Public Health Practice

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Kuwait: medical services and public responses

A community survey proved to be a viable technique for collecting health data and investigating the use made of the health service, the attitude of the people towards it, and their knowledge of health matters in this highly prosperous country.

Kuwait's transition from a seafaring, pearl-diving, Bedouin society to a modern urban one has taken barely 40 years. Today, very few people depend on livestock or the sea for a living; most are engaged in commerce, manufacturing or service industries. The original wealth spurt came from the exploitation of oil reserves; oil sales are still the major source of revenue, but international investments and local industries are steadily increasing in importance. On the basis of the per capita income of about US$ 25 000, Kuwait is one of the wealthiest countries in the world. Another outstanding feature of Kuwait is its rapid and sustained population growth, currently estimated to be about 5% per year. In 1957, only 200 000 people lived in Kuwait, whereas today there are 1.7 million, of whom just under half are Kuwaitis. Some of the non-Kuwaitis are long-term residents, but many are foreign workers on short-term contracts. The crude birth rates among both Kuwaitis (47 per 1000) and non-Kuwaitis (29 per 1000) are high, creating a society that is predominantly young: 16% of the people are under 5 years of age, 29% are under 10, 49% are under 20, and only 15% are over 40.

There is a comprehensive state medical system, providing access to a full range of largely free medical, dental and paramedical services. Some nominal charges are made, e.g., for the provision of orthopaedic aids and certain kinds of dental treatment. Each health district, containing about 25 000 people, has a primary care clinic that provides general practitioner services. The line of referral is from the primary care clinic to a polyclinic or hospital. Polyclinics provide certain specialist services and are equipped with simple laboratory screening facilities. Mother and child care clinics and dental clinics are organized at the district level, and there is a network of school health clinics. There are six modern general hospitals, with a total of 2780 beds. In addition, there are specialist maternity, dental, orthopaedic, cancer, infectious diseases, and psychiatric centres. The Ministry of Public Health also has branches responsible for health planning, monitoring chronic and infectious diseases, compiling statistics, and organizing health education and vaccination programmes.

The ratio of doctors to patients is 1:590; in Sweden and Sudan the corresponding ratios are 1:450 and 1:9960. Most of the health care

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professionals working in Kuwait are expatriates, but it is planned that more Kuwaitis will enter this field. Kuwait University's Faculty of Medicine produced its first graduates in 1983. Medical students, about half of whom are women, complete a 7-year course, and then spend 1 year in health service rotation. It is expected that the medical faculty will soon be producing 80–100 doctors each year. The Ministry of Health's Nursing Institute produces 70–100 nurses annually, about half of them Kuwaiti. The vast majority of nurses currently working in Kuwait, however, were recruited abroad, e.g., in Egypt, India, and the Philippines.

In this wealthy country undergoing rapid change and development, how do people cope with illness and react to the medical services? A community survey was undertaken in an attempt to find the answers.

Community Survey

This approach has many advantages over the interviewing of patients who attend clinics. It takes account of the fact that in most societies the overwhelming majority of illness episodes are confronted without professional help. Unless a community survey is conducted, it is not possible to discover how symptoms are handled, or whether a decision not to seek professional assistance is wise. Furthermore, people who attend clinics could present a very biased picture of the general public's health, for they may be atypically unhealthy or unusually frequent or effective users of the health services; community surveying provides a more balanced picture.

Our aim was to contact about 1 in 2000 of the adults living in Kuwait by drawing a random sample of legal residents aged over 18, and to record their views. Difficulties were experienced in finding people, because only recently has the numbering of areas, streets and houses become widespread in Kuwait; it was often necessary to go to an area and search for the family or organization indicated. Telephone numbers proved useful, and trade directories provided helpful leads. But surprisingly often it was a shopkeeper, or children playing in the streets, who directed us to the correct house or office. About half of the people sought could not be found because of inadequate or out-of-date information. We have no reason to suspect, however, that this created any systematic bias.

Once individuals were located, the problem was to secure their cooperation. A period of familiarization was required to gain their trust and interest. This involved meeting and being entertained by people. After the aims of the study had been explained, confidentiality assured, and a trusting relationship formed, people seldom declined to participate. Once committed, interviewees were typically very forthcoming and detailed in their replies. The interviewers were carefully selected for their maturity and linguistic ability, and were extensively trained. Bangladeshi, Indian, Iranian, Korean and Pakistani respondents were interviewed in their native languages. The 527 people interviewed constituted a sample of 0.07% of the adults in Kuwait. The nationality, age and sex profiles of the sample were similar to those in the census carried out during the same year.

The patient population in Kuwait is very diverse; migrant workers come from many different countries, some more developed than Kuwait, some less, each with its own pattern of chronic and infectious diseases. The sheer range of languages spoken poses a problem for medical care. It is not uncommon for a doctor or nurse to have no common language with the patient being treated. Furthermore, patients have a wide variety of cultural backgrounds, and probably differ considerably in terms of their health care practices, expectations, and use of medical services. Among the Kuwaitis there are likely to be differences in health knowledge, expectations and health practices between the generations, and possibly in the use of modern versus traditional forms of healing.

Less than a quarter of those interviewed said they would discuss personal problems with their doctor.

Access to services

People were asked a number of questions on their use of medical services (*1*). The vast majority emerged as wholly or mainly dependent on the state medical system; only 14% stated that they typically used private services. Indeed, the private medical sector in Kuwait is very small, involving only 9% of doctors and 10% of beds. People generally found clinics easy to get to (70% said it took them less than 15 minutes), and reported that waiting times were short (70% estimated less than 30 minutes). Such data reflect well on the distribution of clinics. As would be expected in a highly mobile society, many patients had been with their current doctor or clinic for a relatively brief period: 23% for less than 2 years, 50% for less than 5 years. It was felt by 71% of the people interviewed that their doctor or doctors at the local clinic spent enough time listening to them and doing all that was necessary. Most of those who complained that consultations were too rushed attributed this to the pressure of work facing doctors, who were seen as concerned and caring. Only 8% of those interviewed felt that their doctor did not care and that he or she would write a prescription without listening fully to what was wrong. It was claimed by 89% of interviewees that they always tried to do precisely what the doctor advised, even if this was not very easy or pleasant. Interestingly, only 39% considered that a pharmacist was a good person to ask for advice when one was sick. And in terms of ease of access, patients had little reason to go to the local pharmacy rather than the clinic, because only 8% said that the pharmacy was easier to get to.

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Sources of information

Respondents were asked which people and media had provided them with information about the treatment of different illnesses. A list of possible sources was provided. The person's own doctor was nominated by 75% of respondents, and other doctors were mentioned by 66%. Over half of the interviewees had gained information from parents and television. Newspapers, books and magazines had been used by 48%, radio by 44%. Other relatives, friends and neighbours, and nurses had provided information to over a third. Sharper differentials appeared when people were asked which constituted their major source of information. Radio, friends and neighbours, newspapers, books and magazines, and nurses were nominated by less than 3%. Television was mentioned by 11%, relatives other than parents by 10%, and doctors other than their personal physician by 15%. The prime sources, however, turned out to be parents, mentioned by 28% of those interviewed, and the respondent's own doctor (31%). Thus a person's doctor, his parents, and possibly television were evidently the most influential sources of health education. Only about a third of the people interviewed reported moderate or great interest in reading about or discussing health matters. Almost three-quarters of those contacted had no first-aid or medical book in the house.

Health knowledge

People were asked for their opinion concerning the contagiousness of diabetes, poliomyelitis, bronchitis, tuberculosis and anaemia. About one in five replies were 'don't know'. Tuberculosis was the disease people were most confident about: 93% correctly described it as contagious. About a quarter of the answers were wrong. Perhaps surprisingly, only 15% of the interviewees correctly described poliomyelitis as contagious, despite the fact that this disease has a recent endemic history in Kuwait. There is, therefore, a need for further health education.

Use of services

Official figures show that the average patient makes nine visits a year to a doctor, twice as many as in the USA. Excessive consultation is a potential problem; previous research has indicated, for example, that mothers with young children may be using clinics for social

rather than medical reasons (*2*). Our own data suggest that there are wide individual differences in rates of consultation. Asked how often they had visited a doctor during the preceding year, 21% of the interviewees claimed not to have done so, 18% recalled having done so once only, and 34% said they had seen a doctor 2–4 times; 16% had done so more than 10 times. Nearly a quarter had consulted a doctor in the 2 weeks prior to the interview.

It appears that a minority of people in Kuwait consult doctors extremely frequently, sometimes probably without need. One possible reason for a high consultation rate would be a very high expectation among patients of the effectiveness of doctors in curing illness. People were asked for their opinion as to whether doctors could (*a*) cure, (*b*) help, or (*c*) not help patients with rheumatism, a bad cold, corns, skin cancer, arthritis, depression, sleeplessness, frequent headaches, or bronchitis. The percentages believing that doctors could provide a cure ranged from 24% for depression to 74% for bronchitis.

When asked what they would do if they felt depressed for 3 weeks, as many said they would treat themselves as said they would consult a doctor. Less than a quarter of those interviewed said they would discuss personal problems with their doctor. It may be that the considerable mobility of patients generates a situation in which they have a relatively brief association with their doctor and are therefore less comfortable in seeking help from this source.

Encouragingly, we found no evidence of uncontrolled access to drugs, such as is sometimes encountered in developing countries, nor of excessive prescribing of psychotropic drugs such as sleeping tablets, antidepressants and tranquillizers.

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Although very time-consuming, the community survey was a viable technique for collecting health data and investigating the use made of the health service. It also provided much-needed information about how people viewed the services available, what they expected from them, and how they decided when to consult and when to treat themselves. Such information is vital for assessing the appropriateness of people's actions, and for deciding on priorities for health education and service reorganization. □

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