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One-year Evaluation of Team-based Care in Primary Healthcare in Saudi Arabia: Achievements, Barriers, and Challenges

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ABSTRACT

Introduction: Evidence shows that in most developed countries, PHC has gradually transformed into team-based care, where health professionals work to the top of their skills and can interact within a team or across teams, coordinating and integrating services, resulting in better health care delivery.

Aim: Assess the team based care in the primary healthcare in Saudi Arabia from patients prospectives.

Method: descriptive cross sectional research design was utilized.

Settings: It was conducted in four primary healthcare (PHCs) at JEDDAH city, Saudi Arabia, during August-December 2024. This PHCs were selected using stratified random sampling from 95 PHCs in Jeddah.

Sampling : Stratified random sampling was utilized to select proposed sample 425 patent were assigned to participate in the questionnaire

Tools: one tool was utilized to assess patients prospectives satisfaction toward team-based care.

Results: this study reveals that that they perceived high level of satisfaction70.184 with mean SD (87.73± 29.34) regarding team based are . In addition, they perceived high level related to Overall satisfaction of service, Early screening, Health education and follow up, Beneficiary satisfaction of service, Easy Accessibility, and communication, (66.4%,70.00%,66.8%,73%68.3%, and 72.3%)respectively . The Beneficiary satisfaction of service was the highest dimension (72.3%) while over all perception regarding service were the lowest one(66.4%). In addition, more than 50% had able to use SehattyApplication. Furthermore, 54.5 % had no difficulty when getting an appointment while using sehatty application. they recommended to enhance the appointment service to decrease waiting time in the clinics , although the three quarter had no recommendation.

Conclusion: team-based care is an important service in the primary healthcare and patients who utilized this service were satisfied.ssessing patients' perspectives on TBC using the PHC system is the aim of this study. Our research indicates that patients were generally satisfied with their service. The type of the services provided and patient characteristics were shown to be two of the many factors that contribute to satisfaction.

Implications: develop a strategy to enhance appointment services in the team-based care.

Keywords: patient prospectives, team based care, Primary healthcare.

INTRODUCTION

traditionally, primary health care (PHC) has been a doctor-centric organization, and most of the PHC services have their own mandate and professionalism. However, it has been argued over time that in such a complex service, the "team" that works together can add value, lead to better quality of service, be more effective, and provide cost savings. Over the years, numerous countries have introduced team-based care as a more collaborative and sustainable model for delivering health care services in a more integrated and friendly way(Hanson, et al.,2022). Evidence shows that in most developed countries, PHC has gradually transformed into team-based care, where health professionals work to the top of their skills and can interact within a team or across teams, coordinating and integrating services, resulting in better health care delivery. On the other hand, in many low- and middle-income countries, the reality remains challenging, with team-based care struggling against more traditional aspects of care. While the benefits of team-based care are many, research has also

identified a wide range of barriers to teamwork. Factors include doctors' leadership resulting in power imbalances between different groups of professionals, as well as individual and professional factors such as trust and respect, differences in professional skills, and professional autonomy(Rosen, et al., 2018). Although some recent qualitative attempts have identified potential barriers across different health conditions and countries, evidence remains partial regarding whether these might permeate the development of primary health and community services in low- and middle-income countries, where the health system context may be different and competing health priorities may also have an impact(Baryakova, et al., 2023).

1.1. Background and Significance

Primary healthcare is defined as the set of socially relevant, preventive, curative, and rehabilitative activities that are required to maintain the physical, mental, and social health and to improve the quality and expectation of life of individuals and families in a comprehensive and continuous way by health professionals who integrate or act in that area. The knowledge and skills are organized according to the levels of complexity. Family Health Teams, Oral Health Teams, NASF, and Home Care Services are examples of primary healthcare coordination with varying degrees of complexity. The Family Health Teams are integrated into the primary network of care, structuring the basis of the primary healthcare model in the country. They are equipped with basic clinical diagnostic methods and knowledge of the respective territorial reality of their area of competence. All work in a teamwork model and share long-term, comprehensive, and continuous care with the community assisted by the service(Behera, & Prasad,2022).

Studies report that reorganizing services to a team model with multidisciplinary components, integrative approaches, and frequent communication between members results in better health outcomes. Observational studies also indicate that community health centers that use effective teamwork models achieve higher levels of patient satisfaction and improved staff satisfaction, resulting in reduced emergency department use and hospitalization rates(Bendowska, & Baum, 2023). These differences are particularly relevant for lower-income and uninsured populations. The theoretical framework of team-based care includes organizational, relational, and functional dynamics. The model used takes into account three fundamental characteristics of the work developed: clear objectives, a well-functioning composition, and a process of collaboration. The development of team-based care depends on professionals' practices, their formal and informal organizational culture, and the legal, bureaucratic, and technological resources available. However, the emergence and configuration of teamwork can be influenced by internal and external factors(Ricketts, & Goldsmith,2005). These conditions can be beneficial or harmful; that is, they can promote or undermine the implementation of interaction processes among the members of the Health Professional Team.(Bendowska, & Baum, 2023)

1.2. Definition of Team-Based Care

Team-based care has gained increasing recognition as an important factor in the United States to achieve the "triple aim" of health care – improved quality of care, improved health of populations, and reduced per capita cost of health care. Multiple leaders and agencies are promoting the importance of family-centered, linked, and continuous care that can be better provided by team-based care. TBC is defined by the National Academy of Medicine as “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers to the extent preferred by each patient to accomplish shared goals within and across settings to achieve coordinated, high-quality care” (Will,et al., (2019).

Mitchell, (2012) claimed that effective team-based care has been linked to multiple parameters reflecting the triple aim of health care. Promoting the optimization of the role of patients and their families, coordinating and integrating care, and improving safety and shared decision-making are important components of family-centered, linked, and continuous care. Cross-training, clearly defined roles, shared goals, and organizational support are critical in making use of the knowledge and skills of all team members as well as in sustaining staff morale. Team leaders of team-based care hold an important key to the successful implementation and sustainment of the concept.although many studies have explored various facets of OR teamwork [Mitchell, (2012; Gougeon, L., Johnson, J., & Morse, H. (2017).], there has yetto be a systematic assessment of teamwork barriers and enablers that can directly informbehavior change interventions. Instead, there has remained a gap between observational studies of teamwork offering in-depth accounts of practices within a particular context and interventional studies that aim to improve teamwork. For example, most interventions involve team training to improve some element of teamwork (e.g. communication) [Harris, et al., 2016), yet observational research indicates that teamwork is a complex phenomenon influenced by multiple factors across multiple levels (i.e. individual, team, organization) Karam, et al (2018). A single-faceted strategy such as team training is unlikely to address the multilevel factors required for a substantial and sustainable improvement in OR teamwork as a whole. Not surprisingly, most teamwork interventions result in a limited effect on teamwork and associated outcomes (Harris, et al., 2016). In addition, there has not been any substantial reduction in patient safety events in recentyears (Karam, et al 2018). In this study, theresearchers focus specifically on TBC that happens at a

primary care setting where health professionals from various disciplines are engaged in care to improve diabetes outcomes. TBC has also been found to increase the satisfaction and productivity of primary care practices (TBC is particularly important for under-resourced settings because it results in expanded access to care, more efficiency in the use of limited resources, reductions in care fragmentation, and comprehensive patient- centered care where each member of the team renders servicesinterdependently avoiding duplication Karam, et al (2018). TBC has been considered a way to increase quality and strengthen the healthcare systems (Schmitz, et al., (2017). Interprofessional Collaboration (IPC) is a key element of TBC where "multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, careers, and communities to deliver the highest quality of care across settings" (Levis-Peralta,et al 2017).

Team- based care (TBC) is one of the 10building blocks of high-performing primarycare, and has been shown to result in betterhealth outcomes, higher patient satisfaction,decreased provider burnout and improvedpatient access.Schmitz, et al., 2017 clarifies roles and responsibilities of clinicians and staff, reduces duplication of tasks and poor communication,and standardizes day-to- day processes suchas scheduling and screening. Care teams(Schmitz, et al., 2017)

The Theoretical Domains Framework (TDF) is a tool used in the field of implementationscience to close the gap between research and practice. It was specifically developed to elicitdeterminants of clinical behavior and to inform the design of behavior change interventions(Atkinset al.,2017). As a comprehensive framework comprised of key psychological theories and constructs, the TDF has been applied in a variety of healthcare settings to understand the factorsdriving current practice in order to change clinician behavior. Applying the TDF tobehavior (e.g. teamwork) allows its determinants (i.e. barriers and enablers) to be mapped tospecific behavior change techniques and modes of delivery (Atkinset al.,2017)This approach increasesthe likelihood of influencing healthcare professional behavior in a meaningful and clinicallysignificant way (Etherington, et al., 2021).

Patient's Perspective

Patient satisfaction and experience are essential factors to consider when evaluating the effectiveness of team-based care in healthcare settings. Previous research demonstrated the relevance of patient satisfaction measure as a reliable reflect for the health care quality in various settings . Further studies demonstrated a positive association of patient satisfaction and experience with adherence to treatment (Farley, et.,2014).). Thus, measuring patient satisfaction constitutes a critical indicator to inform continuous quality improvement (Morgan, D. G., Kosteniuk, J., Stewart, N., O'Connell, M. E., Karunanayake, C., & Beever, R. (2014).). Consequently, understanding and improving patient satisfaction would foster synergy and trust relationship between the health system and the served population, which will ultimately reflect on improved patient outcomes (Bird, et al., 2020)., Wasfi, et al., 2008).

Although several studies have shown positive associations between patient experience and satisfaction and compliance with medical treatments, as well as improved patient-reported quality of life and care metrics, many studies failed to demonstrate such a relationship. This indicates the value of patient experience and satisfaction as independent outcome measures and encourages efforts to focus on both patient's perspective and technical quality (Farley, et.,2014).).

Significance of the study

This study therefore aimed to identify factors that facilitate The present work aims at providing a multidimensional evaluation of TBC approach in primary care, one year after its implementation in the Kingdom of Saudi Arabia. Data from this research project will enable informing decision-makers regarding the performance and achievements in terms of improvement in care quality and determine the eventual challenges, barriers and opportunities to enhance its performance or implementation.

Aim of the study

Objectives

The objectives will be divided into three levels, each will give raise to a separate data collection and analysis:

1- **Patient's Perspective**: This dimension will focus on assessing patients' satisfaction of the care services received during the TBC using a comparative approach with the traditional system (pre-TBC period). Dimensions such as autonomy, empowerment, perceived health gains, equity and equality, etc., will be explored. Specific groups of patients will be targeted, such as those having chronic diseases (cardiovascular diseases, diabetes mellitus, etc.).
2- **Healthcare professionals' perspective**: This dimension will focus on health care workers and will have two core objectives:
   2.a. To assess knowledge and attitudes among HCW about TBC
   2.b. To assess the perceived change in performance among HCWs since the TBC implementation by comparison to the traditional system (pre-TBC period). Dimensions like self-efficacy, effectiveness of

multidisciplinary teams, care continuity, time management, professional value, work strain, appropriateness of the electronic system with the new system, etc., will be tackled.

3- **Organizational level**: This dimension will probe into indicators pertaining to the care organization and the impact of the TBC in improving the organization of care services. Dimensions such as length of appointments, human resource management, patient flow, etc. will be included.

Methods

Setting:

Design

Descriptive, cross-sectional study was utilized to conduct this research

Settings

It was conducted in 17 primary healthcare (PHCs) at JEDDAH city were selected using bstratified random sample see table 1, Saudi Arabia, during August-December 2024. This PHCs were selected using stratified random sampling from 95 PHCs in Jeddah.

Adult patients following for at least one chronic disease at the participating center, for more than 2 years in the same PHC. Exclusion criteria: relocation during the past 2 years, communication disorder, dementia, being a healthcare provider even in another hospital.

Sampling

A multistage stratified, cluster sampling method will be used to select a representative sample of participants in this phase (**Table 1**). In stage 1, Jeddah region was divided into 8 sectors (strata), each represented by a coordinating center managing 6 to 19 PHCs. In each sector (stratum), a random proportional allocation method will be used to select one PHC (cluster) for every group of five PHCs. The total number of PHCs targeted for selection within each sector was determined by dividing the total number of PHCs in that sector by five, and then rounding the resulting quotient down to the nearest whole number. Hence, a total of 17 PHC will be targeted. In stage 2, an equivalent number of patients will be recruited from each participating PHC, estimated as the total sample size (385) divided by the total n umber of PHCs (16), which equals 25 patients by PHC. A convenience sampling will be used to include consecutive, eligible and consenting patients who will be attending the participating PHC during the study period.

Sample size

The target sample size was calculated to detect an unknown satisfaction rate (P=50%) with TBC among an infinite population, with 5% type 1 error, 95% confidence interval (95%CI), and 80% statistical power. The sample size was calculated as 385 patients, which was rounded to 400.

Table 1. Stratified-cluster sampling method used in Phase 1 of the study

Coordinating center	**No. PHCs**	**No. sampled PHCs**	**Randomly selected PHCs**	**Targeted No. patients**
King Fahad H.	13	2	ALMarwa, ALNahdah	50
King Abdulaziz H.	6	1	ALMahgar	25
Jeddah East H.	10	2	ALRAghamah, AL Rehab	50
King Abdullah Medical City	12	2	ALRayan ,khaled	50
Althagher Hospital	7	2	Kilo 13, Umm ASALAM	50
Alith Hospital	19	3	ALMARAJ, Bani Yazeed, JADAM	75
Rabigh Hospital	13	2	Hajar,kelyah	50
Adom Hospital	15	3	ALJaezah, Bani Afif, ALARJ	75
Total	**95**	**17**	-	**425**

Tools

One tool was utilized for this research

Picker Patient Experience (PPE-15)

It was developed and validated in the context of in-patient setting, by Jenkinson et al. in 2002 . adapted for use in the context of TBC in PHC. It was used to assess Patient's experience .a modified version of the was The PPC-15 questionnaire is a short version of the Picker Adult in-patient Questionnaire (PAIPQ, 40 items). (27). It consists of 15 items that encompassed different aspects of the patient's experience, divided into 7 dimensions. In the dimension of Information and Education, participants were asked about their understanding of important information provided by doctors and nurses when they had questions. The dimension of Coordination of care explored whether participants experienced inconsistent information from different healthcare providers. The dimension of Emotional support included items related to discussing anxieties or fears with doctors and nurses. The dimension of Respect for patient preference included feeling respected and involved in decisions about their care. Physical comfort was assessed by inquiring about pain experiences and the effectiveness of pain management. Involvement of family and friends was addressed by investigating opportunities for family members to communicate with doctors and the provision of necessary information for their support. Lastly, Continuity and transition were examined by assessing the explanation of medication purposes, information about medication side effects, and knowledge of danger signals after leaving the hospital. As such, the PPE-15 questionnaire is a comprehensive tool to capture the multifaceted aspects of patient experience in this study.

In the adapted version for this study, items were reformulated to reflect the context of TBC in PHC. This implied removing the distinction between doctors and nurses, and replacing redundant items (#2 and #8) by alternative items adapted from the PAIPQ that fall under the same dimension of the deleted item. See appendix A. Additionally, two items were added to explore availability and accessibility to healthcare providers. Assessing the accessibility of healthcare providers and their availability in the context of team-based care (TBC) is highly relevant for several reasons. Firstly, accessibility and availability are crucial components of patient-centered care, which aims to ensure that healthcare services are easily accessible and readily available to patients. Secondly, TBC emphasizes collaborative and coordinated care delivery, where multiple healthcare providers work together to address patients' healthcare needs. Assessing the accessibility and availability of healthcare providers allows us to understand if TBC effectively facilitates patient access to the right providers at the right time. Lastly, evaluating accessibility and availability in the context of TBC provides insights into the efficiency and effectiveness of the care delivery model. If patients face difficulties in reaching or experience a lack of available time with healthcare providers, it may impact their overall satisfaction, engagement, and health outcomes. By understanding these factors, healthcare organizations can identify areas for improvement and implement strategies to optimize access to care and enhance the patient experience within the TBC framework.

Ethical consideration

The participated nurses and physicians were instructed by the researchers about aim and benefits of the study and verbal agreement was taken before data collection. The participants were assured that their participation was totally voluntary. Information obtained was treated with utmost confidentiality.

Data collection

Preparation of data collection tools was carried out over a period of three months from January to February 2024 after extensive literature of review. The tools were translated into Arabic format. Then the tools were revised for content validity by 5 juries who were experts in the related field, for clarity, relevance, comprehensiveness, and applicability. Official letter was taken from the Authorized person in the pre mentioned family medicine clinics to facilitate collection of data, and then oral consent was taken from nurses and physicians. 28of study subject was conduct for pilot study (20 nurses) and (8 physicians) were included in pilot study to identify the clarity, time needed and applicability of the tool.

The data collection was taken in two months from June APRIL toMAY 2024. The data collected by researchers through distributing the questionnaire to nurses and physicians during her work hours, after meeting with unit managers and study subjects to explain the aim of the study to accept their participation as well as organizing and arranging the nurse's participation according to units needs and activities, the average number of collected questionnaire from both physicians and nurses were between 4-5 per day. The collaboration questionnaire took from 15-20 minutes and patient safety climate questionnaire took 20-25 minute to be completed

Statistical design

A compatible personal computer (PC) was used to store and analyze data. The Statistical Package for Social Studies (SPSS), version 24 was used. Data were coded and summarized percentage distribution for qualitative variables. Comparison was performed using chi square test.

RESULTS

Table 2: general characteristics of studied participants

		No	Column N %
العمر Age	Under 18 years	4.4	1.1%
	Over 60 years old	46	11.5%
	from 18 to 30 years	41.2	10.3%
	from 31 to 45 years	148	42.5%
	from 46 to 60 years	138	34.5%
Gender	Male	65	16.1%
	Female	335	83.9%
Marital status	Single	83	20.7%
	Married	239	59.8%
	Divorced	55	13.8%
	Widow	23	5.7%
Professional status	Not employed	124	31.0%
	Employed	276	69.0%
Educational level	Not educated	4.4	1.1%
	Read and write	4.4	1.1%
	Primary education	4	1.1%
	Secondary education	74	18.4%
	BSCs	272	78.2%

Table 2 pointed that 34.5 of studied participants were in age group 31-40 years old. The majority were female. Regarding marital status 59.8% were married. And nearly two third were employed (69.9%). According to their educational qualification 78.2 % had BSCs.

Table 3: Mean and standard deviation of patient prospective satisfaction of primary healthcare

	Min-Max	**Mean ±SD**	**Mean score %**
Overall satisfaction of service	6.00- 30.00	19.92± 7.94	66.4%
Early screening	4.00- 20.00	14.0±4.68	70.00%
Health education and follow up	2.00 10.00	6.88± 2.56	66.8%
Beneficiary satisfaction of service	9.00-45.00	32.85± 11.79	73%
Easy Accessibility	2.00- 10.00	6.83± 2.48	68.3%
Communications	2.00 -10.00	7.23± 2.59	72.3%
total satisfaction& experience	25.00-125.00	87.73± 29.34	70.184

Table 2 pointed that they perceived high level of satisfaction70.184 with mean SD (87.73± 29.34) regardingteam based are . In addition, they perceived high level related to Overall satisfaction of service, Early screening, Health education and follow up, Beneficiary satisfaction of service, Easy Accessibility, and communication, (66.4%,70.00%,66.8%,73%68.3%, and 72.3%)respectively . The Beneficiary satisfaction of service was the highest dimension(72.3%) while over all perception regarding service were the lowest one(66.4%)

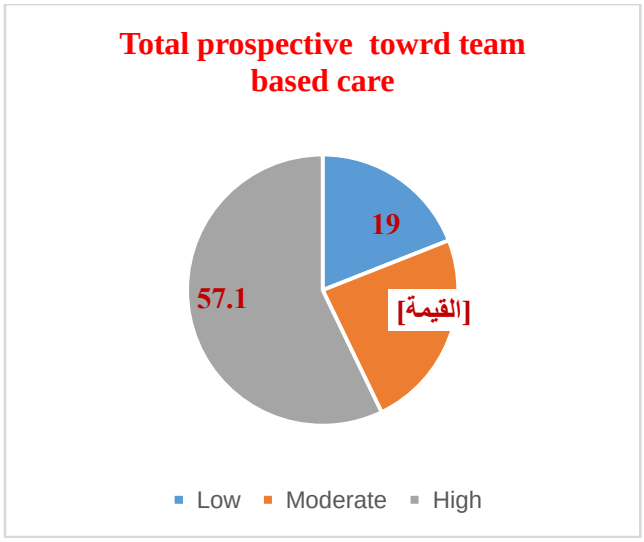

Figure 1: Total prospective toward team based care

Figure 1 illustrated that more than fifty percent had high level of satisfaction regarding their experience in PHCs with team based care, while only 19% had perceived poor toward service

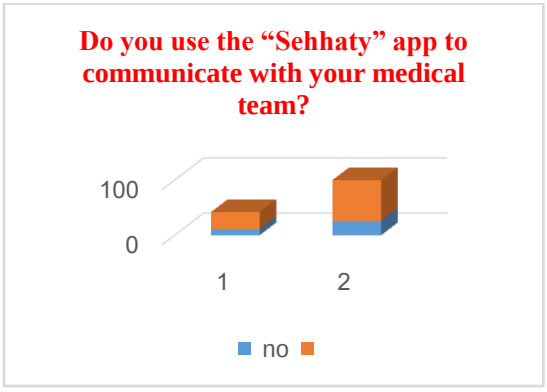

Figure 2: use the “Sehhaty” app to communicate with your medical team

Figure 2 pointed that 73.8 of study participant were used Sehhaty app to communicate appointment. Moreover nearly fifty percent of them had excellent experience with the applications .while 14.3 had poor experience with the application see figure 2

Figure 3: the experience of participant about using SEHHATY App

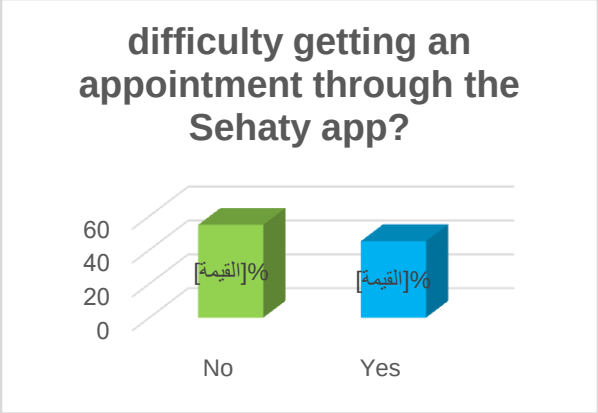

Figure 4: the extent of difficulty of using Sehaaty app

Figure 4 illustrated that 54.5 % had no difficulty when getting an appointment while using sehatty application

Table 4: recommendation for improvement the services

What improvements would you suggest for the TBC?	No	%
• Relying on the most precise health specialties to provide care	22	5.5
• Clarity and communication	42	10.5
• Facilitating appointments	50	12.5
• Increase the number of health staff	42	10.5
• No recommendation	172	43

Table 4 show that 43% of the studied participant had no improvement comment and accept the provided services in PHCs .10.5% of them recommended clear communication with them . moreover, 20% recommended to further development in healthcare. 12.5% of them recommended to facilitate appointment to receive service

DISCUSSION

This study provides new insight into patients' experiences with team-based care and contributesto addressing the paucity of research in this area. While for most measures of care, patients reported no change, they do appear to value team-based care for the benefits they feel they gain from having other health professionals involved in their care, such as increased education and knowledge about their condition and how to manage it, and improved psychological wellbeing and health care independence. These are important factors in enhancing patients' quality of life. Our survey findings showing improved patient education are consistent with results of a randomized trial16 and indications of improved patient self-managementsupport data obtained from focus groups.

the introduction of the concept of family doctor to the PHC level is one of the mostsignificant changes that have been introduced by the reform program. For many years patients have been examined by specialists at different levels of health care services. Changing this concept and pursuing patients to accept being examined by a GP and referred to a specialist, if needed, is a crucial issue that highly influences patients` satisfaction with their doctors and the overall services provided at the PHC units. Two factors highly influence patients` satisfaction with accessibility of PHC services. The first factor is the availability of doctors in the health care unit. Alghamdi et al 2020. suggested conducting routine evaluations of patients' satisfaction with PHC services so as to improve the quality of care provided. Current studies in Saudi Arabia have examined patients' satisfaction with PHC services provided in different regions of the country, which ranged from 78% to 83%, but few have covered all the regions of Saudi Arabia [9].

the findings of the current study demonstrated that most of the participants were perceived high level of satisfaction70.184 with mean SD (87.73± 29.34) regarding team based are . In addition, they perceived high level related to Overall satisfaction of service, Early screening, Health education and follow up, Beneficiary satisfaction of service, Easy Accessibility, and communication, (66.4%,70.00%,66.8%,73%68.3%, and 72.3%)respectively . The Beneficiary satisfaction of service was the highest dimension(72.3%) while over all perception regarding service were the lowest one(66.4%), The foundation of this high degree of satisfaction is

the healthcare provider, since our survey found that patients were most satisfied with the services provided by healthcare practitioners, then nurses. These findings are consistent with those of Owaidh et al. 2018 [10], who found that patients who visited PHCs had a high percentage of patient satisfaction in their study, which was carried out in the Al Baha region of Saudi Arabia. Ninety percent of patients in the aforementioned study expressed satisfaction with the medical care they received.

According to Senitan et al. (2018) who found that 83% with the nurses' services, and 80% with the facility's cleanliness, tranquility, and layout. Manzoor, et al., . (2019) claimed that an integral part of patients' satisfaction is physician communication, which can have further effects on such satisfaction. Similar research has found that interactions between the physician and the patient are critical. These results highlight the influential and significant role that healthcare providers have on the overall patients' experience.

Similar patient satisfaction ratings to those reported by Mohamed et al. (2015) in Al Majmaah city (82%), which is situated in Saudi Arabia's Central region, were reported by the current study. Furthermore, our investigation showed that the primary factor contributing to these outcomes was the care provider, which was followed by personal concerns (patient privacy, clinic cleanliness), and finally the nursing domain. However, according to Mohamed et al. (2015), the centres' cleanliness, staff proficiency, respect, and superior handling were the main reasons why their patients were happy. According to the authors of another study conducted in the Al Hasa region of Saudi Arabia, 86% of patients were satisfied with the PHC services they received, which supports the findings of the current study.

In addition to the aforementioned, a study by Gao et al. (2022) in China, which involved 1,138 patients who attended 728 PHC centres spread across 31 counties, revealed a satisfaction level of about 68%. Our study's findings greatly surpassed this level. Nonetheless, Gao et al. (2022) found a comparable correlation between patient satisfaction and healthcare provider characteristics such professional level, consultation procedure, accessibility, and convenience.

Facilitating access to healthcare services and enhancing their effectiveness and quality are two of Saudi Vision 2030's main goals. The NTP 2020 reform strategy highlights the need to close the healthcare access gap, with a particular emphasis on Universal Health Coverage (UHC), in accordance with Saudi Vision 2030. A global initiative, the UHC seeks to guarantee that everyone has access to the medical care they need. The services can include public health initiatives aimed at preventing disease (like immunisations) or promoting better health (like anti-tobacco awareness campaigns and taxes), as well as treatment, rehabilitation, and palliative care (like end-of-life care). (Prinja, 2023).

patient results. In this study, we sought to determine how satisfied patients and their carers were with PHC in the Al-Ahsa region and to look into potential areas where our healthcare system could be improved. The general level of satisfaction with PHC was good and on par with other KSA regions [6,17]. On the other hand, a Jeddah survey found that overall satisfaction was lower at 60%. Patients who live far from PHC centres and are unaware that their closest PHC centres have Family Physicians (FPs) may be the cause of this (Senitan et al., 2018).

Kuwait, Lebanon, and Egypt all had higher satisfaction ratings (99.6%, 98%, and 96.6%, respectively). The lack of explicit healthcare expectations and goal assessment for our study population, cultural differences, and variations in the assessment tool can all account for this (Szafran et al. 2018). According to one survey, staff and communication in Riyadh had the greatest satisfaction percentages, at 72.7% and 73.4%, respectively. Participant satisfaction in our study was highest when it came to team-based care visits and communication (66.8%). Factors pertaining to participants' GP visits and patients' happiness with medical consultation at PHC centres varied considerably depending on the participants' ages and work status, with retired or jobless people reporting lower levels of satisfaction.Participant satisfaction in our study was highest when it came to team-based care visits and communication (66.8%). Participants' ages and employment status had a significant impact on the characteristics pertaining to patients' happiness with medical consultation at PHC centres and their GP visits; those who were retired or unemployed had lower satisfaction..This could be explained by the larger expectations that these two patient groups had that were not fulfilled. Furthermore, individuals' satisfaction levels with nursing care varied considerably by gender, with female participants reporting lower satisfaction levels.

Different studies came to different conclusions. Younger participants reported lower levels of satisfaction, according to one study done in Abha, which found that participants' overall communication scores varied significantly depending on their age groups [Senitan et al., 2018].Furthermore, compared to men, women indicated less enjoyment. A parallel study conducted in Jeddah found that insufficient communication caused almost 40% of the patients to express unhappiness with their relationship with the FP (Tabekhan et al., 2018).

Additionally, a study conducted in Lebanon found that despite a mean waiting time of 28 minutes for consultation, overall satisfaction was high (96.6%), a finding that could be investigated in future research conducted in the Kingdom of Saudi Arabia (Hemadeh et al., 2019). Nearly every patient in the family practice clinics wanted to be treated by a doctor over any other medical practitioner. Patients seem to view physicians as the team leader who makes all treatment decisions, with other medical specialists serving as a supporting role..

This is in line with another Canadian study that found that just 48.3% of patients in family practices would be open to scheduling a regular or follow-up appointment with a non-physician practitioner. Tahiri and colleagues (2014). et al., and Abd Sa'adoon (2008). suggesting that patients favoured talking to their doctor about their prescriptions. According to a US study, people favoured physicians based on their training and technical proficiency, whereas they chose physician assistants and nurses for their ability to interact with patients (Al-Azmi et al., 2006).

Our findings suggest thatfamily practice patients still embrace traditionalprofessional roles, even within an environmentof interprofessional team-based care. Perhapsthe teams that patients encountered in our studywere at the early stages of teamwork, having notyet evolved into integrative team functioning,thus still adhering to traditional roles. Moreover,physicians may not readily share leadership roleswith team members. a study of physicians' perspectives on interprofessional teamwork foundthat family physicians also see themselves as theteam leaders. (Weber, et al 2011). The College of Family Physicians of Canada advocates for family physiciansbeing the 'most responsible provider' within thePatient-Centered Medical Home, hence in theleadership role. Other health professionals havedifferent perspectives on team leadership, whichcan result in tensions in professional relationships.Clarity of team member roles is necessary to avoid patient confusion and facilitateeffective working relationships. (Szafran et al. 2018).

CONCLUSIONS

ssessing patients' perspectives on TBC using the PHC system is the aim of this study. Our research indicates that patients were generally satisfied with their service. The type of the services provided and patient characteristics were shown to be two of the many factors that contribute to satisfaction. Furthermore, there is no single factor that can fully reflect attitudes regarding PHC service satisfaction. The level of satisfaction changes and is impacted by the type of service being measured. Furthermore, the traits of the person who will be getting the service also have an impact. By examining the cause of the overall decline in contentment and pointing out additional causes of discontent not covered in this study, future research may build on this one.

In light of the fact that, even with our best efforts to schedule and coordinate patient consultations, unforeseen circumstances such as patients with urgent medical complaints, drop-ins, and patients with complex medical complaints requiring extensive evaluation, as well as patients who arrive earlier than scheduled, may contribute to waiting times and should be taken into consideration when evaluating waiting times, this is a crucial area for future policy improvement.

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