http://jmscr.igmpublication.org/home/
ISSN (e)-2347-176x ISSN (p) 2455-0450
crossref DOI: https://dx.doi.org/10.18535/jmscr/v11i1.26

IGM Publication
Journal Of Medical Science And Clinical Research
An Official Publication Of IGM Publication

Maximizing the Usage of the Ancillary Departments
By Collaboration Strategy with Civilian Hospitals

Author
Mesfer Jamman Alamri

The healthcare system in the Kingdom of Saudi Arabia (KSA) is operated by the government through the ministry of health (MOH) (Alkhamis, 2012). The ministry operates a total of 274 civilian hospitals as well as 2, 325 primary healthcare centers. In addition to these healthcare facilities, other KSA organizations that provide healthcare services include; referral hospitals such as King Faisal Specialist Hospital and Research Centre, military services such as the armed forces and national guard health facilities, universities and schools health units by the ministry of education. The military hospitals in KSA such as Riyadh Military Hospital are particularly important because they provide advanced healthcare services to military personnel, their dependents, and eligible civilian population. In addition, the military health professionals provide emergency medical services to the civilian population in times of emergency such as natural disasters and terrorist attacks (Mufti, 2000).

However, the burden in civilian hospitals is increasing considering the rising civilian population in KSA. For instance, the 2010 KSA census showed that the total population in the kingdom is 27.1 million, which represented a 3.2% population growth compared to the 22.6 million total population reported in 2004 (Alkhamis, 2012). Projections by the United Nations indicate that the KSA population is expected to rise to 39.8 million by 2025 and 54.7 million by 2050 (Alkhamis, 2012). It is also estimated that the aging population of Saudis aged 60 years above, who are at increased risk of diseases, would rise to 2.5 million by 2020 (Yusuf, 2014). In addition, the tertiary healthcare facilities are not sufficient to accommodate patients with chronic diseases who are referred for specialist medical care (Saleh & Otaibi, 2010). Therefore, the increased population growth in KSA is expected to increase the pressure in civilian hospitals, which are the main facilities where most of the KSA population access healthcare services. According to Lingawi et al. (2016), the population growth and lifestyle changes in the KSA population has led to increased demand for healthcare services. Consequently, the available healthcare infrastructure is strained while investment in new healthcare facilities to increase capacity place a growing burden on public finances (Lingawi et al., 2016).

In addition to putting the civilian healthcare facilities under strain, the growing KSA

population has also been associated with poor healthcare due to inadequate health resources in civilian hospitals. For instance, Mousa and Aldehayyat (2018) found that some of the healthcare facilities, especially those outside Riyadh, have insufficient resources to meet the public demand.

Therefore, the civilian hospitals that are available in KSA and can be accessed for free by KSA citizens (Alkhamis, 2012) have inadequate resources to support the provision of quality healthcare services.

The inadequate healthcare resources and infrastructure in public hospitals in KSA have led to the utilization of private healthcare services. Indeed, Al-Otaibi (2010) found that the number of patients that used private healthcare facilities, 75% of them being Saudi citizens, increased by approximately 33.3% between 1994 and 1998. However, the private sector only provides 23% of KSA's healthcare services and are only available in large cities (Al-Otaibi, 2010; Albejaidi, 2010; Yusuf, 2014). In addition, there is low access to private healthcare services in KSA due to affordability issues (Lingawi et al., 2016). Therefore, several strategies have been used to ensure the provision of equitable and accessible quality healthcare services in KSA. According to Lingawi et al. (2016), some of the strategies include; developing new facilities and providing qualified manpower, developing the healthcare infrastructure of tertiary hospitals, and attracting the private sector investment to improve healthcare capacity. However, these strategies put a heavy financial burden on the KSA government and increase the healthcare cost.

Attracting more private sector investment to provide healthcare services will indeed increase the healthcare capacity in the country but with a high cost on the citizen who already cannot afford most of the private healthcare services.

Therefore, it is necessary to develop strategies that will not place a heavy financial burden on the government or increase the cost of healthcare but improve equitable and accessible quality healthcare. One of the strategies is to maximize the use of ancillary departments in military hospitals by civilians to provide affordable, advanced, and quality healthcare services. In KSA, there are five major military hospitals that are operated by the Ministry of Defense Medical Services Division and offers healthcare services to military officers and their dependents as well as eligible civilians, especially during emergencies such as natural disasters and terrorist attacks (Mufti, 2000). The five military hospitals include; Prince Sultan Military Medical City in Riyadh with a capacity of 1400 beds (PSMMC, 2018), Prince Salman North West Armed Forces Hospital in Tabuk with a 400-bed capacity (NWAFH, 2018), King Fahd Armed Forces Hospital in Jeddah with a 420-bed capacity (KFAFH, 2018), Alhada Hospital for Armed Forces in Taif with a 350-bed capacity (AHAF, 2018), and King Fahd Military Medical Complex in Dhahran with a 400-bed capacity (Lingawi et al., 2016).

In other countries, civilian utilization of military hospitals has been reported. For instance, children at an expeditionary military hospital in Iraq. the military hospital can also be utilized by civilians where there is a need to access affordable and quality medical care. In the United States, for instance, discussions between military and civilian health executives have been carried out with the aim of increasing collaboration between the two healthcare entities (Hulsey, 2015). Details of the discussion were reported to include strategies for exploring opportunities for improving access to healthcare (Hulsey, 2015).

This is a good idea that can be used to relieve the government of its healthcare and financial burden, as proposed by this project.

Advantages, Challenges, and Limitations

Advantages

The utilization of the military healthcare services is expected to have numerous advantages to the civilian population.

First, civilian utilization of the military hospitals shall increase access to healthcare services that are not available in the civilian hospitals. According to Mousa and Aldehayyat (2018), civilian hospitals in KSA, especially those outside Riyadh, have insufficient resources to meet the public demand. Other reports have also shown that civilian hospitals in KSA have; limited health personnel to offer advanced healthcare services (Al-Ahmadi & Roland, 2005), a shortage of essential diabetic drugs and laboratory tests (Al-Khaldi & Al-Sharif, 2002), deficient rehabilitation services for trauma patients(Al-Ahmadi & Roland, 2005), and other limitations such as lack of bed spaces, unavailability of anesthetist, and unavailability of theatres (Sultan et al., 2012). These inadequate health resources and infrastructure that are lacking in civilian hospitals can be readily accessed in military hospitals.

Secondly, civilian utilization of military hospitals in KSA will promote accessible and equitable healthcare to the general public. The provision of accessible and equitable healthcare services in the midst of a growing Saudi population and a straining healthcare resources has been a significant challenge for the government (Al-Hanawi, 2017). The utilization of military hospitals by civilians can, therefore, help address this challenge through a cost-effective strategy. The use of military hospital is a cost-effective strategy because, unlike other strategies such as expanding the healthcare facilities, it may not put the government under heavy financial burden then (Lingawi et al., 2016). Instead, the funds that may have been used to build new healthcare facilities.

Thirdly, the strategy can increase accessibility to safe and quality healthcare services. One of the problems the quality and safety of healthcare services in KSA civilian hospitals have been found to be affected by the increasing number of patients requiring healthcare (Alkhamis, 2012). Therefore, use of military hospitals by the civilian population is expected to minimize the number of patients seeking care in civilian hospitals, improve the availability of health resources.

Challenges and limitations

Civilian-military collaboration in providing healthcare has been reported to be faced with the challenge of lack communication and security barriers which limits access to certain areas of military hospitals (Auerbach et al., 2010). The same challenges may be faced when the civilian population is allowed to use military healthcare services in KSA. Therefore, some of the potential limitations of this proposal may include; communication challenges between the civilian and military hospital, lack of database for the patients

Implementing the Change

The proposed change in KSA healthcare system where the civilian population would be allowed to receive healthcare services from military hospitals will be implemented using the Coghlan and Brannick (2014) organizational change model to ensure its lean operation. The model is an action research cycle consisting of four main phases; constructing, planning action, taking action and evaluating action (Figure 2) (Coghlan & Brannick, 2014). The action, in this case, shall be maximizing civilian usage of ancillary departments in a military hospitals.

This change shall take place between a civilian hospital in Sharurah and a nearby military hospital (Sharurah armed forces hospital).

The change will be directed by a multidisciplinary team including executives and professionals from the civilian and military hospitals.

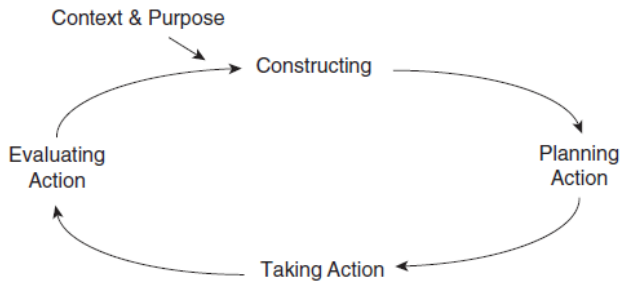

Figure 2: The action research cycle as per Coghlan and Brannick (2014) organizational model for change

1. Phase I: Constructing

In the Coghlan and Brannick (2014) organizational change model, constructing is the first phase of initiating organizational change. In this phase, the theoretical and practical foundations or drivers that the change can be based upon are identified. Theoretically, one of the drivers of any collaboration between two healthcare entities is the utilization of available information and communications systems (Reid, Compton, & Grossman, 2005). In this change, a computer program that does not contain the military hospital's security can be developed and installed in the computers of the two hospitals to allow the exchange of information during referral and for other communication purposes. In addition, another theoretical driver for the change is the availability of civilian and military health executives and professionals who can be utilized to guide the development and implementation of this change. The practical drivers will be identified by the multidisciplinary team through a survey in the civilian and military hospitals.

Once identified, the theoretical and practical drivers for this change will be used to develop the necessary tools such as program protocols and standard operating procedures to be used by the civilian hospital while referring a patient and channels of communications between the two hospitals. In addition, the necessary ethical guidelines and security protocols shall be developed at this stage by the team to guide the civilian-military hospitals' collaboration without compromising the security of the military personnel. After all the necessary tools have been developed and ethical clearance obtained from both hospitals, the program will be piloted using a few number of patients from the civilian hospital to the military hospital. During the piloting, the entire collaboration in terms of patient referral procedure, healthcare services provided in the military hospital, communication between the two hospitals, modes of payment, emerging ethical and security issues, and any other aspect of the collaboration shall be noted and used to amend the tools and the entire program accordingly.

2. Phase II: Planning action

In this phase, ethical documents shall be used in negotiations with the military and civilian hospitals to allow the implementation of the proposed change in their hospitals. The multidisciplinary shall lead the negotiations with the authorities. If allowed, appropriate training tools and programs shall be developed at this stage for training the healthcare providers on the new civilian-military collaboration in the provision of healthcare services in the next phase. The training will be conducted among healthcare providers of all cadres; doctors, nurses, pharmacists, laboratory officers, health record officers, public health officers, occupational therapists, and other medics and paramedics. The healthcare providers shall be recruited in the process from both hospitals using a convenient sampling technique based on their qualifications and willingness to take part in the program.

3. Phase III: Taking action

According to Coghlan and Brannick (2014), the "taking action" phase involves the collaborative implementation of the plans and interventions. In this change, the previously recruited healthcare providers shall be trained on the new collaboration between the civilian and military hospitals. The training shall cover all the aspects of the collaboration using documents, tools, and computer programs that shall have been developed

by the multidisciplinary team. After training the healthcare providers, the entire program shall be implemented in both the military and civilian hospitals using appropriate tools that shall have been developed. Members of the multidisciplinary team will be divided into two groups with each group having at least one health executive and two healthcare providers from both hospitals. One group of the multidisciplinary team shall monitor the implantation of the program in the military hospital while the other in the civilian hospital.

4. Phase IV: Evaluating action

Evaluating the implemented action or change is the last phase of the action research cycle where both intended and unintended outcomes of the project are evaluated(Coghlan & Brannick, 2014). In this change, the intended outcomes are; reduced utilization of civilian healthcare institutions, minimize the number of patients in the waiting lists in the civilian hospitals and improving the quality. a survey of the number of patients in the nearby secondary and tertiary healthcare institutions two months before implementing the change, six months after implanting the change, and annual follow-ups carried out. The cost of the basic healthcare services at civilian healthcare institutions in KSA in comparison with the costs in military hospitals shall also be carried out at the same timeframes. The safety and quality of the healthcare services received by the patients in the two hospitals at the three time periods will also be assessed using patient safety and patient satisfaction questionnaires.

Conclusion

With the growing KSA population, there is pressure on the available civilian health facilities which have been reported to lack adequate resource needed to provide quality healthcare services. This has left Saudi citizens with the option of receiving care at private hospitals but the private health facilities are few and associated with a high healthcare cost on patients. The recommended strategies for addressing these healthcare challenges in KSA have placed a huge finical load on the government hence the need to recommend an alternative strategy that does not increase the government's expenditure on healthcare. Therefore, this project proposes maximizing the usage of ancillary departments in military hospitals. The change shall be implanted using the four phases of the Coghlan and Brannick (2014) organizational change model.