include privacy, convenience, quiet, comfort, and so on. The next circle (number 3) outwards crosses the boundary of care provided by health care providers within institutional health care systems to care provided by non-professionals. This circle represents contributions to care of the patients themselves, as well as members of their families. The outermost circle (number 4) represents the care received by the community as a whole. At this level of care, issues like access, equity, and the social distribution of care resources in the community become important (Donabedian, 1988).

That is, depending on where they are and what they do within the health care system, some stakeholders may adopt wider or more expansive definitions of health care that include added elements (concentric circles in Figure 1) that are not considered relevant by other stakeholders (Donabedian, 1988; Øvretveit, 1992). For example, Campbell et al. (2000) focused their discussion only on the care provided within formal institutional health care systems. That is,
they deliberately excluded the outer two levels of care (Figure 1), which may be of equal importance to some stakeholders.

However, these concentric levels of health care (Figure 1) are not detached from one another. Rather, they are interconnected and the success (or failure) of health care does not solely depend on the performance of the health care provider. Like in other services, user participation in health care is extremely important as it influences the implementation of care and hence its effectiveness (Zeithaml, 1981; Lewis, 1989). For example, the patient and/or family members (circle 3 in Figure 1) have a responsibility to provide relevant information and to cooperate with the prescribed treatment (Zeithaml, 1981; Donabedian, 1988). The patient’s adherence to treatment is itself influenced by the provider’s management of the interpersonal relationship with the patient (circle 1 in Figure 1). In the same manner, the care provided within institutional health care system (circles 1 & 2 in Figure 1) plays a significant role in determining the social distribution of health care resources in the community (circle 4 in Figure 1). However, other factors, beyond the health care providers’ control, also influence the distribution of health care resources.

The several formulations of the concept of health care result from the various prevailing mind-sets within each stakeholder group (Silberman, 1995). Moreover, various conceptions of health care are possible depending on how narrowly or broadly the concept of health is defined. It may be contested among stakeholders whether health care practitioners should be responsible for bringing about improvements only in specific areas of physical or physiological functioning or whether social and psychological functioning are as well within their area of responsibility (Donabedian, 1988).
For the purpose of this study, ‘health care’ comprises the care provided within formal institutional health care settings by the organised, legally sanctioned healing professionals, including physicians and other recognised paramedical professionals (Helman, 2007). It is the quality of this care that this study aims to explore.

3.4. Social Construction of Health and Health Care

The several formulations of the concepts of health and health care are in part due to the different conceptions held by the different stakeholder groups of health and illness. Health and illness are socially constructed phenomena: their nature is conceptualised differently in different cultures and societies and across different historical periods (Eisenberg, 1977; Helman, 1981; Mishler, 1981; Morgan et al., 1985; Wildes, 1999; Burr, 2003; Yadavendu & Kumar, 2009). They are culturally laden, socially constructed categories that give meaning to particular events. Whether certain experiences or behaviours are perceived by a given society as symptoms of an illness is dependent upon a number of factors, including the social norms and cultural values shared by members of the society (Mishler, 1981; Morgan et al., 1985; Calnan, 1988; Marcum, 2008; Dutta, 2008; Sheikh & Gatrad, 2008).

Apparently, this view of illness is in conflict with the traditional biomedical model which defines episodes of ill-health with reference to generic, culture-free parameters (Helman, 1981; Mishler, 1981). The dominant biomedical model of health illness is described as an approach that uses medical observation and investigations that can be logically examined and analysed. At the same time, it marginalises the feelings and social experiences of patients (du Pré, 2005). The mainstream biomedical model has been the basis of modern medicine and dominates clinical practice, medical education, and health-related research. It does not, however, include the patient
and his or her attributes as a person (Drossman, 1998; Ghaemi, 2010; Holland & Hogg, 2010). The biomedical model reduces the explanation of disturbances in health down to their most basic elements: malfunction or disruption of biological and biochemical processes (Feinstein, 1987; Jarvis et al., 2002; Ghaemi, 2010; Holland & Hogg, 2010). In the biomedical model, it is generally assumed that individuals are primarily responsible for their own health (Helman, 2007; Holland & Hogg, 2010). There are several criticisms and limitations to the biomedical model, most prominently that it neglects some of the psychological causes of behaviour and sees the individual as a body in which some parts are malfunctioning, rather than a whole person (Feinstein, 1987; Jarvis et al., 2002).

However, despite being generally regarded as the superior system of health care delivery (Thorne, 1993; Holland & Hogg, 2010), the biomedical model is in competition with other health belief systems. For example, in personalistic health belief systems, illness is believed to be caused by a supernatural force (for example, witches, sorcerers, gods, and evil spirits). An ill person, according to personalism, is believed to be an object of aggression or punishment, whether or not this aggression is justified (Jackson, 1993; Holland & Hogg, 2010). The cause of illness according to this view is a force beyond the individual’s control. One example of such a force that is found in the Middle East and other parts of the world is the notion of ‘evil eye’—the malevolent power of the glance of a jealous person (Helman, 2007; Holland & Hogg, 2010). Taking care of one’s health in a personalistic system of health belief typically involves active maintenance of good relationships with one’s family, community, and god. Personalistic health belief models, unlike the biomedical model, however do not have a strong scientific basis (Holland & Hogg, 2010).
The reductionist biomedical model is subsumed within the more expansive biopsychosocial model (Juergens et al., 1990; Ghaemi, 2010). In this latter model, the definitions and descriptions given by the biomedical model are considered as one set of inputs—that together with social norms, values, and traditions—define the meanings of illness. That is, even though the biological processes and abnormalities that produce disease are the same in different cultures, they are given different meanings and dealt with in different manners. It is recognised that culture plays a large and important role in shaping health-related beliefs, values, and behaviours (Helman, 1981; Mishler, 1981; Betancourt, 2004; Ahmed, 2007; Helman, 2007; Holland & Hogg, 2010).

In recent years, the biopsychosocial model of health has found more general acceptance in a number of health care fields, including primary care (Beitman et al., 1982; Drossman, 1998; Gatchel et al., 2007; Yehia & Dutta, 2010; Álvarez et al., 2012). There is now a growing recognition of the need to explore the ways in which meanings are attached to different health-related experiences of people. It is also increasingly recognised that it is important to understand how the meanings of health are constructed within their local cultural contexts (Helman, 2007; Yehia & Dutta, 2010). This recognition builds, at least in part, on the notion that individuals perceive and understand their health and make their health-related decisions on the basis of their interpretations, which, in turn, derive from and are influenced by their cultural worldviews (Klein, 2004; Helman, 2007; Yehia & Dutta, 2010; Holland & Hogg, 2010).

A distinction has been made in the literature (Eisenberg, 1977; Helman, 1981; Radley, 1994) between the two terms ‘disease’ and ‘illness’, which describe the different views of ill-health held by health care providers and users, respectively. The term disease refers to the biological abnormalities and pathologies as defined by the scientific paradigm of modern
medicine. These abnormalities, which can be measured objectively as deviations from the biological norms, are often accompanied by impairment of function in body organs.

*Illness*, on the other hand, is the patient’s perspective on their ill-health. It refers to the patient’s experience and subjective response to being unwell. In addition, the term includes the meaning that the patient gives to the whole experience (Eisenberg, 1977; Helman, 1981). People’s experiences of illness and health occur within the social context of their lives; their experiences go beyond the biological changes within their bodies to affect those around them (Radley, 1994; Lorber & Moore, 2002). As Cassell (1995) notes, the word ‘illness’ is used to represent “what the patient feels when he goes to the doctor” (p.48), whereas the word ‘disease’ is used to represent “what he has on the way home from the doctor’s office” (p.48).

Although most cases of disease are accompanied by illness, disease can occur in the absence of illness. For example, asymptomatic conditions, like hypertension or early cervical cancer, are recognised by health care professionals as diseases even though the sufferer may not feel ill. Also, in acute severe conditions which result in sudden loss of consciousness, such as cerebral haemorrhage, there may be no time for the ‘illness’ to be experienced by the patient (Helman, 1981). Similarly, illness can occur in the absence of disease. Examples include functional bowel disorders and hypochondriasis (Helman, 1981; 2007).

Because health care providers and users perceive health and illness differently, they have radically different expectations of health care and, hence, radically different ways of assessing health care quality (Silberman, 1995). Physicians, often, treat the ‘disease’ and ignore “all the distinctively human reactions—love, hate, joy, sorrow, distress, gratification—that differentiate people from animals or molecules” (Feinstein, 1987, p.223). Failure by physicians to address the
‘illness’ dimension is not due to their insensitivity or lack of concern to the patient’s suffering, but to the prevailing mind-set within this stakeholder group: physicians are trained to seek what they consider as ‘objective’ or ‘hard’ data about the patient; information about how patients feel or what they think are considered ‘subjective’ or ‘soft’ by many physicians (Feinstein, 1987; Silberman, 1995).

In practice, many of the social problems and human processes are being treated as ‘diseases’. Sociologists use the term medicalisation to describe this growing phenomenon, which defines many human experiences and physical states as diseases. Being recognised as diseases, they come under the authority of health care professionals, which are viewed as the experts in this area. The knowledge possessed by the users of health care about their own lives may be seen as of secondary importance, or may even not be a part of the management of their ‘diseases’ (Lorber & Moore, 2002). Abstracting disease from its social and cultural framework could lead to improper and incomplete understanding of the disease within the context of the patient’s life. The scientific model of medicine may tend to objectify patients and deny their status as social beings. Thus, it may obscure the relationship between disease and the surrounding social and cultural factors which affect its behaviour and development (Yadavendu & Kumar, 2009).

However, both illness and disease should be treated. While the same set of symptoms may be viewed differently by health care providers and health care users, health care quality cannot be improved unless both realities are incorporated into clinical practice (Helman, 1981; Silberman, 1995; Lorber & Moore, 2002). The different views of health care providers and users should be reconciled. Diagnosis and treatment prescribed by the health care provider should make sense to the health care user for them to be considered. Failure by the health care provider to address the ‘illness’ dimension could result in a number of unwanted consequences, including

Not just health and illness, health care, itself, has been regarded as a social construction. Health care is practised in specific social and cultural contexts; different providers may have different cultural backgrounds and may subscribe to different belief systems which will ultimately impact the way they provide health care (Burr, 2003; Marcum, 2008; Yadavendu & Kumar, 2009). Several social and cultural forces define the nature of encounters between health care providers and users in the society. These forces also decide whether or not certain health care procedures are to be provided, and/or paid for, by the society; for example, abortion. In general, the entirety of health care is shaped by the culture, norms, and values of the society in which it is practised (Donabedian, 1966; Yadavendu & Kumar, 2009; Holland & Hogg, 2010).

Thus, health care should not be seen as a set of technical procedures and skills that measure deviations from biological norms. Rather, health care is an interpretive field which takes into account—among other things—the cultural significance of events and occurrences experienced by individuals (Mishler, 1981; Yadavendu & Kumar, 2009), and which affect their health, with health being broadly defined as a ‘state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization, 1948).

3.5. Health Care: A Unique Service

Like other services, the health care service sector is characterised by intangibility, heterogeneity, inseparability, and perishability, the four characteristics that make services distinct from physical goods. The health care sector is, however, characterised by a number of other features.
While some authors might argue that the health care sector is no different from any other service sector, there are a number of features that distinguish it from other services. First, the demand for health care is a *derived demand* for health, which, in turn, is influenced by a wide range of factors of which health care is one (Hurley, 2000; Arrow, 1963). It is health, not health care, that it is of value to users; health care per se does not have any intrinsic value. In itself, independent of its anticipated health outcomes, health care generally is negative and undesirable. It is often associated with pain, discomfort, and inconvenience, and when misadministered, could result in serious injury and/or death (Evans, 1984). No well person should wish to receive health care regardless of the value of amenities associated with it. As Evans (1984, p.5) notes, “Anyone who seeks care when he is not sick, is sick”.

Second, the knowledge possessed by the health care provider relating to the treatment options and their consequences is necessarily greater than that of the user (Arrow, 1963; Pauley, 1978; Evans, 1984; Mills & Gilson, 1988; Hodgson, 2007). This contrast in medical knowledge between providers and users has been referred to in the literature as *information asymmetry*. Health care users are generally ignorant not only of how health care is produced, but also of how it will be of help to them (Evans, 1984). This ignorance of the user is probably the most important potential difference between health care and other sectors (Pauley, 1978). Health care users, in general, would have little knowledge, if any, of the effectiveness of health care, the consequences of the different health care choices, and the cost of choosing not to receive health care at all. In fact, there is no counterfactual situation against which to judge the health care modalities chosen for a given patient (Mills & Gilson, 1988).

In general, health care users are unaware of what is best for them regarding their health problems, and thus depend on advice from the provider, which is generally perceived to have
significantly greater knowledge (Evans, 1984; Hodgson, 2007). In addition, users are not technologically competent to judge the quality of significant aspects of health care (Mills & Gilson, 1988; Øvretveit, 1992; McGlynn, 1997). Also, health care, as a service, is high in credence attributes—attributes that cannot be evaluated by the user even after consumption. For example, a patient may not be able to tell how well a surgical procedure has been performed even well after the procedure (Zeithaml, 1981).

The phenomenon of information asymmetry in health care is aggravated by a number of factors. The knowledge acquired from one’s own past experiences rapidly becomes obsolete. Besides, the distinctiveness of each case limits the probability of learning from others’ experiences (Mills & Gilson, 1988). The user entry into the market is generally infrequent, particularly in the case of severe illness (Arrow, 1963). The urgency of many illnesses makes information gathering impractical. Health care professionals, in general, have little incentive to provide information to users (Mills & Gilson, 1988; Steves & Dowd, 1999; Gallagher et al., 2003; Weissman, 2004; van der Voort & Kerpershoek, 2010). And, when presented with ‘second opinions’, health care providers are traditionally reluctant to disagree with their colleagues (Mills & Gilson, 1988; Armstrong, 1999; Manias & Street, 2001; Axon et al., 2008).

Third, health care is characterised by uncertainty with respect to the need for health care (Hurley, 2000). In contrast to information asymmetry—which describes the differences between providers and users in knowledge about the present situation—uncertainty is used to refer to the unpredictability of future events (for example, illness) shared by both providers and users (Evans, 1984). The onset of illness is unpredictable, and so is the need for health care. Similarly, the effectiveness of health care is ambiguous, and the recovery from illness is as unpredictable as its incidence (Arrow, 1963; Evans, 1984; Leatt & Porter, 2002). In addition, the costs associated
with ill health, whether monetary or otherwise, are also unpredictable but often large (Evans, 1984; Mills & Gilson, 1988). Apart from the costs of health care, illness is in itself costly: it is frequently associated with loss or reduction of one’s earning ability (Arrow, 1963). Even though the costs are large, one cannot plan his/her health care consumption in the same way he/she can plan consumption of other commodities (Evans, 1984; Mills & Gilson, 1988; Olsen et al., 2004).

Fourth, in many instances in health care, the behaviour of one party spills-over to affect other parties. These spill-over effects are known as externalities (Mills & Gilson, 1988). A typical example is immunisation against infectious diseases. Immunisation not only protects the person immunised but indirectly protects against the spread of the infectious disease. Externalities are widely spread in public health care in particular (Hodgson, 2007).

3.5.1. The Doctor-Patient Relationship

The features of health care described above, undoubtedly, set it apart from other services. Furthermore, they have certainly contributed to the unusual and unique relationship between providers and users in the health care sector (Mills & Gilson, 1988). The doctor-patient relationship is the prototype example. In this relationship, the patient delegates decision making to the doctor, which is generally assumed to have a greater knowledge than the patient (Shmanske, 1996). The doctor, being the expert in this matter, is expected to act in the best interest of the patient, rather than substitute his/her own preferences and values for those of the patient (Donabedian, 1980). This gives rise to what is known as the agency problem. According to the agency theory, the problem arises when a person—called the principal—delegates a certain task to another person—called the agent. It arises because the information and the motives of the agent are different from those of the principal, and hence the delegated task will
not be performed as the principal intends (Shmanske, 1996). In health care, the agency problem may manifest in a number of ways. For example, demand for health care is often supplier-induced, since health care use typically depends on advice offered by health care providers, whose motivations may not always be—at least in theory—in the best interest of the user (Mills & Gilson, 1988; Hodgson, 2007). The motivations of providers may lead, for instance, to prescribing more expensive brand-name medications to gain favour with pharmaceutical firms or to ordering extra tests to protect self from potential legal liabilities (Shmanske, 1996).

The doctor-patient relationship is very unique in that it is characterised by trust: the decisions and behaviours of health care provider are governed by a concern for the patient’s welfare. Profit-seeking behaviour is typically absent in health care. This distinguishes health care from many services where self-interest is the accepted norm (Arrow, 1963; Pauley, 1978). The doctor-patient relationship must be personal and intimate, yet professional and objective. At the patient care level, the process of decision making is extremely complex: while there may be several treatment options, the optimal decision is usually unknown. Furthermore, the treatment decision is to be negotiated between the doctor and the patient but with incomplete knowledge (Leatt & Porter, 2002). As well, decision making at the patient care level is risky and possibly irreversible: the consequences of medical error are serious and may result in mortality or permanent disability (Mills & Gilson, 1988; Leatt & Porter, 2002).

In the preceding account, it has been argued that health care is different from other services. The factors mentioned above have contributed to uniqueness of the health care service sector. Health care cannot be viewed in the same way as other services (Øvretveit, 1992). Therefore, definitions of service quality fail to capture the whole concept of health care quality, which would better be studied in its own context.
3.6. Health Care Quality

Given the unique characteristics of health care described above, health care quality has been studied as a separate concept from service quality. It is widely agreed among health care quality researchers that defining health care quality is a remarkably difficult task. It is particularly difficult to provide a generally applicable definition that does justice to all dimensions of health care quality (Donabedian, 1966; Vuori, 1982; Reerink, 1990). The concept of health care quality has been defined in various ways and from a variety of perspectives. Embedded in each definition there tends to be an implicit emphasis on or bias towards certain aspects of health care. Thus, it is practically difficult to formulate a realistic definition of health care quality that does not have, within it, an implied focus on certain elements of health care (Buttell et al., 2008). As Vuori (1982) puts it, “it may be impossible to develop a [health care quality] definition that would satisfy all its users” (p.35). This has prompted some authors to develop stakeholder-specific definitions of health care quality (Øvretveit, 1992).

Various attempts have been made to define health care quality. Experts in the area of health care quality have struggled for decades to formulate a concise and generally applicable definition of health care quality (Blumenthal, 1996). Donabedian (1966) noted that “the quality of care is a remarkably difficult notion to define” (p.692). He concluded that the criteria upon which health care quality is defined are value judgements that are applied to several aspects, components, or attributes of health care, and as such health care quality ‘may be almost anything anyone wishes it to be’. In his early attempt, Donabedian (1966) defined health care quality as the extent to which actual care is in conformity with preset criteria for good care (cited in Reerink, 1990). This definition is considered to be of landmark importance in the literature, as it first introduced the idea of evaluation as a basis for defining health care quality (Reerink, 1990).
Prior to Donabedian’s (1966) definition, descriptions of health care quality took the form of long lists of elements that comprise high quality health care. However, this catalogue approach to defining health care quality has been described as handicapped—the lists developed to describe the elements of health care quality are necessarily incomplete (Reerink, 1990). Donabedian’s (1966) definition marked the beginning of a new era for health care quality definitions, where the evaluative approach has replaced the categorical definitions as the primary method of defining health care quality (Reerink, 1990).

In view of policymakers’ increasing attention to the rising costs of health care service (Katz & Sangha, 1997), the Institute of Medicine (National Academy of Sciences, 1974) defined high quality health care as ‘effective health care to improve the health status and satisfaction of a population within the resources which society and individuals have chosen to spend for that care’, thus adding an emphasis on the health care system’s efficiency (Reerink, 1990). Williamson (1978) proposed a similar definition whereby health care quality is ‘the extent to which care is in conformity with preset criteria with a minimum of unnecessary expenditures’.

Later, the Institute of Medicine formulated another definition, which has soon become one of the most widely cited definitions of health care quality (Blumenthal, 1996; Helminen, 2000; Buttell et al., 2008; Nakkeeran & Thiagarajan, 2010). According to it, quality is constituted by “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr, 1990, p.4). Implicit in this definition is that health care quality is not equated with outcome. The definition indicates that high quality health care increases the likelihood of desired health outcomes. It implies that poor outcomes occur despite high quality health care and that the desired health outcomes may manifest despite poor quality health care. The definition also
emphasises the health care professional’s point of view. It emphasises that what is considered high quality is tied to the current professional knowledge in health and health care and is thus historically contingent; what has been considered best practice a few years ago is now considered of suboptimal quality.

Most definitions and assessments of health care quality, until recently, have focused mainly on the viewpoint of the health care professional. Some definitions have included aspects of health care service efficiency and cost control as constituents of health care quality. Campbell and his colleagues (2000) argued that health care quality can be defined at two levels: the individual and the population; and they argued that efficiency of the health care service is only relevant when defining health care quality at the level of the population, because achieving optimal outcomes for all individual health care users may not be an affordable goal at this level. Hence, they define that health care quality for populations as “the ability to access effective care on an efficient and equitable basis for the optimisation of health benefit/well-being for the whole population” (p.1617).

The viewpoint of the individual user of the health care service has largely been ignored until recently (Graham, 1995; Blumenthal, 1996; Helminen, 2000; Buttell et al., 2008). Traditionally, there has been a significant imbalance between health care providers and users, with those at the receiving end generally less able to comment on the health care services they experienced (Jenkinson et al., 2003). There is now, however, a growing recognition that the perspective of the health care user is important. The view that the service user should be able to make judgements about the service has pervaded all service sectors and was bound to eventually influence the health care service. Social and economic developments—often linked to the wider culture of consumerism—have fostered the growing emphasis on the legitimacy and importance
of the health care users’ views (Blumenthal, 1996; Marshall & Campbell, 2002; McIver, 2006). The concept of ‘patient-centred care’ is one manifestation of the growing recognition of the users’ views (Blumenthal, 1996; Jenkinson et al., 2002). There is now increasing interest and recognition in eliciting feedback from health care users about their own care. Patient reports are now central to the evaluation of health care quality in a growing number of national health care systems; indicators of patients’ experience are being increasingly incorporated into performance indicators of national health care systems (Jenkinson et al., 2002; 2003; Garratt et al., 2008).

Recognising the significance of user-centeredness in health care quality, Buttell and his colleagues (2008) expanded the Institute of Medicine’s (Lohr, 1990) definition of health care quality to read “Quality consists of the degree to which health services for individuals and populations increase likelihood of desired health outcomes, are consistent with current professional knowledge, and meet the expectations of healthcare users” (Buttell et al., 2008, p.62).

However, over-emphasis on user-centeredness and user satisfaction has been criticised. Deming (1986) thought that although user satisfaction is important, quality means more than just satisfying the users. Al-Assaf (2001) emphasises that the health care service should meet the needs, not the wants of the health care user. Øvretveit (1992) argues that while satisfaction is an important aspect of health care quality, it should not be restricted for those users who receive the service. Rather, high quality health care should ensure that all who need the health care service can and do get it. He defined health care quality as “fully meeting the needs of those who need the service most, at the lowest cost to the organization, within limits and directives set by higher authorities and purchasers” (Øvretveit, 1992, p.2). High quality health care should not ignore those who need care but cannot access it. It is argued however that because of the information
asymmetry inherent in health care, health care users may not be able to determine accurately their health care needs. Demand for health care is typically supplier-induced. Therefore, Øvretveit argues that the health care provider’s judgement of the user’s health care need is important for the need to be legitimate. Moreover, high quality health care should not just meet the needs of those who need care, it should meet their needs in the most efficient way (Øvretveit, 1992).

As apparent from the several definitions, there are several perspectives to health care quality. As Donabedian (1988) puts it, “several formulations are both possible and legitimate” (p.1743) depending on the stakeholder’s position within the health care system and the nature and extent of his/her responsibilities. All definitions, however, seem to assume that high quality health care should, on average, lead to better health outcomes than lower quality care (Katz & Sangha, 1997). Moreover, it is also evident that the definitions of health care quality have evolved and changed over time to accommodate the interests of the many stakeholder groups that now play a part in the health care system (Blumenthal, 1996; Helminen, 2000). The definition of health care quality has over time included additional elements that are of value to the key stakeholders, including the health care user. Emphases on the health care users’ views are now increasingly included in definitions of health care quality.

Logically, different perspectives on and definitions of health care quality call for different goals and priorities and for different approaches to its measurement and management (Blumenthal, 1996; McGlynn, 1997; Buttell et al., 2008). Also, various ways in which the concept of health care quality has been defined indicate that the concept is complex.
There is widespread agreement that health care quality is a multidimensional construct (Maxwell, 1984; 1992; O'Leary & O'Leary, 1992; Campbell et al., 2000; Donabedian, 2003). Scholars seem to agree that health care quality consists of a number of components or dimensions, and that each individual dimension, when viewed on its own, provides a partial, but specific, picture of quality (Campbell et al., 2000). It is particularly helpful to describe health care quality in terms of its dimensions. These dimensions, together, constitute the definition of health care quality (Campbell et al., 2000; Donabedian, 2003).

Maxwell (1984; 1992) identified six dimensions of health care quality: effectiveness, acceptability, efficiency, access, equity, and relevance. O'Leary and O’Leary (1992), on the other hand, proposed that health care quality has the following dimensions: effectiveness, patient perspective, efficiency, accessibility, continuity, and efficacy. A similar list of seven dimensions was developed by Donabedian (2003): efficacy, effectiveness, efficiency, optimality, acceptability, legitimacy, and equity. Although the lists are slightly different, there seems to be a general consensus that certain elements are integral to health care quality. For example, both Maxwell (1984; 1992) and Donabedian (2003) list acceptability—which refers to the cultural distance between the health care system and its users (Javanparast et al., 2009)—as a dimension of health care quality. Similarly, O’Leary and O’Leary’s (1992) idea of accessibility includes cultural accessibility of the health care service—in addition to geographic and physical accessibility. These views of the dimensions of health care quality demonstrate that cultural suitability is an integral component of the concept.
3.6.1. Cost as a Consideration

Whether or not the monetary cost of health care should enter the definition or assessment of health care quality is a perplexing question. Theoretically, health care quality can be separated from inefficiency. Technical quality is judged by the extent to which health benefits are expected to be attained. And, inefficiency is judged by extent to which health benefits are achieved in an unnecessarily costly manner. In practice, however, lower quality health care and inefficiency coexist. Wasteful care is either directly harmful to health or indirectly harmful by displacing more useful care (Donabedian, 1988).

It is believed that each added care, if appropriate, corresponds to an improvement in health as well as an increase in cost. The corresponding improvement in health, however, becomes progressively smaller with each additional care, while cost continues to increase unabated. There will be a point beyond which any additional care will result in health improvements that are too small to be worth the added cost (Donabedian et al., 1982; Donabedian, 1988). Health care quality can be viewed as care that is expected to achieve the greatest improvement in health; this is a maximalist specification of quality. Alternatively, if cost is a consideration in the definition of health care, it may be set out that care should stop before any additional care is disproportionately costly compared to the health benefit it is expected to produce; this is an optimalist specification of quality (Donabedian, 1988). Providing optimalist care requires—in addition to medical knowledge of whether elements of care are likely to be useful—the knowledge of the cost of each element of care. For this reasons, health care professionals tend to prefer the maximalist view of health care quality (Donabedian, 1988).

A distinction has been made in the literature between two levels of defining quality: the individual and the population (Donabedian, 1980; Donabedian et al., 1982; Campbell et al.,
At one level, the level of the individual, the judgement of health care quality takes into account the expectations, values, and wishes of the individual user of health care. At this level, the principal aim of the health care service is to maximise the health benefits of the individual irrespective of the costs imposed on the system. However, individual users undoubtedly differ in their values and expectations; they differ in what they need or want from the health care system. They are also different from one another in the type and magnitude of their health problems, as well as their socio-demographic attributes which have an effect on the natural course of their health problem and its response to treatment. Similarly, health care users may place different valuations on the various benefits and risks associated with certain forms of care. At this level of quality, elements like efficiency and equity may not be relevant; the goal of high quality health care is to maximise the individual’s health benefits (Campbell et al., 2000). It has to be noted that at this level of defining health care quality, the individual user’s wants and preferences are not necessarily superior to the health care professional’s views. The top priority of the health care service at this level is to produce the maximum health benefits for each individual user, regardless of any other confounding factor.

At the other level, the level of the population, quality is defined with respect to the aggregate net health benefit for the whole society (Donabedian, 1980). Because the resources available to health care systems are limited, maximising health benefits of all users may not be a reasonable objective (Campbell et al., 2000). The society places different valuations on the different forms of care: some forms of care are valued more than others by the collective society. These different valuations depend on how the society perceives some forms of care—which it values—to be associated with externalities for the society, that is, to be beneficial to more people than just the individuals who receive them (Donabedian, 1980). For example, the society may
place a significant value on immunisation given its cost-effectiveness and positive externalities. This may result in potential conflicts between care for the entire population and care for the individual user (Donabedian et al., 1982; Campbell et al., 2000; Hodgson, 2007). That is, what the health care system has to provide to an individual user depends on what has been provided to all other users and the subsequent availability of resources within the system (Campbell et al., 2000). For instance, in a publicly-funded health care system where zero out-of-pocket payment is the rule, individual users may prefer forms of care that are both more costly and more beneficial than the society would. In other words, the society tends to accept a smaller net gain in health than individuals might want (Donabedian et al., 1982). At this level of defining health care quality, additional elements—not relevant at the level of the individual—such as equity, efficiency, and cost become important (Campbell et al., 2000).

Additionally, the distribution of the aggregate net benefit within the population is of key importance at the social level of defining health care quality. That is, the society may place different weights of importance on the different segments of the population; for example, the elderly or the disabled. These valuations, however, are directly influenced by the norms and values shared by members of the society (Donabedian, 1980; Donabedian et al., 1982). Hence, they are historically and culturally specific: what one community may regard as necessary may be deemed inappropriate in another (Burr, 2003).

3.6.2. Stakeholder Perspectives on Health Care Quality
The relative importance of each dimension of quality varies considerably across the different stakeholders within the health care industry. That is to say, quality is, certainly, relative to the stakeholder. The expectations held about the different aspects of health care quality are likely to
vary among stakeholders. That is why different stakeholders perceive quality differently (Donabedian, 1980; Deming, 1986; Donabedian, 1988; Øvretveit, 1992; Campbell et al., 2000; Nakkeeran & Thiagarajan, 2010). As has been illustrated earlier, the concept of health care quality has developed from a purely technical to a multifaceted issue that now seeks to satisfy the needs and interests of three principal interest groups (Donabedian, 1988; Øvretveit, 1992; Nakkeeran & Thiagarajan, 2010). These groups have been described as those who provide care, those who manage it, and those who use it (Øvretveit, 1992; Nakkeeran & Thiagarajan, 2010). They place different valuations on the various attributes and components of quality and often hold different perspectives on what constitutes quality. For example, the focus of attention for health care providers may be on the processes of care, while for health care users it may be on other factors, like accessibility. In the same way, the principal concern for health care managers is possibly efficiency, which users may not value as much (Øvretveit, 1992; Haddad et al., 1998).

In fact, even the same stakeholder may value different components of quality in different situations. For example, different segments of health care users may value different attributes of health care. Patients with life-threatening illnesses may give up many of the amenities of care—like a private room and a choice of meals—for technical excellence. In contrast, patients with chronic illnesses, where improvement tends to little and slow, may appreciate the different amenities and complementary services (Donabedian, 1980). Quality, as Deming (1986, p.168) concludes, “can be defined only in terms of the agent” since different stakeholders value different components of quality. This variation in how different stakeholders view and perceive quality has prompted authors to define quality from a number of different perspectives, each viewing quality from a given stakeholder’s standpoint (Øvretveit, 1992).
Accordingly, many definitions of health care quality view the concept from the perspective of one stakeholder, often neglecting other stakeholders’ points of view (Donabedian, 1980; 1988; Øvretveit, 1992; Campbell et al., 2000). Health care quality is viewed differently across different stakeholder groups. These differences arise from differences in the scope and concern for quality held by the different stakeholders (Donabedian, 1980; 1988). That is, depending on where they are and what they do within the health care system, some stakeholders may adopt wider or more expansive definitions of health care (see Figure 1), which directly affect their conceptions of health care quality (Donabedian, 1988; Øvretveit, 1992). In response to these differences in stakeholders’ views, some authors (Øvretveit, 1992) have proposed multiple stakeholder-specific definitions of health care quality, each looking at the concept through the lens of a given stakeholder.

As McGlynn (1997, p.9) notes, “quality is in the eye of the beholder”. Different health care stakeholders hold different perspectives on health care quality. Different perspectives on health care quality call for different goals and priorities and different approaches to quality assessment. The different stakeholder groups have different values and expectations about the health care system and the various dimensions of health care quality. All these difference between stakeholders’ perspectives and expectations result in different requirements and preferences about health care quality adopted by the various stakeholders. These preferences are often in conflict with each (Donabedian, 1980; 1988; Øvretveit, 1992; Blumenthal, 1996; McGlynn, 1997; Campbell et al., 2000; Buttell et al., 2008).

As has been illustrated earlier, the concept of health care quality has evolved over time to accommodate the multiple competing interests of stakeholders. It has included additional elements that are valued by the various stakeholders (Blumenthal, 1996; Helminen, 2000;
George & Sanda, 2006). The concept of health care quality has moved, over the years, from a solely technical subject to a comprehensive and multifaceted issue (Donabedian, 1988), that now seeks to satisfy not only health care professionals—as it has done for decades—but also the users, managers, and purchasers of health care (Øvretveit, 1992; McGlynn, 1997; Camilleri & O'Callaghan, 1998; Jenkinson et al., 2003; George & Sanda, 2006; Jenkinson et al., 2002).

The current thinking in health care policy and management places a great emphasis on the perspective of the health care user. There is now increasing interest among health care systems in eliciting feedback from health care users about several aspects of care to monitor and improve health care quality (Jenkinson et al., 2002; Chow et al., 2009). Health care services now seek to provide not only evidence-based and clinically effective care but also—increasingly—care that is judged by health care users as acceptable. Patient-centred care can be viewed as one that approaches the patient as a unique human being with his or her own story to tell. Patient-centred care is thus an approach or strategy through which the health care provider aims to gain an understanding of the patient as well as the disease; this is in contrast to focusing strictly on the disease (Saha et al., 2008). Patient-centred care, in general, seeks to explore the illness experience as perceived by the patient; to understand the patient as a whole person rather than a disease; and to find common grounds regarding management between the perspectives of the doctor and the patient. In addition, patient-centred care aims to enhance the doctor-patient relationship and to incorporate the important elements of health promotion and health prevention in the management plan (Mead & Bower, 2000; Stewart et al., 2003; Saha et al., 2008).

A number of tools have been developed to assess the health care from the perspective of the health care user. One of the most widely used tools for this purpose is the Picker Patient Experience (PPE) questionnaire—a survey instrument developed for the purpose of measuring
patients’ experiences of their care. The PPE questionnaire is composed of 15 questions that measure patients’ experience within eight areas relating to their care—including information and patient education; emotional support; physical comfort; respect for patient preferences; involvement of family and friends; coordination of care; continuity and transition; and the overall patient impression about their health care experience (Jenkinson et al., 2002). The PPE questionnaire is now used by a number of governments and national health care systems to monitor their health care services performance and quality of care (Jenkinson et al., 2002; 2003).

Patients, however, or health care users in general are not a homogenous group. They are culturally diverse and their preferences about health care quality vary. They also differ in their assumptions and expectations about health care quality, which may have been shaped in response to previous experiences or a friend’s word-of-mouth (Zeithaml, 1981; Donabedian, 1988; Øvretveit, 1992; Silberman, 1995; Haddad et al., 1998). Differences in health status, health care quality, and use of health care services have been documented in the literature across different cultural groups, different age groups, and between men and women, among other variables (Nickens, 1995; Bethell et al., 2003). This demonstrates that the provision of culturally sensitive high quality health care is both challenging and important.

Because health care professionals and users understand disease differently, they have different expectations of health care and therefore different ways of evaluating health care quality (Helman, 1981; Mishler, 1981; Silberman, 1995; George & Sanda, 2006). Health care users tend to evaluate health care in terms of its responsiveness to their individual needs. They judge the quality of health care by its impact on their lives (Silberman, 1995; McGlynn, 1997). Their judgments of health care quality are therefore influenced by the cultural lenses through
which they interact with the health care system and experience the health care service (see Chapter 4).

The health care user perspective on health care quality may provide a unique insight into their experience and their perceived health care quality. The perspective of the patient can reflect the distinct views of the patient, about how they have experienced their health care, which may not be immediately evident to the health care provider. For example, a health care provider may understand the patient’s lack of gastrointestinal bleeding, and the consequent lack of need for blood transfusion, as a sign of high-quality health care, whereas the patient may not fully recognise the benefits of averted transfusion. The patient, instead, may recognise the full impact of erectile dysfunction—something that may not be immediately noticeable by the health care provider (George & Sanda, 2006).

Health care quality can be characterised from either or both of the patient and provider perspectives, as illustrated in Figure 2 (George & Sanda, 2006; Chow et al., 2009). The perspectives of the patient and the provider may provide distinct and complementary views on health care and health care quality depending on the area or domain of health care being evaluated. In non-overlapping areas (the blue and yellow shaded areas in Figure 2, respectively), the patient and the provider may have distinct and contrasting perspectives on, for example, the severity of the treatment side effects, each reflecting distinct elements of the quality of care received (George & Sanda, 2006) In these areas, the patient perspective is exceptionally valuable since it assesses areas that are inaccessible to the health care provider, including the patient-reported health status, quality of life, and satisfaction with care. On the other hand, in areas where the perspectives of the patient and the provider overlap or converge (as in the green shaded area in Figure 2), the patient and the provider may share similar views regarding health
care and its quality. Other areas of health care quality may remain ambiguous or incomprehensible to the patient or the provider. These areas (shown in Figure 2 as the unshaded areas within the health care quality rectangle) represent the elusive component of health care quality where medical knowledge is lacking about the effectiveness of particular treatment modality (George & Sanda, 2006).

Figure 2: Health care quality from the patient- and the provider-perspectives

On the other hand, health care managers’ concern may be on how well the system’s limited resources are to be spent. Health care management tends to evaluate quality in terms of the perceived efficiency of health care. From the management point of view, quality is seen as
the efficient distribution of resources to meet the needs of the users within, of course, the limits and constraints of the system (Øvretveit, 1992). The expectations of the health care users and those of the management may, therefore, be poles apart. The viewpoints of health care managers and users on issues like the choice of provider and access to care are likely opposing (McGlynn, 1997).

Health care professionals, on the other hand, tend to evaluate quality in terms of the processes of care and their capacity to produce desired health outcomes, based on scientific evidence. Their judgements, typically, focus mainly on the technical aspects of health care (Donabedian, 1988; Bruce, 1990; Øvretveit, 1992; Haddad et al., 1998). They, however, may appear to be caught between the competing demands of the other stakeholders, specifically, the attempts to control the costs of health care provision; the demands of health care users; and their beneficence-based professional judgement about best practice.

The interests of the key stakeholder groups in health care are in conflict (McGlynn, 1997). Due to the conflicting requirements of the different stakeholders, many definitions of health care quality are biased towards a particular stakeholder. Definitions of quality in the service sector tend to be focused entirely on the user. However, because of the information asymmetry present in health care but not in many other service industries, health care quality cannot—and should not—be entirely based on the health care users’ wants and preferences. Therefore, many studies use stakeholder-specific definitions of health care quality (Haddad et al., 1998). The concept should, though, address the different perspectives of key stakeholders and integrate or balance their competing viewpoints (Øvretveit, 1992; McGlynn, 1997).
3.6.3. Cultural Competence

As the patient-centred approach to providing health care gained more recognition in recent years, so did the concept of cultural competence in health care. Each concept has been viewed by proponents as one aspect of the other: cultural competence has been viewed as merely an element of patient-centeredness, while patient-centeredness has been viewed as one aspect of cultural competence. In any case, however, many of the core principles of cultural competence are the same as those of patient-centered care. Respect for patients as individuals; engagement with them as partners; and holistic consideration of the sociocultural context are viewed as key principles from both the perspectives of patient-centeredness and cultural competence (Carillo et al., 1999; Saha et al., 2008).

The primary driving force for the cultural competence movement is the recognition that cultural, social, and linguistic barriers hinder the delivery of effective health care and contribute to the widespread health disparities across the population (Betancourt et al., 2003; 2005; Saha et al., 2008). In many health care systems, clinicians are increasingly seeing patients from a broad range of cultural backgrounds (Betancourt et al., 2003; 2005). At its core, cultural competence seeks that the clinician sees the patient’s illness experience through the patient’s eyes (Saha et al., 2008). Recognizing that both the health care provider and user bring cultural perspectives to the encounter, it is important to bridge the cultural distance that exists between the health care provider and the health care user (Kleinman et al., 1978; Saha et al., 2008). From a cultural competence viewpoint, physicians are encouraged for example to explore their own cultural input into the health care encounter; to reflect on the social power associated with their status as medical professionals; and to critically question and deconstruct the medico-centric perspective (Kleinman et al., 1978).
Familiarity with the various cultural perspectives a health care provider might encounter in clinical practice is thought to be beneficial for providing a culturally competent care. Clinician’s awareness of and respect for different cultural traditions is equally valued. A good grasp of knowledge about all cultural perspectives a clinician might encounter is however infeasible if not at all possible (Saha et al., 2008). In addition, viewing patients as members of cultural groups rather than individuals with unique perspectives and experiences could lead to stereotyping patients and consequently providing inappropriate care (Saha et al., 2008).

The concept of cultural competence itself has evolved and expanded over time to incorporate aspects of health care beyond the interpersonal doctor-patient encounter such as how the health care service is organised and delivered to all cultural minority groups within a given society—who are most affected by racial or ethnic disparities in health care (Carillo et al., 1999; Betancourt et al., 2003; 2005; Saha et al., 2008). Additionally, the concept of cultural competence in health care expanded beyond culture itself and encompassed issues such as prejudice, discrimination, stereotyping, and social determinants of health external to the health care system (Betancourt et al., 2003; Saha et al., 2008).

3.6.4. The Structure-Process-Outcome Model
Donabedian (1966; 1980) has proposed a systems-based framework to define the categories of health care: the structure-process-outcome model. His framework has been used as a basis for defining health care quality (Campbell et al., 2000) and has proven to be a potentially valuable model to study the concept and determine its components (Baker, 1988; Campbell et al., 2000; Rubin et al., 2001). Donabedian’s model makes a distinction between three broad domains of health care: structure, processes, and outcome (Donabedian, 1980).
The *structure* of health care refers to the settings through which care is delivered, including physical as well as organisational settings. It includes the resources needed to provide health care, whether human, physical, financial, or otherwise. For example, it includes staffing, equipment, and buildings, as well as their characteristics in all detail. However, the term goes beyond resources to include the ways in which these resources are organised and controlled; that is, it includes how the health care service is financed, delivered, and regulated (Donabedian, 1966; 1980). For example, opening hours and appointment booking systems are structural features of health care.

As can be drawn from the above, health care structure provides the opportunity for individuals to receive care. It does not, however, guarantee it (Campbell *et al.*, 2000). Structure merely acts as the conduit through which health care is delivered. Obviously, the lack of certain structural features can have a direct impact on health care, which can only be delivered through certain settings and structures. Yet, the presence of these structures is not necessarily associated with proper health care delivery, which, in turn, depends on how well these structures are utilised. Therefore, it has been suggested that structure is not an integral component of health care. Rather, it may be considered as the means by which care is provided (Campbell *et al.*, 2000).

It has to be noted that the term ‘structure’ has been used in organisational theory, depending on the context, to refer to a number of different but related constructs. It could refer to either or both of the *physical structures* and the *social structures* within an organisation (Fombrun, 1986; Sheaff *et al.*, 2004). In his model of structure-process-outcome, Donabedian (1966; 1980) used the term *structure* to describe both the physical and social structures within
health care organisations. Donabedian’s structure does not, therefore, include *agency* (Giddens, 1984), the capacity of individuals to act independently within physical and social structures.

The *process* of health care involves the interactions between users and the health care structure. They can be considered as activities that constitute the actual delivery and receipt of care, and include what is actually done to or with the health care users (Campbell *et al.*, 2000). Processes of health care (represented by the central core in Figure 1) can be divided into two key categories: technical and interpersonal (Donabedian, 1980; 1988). The technical processes include aspects of the user-provider interactions that are directed primarily against the user’s health problem; they deal more explicitly with the *biomedical* aspects of the health problem (Donabedian, 1980; Campbell *et al.*, 2000). The terms ‘technical care’ and ‘clinical care’ have both been used to describe this category of processes; however, it has been suggested that clinical care is a more appropriate term since there are, arguably, technical aspects to interpersonal care (Campbell *et al.*, 2000). The goodness of clinical processes is often based upon the findings of scientific evidence and research (Donabedian, 1980; 1988; Campbell *et al.*, 2000).

On the other hand, interpersonal processes describe aspects of the user-provider interactions that deal more with the *psychosocial* element of the user’s health problem (Campbell *et al.*, 2000). Unlike clinical processes, the interpersonal processes of care are less likely to be based upon scientific evidence; rather, they tend to be influenced by the social norms and values that govern the relationships among people, in general, and between health care professionals and users, in particular (Donabedian, 1980). Since these norms and values are culturally shared, they tend to vary across different cultures. Therefore, the interpersonal processes of care are likely to differ among different cultures and societies (Burr, 2003). Similarly, interpersonal
processes of care are influenced by individual and social expectations and standards, whether these are in accordance or in conflict with clinical processes (Donabedian, 1988).

The two categories of process are closely interrelated and reciprocally linked. The success of clinical management, in many health care settings, is heavily influenced by the nature of the interpersonal relationship between the user and the provider (Donabedian, 1980; 1988; Øvretveit, 1992). This suggests that quality of health care is multifaceted. It is not exclusively dependent on the provider’s performance: the responsibility of the health care user may be equally important (Donabedian, 1988). The health care user participation in the receipt of health care is crucial as it directly affects the quality of care received. The user should perform his or her part of the health care transaction to ensure the receipt of high quality care by the provider. For example, the user may need to give an extensive description of his or her symptoms so that the health care provider can arrive at an accurate diagnosis (Zeithaml, 1981). In addition, the effectiveness and types of clinical modalities can, with time, shape the doctor-patient relationship. In some settings of health care, for example, psychotherapy, the two types of processes cannot be easily separated from each other (Donabedian, 1980). Since clinical care is not completely based on scientific evidence and interpersonal case is, at least in part, based on science, the distinction made between the two categories is not an absolute one, and the two categories may possibly overlap (Donabedian, 1980).

The third domain of health care in Donabedian’s (1966; 1980) model is outcome. Outcomes are the consequences of care, whether or not directly related to the health problem for which care was sought. They refer to the change in the patient’s present and future health, as it is broadly defined by the World Health Organization (1948). For example, resolution of symptoms, social restoration, and rehabilitation are all possible outcomes of health care (Donabedian, 1966).
However, the outcomes of care extend further to cover the psychosocial aspects of and the users’ attitudes towards health care. Examples of such outcomes include patient satisfaction and health-related behavioural changes (Donabedian, 1980). It has been argued that outcome is not a component of health care. Rather, it is a consequence of care (Campbell et al., 2000).

However, despite its general acceptance and widespread use, Donabedian’s structure-process-outcome model has been criticised on a number of accounts. The model’s assumption that structures affect processes, which in turn affect outcomes, has been described as too linear to accurately represent the relationships between the various domains of health care (Mitchell et al., 1998). In addition, the structure-process-outcome model has also been criticised for failing to account for antecedents of medical care, primarily patient and environmental risk factors, which may have a significant influence on health care quality or outcomes of care (Mitchell et al., 1998; Coyle & Battles, 1999).

It has been suggested that the relative lack of correlation between health care process and outcome is the result of lack of inclusion of important patient characteristics that had an impact on the outcomes measured (Coyle & Battles, 1999). It has been suggested that factors such as patient factors—including genetics, socio-demographic attributes, health beliefs, and health-related behaviours—and environmental factors—such as the patient’s personal, social, and cultural characteristics—are all absolutely necessary for understanding of the effectiveness of health care process (Coyle & Battles, 1999). Failure to include such relevant and important factors in the structure-process-outcome model may have limited the model’s utility for recognising how the three domains of health care interact with and influence each other (Coyle & Battles, 1999; Carayon et al., 2006).
3.6.5. **Approaches to Health Care Quality Assessment**

Given the complexity of health care quality, there is no single gold standard approach for assessing it. In 1983, a working group of the World Health Organisation divided health care quality into four areas: professional performance (technical quality), use of resources (efficiency), risk assessment, and patient satisfaction with the health care service (World Health Organization, 1983). However, this classification is considered somewhat outdated as it appears very technically driven and provider-focused (Greenhalgh & Eversley, 1999).

Donabedian’s (1966; 1980) triad system of structure, process, and outcome is probably the best-established taxonomy of health care quality (Greenhalgh & Eversley, 1999; Campbell et al., 2000; Rubin et al., 2001). Data from the three domains of health care—structure, process, and outcome—have been used to assess health care quality (Donabedian, 1980; Rubin et al., 2001). While it is possible to use data from any of the three domains, the differing approaches to quality assessment will likely yield different judgements about the goodness of health care. Donabedian (1966) described the attributes and characteristics of high quality as ‘value judgements’ that are applied to the several aspects, properties, or components of any of the three domains of health care. As such, he concluded that health care quality “*may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part*” (p.692). Due to their conflicting and competing interests, stakeholders apply different ‘value judgements’ to the various aspects of health care quality depending on how they value them. As well, stakeholders may have different preferences for approaches to health care quality assessments. As will be discussed in Chapter 4, values are an important part of the cultural system.
Because of their differing emphases, different approaches to the assessment of health care quality yield different judgements about it. Donabedian (1980) argues that the most way to assess the quality of health care is to examine that care; that is, to examine the actual process of that care. In other words, it is argued that the goodness of health care is determined by the performance of the health care system or the processes of care—whether clinical or interpersonal—within the system. Assessment of health care quality by examining the process of care is justified, because the assessor is not interested in the power of medical technology to achieve results—in general; rather, he or she is interested in whether what is now known to be good and effective health care has actually been applied (Donabedian, 1966). There is considerable debate however regarding a process-based evaluation of health care quality (Rubin et al., 2001).

It has been stated earlier that health care processes can be divided into two categories: technical (or clinical) and interpersonal. With regard to the clinical processes, the relationship between them and their outcome is determined by the current state of science and technology (Donabedian, 1980; 1988; Rubin et al., 2001). How good a certain clinical process is is dependent upon its expected ability to result in improvements in health status, based on the current knowledge in health care (Donabedian, 1988). For a process measure to be valid, there must be a strong relationship between the process and the outcome measures (Rubin et al., 2001). That is to say, even if the expected improvements have not been achieved, quality of clinical management is said to be good as long as it conforms to the practice that is currently expected to result in the greatest improvement in health.

Therefore, quality of clinical management is limited by our current knowledge of health and medicine. The current knowledge of what is considered current best practices has formed,
over time, because on the average these practices are known to produce the greatest improvement in health (Donabedian, 1988). However, although some areas of the current knowledge in health care sciences are firm and detailed, other areas are still lacking and incomplete (Donabedian, 1988; Rubin et al., 2001). For example, some of our current knowledge of health care may have been derived from biased observations or improperly conducted studies, and hence are of questionable validity. Nevertheless, the quality of clinical management is not expected to go beyond the limits of our current knowledge in health and medicine. That is, if the realised fraction of what is currently known to be achievable in health status is called effectiveness, the quality of clinical care becomes proportionate to its effectiveness (see Figure 3) (Donabedian, 1988).

The solid line indicates clinical effectiveness in a certain disease, which represents the power of medical knowledge to achieve health improvements. For example, care 1 is said to be of higher clinical quality than care 2 because at the time it was given, it was known to produce a greater proportion of what was known to be clinically achievable.

**Figure 3: Clinical effectiveness of care**

On the other hand, the management of the interpersonal processes is governed, as mentioned earlier, by the values and norms of a given society, rather than science (Donabedian,
The goodness of interpersonal performance is therefore judged by the extent to which interpersonal processes are in accordance with these values and norms, within the frame of accepted individual and social standards. Therefore, the interpersonal process must adapt to so many variations in the preferences and expectations of individual users of health care (Donabedian, 1980; 1988). Although the interpersonal process is a vitally important element of health care quality, it is often ignored in quality assessments, mainly because the information about it is not easily available (Donabedian, 1988).

It can be concluded that the quality of the health care process has been defined as a normative behaviour, the norms being derived from both the science of medicine and the values of the society (Donabedian, 1980). Hence, assessing health care quality by examining the health care process depends on the evidence that links the health care process with improved health outcomes. That is, for quality measured using data on the process of health care to be credible, it has to be demonstrated that a change in the process leads to a change in the outcome. Health care quality cannot be measured for processes for which no research is evidence is currently available (Davies & Crombie, 1995; Brook et al., 1996; 2000).

Stakeholders may hold different preferences for different (types of) processes. For example, health care users with serious or life-threatening conditions may subordinate interpersonal communication to clinical competence, on which they place the highest value. On the other hand, users with mild or self-limiting conditions may value the interpersonal processes of care over the clinical ones (Donabedian, 1980; Brook et al., 2000). In addition, the individual user’s value system may also play a role in his or her preference for certain processes of care over others (Silberman, 1995; Brook et al., 2000).
Another approach to assess health care quality is to examine the structure of health care. The goodness of health care structure may be a less direct judgement on health care quality than judgements made on the health care process itself. It is generally assumed that the quality of care is contingent upon the presence of an appropriate environment that is facilitative to high quality health care delivery (Donabedian, 1966). That is, structure can influence health care quality indirectly by either increasing or decreasing the likelihood of good performance (Donabedian, 1980; 1988). Proper system design and sufficiency of resources can, undoubtedly, boost the quality of care; however, these attributes of structure do not guarantee, by themselves, that high quality of care will follow. For example, care from a trained health care professional with poor communication skills does not constitute high quality health care. The mere availability of good structure is not guaranteed to produce high quality health care. Health care structures are, therefore, indirect influences on quality (Campbell et al., 2000). Yet, structure may have influence on the process of care. For example, staff shortage or treatment unavailability could possibly disrupt health care processes and subsequently the functioning of the service. That is, health care providers cannot provide high quality care in the absence of necessary resources (Campbell et al., 2000).

In addition, the health care outcome has been frequently used as a measure of the quality of health care. Examples include the studies of perinatal mortality rates and surgical fatality rates (Donabedian, 1966; Needleman et al., 2002; Starfield et al., 2005; Chow et al., 2009). Unlike health care process, assessments of health care outcomes reflect both the power of medicine and medical science to achieve certain health-improving results under certain conditions and the extent to which ‘scientific medicine’—as currently conceived—has been applied in the instance under study. This may limit the use of outcome as a relevant measure of health care quality.
because what is needed is actually to separate the two effects rather than measuring their sum (Donabedian, 1966).

More importantly, health care outcomes are only partially produced by health care. They are contingent upon a multitude of factors including, but not limited to, the structure and process of health care (Donabedian, 1966; 1988; Brook et al., 2000; Campbell et al., 2000; Rubin et al., 2001). For example, most people get well in spite of medical errors and poor health care, in general (Brook et al., 2000). When a health care provider discovers that his patients had worse outcomes than another provider’s patients, it may be unclear what, if anything, should be done about it (Rubin et al., 2001). The assumption is that outcomes reflect the quality of health care provided; hence, poor outcomes are the result of deficiencies in care (Davies & Crombie, 1995). However, the presence of good structure and good process only increases the likelihood of good outcome (Donabedian, 1988; Campbell et al., 2000), which is influenced by other factors. In fact, it is impossible to know for sure the extent to which an outcome is attributed to a certain process of care. Health care outcomes reflect all components of care provided by all members of the health care team, among other things. In theory, all significant factors other than health care should be held constant during and after care, so that valid conclusions can be drawn about the outcome of health care (Donabedian, 1966; 1988). In addition, the relationship between the health care systems—being made up of structures and the processes taking place within them—and their outcomes is often causal rather than logical. That is, an expected outcome will not necessarily follow from certain processes using certain structure, as logically expected (Campbell et al., 2000).

Moreover, many outcomes occur years after the health care encounter, which renders their use in assessing health care quality problematic and questionable. Many outcomes that are
important to the patient, such as functional status and quality of life, may require years after the illness for them to be measured (Donabedian, 1966; Davies & Crombie, 1995; Brook et al., 2000; Campbell et al., 2000; Rubin et al., 2001). Another consideration that limits the use of outcomes as a measure of health care quality is that many health care outcomes are themselves difficult to measure. Examples of these include social restoration, physical disability, and rehabilitation (Donabedian, 1966; Davies & Crombie, 1997; Castle & Ferguson, 2010). Other important outcomes may be relatively rare that an evaluator would need to wait to accrue a larger sample of patients, thus increasing the time for evaluation (Rubin et al., 2001).

In addition, the face validity that some outcomes have as measures of high or poor quality health care is not absolute and may be debated. Some types of medical treatments, while considered good medicine in some cultures, can be incapacitating in others. For example, surgical correction of developmental hip dysplasia for the Navajo Native American—who spends much time seated on the floor—can be crippling (Donabedian, 1966). Health care providers are generally wary of health care outcome measures that are influenced by several other factors than health care and are hence of questionable validity (Rubin et al., 2001). Health care outcomes must therefore be used with discrimination in quality assessments. As Donabedian (1966) notes, health care outcomes remain, however, “the ultimate validators of the effectiveness and quality of medical care” (p.694).

Many empirical studies have examined the relationships between health care quality and the three domains of health care—structure, process, and outcome. It is generally assumed that good health care structure increases the likelihood of good process and good process increases the likelihood of good outcomes (Donabedian, 1988; Campbell et al., 2000). Knowledge about the relationships of the different health care domains comes from a variety of sources. For
example, knowledge about the relationship between structure and process (and outcome) comes from organisational sciences. What is known from these sciences suggests that the relationship between health care structure and health care process is rather weak and inconsistent (Donabedian, 1988; Brook et al., 2000; Campbell et al., 2000; Sheaff et al., 2004). Similarly, the relationship between structure and outcome is, too, inconsistent (Mitchell et al., 1998; Campbell et al., 2000; Sheaff et al., 2004). From structure, it can only be inferred that settings are conductive or facilitative to good care. It cannot be asserted from structure, however, whether care was of high or poor quality (Donabedian, 1988).

Knowledge about the relationship between the attributes of the interpersonal process of health care and outcome proceeds from the behavioural sciences. However, assessments of the interpersonal aspects of care have often been ignored from assessments of health care quality because information about them is not easily available. Moreover, the criteria and standards upon which the interpersonal process of care can be assessed are not well-developed, due in part to the great variation in the preferences and expectations of the individual users of health care (Donabedian, 1980; 1988). Furthermore, what is known about the relationship between the clinical process of care and outcome derives, obviously, from the health care sciences. Quality of the clinical process is, therefore, limited by the extent of our knowledge of these sciences (see Figure 3) (Donabedian, 1988).

As a general rule, the best system of health care quality assessment should include elements of the three domains, structure, process, and outcome. Such a system allows supplementation of one approach’s weaknesses by strengths from another approach (Donabedian, 1988).
The structure-process-outcome model of health care quality (Donabedian, 1966; 1980) has dominated approaches to understanding and evaluating health care quality. In contrast, much less has been written about the relationship between health care quality and culture. It is known from the literature that the concepts of health and health care are influenced by cultural factors (Eisenberg, 1977; Helman, 1981; Mishler, 1981; Morgan et al., 1985; Wildes, 1999; Burr, 2003; Yadavendu & Kumar, 2009). However, the mechanism of how culture influences health care quality has not been explicitly studied.

### 3.7. Primary Care

As this study aims to explore the concept of health care quality in the primary care settings, it is appropriate—and important—to, at least briefly, discuss the context of primary care. Interest in primary care has been increasing. The importance of primary care is increasingly recognised in health care systems around the world (World Health Organization, 2003; 2008). Many health care systems, including that of Kuwait, place a particularly strong emphasis on primary care (Fraser, 1995; Abyad et al., 2007; Kuwait Institute for Medical Specialization, 2008). This growing global interest in primary care is not surprising and is due to the multiple benefits associated with this level of health care.

Studies have consistently shown that a strong primary care system is associated with better health outcomes (Franks & Fiscella, 1998; Starfield et al., 2005; Beasley et al., 2007; Starfield & Shi, 2007; Stange & Ferrer, 2009). In a review of the contributions of primary care to health care systems, Starfield and her colleagues (2005) found that the studies reviewed have constantly shown that a strong relationship exists between primary care and most of the health outcomes reviewed. For example, it has been shown that primary care has a significant influence
on total mortality; the more primary care-oriented a health care system is, the lower the overall mortality (Shi, 1992; 1994; Shi et al., 1999; 2003a; 2003b; Macinko et al., 2003). Moreover, primary care is associated with lower disease-specific mortality for a variety of conditions, including heart disease, lung disease, cancer, and stroke (Shi, 1992; 1994; Shi et al., 1999; Macinko et al., 2003). Furthermore, research on the effects of primary care on health has shown that primary care has a positive impact on life expectancy (Vogel & Ackermann, 1998; Shi et al., 1999). As well, research has demonstrated that health care systems with orientation towards primary care perform better in other health indices, like infant mortality rate, postneonatal mortality rate, and low birth weight rate (Shi, 1992; 1994; Vogel & Ackermann, 1998; Shi et al., 1999; 2004b). Good experiences with primary care are generally associated with better self-reported health on the side of the patient (Shi & Starfield, 2000; Shi et al., 2002; Shi et al., 2004a). These associations between primary care and health outcomes have been attributed to the four main elements of primary care practice, namely first-contact care, longitudinality, comprehensiveness, and coordination (Starfield, 1992).

Another well-established benefit of primary care is that it reduces the negative effects of socioeconomic inequalities on population health (Shi et al., 1999; Shi & Starfield, 2000; Shi et al., 2002). It is well known that socioeconomic deprivation has a significant negative impact on health of people who are further down the social ladder. Within any society, most diseases are more common further down the social ladder. Life expectancy is strongly but inversely related to poverty and deprivation (Quick & Wilkinson, 1991; Marmot & Wilkinson, 1999; Wilkinson & Marmot, 2003). Studies have shown that primary care has a great potential to reduce health disparities associated with socioeconomic deprivation. The effects of primary care on health are most prominent in the more deprived and disadvantaged communities (Van Doorslaer et al.,
2004; Starfield et al., 2005), and extend to cover many health outcomes, including total
mortality, heart disease mortality, cancer mortality, and stroke mortality (Shi et al., 2005a;
2005b; Starfield et al., 2005). As well, primary care reduced disparities in infant mortality,
postneonatal mortality, and low birth weight across the social ladder (Shi et al., 2004b). There
are fewer disparities in self-reported health in health care systems with orientation towards
primary care (Shi & Starfield, 2000; Shi et al., 2002).

Furthermore, in addition to its health benefits, primary care is also associated with lower
total costs of health care (Franks & Fiscella, 1998; Starfield & Shi, 2002; 2007; Starfield et al.,
2005). This is, at least in part, because primary care provides better preventive care services and
reduces the costly and inappropriate hospital care (Franks & Fiscella, 1998; Starfield, 1998;
Starfield et al., 2005). Research has shown that compared to hospital- or institutional-based care,
primary care providers can manage common diseases in the population at lower cost—without
compromising patient outcomes (Whittle et al., 1998). Studies have shown that strong primary
care is associated with reduced costs (Franks & Fiscella, 1998). National health care systems
with stronger primary care had lower total costs of health services, while those with less
emphasis on primary care had significantly higher costs. Countries with greater proportion of
their physicians practising primary care tend to have lower per capita health expenditure than
those with a greater proportion of specialists (Starfield, 1998; Starfield & Shi, 2002).

The evidence is strong and consistent in showing that—across health care systems—
primary care is linked to better health outcomes, reductions in health disparities, and reductions
in health care costs. These influences of primary care have been demonstrated in various health
care systems throughout the world. They have been demonstrated over time and across all types
of studies (Starfield et al., 2005; Starfield & Shi, 2007). The multiple benefits of primary care
continue to attract the attention of health care providers and policy makers. With the increasing pressures and rising costs of health care, there is a growing need to shift the focus to primary care and to intensify research on health care quality in primary care, especially in health care systems that place greater emphasis on this level of health care.

### 3.7.1. Defining Primary Care

There is no consensus definition of primary care. Various definitions have been put forward by various authors and authorities. In these definitions, primary care has been variously viewed as a strategy for organising health care services; a set of attributes or functions; or a level of care. This considerable diversity of opinion about the scope and nature of primary care has made it difficult to adopt a consensus definition of the term (Donaldson et al., 1994; Lee et al., 2007; 2009). However, a number of commonalities are shared across many of the widely-cited definitions of primary care (Muldoon et al., 2006). In a report by the Institute of Medicine, primary care was defined as follows.

*Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.*

(Donaldson et al., 1996, p.1)

Another definition of primary care was proposed by Starfield. She defined primary care as:

*First-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system.*

(Starfield, 1994, p.1129)

Starfield presented another definition, which became commonly cited. The definition holds that primary care is

[That] level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not diseases-oriented) care over time, provides care for all
but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others. (Starfield, 1998, pp.8-9)

The definition of primary care has been sequentially modified since the introduction of the term (Pearce & Matheny, 2003). A number of elements of primary care are common to the above definitions—and many others in the literature. Identification of the key elements or attributes of primary care has been a prominent feature in the literature of the subject. An early monograph by Alpert and Charney (1973) described three fundamental characteristics of primary care: first-contact care, longitudinality, and coordination (or integration). These characteristics are, at least in part, based on the descriptions of primary care provided in the Millis Commission report, which had earlier noted that primary care provides first-contact medical care; assumes the longitudinal responsibility for the patient regardless of the presence or absence of disease; and integrates the physical, mental, and social aspects of health (Millis, 1966). A report by the Institute of Medicine (Scheffler et al., 1978) proposed that accessibility, comprehensiveness, coordination, continuity, and accountability are essential to the practice of good primary care. These attributes are consistent with other reports that emphasised first-contact and longitudinality as key aspects of effective primary care (Starfield, 1992; 1994; Green et al., 2004). Sometimes, ‘affordability’ is mentioned as an attribute of primary care, adding emphasis to equity and equitable distribution of resources (Green et al., 2004).

The Declaration of Alma-Ata, probably one of the most frequently cited landmark events in the literature of primary care, further emphasised the importance of social and cultural suitability of primary care services. It defined primary care as

[Essential] health care based on practical, scientifically sound and socially acceptable methods of technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-

Starfield (1992; 1994; 1998) proposed that the elements of first-contact care, longitudinality, comprehensiveness, and coordination are crucial to the practice of primary care. These have been reaffirmed by other authors as important attributes of primary care (Blumenthal et al., 1995; Flocke, 1997; Safran et al., 1998; Wong et al., 2010). Discussion of the importance and benefits of each attribute is beyond the scope of this report. Starfield (1992) remarks that many of the elements proposed by the Institute of Medicine (Scheffler et al., 1978) as attributes of primary care could be attributes of secondary or tertiary care as well, and thus are not specific attributes of primary care.

These attributes are integral to health care quality in primary care. Campbell et al. (2000) suggested that three of the four attributes of primary care—namely first-contact care, comprehensiveness, and longitudinality—are sub-components of health care quality in primary care.

Though discrete in concept, the four attributes of primary care are understandably interrelated. Their interdependence is well recognised in the literature, as well as their conceptual separability. Their benefits are additive. Without being interdependent, the attributes would lose much of their potential. For example, without coordination of care, the first-contact function of primary care would become purely administrative, and comprehensiveness of care would be made extremely difficult.
3.8. Chapter Summary

The purpose of this chapter was to explore the concept of health care quality. As discussed thus far in the chapter, it has been argued that even though health care is a service characterised by intangibility, heterogeneity, inseparability, and perishability, the health care service has a number of distinguishing features that sets it apart from other services. The demand for health care is a derived demand for health. In itself and independent of its consequences, health care is generally considered to negative and undesirable. Health care is characterised by a high degree of information asymmetry between health care professionals and users, which leads to supplier-induced demand. Many events in health care are uncertain and unpredictable. Desirable health outcomes are unpredictable despite best possible care. Moreover, externalities are widespread in health care.

In addition, the relationship between the health care service provider and service users is unique. Unlike other services where self-interest is the accepted norm, the health care professional is expected to act in the best interest of the patient, who may be technically incompetent to act in his or her own behalf.

Due to these unique characteristics, health care quality has been studied as a separate concept from service quality. Researchers have struggled to provide a generally applicable definition for health care quality that does justice to all its dimensions and satisfies the interests of all key stakeholders. The viewpoint of health care users, which has largely been ignored in definitions of health care quality, is now being increasingly recognised.

The structure-process-outcome model was developed by Donabedian (1966; 1980) as a basis for studying and evaluating health care quality. The model has dominated approaches to
understanding and evaluating health care quality. It provided a foundation for a growing body of research that pertains to understanding health care quality and assessing its various components.

There is, however, a paucity of literature on the ways in which culture affects health care quality. It is known from the published literature that the concepts of health and health care are influenced by cultural factors. In fact, the entirety of health care is shaped by the culture within which it is provided and practised (see Chapter 4). It is not known, however, how culture influences conceptions’ of health care quality. More research is therefore needed to explore how competing stakeholders’ perspectives of health care quality interact with parts of the cultural system to influence the construction of health care quality and the enactment of government health care policy objectives. This study intends to contribute to this gap by adding further insights in to the social construction of health care quality, and, in particular, how it is influenced by culture.

The next chapter will explore the concepts of culture and national culture. It will then overview the culture of Kuwait, where this study will take place.
Chapter 4

Culture

4.1. Introduction

Culture is pertinent to the study of health care quality because it has important implications for health and health care. The cultural background of the individual has an important influence on many aspects of his or her life, including beliefs about health and illness. As has been highlighted in Chapter 2, health and illness are socially constructed phenomena, and hence their nature is conceptualised differently in different cultures (Eisenberg, 1977; Helman, 1981; Mishler, 1981; Morgan et al., 1985; Wildes, 1999; Burr, 2003; Helman, 2007; Yadavendu & Kumar, 2009).

The objective of this chapter is to explore the concept of culture and examine how it is related to health care quality. The chapter will first define and describe the concept of culture which forms a part of the theoretical framework for this thesis. The chapter will then focus in more depth on the narrower concept of national culture and examine the various theoretical models of national culture. This will be followed by a section dedicated to the culture of Kuwait.

4.2. The Concept of Culture

The word culture is a much-maligned word in the world of academia (Asser & Hodges, 2010). It appears to mean different things to different people (Metle, 2002; Triandis & Suh, 2002; Asser & Hodges, 2010; Hofstede et al., 2010). Our knowledge about culture comes from a variety of disciplines, including anthropology, ethnology, management, and sociology. However, there is no consensus on a definition of the concept. Culture has been variously defined as ‘collective
soul’, ‘collective programming of the mind’, ‘values that are shared among a group of people’, and ‘some type of “social glue” that holds people together’ (Hill, 2001; Warner & Joynt, 2002; Hofstede et al., 2010). From its Latin etymology, cultūra, one might broadly define culture as ‘the result of human action’ (Cartwright, 1999; Warner & Joynt, 2002; Hofstede et al., 2010).

In their review, Kroeber and Kluckohn (1967) found 164 different descriptions of culture, which they have classified into categories. Although these categories are not mutually exclusive, they can be used to reflect the various aspects of this diffuse concept (Torres, 2006). Culture is therefore characterised by the following aspects: it contains several components; it refers to social heritage and traditions; it comprises ideals and expected behaviours; it is based on adaptation to environmental conditions, learning, and behaviour; it regulates human social life; and it is reflected in ideas, symbols, and artefacts (Kroeber & Kluckohn, 1967).

A similar list of propositions on the theory of culture was proposed by Herskovits (1948). He argued that culture is the instrument whereby the individual adjusts to his or her total setting, and gains the means of creative expression. He argued that it derives from the biological, environmental, psychological, and historical components of human existence. He also argued that culture is dynamic and learned—rather than innate (Herskovits, 1948). Many social scientists agree with Herskovits’ propositions (Heidrich, 2002).

A more comprehensive definition of culture is to view it as “that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society”. This definition was proposed by Tylor in 1871 and is one of the most famous definitions of culture (Keesing & Strathern, 1998; Helman, 2007; Holland & Hogg, 2010). Another definition of culture holds that it is “a system of shared ideas, a
system of concepts and rules and meanings that underlie and are expressed in the ways the human beings live” (Keesing & Strathern, 1998, p.16).

A similar definition was proposed by Blackwell and his colleagues (2001). They defined culture as “a set of values, ideas, artefacts, and other meaningful symbols that help individuals communicate, interpret, and evaluate as members of society” (p.514). Nakata and Sivakumar (2001) stated that social scientists define culture as patterns of thinking, feeling, and acting rooted in common values and conventions of a society. Heidrich (2002) defines culture as “the distinctive way of life of a group of people, their complete ‘design for a living’” (p.25).

From these definitions, one can see that culture is a set of guidelines and rules, whether implicit or explicit. It includes both conscious and unconscious values, ideas, attitudes, and symbols. These unwritten rules and guidelines provide a set of orientations for members of the society and tell them how to view the world, how to experience it, and how to behave in it. That is, they shape the behaviours of society members and provide the basis for acceptable social behaviour within the society (Torres, 2006; Helman, 2007; Asser & Hodges, 2010; Hofstede et al., 2010; Leng & Botelho, 2010). In sum, culture provides the standards for deciding what is; what can be; how one feels about it; what to do about it; and how to go about doing it (Goodenough, 1961).

Culture can be seen as the ‘lens’ through which the individual experiences, perceives, and understands the world that he or she inhabits, and learns how to live within it (Klein, 2004; Helman, 2007). This cultural ‘lens’ filters and organises incoming information received through it; it focuses sense-making, structures planning and adaptation activities, and frames interactions and communication (Klein, 2004). Culture, thus, affects people’s behaviour. People are often
conditioned by their cultural environment to behave in specific ways and become products of their culture (de Mooij, 2004). For example, the ways in which health care is practised are shaped by the cultural values and norms of the society in which it is practised. Different medical professionals have different cultural backgrounds which impact the way they provide care (Helman, 2007; Marcum, 2008; Yadavendu & Kumar, 2009). It is now increasingly recognised that culture plays an important role in determining how people perceive the world and behave in it (Lowe & Corkindale, 1998; Heidrich, 2002; Leng & Botelho, 2010).

This view of culture is consistent with computer system analogy used by Hofstede (1984b; 2001). He argued that culture is “the collective programming of the mind that distinguishes the members of one group or category of people from others” (1984b, p.51; 2001, p.9). This view of culture, as the ‘software’ of the mind as Hofstede puts it, does not mean that people are programmed the way computers are. A person’s behaviour is only partially predetermined by the ‘software’ of his or her mind. He or she has a basic ability to deviate from the ‘software’ and to react in new, creative, or unexpected ways (Heidrich, 2002; Hofstede et al., 2010).

The unwritten rules and guidelines that constitute culture are learned or acquired. They are not innate; they do not derive from individual’s genes. Rather, they derive from the individual’s social environment (Herskovits, 1948; Heidrich, 2002; Torres, 2006; Hofstede et al., 2010; Leng & Botelho, 2010). People are very much influenced by the social environment surrounding them, where they grew up and collected life experiences. They are affected by their families, neighbourhoods, school, youth groups, work place, and the community at large (Metle, 2002; Hofstede et al., 2010). That is why definitions of ‘health’ and ‘illness’ vary between cultural groups and social classes. ‘Health’ is a multidimensional and holistic concept that
includes physical health, mental health, and social health. Therefore, a disturbance in any one of these—for example, a major conflict with a family member—may be seen as a form of ‘illness’, especially if it interferes with daily life and activities (Helman, 2007). In many societies, health is conceived as balance, within self as well as in relation to the nature (and possibly the supernatural world) and with others. An imbalance in any of these elements—especially if it manifests itself by physical or emotional symptoms—may prove that one is ill (Helman, 2007).

These rules and guidelines are transmitted from generation to generation through learning. Each generation inherits its cultural ‘lens’ from the previous generations through the use of language, symbols, art, and ritual. Growing up within any society can be thought of as a form of *enculturation*, whereby the individual slowly acquires the cultural ‘lens’ of that society. Because members of the society grow up in similar environmental and social contexts, they have shared experiences (Klein, 2004; Helman, 2007). Although value systems are found in every society, significant differences may exist between different societies. These differences are the result of the different priorities societies place on each cultural value or principle (Kalliny, 2010).

The contextual commonalities that members of a particular society experience together generate common behavioural and social patterns in the society (Klein, 2004; Helman, 2007; Kalliny, 2010). Because they have common needs and face similar challenges, they organise as families, communities, organisations, and nations. People form societies to address their similar challenges. Because members of the society share many contextual commonalities, they also share the way they see the world. This provides the basis for a shared conception of the world among members of the society. Without such a shared perception, cohesion and continuity of the society would not be possible (Klein, 2004; Helman, 2007; Kalliny, 2010).
A crucial aspect of any culture’s ‘lens’ is the division of the world and the people within it into different categories. In every culture, people are divided into different social categories. For example, all cultures divide up their members into men or women, children or adults, young or old, healthy and ill, and so on. In each culture, there are elaborate ways of classifying people into social categories, of moving them from one social category to another, and of confining people—sometimes against their will—to the categories into which they have been classified. For instance, in a particular culture, an individual may be classified as ill despite the lack of a biomedical diagnosis and despite the disagreement of health care professionals. Also, an individual may be labelled as disabled or elderly in certain cultures despite his or her disagreement (Helman, 2007). One powerful example that demonstrates this is the Rosenhan experiment (Rosenhan, 1973). In the experiment, eight actors presented themselves to mental health hospitals with fabricated claims of psychiatric symptoms. All were admitted and most were given a diagnosis of schizophrenia, even though they immediately ceased fabricating symptoms after admission. The experiment showed that mental illness was socially constructed. Once having been labelled as mentally ill by the society (or a subset of the society), there was nothing the actors could have done to overcome the tag (Rosenhan, 1973). The findings of the Rosenhan experiment indicate that clinical opinion is swayed by personal and cultural beliefs. The practice of health care, in general, is very much influenced by the cultural ‘lens’ through which health care professionals experience and perceive the world.

Each of the social categories within a culture is marked by its own distinctive cultural attributes. Each social category has its own distinct cultural background including language, ritual, manners, and so on. For example, children, adults, and the elderly have different views of the world and are subject to different rules of behaviour. To some extent, even men and women
can have their own unique ‘cultures’ within the culture of the larger society. For example, in some cultures men and women are expected to conform to different norms and different expectations (Helman, 2007).

Many of the social categories (or groups) within a society will undergo some degree of *acculturation* over time, whereby they incorporate some of the cultural attributes of the larger society into their own culture. Through acculturation, the smaller social groups within a society adapt themselves to the larger cultural mainstream group by learning and acquiring cultural features of the larger culture (Helman, 2007). Acculturation is especially important in societies that have within their borders religious and ethnic minorities, migrant workers, and recent immigrants, each of whom have their own unique culture. Many of these social groups will undergo acculturation, while others will not (Helman, 2007). The Kuwaiti society, for example, is often depicted as a diverse society made up of people from different ethnic groups, each with its distinctive cultural traditions. More than two-thirds of Kuwait’s population are foreigners (Central Statistical Bureau, 2012), mostly from Asia and other Arab countries, but people of more than 120 nationalities live in Kuwait (Crystal, 1992; Al-Juhaim, 2008; O'Shea & Spilling, 2010). These varied cultural groups are in constant interaction with each other and with the dominant culture in Kuwait. As such interactions occur, these cultural groups adapt and change; they often ‘borrow’ from each other’s cultural traditions (Helman, 2007).

Culture can be further subdivided into the various professional subcultures that exist, including the medical, legal, or military professions. People in each of these professional subcultures form a group apart, with their own concepts, rules and social organisation. Even though these professional subcultures are part of the larger mainstream culture from which they have developed and thus share many of its concepts and values, they also have unique,
distinctive attributes of their own. For example, medical students undergo a form of enculturation where they slowly, over many years, acquire the ‘culture’ of their chosen career. In the process, they also acquire a different perspective of life from people who are outside this culture (Helman, 2007). This different perspective is the result of the different cultural ‘lens’ they acquire in the process of enculturation. Of course, this newly acquired ‘lens’ through which medical professionals, for example, see the world interferes directly with the way they view and understand health, health care, and health care quality. For example, due to this ‘lens’, medical professionals tend to overlook the ‘illness’ dimension which they consider ‘subjective’ or ‘soft’ data and focus solely on the ‘disease’ dimension (Feinstein, 1987; Silberman, 1995).

The various cultural lenses can also be demonstrated by the multiple stakeholder-specific definitions of health care quality, each looking at the concept from a particular stakeholder’s perspective (Øvretveit, 1992). De Santis (1994) argues that at the patient-provider clinical encounter there is in fact a meeting of three cultures—the health care providers’ own professional cultures; the patient’s culture; and the culture of the health care setting in which the encounter takes place; each with its beliefs, values, and practices. Understanding of how these three cultures interact is essential in ensuring culturally safe and appropriate care. Health care providers’ awareness of how their own culture can influence their relationships with health care users is an important step to prevent discrimination and prejudice in health care (Holland & Hogg, 2010). The significance of cultural suitability as a dimension of health care quality has already been demonstrated in the previous chapter.

Modern societies consist of many of the social groups and professional subcultures described above, each with its own set of rules and values. That is, modern societies are never culturally homogenous. Rather, they are a patchwork of different subcultures, each with its
unique view of the world, coexisting together and affecting each other (Helman, 2007). Culture is, therefore, not constant. Culture is a dynamic system. It emerges from a particular setting and constantly evolves and adapts to the changes in the setting over time. Many communities can now be said to occupy two or more cultures at the same time, with different competing views of the world (Klein, 2004; Helman, 2007; Leng & Botelho, 2010).

### 4.3. Levels of Culture

It has been proposed that there are three levels of culture in each human group (Hall, 1983; Schein, 1985). These three levels range from the explicit, manifest, tertiary level culture visible to the outsider—such as the traditional dress of the group, festive occasions, and social rituals—to deeper levels of culture only known by members of the cultural group themselves. The tertiary level culture may be seen as the ‘public facade presented to the world at large’ (Helman, 2007). This level of culture has also been referred to as artefacts and creations, like behavioural patterns and arts. According to Schein (1985), this level of culture includes tangible or observable elements that can be recognised by people who do not belong to the culture.

Below this outer level lies the secondary level culture, where implicit assumptions, beliefs, values, and rules that constitute the ‘cultural grammar’ of the group known to its members but rarely shared with outsiders. The primary level culture is the deepest level of culture where the rules and assumptions are known to and obeyed by all members of the cultural group, but they are seldom if ever stated or talked about. At this deepest level of culture, the rules, beliefs, and assumptions are implicit but taken for granted (Schein, 1985; Helman, 2007) (see Figure 4).
While the tertiary level culture is easiest to observe, change, and manipulate, the deeper levels of culture—primary and secondary levels—are hidden and much more stable and resistant to change (Helman, 2007). This may have major implications for health and health care, where for example patient education and health promotion efforts may only be partially effective in changing many of the beliefs and misconceptions about health that are deeply rooted in the larger culture of the society.

Hofstede and his colleagues (2010) proposed a similar model. They argued that all manifestations of culture can be neatly covered by the following four elements: symbols, heroes, rituals, and values. The four elements can be pictured as in Figure 5. For example, words and gestures belong to symbols, as do dress, hairstyles, and flags. Symbols are the most superficial manifestations of culture. New symbols are easily developed and old ones disappear. It is not uncommon for symbols to be copied from one cultural group by others. That is why symbols are in the outermost later of the culture ‘onion’. Heroes are persons—whether real or imaginary, alive or dead—with characteristics highly prized in a culture, and thus serve as models of behaviour within that culture. Rituals are collective activities that are technically superfluous but within a culture are considered socially essential and are carried out for their own sake. Ways of
greetings and paying respect to others are examples of rituals, as well as the way language is used in daily interaction—discourse. The outer three layers of the culture onion are visible to an outside observer. Their cultural meaning, however, lies only in the way these practices are interpreted by the insiders (see Figure 5). The core of culture is formed by **values**. Values in this context are the broad preferences for one state of affairs over others (Hofstede, 1985; Hofstede *et al.*, 2010). They are often acquired in childhood and are therefore deeply held and relatively resistant to change. Values deal with pairings such as moral versus immoral, normal versus abnormal, permitted versus forbidden, and so on (Hofstede *et al.*, 2010).

![Figure 5: The 'onion': manifestations of culture at different levels of depth. Adapted from Hofstede *et al.* (2010, p.8)](image)

In this sense, culture can be viewed as a metaphorical iceberg. The visible part of the iceberg is outer layer of culture in Figure 5: the language, gestures, and other visible ways of life. However, the greater part of the iceberg lies beneath the surface and is invisible to outside observers (Jiang, 2000). This greater part includes values.
Moreover, culture can be conceptualised at different levels. For example, a national level, a regional level, a religious level, a gender level, a generation level, a social class level, an organisational level, and so on. This is because in the course of our lives, we move in and out of various social circles and groups, each with its own set of rules and assumptions that constitute its culture. As people move in and out of these social circles, they acquire some of their cultural characteristics. Because almost every individual belongs to a number of different groups and social categories at the same time, the acquired cultural characteristics correspond to different levels of culture which may not necessarily be in harmony with each other (Hofstede et al., 2010).

One level at which culture can be conceptualised is the national level, that is, according to the individual’s nation (or nations, for those who migrated during their lifetimes) (Hofstede et al., 2010). In fact, as Heidrich (2002) noted, the word ‘culture’ is often substituted for ‘nation’; the two terms are often used interchangeably. In many cases, what are called cross-cultural differences are really only cross-national differences (Heidrich, 2002). The following section will tackle aspects of national culture theory.

### 4.4. The Concept of National Culture

As mentioned earlier, one level at which culture can be conceptualised is the national level. The concept of national culture is driven by the belief that the people of each country have shared history and experiences that create some cultural homogeneity between them (Alajmi et al., 2011). Like culture, the concept of national culture has been defined in various ways. For example, Erez and Early (1993) define national culture as the ‘shared values of a particular group of people or individuals of one nation or country’ (p.20). They argue that national culture
shapes the norms, attitudes, and behaviours of people who identify themselves as belonging to that particular culture.

Hofstede (1980a; 1991) defines national culture as the collective mental programming of the people of any particular nationality. He suggests that people of a particular nation share a collective national character dictated by their mental programming, which shapes their values, attitudes, behaviours, and perceptions of priority. As illustrated in Figure 5, the core of national culture is formed by values, which are often acquired during childhood and are transmitted from generation to generation. These values ‘are programmed into us first, that is, right from the day we are born’ (Hofstede, 1989b, p.391). They are thus deeply rooted within us. They form the most profound level of our mental programming, our values. By the time we are adults, these values are well settled and are very difficult to change (Hofstede, 1989b; Hofstede et al., 2010).

A central theme of Trompenaars’ (1994) view of national culture is that people with a particular national culture have formed a set of implicit logical assumptions that enable them to organise themselves in such a way as to increase the effectiveness of their problem-solving processes. Each national culture distinguishes itself from others by its solutions to the common problems or challenges it faces, such as how its people relate to each other, how they relate to time and to the environment (Trompenaars, 1994).

Fukuyama (1995) considers national culture as inherited ethical habit. An ethical habit can consist of an idea or a value. These ideas and values constitute the ethical codes by which societies regulate behaviour. They are nurtured by repetition, tradition, and example, and are reinforced by habits, social opinions, and images (Fukuyama, 1995).
One could argue, however, that national societies are rarely homogenous. They are often a patchwork of different cultures, each with its unique set of rules and assumptions (Helman, 2007). Hence, it is an oversimplification to argue that the cultural boundaries correspond exactly to the national (or political) borders (Heidrich, 2002). It is argued that the differences in the mixture of and interaction between the different cultures within political borders of a nation will result in distinctive values, norms, and beliefs systems that we can call the national culture of that nation. The national culture, thus, reflects the interaction between the unique—yet contested—cultural components present within particular political borders (Hofstede, 1984b; Heidrich, 2002).

However, it is also argued that the different cultures and subcultures within a nation are somehow the imperfect representations of its whole national culture. The interaction between the various cultural components within a nation only partially reflects its national culture. Moreover, many of the cultures and subcultures within a nation share common sets of attributes which comprise the national culture, including language, religious affiliations, racial mix, and other intangible attributes. The common influence of these cultural attributes implies that the various subcultures within a nation are identified with a particular national culture (Hofstede, 1984b; Very et al., 1993; Heidrich, 2002).

In spite of these limitations, it is still meaningful to study culture at the national level. Research has shown that national cultures are remarkably stable over time (Hofstede, 1984b; 1985; 1989a; 1989b; Hofstede & Usunier, 2003). This is so because national cultures differ at the level of the values held by a majority of the population which are often acquired in childhood and are deeply held. That is why national culture, which generally describes the values of the society at large, is stable.
To conclude, national culture is a collective phenomenon shared by a group of people who have similar values, beliefs, and behaviours within one nation. It influences how people within a particular nation behave, and, in this sense, makes them different from others (Hofstede, 1980a; 1991).

4.5. Dimensions of National Culture

As was highlighted earlier, national societies face similar challenges. Different societies, however, deal with their challenges differently. The national culture of a society influences how members of that society behave and respond to their challenges, and this is what makes every society unique. Hofstede (1991) argues that the common challenges that each society faces can be summarised as follows:

1. The social inequality including the relationship with authority.
2. The relationship between the individual and society.
3. The social implications of having been born as a boy or girl.
4. Ways of dealing with uncertainty, relating to the control of aggression and the expression of emotions.
5. The society’s orientation to time horizon—that is short- versus long-term orientation.

Based on these five areas, Hofstede (1980a; 1991) proposes five bipolar dimensions which became the basis of his characterisation of national culture (Jones, 2007). Hofstede (1980a) identified four—of the five—dimensions based on the findings of a large study involving a large multinational company. The study found that the four dimensions of national culture can be summarised as follows:

1. *Power Distance*, which is the extent to which the society deals with the fact that people are unequal. High power distance means high levels of inequality in terms
of power and wealth, while low power distance indicates greater equality (Hofstede, 1980a; 1991).

2. **Uncertainty Avoidance**, which is the extent to which the society copes with uncertainty and deals with risk. A society with high uncertainty avoidance is a one that is not comfortable with uncertainty or unknown situations. On the other hand, a society with low uncertainty avoidance is more open for unpredictability and ambiguity (Hofstede, 1980a; 1991).

3. **Individualism-Collectivism**, which is the extent to which members of a given society identify themselves as individuals or members of the social group. This dimension refers to the relationship, within a society, between the interests of the individual versus those of the group (Hofstede, 1980a; 1984a; 1991). The ties between members of individualist societies (high individualism ranking) are loose compared to those in collectivist societies.

4. **Masculinity-Femininity**, which is the extent to which members of a particular society are oriented towards either the role of men or women. It identifies the dominant gender role pattern in the society and the degree to which the society allows overlap between the roles of men and women. Men dominate a significant portion of the society in societies with high masculinity. Societies with low masculinity ranking, on the other hand, have low levels of discrimination between genders (Hofstede, 1980a; 1991).

Like any theoretical framework, Hofstede’s model of national culture has been criticised on a number of grounds. It has been criticised as having limited generalisability or reliability since it was based on a single company (Schwartz, 1994; Smith *et al.*, 1996; Hill, 2001; McSweeney, 2002). In addition, data were collected between the years 1969 and 1973, meaning that the study findings may be outdated. Cultures do not stand still, they evolve over time, albeit slowly (Hill, 2001; McSweeney, 2002).

Another criticism of Hofstede’s model came from Hofstede himself and his colleague (Hofstede & Bond, 1984; 1988; Hofstede, 1991). They acknowledged that the validity of ‘uncertainty avoidance’ in some Asian cultures is questioned. This led to the addition of a fifth dimension: **Confucian Dynamism** or **Long/Short Term Orientation**. This dimension describes the extent to which members of a particular society adopt a short-term outlook versus a long-term
outlook. In other words, long/short term orientation is the extent to which members of a given society accept delaying satisfaction of their physical, social, and emotional needs and wants (Hofstede & Bond, 1984; 1988; Hofstede, 1991). Long-term oriented societies tend to attach greater importance to the future, whereas short-term oriented societies tend to look to the past and the present more than to the future. Members of short-term oriented societies tend to foster values related to the past, such as respect for tradition and national pride (Hofstede, 1991; Alajmi et al., 2011).

Hill (2001) also criticised Hofstede’s model as being culturally bound. According to Hill (2001) the research team was composed mainly of European and American researchers. Their analysis may well have been shaped by their own cultural biases and concerns. Hofstede (1980b; 1991) himself comments that the author of any particular theory or model is as much culturally ‘conditioned’ as anyone else. As such, most if not all theories in social sciences are culturally-bound. They reflect common beliefs that derive from the common culture. The author of any theory is as human and as culturally biased as other mortals (Hofstede, 1991).

However, despite criticism, Hofstede’s model is the most widely used framework of national culture across many disciplines, including management, sociology, psychology, marketing, and others (Søndergaard, 1994; Steenkamp, 2001).

In addition to Hofstede’s model, Schwartz (1994; 1999) proposes an alternative model based on cultural values. His cultural model (1994; 1999) presents seven types of values on which national cultures can be compared by considering three issues that confront all national societies, which can be summarised as follows:
The first issue is how members of a particular society define the nature of relationship between the individual and the group: *Conservatism-Autonomy* dimension (Schwartz, 1999). It correlates closely with the individualism-collectivism dimension in Hofstede’s model (Gouveia & Ros, 2000). One pole of this dimension, *Conservatism*, describes cultures in which the individual is viewed as an entity that is embedded in the collectivity. The opposite pole, *Autonomy*, describes cultures in which the individual is viewed as an autonomous entity who finds meaning in his or her uniqueness (Schwartz, 1994; 1999). Schwartz (1999) argues that it is possible to distinguish conceptually between two types of Autonomy: *Intellectual Autonomy*, which refers to ideas and thoughts, and *Affective Autonomy*, which refers to feelings and emotions. Therefore, three value types are derived from this dimension: conservatism, intellectual autonomy, and affective autonomy.

The second issue that confronts all national societies is how members of a particular society behave to preserve the social fabric of the society. At one pole of this issue, *Hierarchy*, the society puts emphasis on the legitimacy of an unequal distribution of power and resources. At the opposite pole, *Egalitarianism*, there is a cultural emphasis on transcendence of selfish interests in favour of voluntary commitment to promoting the welfare of others. Accordingly, two value types are derived from this dimension: hierarchy and egalitarianism.

The third basic issue confronting all societies is the relation of humankind to the natural and social world. At one end of this dimension, the society response is to actively master and change the world to assert control and exploit it in order to further personal or group interests. Schwartz (1994; 1999) calls this value type *Mastery*. The opposing resolution to the issue is to accept the world as it is and try to fit in it, *Harmony*. That is, two value types are derived from this dimension: mastery and harmony.
A similar model was proposed by Trompenaars and his colleague (Trompenaars, 1994; Hampden-Turner & Trompenaars, 1994; 2000). They propose that national cultures can be categorised based on the following value dilemmas:

1. **Universalism versus Particularism**: universalism emphasises rules that apply to a universe of people, whereas particularism emphasises exceptions and particular cases. That is, universalist cultures attach great importance to the observance of rules, while particularist cultures attach a greater importance to the special circumstances or uniqueness of situations.

2. **Individualism versus Communitarianism**: this dimension describes the extent to which cultures lean towards the interests of the individual versus those of the collective group. This dimension is almost identical to Hofstede’s dimension, Individualism-Collectivism, described earlier.

3. **Neutral versus Emotional**: this dimension describes the extent to which it is appropriate within a society to display emotions. In high emotional cultures, individuals tend to show their feelings openly, whereas in neutral cultures, individuals keep their feelings carefully controlled and do not carry them out.

4. **Specific versus Diffuse**: this dimension describes the extent to which individuals in a particular culture tend to separate their private and working lives. In specific-oriented cultures, areas of private and working life are kept separate, whereas in diffuse-oriented cultures they are closely linked.

5. **Achievement versus Ascription**: this dimension describes how status is accorded within cultures. In achievement-oriented cultures, status is judged based on accomplishment, while in ascription-oriented cultures, status is ascribed rather than achieved, and is determined by factors like the individual’s age or origin.

Other categorisations of national culture dimensions exist. For example, another model of national culture was developed by Hall and Hall (1990). They differentiate cultures based on how individuals seek information and knowledge into high context cultures and low context cultures. They argue that this is a distinct dimension of national culture (Hall & Hall, 1990). Individuals from high context cultures tend to seek information from personal information networks, including family members, friends, and work colleagues. Individuals from low context cultures, on the other hand, tend to obtain information from a research base. Individuals from
such cultures place greater emphasis on written reports and data sources than on information gathered from personal sources.

To summarise, national culture has been defined in various ways. However, there is a general agreement among theorists that national culture is a multidimensional construct. Many authors proposed various dimensions of the concept. The dimensions of national culture reflect the basic issues or problems that face a particular culture and how that particular culture confronts these basic issues. The dimensions of national culture can explain many of values, beliefs, and priorities of people who belong to a particular national culture.

4.6. The Culture of Kuwait

Crystal (1992) claimed that Kuwaitis share a distinct identity that is built on a base of concentric circles: Islamic, Gulf Arab, and Kuwaiti (see Figure 6). The culture of Kuwait is a mixture of Islamic and Arab culture, although the people of Kuwait have a strong sense of national identity (Crystal, 1992; O'Shea & Spilling, 2010). They have ‘a sense of themselves as distinct from and more privileged than non-Kuwaitis’ (Crystal, 1992, p.71). The Kuwaiti society can be regarded as a traditional society. It is sustained by three factors that support traditional values and behaviour: language, religion, and the family system (Al-Juhaim, 2008).
At the outermost concentric circle is the Islamic identity of Kuwait (see Figure 6). Kuwait is an Islamic society and the vast majority of Kuwaitis are Muslims (Al-Juhaim, 2008; Al-Suwaihel, 2009; O'Shea & Spilling, 2010). Their Muslim identity is as important as their Kuwaiti and Arab identity. Religion and culture interact in various ways. To Muslims, Islam is more than a set of beliefs; it offers a complete guide to every aspect of life and influences their daily behaviour (O'Shea & Spilling, 2010). It thus plays an important role in defining Kuwait’s culture. Many of Kuwait’s cultural values were actually shaped by religious beliefs and practices (Al-Juhaim, 2008). Even though most Kuwaitis are Muslim, Christian churches and other places of worship can be found throughout Kuwait, and all religions are allowed to practice without prejudice. The constitution of Kuwait recognises religious freedom (O'Shea & Spilling, 2010).

At the second concentric circle is the Arab identity of Kuwait. Kuwait is a Gulf Arab society. Kuwaitis identify themselves as Arabs from Kuwait. But Kuwait also has a specifically Gulfian identity, a common cultural identity it shares with Bahrain, Oman, United Arab Emirates, Qatar, and Saudi Arabia. This identity is a unique local mixture of the Islamic and Arab identities, with African, Indian, and Persian influences (Crystal, 1992; O'Shea, 2000; O'Shea & Spilling, 2010).
An important element of this Gulf Arab identity is the way people in Kuwait speak. Arabic is the native language of the majority of Kuwait’s population and is the official language of Kuwait (Al-Juhaim, 2008; Al-Suwaihel, 2009; O'Shea & Spilling, 2010). The Arabic language seems to be a factor that creates a sense of personality among its speakers. The identity of Arabs is primarily based on Arabic language (Kabaskal & Bodur, 2002). The language is very context-sensitive; the use of indirect and inferred language patterns—whose meanings are only apparent when the context of the message is understood—is ubiquitous in everyday Arabic language (Burgmann et al., 2006). English, particularly American English, is the second language for most educated Kuwaitis (O'Shea & Spilling, 2010). It is unofficially considered to be the country’s second language and is widely spoken (Al-Juhaim, 2008). Many other languages are also spoken in Kuwait, reflecting the diverse origins of many expatriates in the country (O'Shea & Spilling, 2010).

At the innermost core in Figure 6, Kuwait has a specifically Kuwaiti identity, a sense of citizen loyalty narrower than any of these other loyalties (Crystal, 1992). Crystal (1992) points out that this particular identity ‘emerged initially as a result of the shared experience of migration and the common effort to build a new settlement and society in Kuwait. The pre-oil economy knit society together, as all were involved in some way in the shared enterprise of wrestling a living from the desert and the sea’ (p.66).

These identities (in Figure 6) have been nurtured by social institutions. Like most societies, the family forms the basis of society in Kuwait. Many of the society’s values derive from the family (Crystal, 1992; Al-Juhaim, 2008). It plays a major cultural role. The importance of family is further enhanced by the country’s small size and is supported by government policy. The Kuwaiti government provides lucrative incentives for every Kuwaiti couple getting married.
They receive the equivalent of £4,000 as a gift from the government as well as £4,000 as an interest-free long-term loan. They also receive a direct monthly £200 increase in salary and £100 for each child (Al-Juhaim, 2008). Decisions are typically made within the context of family. The extended family, also, plays a role in providing social and economic support to its members. Men occupy a prominent role in leading the family, as well as providing support and security to all family members (Al-Juhaim, 2008).

One unique social institution that plays an important role in nurturing the Kuwaiti identity is the diwaniyyah, a regular weekly meeting—generally of men who are relatives and friends—over coffee to discuss business and politics, arrange introductions, and obtain or grant favours through the development and maintenance of social connections (Crystal, 1992). Given the small size of the society, this social institution is designed to pass concerns upward, to link family clusters to the state (Crystal, 1992). Diwaniyyah can also provide a forum in which members of the society can address grievances (Al-Suwaihel, 2009).

Furthermore, Kuwait has developed an extensive welfare system that gives comprehensive welfare benefits to all Kuwaitis (Khalaf & Hammoud, 1987; Al-Juhaim, 2008; O'Shea & Spilling, 2010). The welfare benefits range from free education—including at university level—to free health care; to social services; to guaranteeing a job to all who seek employment; to providing free housing for citizens with low-income; to subsidising water, electricity, telephone services, gas, transportation, and basic food items, like milk, rice, and bread. These services are provided without imposing any fee or tax (Al-Juhaim, 2008).

Kuwait’s welfare system together with its young population has resulted in a number of challenges for the country including high reliance on foreign labour (Al-Juhaim, 2008; O'Shea &
Spilling, 2010). The labour force represents less than a third of the total population. This can be attributed to a number of factors such as the relatively large proportion of young population and the lower level of women’s participation in the labour force, due to social or cultural constraints. In addition, the welfarist policies of guaranteeing jobs to citizens have led to disguised unemployment in the form of over-employment. This has also led to low productivity and high levels of bureaucracy in the public sector (Al-Juhaim, 2008; Al-Suwaihel, 2009).

Hofstede’s seminal study (1980a) did not examine the national culture of Kuwait separately from other Arab countries. The study grouped together most Arabic-speaking countries, assuming all have homogenous national cultures. As a result, a single score for each dimension was given to all Arab countries. Along Hofstede’s (1980a; 1991) dimensions of national culture, Arab countries scored high in power distance, high in uncertainty avoidance, high in masculinity, and low in individualism. Later, data about the national culture of Kuwait were made available (Hofstede et al., 2010). These data demonstrated that Kuwaiti culture had a similar profile to the overall Arab culture but with higher scores on power distance and uncertainty avoidance and lower scores on masculinity and individualism (Hofstede, 2001; Hofstede et al., 2010). The main difference between Kuwait and other Arab countries was on masculinity.

The high score of Arab culture on the Power Distance dimension (a score of 80 out of a maximum 100 points) means that Arab people accept a hierarchical order in which everybody has a place and which needs no further justification (Hofstede, 2001; Hofstede et al., 2010). This points to high levels of inequalities in the distribution of power and wealth within the collective Arabic society. Generally, there is an expectation, and acceptance, that leaders will separate themselves from the subordinates (Hofstede, 1980a; 1991). Kuwait has an even higher score on
this dimension (a score of 90), which means inequalities in the distribution of power and wealth are more well accepted (Hofstede et al., 2010).

The Arab culture, with a score of 68 on the Uncertainty Avoidance dimension, has low tolerance for uncertainty. Cultures exhibiting high uncertainty avoidance tend to maintain rigid codes of belief and behaviour. They tend to adopt strict rules and policies to control the unanticipated and subsequently to reduce uncertainty (Hofstede, 1980a; 1991). The pattern is more exaggerated in Kuwait, which has an uncertainty avoidance score of 80, much higher than that of the Arab culture (Hofstede et al., 2010). One manifestation of high uncertainty avoidance is the highly bureaucratic system in Kuwait (Abdalla & Al-Homoud, 1995; Metle, 2002).

Kuwaiti bureaucracy has been described as being ‘rigid, non-innovative, insensitive to the masses, incompetent, adhering to red-tape, valuing hierarchy of authority and having too many managers and supervisors and very few functional staff’ (Abdalla & Al-Homoud, 1995, p.15).

In addition, both Arab and Kuwaiti cultures score low on Individualism, and both are considered collectivist cultures, though Kuwait has a lower score (25 compared to 38) (Hofstede et al., 2010). Close and long-term commitment to family is a characteristic of collectivist societies. Loyalty is paramount in collectivist cultures; it overrides most other social values. Offence in such cultures leads to shame and loss of face (Hofstede et al., 2010). The concept of ‘face’—pertaining to prestige and reputation—exists in Kuwait as it does in the West; its intensity in Kuwait is, however, much higher. A Kuwaiti spends his or her life building and maintaining face. This sense of maintaining face lies behind most behaviour in social and business settings (O'Shea & Spilling, 2010).
Kuwait scores 40 on the Masculinity-Femininity dimension, which means it is considered a relatively feminine culture (Hofstede et al., 2010). The Arab culture, on the other hand, with a score of 52, is considered a masculine culture. In feminine cultures, people tend to ‘work to live’ rather than ‘live to work’. People in feminine cultures value solidarity and quality in their working lives (Hofstede, 2001; Hofstede et al., 2010).

In addition, based on Hall and Hall (1990) classification of cultures, highlighted above, the Arab culture is a high context culture. That is, people in such a culture tend to seek information from personal information networks, like the family. They tend to rely more heavily on word-of-mouth and prefer oral communication (Hall & Hall, 1990).

In the previous paragraphs, the culture of Kuwait was discussed. Its distinct identity, which is built on a base of three concentric circles, has been highlighted. It was also highlighted that the Kuwaiti society is a traditional society. It is held up by three elements that support traditional values: language, religion, and the family system.

4.7. Chapter Summary

This chapter aimed to explore the concepts of culture and national culture and also to describe the culture of Kuwait. The chapter began by defining culture and then gave an overview of the concept examining how it can be conceptualised at different levels, including the national level. Then, the concept of national culture was discussed and the various models of national culture examined.

The chapter argued that the concept of culture can be conceptualised as the values, beliefs, and assumptions shared by a social group, that together form the ‘lens’ through which
members of the group experience, perceive, and understand the world. Culture has been conceptualised in the literature as a multi-layered construct, where the outer layer is easily visible to an outsider while the greater part of it is hidden and invisible to outside observers.

The chapter then described the culture of Kuwait, drawing on the various theoretical models of national culture.

In the following chapter, the research methodology used in this study will be presented and discussed.
Chapter 5

Research Methodology

5.1. Introduction

This chapter outlines the methodology of this study. It begins with presenting the research aims and questions, followed by a description of the research philosophy underpinning this study. The chapter then presents the proposed research design and data collection methods and data analysis and outlines their suitability for the proposed study. Finally, the considerations taken to ensure the rigor and quality of the study are presented.

5.2. Research Aims and Objectives

The main aim of this thesis is to examine how national culture influences the social construction of health care quality in primary care. Specifically, the thesis explores this in the context of the Kuwaiti primary care service. The study examines, compares, and contrasts the perspectives of the key stakeholder groups involved in primary care in Kuwait—including health care providers, users, managers, and policy makers—whose views of the service can make a key contribution to the planning and decision making processes.

Health is a socially constructed phenomenon. Therefore it is conceptualised differently across different cultural groups (Eisenberg, 1977; Helman, 1981; Mishler, 1981; Morgan et al., 1985; Wildes, 1999; Burr, 2003; Yadavendu & Kumar, 2009). Further, how it is practiced in specific cultural contexts which impact the ways it is provided (Burr, 2003; Marcum, 2008; Yadavendu & Kumar, 2009). Different cultural groups adopt different definitions of the nature or
scope of health care (Donabedian, 1988; Øvretveit, 1992). Arguably, these different definitions result from the various prevailing mind-sets within each cultural group (Silberman, 1995).

However, there appears to be a relative paucity in the literature regarding the ways in which culture shapes or influences how health care quality is socially constructed, produced, and represented to and by the stakeholders involved. This thesis aims to contribute to filling this gap in the literature. To achieve this aim, the thesis has set the following objectives:

1. To examine how the various stakeholders define health care quality in the Kuwaiti primary care.
2. To explore the similarities and tensions between the various stakeholders’ constructions of health care quality.
3. To investigate how the Kuwaiti national culture influences the various definitions and perceptions of health care quality.

Given the above objectives, this thesis seeks to answer a number of research questions. They are formulated as follows.

1. How do the various stakeholders define health and what are the differences and similarities in definitions between the various stakeholders?
2. How do the various stakeholders recognise health care quality in the primary care sector and how do they differ in their perceptions of health care quality?
3. Which cultural factors influence the stakeholders’ perceptions of health care quality and how do these factors differ between the various stakeholders?
4. How and why do particular cultural factors influence the stakeholders’ perceptions of health care quality?

The study seeks to understand and explain how health care quality is viewed and perceived by the key stakeholder groups involved in the Kuwaiti primary care and how culture affects how it is viewed. It is therefore an exploratory study (Saunders et al., 2007; 2009).
5.3. Research Context

The study takes place in Kuwait, specifically in the Kuwaiti primary care sector.

*Kuwait* (Arabic for ‘a fortress adjacent to water’) is a small country—slightly smaller than Wales—that lies at the northwest corner of the Persian, or Arabian, Gulf. It is surrounded by much larger neighbours: Saudi Arabia and Iraq (Takahashi, 1985; O'Shea, 2000; O'Shea & Spilling, 2010).

According to the 2012 figures, the total population in Kuwait stands at approximately 3,600,000, of which more than two-thirds are foreigners (Central Statistical Bureau, 2012). The population growth rate in Kuwait is 3.3% (Central Statistical Bureau, 2010). However, since the 1950s, the annual growth rate of non-Kuwaitis has been higher than that of Kuwaitis, due to the high rate of immigration. This has resulted in Kuwaitis being a numerical minority in their own country (Khalaf & Hammoud, 1987; Al-Juhaim, 2008; O'Shea & Spilling, 2010).

Moreover, Kuwait has one of the youngest populations in the world, with the average age being 26 years old. A little less than half (44%) of the population are under the age of 15 years (O'Shea & Spilling, 2010). A number of factors contributed to this high proportion of young people in Kuwait, including the Kuwaiti traditions of early marriage and polygamy, both of which contribute to the high birth rate seen in Kuwait (Al-Juhaim, 2008).

The health care system in Kuwait is based on three levels of care: primary, secondary, and tertiary (World Health Organization, 2006; Al Sharafi, 2009). Since this study was conducted in the primary care service, it is necessary to provide a brief overview of the service and how it has developed. Primary care is mainly provided through a comprehensive network of community-based primary care practices. These practices, a doctor-led service, offer a wide
range of services including general practice, pharmacies, medical laboratory, and dental services. Primary care physicians have a gatekeeper role to hospital-based specialist care. Primary care practices provide their services on a drop-in basis (World Health Organization, 2006; Al Sharafi, 2009; Kieft et al., 2012). The appointment system is used on a very limited basis (Al-Kandari et al., 2008).

The primary care service is available around-the-clock. Typically, service is provided to the residents of a residential neighbourhood by a local primary care practice within the neighbourhood. Most practices operate in two or three shifts collectively lasting for more than 16 hours a day. In addition, within each health region, at least two practices provide primary care services throughout the day, seven days a week. That is, primary care services are available in weekends and public holidays.

The primary care service is government-funded. In 1999, however, a law was enacted that imposed fees against the use of health care services. Now, non-citizens pay fees for the use of primary care services (World Health Organization, 2006; Al Sharafi, 2009). While the fee for health care is minimal (the equivalent of £2), it is arguably the equivalent to a day’s pay for many non-citizen workers (WikiLeaks, 2004). Kuwaiti citizens, on the other hand, continue to enjoy the health care service free of charge.

However, despite the extended working hours, relative affordability, and relative comprehensiveness of the primary care service in Kuwait, primary care still has a low status in the eyes of the public. It has received particularly strong comments and harsh criticism from many of its users, as well as the politicians and the media. In addition, increasing public demands are continuously being made for improved primary care services. Despite the Ministry of
Health’s quality improvement efforts, the criticisms made by the public do not seem to have changed (Al Sharafi, 2009; al-Rajhi, 2011; Abdullah, 2012; Kieft et al., 2012).

5.4. Research Philosophy

The research philosophy can be viewed as the researcher’s set of beliefs, feelings, assumptions, and values about the world and how it can be known and understood. It is the net that contains the researcher’s ontological, epistemological, and methodological premises (Denzin & Lincoln, 2005). The research philosophy, thus, represents “a worldview that defines, for its holder, the nature of the ‘world’, the individual’s place in it, and the range of possible relationships to that world and its parts” (Guba & Lincoln, 1994, pp.107, italics in original). The set of beliefs and assumptions contained in the research philosophy can have a significant impact on the research design and methods—which should be congruent with the research philosophy (Guba & Lincoln, 1994; Saunders et al., 2007; Saunders & Tosey, 2012).

It has been argued that since these research philosophies represent the researcher’s set of basic beliefs, there is no way to establish their ultimate truthfulness (Lincoln & Guba, 1985; Guba & Lincoln, 1994). They are not open to proof in any conventional sense; they must be accepted simply on faith. Guba and Lincoln (1994) contend that if there was a way to establish the credibility of each research philosophies, the philosophical debates surrounding them would have been resolved a long time ago. Therefore, there is a general agreement among researchers that no one research philosophy is better than another (Guba & Lincoln, 1994; Saunders et al., 2009). Each research philosophy is ‘better’ in different contexts. Which philosophy is ‘better’ depends on the research questions being asked (Saunders et al., 2009).
This study adopts a *constructivist* philosophy. Constructivism assumes that there is no single objective reality. It rejects the positivist perspective that views the concept of reality as existing ‘out there’, external and independent of the researcher or the knower. Rather, it assumes that reality is internally constructed. We perceive the world differently; therefore, reality is relative to each of us. Consequently, multiple ‘realities’ exist. These realities represent our intangible mental constructions based on *how* we experience the world. Our constructions of reality are, therefore, socially and experientially based (Guba & Lincoln, 1994; Madill *et al.*, 2000; Agostinho, 2004; Krauss, 2005; Bowen, 2008; Saunders *et al.*, 2009).

In addition, because meanings are socially embedded, our constructions of ‘reality’ are local and specific in nature—although some elements of these constructions may be shared across individuals of the same culture (Guba & Lincoln, 1994). In constructivism, knowledge is established through the meanings and constructions we attach to events and phenomena. Knowledge, under this philosophy, is therefore socially constructed, and is context- and time-dependent (Guba & Lincoln, 1994; Madill *et al.*, 2000; Krauss, 2005; Saunders *et al.*, 2009). In addition, the constructivist philosophy assumes that the constructions held by an individual are alterable; they may change, as may their associated ‘realities’. Reality is therefore dynamic, rather than a static condition (Guba & Lincoln, 1994; Madill *et al.*, 2000; Agostinho, 2004). Hence, due to its construal of a socially constructed reality, the constructivist philosophy is *ontologically subjective*; it assumes a relativist ontology (Van de Ven, 2007).

Constructivism contends that the researcher interacts with the subject of study. The researcher and the subject of study are assumed to be interactively linked so that the findings of the study are literally created as the research process continues (Jaeger & Rosnow, 1988; Guba & Lincoln, 1994; Madill *et al.*, 2000). That is, the philosophy takes the position that “*the knower*
“and the known are co-created during the inquiry” (Krauss, 2005, p.761). Constructivism, therefore, denies an objective and impartial representation of social reality: it adopts a subjective epistemology (Jaeger & Rosnow, 1988; Guba & Lincoln, 1994; Van de Ven, 2007; Saunders et al., 2009).

The constructivist philosophy—which Lincoln and Guba (1985) previously called naturalistic inquiry—is characterised by research in natural settings, rather than in controlled or experimental ones; the use of qualitative research methods; purposive sampling; inductive analysis; a grounded theory approach; and special criteria of trustworthiness (Lincoln & Guba, 1985; Bowen, 2008).

As this study aims to explore and understand how health care quality is viewed and perceived by the various stakeholders in primary care and how culture may affect their views and constructions, the constructivist philosophy is well suited for this study. The research philosophy did, as will be seen in the following sections, inform the choices of research strategy, data collection techniques, and data analysis procedures.

5.5. Research Design

To answer the above research questions, this study uses a qualitative research methodology. Qualitative and quantitative methods are both used in research—albeit in different situations and for different types of research questions (Strauss & Corbin, 1990; Britten et al., 1995; Mays & Pope, 1995; Pope et al., 2002; Saunders et al., 2007; Silverman, 2010). The choice of research methodology depends to a large extent on the nature and context of the research questions asked (Strauss & Corbin, 1990; Mays & Pope, 1995; Pope & Mays, 1995; Lee et al., 1999; Denzin & Lincoln, 2005; Silverman, 2010). Research questions that begin with ‘how’ or ‘what’—which
typically arise when the existing theory is underdeveloped and cannot adequately explain a phenomenon—tend to lend themselves to qualitative research methodology (Creswell, 1998; Lee et al., 1999; Merriam, 2002; 2009). For example, qualitative research methods are appropriate when studying topics that are ill-defined or poorly understood to determine the nature of the area of study. They are particularly appropriate for describing, interpreting, and explaining phenomena and experiences, especially where they are complex and multifaceted. Qualitative methods can provide intricate details—and hence a better understanding—of phenomena that are difficult to describe with quantitative research methods. Qualitative research methods are also useful for exploring and uncovering the issues behind phenomena which have been understudied (Strauss & Corbin, 1990; Firestone, 1993; Silverman, 1993; Britten et al., 1995; Lee et al., 1999; Silverman, 2010). These characteristics make qualitative methodology particularly well-suited for this study.

Broadly defined, qualitative research means “any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification” (Strauss & Corbin, 1990, p.17). The goal of qualitative research is to study and understand social phenomena and events in their natural settings—rather than in controlled or experimental ones—and to make sense of or interpret these phenomena in terms of the subjective meanings, values, and experiences of the people involved (Nelson et al., 1992; Pope & Mays, 1995; Patton, 2002; Pope et al., 2002; Denzin & Lincoln, 2005). That is, qualitative research is typically concerned with the viewpoints of those who are being researched rather than the researcher’s. It seeks to study the phenomena of interest from an emic perspective, which attempts to understand the world from the viewpoint of those being researched (Britten et al., 1995; Denzin & Lincoln, 2005). A qualitative approach to research is thus well-suited for this study which aims to add to
our understanding of how national culture influences the social construction of health care quality.

Qualitative researchers believe that there is a wide range of ways of making sense of the world. Qualitative methods, in general, are more able to provide a richer description and a deeper understanding of social phenomena than their quantitative counterparts (Silverman, 2010). Through methods such as detailed interviewing, qualitative research can get closer to the actor’s perspective and capture the views from the frame of reference of the actor. Qualitative research—as the word *qualitative* implies—emphasises on the qualities of things and phenomena that are not experimentally measured or quantified. It, thus, emphasises the social construction of reality and the intrinsically value-laden nature of the inquiry (Denzin & Lincoln, 2005). Qualitative research methods—where close and trusting relationships can be forged between the researcher and the researched—can access areas that may not be amenable to quantitative research methods (Firestone, 1993; Britten et al., 1995; Pope & Mays, 1995; Holloway & Wheeler, 2002; Pope et al., 2002).

It is now increasingly recognised that the views of health care quality depend on the stakeholder’s perspective and that different stakeholders may have contested views of what constitutes health care quality. It is also widely agreed upon that the concept of health care quality is complex and multidimensional, which makes some areas within it inaccessible to quantitative research methods (Pope et al., 2002). Moreover, the concept of health care quality has moved from a solely technical subject to a comprehensive and multifaceted issue that now seeks to contain the views of not only health care providers, but also users, managers, and other health care stakeholders. Given this and the complexity of the concept, health care quality cannot now be assessed by simply monitoring quantitative measures and indicators. Understanding of
the perspectives and experiences of the various stakeholders and the meanings they attach to their experiences is now crucial to understanding health care quality. A qualitative research design is, therefore, most suitable for the research questions of this study (Pope et al., 2002).

5.6. Data Collection

Methods of data collection should be consistent with the research questions, aims, and design. Ideally, they should be specifically determined by the research questions (Merriam, 2002; Saunders et al., 2007). For this study, face-to-face semi-structured interviewing was chosen as the data collection method. This method was chosen for its suitability for the research questions and overall design. As has been highlighted above, interviewing can get closer to the actor’s perspective and capture the meanings from the actor’s point of view (Britten, 1995; Denzin & Lincoln, 2005). Through personal contact—where close and trusting relationships can be forged between the interviewer and the interviewees—interviewing permits the interviewer access to areas of data that would not be accessible with other methods of data collection (Firestone, 1993; Britten et al., 1995; Saunders et al., 2007). Moreover, since this is an explanatory study—where ‘probing’ answers provided by the respondents to explain their views further is extremely valuable—semi-structured interviewing is favoured (Saunders et al., 2007).

Semi-structured interviewing is a type of interviewing that is commonly used in qualitative research. As the name suggests, semi-structured interviews are less structured than, for example, structured interviews, but are not completely devoid of structure—so that data about the topic of interest can be obtained (Britten et al., 1995; Taylor, 2005; DiCicco-Bloom & Crabtree, 2006). The conversational tone and nature of semi-structured interviews allow the interviewer and the interviewee to engage in a two-way dialogue through which the topic at hand
can be explored. In semi-structured interviews, the interviewer has a flexible interview guide that outlines the themes and issues to be explored, rather than a rigid interview script; the exact wording of questions is not determined beforehand. The interviewer or the interviewee may diverge from the loose topic guide of the interview in order to pursue pertinent ideas in more detail. Similarly, the interviewer may choose to omit or add some questions depending on the nature or context of a particular interview. That is, questions emerging from the dialogue may be asked by the interviewer to explore the research questions further. The order of questions in a semi-structured interview may vary from one interview to another, depending on the flow of the conversation (Britten, 1995; Britten et al., 1995; Merriam, 2002; Pope et al., 2002; Taylor, 2005; DiCicco-Bloom & Crabtree, 2006; Saunders et al., 2007).

As with any qualitative research data collection tool, the aim of semi-structured interviewing is to understand the participant’s own framework of meanings and concepts, to explore the ‘insider perspective’, rather than impose the researcher’s assumptions and structures. Therefore, qualitative researchers conducting semi-structured interviews use open-ended questions and try to be as interactive and as responsive to the language and concepts used by the interviewee as possible; they try to remain open to the possibility that the concepts that emerge may be very different from what might have been predicted before the interviews (Britten, 1995; Britten et al., 1995; Taylor, 2005).

Moreover, semi-structured interviews provide the interviewer with the opportunity to ask follow-up questions and probe the interviewee’s responses further in order to establish the significance and meaning of each response and ensure that what the interviewee meant is well-understood. The interviewer can ask open questions to encourage the interviewee to provide a comprehensive answer and follow-up with a supplementary question where an open question
does not elicit a relevant response. In addition, semi-structured interviews have the benefit of uncovering issues or concerns that had not previously been anticipated or considered by the researcher, which can further understanding of the interviewees’ accounts and views (Britten, 1995; Pope et al., 2002; Saunders et al., 2007; Tong et al., 2007). This was succinctly summarised by Britten (1995) who noted that qualitative interviewers aim to “go below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research” (p.252).

All of the interviews for this study were conducted by the researcher. They lasted between 45 and 90 minutes. Most interviews took place either in private meeting rooms at the primary care practice or at the interviewee’s office, depending on their preference. The interviewer in semi-structured interviews is interested in not only what the interviewees say, but also the way in which they say it. That is, picking up non-verbal cues and body language gestures expressed by the interviewees is of immense value (Britten, 1995; Saunders et al., 2007). In order to listen attentively to what the interviewee says and concentrate more fully on the non-verbal cues expressed by the interviewee, the interviews conducted for this study were audio-recorded. The benefits of audio-recording the interviews were explained to the interviewees beforehand and permission to audio-record was obtained from them. In addition, brief notes were made during the interview to record the interviewee’s facial expressions and other non-verbal cues which cannot be captured through audio-recordings. (Saunders et al., 2007). The audio-recordings of the interviews were then transcribed and translated (from Arabic to English), which was a time-consuming process (Britten, 1995; Braun & Clarke, 2006; Pope et al., 2006). Particular care was taken to produce a thorough orthographic transcript that contains a verbatim record of all pertinent verbal and non-verbal utterances. It is worth noting that the
process of transcription, while labour-intensive and time-consuming, was used by the researcher as a way of familiarisation with the collected data, to gain an overview of the depth and breadth of the data, which was very useful during data analysis. The time spent transcribing was therefore not wasted (Braun & Clarke, 2006).

5.7. Sampling Strategy

As this study aims to explore the views and perceptions of key stakeholder groups towards health care quality, the following groups were chosen: primary care physicians, users of the primary care service, and health care managers. These groups were chosen due to their role as key stakeholders in the Kuwaiti primary care sector. They were chosen to represent as diverse a range of views and perspectives on health care quality as possible. One aim of this choice is to ensure that any differences (or similarities) in perspectives across the various stakeholder groups can be examined. In addition, this choice is supported by the literature which views the concept of health care quality from the viewpoints of three principal interest groups: those who provide care, those who manage it, and those who use it (Donabedian, 1988; Øvretveit, 1992; Nakkeeran & Thiagarajan, 2010).

Since this study seeks to understand the meaning of health care quality from the perspectives of primary care stakeholders and does not seek to measure health care quality or provide statistical generalisations about it, probabilistic sampling is neither necessary nor justifiable (Mays & Pope, 1995; Pope et al., 2000; Merriam, 2002; 2009). Instead, this study used a non-probabilistic purposive sampling strategy, where the researcher purposely selects information-rich individuals for their relevance to the topic being studied. That is, purposive sampling is a strategy in which the researcher purposefully selects cases that will contribute the
most to the information needs of the study (Merriam, 2002; Patton, 2002; Pope et al., 2002; Ritchie et al., 2003a; Saunders et al., 2007; Polit & Beck, 2009; Saunders et al., 2009).

One aim of purposive sampling is to ensure that all key constituencies relevant to the topic being studied are covered. This means that cases are sampled based on specific pre-determined criteria to cover the range of characteristics relevant to the study (Mays & Pope, 1995; Merriam, 2002; Pope et al., 2002; Ritchie et al., 2003a). Depending on the aim of the study, a specific approach to purposive sampling is chosen—the approach, in turn, determines the range of criteria to be covered and, thus, the composition of the sample. In this study, within each of the three groups selected above, a maximum variation sampling approach was utilised, so that the sample is selected in ways that provide a broad range of information (Lincoln & Guba, 1985; Patton, 2002; Saunders et al., 2009; Marshall & Rossman, 2011).

Maximum variation sampling involves deliberately selecting cases with a wide range of variation on the criteria of interest (Lincoln & Guba, 1985; Patton, 2002; Saunders et al., 2009; Marshall & Rossman, 2011). This sampling approach ensured the inclusion of a diversity of experiences within each stakeholder group. For example, within the health care providers group, it ensured that clinicians of different characteristics (for example, Kuwaiti versus non-Kuwaiti physicians; clinicians from across the various health regions; and junior versus senior clinicians) were sampled. Similarly, the literature has demonstrated differences on health care quality across different cultural groups, different age groups, and different genders (Nickens, 1995; Bethell et al., 2003). Therefore, within the health care users group, the sample was selected to ensure the inclusion of patients from various socio-economic backgrounds (for example, both Kuwaitis and non-Kuwaitis); across different age groups; across genders; and across the various health regions.
In this approach, sampling ensures that the views of the powerful as well as the disenfranchised are represented (Kuzel, 1999). Any common pattern that emerges from great variation is of particular value and interest in capturing the central theme and shared aspects (Patton, 2002). The sampling process began with an initial selection of informants within each group, and was then supplemented with new respondents through snowballing (Polit & Beck, 2009).

As this study is a qualitative study, it seeks to achieve theoretical generalisability; it does not seek statistical representativeness or generalisability. It, therefore, focuses in depth on a relatively small sample of carefully selected information-rich cases whose study does provide a comprehensive understanding of the topic. Typically, qualitative research is less concerned with sample size than its quantitative counterpart (Britten, 1995; Myers, 2000; Patton, 2002; Pope et al., 2002; Bowen, 2008; Polit & Beck, 2009). Instead, the focus in qualitative research is on sampling adequacy or the quality of information obtained from the sample. The sample must be ‘appropriate’; that is, comprised of participants who best represent or have knowledge of the topic being studied (Morse et al., 2002). Many qualitative researchers recommend continuing data collection until the point where additional episodes of data collection do not add any new information and data saturation is reached—as indicated by data replication and redundancy. At the point of data saturation, no new themes are identified and no additional data relevant to conceptual categories can be found. At this point, data categories are already validated and well-established, and new data fit easily into them (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Boeije, 2002; Morse et al., 2002; Burns & Grove, 2005; Bowen, 2008; Polit & Beck, 2009; Saunders et al., 2009).
The sample size in qualitative studies is, thus, related to the informational needs of the study and is only relevant as it relates to achieving data saturation (Pope et al., 2000; Bowen, 2008; Polit & Beck, 2009). Sampling adequacy is judged on the basis of theoretical data saturation; that is, whether sufficient data account for all the theoretical categories that have been devised, as indicated by the depth as well as the breadth of data (Morse et al., 2002). However, Guest et al. (2006) provided some practical guidelines as to the appropriate sample size in non-probability samples. Based on their research, they posit that data saturation is reached after twelve in-depth interviews where the sample is fairly homogenous. They note, however, that twelve in-depth interviews are unlikely to be sufficient to reach data saturation where the study sample is heterogeneous (Guest et al., 2006).

5.7.1. Participant Recruitment

As described earlier, sampling began with an initial selection of informants within each group. This initial sample was later supplemented primarily through snowballing. After recruiting potential study participants, each was approached, briefly explained the purpose of the study, and asked whether they would like to take part in it. Potential participants from the health care ‘providers’ and ‘managers’ groups were, for the most part, approached at their offices. Some participants were recruited through networking and snowballing techniques through other participants who took part in the study. Care was taken to include as diverse a range of views and perspectives on health care quality as possible. Participants who were asked for help recruiting other potential study participants were typically asked to recruit, depending on the sampling needs of the study at the time, with certain socio-demographic characteristics. For example, at times during the research process, efforts were directed to recruit non-Arab physicians, at other times, female managers, and so on depending on the sampling needs of the research.
Based on Guest et al. (2006), and given that the ‘health care providers’ and ‘health care managers’ groups are fairly homogenous, this study began by interviewing twelve cases within each of these groups (Guest et al., 2006). However, several pre-arranged interviews with health care managers were cancelled by potential participants at late notice due to commitments on their part. In other cases, potential participants did not cancel the arranged interview but simply failed to show up at the scheduled time and failed to respond to repeated contact attempts. This was especially the case with some participants from the health care managers group.

The ‘health care users’ group, on the other hand, is relatively heterogeneous. Like with the other two sample groups, recruitment of health care users began an initial selection of a few informants but was mainly supplanted with participants recruited through snowballing by asking primary care physicians (from the ‘providers’ group) to suggest potential participants. As data collection progressed, recruitment was more selective for participants whose attributes may have been underrepresented in the growing study sample. For example, as more data were collected and analysed, the researcher recognised the need to sample more participants from the Indian subcontinent.

Within the ‘users’ group, the researcher began by interviewing Kuwaiti and non-Kuwaiti participants. When data saturation was not reached upon completion of twelve interviews in each group, further sampling continued until data saturation was reached (Guest et al., 2006).

Altogether, 42 participants were interviewed in the study, including 19 health care users, 16 health care providers, and 7 health care managers. However, even though the initial plan was to interview more health care managers so that data saturation can be reached—as per Guest et al.’s (2006) recommendation—analysing the data has shown good data saturation. The total
sample included males (26) and females (16) from diverse cultural backgrounds, across all age
groups (except children), and across geographic localities. Participants’ ages range between 26
and 63 years, with the largest proportion being in the 30–39 years age group (15).

Table 1 summarises the demographic characteristics of the study sample.
| Stakeholder group | Respondent | Gender | Age group year
douible | Nationality | Health region | K: 8; NK: 8; 10; 6; 25-29: 1; 30-39: 7; 40-49: 4; 50-59: 3; 60-64: 1; Non-Capital: 9 |
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<td></td>
<td>2</td>
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<td>3</td>
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<td>♂</td>
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<tr>
<td>K: Kuwaiti; NK: Non-Kuwaiti</td>
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**Table 1: Summary of the demographic characteristics of study participants**
5.8. Data Analysis

Qualitative data analysis progresses simultaneously with data collection. The process of analysing data begins during data collection; it typically begins during the first interview and continues throughout all phases of research. The qualitative researcher continually goes back to previously collected data and compares them with newly gathered data. This cyclical and interactive nature of qualitative data analysis allows the researcher, while ‘in the field’, to make adjustments to the research and interview questions—that should shape and better inform subsequent episodes of data collection (Britten et al., 1995; Pope et al., 2000; Thorne, 2000; Merriam, 2002; Ritchie et al., 2003b; Pope et al., 2006; Bowen, 2008).

Although the process of data analysis in qualitative research begins while the researcher is ‘in the field’, there is still much analytical work to do once the researcher has left the field (Pope et al., 2000; 2006). The purpose of this analytical work is to organise and provide structure to and to elicit meaning from the collected data (Polit & Beck, 2009). Much qualitative analysis falls under the general heading of thematic analysis (Lacey & Luff, 2001; Braun & Clarke, 2006). Many authors (Boyatzis, 1998; Ryan & Bernard, 2000; Holloway & Todres, 2003) characterise thematic analysis as a generic skill or tool that is used across qualitative analysis, rather than a specific method of qualitative analysis in its own right. Some authors (Ryan & Bernard, 2000) identify thematic analysis as a process performed within ‘major’ qualitative analytic traditions—such as grounded theory.

The choice of a specific approach to data analysis depends on the aims and nature of the research as well as the research questions (Strauss & Corbin, 1990; Mays & Pope, 1995; Pope & Mays, 1995; Lacey & Luff, 2001; Denzin & Lincoln, 2005; Pope et al., 2006; Silverman, 2010). This study made use of thematic analysis and some elements of grounded theory. Grounded
theory can be thought of as both a strategy for conducting qualitative research and an approach to qualitative data analysis (Robson, 2002; Saunders et al., 2009). Robson (2002) indicates that it is possible to design a study which incorporates some aspects of grounded theory while ignoring others.

Thematic analysis involves the search for and recognition of common threads or patterns within the data (Bowen, 2006; Braun & Clarke, 2006). Once out of the field, the researcher familiarised himself with the collected data; he immersed himself in the raw data to comprehend their meaning in their entirety and to gain an overview of their depth and breadth. Immersion in the data is an important first step in qualitative analysis (Aronson, 1994; Pope et al., 2000; Lacey & Luff, 2001; Braun & Clarke, 2006; Bradley et al., 2007). During this step, the researcher wrote memos and listed the key ideas and recurring topics within the data, as well as thoughts and questions in relation to them. Memo writing (or ‘memoing’) is an important tool for capturing comparisons and connections the researcher makes. It helps crystallise questions and directions the researcher wants to pursue and therefore informs the research (Gomm, 2004; Charmaz, 2006; Birks et al., 2008; Kodish & Gittelsohn, 2011).

Once data have been read and reviewed and there was a general understanding of their scope and contexts, they were coded in order to reduce them into meaningful segments for interpretation. Coding is a process of conceptualising data that consists of identifying and labelling the key concepts in the data. It provides a formal system for organising data and for identifying and documenting links within and between concepts described in the data (Bradley et al., 2007; Corbin & Strauss, 2008; Kodish & Gittelsohn, 2011). Codes are tags (or descriptive labels) that are applied to segments of data to help catalogue the key concepts described in them while preserving the contexts in which they are described (Miles & Huberman, 1994; Bradley et
They refer to the most basic element of the raw data that can be assessed in a meaningful way regarding the phenomenon under study (Boyatzis, 1998; Braun & Clarke, 2006). Coding, thus, enables the researcher to organise and group similarly coded data into groups or ‘families’ (Corbin & Strauss, 2008; Saldaña, 2009). The process of coding can be thought of as ‘mining’ the data for hidden treasures within them (Corbin & Strauss, 2008).

Coding can be inductive, deductive, or integrated—employing both inductive and deductive coding approaches (Bradley et al., 2007). In this study, coding was more inductive. That is, codes, for the most part, were data-driven. Analytic induction is an example of the simultaneity of data collection and analysis in qualitative research (Braun & Clarke, 2006; Bradley et al., 2007; Kodish & Gittelsohn, 2011; Suter, 2012). The study drew upon emergent issues raised by the interviewees themselves and views or experiences that show recurrence or patterning in the data. In addition to inductive coding, the study also drew upon a priori knowledge and questions derived from the aims of the study for identification of key concepts within the data. Conscious effort was made not to impose or erroneously ‘force’ a priori assumptions and preconceived notions upon the codes. Rather, a priori knowledge was used to inform the emergence of concepts during the analytic process (Aronson, 1994; Gomm, 2004; Pope et al., 2006; Bradley et al., 2007; Kodish & Gittelsohn, 2011). For identification and classification of the codes, this study used the constant comparative method—an approach originally developed for use in the grounded theory (Glaser & Strauss, 1967). Many qualitative analytic strategies, including thematic analysis, rely on this method of constant comparisons to identify and understand the key concepts within data (Aronson, 1994; Thorne, 2000; Floersch et al., 2010).
The process of coding in the initial phase began with *open coding*, where data were examined to identify concepts within them. Care was taken to identify as many codes as possible (Braun & Clarke, 2006; Pope et al., 2006). Data were reviewed in detail and as a concept became apparent, a code was assigned. Thematic analysis does not specify a particular length of text to code; codes can be assigned to lines, sentences, paragraphs, or longer text segments that illustrate the chosen concept. As more data were reviewed and more concepts were coded, codes were developed and refined to fit the data (Bradley et al., 2007; Floersch et al., 2010). Whenever possible, data were coded using in-vivo codes—that is, using the exact words of interviewees (Ryan & Bernard, 2000; Lacey & Luff, 2001; Corbin & Strauss, 2008). The process of open coding the data is illustrated in Table 2 below.
<table>
<thead>
<tr>
<th>Table 2: Line-by-line coding of excerpts from interview transcripts</th>
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</thead>
<tbody>
<tr>
<td><strong>Interview excerpt</strong></td>
</tr>
<tr>
<td><strong>Line-by-line coding</strong></td>
</tr>
<tr>
<td>Medicines and blood tests should always be made available</td>
</tr>
</tbody>
</table>
| Kuwaiti patients should receive the best care | - Feeling entitled  
- Justifying discrimination |
| regardless of the cost | - Not caring about expenses |
| I almost never seen more than just a few surgeries running at a time | - Non-responsive service  
- Physicians’ inflexibility contributing to waits |
| **Interview excerpt** | **The ministry [of health] should stop recruiting cheap, poorly trained doctors from Egypt or India to save on costs. Most of them didn’t choose primary care but were most likely forced into it. They are a main reason for the negative public image of the service ... the practice sometimes feels like a grocery store. Many Kuwaitis only use primary care to get ‘sick leave’ notes. They don’t trust primary care even with the smallest stuff, they don’t trust the medicines provided by primary care.**  (P11) |
| **Line-by-line coding** | **Codes** |
| The ministry [of health] should stop recruiting cheap, poorly trained doctors | - Importance of well-trained physicians |
| from Egypt or India | - Feeling of superiority (over physicians from other developing countries)  
- Us versus them distinction |
| to save on costs | - Emphasising investment in skilled physicians |
| reason for the negative public image of the service | - Physicians’ incompetence contributing to negative image of the service |
| the practice sometimes feels like a grocery store | - ‘Chaos’ at the practice  
- Holding the service in low regard |
| Many Kuwaitis only use primary care to get ‘sick leave’ notes. They don’t trust primary care | - De facto repurposing of the service  
- Lacking trust in the service |
| **Interview excerpt** | **Doctors are suspicous of patients or patients’ motives ... young patients are always seen by doctors as lying until proven otherwise ... they are always seen as lying to gain something ... like a sick leave!**  (P14) |
| **Line-by-line coding** | **Codes** |
| Doctors are suspicious of patients | - Tensions between physicians and patients |
| seen as lying to gain something | - Physicians misunderstanding patients |
Text segments were then compared to each other to ascertain whether codes are appropriately assigned. They were compared with other segments that have been assigned the same code to verify whether they reflect the same concept. Within-code comparisons can help uncover the different properties and dimension of the code (Pope et al., 2006; Bradley et al., 2007; Corbin & Strauss, 2008). In addition, codes were compared against other codes from the same interview, as well as codes from other interviews.

As segments of text are compared, the researcher made use of questioning to identify similarities, differences, and patterns within the codes: ‘What are the characteristics of the code?’ ‘What forms does it take?’ ‘How is this text segment similar to or different from preceding segments?’ All these questions enabled the researcher to probe deeply into the data and to examine their properties and dimensions (Pope et al., 2006; Bowen, 2008; Corbin & Strauss, 2008). In addition, asking questions enabled the researcher to identify new or uncoded concepts in the data. When new concepts were suggested, previous transcripts were analysed again to determine the presence of those concepts. This back-and-forth interplay between the researcher and the data continued until all relevant key concepts in the data were identified and coded (Bowen, 2008). Interview transcripts were read and reread to identify all data related to the already identified codes and code them accordingly. This means that a single passage of text may encompass multiple concepts and thus was cross-coded (Aronson, 1994; Braun & Clarke, 2006; Pope et al., 2006). A common criticism of coding is that the context is lost. Therefore, care was taken to code data inclusively—that is, to leave as little as possible out of the relevant surrounding data (Pope et al., 2002; Braun & Clarke, 2006).

In addition, the process of constant comparisons involves a constant search for negative cases or disconfirming evidence (Glaser & Strauss, 1967; Britten et al., 1995; Ryan & Bernard,
Negative cases could disconfirm or refute the emerging theory and suggest that new conceptions need to be made. The presence of a negative case, however, does not necessarily negate the researcher’s conceptualisations. The negative case, often, represents a dimensional extreme or variation on the conceptualisation of the data. That is, looking for the negative case provides for a fuller explanation of the concepts in the data (Corbin & Strauss, 2008).

As the process of coding continued, the researcher developed a codebook as part of the process. A codebook is simply a reference tool that contains the codes and their respective specifications and definitional parameters, including full descriptions of each code and when to or not to apply it. The use of a codebook guides the researcher throughout the coding process and helps establish stability and consistency when coding. A clear and comprehensive codebook promotes the quality of subsequent analysis (Bradley et al., 2007; Kodish & Gittelsohn, 2011). For example, code inclusion criteria were developed for each code and were logged in the codebook to make sure data are coded consistently and unambiguously (Maykut & Morehouse, 1994; MacQueen et al., 1998). In addition, in later stages of the coding process, the use of a codebook provided a visual representation of the relationships among the codes and thus served as an ‘audit log’ of the procedures followed as the analysis proceeded (Lincoln & Guba, 1985; Bowen, 2008).

Towards the end of open coding, the larger mass of textual data was reduced into manageable groupings of codes, which were used to make relationships among the concepts in the data in a process called axial coding (Bowen, 2008; Corbin & Strauss, 2008). During data analysis, however, “open coding and axial coding go hand in hand” (Corbin & Strauss, 2008, p.198); the distinction made between them is for explanatory purposes. As the process of coding
continued, coded data were constantly compared and scrutinised, data segments were coded and recoded and the codes became more refined. Several of the initial or ‘first cycle’ codes were relabelled, subsumed by other codes, or dropped all together. Codes underwent multiple iterative rounds revisions, refinements, and rearrangements until high-level concepts emerged (Bowen, 2008; Saldaña, 2009; Suter, 2012).

As the identified codes were compared with each other, some codes seemed to cluster together. Conceptually similar ones were grouped together under higher-level descriptive concepts called themes (or categories). For example, several codes or first-order concepts—such as, being productive; being able; being independent; contributing to society; not being in need; and health being a means not an end—were grouped together to form the second-order category or theme, health as being able. The constant comparative method allowed the researcher to differentiate themes from one another and to identify the properties and dimensions specific to each theme. Besides comparing units of text from the transcripts with each other as illustrated earlier, the discovered themes were compared with the literature to recognise patterns in the data. The researcher axially categorised and grouped together lower-level concepts (codes) according to their shared properties (Corbin & Strauss, 2008; Floersch et al., 2010). In addition, the researcher attempted to identify how concepts relate to each other. In doing so, some of the initial codes went on to form themes (or subthemes).

The frequent use of key terms by the interviewees may suggest their relevance as conceptual categories or themes (Braun & Clarke, 2006; Bowen, 2008). However, the significance of a theme is not determined by its frequency but by its consistency across and within interviewees. A theme is also significant when it deepens understanding of extant knowledge (Floersch et al., 2010).
A collection of themes was identified towards the end of axial coding. Next, they were developed into higher-level concepts that can be referred to as central themes (or core categories). This final level of coding is known as selective coding—“the process of selecting the central or core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development” (Strauss & Corbin, 1990, p.116). This process involved connecting and consolidating the axial codes and analysing them to identify central themes that cut across the data (Braun & Clarke, 2006; Bowen, 2008). To ascertain whether the identified themes adequately capture and accurately represent the data, they were judged for both internal homogeneity—the extent to which data within them cohere together in a meaningful way—and external heterogeneity—the extent to which there is a clear and identifiable distinctions between them (Patton, 1990). For example, the themes health as being able; health as being free from disease; health as what the health service ought to provide; health as a holistic balance; and health as a divine blessing were consolidated into a central theme (or core category) that was labelled the meanings of health (see Figure 7). The interview transcripts were reread to ascertain that the identified themes form a coherent pattern and capture the essence of the data, and also to code any additional data that might have been missed during earlier rounds of coding (Braun & Clarke, 2006).
At the end of the coding process, a thematic map was created that identified the essences of the different themes, how they relate to each other, and how—together—they represent the meanings evident in the data (Braun & Clarke, 2006; Bowen, 2008).

### 5.9. Rigor

Historically, qualitative research has been viewed as inferior to its quantitative counterpart. It has often been seen as ‘unscientific’ and heavily influenced by the researcher’s views and values.
Qualitative research methods have been treated as relatively minor methodologies that are to be used, if at all, in the early exploratory stages of a study. The works of qualitative researchers have been described as ‘soft science’ and as being entirely personal and full of bias (Silverman, 1993; Denzin & Lincoln, 1994). All these perceptions of qualitative research had relegated it to “a subordinate status in the scientific arena” (Denzin & Lincoln, 2005, p.2). These views of qualitative research have particularly strong repercussions in the health care field—with its strong quantitative and experimental research tradition (Mays & Pope, 1995).

However, the continuing shifts in the focus among health care researchers—which had often responded to the socio-demographic changes and health care policy requirements—have necessitated an increasing dependence and emphasis on qualitative research (Bryman & Burgess, 1994; Britten et al., 1995; Mays & Pope, 1995). The simplistic traditional view of quantitative research that depended solely on quantitative measures and performance indicators has been replaced by mainly a qualitative approach (Pope et al., 2002). Assessment of health care quality requires a thorough understanding of the views and experiences of the various stakeholders involved, especially that it is stakeholder-dependent. Many areas within health care quality may be inaccessible to quantitative research methods—which makes qualitative approaches particularly useful and appropriate in this study.

Like quantitative research, qualitative research has its strengths and weaknesses. Both quantitative and qualitative researchers believe that they know something about the world worth telling but use different methods and approaches to convey their findings (Denzin & Lincoln, 2005). Qualitative methods are arguably no worse and no better than their quantitative counterparts; they just tell different kinds of stories (Pope & Mays, 1995; Denzin & Lincoln,
Both types of methods may study similar topics but approach them differently, addressing different types of research questions (Britten et al., 1995).

Nonetheless, qualitative research is not protected from the rigorous standards that should be applied to any research (Silverman, 2010; Suter, 2012). Qualitative researchers should strive to provide evidence that their findings are sound and credible. In qualitative research, it is widely accepted that the researcher is regarded as the research instrument (Britten, 1995; Mays & Pope, 1995; Madill et al., 2000; Patton, 2002; Golafshani, 2003).

To ensure rigor in this study, the methods described in the sections above were consistently and systematically followed, in all steps of the research. Data were collected thoroughly and meticulously, and special attention was paid to the crucial non-verbal cues and utterances that interviewees have sometimes displayed. Similarly, gathered data were systematically analysed and interpreted; a clear account of the analysis was provided. During data analysis, the researcher has continuously searched for ‘disconfirming’ cases and reviewed the findings accordingly (Britten et al., 1995). Additionally, multiple sources of data were used in this study to enable comparison of data sets against each other and confirm their credibility (Patton, 2002; Suter, 2012).

5.10. Ethical Considerations

Ethics, according to Saunders et al. (2009), can be defined as “the appropriateness of the researcher’s behaviour in relation to the rights of those who become the subject of a research project, or who are affected by it” (p.600). A number of ethical issues are likely to arise throughout all phases of research—from choosing and formulating the research topic to writing up and reporting the findings of the research, passing by designing the research and collecting,
processing, storing, and analysing the data. These ethical issues require special consideration. In addition to being methodologically sound, research has to be morally defensible (Creswell, 2003; Gomm, 2004; Saunders et al., 2009). In this study, the following ethical issues were considered.

At the start of the research, ethical clearance was obtained from both the University of Surrey’s Ethics Committee and the Kuwait Institute for Medical Specialisation (KIMS)—the supreme authority responsible for postgraduate medical training and the national body responsible for reviewing health care-related research in Kuwait.

Participants were assured of their anonymity and confidentiality. Identities of research participants remain unknown; their names were substituted by codes as a form of identification. The information provided by the research participants were handled in a confidential manner (Britten et al., 1995; Gomm, 2004; Saunders et al., 2009).

Voluntary consent of all research participants was obtained before data collection. An informed consent statement was read to all participants at the beginning of each interview. The statement—which was written in language appropriate to the participants—explained the nature and purpose of the research and the research procedures and asked for potential participants’ consent to participate. It was made clear to participants that their participation in this research is voluntary and that they are free to participate or not to participate. In addition, they were advised of their right to withdraw at any stage of the research, particularly on grounds for concern of their wellbeing should they have continued to participate. Non-maleficence is a key issue in conducting research (Gomm, 2004; Saunders et al., 2009).
5.11. Study Limitations

The role of the researcher, having come from a clinical background, in analysing the data and interpreting them must be recognised. A researcher from a different background may analyse the data and interpret the research findings differently.

Other limitations of the study not inherent in the study methodology will be discussed in Chapter 9.

5.12. Chapter Summary

In this chapter, a detailed description of the research design and methodology was discussed. The research aims and objectives were described, together with the research questions. The research context was also briefly described. It was explained that this study adopts a constructivist research philosophy and uses qualitative research methods. The methods of sampling, data collection, and data analysis were described and the rationale for choosing these methods was explained. The measures taken to ensure rigor, as well as the ethical considerations relating to the study were described.

In the following chapter, the findings of this study are presented.
Chapter 6

Findings I

6.1. Introduction

This chapter presents the findings of the research relating to the beliefs and perceptions held by health care stakeholders about the concept of health and the extent of the health care system’s responsibilities to care for and promote it. The chapter aims to contribute to answering the first research question raised in Chapter 5 on the stakeholders’ definition of health:

1. How do the various stakeholders define health and what are the differences and similarities in definitions between the various stakeholders?

This chapter presents the various beliefs, perceptions, assumptions, and perspectives reported by participants about health. Specifically, it focuses on the different stakeholders’ views about health, what it means, and, therefore, who is responsible for promoting and sustaining it. While some stakeholders are of the view that the health care system (or the public purse) is solely responsible for caring for the individual’s health and for ensuring that their health needs are met, others believe that the individual is primarily responsible for caring for their own health. In this latter view, the individual person—rather than the health care system—is responsible for their own health and well-being by avoiding health-risking behaviours and by adopting a healthy lifestyle.

The chapter will begin by presenting an overview of the main themes and the sub-themes within them. The findings of this research revealed a number of themes that are presented in three themes (in chapters 6, 7, and 8 respectively): meanings of health; attitudes towards primary care service; and differential access to primary care.
The themes and the sub-themes within them are summarised in the following table.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| Meanings of health              | • The meaning of health  
|                                 | • Responsibility for one’s health  
|                                 | • Tensions in doctor-patient relationship                                  |
| Attitudes towards primary care service | • ‘Undervalued’ and ‘untrustworthy’  
|                                 | • Gender issues  
|                                 | • Cultural suitability  
|                                 | • Work environment                                                        |
| Differential access to primary care | • Disproportionate distribution  
|                                 | • Waiting times  
|                                 | • Institutional discrimination                                              |

### 6.2. The Meaning of Health

Participants identified the meaning of health through varying narratives. Firstly, health was seen by many participants as ‘being able’ or independent. In the same way, illness was seen as entailing the loss of the individual’s earning capacity and as being in need—in this case for care or support from others. Participants used words like ‘active’, ‘able’, ‘productive’, and ‘contributing’ to convey their conceptions of health. One participant, a Sri Lankan female domestic worker in her thirties, said,

[Health] is when I am able to work well. I fear that I won’t be able to work when I’m sick or injured … or when I get older … or maybe I won’t be able to work as hard. (P6)
This sentiment was echoed by several other participants, all of whom reported feeling somewhat worried or fearful about being unable to work or provide adequate support to their families when their health is compromised. All participants who reported such a feeling were from South Asian countries—including India, Bangladesh, Sri Lanka, and Iran. Three of these participants had dependents in their home countries that they saved for and supported.

This suggests that such immigrant workers place a high value on productivity and work ability as they associate these attributes with their earning capacity, especially given that they are primarily unskilled or low-skilled migrant workers whose principal source of income comes from their ‘fitness’ for work. Previous research has shown that this functional definition of health is common among poorer people, possibly due to their relatively greater economic need to work (Helman, 2007). In this view of health, ill health is seen as a direct threat to income-earning capacity. A key insight that emerged from the data was the belief that healthy individuals are, in general, more productive and can therefore contribute better to their families and society. One clinician, a female physician from Egypt, made the remark that “health is a means, not an end in itself” (P24).

Another key narrative that emerged during the interviews was of health as ‘normal functioning’ of the body and mind or simply the absence of pathology. Most perspectives that contributed to this narrative came from health care providers—but not exclusively. In this narrative, health was seen as the normal physiological functioning of all organ systems and of the human body as a whole and ill health as an abnormality or deviation from the normal functioning of the body. This view of health is very much in harmony with the so-called biomedical model of health and illness, which defines health according to culture-free parameters (Helman, 1981; Mishler, 1981).
[Health] is an indicator of how well the body functions. (P16)

To be healthy is to be free of diseases and abnormalities in general ... and not in need of medical care or any medical intervention. (P11)

Health to me is being free of disease and feeling well generally ... and living a good quality life ... one has to feel good and be generally well in all aspects of life to be healthy. (P26)

As is apparent in the excerpt above, participants who expressed this view of health tended to equate health with ‘feeling well’ in general. In their view, mental well-being is subsumed under the general meaning of health. Some participants raised the notion that mental illness worsens physical health and thus health cannot be defined without the consideration of mental well-being.

However, one general practitioner warned about “unreasonably expanding the definition of health”. In what can be seen as a distinct narrative, he argued that for the definition of health to be of practical utility, it should take into consideration the resources available for, and the extent of responsibilities of, the health care system. He strongly argued against what he described as “expanding the definition of health” to include areas or activities beyond the scope of the institutional health care providers’ responsibility. He said,

We should be careful with expanding the definition of health too much ... not to end up with a very loose definition of health that includes everything. [...] The definition of health should be context-dependent. One appropriate context in which to define health is the context of the health care system’s responsibilities. Expanding the definition too much would place additional burdens on the health care system. (P15)

This narrative seems to be more concerned with the practical utility of defining health: what is the practical value of defining health if the defined areas lie outside the scope of responsibility of the health care provider? Such a view appears to equate defining health with the extent of responsibilities and duties of the health care provider and rejects the notion of mismatch between the definition and practice. According to this ‘utilitarian’ definition, health is
what the health care system ought to care for and therefore including additional elements that the
health system ought not to provide care for to the definition of health would be meaningless.

Rather than defining health in terms that remain largely in the theoretical realm—such as ‘fitness
for work’ or ‘being free from disease’—this narrative attempts to provide a definition for health
that is relevant to the practical realm; it attempts to define health pragmatically as what the health
care service can afford to provide.

Another key narrative that recurred in some of the interviews was of health as a ‘divine
blessing’. In this narrative, health and illness were characterised as the will of a deity or some
other supernatural entity.

[Health] is a great blessing given to us by God ... and God can take it back whenever he
wants. (P39, a health care user)

[Illness] is sometimes a reminder from God ... a reminder that good health is a real blessing
from God ... the biggest blessing one can ask for ... and that we should be always grateful for
God’s blessings. We often overlook the blessings of God until God takes them away. (P6, a
health care user)

Some participants held that even response to medical treatment is determined by God—
perhaps reflecting the dominance of religious beliefs in the Kuwaiti society: it is God who heals,
not man.

Allah knows what is best for us than we do and give it to us in the time he desires ... regardless
of what we desire. (P32)

The only physician to express this view explained,

What we do as doctors is merely using our knowledge ... and trusting God’s power. [...] We
are simply instruments of God. [...] Doctors do what they know and what they can ... the rest
is upon God’s will ... it is God who heals. (P18)

This view of health reflects the dominance of cultural values of the Kuwaiti society
which draw from a range of influences including religion. Religious beliefs do not seem to be
limited to the lay person but, rather, appear to be embraced even by health care professionals. Health care professionals who can be regarded as having their own subculture—with its ways of looking at the world, its social hierarchies, and its empirically based conceptualisations of health and illness—are influenced by the views of the society at large (Helman, 2007), suggesting that the dominant cultural value system influences several aspects of human behaviour, including professional medical practice.

The excerpt above demonstrates how—at least for some clinicians—the notion of ‘God’s will’ pervades (or invades) aspects of medical care; the perceived effectiveness of health care seems to be strongly tied to whether response to treatment is within God’s plan or will. The concept of divine will is a central concept in Islamic theology. Muslims are instructed in the Quran never to speak of the future without also speaking of God’s will:

*And never say of anything, “I will do that tomorrow”. Except [when adding], “If Allah wills”.*
(Quran 18:23-24)

This view of health appears to draw much on the teachings of Islam, which views health generally—like all other ‘good things’—as gifts from God. Health, for example, is seen as a blessing that God has bestowed upon the healthy. The dominance of religious beliefs and conservative traditional values has important consequences for the quality of care provided in Kuwait. Participants reported that there are several powerful social stigmas in the Kuwaiti society that deter individuals from seeking medical care for particular conditions, including mental disorders, substance abuse, and sexually-transmitted diseases. A Kuwaiti woman in her fifties provided this account:

*Seeking care for, or even just reporting symptoms of, mental illness are [unacceptable] ... likewise, alcohol-related problems are strong taboos […]. The biggest taboo is undoubtedly associated with [sexually-transmitted diseases] … sufferers choose to self-treat […] sometimes with medicines purchased [without a] prescription or to seek care at private clinics …*  
(P13)
She explained that a great fear for individuals in the society in Kuwait is being stigmatised or associated with an unwanted characteristic in the eyes of their fellow social group members:

"People's main concern is how the society will see them when they have these health problems ... or when they're labelled as 'mental patient' or a case of 'sexual infection'. This concern is deserved given the small size of the Kuwaiti society." (P13)

This perspective shows, among other things, how powerful these social stigmas are, which reflect the dominance of religious and conservative values in the Kuwaiti society. Other participants reported that some Kuwaiti patients prefer to seek care from foreign doctors for conditions like mental disorders and sexually-transmitted infections, as they feel more stigmatised disclosing symptoms of such conditions to a fellow citizen.

Furthermore, another narrative that appears to be closely intertwined with, and dependent upon, the view of health as a divine blessing was of health as a state of ‘balance’. This view was presented by one participant, a teacher by background. She said,

"We can define health in purely scientific terms ... but this definition would be too narrow. Health means more than just physical abnormalities within our bodies ... we can define it broadly as having a balanced and a positive relationship between the different areas of our lives ... between the different [organs] in our bodies, between one person and another, and with the whole world and God ... Think about it ... having a negative relationship with God, husband, or friend affects other areas of one’s life ... and vice versa. [...] The key is in balance and moderation ... ‘no excess and no negligence’. [...] Of course with modern science we know a lot about our bodies but there’s still so much that we don’t know and will never know." (P37)

This view appears to place a strong emphasis on the notion of ‘balance’—between the different areas of one’s health, physical, mental, social, and spiritual: promoting one area at the expense of others would result in a dysfunction of the neglected area which would manifest as illness. In this regard, this view appears to be in an overall agreement with the World Health Organization’s definition of health which sees health as much more than just the absence of
unpleasant physical symptoms; according to the World Health Organization, health is “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948).

This view of health as a balance—like the view of health as a divine gift—also draws greatly on the teachings of Islam. The notion of ‘balance’ or ‘moderation’ is also central to the Islamic faith as can be seen from Islamic teachings:

Thus, we have made you a moderate nation. (Quran 2:143)

As is apparent in the quote above, these culturally-specific definitions of health—as a divine gift or as a balance—do not appear to reject completely the culture-free view of health. The view of health as entailing cultural elements, such as religious beliefs, traditions, and social values, while at the same time accepting modern science-led medicine as a means of healing appears to attempt to reconcile between the objective, culture-free view of health commonly held by medical professionals and the holistic, value-laden view that emphasises, in addition to physical health, on other areas of health, such as mental health, social health, and spiritual health. This view does not completely reject the value-free (or scientific) definition of health but seems to recognise that human knowledge, while great in extent, is limited, and holds that one therefore should make use of the ‘knowledge’ revealed to humankind by divine intervention through sacred texts and transmitted by the clergy. Therefore, in effect, this view puts more emphasis on the cultural, social, and spiritual aspects of health.

The need to reconcile the two contrasting, and potentially conflicting, belief systems (the scientific and the spiritual) on the meaning of health is likely due to the high cost or perceived stigma associated with rejection of either one. On one hand, rejecting the secular or scientific viewpoint, especially for a health care professional, would essentially disenfranchise them. On
the other hand, rejecting the dominant religious viewpoint, at least openly, is highly stigmatised. This may not be surprising in a collectivist culture where conformism is the expected norm (Smith & Bond, 1993; Bond & Smith, 1996; Kim & Markus, 1999).

This way of looking at health and the process of illness—which attempts to interpret patterns of illness, offer explanations of ill health, and cast a personal and social meaning to the experience of illness—has been termed the explanatory model (Kleinman, 1980). Explanatory models are culturally determined interpretations of illness that draw on social and cultural constructions to provide explanations for aspects of illness, including its aetiology, pathophysiology, course and response to treatment. According to Kleinman (1980), these explanatory models are thought up in response to a particular episode of illness and are distinct from the general beliefs of illness held by the society; they are thus heavily influenced by personal and cultural experiences. These notions about a particular episode of illness are employed by both laypeople and health care professionals alike—even though their views may differ widely due to the differing backgrounds and personal experiences. Expectedly, differences in educational and cultural backgrounds and experiences result in different understandings of the physiology of the body and therefore different interpretations of a particular illness episode, especially in terms of its aetiology, symptomatology, and treatment (Kleinman, 1980; Coreil, 2008; 2010).

6.3. Responsibility for One's Health

In general, there appears to be a dichotomy between the clinicians’ and managers’ view on the formal health care system’s responsibility for one’s health, on one hand, and the views of health
care users, on the other. Several clinicians and managers emphasised the individual patient’s responsibility for their own health.

[The] locus of responsibility for the patient’s health lies with the patient himself ... the health care system’s responsibility is secondary to the patient’s primary responsibility to care for themselves ... and to avoid high risk behaviours in the first place. (P8, a clinician and manager)

[The] health care system provides care for people according to their health needs ... the system has a responsibility to provide care ... but patients are responsible too ... they are responsible firstly for avoiding health-risky behaviours and adopting a healthy lifestyle ... and secondly, for cooperating with the doctor and complying with the doctor’s advice. (P17, a clinician)

The view expressed by health care providers and managers alike assumes that while the health care system has a responsibility to provide care for those who need it. It assumes, however, that this responsibility is not exclusive to the system but shared with the individual. This view holds that the individual is primarily responsible for their own health. Several clinicians reported that health care users in Kuwait, in general, are either passive recipients of care who are not taking a role in their own health or are uncooperative or careless patients who fail or refuse to comply with the doctor’s treatment plan.

A related point was made by a health care manager, a clinician by background, who argued that the individual patient’s responsibility for their own health also includes their cooperation with health care professionals—both during and after the clinical encounter. He argued that patient cooperation is especially important in primary care due to the ambulatory nature of primary care. He elaborated,

Because of the [ambulatory] nature of primary care [...] health care quality in primary care depends greatly on patient cooperation [...]. [Patients] should cooperate with treatment recommendations ... since [they] are treated on an outpatient basis [their] compliance at home is crucial to [the] success of treatment. (P26, a health care manager)
This perspective was echoed by other health care managers and clinicians, some of whom argued that patients’ non-compliance or non-cooperation with primary care can be attributed to the way they perceive the primary care service and the extents of its role and responsibility. Furthermore, clinicians reported different views on the extent of the health care system’s responsibility for providing care. Most clinicians were of the view that the primary care service has a duty to provide care to meet the physical health needs of the population, but not the mental, emotional, social, spiritual, or other needs. Some argued that expanding the extent of the system’s duties and responsibilities, to include care for—for example—emotional and social needs, would place additional burdens on the system, which is already overburdened. Proponents of this view argued that the health care system has historically attended to the physical aspects of health—which are more visible and more clearly connected with institutional health care—and that there are other national bodies and institutions to which the responsibilities of providing emotional, social, and spiritual care and support have been (or should be) assigned.

_These areas [social and mental well-being] complement [physical] health ... but it would be unreasonable to include them to the existing burdens of the system._  (P15, a clinician)

_Mental and social wellness are also part of health ... but [the primary care service] classically deals with the physical aspects of health and disease ... mental health and social health have to be taken care of, sure, but not by the [primary care] service._  (P11, a clinician)

Another view expressed by clinicians was that the various elements of health—physical, mental, and social—are all interrelated and interdependent; illness or disturbance in one area affects the others. Therefore, all aspects of health should be addressed by the primary care physician; primary care should provide holistic care that addresses the physical, mental, and social elements of the patient’s health, especially that it is the first point of contact individuals have with the health care system.
These views on the extent of the system’s responsibility to provide care for the individual’s health appear to be directly—and heavily—influenced by participants’ views on the meanings of health presented earlier. It appears that the perceptions and beliefs held by an individual (whether a health care user or provider) on the meanings of health and illness strongly influence their views of where the locus of responsibility for one’s health lies on the continuum between the individual person themselves, their family and society, the health care system, or a supernatural being—or on a combination of a few. This view is consistent with Helman’s (2007) argument that lay theories of illness causation can be placed in one (or a combination) of four sites: within the individual, in the natural world, in the social world, or in the supernatural world.

The theories and understandings of a particular illness episode held by an individual (the individual’s explanatory model) also appear to impact their view on the extent of health care system’s duty to care for them in that episode. This is confirmed by previous research by Zola (1966; 1973) that has shown that reasons for seeking care vary from one person to another depending on how they (or others around them) perceive their ‘health’ problem and the extent to which it interferes with their lives. An individual’s perception of whether a particular symptom is abnormal and therefore requires medical intervention is influenced by their cultural background factors—including their ethnicity (Zola, 1966), socioeconomic status (Hackett et al., 1973), and how common the symptom is in their society (Zola, 1973).

In this study several clinicians said there was a ‘popular’ perception that the state, represented by the health care system, is solely responsible for the welfare and health of the people and that patients in general are therefore over-demanding or ‘very difficult’.

Many people wrongly assume that the whole burden of this responsibility rests on the health care system ... you’d find them engaging in all sorts of health-damaging behaviours and then
seeking help from the health system ... this is unreasonable ... the state can’t provide everything for everyone from cradle to grave.  (P8, a clinician and manager)

Similarly, other clinicians and health care managers described demand for primary care services, in general, as inappropriately high and reported that it does not reflect the actual health needs of the population.

6.4. Tensions in Doctor-Patient Relations

One health care manager, a female middle-level manager at the district level, remarked,

Our patients are over-demanding ... current demand for [primary care] is unreasonably high ... regardless of whether it is appropriately met by the system, the demand itself is inappropriate ... and is not driven by true health needs.  (P35)

This view, which was shared by several physicians, suggests that it is widely believed among health care providers and managers that the pattern of primary care utilisation is disproportionate to the actual health needs of the population.

Quality is good ... but patients are over-demanding ... patients [in Kuwait] are unreasonably demanding ... they treat primary care practices like shopping centres or boutiques which isn’t fair for the service and the service providers ... our duties as primary care doctors are limited to certain tasks and do not extend to providing a white-glove spa service!  (P15, a clinician)

In general, many of the perspectives shared by health care providers were accusative of users. It has been pointed out in the literature that health care professionals tend to subscribe to the premise that there is simply a key element that once manipulated in the ‘right way’ the whole health care system would work as desirable. They tend to assume that this element, considered as the primary barrier to health care, lies within the target community, the health care users, rather than the system itself and its bureaucratic institutions (Foster, 1982; Coreil, 1990; Nichter, 1991; Helman, 2007). Scholars warn however that this “hopeful assumption” (Foster, 1982, p.193) is myopic and misleading (Foster, 1982; Nichter, 1991; Helman, 2007).
Several reasons for the high use of the primary care service were noted by participants. One reason that was reported was the ease with which patients can access the service—without the need for a prior appointment. One physician reported that patients, especially Kuwaiti patients, tend to visit primary care practices near and around public holidays so they can benefit from an extended time off work (by merging the public holiday break with the paid sick leave). This suggests that, on the whole and at least for Kuwaiti citizens, there are no significant barriers hindering or discouraging access to primary care service.

*Patients just walk in any time the practice is open ... sometimes even on their way to the local supermarket.* (P1, a clinician)

*There is zero or near-zero out-of-pocket expense on the patient ... patients use the service at no cost or obligation.* (P2, a clinician)

These quotes suggest that there is no cost—monetary or otherwise—to the patient for seeing the primary care doctor, regardless of the reason for the visit and regardless of how trivial or negligible it may be. One clinician said that primary care physicians are seen by the community as “salaried state employees” who are “there to serve [the people] with anything health-related” (P2).

Some physicians pointed out that the provision of medicines free of charge to users of primary care also drives up demand for the service.

*The most important driving force behind [the increased demand] is that medications are offered for free at in-practice pharmacies. [...] There have been several reports of unused medications dispensed by the in-practice pharmacy found discarded in trash bins in or around the practice! Patients have nothing to lose. If they’re given medications they don’t want or don’t need, they’d simply just throw them away.* (P15, a clinician)

It is therefore thought that people find no barriers to seeing the doctor for any reason however trivial, especially that the primary care service is a walk-in service requiring no prior booking. This is consistent with Andersen’s (1995) model of health service use, which addresses
how the individual assesses the (perceived) benefits and costs of seeking care for a particular illness episode before deciding whether or not to use the health service. The model posits that upon making the decision, the individual takes into consideration the perceived seriousness of the illness, perceived need for health care, and accessibility of the health service, among other factors (Andersen, 1995). The model predicts that, *ceteris paribus*, increased access—as manifested by absence of perceived barriers to access—leads to increased health service use.

Several clinicians and health care managers reported that there is a general tendency in the population to seek medical care (at institutional facilities) for minor conditions. One physician commented that most patients he sees seek care for minor symptoms that could be easily and successfully treated at home, without the need to see a professional health care practitioner. A similar remark was made by another physician:

»Most of our patients only need self-care or over-the-counter medicines.« (P8, a clinician)

As noted earlier, perspectives of clinicians in general appear to be accusative of health care users. Many clinicians seem to be sceptical or suspicious of the users’ motives for seeking care.

Some clinicians described communication with patients in the surgery room as tense. They reported that it is not uncommon or unusual during these doctor-patient encounters for patients to argue with the clinician if they dislike or disagree with their medical decision. It was reported that patients in primary care routinely dispute medical treatment decisions made by clinicians. Often, it was reported, the patient’s own perception of medical need influences the actual medical decision made by the treating physician. One clinician said,

»The patient’s perception of need influences to a great extent the medical decision in the [doctor’s] surgery. [...] Actually, there [is] a social stigma against denying [care] asked for
by the patient regardless of need. [...] In practice, when a patient is denied a particular service, he can likely obtain it from another surgery, even in the same practice. That’s why doctors rarely deny care; they give care they know is inappropriate. (P2)

Another clinician criticised some of his colleagues who, he claims, resort to sending inappropriate referrals to hospital specialist clinics to reduce or temporarily disperse the patient load. Some physicians, he said, “shamelessly identified that ‘the patient insisted’ as the reason for referral” (P1). This suggests that the balance of power in the doctor-patient relationship—which normally is significantly in favour of the doctor (Johns, 2002; Helman, 2007)—is shifted towards the patient in practice.

[Patients show] no regard for the doctor’s role or knowledge. Some patients even send their personal housemaids or chauffeurs with a prescription refill or a list of other requests. (P1)

Some clinicians reported that patient disagreement over the doctor’s medical decision is much more likely to be voiced in culturally discordant clinical encounters where Kuwaiti patients deal with non-Kuwaiti physicians. They explained that non-Kuwaiti physicians generally try to avoid confrontations with Kuwaiti patients out of fear of losing their jobs or ‘getting into trouble’. This suggests that among the factors that influence the interaction between lay and professional explanatory models, citizenship (of both the patient and the physician) is especially significant.

On the other side of the health care equation, the patient side, many participants expressed concern about physicians ‘not listening’ properly to them during their time in the doctor’s surgery. Some users described experiences of not being given enough time in the surgery or of being cut off by the doctor during the consultation. One health care user, a 34-year-old man from India, gave the following account of his experience:

[Doctors] should listen to me and not pretend that they’d know what I am feeling or what I have to say ... each case is unique ... and doctors can’t know what I’m really feeling until I actually say it. [...] A big problem here is that doctors don’t listen ... or at least they don’t
seem to listen. [...] Almost always, the doctor will have started writing down my treatment while I am still trying to fully explain what I feel.  (P19)

Several health care users described similar experiences. Some of them commented on how they often feel rushed while at the doctor’s surgery. Users’ accounts were supported by one clinician who expressed a similar sentiment about some of his colleagues,

[They] appear to be in a rush when they spend time with their patients at the surgery ... and hence, don’t offer preventive care or health promotion advice.  (P1)

In addition, some users spoke of physicians not providing proper patient education to them, not explaining their conditions or treatment clearly enough, or of sometimes belittling their questions. One health care user explained her dissatisfaction with the manner in which physicians perceive and communicate with patients. She said,

Doctors are suspicious of patients or patients’ motives ... young patients are always seen by doctors as lying until proven otherwise ... they are always seen as lying to gain something ... like a sick leave! [...] Some doctors would interrupt the patient and so bluntly ask ‘how many days off work do you want?’ ... This is rude and insulting!  (P14)

This account by a 29-year-old Kuwaiti woman concurs with accounts reported by physicians and suggests that the prejudices and preconceived notions held by several primary care physicians are in fact perceived by (at least by a subset of) health care users and are a source of concern for them.

Several other participants made similar remarks that physicians never or very rarely provided patient education or health promotion advice. Some reported that physicians seldom provided satisfactory explanations about their patients’ conditions and seldom provided adequate answers to their patients’ questions.

Doctors should actively educate their patients. ... They should answer patients’ questions and provide simple and clear explanations that [patients] can understand. Not doing so enforces the misunderstandings many of the patients have about medical conditions. [...] [The doctor]
shouldn’t give me the impression that my questions or requests are useless or time-consuming ... (P13)

In what can be regarded as their defence, a number of physicians raised concern that the high doctor’s patient load and the heavy burdens on the physician, in general, negatively impact the quality of care provided by primary care. One clinician described his experience of running a practice surgery as “working in a grocery store” (P1). Similar descriptions of primary care practices as ‘grocery stores’ have been provided by other physicians.

Due to the nature of work in primary care ... and the huge patient load we see every day, we are unable to ‘just listen’ to patients like therapists or social workers do ... sometimes we have to lead the encounter, if you know what I mean. (P10)

With such a heavy patient load, [doctors] are unable to personally know every patient they see ... and to know his medical and family histories ... it is impossible and nobody expects us to do so in the current situation. (P42)

We’re ... almost always packed with patients ... and even more patients are usually waiting in the waiting area ... so we can’t provide patient education to each case at length ... neither can we answer each and every one of their questions. (P15)

This suggests that the doctor-patient encounter—generally seen in the literature (Johns, 2002; Helman, 2007) as an important window for patient education—is not well-managed or utilised by the doctor. Doctor-patient transactions are opportunities for medical professionals to mould erroneous or inaccurate patients’ explanatory models to fit with the medical model of disease (Johns, 2002; Helman, 2007). Findings from this study suggest that these valuable opportunities are often neglected by health care providers.

As can be seen from the data there are issues with the balance of power between health care providers and users. The previous quotes demonstrate the hegemony of the dominant cultural values, norms, and ideas over the principles and methods of practising medicine. That is, contrary to the literature that affirms the inherent superiority of the professional explanatory models over the lay explanatory models during clinical encounters (Helman, 1981; 2007).
Participants’ accounts suggest that lay explanatory models often prevail during consultations. The ‘power’ vested by the community in medical professionals does not appear to be sufficient to overcome the enormous power that the community has also bestowed upon its deeply held beliefs and assumptions about health and illness—regardless of their source. Physicians’ refusal to provide care that they reasonably believe to be inappropriate to a patient who asks for it appears to be highly stigmatised. On the other hand, there appears to be no cost to the patient for disputing a decision made by a competent medical professional within the purview of medicine. That is, the balance of power in the doctor-patient relationship appears to be shifted toward the general public’s favour—often despite consensus among clinicians. This dominance of cultural values over scientific rationality could pose a significant challenge to providing high quality care and could threaten the very raison d'être of the primary care service. In other words, the professional sector of health care, which has its own ways of explaining and treating ill health—that distinguishes it from the popular and folk sectors of health care (Kleinman, 1980; Helman, 2007)—appears to be rendered less effective by the dominant cultural values of the society.

Arguably, this hegemony of cultural beliefs and values challenging established medical practices and institutions might have been enabled, or at least assisted by, the collectivist values of the Kuwaiti culture. Research has repeatedly shown that members of collectivist cultures, of which Kuwait is one, show higher levels of conformity than those of individualist cultures (Smith & Bond, 1993; Bond & Smith, 1996; Kim & Markus, 1999). Members of collectivist cultures tend to identify themselves as members of social groups and place the interests of these groups—which are seen as the basic units of the society—before the rights of the individual (Hofstede, 1980a; 1984a; 1991; Kim & Markus, 1999). In collectivist societies, conformity is generally seen as essential for strengthening the social fabric and the social cohesion in the
society. It is not surprising therefore that these societies encourage conformity and tend to
discourage deviance or dissent, which are seen as undermining the group (Smith & Bond, 1993;
Kim & Markus, 1999). Collectivist societies typically reward conformists—with approval and
social acceptance—and punish nonconformists—with social rejection and isolation (Gilbert et
al., 1998). As evident in the quotes above, clinicians have often knowingly provided
inappropriate care, possibly to avoid being seen as deviant or intransigent.

6.5. Chapter Summary

This chapter has presented sub-themes related to participants’ beliefs and assumptions about the
concept of health, what it is, and therefore who is responsible for promoting and sustaining it. A
number of different views on the meaning of health were shared by the participants. These
ranged from the functional definition of health—which viewed it essentially as fitness for
purpose; to the utilitarian definition—which pragmatically saw health simply as what the health
care service ought to provide; to the reductionist clinicians’ perspective which defined health as
‘normal functioning’ of the body or basically the absence of disease; to the holistic concept of
health—which defined it broadly as ‘balance’ between its interrelated physical, social, mental,
emotional, and spiritual dimensions; to, finally, the view that health, like all other ‘good things’,
is a gift from God and is largely in the realm of the divine.

It is notable that several of these views or ideas of the concept of health appear to be
strongly influenced by the traditional cultural values in Kuwait, which themselves draw from a
range of traditions including religion. Some of these culture-centric views of health have been
expressed by medical professionals; this demonstrates the hegemony of the dominant culture and
values of the Kuwaiti society which seem to pervade even some aspects of medical practice.
Perhaps also reflecting the hegemony or pervasiveness of the traditional values of the society is the attempts by some participants to reconcile the, potentially conflicting, secular and traditional views of health—possibly due to the high cost (or stigma) of rejecting either view.

The chapter also presented the participants’ beliefs and assumptions regarding where the onus of responsibility for one’s health rests, which appear to be strongly influenced by their views on the meaning of health. In general, there was a dichotomy of views between health care providers and managers, on one hand, and health care users, on the other, on the extent of the individual’s (versus the health care system’s) responsibility for their own health.

The tensions and the misunderstandings between doctors and patients have been discussed in this chapter. On one hand, health care providers claimed that users are abusing the service, while health care users, on the other hand, stated that health care providers ‘are not doing their duty’.

The next chapter presents interviewees’ perceptions and attitudes towards primary care, the primary care service, and primary care professionals.
Chapter 7

Findings II

7.1. Introduction

This chapter presents the findings of this study relating to participants’ beliefs and perceptions about and attitudes toward the primary care service. As was presented in the previous chapter, key health care stakeholders hold different and potentially conflicting views on the meanings of health and illness, and, therefore, where the locus of responsibility for caring for one’s health lies. While influencing general perceptions of primary care in Kuwait, such views appear to have also resulted in tensions between health care users and providers.

The public image of the primary care service, primary care practices, and primary care professionals as well as public attitudes toward them are likely shaped by general beliefs and assumptions held by the society about health and how the primary care service should provide care for it. The beliefs and assumptions held by participants about what the primary care service ought to provide together with their assessment (or perception) of what the primary care service actually provides and how it provides may have a significant impact on the general perceptions of and attitudes toward the service.

This chapter aims to contribute to the third research question of this study:

3. Which cultural factors influence the stakeholders’ definitions of health care quality and how do these factors differ between the various stakeholders?

The next sections present the participants’ perceptions about the primary care service—from the general attitudes toward and trust in the service held by stakeholders, to whether or not
stakeholders perceive the primary care service as providing culturally competent care, to the primary care workers’ perceptions about the work environment in the primary care service.

7.2. ‘Undervalued’ and ‘Untrustworthy’

Several clinicians thought that the contemporary culture in Kuwait, in general, has a low regard for primary care (and primary care workers). Some clinicians revealed that they feel undervalued by the society at large.

_The culture of primary care is immature [in Kuwait] ... the dominant culture here is a specialist culture that undervalues generalists ... the role of family physicians is undervalued ... as well as the role of primary care in general ..._ (P2, a family practitioner)

_Not infrequently during the night shift or the after-hours, patients would visit the surgery for a ‘sick leave’, or sometimes, for well person check-ups or for minor complaints like common cold. Some visit the surgery during night shifts for symptoms that have been present for quite a long time._ (P1, a family practitioner)

_[The] patient’s perception of need influences to a great extent the medical decision [...]. Theoretically, doctors can refuse [patient’s] requests if they don’t see them needed but in practice they don’t ... for social reasons [...]. Doctors who do [refuse these requests] are considered mean._ (P2)

Furthermore, a number of clinicians in this study described how, sometimes, local people send their chauffeur or housemaid to the practice with a list of requests without them being present. They described how they, sometimes, feel like they are working in ‘a grocery store’ and that they are low-skilled pink-collar workers rather than health care professionals. Clinicians in this study emphasised the growing need for conducting government-sponsored, nation-wide, comprehensive awareness programmes to counter and dispel the various misconceptions and beliefs held by the general public about the primary care service.

_Additionally, several clinicians alleged that the contemporary society in Kuwait does not respect their professional autonomy, knowledge, or specialism. One clinician reported that it is_
widely perceived by the public that primary care physicians are “doctors who haven’t undertaken any vocational training after completing medical school” (P1), which, he said, does not reflect the actual reality. Also, as described in Chapter 6, it is not uncommon or unusual for patients to argue with physicians if they disagree with their medical decision or if they are denied access to a particular health service that they want. This suggests that the society does not have a high regard for the professional role of primary care physicians; their professional autonomy; or their medical knowledge.

Possible reasons for the low opinion the public holds of primary care can be drawn from the health care users’ accounts of primary care physicians. Several health care users reported that they believe that primary care physicians, in general, are less competent than their hospital specialist counterparts. Participants believed that many primary care physicians have not chosen primary care but were rather forced into it due to their clinical incompetence. Some participants thought that primary care physicians are essentially ‘bad doctors’ and this is the very reason they are in primary care; they are not ‘hospital quality’. They are, as one participant put it, “second-class doctors” (P19).

It was generally believed by many of the health care users that primary care physicians lack medical knowledge compared to their hospital specialist counterparts. Some participants reported that they feel primary care physicians are especially lacking in knowledge of newer evidence relating to the practice of medicine, including newer diagnostic and therapeutic options, and that they are lacking in knowledge regarding proper management of serious medical conditions—or real medical conditions as one participant termed them.

*I am not a doctor, but I think I know that [my primary care doctor] is not the best knowing doctor. I feel his knowledge is old … I mean outdated. Maybe there are new things out there he*
doesn’t know [...] I wouldn’t trust him if this was in a hospital setting, where knowledge of the latest about disease and treatment is important and critical. (P20, a health care user)

Primary care here is nothing. Everyone knows it is only good as a channel for treating trivial conditions ... and for getting referrals for the ‘real’ medical conditions. (P14, a health care user)

One young Kuwaiti woman said she believed that primary care physicians ‘experiment’ on patients by trying new drugs or combinations of drugs.

These perspectives seem to draw a strong distinction in terms of staff competence between primary care and other levels of care—not necessarily to commend or endorse other levels of care but more to inveigh against the primary care service. The service was excessively criticised as unsuitable for managing ‘real’ or serious medical conditions.

In addition, it is also generally believed that many primary care physicians chose the field of primary care for lifestyle reasons rather than truly for reasons of professional aspiration. Many participants thought that primary care physicians only chose the field of primary care to avoid the long working hours and the demanding environment of the hospital.

[Primary care physicians] chose primary care to avoid the work nature and hours of the hospital ... they didn’t choose it because they like the field ... they just chose it because they want a more comfortable work. (P27, a health care user)

[Primary care physicians] chose a relaxed lifestyle and a comfortable environment from the very beginning of their career, so it isn’t surprising that they’re just being lazy and careless, they’re ‘getting comfy’ here ... (P14, a health care user)

Furthermore, many participants thought that health care workers in the primary care service, in general, are negligent and unprofessional. One participant thought that lack of professionalism among most primary care workers stems from the very reason that they chose primary care as a career: they deliberately chose a comfortable work environment. She attributed negligence and lack of professionalism among them to their lack of discipline and moral integrity—rather than to improper training:
I don’t think it is education or training, it is their attitude and how they, themselves, view their job, their profession, how they view primary care and their patients. It revolves around how they see themselves compared to their hospital colleagues [...] it all goes down to their morals: good doctors work selflessly, diligently, and with dedication even with no supervision; bad doctors just don’t, they lack dedication and discipline. (P14, a health care user)

These perspectives from health care users were echoed by a senior practice manager, a 63-year-old male who is a clinician by background. He reported that many junior physicians, after their internships, work in the field of primary care on a temporary basis, as a period of lighter workload, until they decide on a career path. He said,

Many junior doctors—fresh out of internship and before joining a residency programme—join our practice and work here for a year or so until they make up their mind on a medical specialty, or sometimes until residency programme openings ... we understand this, we can’t expect these ‘temporary doctors’ during this short period to learn about family medicine or primary care ... especially that they chose primary care, and not any other setting, because they feel that the workload is lighter here. So in reality they consider this a period of convalescence after medical school ... or a period of rest until their ‘real career’ begins. (P25, a health care manager)

This suggests that the primary care service is viewed—even by physicians—as less ‘real’ a medical setting than hospitals. Such lack of trust in the primary care service, as was reported by several health care users and acknowledged by several primary care workers, is demonstrated aptly in the following quotes.

Many Kuwaitis only use primary care to get ‘sick leave’ notes. They don’t trust primary care even with the smallest stuff, they don’t trust the medicines provided by primary care. (P11)

Most people don’t trust the primary care service ... Many people perceive primary care as a warehouse or a place to top-up their household stocks of medicine ... or in many cases a place to get ‘sick leave’ reports. (P23, a primary care nurse)

The lack of trust in primary care was not only expressed by health care users but also shared by the top leadership and senior executives at the Ministry of Health. Several physicians noted that the senior management at the ministry does not trust primary care physicians with resource-intensive diagnostic and therapeutic modalities.
We can’t directly request costly and high-tech investigations like CT and MRI. Cases that require these procedures must be referred to a hospital specialist who’d decide the whether a scan is appropriate … (P1)

Not all treatments are available here. There are restrictions on primary care doctors. We can’t prescribe certain meds or request certain tests. (P10)

One physician held that the lack of trust came from many years of poor experiences and adverse events that patients had with the system, and that for the system to gain the public’s trust it must first deserve this trust.

The public mistrust in primary care has developed over the past three decades, during which time the ministry focused on hospital and specialist care ... and largely neglected primary care, which emphasises prevention and health promotion. [...] What has accumulated over several decades can’t be fixed overnight. (P2)

This account appears to attempt to justify the widespread lack of trust in the primary care service that, according to the physician, is the fruit of decades of failures and poor experiences. That is, the widespread lack of trust in the primary care service is not irrational or illogical but, according to P2, is reflective of the lack of priority it has been afforded by government policy.

7.3. Gender Issues

The primary care service in Kuwait has a disproportionate percentage of women doctors (Al-Jarallah & Moussa, 2002; 2003; Al-Jarallah, 2008; Al-Jarallah et al., 2010), which may be a factor in respect of the low regard in which the service appears to be held. Participants in this study reported that, generally, women doctors are effectively compelled to choose family medicine because often have very few choices of medical career readily and practically available to them. Family medicine is often the most convenient for a variety of social reasons including, importantly, the availability of training programmes locally—since the prospect of women training and living abroad for extended periods is not socially acceptable in the conservative Kuwaiti society (Al-Jarallah & Moussa, 2003; Premadasa & Al-Jarallah, 2007; Al-Jarallah et al.,
Many Kuwaiti families are reluctant to allow their female family members to be trained abroad unless they are accompanied by an adult male family member (Al-Jarallah & Moussa, 2003). Kuwaiti women, in general, are more vulnerable to family pressure than men; women doctors are no exception (Al-Jarallah & Moussa, 2003; Premadasa & Al-Jarallah, 2007). In addition, the relatively low likelihood of being called for emergency duties at irregular hours that characterises primary care makes it an especially desirable setting for many female physicians. Previous research has shown that Kuwaiti female physicians tend to choose work settings that offer ‘controllable lifestyle’, such as family medicine. Arguably, such a work setting provides female physicians with the ability to select an acceptable work schedule and to accommodate other responsibilities they might have towards their families (Osler, 1991; Abyad et al., 2007; Premadasa & Al-Jarallah, 2007).

Many female doctors come to family medicine for social reasons ... in many cases family medicine is in a way their only choice of career ... they’re cornered into it ... they can’t go abroad [for training], they can’t work nights, and they can’t work far from home. [...] Most [female family doctors] are married and have children so the work environment of the hospital isn’t their ideal work setting. (P38)

This quote confirms findings by previous research (Al-Jarallah & Moussa, 2003; Premadasa & Al-Jarallah, 2007) and indicates that there are gender-related social and cultural factors that practically make it difficult for female clinicians to pursue a career in certain medical specialties. Working near home in a residential neighbourhood, having flexible and controllable work schedules, having limited mainly day-time work hours and minimal night duties all make primary care especially convenient a career for female physicians. That is, primary care makes for a female physician-friendly work environment.

The quote also reflects the important gender division within the Kuwaiti society. Even though legal restrictions play a significantly smaller role today than they did in the past (Crystal,
1992; Al-Suwaihel, 2009; O'Shea & Spilling, 2010), customs and social norms still play a major role in directing or limiting career options for female physicians, and women in general, in the Kuwaiti society (Crystal, 1992). Many of the social norms in Kuwait derive from the views of patriarchy, in which women are assumed to be in need of men’s protection and supervision (Tétreault & al-Mughni, 1995; Johnson, 2005); paternalism, in which the autonomy or freedom of the subordinate is limited for their supposed own good (Ali, 1996; Al-Moosa et al., 2003); and Islamic complementarianism, which espouses that men and women should have different roles.

It is not clear whether the disproportionate percentage of female physicians in the primary care service is related to the general lack of trust and respect felt and reported by several primary care physicians. In addition to the points reported in the previous section, the widespread lack of trust can be, in part, attributed to the fact that the primary care service is provided by a predominantly women workforce. The literature has shown that primary care is increasingly becoming the first choice for female physicians in Kuwait (Al-Jarallah & Moussa, 2003; Al-Baho & Serour, 2007; Premadasa & Al-Jarallah, 2007).

7.4. Cultural Suitability

Participants highlighted that the culture in Kuwait places a particular importance on a number of values relevant to the health care setting, namely, privacy, dignity, and respect. Individuals from Arab societies, in general, tend to emphasise the importance of traditional values such as privacy, modesty, and a preference for same-gender physicians (Lipson & Meleis, 1983; Meleis & La Fever, 1984; Hammoud et al., 2005; Yosef, 2008). One practice manager said,

[Emergencies] are relatively uncommon in primary care ... our clients in most cases are ambulatory ... and present with common conditions ... because of this, it is even more important in primary care than in other health care settings that the provider deals with the
patient as a human being ... and in a culturally suitable manner ... values like human dignity and respect ... and privacy are extremely important ... especially in our conservative and religious culture.  (P26, a health care manager)

This is consistent with Donabedian’s (1980b) observation that patients with acute or severe illnesses tend to value different components of care, for example, clinical competence, than patients with mild or stable chronic illnesses, where improvement tends to be little or slow. This latter group of patients may, for example, value complementary components or amenities of care (Donabedian, 1980b).

On the whole, there was a general agreement among participants that care provided in the primary care sector is culturally acceptable. One health care user, a Kuwaiti woman, said,

*Care provided here is culturally acceptable ... even (emphasis added) foreign doctors know and respect our cultures [in Kuwait] and abide by our norms and values ... care and the way it is delivered conform to our culture.*  (P13, a health care user)

While suggesting that care provided by primary care practitioners is generally deemed to be culturally acceptable by local people, this perspective also shows clearly the immensity of the traditional division between Kuwaiti citizens and foreigners in the Kuwaiti society. In this perspective, there is a sharp distinction between local people, who to a large extent share the same cultural values, and foreigners, whom appear to be largely viewed as the ‘others’.

Furthermore, the previous quote appears to view prescriptively a particular set of beliefs and values that is dominant in the Kuwaiti society as normative and assumes that individuals foreign or alien to that set are required to comply with it. Additionally, this perspective suggests that Kuwaitis share one homogeneous culture, which is likely to be an oversimplification.

The assumption that Kuwaitis share a homogenous culture that is the standard or accepted form culture to which health care should conform makes the primary care service institutionally discriminatory. That is, to provide care in a certain way that is suitable to a small
subset of health care users but not necessarily to others is by itself a form of institutional
discrimination that will likely have an impact on the quality of care provided to those concerned.
Participants’ experiences relating to institutional discrimination will be discussed in Chapter 8.

Moreover, to the issue of cultural suitability of care, one participant argued that much of
the knowledge about the culture in Kuwait lies within the realm of ‘common knowledge’ and
may, hence, be inaccurate. He said,

[Much] of what we think we know we know [sic] about our culture comes from common
knowledge and everyday experience … we know what we know because we have lived [in
Kuwait] for significant period of time … and because we were trained here … and have been
working in the system for a long time … so we can’t expect providers from other cultures to
provide culturally suitable care ‘out-of-the-box’ … we can’t expect them to instantly have this
knowledge about our culture, that we had learned as locals … especially that this knowledge
only exists in our minds … I mean, it isn’t based on any evidence … so it could well be that
[what] we think we know about our culture is inaccurate, biased, or even completely false …
(P26, a health care manager)

He also noted that it is difficult for health care practitioners, alien to the local culture in
Kuwait to learn about it due to the lack of any documentation on the subject in common
broadcast media such as film and television, as is the case with the film industry in the West for
instance.

Another reason that makes knowledge about Kuwaiti culture virtually unavailable to
foreigners is the sharp divide between Kuwaiti nationals and foreigners (Crystal, 1992;
Kapiszewski, 2004; 2006). There are numerous tensions between nationals and foreigners in
Kuwait. In general, many nationals feel mistrust of or detachment from non-nationals—
especially non-Gulf Arabs (Birks & Sinclair, 1980; Kapiszewski, 2004; 2006). The general
perception among Kuwaiti nationals is that expatriates—especially those that are poorly
educated or poorly skilled—come only to take their money and leave (Alessa, 1981;
Kapiszewski, 2004; 2006), and thus are perceived as a “necessary evil” (Brochmann, 1993,
In the same vein, many non-nationals often feel perceived by Kuwaiti nationals as disloyal to their hosts. Many feel that Kuwaiti nationals often act out of prejudice and stereotypical views against them (Kapiszewski, 2004; 2006). Kuwaiti nationals’ attitudes towards non-nationals are generally negative. According to Salame (1988), themes of exploitation, greed, arrogance, and discrimination often surface in the discourse of non-nationals about their personal experiences in the Gulf States. Furthermore, according to a recent report by the World Economic Forum, the score for the attitude of the Kuwaiti population toward foreigners was one of the lowest of 140 populations featured in the report (Blanke & Chiesa, 2013). Nationals of Kuwait—and of the Gulf Arab nations in general—are notoriously known for separating themselves, socially and culturally, from non-nationals (Crystal, 1992; Kapiszewski, 2006). For these reasons, knowledge about the culture of the local people in Kuwait may be exceptionally difficult for foreign workers to learn.

Contrary to the perception of a shared homogenous culture, one health care manager commented on the need to provide a service that is responsive to diverse cultures:

*The community [in Kuwait] is greatly diverse in terms of the various cultural groups and ethnic minorities that live and work here and get health care from here. In most cases the doctor providing care is from a different cultural background than the patient’s. So even local doctors should have at least a minimal knowledge of the needs or preferences of the various cultural ethnicities, what suits them, and whatnots, to be able to offer a culturally competent service.*  
  
(P26, a health care manager)

Providing culturally competent care could, therefore, be a challenging task given that a considerable proportion of clinical care delivery takes place within culturally discordant doctor-patient relationships.

The problem of providing culturally *in*competent care to minority groups is further compounded by the fact that the primary care physician acts as the gatekeeper to more
specialised hospital care. This makes the responsibility of the primary care provider to improve their sensitivity to the cultural beliefs, expectations, and practices of their patients, especially from minority groups, more challenging and more important.

Another facet of the problem is that the interests of minority groups, especially non-Arabs, are not voiced. According to Betancourt et al. (2003), the lack of cultural diversity at the policy-making level often results in policies and procedures inappropriately designed to serve the health care needs of socially and culturally diverse populations. A report by the Ministry of Health (2012) showed that physicians from the Indian subcontinent—whose nationals make up around half the country’s population (al-Jasser, 2012)—constitute less than one-tenth of the nation’s physician workforce (Ministry of Health, 2012). The next section goes on to describe how such matters have important consequences for the working lives of primary care physicians.

7.5. Work Environment

Several clinicians and managers shared their perspectives on the nature of their workplace relationships and on their workplace environment in general. A number of them stressed the importance of a healthy work environment for health care providers. One participant, a practice manager, described the importance of improving and maintaining positive staff morale and healthy work climate:

*To me doctors’ morale is extremely important ... both for the long-term performance of our team and for the quality of the service we provide as a whole. Our aim is to always maintain a positive and positive work environment ... one that our employees would find stress-free. [...] We hold weekly staff meetings for the doctors ... we also hold journal clubs meetings once a month ... we occasionally organise events and social activities for our medical team. ... We aim to create a work environment that is enjoyable for our staff.* (P9, a health care manager)
He believed that periodic staff meetings are beneficial for improving intra-professional relationships and cohesiveness. He put great emphasis on positive relationships among health care workers as a means of achieving a healthy work environment. He thought that having a positive professional relationship with one’s colleagues helps reduce work-related stress and drives up employee morale, satisfaction, and motivation. Another participant, a practice manager, provided a similar perspective. He said,

*Positive relations between doctors improve the work climate within the practice and essentially add flexibility. [...] From my experience, most workplace conflicts between doctors arise from disagreements on the shift-work schedules ... usually their perceptions of the fairness of the shift-work schedule. We try to distribute the shifts between doctors fairly but flexibility and friendly relations between them is often more important.*  (P26, a health care manager)

A third practice manager shared a similar account:

*We host a number of activities throughout the year ... scientific activities and social activities. Also, for our permanent doctors, we hold a monthly meeting where we usually have one of our doctors present a lecture on a topic relevant to primary care ... these meetings make a valuable opportunity for our doctors to socialise with each other especially that they can’t usually afford such a chance during their rostered shifts.*  (P25, a health care manager)

He believed that periodic staff meetings are beneficial for improving intra-professional relationships and cohesiveness. One clinician, a veteran physician with more than 20 years of experience at his practice, provided a lengthy comment on the importance of the work ethic and work environment in primary care. He said,

*I have had and maintained good, positive and professional relationships with so many of my patients over these years ... also, a very good relationship with my colleagues ... doctors, pharmacists, receptionists ... I’m almost friends with everyone here [...] I don’t mind working everyday, honestly [...] I think of my colleagues as my family ... and I really like the easy-going and lenient way in which we deal with each other.*  (P18)

However, despite the emphasis placed on intra-professional relations, the medical body in the primary care service is not without its divisions, as several clinicians reported. One major
division is between Kuwaiti physicians and non-Kuwaiti physicians, mainly from Egypt. One physician from Egypt shared his perspective on this division:

Did you know that Kuwaiti doctors earn around three times as much as other doctors? I understand that they’re nationals employed by their government but this huge discrepancy is certainly unfair … we feel unfairly disadvantaged … especially that we do the same work … actually many times much more … plus, we’re usually allocated to [practices] that are very crowded … yet we receive less than half … this is unfair. You can imagine how this impacts our motivation and morale. (P15)

This perspective suggests that there is a great deal of tension about pay equity (or lack thereof) between Kuwaiti and non-Kuwaiti physicians—at least in the latter’s minds. This perspective was shared only by one participant, it is likely shared by other non-Kuwaiti physicians who might have preferred not to disclose their opinion on this matter to the interviewer, who himself is a Kuwaiti physician. One practice manager reported that non-Kuwaiti Arab physicians working at his practice have once in a while collectively made petitions asking for a raise. He reported that these petitions never asked for equal pay as Kuwaiti physicians, but only for a pay raise not particularly pegged to Kuwaiti physicians’ pay.

In addition, the same physician added that physicians’ career promotion scheme makes moving up the grades almost impossible to achieve for non-Kuwaiti primary care physicians. He reported that unlike their Kuwaiti counterparts, non-Kuwaiti physicians in practice are capped at a particular grade.

Our promotions are extremely difficult … unlike those of Kuwaiti doctors … it isn’t uncommon that young Kuwaitis move up the ranks and outpace their non-Kuwaiti colleagues … actually this is the norm here. I’ve been in [the primary care service] for nearly 10 years and have seen many younger Kuwaiti doctors outrank me in a few years … I’m not surprised because these aren’t rare occurrences … but I and many others feel unfairly discriminated against … it isn’t fair. (P15)

This non-Kuwaiti physician’s account demonstrates the tension and the perception of being unfairly discriminated against at work as a group. This perception could have a negative
impact on the physician’s performance and quality of care they provide. The negative effects of perceived workplace discrimination on work-related attitudes and behaviours of the employee are well documented in the literature. Studies have shown that perceived discrimination contributes to decreased job satisfaction, decreased organisational commitment, and higher levels of work-related stress (Valentine et al., 1999; Ensher et al., 2001; Deitch et al., 2003). In addition, there is evidence that a physician’s perception of discrimination in their workplace—whether having an objective basis or not—can ultimately affect the quality of patient care (Coombs & King, 2005; Rothenberg, 2013). Moreover, there is evidence that having a two-tier promotional system whereby workers perceive they have unequal opportunities as their colleagues can decrease their job satisfaction and eventually affect patient care (Coombs & King, 2005).

There are divisions, it was reported, even among Kuwaiti physicians in the primary care service. A major dividing issue among Kuwaiti physicians is that of favouritism, nepotism, and cronyism plaguing the entire public sector, including the health care service. A number of participants reported that these preferential treatment practices are prevalent throughout the health care system and, in many cases, are the norm rather than the exception. Participants reported that they are especially rampant in promotion and selection for leadership and supervisory positions in the health care service. One participant, a clinician, said,

*Almost anything can be achieved through wasata ... it’s the norm not the exception ... that’s why people here diligently invest in their wastas ... someone in a position of authority would typically offer favours to those around him so he can ask them favours should he need later ... it’s a vicious circle ... I offer someone a favour, they’re expected to pay back ... it even makes asking them for favours less uncomfortable that they’re owed.* (P2)

Another participant, a health care manager, said,
Directors and [senior] managers know that their position authority won’t last forever … but their needs or those of their dependents will …whether in the ministry of health or elsewhere … so they’d build up their ‘vitamin O’ stock while they can … you know, saving for the rainy day. (P36)

The term ‘vitamin O’ is a colloquial expression used by some Arabic speakers to describe the significance of *wasta* in everyday life—where the letter O corresponds to the Arabic letter wāw with which the Arabic word *wasta* begins. The term implies that *wasta* is as essential as vitamins for the human body.

The above quotes suggest that the entire health care service is plagued by *wasta*. This finding has been supported repeatedly in the literature (Cunningham & Sarayrah, 1993; 1994; Shah et al., 1996b; Kilani & Sakijha, 2002; Budhwar & Mellahi, 2006; Zaqqa, 2006; Al Suwaidi, 2008; Mohamed & Mohamad, 2011). As well, there is some evidence to suggest that there is some link between *wasta* and collectivist values. In contrast to individualist societies, collectivist societies, like Kuwait, generally place high value on the group—be it family, clan, tribe, ethnic or religious group. Devotion, loyalty, and conformity to the group are strongly emphasised, as well as cooperation between in-group members and attending to their needs (Cunningham & Sarayrah, 1993; 1994; Weir, 2003; Al Suwaidi, 2008; Brent & Lewis, 2013). It may not be surprising therefore that in-group favouritism is more common in collectivist cultures as compared with individualist cultures (Yamagishi et al., 1998). It was also reported in the literature that practices of in-group favouritism or *wasta* are usually associated with expectations of reciprocity among—but not extending beyond—in-group members (Yamagishi et al., 1998).

Another type of division in the body of primary care medical professionals was reported. One participant, a clinician, described groupings of physicians, usually of the same ethnic backgrounds, each of which would function effectively as a group to lobby for the work-related
interests of its members. These groups of physicians have no formal internal structure, he reported, but are usually led by a senior or a more veteran physician within each group.

I always see the system here as groups of doctors like ‘gangs’ or ‘tribes’ each with their own practices and interests … for example you’d see an Egyptian group, a Syrian group, a Pakistani group, another Egyptian group, and so on. [...] They’d advocate the interests of their [members] … things like making the work roster, assigning surgery rooms to particular doctors, or shifting tasks like organising social events and lecture days to particular doctors. [...] Some of these groups are more influential than others … for example some groups are very close to the [practice] manager … and sometimes there are rivalries between the groups. (P16)

This perspective too suggests that there is a great deal of tension between primary care physicians (or groups of physicians). It is worth noting that this perspective was shared only by one participant, a physician, about the case at particular primary care practice and may not necessarily reflect the case at other practices or represent a general behaviour.

7.6. Chapter Summary

This chapter has presented an overview of participant’s perceptions of and attitudes toward the primary care service. A number of sub-themes relating to how the primary care service is generally perceived by the public have emerged during data analysis, namely, attitudes toward primary care, cultural suitability of primary care, and the work environment in the primary care service.

The chapter has presented that the primary care service is, generally, viewed by the public as low-status, ‘undervalued’, or ‘untrustworthy’ as primary care physicians reported. They reported that the society does not respect their professional autonomy or skill. This low value assigned to primary care may be attributed to the perceived incompetence and unprofessionalism of primary care clinicians, a career choice for lifestyle reasons or necessary for social reasons,
particularly those associated with gender. The chapter has argued that this lack of trust may be related to the fact the primary care service is predominantly a female career choice.

The chapter has also discussed the importance of providing culturally competent health care service, highlighting the sharp cultural division between Kuwaiti citizens and foreigners in the Kuwaiti society. This division poses a challenge to providing culturally suitable care, especially since the cultural interests and preferences of most minority groups are not voiced.

Another aspect that the chapter presented was the workplace environment as perceived by primary care clinicians. While there are continuing efforts to improve intra-professional relationships, the findings indicated a great deal of tension between primary care physicians. One area where there is manifest relates to the huge pay discrepancy between Kuwaiti and non-Kuwaiti physicians. The chapter has also discussed the reportedly great impact of *wasta* on primary care workers’ career advancement, perhaps more than any other factor, including their actual performance. This finding is supported by a number of studies that have shown that *wasta* plays a major role in the career development of most individuals in Gulf Arab nations, often regardless of the individual’s qualifications or lack thereof, and despite widespread negative perceptions of it (Mohamed & Mohamad, 2011; Kauser & Tlaiss, 2011). Another area that was discussed is the ‘tribe-like’ groupings of physicians centred usually around a common ethnicity.

The next chapter will present themes identified on the topic of health care access and health care quality. Under the central theme *differential access to primary care*, the chapter will present three sub-themes: *disproportionate distribution, waiting times, and institutional discrimination*. 
Chapter 8

Findings III

8.1. Introduction

This chapter presents the experiences and perceptions reported by participants relating to the third and fourth research questions concerning what cultural factors influence the stakeholders’ perceptions of health care quality and how they do so. The research questions were formulated as follows.

3. *Which cultural factors influence the stakeholders’ perceptions of health care quality and how do these factors differ between the various stakeholders?*

4. *How and why do particular cultural factors influence the stakeholders’ perceptions of health care quality?*

The chapter examines participants’ perceptions relating to health care access as a component of health care quality, as well as their perceptions and experiences relating to other components of health care quality, including physician-patient interpersonal communication. The central focus of this chapter will be on the central theme *differential access to primary care.* Within this central theme, three sub-themes emerged during data analysis, namely, *disproportionate distribution, waiting times, and institutional discrimination.* These sub-themes will be presented and described in further detail throughout the chapter.

8.2. Disproportionate Distribution

It was generally agreed among participants that the primary care service is adequately accessible. In terms of geographic accessibility, most participants reported that primary care practices are located in prime locations in the heart of each residential locality throughout the country. One
participant said, “primary care practices are within walking distance from virtually anywhere within the [locality]” (P1). Another made a similar remark, “the closest [practice] is usually within two-minute drive of every home in the neighbourhood” (P3).

These reports were confirmed by Ministry of Health authorities. The Undersecretary for Health has stated that the policy of the Ministry of Health is to have a primary care practice in every residential neighbourhood (al-Rajhi, 2010). In a recent statement made to the press, the head of Department of Primary Care of the Kuwaiti Ministry of Health said,

Since the establishment of the current health care system in the country, the primary care service has enjoyed a privileged position within the health policy agenda. The service has been consistently praised by the WHO advisors, as it provides equitable distribution of health care and comprehensive coverage of residential neighbourhoods, where the layout of any new residential development takes into account the health needs of the population. (Dr Al-Watyan as cited in Abdelmabood, 2013)

However, despite consistent reports of very adequate geographic accessibility, several participants—from the health care users’ group—commented that the primary care service could benefit from developing its existing facilities and adding additional services to better meet the health care needs of the communities they serve.

[Primary care] centres lack essential facilities and equipment that are needed by the primary care providers themselves ... things like X-ray and ultrasound. ... Labs are also lacking in the range of tests they can do ... many tests have to be sent to a hospital lab. (P14)

Most good medicines are only available at the hospital. Medicines at the local practice pharmacy are often unavailable ... at least this is what we’re told by the pharmacist ... medicines and blood tests should always be made available [...] regardless of the cost. (P13)

While geographic accessibility is widely believed among participants to be sufficiently adequate already, additional resources spent on development of new facilities or expansion of existing facilities are likely to be disproportionately high compared to the added health benefit such spending is expected to produce; the added health improvements, if any, are likely to be too small to be worth the added cost (Donabedian et al., 1982; Donabedian, 1988). Yet, demands for
additional spending on primary care persist. This supports the view reported by several clinicians—and presented in Chapter 6—that health care users are ‘over-demanding’ and ‘difficult to please’, which possibly reflects a culture of abundance, indulgence, and consumerism rooted in the Kuwaiti society (Kamel & Martinez, 1984; Kassem, 1989a; Al-Naser & Sandman, 2000). Indulgence—defined as the extent to which members of a society attempt to control their personal desires and impulses—is one of the dimensions of national culture proposed by Hofstede et al. (2010). Societies with predominantly relatively lax control—that is, indulgent societies—typically, allow relatively free gratification of human desires related to leisure and enjoying oneself (Hofstede et al., 2010; Hofstede & Minkov, 2013). Even though there exist no data specifically on the indulgence versus restraint score for Kuwait (Hofstede et al., 2010), several authors have shown that extravagance, conspicuous consumption, and wasteful behaviours characterise the Kuwaiti and the wider Gulf Arab society (Luqmani et al., 1988; Kassem, 1989a; O'Shea, 2000).

In addition, the persistence of the demands to develop new primary care facilities and expand or refurbish existing ones may be related to the great emphasis placed on public imagery and outward appearance of the service in the Kuwaiti—and the Gulf Arab—culture (Luqmani et al., 1988; Kassem, 1989a; 1989b; Al-Kazemi & Ali, 2001). Previous studies have shown that Gulf Arab cultures generally place greater emphasis on organisational imagery and external manifestations and appearances of quality, such as lavish buildings and modern equipment, than on the performance, reliability, and quality of the service (Luqmani et al., 1988; Al-Kazemi & Ali, 2001).

Furthermore, participants reported that there were substantial regional disparities in availability of care. There was a broad agreement among participants that primary care practices
in Kuwait City and Hawalli—which is contiguous to Kuwait city—have a greater supply of primary care physicians and in general higher staffing than practices in other areas. Participants consistently reported that primary care physicians in Kuwait City and Hawalli are better qualified and often more experienced than their counterparts in other areas. Several participants criticised the availability of care as disproportionate to the patient load for the practices at which they provide or receive care. They alleged that in some practices, available care resources—including importantly primary care physicians—are extremely limited relative to the high volume of patients at these practices. This is especially the case in practices in Farwaniya, Ahmadi, and other areas farther away from Kuwait City—which usually care for larger predominantly expatriate populations with disproportionately higher rate of low-income households and higher health care needs than the general population in Kuwait City (Central Statistical Bureau, 2010; 2011). Participants from these areas reported that patient waiting times are constantly long; it was reported that in some practices patients wait for more than an hour before receiving care. One participant, a 54-year-old handyman from Iran who receives care in the Farwaniya area, reported that waiting times were consistently long:

"My main complaint is the long wait ... sometimes I have to wait over an hour, sometimes even two hours ... the [practice] is always crowded no matter what time I go: morning, afternoon, evening. [...] Oftentimes the waiting area is too crowded people can’t find a seat ... Imagine standing on your feet for two hours, waiting to see the doctor!" (P32)

There was a near-consensus among participants who receive care from practices outside the capital area that waiting times are generally long. This is in spite of the widespread distribution of primary care practices throughout the country; that is, despite adequate geographic accessibility to primary care facilities, long waiting times pose a significant barrier to health care access and utilisation. In the capital, however, waiting does not seem to be a common problem. A family practitioner practicing in Kuwait City said "Waiting isn’t an issue at all in
The issue of waiting times will be discussed in more detail in the next section (section 8.3).

In addition, some participants reported that practices in Kuwait City and Hawalli, which serve predominantly affluent Kuwaiti population, have, in general, larger and more comprehensive supply of medications. Two practice managers reported that most of these differences in the availability of medications are due to what they described as ‘power struggles’ within the health care system. One practice manager told that there is subtle rivalry and competition between practice managers for primary care-related resources, including premises, health care workers, and medications; more influential managers are able to secure more—and more valued—resources for their respective practices.

Heads of primary care practices—and medics in general—are in a state of constant competition and sometimes distrust. From the moment they enter the job market, they compete against each other ... always trying to top one another. This competition is much more fierce when they compete for posts that are by their nature in short supply, like heads of primary care practices and hospital directors and so on. [...] Political power and influence of practice managers for example is often reflected in the quantity and variety of resources available at their practices. (P9)

Such struggles have unsurprisingly resulted in—or aggravated—variation in availability of health care resources across primary care practices. This suggests that primary care resources are not evenly or equitably distributed across the country, contrary to claims by Ministry of Health officials. That is, not only are resources not equitably distributed at the regional level, there appear to be differences in allocation of resources even at the level of the individual practice. The distribution of resources among primary care practices appears to be disproportionate to the size, and possibly the health needs, of the local populations they serve. It appears to be skewed towards a small proportion of the population residing in Kuwait City and surrounding areas.
8.3. Waiting Times

The issue of waiting times was brought up repeatedly during the interviews. There was a general agreement among participants that reasonable waiting times are very important, especially in the primary care setting. As to what they regard as ‘reasonable’ waiting time, most participants believed that primary care waits should in general be no longer than the wait times in hospital outpatient clinics; most believed that waiting times most of the time should be a lot less. One participant noted that long waits are not acceptable in primary care, especially as it is the first line of contact with the health system. Another participant, a health care manager, stated,

*Waiting times are an important indicator of how efficient the service is ... and importantly an indicator of access to the health care service ... which is particularly important in primary care being the first point of contact with the health service ... we aim to reduce waiting time as much as we could ... it is a key priority to us.* (P9)

However, despite the priority given to waiting times, there have been consistent reports by the study participants that waiting time in primary care is indeed a problem at least in practices far from the country’s capital, Kuwait City. Several participants reported that waiting times are constantly long in practices far from the capital. Some clinicians attributed long waiting times, in part, to the drop-in nature of primary care practices in Kuwait. They claimed that walk-in service model of the primary care service—where patients can walk in to be seen at any time without an appointment—increases the demand for the service and contributes to unnecessary service use and inappropriate care. They argued that the service, especially wait times, would benefit greatly from introducing an appointment-scheduling system. Clinicians called for a transition from the current walk-in service model to an appointment-only model, which, they reported, would allow them to spend more time with their patients at the surgery. One clinician held that an appointment-only service model would significantly reduce patients’
average waiting time and inappropriate service utilisation especially by ‘frequent attenders’, a common phenomenon in the primary care service, as was reported by clinicians (see Chapter 6).

With an appointment booking system in place, patients won’t have to wait in long queues ... they will be given enough time in clinics to ask questions ... the doctor will have enough time to listen, provide patient education and preventive care ... the doctor will be able to review the patient’s medical record before seeing the patient. (P1)

The notion of appointment-only model, however, was not well accepted among health care users. Even though it was welcomed by a few, most health care users interviewed thought that such a system would be detrimental to their access to health care and would likely result in longer wait times in practice. Some participants noted that one of the most common reasons for their seeking care is when they have emergent symptoms that they believe ‘cannot wait’ and need prompt attention; a walk-in model is therefore best suited for primary care. One participant said,

I mostly go to the doctor for minor conditions that most people experience at one time or another ... I mean these conditions are not serious or deadly but usually cause enough discomfort that they require immediate treatment ... for instance headache or period pain. (P22)

Other participants cited other reasons for their objections to an appointment-only model such as work and other commitments.

My working conditions are good but inflexible ... I can’t just take time off on any day of the week. (P12)

Illness doesn’t make appointments ... it shows up unannounced. [...] Sometimes I need to take sick leave ... and my employer would only accept a doctor’s note dated the same date as my absence ... doctors refuse to write the note retroactively ... so an appointment system wouldn’t work. (P28)

The walk-in model of the primary care service appears to be a convenience that is much liked and appreciated by users. Users voiced strong disapproval of the appointment-only approach, which would limit their ability to access the primary care any time their primary care practice is open. This may not be surprising given the findings presented in the previous chapter.
that the culture of entitlement is widely prevalent and deeply ingrained in the Kuwaiti society (Al-Waqfi & Forstenlechner, 2012; AlShalfan, 2013). As was described in Chapter 6, there appears to be a belief of exclusive entitlement among many users of primary care to use the service any time and for any reason. As such, it seems that patients who participated in this study strongly oppose any policy that would limit their access to primary care.

In addition, users’ objections to the appointment-only model in the primary care service may be linked to a characteristic common in the Kuwaiti culture: poor punctuality. Research has consistently shown that poor punctuality and poor regard for time are common features in the Kuwaiti culture and the wider Gulf Arab culture, in general (Elmusa, 1997; Muna & Zennie, 2010; Al-Omari, 2013; Haase, 2013). Arguably, users may be concerned that such a model of service provision would make their access to primary care more difficult and would require a greater level of punctuality on the part of users. Moreover, some users expressed their doubts about whether an appointment-only model would function as intended in practice. One participant, who favoured the introduction of an appointment system, was highly sceptical about how well it would work in practice. She said,

*I’d wish that we’d have an appointment system like in the UK for example ... but I’m very sceptical that it’d work even half as well ... our hospitals have an appointment system in place but waiting is still too long there ... people wait for as long as two or three hours sometimes ... but of course if you have ‘wasta’ or know someone then you won’t have to wait.* (P14)

This perspective suggests that there is scepticism that such a change can or will be properly implemented. Much of this scepticism, it seems, stems from the belief that the system is plagued by corruption and nepotism (or *wasta*). Much has been written about how *wasta*—defined as the use of connections for personal gains—pervades the culture of all Arab countries and permeates almost all aspects of life (Cunningham & Sarayrah, 1993; 1994; Shah *et al.*, 1996b; Kilani & Sakijha, 2002; Budhwar & Mellahi, 2006; Zaqqa, 2006; Al Suwaidi, 2008;
Mohamed & Mohamad, 2011). *Wasta* itself appears to be largely driven by the collectivist values embedded in the Kuwaiti (and wider Arab) society such as tribalism, interdependence, and cooperation between in-group members. Collectivist societies, of which Kuwait is one, place great emphasis on the closely knit social groups and networks: protection of in-group members and attending to their needs and demands are highly valued (Cunningham & Sarayrah, 1993; 1994; Weir, 2003; Al Suwaidi, 2008). Many people in Kuwait commonly utilise their social connections and networks and use *wasta* to facilitate access to health care or to obtain other benefits (Shah *et al*., 1996b). In addition, the institution of *wasta* may also be driven by the Islamic understanding of the value of intercession contained in the Quran:

> Whoever intercedes for a good cause will have a reward therefrom; and whoever intercedes for an evil cause will have a burden therefrom. (Quran 4:85)

Furthermore, users’ objections to an appointment-only model may also be linked to their belief that the crux of the issue of waiting times does not lie in the walk-in service model but rather in the way physicians organise their time distribution. A number of health care users ascribed the long waiting times, among other things, to physicians’ practice of splitting their shifts with their colleagues so that only half as many surgeries are available. One user reported that even during the busiest hours, primary care practices do not function to their full capacity with several surgery rooms closed and physicians taking breaks.

> All practices I’ve been to have been designed with many doctor surgeries to be open at the same time but I almost never seen more than just a few surgeries running at a time in spite of a long queue of people waiting. (P13)

These accounts were supported by some physicians who criticised such practices by their colleagues—and themselves—and acknowledged that they contribute, at times, to the long waiting times. One physician said,
It is now customary in all [primary care] centres that doctors split their shifts with each other ... sometimes in halves or in different arrangements depending on how many doctors are on the shift roster ... and this naturally results in longer waits ... each doctor now has to serve twice as many patients. (P1)

Some Egyptian doctors are known for their [shift-splitting] ... they'd even bluntly offer their 'services' to newcomers and young Kuwaiti doctors ... and it isn't just splitting shifts ... there's also trading shifts: these doctors would take up shifts from their colleagues for pay ... all of these arrangements are of course informal ... but these [shift-traders] are very well-known that they're almost daily called by doctors who want to give up their shifts, especially night shifts. (P4)

These accounts suggest that clinicians in primary care work inflexibly and are, in general, unwilling to bend on their shift swaps and shift splits; they appear to be unwilling to respond to fluctuations in demand at an appropriate pace or not at all, which exacerbates the problem of waiting.

Moreover, there seems to be limited intervention from the practice management to address the situation. One practice manager stated,

Our relationship with the doctors is based on trust. [...] We don't interfere with the ways our doctors cooperate or distribute their work ... unless of course there's a problem or complaint. [...] Our interference would lead to some kind of unfairness because doctors have agreed to and already split their shifts. (P25)

This rather passive stance by the practice management may reflect the reactive nature of management in primary care and possibly in the wider public service. Cultural studies focused on Kuwait and the Gulf Arab states in general have consistently shown that opportunism and reactive management are the norm in these cultures (Luqmani et al., 1988; Kassem, 1989a; 1989b; Al-Kazemi & Ali, 2001). Rather than take the initiative, anticipate and plan ahead, managers in Gulf Arab states tend to be passive and resort to reactive measures. Long-term planning is often completely avoided, as ‘the future belongs to god, not man’ (Luqmani et al., 1988; Kassem, 1989a). This may be linked to the values of Islam, namely fatalism and
predestination—the notion that future is predetermined by a divine decree and hence is beyond one’s control (Sidani, 2006; Sidani & Thornberry, 2010).

In addition, it may also be the case that such a non-interventionist stance on the part of practice managers—who are physicians by default—may be driven by the values of collegiality and professional solidarity among physicians across the world. The ‘unity of the profession’ is a core value among medical professionals and is an important driving force within the medical body (Freidson, 1970a; 1970b; Øvretveit, 1985; Gray & Harrison, 2004). Possibly to preserve the image of this unity, physicians are typically reluctant to disagree with their colleagues when asked for ‘second opinions’ (Mills & Gilson, 1988; Armstrong, 1999; Manias & Street, 2001; Axon et al., 2008). Moreover, physicians are notoriously known for ‘sticking together’ through their shared challenges and struggles (Quinn et al., 1996; Smith, 1998; Palmer et al., 2002; Gray & Harrison, 2004; Annas, 2008). In addition, ‘professional tribalism’ within the medical establishment has contributed, among other things, to the growing awareness of the importance of collegial relationships among physicians (White & Harris, 2001; Goodwin et al., 2004). Collegial relationships are even more valued in a collectivist culture like Kuwait where personal relationships are highly valued and emphasised (Hofstede, 1980a; 1984a; 1991; Hofstede et al., 2010). This is especially pertinent considering how widespread wasta is in almost all areas of life (Cunningham & Sarayrah, 1993; 1994; Weir, 2003; Al Suwaidi, 2008). Personal and professional relationships are often generally thought to be more important in collectivist cultures than one’s performance, tasks, or schedules (Hofstede, 1991; Al Suwaidi, 2008; Hofstede et al., 2010; Haase, 2013).

Other than the issue of waiting time, most participants reported that the primary care service hours are long and suitable for most of their needs.
The normal working hours in primary care are in two shifts: 07:00 to 14:00 and 14:00 to 21:00 hours ... and on weekdays, there is the daily after-hours from 21:00 to 00:00 hours. (P3)

During weekends and public holidays, however, most practices are closed and patients have to seek care at other practices than their own. “At weekends and holidays, within each health district there are at least two [practices] that operate throughout the day” (P3).

Participants reported that this closure results in significantly longer waiting times at the few operating practices during weekends. It was reported that waiting times at weekends are so long that many patients choose to seek care at private clinics or just wait until after the weekend. Some patients, it was reported, go directly to hospital emergency departments. One participant, a medical director at a primary care office at the district level, reported that patients increasingly bypass primary care and seek care directly at hospitals.

Lots of patients ditch the usually choking [primary care] practices on weekends and go straight to the hospital ... in turn choking the casualty ward at the hospital and possibly delaying people with genuine and immediate care needs. (P36)

This is supported by the finding of Shah et al. (1996b) that more than half the cases seen by hospital emergency physicians were judged by them as non-urgent or not requiring emergency care. A number of studies have documented similar findings (Shah & Shah, 1994; Shah et al., 1996a; Al-Hay et al., 1997). Bypassing primary care and seeking care directly from hospital impairs the gatekeeping function of primary care and could possibly nullify some of its intended benefits, including reducing costs and improving continuity of care (Starfield, 1992; 1998; Starfield et al., 2005). In addition, it was reported that care provided at the weekend is, in the main, of poorer quality. Some health care users reported that doctors covering on weekends always seem to be in a hurry and do not spend enough time with patients at the surgery. One health care user, a young woman, said,
My [primary care] practice runs only during weekdays ... it's like they think people don't get sick at weekends ... we have to go to another practice and I hate this ... the covering doctor [at the 'away' practice] isn't my doctor and doesn't know me ... so he'd give a ‘temporary’ treatment until I see my doctor next week ... this wastes my time!   (P14)

This participant’s account suggests that care provided at so-called ‘away’ practices during weekends would not only be of poor quality, but would also compromise continuity of care, an essential attribute of primary care (Starfield, 1980; 1992; 1998). In addition, being of temporary nature, care received during weekends would typically need to be followed up by another episode of care at the user’s ‘home’ practice. This could lead to overutilisation of the health care service and increased health care costs.

8.4. Institutional Discrimination

It is worth noting, before presenting the findings in this section, that the great majority of the population in Kuwait are not Kuwaiti but foreign workers. Non-citizens constitute more than two-thirds of Kuwait’s population, of whom the vast majority are South Asians (O’Shea, 2000; Shah et al., 2002; Kapiszewski, 2006; Central Statistical Bureau, 2011; al-Jasser, 2012). Nationals of the Indian subcontinent constitute the largest community in Kuwait, making up around half the country’s population (Shah et al., 1991; 2002; al-Jasser, 2012).

Participants reported that Kuwaiti nationals could access the primary care service without any out-of-pocket payment, while non-Kuwaitis have to pay a nominal fee (the equivalent of £2) at the point of care. In general, the service was thought to be very affordable even by non-Kuwaiti health care users. This discrimination between citizens and non-citizens with respect to user charges, albeit small, may be a sign of institutional discrimination in the health care system. This discriminatory treatment, which is the result of the Alien Health Act of 1999 (State of Kuwait, Law № 1 of 1999), is seemingly in direct conflict with the health disparity-reducing
attributes of primary care (Shi et al., 1999; Shi & Starfield, 2000; Shi et al., 2002). This discriminatory Act has been the subject of much debate controversy and criticism in the national media since its introduction (Akbar, 2003; Kronfol, 2012). It has been argued that while the fee for health care is minimal, it is nonetheless the equivalent to a day’s pay for many non-citizen workers (WikiLeaks, 2004).

Several participants in this study reported that the best medications are only available to Kuwaiti citizens, and that there are separate lists of medications for citizens and non-citizens. One participant, a 48-year-old Egyptian man, said,

*It is so unfortunate that the best medicines are reserved not for the sickest or the most in need, but for citizens, who are usually well off and can afford such expensive medicines on their own.*  (P30)

This is an example of institutional discrimination in the Kuwaiti primary care service based upon citizenship status. A number of researchers have shown that health care discrimination based on citizenship is widespread across all Gulf Arab countries—not just Kuwait—and is most evident against immigrant labourers from South Asia as well as other non-citizen groups (Kronfol, 2012; Batniji et al., 2014). It is not uncommon in the Gulf countries for some health care services to be restricted to citizens of these countries and other services—typically receiving significantly lower funding from the government—to be reserved for non-citizens (Kronfol, 2012).

Kuwaiti participants generally reported that they were comfortable, in general, with the providers’ attitudes towards them; most reported that they were satisfied with the way clinicians treated them and understood them. In contrast, several participants from South Asia were not satisfied with how clinicians communicated with or treated them. A young man from India reported that the health care service is not acceptable to many people from the Indian
subcontinent; he held that the needs of patients from the Indian subcontinent are too often ignored or overlooked. He expressed his concerns about how physicians do not seem to listen and seem to provide pre-packaged, one-size-fits-all care. He reported experiences of discrimination and prejudice that he attributed to his ethnicity.

*People from Kuwait and other Arab countries would not have similar experiences as mine, being Indian. Being Indian greatly influences how the whole society, including the health system, sees and treats me. We are perceived in the Kuwaiti society as disempowered and disadvantaged expatriates who are just here for the 'money'. As such, we can’t complain about poor quality and medical negligence … even if we do, our complaints won’t be taken seriously, especially if they’re made against a local. So … we are perceived and dealt with here as a ‘special category’ … we definitely experience health care differently. (P19)*

As is apparent from this comment, there is a perception that Indian nationals—and possibly natives of the Indian subcontinent collectively—in Kuwait are underprivileged, disadvantaged, and are often discriminated against. They usually have little or no room to protest their discrimination out of what Batniji *et al.* (2014) argue are well-founded fears of being persecuted or even deported from Kuwait. In addition, a number of other participants from the Indian subcontinent reported similar experiences.

*Doctors here—and people in general—are selective about which cases to treat with respect and quality and which cases not to … I asked doctors [in primary care] many times for referral to a skin doctor but was always just given creams … the only time I was given a referral was when the health inspector gave me a temporary suspension.* (P31)

P31 is a 45-year-old gentleman from India. He is a restaurant worker. He reported having fungal infections on his hands for which he was temporarily suspended from working at the restaurant.

Another participant reported a similar experience:

*Good medicines are reserved for Kuwaitis … medicines for [non-citizens] are cheap, locally made ones … I doubt they help much so I ask for a private prescription.* (P39, a 40-year-old man from India)
Another user, a woman from Sri Lanka, reported that she is sometimes unable to explain her symptoms in a language that is not her first language and that none of the doctors or nurses at her practice speak her language.

*I consider myself to be moderately okay in Arabic ... sometimes, however, I have to describe specific and complex experiences of illness that I find difficult describing even in my own language ... and almost impossible using another language.* (P6)

She reported concerns about poor communication with health care providers because of language barriers and cultural differences. This might present a barrier to seeking care even when the specific health care services needed are available and physically accessible, possibly due to lack of awareness of their availability or effectiveness or even due to perceptions of difficulties related to language differences and cultural competence (Goddard & Smith, 2001; Cooper & Roter, 2003; Dixon-Woods et al., 2005; Kronfol, 2012). A body of research suggests that using health care services requires considerable effort on the part of patients in terms of having the appropriate knowledge of the health care services available and the ability to communicate effectively with health care providers (Dixon-Woods et al., 2005).

Furthermore, the above accounts made by participants from the Indian subcontinent suggest that there are widespread differences (or health disparities) against people of Indian origin in terms of access to health care. These differences, however, do not appear to be due to formal institutional constraints; that is, they are not formally mandated or explicitly adopted by regulation, policy, or legislation by the department of primary care or the ministry of health; and they are not created, communicated, or enforced through the officially sanctioned channels of decision-making (Nee, 1998; Helmke & Levitsky, 2004). Rather, they appear to be individual or group acts driven by attitudes or prejudices held by society members, including health care workers, against natives of the Indian subcontinent. However, although these practices by health
care workers do not appear—in this case—to be formally regulated or guided by policies or other ‘formal’ organisational directives, they would not be regarded as a form of isolated (or interpersonal) discrimination given the seemingly overwhelming ‘informal’ consensus among health care workers to maintain the *status quo* in terms of their practices toward ethnic minority groups (Feagin & Feagin, 1978; Feagin & Eckberg, 1980; Karlsen & Nazroo, 2002; McKenzie, 2003). These practices are likely shaped to a large extent by ‘informal’ institutions, from social norms to culturally accepted customs and behaviours, at both the national and sub-national (municipal) levels of the primary care service (Richards & Lucas, 1985; Nee, 1998; Helmke & Levitsky, 2004). They can therefore be regarded as another form of institutional discrimination (Karlsen & Nazroo, 2002; McKenzie, 2003).

Researchers have used several theoretical models to conceptualise discrimination. One model that has been applied frequently and has been noted as having significance in the understanding of discrimination is the social dominance theory (Kitano, 1997; Sidanius & Pratto, 1999; 2012). The theory posits that societies are organised in group-based social hierarchies with a dominant group at the top of the hierarchy and subordinate groups at the bottom; members of the dominant or hegemonic group tend to enjoy a disproportionate share of ‘positive social values’ or desirable societal resources while members of subordinate groups are left with fewer (and less valuable) resources; and that this hierarchy is produced and maintained by intergroup behaviours such as discrimination and prejudice (Sidanius & Pratto, 1999; Pratto *et al.*, 2006). It is argued that consensually shared beliefs and value systems, prevalent in the society, provide the moral justification for the establishment and maintenance of group-based social inequalities and intergroup discrimination in this system of social hierarchy. These legitimising ideologies and social institutions (collectively termed ‘legitimising myths’) consensually held by members of
the dominant group justify and legitimise hierarchy-enhancing behaviours and actions that favour the dominant group over subordinate groups (Sidanius, 1993; Levin & Sidanius, 1999; Sidanius & Pratto, 1999; Pratto et al., 2006). The idea of legitimising myths is similar to the concept of ‘symbolic universes’ proposed by Berger and Luckmann in their 1966 book *The Social Construction of Reality* as a set of beliefs that aim to provide plausible explanations for the established institutions by “[putting] everything in its right place” (Berger & Luckmann, 1966, p.116). In doing so, these symbolic universes—which can take the form of maxims, proverbs, or religious and mythological systems of thought—provide legitimation for the established institutions in society (Berger & Luckmann, 1966).

These instances of institutional discrimination in the primary care service, mentioned above, whether driven by formal instruments, such as organisational policies (as in the examples of imposing fees for health service on non-citizens and restricting access to some vital medicines to citizens only) or informal institutions, such as shared value systems (as in the cases of discrimination against ethnic Indians) are understandably difficult to eliminate. Since these discriminatory actions and behaviours are backed by the powerful institutions of the dominant group, members of the dominant group must actively take responsibility—which makes difficult disrupting or overthrowing the established institutional order that has been firmly legitimated by the society (Berger & Luckmann, 1966; Kitano, 1997).

In addition, the above accounts also suggest that linguistic and cultural barriers affect access to health care among individuals of Indian origin. Primary care in Kuwait is provided by predominantly Arab health care providers—mostly Kuwaiti and Egyptian. Physicians from the Indian subcontinent constitute less than 9% of the nation’s physician workforce—and yet the vast majority of those are specialist physicians working in hospitals rather than in primary care.
clinics (Ministry of Health, 2012). This is especially notable because nationals of the Indian subcontinent constitute the largest community in Kuwait, making up around half the country’s population (al-Jasser, 2012). It is not uncommon therefore for a patient to have no common language with the health care provider with whom they consult (Harrison, 1985), in which case a pidgin—a grammatically simplified form of language with a restricted set of vocabulary borrowed from several languages (Aarts et al., 2014)—is typically employed as the principal means of communication between patients and physicians (Smart, 1990; Næss, 2008). This, without doubt, poses a major problem for the provision of care and a direct threat to health care quality.

The problem of language barriers in health care is further complicated by the unavailability of professional medical translation services. One clinician reported that “There is no formal channel through which patients can request a medical translator” (P1). Lack of medical translation facilities constitutes a significant barrier to accessing health care for patients from some ethnic groups (Goddard & Smith, 2001; Kronfol, 2012). One clinician reported that in circumstances where communication between the health care provider and the patient is poor, inadequate, or even absent, practice employees such as porters and messengers who happen to speak the patient’s language are called to help with the impromptu translation as interpreters. While this could greatly improve communication between health care providers and patients, it certainly constitutes a major violation of patient’s privacy—even though the patient is assumed to have implicitly given consent when they comply and communicate with the ‘interpreter’.

The mainstream culture in Kuwait appears to regard expatriates or non-citizens as a second-class group and, as a result, treats them differently than Kuwaiti citizens. This feature does not seem to be limited to the Kuwaiti society but appears to be widespread throughout the
societies in the Gulf Arab states (Kronfol, 2012; Batniji et al., 2014). Previous research by Shah and her colleagues (1996a) has revealed differences in access to primary care between citizens and non-citizens in Kuwait. The researchers have concluded that citizenship was a highly significant factor in determining the individual’s access to primary care (Shah et al., 1996a).

Fuelled by such a culture, a de facto two-tier health care system has formed whereby a small group of individuals—who can afford an extended health care coverage by means of their citizenship—receive more extended and comprehensive health care service, while other individuals receive substantially inferior care either due to formal institutional constraints or individual personally-mediated discrimination.

8.5. Chapter Summary

This chapter has presented the sub-themes under the major theme differential access to primary care. Three sub-themes were identified under this theme: disproportionate distribution, waiting times, and institutional discrimination. The three sub-themes, collectively, demonstrate the considerable variation access to primary care on a number of levels and grounds, including citizenship, ethnicity, and geographic location.

The chapter demonstrated that despite adequate geographic accessibility, demands continue for additional spending on primary care, possibly reflecting the culture of indulgence prevalent in Kuwait. Such an investment seems to be unwarranted given the consistent reports of substantial investments made in primary care premises and facilities. The added health improvement, if any, is likely to be too small. It was also demonstrated that there is substantial regional variation in the availability of primary care physicians and other resources. Some
regions, especially those away from the capital and areas inhabited by predominantly expatriate population, appear to be particularly underserved.

In addition, the issue of waiting appears to be of paramount importance—even though some reported that it “isn’t an issue at all” (P3) in the capital and surrounding areas. The problem of long waiting, exacerbated by a seemingly inequitable regional distribution of primary care resources, is much more severe in areas far from the capital. It was attributed to a number of factors including the drop-in nature of the primary care service, which was reported to be associated with increased unnecessary demand, and the strict and inflexible working style of physicians coupled with a passive, non-interventionist management by practice managers.

The chapter also presented what can be described as signs of institutional discrimination on the basis of nationality, in terms of mandatory payment by non-citizens at the point of care and access to medications of inferior quality. In addition, experiences and instances of cultural and linguistic barriers as well as of interpersonal discrimination against some ethnic minority groups were described.

In the following chapter, the results of this study are summarised and the general conclusions and implications drawn.
Chapter 9

Discussion and Conclusions

9.1 Introduction

This thesis aimed to contribute to a better understanding of how national culture influences the social constructions of health care quality.

Specifically, it examined how culture influences primary care stakeholders’ social constructions of health care quality in Kuwait, a high-power distance culture. Results suggest that the dominant socio-cultural value system in Kuwait has a significant impact on health care quality, whether directly or indirectly. The results indicate that culture influences health care quality through two main channels: a direct one—by affecting the clinical and interpersonal processes of care—and an indirect one—through either limiting or enhancing users’ access to care.

In this chapter, the main results of the study are summarised and the general conclusions and implications are drawn. The chapter also provides a number of policy and academic research recommendations based on the main results of this research.

Before discussing and contextualising the findings of the study with respect to how health care quality in the Kuwaiti primary care service is socially constructed, it is worth noting that the findings can generally be said to occur in two distinct domains: participants’ beliefs about the nature health care quality in the context of primary care and their views on how health care quality in the Kuwaiti primary care service actually is—that is, participants’ judgment of health care quality in the primary care service as it is currently provided.
In other words, the findings of this study can be characterised as occurring in the theoretical realm—interested in how health care quality is conceptualised and constructed—and the practical realm—which focuses on how the health care service is perceived in terms of the quality of care it provides. This is closely related to the *is-ought distinction* (raised by David Hume) with the latter of the two being the descriptive statement and the former the prescriptive (or normative) one. For purposes for brevity, the two domains will be referred to hereafter as descriptive and prescriptive.

Borrowing from Zeithaml et al.’s (1990) expectancy-disconfirmation model, descriptive statements about health care quality appear to be related to and to an extent determined by prescriptive statements about health care quality or what it should be. Arguably, participants’ descriptive statements about quality of care are collectively determined by their prescriptive beliefs about what health care quality should be.

Participants’ prescriptive statements on health care quality are, in turn, determined by a multitude of factors, not least of which where they are located within the health care system and the nature and extent of their involvement or responsibilities within the system; that is, the stakeholder lens through which they see and experience health care. More generally, this stakeholder lens is one of a set of multiple possible lenses through which a particular individual experiences their world. Collectively, these lenses together can be referred to as culture, or, more precisely, the individual’s cultural lens.

How the various cultural lenses influence their wearer’s perception of health care quality is central to this thesis and is discussed further in this chapter. In general, participants’
prescriptive statements appear to be largely influenced by their beliefs on how they perceive the health care service in terms of the quality of care it provides.

9.2 Meanings of Health and Utilisation of Primary Care

The study found that participants held various meanings for the concept of health (or ill health), ranging from a functional definition which views health as fitness for purpose; to a utilitarian definition which sees health pragmatically as what the health care service ought to provide; to a reductionist view which defines health as the normal functioning of the body organ systems; to a holistic perspective on health which sees it as balance between its interrelated and interconnected physical, mental, social, and spiritual dimensions; to, finally, a view of health as a divine blessing bestowed upon the healthy that can be taken away by God’s will.

These views on health appear to be linked to the person’s beliefs on where the locus of responsibility for one’s health rests: whether with the individual person himself or herself or with the health care system, or perhaps with other parties like their family. Previous research has shown the person’s beliefs about health and illness may have a direct and significant impact on their health-seeking behaviour—including where they seek care and the extent to which they comply or cooperate with the health care provider’s advice (Jackson, 1993; Helman, 2007; Holland & Hogg, 2010). These views, undoubtedly, dictate to a large extent their holders’ health care-seeking behaviour—as was explicitly stated by some participants—thus determining to a great extent the likelihood of their primary care service utilisation. This is consistent with Andersen’s (1995) model of health care utilisation, which addresses how the individual assesses the (perceived) benefits and costs of seeking care for a particular illness episode before deciding whether or not to use the health service. That is, the individual’s views on health and on where
the locus of responsibility for it lies essentially function as the threshold point that determines—in conjunction with other elements—the individual’s health care-seeking behaviour.

On a different but related note, a number of powerful social stigmas associated with the dominant Kuwaiti culture reportedly deter individuals from seeking medical care for certain conditions, including mental disorders, substance abuse, and sexually-transmitted diseases. The dominant Kuwaiti culture places a significant value on religious and conservative values. This suggests that threshold for seeking care for any of these conditions is elevated so that people do not usually seek medical care until these conditions are severe or serious enough to interfere with their daily life or perhaps their ability to work. These results support other evidence about the role of social stigmas as barriers to health care (Gary, 2005; Golberstein et al., 2008; Iversen et al., 2011).

In addition, results of this study suggest that because some Kuwaiti users feel stigmatised disclosing symptoms of such conditions as mental disorders and sexually transmitted infections to a fellow citizen, they intentionally seek care from foreign providers to avoid the stigma. In doing so, they appear to be willing to make a trade-off decision between health care quality (as judged for example by longitudinality and continuity of care) and medical confidentiality—as perceived by the user. These results contradict previous research which has shown that some health care users may be reluctant to ‘open up’ and seek care from providers of different ethnic or cultural backgrounds (Conrad & Pacquiao, 2005; Cronan et al., 2008; Siegel et al., 2011). One possible explanation for this phenomenon may be related to the collectivist values dominant in the Kuwaiti society. Collectivistic cultures stress the importance of social groups; such cultures tend to emphasise conformity and discourage deviance (Smith & Bond, 1993; Kim & Markus, 1999). Stigmatised behaviours are seen, in general, as deviation from the accepted norms and
values within the group. This might explain the phenomenon of Kuwaiti users seeking care for ‘stigmatised’ conditions from non-Kuwaiti health care providers, who are perceived out-group members. Within groups, members tend to adjust their behaviours to seek approval and social acceptance from other in-group members (Leary et al., 1995; Gilbert et al., 1998).

Moreover, results of this study suggest that, in Kuwait, the walk-in model of the primary care service increases access to the service, creates new demand, and contributes considerably to the ‘increased’ service use and consequently—as perceived by clinicians in this study—the unnecessary or inappropriate care. Evidence from the literature suggests that the walk-in model of health care service does indeed enhance access to health care (Salisbury et al., 2002a). The walk-in service model does not, however, appear to increase access equally to all segments of the population. Studies have shown that walk-in practices improve access to certain groups of the population, particularly young adults with minor or self-limiting complaints, and thus may increase health inequalities (Salisbury et al., 2002a; 2002b; 2002c). Results of this study support Andersen’s (1995) model of health service use, which proposes that increased access—which is facilitated by the walk-in model—may lead to increased demand on the service without achieving meaningful health gains, especially considering the limited resources typically available to the primary care service (Salisbury et al., 2002a; 2002b; 2002c).

Further, the demand-increasing effect of the walk-in model of service appears to be augmented by the relative absence of significant barriers to the primary care service. In other words, the costs of using the primary care service—monetary cost, stigma cost, and other costs—are so small to many users that they are practically negligible. This, together with the ease of access to the primary care service (afforded in part by the walk-in model of the service), may create new demand for the service and lead to increased service use.
The effect of the walk-in model on the primary care demand can also be explained by the high-power distance characteristic of the Kuwaiti culture. High-power distance cultures tend towards societal structures and hierarchical gaps between the less powerful and the more powerful people in the society. Power and hierarchy are accepted as part of the society, and, as such, the less powerful and the more powerful do not consider each other as equal (Hofstede, 1991; LeBaron & Pillay, 2006; Pawlicki et al., 2011; Samovar et al., 2012). Unlike the primary care service which operates a walk-in model, hospital-based specialist outpatient clinics use an appointment-scheduling system. The appointment systems used in hospitals may serve as a further manifestation of the hierarchical structure and functioning of the high-power distance Kuwaiti society; they restrict or control users’ access to the service and thus contribute to the wide power distance between physicians and patients. In general, patients’ inability to consult a health care provider unannounced and without a prior appointment can contribute to the power distance between providers and patients. The need to book an appointment may be perceived by patients as a barrier to health care access and as a sign of the high-power distance between, for instance, hospital specialists and patients (Gao et al., 2009; St. Germaine-McDaniel, 2010). Absence of such a scheduling system, as in the primary care service, may reduce the power distance between primary care physicians and patients, thus, further reducing the patient’s perceived cost of using the service.

Results of this study indicate that the power distance between primary care physicians and patients is manifestly diminished. The literature generally suggests that in high-power distance cultures, such as Kuwait, subordinates (patients in this case) tend to accede to the authority of superiors (physicians) without negotiation; they are expected not to disagree or argue with their superiors (Adler & Rodman, 2006; LeBaron & Pillay, 2006; Pawlicki et al.,
This, however, does not seem to be the case in the Kuwaiti primary care service. Results of this study indicate that the power distance gradient between primary care physicians and patients is greatly reduced and sometimes even reversed in favour of the patient—as in the cases of Kuwaiti patients receiving care from non-Kuwaiti physicians. This pattern of doctor-patient power relations is interesting as it appears to be unique to the primary care service, compared with other levels of care in Kuwait. This finding is contrary to evidence from the literature that indicates physicians, in general, enjoy relatively high socially prescribed power, prestige, and status granted to them by their profession (Davies et al., 2000; Goodyear-Smith & Buetow, 2001; Gray & Harrison, 2004; Helman, 2007).

A number of studies show that cultural expectations of power distance in a particular health care setting do influence to a large extent doctor-patient communication (Smith, 1999; Nápoles-Springer et al., 2005; Gao et al., 2009). Data from this study suggests that one possible explanation for this pattern of primary care doctor-patient power relations, at least in the context of Kuwaiti culture, might be the negative public image of the primary care service, which in turn may be explained by a combination of factors, including the widespread belief that primary care physicians are essentially incompetent clinicians who were forced into primary care; the public perception that physicians who have chosen primary care had done so for lifestyle reasons and thus are not expected to be motivated to perform effectively; and the generally poor quality of care as judged by providers and users alike.

### 9.3 Institutional Discrimination

Importantly, much of the problem of waiting appears to be caused—or at least aggravated—by the uneven and inequitable distribution of resources across primary care practices. Results of this
study indicate that a significant proportion of primary care resources are concentrated in Kuwait City and surrounding areas, inhabited by predominantly Kuwaiti citizens who are generally less health-deprived.

This inequitable distribution of health care resources appears to be brought about by the lack of cultural diversity at the policy-making level in the primary care service. Kuwaiti citizenship is a strict eligibility requirement imposed by law for mid- and high level policy makers (State of Kuwait, Law № 15 of 1979). They are, therefore, likely to be of similar views on health care policy. Such a lack of diversity at the policy-making level is likely to result in policies and procedures that do not sufficiently address the health care needs of culturally diverse populations (Betancourt et al., 2003; Castro et al., 2010). In addition, the sharp divide between Kuwaiti nationals and non-nationals (particularly non-Gulf Arabs) may also play a role in making knowledge about each group virtually unavailable to the other (Birks & Sinclair, 1980; Crystal, 1992; Kapiszewski, 2004; 2006). Kuwaitis and migrants are typically separated by a great social distance: Kuwaiti nationals tend to isolate themselves socially from non-nationals, effectively excluding them from interacting with Kuwaiti citizens except as subordinates (Tétreault & al-Mughni, 2000; Longva, 2009; Shultziner & Tétreault, 2011).

One conspicuous and important manifestation of this inter-ethnic dichotomy that this study found is institutional discrimination against non-citizens. Previous research has shown that discrimination based on citizenship is generally widespread across all Gulf Arab states but is much more marked against immigrant labourers from South Asia (Shah et al., 1996a; Kronfol, 2012; Batniji et al., 2014). Institutional discrimination has profound impact on health care quality, whether directly through manifesting in the actual processes of care or indirectly through limiting or otherwise jeopardising non-citizens’ access to the health care service. Previous
research by Shah and her colleagues (1996a) found that citizenship has a substantial effect on the individual’s access to the primary care service in Kuwait.

Discrimination against or, more broadly, lack of cultural sensitivity towards patients from social minority groups has implications for their access to the health care service (Anderson et al., 2003; Donabedian, 2003; Castro et al., 2010; Holland & Hogg, 2010). Such instances of discrimination or cultural non-responsiveness effectively act as significant cultural barriers to accessing health care for a large share of the population, and can result not only in less favourable health outcomes but can also be harmful (American Nurses Association, 1998). Failure to provide appropriate patient education or preventive care to individuals with certain health risk factors can lead to life threatening complications. In addition, discrimination or lack of cultural sensitivity can have a significant negative impact on health care quality through their direct effects on the clinical and interpersonal processes of care. This study found that the mainstream culture in Kuwait regards migrant workers, particularly those from South Asia countries, as second-class health care consumers and, accordingly, treats them differently than Kuwaiti citizens. For example, there are separate lists of medications for citizens and non-citizens, with the best, more effective medications reserved for citizens only. While this form of discrimination is most evident against nationals of the Indian subcontinent, this study found that discrimination is also apparent against other ethnic groups including non-Gulf Arabs. As such, this form of ethnic discrimination—taking place at the institutional level as well as at the level of the wider community—appears to be largely driven by pan-Gulf nationalist and local Kuwaiti nationalist ideologies (Chalcraft, 2010; Patrick, 2012), both of which are essentially representations of so-called ethnic nationalism, a form of nationalism that defines national
identity in ethnic terms—that is, in terms of common language, common religion, and common ancestry (McCrone, 1998; Safran, 2008; Stilz, 2009).

Furthermore, results of this study revealed that tension, rivalry, envy, and competition exist between physicians in the primary care service. The results revealed that primary care physicians are divided among themselves on a number of levels. One major divide is between Kuwaiti physicians and non-Kuwaiti physicians, predominantly from Egypt. Physicians in the latter group feel that they are unfairly discriminated against in terms of pay and development opportunities compared to their Kuwaiti counterparts. This feeling, whether justified or not, can have a negative impact on physicians’ performance. Previous research has shown that having a two-tier promotional system whereby workers perceive unequal opportunities as their colleagues can lead to decreased job satisfaction and negative patient care consequences (Coombs & King, 2005).

**9.4 Balance of Power in Clinician-Patient Relationships**

This study found that the patient’s own perception of medical need or of medical diagnosis, often, influences the actual medical decision made by the treating primary care physician. This phenomenon, too, may be related to the finding that the power distance between primary care physicians and patients is considerably diminished or sometimes even reversed. This disruption in the normal ‘imbalance’ of power in the doctor-patient relationship (normally favouring the doctor) is at times aggravated by other factors. Results from this study revealed that citizenship (or ethnicity) of both the patient and the physician is a highly significant factor governing the interaction between them, arguably even more significant than the power normally resting with the doctor in the doctor-patient relationship. This finding is in agreement with previous studies.
conducted in the Gulf States that have consistently shown that citizenship is a significant factor in determining the individual’s interaction with the health care system (Shah et al., 1996a; Lasheen et al., 2009; Panduranga et al., 2010). The balance of power tends to favour the Kuwaiti citizen—whether a health care user or provider—in doctor-patient relationships where the other party is non-Kuwaiti. Citizenship therefore plays a central role in this power imbalance, which does not appear to be linked to social movements emphasising patient empowerment, patients’ rights, and shared decision-making—such as consumerism, feminism, and socialism—as in some other parts of the world (Goodyear-Smith & Buetow, 2001; Fochsen et al., 2006).

The balance of power tends to favour the doctor as it plays an important role in facilitating the healing of patients as part of the health care process. Doctors need power to fulfil their professional responsibilities (Charles et al., 1999; Goodyear-Smith & Buetow, 2001). Disruption of the power balance in doctor-patient interactions, as found in this study, can therefore have a significant impact on the effectiveness of the health care process. Further, the disruption of the power balance between doctors and patients poses a real challenge to providing health care of high quality. For example, results of this study demonstrated how the dominance of lay beliefs over the evidence-based principles of practising medicine can lead to the provision of unnecessary or inappropriate care as the former prevails during the health care encounter.

In addition, this disruption of power balance might explain the general lack of trust that this study showed the public has in primary care physicians and the primary care service. Patients are unlikely to have trust in ‘obedient’ health care professionals who do they are told. Patients are unlikely to trust health care professionals whom they perceive as powerless (Goodyear-Smith & Buetow, 2001).
Moreover, this disruption of power balance may also partially explain the heightened tensions in the interactions between doctors and patients in the primary care service. On the one hand, primary care physicians seemingly feel undervalued and perhaps even disrespected by their patients. Compared to hospital specialists, several physicians reported being generally perceived as ‘second-class doctors’ who are not capable of providing real medicine. In general, primary care physicians do not seem to have acquired the same level of social power or prestige that their counterparts in other levels of care have acquired by means of their professional knowledge and skills (Evans, 1984; Mills & Gilson, 1988; Grant & Briscoe, 2002; Hodgson, 2007) or through the authoritarian communication style that characterise many medical specialties (Grant & Briscoe, 2002; Sjöström, 2006; Marks et al., 2011).

On the other hand, there appears to be a general perception that primary care physicians are essentially incompetent and unprofessional and hence are undeserving of the public trust. This—and the perception of the primary care service as less real a medical setting—might have influenced the utilisation patterns of the service so that many users only use it to acquire ‘sick’ notes or to stock up on medication. In addition, these perceptions about the primary care service appear to have played a role in reducing the patient-perceived cost of, for example, using the service at night for minor or non-urgent symptoms or for brazenly challenging primary care physicians’ clinical decisions. The health care encounter is unlikely to achieve its goals in an atmosphere of mistrust, suspicion, and scepticism (Goodyear-Smith & Buetow, 2001).

9.5 Wasta – Favouritism, Nepotism, and Cronyism

Another important divide relates to the issues of wasta, favouritism, nepotism, and cronyism and their impact on challenging or maintaining the status quo of the non-meritocratic hierarchies
within the medical profession. *Wasta* appears to be used by those higher up in the power hierarchy as an instrument of control. The use of *wasta* appears to be supportive of the *status quo*, since *de facto* decision makers are unlikely to use their authority to the detriment of their own interests. Still, *wasta* appears to be a major source of tension between Kuwaiti physicians in this study, particularly those competing to fill a mid- or senior-level position within the health care service. It appears as if *wasta* is, more or less, an unspoken rule in the ‘game’ or one that has, undeniably, become part of the game but causes considerable stress every time it is exercised. In this analogy, *wasta* would be similar to the *veto* power granted to members in some legislative bodies. Even though it is a legal right, each time it is practised, there is a cost as the majority rule is overridden.

Hence, results of this study indicate that the outcomes of rivalry and competition between primary care physicians tend to be decided not by meritocracy but by the physician’s citizenship or *wasta*. This practice likely leads to discrimination. This is important since previous research has shown that perceived workplace discrimination contributes to decreased job satisfaction, decreased organisational commitment, and rising levels of work-related stress and burnout (Valentine *et al.*, 1999; Ensher *et al.*, 2001; Deitch *et al.*, 2003; Abdulghafour *et al.*, 2011).

There is evidence to suggest that physicians’ job satisfaction influences the quality of care they provide (Edward *et al.*, 2002). The literature also suggests that there is a direct relationship between physician’s job satisfaction and patient satisfaction (Haas *et al.*, 2000).

### 9.6 Negative Public Image

Results of this study indicate that, generally, users perceive the quality of health care delivered by the primary care service to be inadequate. The primary care service in general appears to be
held in low regard by the public. Health care users perceive provider-patient communication as unsatisfactory. Also, providers’ failure to provide necessary preventive care and patient education advice might have contributed to the negative image.

In addition, the fact that the primary care service is provided by a predominantly women workforce may play a role in the widespread lack of respect in the service. There is inconsistent and limited empirical evidence to support the claim that the physician’s female gender is associated with the negative public image of the primary care service (Derose et al., 2001; Adams, 2003; Al-Mandhary et al., 2007). It is therefore not clear whether the female gender *per se* has contributed to the poor public image of the service or the factors that made primary care predominantly a female physician career choice. It is worth noting, however, that the Kuwaiti national culture is predominantly masculine, and that men dominate a significant portion of the society (Hofstede et al., 2010). Masculine cultures tend to place women in a subordinate position to men (Hofstede, 1980a; 1991; 2001; Helman, 2007; Hofstede et al., 2010). The negative public image of the primary care service may therefore be related to this relative subordination of women in the Kuwaiti society and the fact that the service is delivered by a predominantly women workforce.

Further, results of this study indicate that there is a general assumption that many primary care physicians have pursued a career in primary care not for reasons of professional aspiration but rather for the relatively controllable lifestyle that the field of primary care offers. Given this assumption, primary care physicians are generally perceived to be incompetent or unprofessional.
In light of the results of this study, Figure 8 summarises the links between culture and health care quality.
Figure 8: Links between culture and health care quality

**Negative Image**

- Poor quality care:
  - Poor doctor-patient communication
  - Doctors 'not listening'
  - Doctors do not provide patient education
  - Doctors do not routinely provide preventive care

- Poor care outcomes:
  - Poor health outcomes
  - Decreased patient satisfaction
  - Decreased trust in the service

**Access to care**

- Access to care influencing doctor-patient communication
- 'Overdemanding' patients
- Inadequate distribution of resources
- Long waiting times
- Institutional discrimination

**Process of care**

- Low priority given by government policy
- Female-dominated occupation
- Popular belief that primary care physicians are inadequately trained
- Conceptions of the meaning of 'health'
- Conceptions of one's responsibility for own health
- Social stigmas
- Walk-in model
- Lack of diversity at the policy-making level
- Policy-makers' dissociation from the service
- Cultural suitability of care
- Hegemony of traditional values
- Decreased job satisfaction
- Discrimination between primary care workers
9.7 Limitations of the Study

This study sought to gain deeper understanding of the role of culture in shaping the social constructions of health care quality and subsequently to expand theory. What matters, therefore, for such research is its significance for theory; its contribution to knowledge; and the transferability of its findings to other similar settings (Golafshani, 2003; Polit & Beck, 2009; Marshall & Rossman, 2011). Case-to-case transferability of qualitative research findings is arguably a form of generalisation—*theoretical* generalisation—with generalisability being understood as the applicability of research findings to other samples or populations than those under investigation (Polit & Hungler, 1991). Given the relatively small sample size, further research with a larger sample which includes stakeholders from other countries with different types of national cultures is needed to explore the subject in further depth.

Second, interviews for this study were conducted in either Arabic or English. While good command of at least one of these two languages is fairly common in the Kuwaiti society, interviewing participants in their first language (for example, Hindi or Urdu) might have yielded richer accounts on their views and experiences. In addition, interviews conducted in Arabic were translated into English by the researcher, who is not a qualified translator and has not received any specific training as a translator.

Third, the researcher was unable to access some of the more senior health care policymakers with whom prior arrangements for interviewing have been made. Several pre-arranged interviews with senior health care managers were cancelled by the potential participants—sometimes at late notice due to reported commitments on their part. In other cases, potential participants failed to show up at the scheduled time and failed to respond to contact attempts by the interviewer. The implications of this limitation must be stated and recognised.
Access to senior health care policymakers could yield a unique or significant perspective regarding health care quality in the primary care service that was not reported by the study participants.

### 9.8 Recommendations for Policy

These will be discussed in the following five areas: health inequalities, cultural competence, service delivery model, health care leadership, and awareness about the primary care service.

#### 9.8.1. Health Inequalities

The findings of this research indicate the existence of several factors that can contribute to health inequalities. This in a way antagonises the health inequality-reducing effects of the primary care. These factors should be sought and, if possible, rectified.

Importantly, the fees imposed on non-citizens at the point of service act as a barrier for them and likely contribute to health disparities. Elimination of these fees can have a beneficial effect on health inequalities across segments of the population. Similarly, combining the separate lists of medications approved for citizens and non-citizens can also have a positive effect, reducing health disparities within the population. A more equitable distribution of health care resources across Kuwait can contribute to minimising health disparities and benefit the overall health status of the population.

Further, the service could benefit from an initiative started and embraced by high-ranking government officials where local government-funded health care services—including the primary care service—rather than private or overseas health care providers, would be their primary source of care. This could boost public trust in the primary care service much in the
same way that reliance on private or overseas services as the primary source of care results in loss of trust in the publicly funded primary care service. In addition, this would end government officials’ dissociation from the recipient’s perspective of nature and quality of the very service they manage.

9.8.2. Cultural Competence

The primary care service provides care to ethnically and linguistically diverse populations some of whom face significant barriers to care. The service should, therefore, take into consideration the specific cultural needs when developing or providing health care services to individuals from social minority groups or of disadvantaged backgrounds. Health care planners, managers, and providers should pay close attention to barriers to effective communication between health care users and providers, including language and cultural barriers.

For example, the primary care service could benefit from the access to professional medical interpreter services. Introduction of such a service could be especially beneficial at certain primary care practices, the majority of whose users primarily speak different languages than are spoken or understood by health care providers. Previous research has shown that the use of medical interpretation services has a positive impact on reducing health disparities (Jacobs et al., 2001).

Providers’ knowledge of intra- and inter-cultural group differences could help them provide a more culturally competent care. Directing resources to cultural competency training of health care providers would likely help improve the quality of care provided. Such training programmes should incorporate topics that enhance access to care among marginalised populations, including, for example, educating frontline providers about the specific health care-
relevant cultural beliefs, needs, and preferences of these groups. In addition, pre-placement assessment of frontline health care providers should incorporate areas relevant to a potential provider’s ability to deliver culturally competent care. Also, it may be helpful to consider the provider’s relevant competencies and communication skills when allocating them to primary care practices to ensure that the highest possible quality of care can be provided. The service may also benefit from recruiting health care providers from similar cultural and linguistic backgrounds as the populations they will serve.

In addition, one thing that could immensely benefit the primary care service, and virtually any other service, is listening to the service users. This is especially important in the context of the growing health care trends of patient-centred care, patient empowerment, and increasing patient participation (Crawford & Kessel, 1999; Poulton, 1999; Kizer, 2001; Marshall & Campbell, 2002; Flynn, 2004; Seddon & Buchanan, 2004; Sofaer & Firminger, 2005; Bridges et al., 2008; Holland & Hogg, 2010; Mercieca et al., 2014). An accessible, user-friendly, and culturally aware health care provision is a key element in a patient-centred model of care.

Patients are thus an important stakeholder in the continuing process of health care service improvement (Mercieca et al., 2014). Obtaining their views and perspectives—along with those of health care providers and managers—are an important tool for health care service quality improvement (Crawford & Kessel, 1999; Sofaer & Firminger, 2005; Bate & Robert, 2006; Bridges et al., 2008; Mercieca et al., 2014). Involving patients in service improvement and service design (or redesign) ensures that they have a greater role in their own care and that health care services are built around their needs and expectations (Crawford & Kessel, 1999; Sofaer & Firminger, 2005; Bate & Robert, 2006; Mercieca et al., 2014). Patient representation in and
contribution to health care policy-making bodies could inform patient-focused policy making and, therefore, have a positive impact on health service design and development.

Furthermore, another opportunity for improvement can be realised by establishing a system whereby health care users can provide feedback and file complaints easily and anonymously, and, importantly, whereby negative feedback and complaints are taken seriously by the management. Likely, such a system—if implemented properly, fairly, and transparently—would likely curb instances of discrimination against minority groups. The effectiveness of this patient feedback system can be further enhanced by undertaking random clinical audits to critically evaluate the care provided by primary care physicians especially for delivery of preventive care services—an area known to be of concern in patients from disadvantaged backgrounds (Jacobs et al., 2001; Chambers & Wakley, 2005).

9.8.3. Service Delivery

Based on the findings of this study relating to the walk-in model of service delivery, the increased demand it creates, and the role it plays in increasing health inequalities, it may be appropriate to abandon the walk-in service model in favour of an appointment-scheduling system. Such a transition would likely reduce demand and consequently reduce waiting times. In place of the walk-in service there could be, for instance, a doctor-led appointment service and a nurse-led walk-in service, with some of the current responsibilities of physicians relegated to nurses—including, for example, providing ‘repeat’ drug prescriptions, ordering laboratory tests, performing certain screening tests, and other tasks.

An appointment-scheduling system, if properly implemented, will have an impact on doctor-patient interactions through increasing the power distance between primary care providers
and users. Restricting users’ access to the primary care service may conceivably contribute to the power distance between users and providers. The entire process of making an appointment, keeping it, and coming back to see a primary care physician may add a level of formality to the primary care service, thus, impacting doctor-patient power relations (St. Germaine-McDaniel, 2010). Altering the power gradient between primary care providers and users may serve, among other things, to increase the patient-perceived cost of, for example, blatantly challenging medical decisions taken by primary care physicians. This, in turn, could help reduce inappropriate prescribing, inappropriate referrals, and inappropriate care in general.

However, more research is needed in order to understand the ways in which an appointment-scheduling system can impact the primary care service, including its effects on access and wait times. More research is required to ascertain how transitioning to an appointment only model might impact the quality of care provided at the primary care service.


Primary care management should play a greater role in exercising oversight function and holding clinicians and other frontline service providers to account. Holding to such principles as accountability and transparency could have a positive impact on the service, generally curbing *wasta*-driven cronyism and favouritism while encouraging performance-based meritocracy.

Another area that can be improved towards a more open meritocracy is that of primary care workers’ compensation discrimination. This study found that the citizenship-based tiered wage system currently used have an effect on non-citizen primary care physicians’ job satisfaction, which could have a negative effect on the quality of care they provide (Edward *et al.*, 2002; Coombs & King, 2005). Instead, *equal pay for equal work* or *equal value* may provide
a more equitable alternative that could reduce workplace discrimination among primary care workers.

9.8.5. Raising Awareness about Primary Care

To improve the effectiveness of the reforms and suggested policy options set out in this document, the primary care service managers could work alongside the media to raise awareness about the primary care service. Importantly, health care managers should focus on raising public awareness on what the primary care service is and is not. This should inform the public on key issues related to primary care utilisation, including when—and when not—to see a physician; when to treat oneself at home and how; and when to question primary care physicians’ treatment plan and how. Heightened awareness about these issues can help reduce unnecessary and inappropriate use of the primary care service.

Furthermore, primary care physicians may find it useful to launch (via, for example, the national professional body for primary care physicians) a campaign directed at the public at large to raise awareness about the role of primary care in the health care system; the importance of primary care for the provision of preventive care; and the nature of training and professional qualifications of primary care physicians. Public awareness about these topics may have a positive impact on the public image of the primary care service and its physicians, which could influence doctor-patient communication and power relations.

9.9 Recommendations for Further Research

Several issues raised in this study warrant further exploration. Research is needed to investigate factors that influence provider-patient communication in high-power distance settings and where
provider and patient are from different ethnic or cultural backgrounds. In particular, further empirical research is needed to examine the ways in which ‘power imbalance’ in the doctor-patient relationship might impact the quality of care provided. This may be particularly useful in scenarios where there is a reversal of the normal ‘imbalance’ of power in favour of the patient. Special consideration should be given to how such an imbalance might influence clinical decision making, patient trust, and health care quality.

Research is also needed to study the impact of receiving care for stigmatised illness episodes from a culturally discordant health care provider on continuity of care, medical recording, and quality of care.

Furthermore, there is potential to evaluate how an appointment-scheduling system can impact the primary care service particularly in a high-power distance context like Kuwait. Special consideration should be given to the effects of such a system on access to and use of the health care service, especially by vulnerable groups. Consideration should also be given to the impact of such a system on the quality of care, the provision of preventive care, overprescribing behaviour, and the provision inappropriate care in general.

In addition, further investigation is warranted in order to conclude whether the female gender per se is associated with lower levels of respect or regard to the primary care service—being provided by a predominantly women workforce.

Additional research is also required to assess and evaluate the quality of health care provided by the primary care service. The primary care service should consider undertaking clinical audits to evaluate the appropriateness, comprehensiveness, and cultural suitability of care provided by its physicians.
9.10 Conclusion

This thesis has examined the role of national culture in the social constructions of health care quality in the Kuwaiti primary care service. The thesis has demonstrated the influence of national culture, particularly the dimension of power distance. Perceived health care quality in primary care appears to significantly be influenced by perceptions of power differential between health care providers and users. Citizenship, a significant determinant of social power in Kuwait, seems to be a major factor influencing the perceptions of health care quality. Cultural factors appear to influence perceptions of health care quality in both the descriptive and prescriptive domains independently.

Overall, the high-power distance dimension of the Kuwaiti culture appears to impact the social constructions of health care quality on a number of levels: firstly, at the level of the individual doctor-patient communication and direct patient care, where the patient’s own perception of medical need often influences the actual clinical care decisions made by the treating primary care physician; secondly, at the level of the primary care institution, where perceptions of power differentials across social groups seem to contribute to prejudice and discrimination against the less powerful groups; and thirdly, at the level of the Kuwaiti society at large, where low perceived power of primary care professionals appears to be a factor in building the negative public image of and low level of trust in the primary care service.

Overall, this thesis suggests that national culture has an important impact on the social constructions of health care quality. The power distance aspect of Kuwaiti culture affects how primary care services are resourced, delivered and perceived by the various stakeholders.


Cardiac Catheterization in Patients With Acute Coronary Syndrome From the Middle East. *Angiology, 61*(8), pp.744-50.


Appendix A

Favourable Ethical Opinion

Dr Abdulrahman Aldousari
Surrey Business School
FBEL

05 November 2012

Dear Dr Aldousari

The Influence of National Culture on the Social Construction of Health Care Quality
EC/2012/97/FBEL

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 2 October 2012.

The final list of documents reviewed by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
</tr>
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<tbody>
<tr>
<td>Summary of the project</td>
</tr>
<tr>
<td>Research protocol</td>
</tr>
<tr>
<td>Information sheet for participants (English and Arabic versions)</td>
</tr>
<tr>
<td>Consent form (English and Arabic versions)</td>
</tr>
<tr>
<td>Interview protocol</td>
</tr>
<tr>
<td>Risk assessment</td>
</tr>
<tr>
<td>Protocol Submission Proforma: Insurance</td>
</tr>
</tbody>
</table>

This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research. If the project includes distribution of a survey or questionnaire to members of the University community, researchers are asked to include a statement advising that the project has been reviewed by the University’s Ethics Committee.

If you wish to make any amendments to your protocol please address your request to the Secretary of the Ethics Committee and attach any revised documentation.

The Committee will need to be notified of adverse reactions suffered by research participants, and if the study is terminated earlier than expected with reasons. Please be advised that the Ethics Committee is able to audit research to ensure that researchers are abiding by the University requirements and guidelines.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.
Please inform me when the research has been completed.

Yours sincerely

[Signature]

Alison Cummings
Secretary, University Ethics Committee
Academic Registry
Appendix B

Participant Information Sheet

My name is Abdulrahman Aldousari. I am a PhD student at the University of Surrey. I would like to invite you to take part in my study—which I am working on as part of my PhD. It is important for you—before you decide whether or not to participate in this study—to understand its aims and nature as well as the nature and extent of your participation should you decide to participate. Please take the time to read the following information and feel free to ask me if you would like more information.

Thank you for taking the time to read this.

Study Title: The influence of national culture on the social construction of health care quality

1. What is the purpose of this study?

I am working on a research project that explores the influences of culture on the social construction of health care quality. The main aim of this research is to examine how the Kuwaiti national culture influences the social construction of health care quality in primary care. Primary care is the first level of contact people have with the health service system. At this level of care, primary care physicians (sometimes called family doctors or general practitioners) provide care for all but the very uncommon or unusual health needs, which are usually referred to other levels of care.

2. Why have I been invited to participate in this study?

To achieve the aim of the study, I would like to speak with people who provide, manage, or use the primary care services in Kuwait. I aim to interview approximately 50 participants—including primary care physicians, managers, and patients—to discuss how they define health, how they recognise health care quality in the primary care sector, and which cultural factors might have influenced their definitions of health care quality. You have been selected because you are in one of these three groups, either a health care professional, a manager, or a patient.

3. Do I have to participate in this study?

Participation in this study is entirely voluntary. You can decide to or not to take part in this study without giving a reason. If you decide to take part in the study, you still have the right to withdraw at any stage of the research without giving a reason.

4. What will happen if I decide to participate?

When you decide to participate, I will ask you for your contact details so we can arrange a meeting for the interview. The only contact detail required will be a mobile telephone number. The interview will be arranged at a suitable time and location. The location will be in a private meeting room in a primary care centre or another location depending on your preference.
I will interview you only once. The interview will last about 45-60 minutes. With your permission, the interview will be audio-recorded so it can be later transcribed. Should you prefer that the interview is not audio-recorded, I will take notes only during the interview. In the interview, there are no right or wrong answers. What I am interested in is your own experience of health care quality in the primary care. Still, you are free to refuse to answer specific questions or withdraw at any stage of the interview without giving a reason.

5. Will my participation in the study be kept confidential?

Yes. All information provided by you and other participants will be handled in a confidential manner. All audio-recordings of the interviews will be destroyed at the end of the research. The identity of research participants will remain unknown; their names will be substituted by codes. I will be the only person to have access to the audio-recordings, consent forms, and participants’ contact details, or any details that could potentially identify you. No identifiable participant data will be accessible to anyone else. My academic supervisor will only have access to anonymised transcripts of the interview.

Upon your consent, anonymised direct quotes will be used when the findings of this research are presented. You will be simply referred to as ‘Interviewee 1’, ‘Interviewee 2’, or so. No one but you will be able identify your quotes.

6. What are the risks of taking part in this study?

There are no risks. However, in the unlikely event that you become distressed during or after the interview or during discussion of a particularly traumatic experience, I would recommend that you contact or permit me to contact on your behalf your family practitioner so that the necessary support or counselling can be arranged.

Furthermore, to manage the risk of psychological harm, I will provide you—in advance of the interview and while arranging its time and place with you—with a brief list of topics so that you would like to express yourself and decide what you are comfortable discussing. I will also invite you after transcribing the interview to check the content and edit it if necessary.

7. What will happen to the findings of this study?

The findings of this study will be analysed and used in my PhD thesis. In addition, they may be presented at academic conferences or published in academic journals. The anonymity and confidentiality of all research participants be in place in all cases.

8. What should I do if I wish to participate?

If you decide you want to take part in this study or if you have any questions about it, please contact me. Any complaints or concerns about any aspect of the way you have been dealt with during
the course of the study will be addressed. You can contact me by text or phone or email. The following are my contact information:

**Researcher**  Abduirahman Aldousari  
Tel: +965 99750791  
Email: a.aldoosari@surrey.ac.uk

**Academic Supervisors**  
Dr Carole Doherty  
Email: c.doherty@surrey.ac.uk  
Prof Terry Desombre  
Email: t.desombre@surrey.ac.uk

Thank you for taking the time to read this information sheet.

This study has received a favourable ethical opinion from the University of Surrey Ethics Committee.
Appendix C

Participant Consent Form

Title of research project:
The influence of national culture on the social construction of health care quality

Name and position of researcher:
Abdulrahman Aldousari, PhD student, University of Surrey

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. 

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

3. I agree to take part in the study and acknowledge that information provided will be used in accordance with the UK Data Protection Act 1998.

4. I agree to the interview being audio-recorded.

5. I agree to the use of anonymised quotes in publications.

Name of participant: Abdulrahman Aldousari (researcher)

Date: Date:

Signature: Signature:

This study has received a favourable ethical opinion from the University of Surrey Ethics Committee.
Appendix D

Interview Protocol

The Influence of National Culture on the Social Construction of Health Care Quality

Interview Protocol

Introductions

- Explain the purpose of the interview.
- Obtain consent. Have the interviewee read and sign the consent form.
- Ask for permission to audio-record the interview. Otherwise, take notes only.

Interview Questions

1. What does it mean to be healthy? How do you promote your health? What about the physical, mental, and social aspects of health?

2. How do you recognise high-quality primary care? Can you think of a patient encounter that you would regard as high quality? Can you describe it? What in particular made it high quality to you?

3. How would you rate the quality of care provided by the primary care health system in Kuwait?
   - **Probes:** Why do you believe the care provided here is (or is not) of high quality? Does the quality of care provided vary from time to time or centre to centre? Why do you think such variation—if any—exists? At what areas of care—if any—does the primary care system provide high/poor quality?

4. Do you have any thoughts about how the quality of care provided by the primary care system in Kuwait can be improved?

5. How much do you think your cultural background has had an impact on your beliefs/views regarding health and health care quality?

Wrap-Up

- Do you have anything else to add?
- Thank the interviewee for his or her time.