PATIENTS' PERCEPTIONS REGARDING HEALTH CARE SERVICES AT TSHILIDZINI HOSPITAL

BY

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A dissertation submitted in partial fulfilment of the requirements for the degree of Masters in Public Health at the University of Venda.

AT

THE UNIVERSITY OF VENDA

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DECLARATION

I Mugwena Mmbudzeni Thelma declare that "**PATIENTS' PERCEPTIONS REGARDING HEALTH CARE SERVICES AT TSHILIDZINI HOSPITAL**" is my own work, that all sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted for another degree at this university or any other institution.

.....

MUGWENA MMBUDZENI THELMA

04/05/2015

DATE

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DEDICATION

This thesis is dedicated to:

- The all mighty God who through his love gave me the strength not to give up
- My beautiful son Ntanga who gives me a reason to go on. May the almighty God give you the wisdom to always strive for success, and to achieve beyond what I have achieved.
- My late dad who always believed in me. I miss you daddy

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I wish to thank God for giving me the gift of life and for giving me the strength not to give up.

My sincere gratitude goes to the following people who contributed to the success of this study:

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- Ms Phiri C. for the contributions you made in sharing your knowledge
- All participants who gave me their time and information
- Department of Health for allowing me to conduct my study at Tshilidzini hospital
- My beautiful mother for your endless support and love. Thank you mamma
- My siblings for your words of encouragement.

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ABREVIATIONS AND ACRONYMS

DOH- Department of Health

HPCSA- Health Professions Council of South Africa

ICU- Intensive Care Unit

NHC- National Health Council

NHI- National Health Insurance

OPD- Out Patient Department

PHC- Primary Health Care

SA- South Africa

TB- Tuberculosis

WHO- World Health Organisation

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TABLEOF CONTENTS

CONTENTS	Page
Declaration	**I**
Dedication	**II**
Acknowledgement	**III**
Abbreviations and Acronyms	**IV**
ABSTRACT	**X**
CHAPTER 1: INTRODUCTION	
1.1 Background of the study	1
1.2 .Problem statement	5
1.3 Rationale of the study	6
1.4 .Significance of the study	6
1.5. Main objective of the study	7
1.5.1 Specific objectives of the study	7
1.6 Definition and Operalisation of concepts	7
CHAPTER 2: LITERATURE REVIEW	
2.1 Introduction	8
2.2 Data based literature	8
2.2.1 Factors that affect patients' perceptions about health care	8
2.2.1.1 Access to resources	8

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2.2.1.2 Relationship between patients and health care staff 8

2.2.3 Other factors that affect the effectiveness of treatment and care 12
2.2.4 Models of the relationship between patients and health care providers 14
2.2.5 Patients' rights and the need for quality health care service 17
2.5.6 Effectiveness/ efficiency of treatment as perceived by the patients 20
2.2.7 Improving quality of care 26
2.2.8 Patient satisfaction 27
2.2.9 Health care services a global issue 28

2.3 **Conceptual -based literature** 30
2.3.1 The Socially- oriented Analytical Theory 30

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Study design 34
3.2 Study setting 34

3.3 Study population and sampling 35

3.4 Tools for data collection (interview guide) 36

3.5 Measures to ensure data quality 36

3.6 Plans for data collection 38

3.7 Data analysis 39
3.8 Ethical considerations 40

- Validity
- Reliability

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- Confidentiality
- Informed consent
- Anonymity
- No harm to participants

3.9 Scope and Limitations of the study 41

CHAPTER 4: RESULTS OF THE STUDY

4.1 Introduction 42

4.2 Demographic Profile 42

4.3 The Factors that affect Patients' Perceptions about Quality of Health Care 44

4.3.1 Main theme 1: Access to hospital resources 44

- Sub- theme 1: Means of transportation to hospital
- Sub- theme 2: Distance from home to hospital
- Sub- theme 3: Accessing hospital facilities
- Sub- theme 4: Expenditure on transportation and medication

4.3.2 Main theme 2: Patients' Relationship with Health Care Providers 50

- Sub- theme 1: Patients' relationship with hospital staff

4.3.3 Main theme 3: The rights of patients as clients in the hospital 51

- Sub- theme 1: Patients' understanding of their rights

4.3.4 Main theme 4: Patients' views of the medical treatment received at the hospital 52

- Sub- theme 1: Negative views about treatment
- Sub- theme 2: Positive views about treatment

4.3.5 Main theme 5: Patients' views of how the services they receive at the hospital can be improved 53

- Sub- theme 1: Shortage of staff at the hospital

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- Sub- theme 2: Provision of Physical staff for weak patients
- Sub- theme 3: Free access to medical care

CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction 56
5.2 Discussions 56
5.3 Conclusions 66
5.4 Recommendations 66
5.4.1 Recommendations to the Provincial Department of health 66
5.4.2 Recommendations to the hospital management 67
5.4.3 Recommendations to the nurses 68
5.4.4 Recommendations to the hospital administrative staff 69
5.5.5 Recommendations to the community 69

REFERENCES 70

APPENDICES

Appendix A: Research Instrument 75
Appendix B: Participants' Information Sheet 76
Appendix C: Participants' consent forms for Focus Group Interviews 77
Appendix D: Ethical clearance certificate (University of Venda) 78
Appendix E: Ethical clearance certificate (Limpopo Department of Health) 79

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LIST OF TABLES

Table 1: Data analysis instrument 39
Table 2: Demographic characteristics of the participants 43
Table 3: Factors that affect patients' perceptions about quality of health care in hospital 44

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ABSTRACT

Patients' perceptions means the manner in which the client who receives medical attention, care or treatment regards understands or interprets the treatment they receive in health care.
Patients' perceptions of satisfaction are an aspect of health care quality that is being increasingly recognised for its importance.

The aim of this study was to explore the perceptions of patients of between the ages of 18 and 65 years regarding health care service provision at a hospital in Thohoyandou, Limpopo Province, South Africa. The research design was qualitative, explorative and contextual. The sample was purposively selected and comprises of both male and female patients receiving medical care for chronic illnesses. Data was collected through in-depth interviews comprising 8 patients and analysed qualitatively guided by a six step process. Permission to conduct research was sought from the Ethics Committee of University of Venda, Thohoyandou.

The results of the study revealed that most of the respondents in the study were dissatisfied with the health care services they were receiving at the hospital. This dissatisfactions were mostly due to the unreliability of ambulances, not being able to access the hospital resources with ease, costs of transport when patients have to go to the hospital and unable to use public transportation e.g. taxis and therefore having to hire private cars, the cost of medication, and the disrespectful way in which they are treated by hospital staff.

Patients were also asked to give their views about how the services they receive in hospital can be improved. Some of the patients' views were that the hospital should hire more staff. Patients further recommended that they should not be made to wait too long in the queue before seeing a doctor.

Recommendations were made from the findings which included ensuring that there are enough ambulances in hospitals which are in good working conditions, hiring of more hospital staff to avoid staff being overworked and therefore not performing to the best of their ability, making sure that there are employee assistance practitioners at every hospital to assist staff to deal with

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the personal and also work related issues, hospital staff improving their relationships with patients and the manner in which they interact with them and educating patients on a regular basis regarding their rights when they are in hospital.

Key words: Patients

Perceptions

Health

Care

Services

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CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Good quality care has until recently been regarded as a luxury reserved for developed countries. This happened as a result of multiple factors that range from the fact that primary health care does not rely on advanced technology and thus had less need for quality standards; the priority in the developing countries has been more on making services available than on evaluating the quality (Haddad et al., 1998).

According to Wolf (2012), perceptions are the basis of understanding by patients, their families and/or support networks. They also are the foundation of all recollection and at the core of all that will be shared with others. Experience as defined is quite simply, and powerfully, all that is perceived, understood and (perhaps most importantly for healthcare organizations) remembered. Wolf (2012) further says that, because perceptions will vary based on individual characteristics such as beliefs, values, cultural background, one cannot guarantee the "same" experience for anyone. You can only create the circumstances in which you are aware the actions taken in every healthcare interaction will result in a (hopefully positive) perception. Experience efforts, strong organizational cultures and focus at all points on the care continuum will influence an individual's perception. Therefore, the patient perspective must be consistently understood and continuously engaged.

There may be no area of greater significance to patients' perception in healthcare than the vulnerability they feel. Our levels of perception are raised when we find ourselves in a vulnerable situation. As I personally experienced in a recent emergency situation, our senses are heightened, our mind races, our blood pressure increases and we are extraordinarily aware of what is happening around us. These moments ingrain themselves in our memory. So where do healthcare leaders have an opportunity in to impact perception? First, they must recognize the individuality of each patient. Second, build systems to address this through the culture they create and the behaviours of people who engage with patients rather than only planning

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and implementing replicable processes or tactics they think will affect experience (Wolf, 2012).

Patients' satisfaction plays an increasingly important role in assessing the quality of care and health care delivery generally. Measuring patients' satisfaction has become an integral part of hospital/ clinic management strategies across the globe. Moreover, the quality assurance and accreditation process in most countries requires that the satisfaction of patients be measured on a regular basis. Care for patients is the fundamental aim of health services. Although consumers in South Africa are increasingly aware of their rights, they often have no formal mechanism to have their voice heard (Department of Health, 2008).

The Department of Health (2008) further indicated that, patients' health largely depends on the primary health care sector of the country. Primary care involves a sustainable partnership between patients and providers that addresses the majority of a population's health needs over time. It is crucial that primary health care providers ensure that their patients are able to access diagnostic, treatment and rehabilitation services.

Access to health care varies across countries, groups and individuals, and it is largely influenced by social and economic conditions as well as the health policies in place. Countries and jurisdictions have different policies and plans in relation to the personal and population-based health care goals within their societies. Health care systems are organizations established to meet the health needs of target populations. Their exact configuration varies from country to country. In some countries and jurisdictions, health care planning is distributed among patients' participants, whereas in others, planning is made more centrally among governments or other coordinating bodies. In all cases, According to the World Health Organisation (WHO), a well-functioning health care system requires a robust financing mechanism; a well-trained and adequately-paid workforce, reliable information on which to base decisions and policies, well maintained facilities and logistics to deliver quality services (Meyer and Bishop, 2007).

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According to The Patient Protection and Affordable Care Act of 2010, Twenty-three percent of the U.S. population lives in rural areas. Rural residents tend to be older, have lower incomes and are more likely to be uninsured than residents of metropolitan areas. Rural Americans also are more likely to suffer from chronic illnesses than their urban and suburban counterparts. Nearly half of rural residents report having at least one major chronic illness, and chronic diseases such as hypertension, cancer, and chronic bronchitis are up to 1.4 times more prevalent in rural than in large urban areas.

Quality health care has been a major concern to health care professionals for a long time. One of the notable early advocates of quality health care was Florence Nightingale, who in the nineteenth century advocated the use of statistics to help understand and improve health care quality. She strongly believed that hospital operations should be driven by patients' interests and argued for process improvements on the basis of empirical data (Meyer and Bishop, 2007).

During the last decade, increasing attention has been paid to quality of health care as a means of enhancing the effectiveness of health care system in developing countries. There is also an increasing recognition of patient satisfaction as an important indicator of the quality of health care (Ahmad and Din, 2010).

Patients' satisfaction plays an increasingly important role in the quality of care and health care delivery generally. Measuring patients' satisfaction has become an integral part of hospital/ clinic management strategies across the globe. Moreover, the quality assurance and accreditation process in most countries require that the satisfaction of patients be measured on a regular basis. Care for patients is the fundamental aim of health services. Although consumers in South Africa are increasingly aware of their rights, they often have no formal mechanism to have their voice heard (Department of Health, 2008).

Patients' health largely depends on the primary health care sector of the country. Primary care involves a sustainable partnership between patients and providers that addresses the

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majority of a population's health needs over time. It is crucial that primary health care providers are engaged in ensuring that their patients are able to continuously access diagnostic, treatment and rehabilitation services (Department of Health, 2008).

According to the White Paper of South Africa (1995), in improving the service delivery in primary health care clinics, there is a need to place high priority on the consumers and their level of satisfaction with the provided services. Patients' perception of satisfaction is an aspect of health care quality that is being increasingly recognised for its importance. Positive perceptions of patients regarding care often translate into more positive outcomes in their clinical experience and satisfaction is thus assured.

Health care professionals strive to meet universal human needs for care in illness, the promotion of health, and the prevention of disease. They seek to conserve that which is of value to every individual- the optimum functioning of the whole body systems and of the whole as an integrated unit. Above all, nursing is a human health service that has the quality of mercy and the potential for ennobling both the provider and the recipient (Messner and Lewis, 1996).

Each patient is a unique person with a unique personality, with individual methods of coping with stress, a variety of past experiences, and a system of beliefs about the world. The more the health professional can tailor patient education to the individual patient, the greater the likelihood of achieving success. A variety of factors about individual patients will determine not only their reactions to symptoms and diseases but also to patient teaching and recommendations provided. Recognising individual patient needs and priorities helps the health professional to present information in such a way that it will be meaningful for the particular patient to whom it is being directed (Messner and Lewis, 1996).

The district hospital plays a pivotal role in supporting primary health care on the one hand and being a gateway to more specialist care on the other. The district hospital provides level1 (generalist) services to in-patients and outpatients (ideally on referral from a community

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health centre or clinic). The hospital has between 30 and 200 beds, a 24-hour emergency service and an operating theatre. Generalists from a range of clinical disciplines provide the services. In some circumstances primary health care services are rendered where there is no alternative source of this care within a reasonable distance (Department of Health, 2002).

1.2 PROBLEM STATEMENT

The researcher once observed some of the challenges patients face when trying to access health care services at one of the secondary medical facilities at Vhembe districts. Some of the challenges she observed were long lines where the patients had to wait for a long time to get their medical files and to see a doctor. There was also a shortage of medicine and some of the patients went home without the prescribed medication.

On observation, patients complained about the behaviour and attitude of health care professionals. For example, patients said that they were being shouted at and treated unfairly by the health care professionals. Furthermore, family members who came to visit their loved ones who were patients at this secondary medical facility complained that they did not receive proper care. For example, the patients' beddings were not changed or the patients were not fed. Patients travelled long distances from their various homes to access health care services. Though medical care is free at public hospitals and clinics, patients reported that they spent a lot of money on transport.

In spite of these observations, in the absence of scientific evidence based on research, ther is no solid basis for proper planning of health services and monitoring of health programmes. This is the basis for this study.

1.3 RATONALE FOR THE STUDY

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In spite of what is presented under the problem statement (1.2 above), to the best of the researcher's knowledge, no study has been done on the patients' perceptions regarding health care services at Vhembe district.

There has been very little research done on patients perceptions regarding health care services at Vhembe district, despite the fact that our health system still faces a lot of challenges not only in secondary health facilities around Vhembe district but in South Africa as a whole.

1.4 SIGNIFICANCE OF THE STUDY

Findings from this study might benefit the Department of Health by bringing to the department's attention the views of the patients about the services they receive in hospitals and whether they are satisfied or not.

The study might further benefit the Tshilidzini hospital management and help them plan on how they can improve their health care services to patients The health care professionals might also benefit from the study because they are informed on how they can improve their level of service. Patients might also benefit because the level of service might improve and they might receive quality care.

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1.5 MAIN OBJECTIVE OF THE STUDY

The aim of this study was to explore the perceptions of patients regarding the quality of health care at Tshilidzini hospital, Vhembe district, South Africa.

1.5.1 SPECIFIC OBJECTIVES OF THE STUDY

- .To explore the views of the patients in Tshilidzini hospital from the following perspectives:
    1. Access to the hospital from home
    2. Access to the resources/ facilities
    3. The costs of care (transport, medication etc.)

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- To describe the relationship between the health providers in the hospital and the consumers
- To assess the participants' understanding of their rights, duties and obligations as consumers
- To examine the effectiveness/ efficiency of the treatment as perceived by the patients
- To explore the patients' views regarding how the services they receive in the hospital can be improved.

1.6 DEFINITION AND OPERALISATION OF CONCEPTS

PATIENT- This refers to any client who receives medical attention, care or treatment at hospital (Messner and Lewis, 1996).

PERCEPTION- The views of the participants about the services they receive at hospital

HEALTH CARE SERVICE – The physical, clinical, social, emotional and psychological care given to patients at hospital

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CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The researcher conducted a literature review on patients' perceptions with regard to health care services provided. The literature review was divided into two parts:

A. Data- based literature and

B. Theoretical- based literature.

2.2 DATA- BASED LITERATURE

2.2.1 Factors that affect patients' perception about health care

Several aspects may affect a patients' perception about health care and that patient's level of satisfaction. Unless those aspects are resolved and the patient's expectations are met, the patient remains dissatisfied and this may affect their healing process. Patients' perceptions and their level of satisfactions should always be taken into consideration to ensure effectiveness of the treatment they receive.

2.2.1.1 Access to Resources

The shortage of health care professionals is a major issue facing the biggest licensed profession in the health care system. This shortage will affect health care more each day, as it appears not much is being done to avert it. Many emergency rooms have longer waiting times due to less nursing staff, and hospital floors are feeling the effect as well. This is affecting patient care because the number of patients to one nurse is increasing, therefore decreasing the quality of care. This shortage is being felt in hospitals, nursing homes and health care agencies (Meyer and Bishop, 2007).

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Patients usually travel long distances from their various homes to get access to health care services. Though medical care is free at public hospitals and clinics, patients usually have to spend a lot of money on transport. According to Gilmore et al. (2005), Primary Health Care (PHC) services should provide quality services that are affordable, accessible, effective, efficient and sustainable. Health care professionals should put patients first by ensuring that health care services are accessible to patients at all times when the need arises. Patients should not be sent home without receiving medical care (White Paper, 1995).

- **Proximity of health services**

  Limited access to appropriate health care services was cited as a significant problem for culturally and linguistically diverse populations in South-East Queensland. Public transports services are reported to be inadequate and cabs too expensive. The difficulty in physically accessing health services was also raised by health care providers (Nera et al, 2012).

- **Availability of services**

  Inadequate supply of doctors and nurses restricts access to services, along with waiting lists for specialist services, elective surgery and services (Nera et al, 2012).

- **Socioeconomic factors affecting access**

  Impoverished circumstances have a huge impact on patients' not only in their ability to access appropriate health care services but also in them getting nutritious food (Nera et al, 2012).

2.2.1.2 Relationship between patients and health care staff

Each patient is a unique person with a unique personality, an individual method of coping with stress, a variety of past experiences, and a system of beliefs about the world. The more the health professional can tailor patient education to the individual patient, the greater the likelihood of its effective. A variety of factors about individual patients will determine not

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only their reactions to symptoms and diseases but also to patient teaching and recommendations provided. Recognising individual patient's needs and priorities helps the health professional to present information in such a way that it will be meaningful for the particular patient to whom it is being directed (Messner and Lewis, 1996).

Service quality is primarily shaped by functional quality, because patients often find it difficult to access technical quality. Functional quality refers to the manner of delivery of health care and technical quality refers to the accuracy of diagnosis and the procedures. Quality within healthcare service delivery refers to services that meet the set standards, implying excellence, and satisfy the needs of both patients and health care practitioners in a way that add significant meaning to both parties' health care experiences. Quality health care should be regarded as the right of all patients and ought to be the responsibility of all the staff within the health care organisation (Sohail, 2003).

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Hana and Martin (2005) in Quality of Primary health Care in Saudi Arabia says that a patient must have confidence in the competence of their physician and must feel that they can confide in him or her. For most physicians, the establishment of good rapport with a patient is important. Some medical specialties, such as psychiatry and family medicine, emphasize the physician-patient relationship more than others, such as pathology or radiology.

Hana and Martin (2005) in Quality of Primary health Care in Saudi Arabia further says that the quality of the patient-physician relationship is important to both parties. The better the relationship in terms of mutual respect, knowledge, trust, shared values and perspectives about disease and life, and time available, the better will be the amount and quality of information about the patient's disease transferred in both directions, enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Where such a relationship is poor the physician's ability to make a full assessment is compromised and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice. In these circumstances and also in cases where there is genuine divergence of medical opinions, a second opinion from another physician may be sought or the patient may choose to go to another physician.

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The physician may be viewed as superior to the patient, because the physician has the knowledge and credentials, and is most often the one that is on home ground. The physician-patient relationship is also complicated by the patient's suffering and limited ability to relieve it on his/her own, potentially resulting in a state of desperation and dependency on the physician. A physician should at least be aware of these disparities in order to establish rapport and optimize communication with the patient. It may be further beneficial for the doctor-patient relationship to have a form of shared care with patient empowerment to take a major degree of responsibility for her or his care (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia).

Health care providers can influence patients to make healthier lifestyle choices, such as stopping smoking, increasing physical activity, making healthy dietary modifications, and complying with cancer screening recommendations. Capitalizing on this influential relationship depends, in part, on whether or not these two groups can effectively communicate with one another. Effective communication between patients and providers helps to optimize counselling interactions and has a significant influence on patient behaviours and health outcomes (DeVoe et al., 2009).

A dilemma may arise in situations where determining the most efficient treatment, or encountering avoidance of treatment, creates a disagreement between the physician and the patient, for any number of reasons. In such cases, the physician needs strategies for presenting unfavourable treatment options or unwelcome information in such a way that minimizes strain on the doctor-patient relationship while benefiting the patient's overall physical health and best interests (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia).

- **Truth and informed consent**

  How doctors should present information about a patient's condition to the patient has changed over time. There has been a shift from paternalism or "doctor knows best" to the idea that patients must have a choice in the provision of their care, and be given the right to make informed consent to medical procedures. There can be issues with how to handle informed consent in a doctor-patient relationship, or instance, with patients who don't want to know the truth about their condition. There are ethical

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concerns regarding the use of placebo and whether or not giving a placebo leads to an undermining of trust between doctor and patient and whether deceiving a patient for their own good is compatible with a respectful and consent-based doctor-patient relationship (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia).

- **Formal or casual**

There may be differences in opinion between the doctors and patient in how formal or casual the doctor-patient relationship should be. For instance, according to a Scottish study, patients want to be addressed by their first name more often than is currently the case, Some familiarity with the doctor generally makes it easier for patients to talk about intimate issues such as sexual subjects, but for some patients, a very high degree of familiarity may make the patient reluctant to reveal such intimate issues (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia).

- **Transitional care**

Transitions of patients between health care practitioners may decrease the quality of care in the time it takes to re-establish proper doctor-patient relationships. Generally, the doctor-patient relationship is facilitated by continuity of care in regard to attending personnel. Special strategies of integrated care may be required where multiple health care providers are involved, including horizontal integration (linking similar levels of care, e.g. multiprofessional teams) and vertical integration (linking different levels of care, e.g. primary, secondary and tertiary care) (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia).

- **Other people present**

An example of where other people present in a doctor-patient encounter may influence their communication is one or more parents present at a minor's visit to a doctor. These may provide psychological support for the patient, but in some cases it may compromise the doctor-patient confidentiality and inhibit the patient from

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disclosing uncomfortable or intimate subjects. When visiting a health provider about sexual issues, having both partners of a couple present is often necessary, and is typically a good thing, but may also prevent the disclosure of certain subjects, and, according to one report, increases the stress level (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia).

2.2.3 Other factors that affect the Effectiveness of treatment and care

The nurse is the only one who translates information imparted by physicians technically and professionally with a humane touch. Patients' perception of nursing care can be influenced by their pre- service expectations of the service provider that are in turn influenced by a number of factors such as, cultural background, socioeconomic status etc. After receiving a service the patient compares the perceived service with the expected one. The hospital administrators as well as all health care workers must be capable of knowing what the patient actually wants. By getting to know the patients a little more and their views on the care being received one tends to come closer to what the patient considers a good care (Messner and Lewis, 1996).

A variety of factors about individual patients will determine not only their reactions to symptoms and diseases but also to recommendations provided. Recognising individual patient needs and priorities helps the health professional to present information in such a way that it will be meaningful to the particular patient to whom it is being directed (Friedman, 1993).

Patients also have varying views about health and illness. Some believe that health and illness are predetermined and consequently may take on a ''what will be, will be'' attitude, assuming little responsibility for the consequences of their own behaviour. They may scoff at preventive practices such as stopping smoking if they have known people who have smoked all their lives and yet lived to a ripe age. Rather than arguing with these perceptions or expectations, the health care professional will be more successful in most cases if patients'

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needs, priorities, expectations, and perceptions are considered and worked into the teaching plan (Friedman, 1993).

Patients and health care professionals frequently come from different social groups and therefore may have different values, beliefs, and assumptions. Those differences may emerge not only with regard to reactions and interpretations of various life events but also with regard to health and health care in general. If health professionals assume that everyone subscribes to the same values, or if differences in values are not identified between health professionals and patients, there is a misunderstanding as well as a barrier to communication (Friedman, 1993).

2.2.4 Models of the relationship between patients and health care providers

The Paternalistic Model

In health care Paternalism" occurs when a physician or other healthcare professional makes decisions for a patient without the explicit consent of the patient. The physician believes the decisions are in the patient's best interests. But the control in the relationship resides with the physician rather than the patient, much as the control in a family resides with the parents and not the children. In the traditional paternalistic model it was considered acceptable for the physician to decide what to tell the patient about the actual diagnosis, and in cases of terminal disease the patient was sometimes not told the true nature of the illness (perhaps the family was told instead). Or if the patient were informed of the diagnosis, the physician might present the recommended treatment plan as the only one rather than mentioning alternatives that could be considered. Or if the patient were told of alternatives, the physician might make the recommended treatment plan seem clearly preferable in order for it to be chosen (Sohail, 2003).

It is inevitable that providers will act paternalistically in an innocuous sense for much of what goes on in healthcare. For example, a surgeon performing a surgical procedure on a patient will use the techniques he or she feels best fit the situation rather than asking the patient for advice or presenting choices to the patient about technique throughout the operation. Or in deciding upon medications to try to treat an infection, the provider will narrow down the field

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of possibilities to ones that in his or her professional judgment are likely to knock out the particular type of infection rather than presenting long lists of antibiotics to the patient so that the patient may choose. Or in deciding on what kind of continuing professional education conferences to attend or what professional literature to read, the provider will not solicit patients for advice but rather use his or her own judgment about what new knowledge and training will likely best benefit his or her patients (Sohail, 2003).

- **Arguments for Paternalism**

One common argument for paternalism in healthcare is that the physician or other provider has such vastly superior technical knowledge of the medical situation -- the certainty of the diagnosis, the nature of the treatment options and possible benefits, and the risks involved - that it makes more sense for the provider to evaluate the options and make the decisions. Patients are easily overwhelmed by technical details and risk talk and are therefore not in the best position to make the decision. The patient suffering from an illness will often be in a weakened and vulnerable state and has come to the provider seeking expert advice, help, and judgment that the patient lacks (Sohail, 2003).

The patient is usually very emotionally involved and possibly frightened by all the talk of risks and uncertainties, and this might affect the patient's judgment. The physician is less emotionally involved in the situation and can better make the right choice. In fact, upsetting information presented to the patient could harm the patient by throwing him or her into sadness and depressing, and the physician has an obligation not to harm the patient (Sohail, 2003).

It is believed in some quarters that it is virtually impossible for physicians not to act paternalistically because it would be impossible for the physician to present all the medical information to the patient and thus inevitably the physician's own decisions will come into play in picking and choosing what to present to the patient. The

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patient can't decide for him or herself what the physician should present about a procedure, the possible benefits, and risks, and other uncertainties (Sohail, 2003).

- **Arguments against Paternalism**

Paternalism makes two distinct assumptions:

- The provider can properly withhold important information from and make significant decisions for the patient. It is morally permissible to do so. The provider in fact knows what is best for the patient (Sohail, 2003).

- The provider may know what the provider wants out of life, but the provider may not know what the patient wants to get out of life, and the provider most likely is not in a position to know what the patient should want to get out of life. For example, the provider should not simply assume that the patient would not want to be told of a terminal disease because maybe the patient would want that knowledge in order to allow him to take time to get his economic, personal, and spiritual affairs in order before death (Sohail, 2003).

A technical model of the provider-patient relationship sees the provider supplying only technical medical expertise to the patient. Various versions of this type of model are called "informative," "scientific," "engineering," "consumer," etc. The physician diagnoses the disease, explains treatment options to the patient, along with anticipated benefits and potential risks, and gives the probably of favourable outcomes with each option, including discussion of which ones are most popular in the patient's situation, but no significant time is spent discussing patient life or health goals and values, and the patient is given complete freedom to decide on their own what to do. The patient must consider what they want out of life, what risks they are willing to take, etc. and then decide what to do (Sohail, 2003).

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The technical type of model avoids the charge of paternalism because it does not assume that the provider should withhold information from or decide for the patient, and the provider does not presume to know what is best for the patient. But critics of technical models claim that while it might represent what we want out of an auto mechanic or a travel agent, it is probably not what most of us want from a healthcare provider. Though people may not want the provider automatically making the important decisions, they often do want to discuss treatment options with the provider in the context of a discussion about their health and life goals and values. Many patients would welcome a provider-patient discussion about what they want out of life and how to get there. They want the provider's appraisal of the options in light of the provider's knowledge of the patient's goals and values for health and life. Patients may not want the provider to make the decisions, but they want advice and recommendations. They don't want coercion, but many would welcome dialogue. So many critics see technical models as too extreme a reaction to paternalism (Sohail, 2003).

It is likely true that many patients do trust the judgment of the provider about goals and values as they say, "tell me what you would do." The provider then has an obligation to give advice that incorporates the patient's own life goals and values, not the goals and values the provider happens to have for the provider's life (Sohail, 2003).

2.2.5 Patients' Rights and the need for quality health care services.

Patients should be treated courteously with dignity and respect. Before consenting to specific care choices they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to; coverage for qualified second options; timely referral and access to needed speciality care and other services, confidentiality of the medical records and communications with providers; and respect for their legal advanced directives or living wills (Department of Health, 2003).

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The National Health Act 61 of 2003 provides a framework for a single health system for South Africa. The Act provides for a number of basic health core rights, including the right to emergency treatment and the right to participate in decisions regarding one's health.

The patient's rights charter

According to the Patient's Right Charter, patients have the right of access to health care, a healthy and safe environment, to participate in decision making in the provision of their health care management (Department of Health 2008). Access to health care services such as:

- Receiving timely emergency care
- Treatment and rehabilitation
- Provision for special needs
- Counselling
- Palliative care
- A positive disposition
- Health information
- Knowledge of one's own health insurance / medical aid scheme
- Choice of health services
- Be treated by a named health care provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- Be referred for a second opinion
- Continuity of care
- Complain about health services (Department of Health, 2008).

According to the National health council (NHC) of 1995, all patients have the right to:

- Informed consent in treatment decisions, timely access to specialty care, and confidentiality protections.
- Be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their

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condition and treatment options. Patients should be entitled to: coverage for qualified second opinions; timely referral and access to needed specialty care and other services; confidentiality of their medical records and communications with providers; and, respect for their legal advanced directives or living wills.

- To concise and easily understood information about their coverage. This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain health care providers, prescription drugs, and "experimental" treatments). Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.
- To know how coverage payment decisions are made and how they can be fairly and openly appealed. Patients are entitled to information about how coverage decisions are made, i.e., how "medically necessary" treatment is determined, and how quality assurance is conducted. Patients and their family caregivers should have access to an open, simple, and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.
- To complete and easily understood information about the costs of their coverage and care. This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, co-payments, and additional premiums), and any catastrophic cost limits. Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.
- To a reasonable choice of providers and useful information about provider options. Patients are entitled to a reasonable choice of health care providers and the ability to change providers if dissatisfied with their care. Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain providers. The latter should include information about whether and how a patient can remain with a provider who leaves or is not part of a plan network.
- To know what provider incentives or restrictions might influence practice patterns. Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules

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(e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) which could affect provider practice patterns.

Along with patients' rights also comes responsibility.

Every patient or client has the following responsibilities:

- To take care of his or her health.
- To care for and protect the environment.
- To respect the rights of other patients and health providers.
- To utilise the health care system properly and not abuse it.
- To know his or her local health service and what they offer.
- To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
- To advise the health care providers on his or her wishes with regard to his or her death.
- To comply with the prescribed treatment or rehabilitation procedures.
- To enquire about the related costs of the treatment and / or rehabilitation and arrange for payment.
- To take care of health records in his or her possession (Department of Health, 2008).

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2.2.6 Effectiveness/Efficiency of treatment as perceived by the patients

Patients have explicit desires or requests for services when they visit hospitals. However, many cases of patient dissatisfaction can occur due to inadequate discovery of their needs. According to Tateke et al. (2012), patient satisfaction should be investigated since it is an objective of care, a consequence of that care (outcome) that can contribute to the effects of care, as a satisfied patient is more likely to comply with advice, and it is the patient's judgment on the care that has been provided. Moreover Tateke further says that, several patient characteristics have been associated with patient satisfaction including demographic factors, socio-economic status and general health status. Satisfaction is also influenced by the

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manner with which health care is delivered. The type of health care setting and characteristics of the medical provider, such as experience, age and gender, are related to patient satisfaction. Some medical-care satisfaction studies showed that people with poor health status had stronger feelings in either direction and that the most satisfied groups were those with good health or those suffering from chronic diseases

Perceived waiting time is a strong predictor of patient satisfaction. If waiting time is longer than what is expected or considered inappropriate, dissatisfaction will arise no matter how long the actual waiting time (Tateke et al., 2012).

The following are some of the responses that where given in a study conducted by Mashego (2005) in one of the hospitals in Limpopo regarding community perception of quality of primary health care services

- **Examination:**

  "The nurses do not examine you; they just ask what is wrong with you and give you medication. You actually have to know what is wrong with you when you go to these places otherwise you will not be helped. People who complain about feeling pain in general and do not point to any specific place on their bodies cannot be helped. The medication you get is based on the patient's 'own diagnosis' you get medication for what you report. "

  "Nowadays what you get at a clinic are those brown pills or alternatively you will be referred to the hospital. Some few years ago the nurses used to give children thorough examination by using a thermometer for body temperature. Now it is the mother who tells the nurse that my child's temperature is high. "When I am sick I go to the medical doctor because he examines me thoroughly and gives me an injection. The doctor also tells me what I am suffering from. I never get that from the clinic. "At the hospital they use a thermostat to see if the child's temperature is high or not, then they give you medicines. I went there the other day because my child ate 'thollo' (a yellow roundish wild fruit which is known to be poisonous). They checked him thoroughly and then gave him Panadol. Oral rehydration solution and black syrup, which they told me that it stops vomiting. We just got to the doctor or hospital, because they have an apparatus to examine the patients".

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- **Explanations about treatment:**

"When you are ill the first thing to do is to tell them what you are suffering from. They won't tell you what kind of illness it is, what causes it, and the functions of medicines they are giving you. They will only tell you that you must take 1 tablet 3 times a day. They do not tell you that with this kind of disease, you should not eat this and that. "They do not ask, they just take an injection and fill it up, then say undress the baby. They will then say you will massage the buttock on the way, while you are busy walking. It is the clinics and hospitals which do that. They do not tell us what the function of that injection is. We take children to clinic 6 weeks after birth, and we are not told what it is for. At the clinic they do not tell us the reason for injecting us".

- **Responsiveness:**

"The clinics seem to be useless because when you are pregnant, the fe e t become swollen, the nurses will then say, they can't take care of you, they rather refer you to the hospital."

"The nurses did not tell me to come for follow-up consultation; I just knew that if I wasn't feeling better I will go back. "If one is complaining of the same illness for a long time the nurses write a letter of referral to the hospital. They also tell us that at the hospital you will be examined properly. At the private surgery a doctor never refers patients to hospital for thorough examination. "

- **Treatment outcomes:**

"We are not satisfied with the outcome at the clinic, we just tell ourselves that God will heal us because the drugs they are giving us are just useless; they are not strong enough to cure patients. The nurses give us medication for other diseases, not for what we are really suffering from. "The medication we get from the doctors is not diluted and we are satisfied. If you go to the doctor for flu, before the medication gets finished you will be feeling okay. "Myself, I have a problem of 'badimo' (ancestors) or 'malopo' (ancestral spirits), I always dream of dead people. I dream of our great

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grandfathers and mothers. I just dream of living with them and watching them doing nothing. I get sick after having those dreams. So, I have to see the traditional healer immediately so that I can be able to 'wake up'. I go to traditional healers who know how to help me and I always feel better. "I went to M. Hospital when I was in Labour. A certain man at the hospital took me to where the nurses were; I think it was a male nurse. Then I found female nurses busy talking and laughing. They told me to sit on the chair because the baby was still fa r away. While I was sitting, I felt the baby was nearer and stood up, went into the delivery room and sit on the bed. The other old nurse said, 'what's wrong with this woman, why are you taking yourself to the delivery room?' I told her that I can't give birth while I 'm seated on the chair. So, while I was in the delivery room alone, God helped me by bringing a certain girl, she was a nurse. She was surprised to see me delivering by myself when other nurses are busy laughing and talking. Then she helped me. Those other nurses came to check me because they heard the baby crying. They said, if you are a granny knowing how to deliver by yourself, it's better not to come to M. Hospital. The reason why I went to hospital was because on my bed letter it was written that I was going to deliver by operation. "explain that the pain was not very bad by then, it only got worse now. Some rude nurses will say: "there is no such, there's no such...you cannot tell me a thing I have been a nurse for years, you know nothing." If you can ask a nurse in a clinic for Panadol, she will say, it's me who knows what to give you, your illness does not need it, and you think you know it better. "The nurses don't talk to patients well. May be these nurses have mood swings from home. If she had a problem with her family, she becomes crossed with patients for no apparent reason. The nurse will just scold you even if you did nothing wrong. For example, you are on the queue and she says, 'next', while you are still deep in thoughts, she won't speak with you well. She will shout, 'why did you not come here?". "At the private practitioner they communicate with us very well. They don't shout at us. They also tell you to come again when you don't feel better. "

- **Discrimination:**

"They treat you depending on your background, i.e. it depends on the kind of family you come from; your appearance also contributes towards the whole thing. If you come wearing nice clothes and jewelery they will give you first preference. If you

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come in tattered clothes, then things are different. It's as if they are smelling something bad (baankgelwa). "They look at the kind of person you are, if they don't like you, they won't give you the urgent attention. The nurses look at the surname. I f one patient is related to her, the service is faster. And if it happens that you get injured while at the beer halls, the nurses won't give you the urgent attention you deserve, especially if she does not like liquor. "The nurses should not judge us because of where we come from or which families we are coming from. They should treat us in the same way, equally. If I come from a two room house and the other one comes from a big mansion, treatment should be the same.

- **Care and compassion:**

"Nurses do show respect and compassion. May be it is because they know that I am senior to them. When I arrived at the clinic the nurses would say "how are you granny, what can we do for you? Then I 'II tell them that I came to collect some pills for high blood... "One cannot see that the nurse has compassion or not because all they do is to write down my problem and give me medication. I f you go to the clinic having diseases like flu and broken leg, they do show compassion, but not with diseases that are caused by women (drop). The nurses like asking us guys if we don't know a condom. They don't understand that sometimes you meet a girl, she becomes attracted to you, then you decide to have sex, you won't even think o f a condom... " "The nurses are not taking care of us. Nowadays they are full of self-control. They will leave the patient losing a lot of blood just because they will be waiting for an ambulance. I do not think they have compassion because you will find that the queue is long and they are busy drinking tea. Some patients end up leaving without being helped. "I once went to the hospital to check on my daughter who had just delivered. I pushed her on the wheel chair and the nurse said 'leave her, let her go on her own' and I could see my child was in pain, she was very weak, my heart was painful because these people are nurses and should help patients when they are still weak. "

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- **Respect for privacy:**

"The nurses can undress you; they once did that to me. I told the nurse in the clinic that I feel pain somewhere under my navel. She said to me that I should undress. I think she wanted to see me naked. I then told her that I feel pain here (pointing underneath the navel); all you have to do is to give me medication. The nurse told me she has the right to see different body parts of people. I told her that she does not have the right to undress me because it is a clinic, only the hospital nurses are allowed to undress me. I told the nurse that I am not feeling pain on my penis but it's under my navel. "One time the nurse said to me, 'take off your shoes', I did. She said, 'and socks ', I did. 'And trouser", I said 'no ', I better leave with the drips on me.

- **Explanation about drugs:**

"The nurses don't explain how we should take the pills. At the clinic they give you medicines but they do not tell you the function of it. All they tell you are take 3 teaspoons 3 times a day and keep out of reach of children. But at the private practitioner they explain the function of the pill... "

- **Effectiveness of drugs:**

"Sometimes the medicines we get from clinics help but most of the times they are useless. Sometimes you can clearly see that they have added water to the medicines, and they told themselves that the child will just d rink. Clinic medicines are too weak. You can give those medicines to a child with flu; he or she won '1 get better. Two weeks can pass without any change. This thing of diluted medicines forces one to take a child to the private practitioner because he gives stronger medicines unlike in the clinics. "If you give the child Panadol from the clinic, you will still take him back. On the contrary, hospital's Panadol works immediately after being taken. The hospital's Panadol is thicker whereas the clinic's is thin. Probably they added water to it in order to increase the contents. "At the private practitioner you just pay and get good medicines.

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- **Payment for drugs:**

"As a solution to this problem of lack of medication the government should introduce fees for drugs. This will mean that we will get proper undiluted drugs. And if we start paying again we will stop going to the clinic for silly reasons. For instance, now when one goes to a clinic, she will call a friend to accompany her. The friend will just say let me just consult because I am already with you. The friend will claim to be sick so that the nurses will give her medication, which she is just going to keep at home. "

2.2.7 Improving quality of care

Measuring patient satisfaction has become an integral part of hospital/clinic management strategies across the globe. Moreover the quality assurance and accreditation process in most countries requires that the satisfaction of patients be measured on a regular basis. Client Satisfaction tool should be a key instrument in any hospital/clinic management strategy, provided the tool has been well designed and is administered in a scientific manner. To ensure full participation from the client, the tool must be easily understood (Department of Health, 2008).

In improving the service delivery in primary health care, there is a need to put at high priority the consumers' level of satisfaction with the provided services. Patients' perceptions of satisfaction are an aspect of health care quality that is being increasingly recognised for its importance (Dansky & Miles, 1997).

Quality of health care delivered in the public sector remains a major challenge with diminishing resources to meet the increasing health care demands. Improvements in quality health care are identified in the department of health's strategic framework as a key challenge. In order to improve quality, one needs to measure it. The patient's views are important in identifying what is important to them (Awino, 2007).

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Waiting time is a major factor in perception of quality health care. Although other hospitality issues in health care are important to patients, the degree to which they effect perception of quality of health care is difficult to determine because of the overwhelming influence of waiting time (Awino, 2007).

Another issue that can affect patients' perceptions include shortage of health care practitioners. In March 2012, 165317 qualified health practitioners in both public and private sectors registered with the Health Professions Council for South Africa (HPCSA), the health practitioner watchdog body. This included 38236 doctors and 5560 dentists. The doctor-to-population ratio is estimated to be 0, 77 per 1000. But because the vast majority of GPs- 73% work in the private sector, there is just one practicing doctor for every 4219 people (Department of Health, 2008).

2.2.8 Patient satisfaction

Various dimensions of patient satisfaction have been identified, ranging from admission to discharge services, as well as from medical care to interpersonal communication. Well-recognized criteria include responsiveness, communication, attitude, clinical skill, comforting skill, amenities, food services, etc. It has also been reported that the interpersonal and technical skills of health care provider are two unique dimensions involved in patient assessment of hospital care (Andaleeb, 2001).

Determinants of patient satisfaction have been reported extensively. According to previous studies, patient characteristics such as age and education may influence a patient's assessment of hospital performance. A patient's health status and the severity of illness are also important predictors of the patient's overall satisfaction level. Hospital features such as hospital size have been reported to be associated with consumer assessment of hospital quality. The relationship between health care providers and patients (i.e. interpersonal skill) has been reported to be the most influential factor for patient satisfaction; however, the findings were not totally conclusive (Andaleeb, 2001).

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According to Andaleeb (2001) a lack of available information for consumers to choose a preferred health care provider is commonplace in many countries. We also know that personal channels of communication with relatives and friends are a major source of information for people wishing to obtain details concerning hospital performance. Therefore, recommendations from family or friends become an important source of information for selecting health care providers. Recommendation as well as satisfaction is based on personal experience concerning the services that one has received from health providers. Furthermore, of the different settings of health care services (i.e. inpatient care, outpatient surgery, outpatient test/treatment, and emergency care), compassionate patient care, including personal attention, respect, comfort, and the like, were the most important factors influencing a patient's intention to recommend a provider or for that patient to return to the same provider in the future. Patient satisfaction is determined mainly by a provider's attitude and caring rather than technical skills. Nevertheless, they also found that physician care delivery (such as skill, frequency of checking, and explanation) was not associated with patient recommendation or return, which is not a persuasive finding.

Patient satisfaction and the likelihood of recommendation were influenced by somewhat different factors. They found that respect, safety, and understandable instructions were common factors associated with satisfaction and recommendation. On the other hand, the technical skills of nurses and waiting time were associated with recommendation only, and patient's age and insurance status were associated with satisfaction only (Andaleeb, 2001).

2.2.9 Health care services a global issue

The 1998 South African (SA) Demographic and Health Survey found that users of public health care services were more dissatisfied with day hospitals, government clinics and government hospitals. In a community survey in rural South Africa a low accessibility of primary health care: 78% felt that the medical services are poor. These were a significant relationship between not being member of a medical scheme, poor health status and availability of health care services. Medicines being out of stock in clinics, no water and bad attitudes of health care staff are also said to be some of the problems with the health care system in South Africa (Mashego & Peltzer, 2005).

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Chronic disease is a major and growing health issue. According to the world health organisation, 35 million deaths due to chronic disease were reported globally in 2005, with the highest toll evident in low and middle income countries. In Australia, the aging population and changes in lifestyle that have emerged over the past decades call for focusing chronic disease in planning and delivery of health care services. Several Australian states have responded with strategic plans to tackle the challenges posed to the health care system. In Australia, individuals from a culturally and linguistically diverse backgrounds identified as having specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, or language spoken at home, undergo rigorous health checks before migration. Delivering effective health services to these people is complex because of cultural and language barriers. Patients from non-English speaking backgrounds are disadvantaged in terms of access and quality of services compared to the mainstream English speaking population (Nera et al., 2012).

As Australia becomes more culturally and linguistic diverse society, the health care system needs to be responsive to all the patients' needs. Failure to provide culturally competent services would lead to major health care disparities between culturally and linguistic diverse and mainstream populations (Nera et al., 2012).

The health care service market in Taiwan is highly competitive. After implementation of the National Health Insurance (NHI) program in 1995, the situation of competition became more intense. Small-scale hospitals were driven out of the market. The number of hospitals decreased from 828 in 1994 to 669 in 2000; however, the number of hospital beds nationwide increased 21.9% from 103 733 to 126 476 during the same period. Approximately 96% of all citizens in Taiwan (about 23 million) are covered under the NHI, and more than 95% of the hospitals nationwide are NHI-contracted providers. Without a formal referral requirement, people are free to choose any contracted hospitals they wish to receive health care services. Since the Bureau of the National Health Insurance (Bureau of NHI) is the only buyer (or insurer) of health care services, it sets payment schemes for all contracted providers for various kinds of services. Therefore, health care providers have to compete for patients under a mostly fee-for-service reimbursement system with nearly fixed payment schemes. Detailed descriptions of the implementation and influence of the nationwide health insurance program are available elsewhere (Nera et al., 2012).

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The quality of health care varies significantly among hospitals in Taiwan. Almost all of the hospitals are closed systems in that hospitals hire physicians to provide outpatient and inpatient care within the hospitals. While a medical-specialist training program was established in 1988, approximately 30% of practicing physicians have not as yet undergone any form of specialist training. The hospital accreditation system, which was started in 1978 by Taiwan's Ministry of Education and Department of Health, issues levels of the accreditation on the basis of a hospital's capabilities and quality of performance as determined by an expert team's on-site inspection. There are four levels to this accreditation system which, in descending order, are medical centre hospital, regional hospital, district teaching hospital, and district hospital (Nera et al., 2012).

Generally speaking, the level of accreditation is positively correlated with the bed size (which also represents comprehensive ability in subspecialties) of a hospital. Among the 669 hospitals nationwide in 2000, there were 20 medical centres and 63 regional hospitals, with most of these hospitals being large-scale with 500–2000 beds and possessing advanced clinical diagnostic and therapeutic equipment. In spite of the accreditation system, in 2000 there were 163 of the 669 hospitals without accreditation, with most of these being small-sized hospitals with fewer than 50 beds. In Taiwan, a hospital's reputation (or level of people's recommendation) or its bed size was nearly the only information available to prospective patients or their family members in order to select a preferred hospital (Nera et al., 2012).

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2.3 CONCEPTUAL -BASED LITERATURE

THE SOCIALLY- ORIENTED PSYCHOANALYTICAL THEORY

According to Meyer et al. (2003), individuals are able to consciously change and shape their personalities; are not simply victims of past experiences, current experience is equally important. People further have the ability to deal with their own problems.

- The idealised self is the product of a feeling of inferiority, which is especially common in a society that places high value on prestige and competition. The feeling of inferiority causes anxiety, and in an attempt to deal with the anxiety and

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compensate for the feeling of inferiority, the person unconsciously creates an ideal self with unlimited potential

- The actual self represents people as they consciously act on a daily basis. The actual self is often rejected as it does not meet the demands of the ideal self
- The real self is a force which urges the individual in the direction of growth and self-fulfilment.

A person has two basic needs, which are:

- the need for security or safety
- The need for satisfaction

Interpersonal style

- **Movement towards others**

When people move towards others they acknowledge their own helplessness and seek affection and support from those people. This type needs to be liked, loved, wanted, desired and to feel accepted, welcomed, approved of, appreciated and taken care of (Meyer et al., 2003).

- **Movement against others**

People who move against others do not accept their separateness and take it as axiomatic that hostility has to be met with hostility. They mistrust the feelings and intentions of other people and are obsessed with power, prestige, personal achievement and the exploitation of other people (Meyer et al., 2003).

- **Movement away from others**

When people move away from other people they can avoid being dependent on others, but have no wish to be hostile towards them. The disengagement of this type

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of person occurs when the demands of the environment becomes too great. They feel threatened and cut out (Meyer et al., 2003).

The socially- oriented analytical theory is a psychosocial model which aims at explaining how ones personality can have an influence on the manner in which that person will react or the decisions the person will take in a particular situation. Hence it is relevant to this study since the researcher wants to explore patients' perceptions regarding health care services, and this theory explains how an individual's personality can have an influence on the way they perceive the services they receive.

An individual with an idealised self usually feels inferior and this person usually feels anxious. In such a situation a patient might perceive the services they receive at a hospital as not satisfactory because with their feeling of inferiority they will believe that they were not treated with respect because they already feel that they do not deserve respect themselves.

This theory further talks about how two basic needs which are the need for security and satisfaction, so every patient who goes to access services in a hospital will go with the expectation that they will feel safe and be satisfied and if those needs are not met the patient will perceive the services they received negatively.

Furthermore the theory discusses the interpersonal style where people move towards others and acknowledge their own helplessness and seek affection and support from others. A patient with such an interpersonal style will go to the hospital with a positive attitude and believe that they will receive assisted and this attitude will influence the way in which the patient perceives the services they are given. This patient will usually be appreciative of whatever services they are given because they have acknowledged their own helplessness and need for help.

Another interpersonal style is the movement against others wherein they believe that hostility should be met with hostility. They mistrust the feelings and intentions of others and therefore when such a patient goes to seek help at a hospital; it might be very difficult to satisfy them and will usually perceive whatever service they received negatively because of their hostile attitude.

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There are also those individuals with the interpersonal style of movement away from others where this individual avoids being dependent on others but are not particularly hostile. This individual would usually find it hard to go seek help or acknowledge their own helplessness which would make them indifferent to the services they receive or perceive the services with indifference. So whether the services they received were satisfactory of not to them it makes no difference.

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3.1 STUDY DESIGN

Bless et al, (2006) describes a study design as a set of procedures that guide the researcher in the process of verifying a particular hypothesis and excluding another possible hypothesis or explanation. For the purpose of this study the researcher used qualitative research design. The researcher used qualitative research design because she wanted a deep understanding of how patients perceive the health care services they receive at Tshilidzini hospital. The in depth-interview method was adapted as a form of qualitative research design.

3.2 STUDY SETTING

The study was conducted at Tshilidzini hospital which is located in Shayandima township, Vhembe district of the far North region of Limpopo province in South Africa. Limpopo province is comprised of five districts; the study area is in one of the districts called Vhembe district. Tshilidzini hospital is a rural hospital under Thulamela municipality (Vhembe district) in the Limpopo province. It is a community hospital with 13 wards which are, Male surgical and medical: Female medical and surgical: Paediatric medical and surgical, TB (Tuberculosis) ward: Male and Female Psychiatric ward: Intensive Care Unit (ICU): Out Patient Department (OPD): Causality: Private ward and the Maternity ward. They also have an HIV/AIDS clinic.

Some of the areas served by Tshilidzini hospital include: Shayandima Township, Maungani village, Tshisaulu village, Muledani, Manini, and Tsianda village to name a few. The health status of the people in the district is poor due to multiple burdens of disease from the combination of poverty- related diseases, emerging and re- emerging disease and injury. The HIV and AIDS epidemic has exacerbated this in the recent years resulting in an increase mortality rates and reduced life expectancy. Tuberculosis is the most prevalent disease followed by malaria (Barmford, 2000).

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3.3 STUDY POPULATION AND SAMPLING

According to Goddard and Melville (2001) a study population is any group that is the subject of research interest. In this study the study population was both male and female, in and outpatients accessing services at Tshilidzini hospital. These patients were from 18 up to 65 years old. The researcher used Non-probability Sampling technique where the odds of selecting a particular individual were not known because the researcher did not know the population size or the members of the population (Babbie, 2008).

Sampling is the technique which a sample is drawn from the population (Bless el al, 2006). The researcher used the in-depth interview method and for this purpose the study sample comprised of eight adult patients, both male and female

In order to select the eight respondents, the researcher used purposive sampling which is defined as a sampling procedure where the judgement of the researcher as to who can provide the best information is considered in order to achieve the objectives of the study (Babbie, 2008).

The researcher used purposive sampling because she approached the sample with her knowledge of the population, its elements and the nature of the research aims. The main important factor in this method is that the researcher verified that the selected respondents meet the criteria.

Inclusion criteria: The researcher looked for the following characteristics from the respondents:

1. Patients accessing medical care at Tshilidzini hospital
2. Both male and female patients were be included
3. They were between the age of 18 and 65 years old and were both inpatients and outpatients

The exclusion criteria:

1. All patients who are not accessing medical care at Tshilidzini hospital were excluded
2. All patients under the age of 18 and above the age of 65 years were excluded

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3.4 TOOL FOR DATA COLLECTION (Interview Guide).

An interview guide was used to collect data. It consisted of open ended questions and guided the researcher when collecting data. Based on the specific objectives, the researcher prepared questions that assisted her to start and guide the conversation. The purpose of the interview guide was to assist the researcher in introducing topics and focusing on those objectives throughout the study. The interview guide consisted of open ended questions for the respondents to give unlimited responses. Open ended questions are designed to encourage the respondent to give full, meaningful answers, using respondent's own knowledge and feelings (Gilmore and Campbell, 2005).

The research instrument was guided by the following themes:

- Access to the hospital and resources
- Costs of care (transport, medication etc.)
- Relationship between the health care providers and patients
- Patients' understanding of their rights, duties and obligations
- Effectiveness/ efficiency of the treatment as perceived by the patients
- Improvement of services

3.5 MEASURES TO ENSURE DATA QUALITY

TRUSTWORTHINESS

Babbie, (2008) says that, trustworthiness is where the study accurately represents how the researcher persuades his/her audience that the findings are worth paying attention or worth taking note of. It relates to the neutrality of the study's findings or decisions. In this study reliability and validity was ensured by means of establishing trustworthiness. In order for the researcher to ensure data quality and for the findings to reflect the truth, the findings needed to be accurate, unbiased and to represent the experiences of the target group.

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Mouton & Devos (2001) describe Lincoln and Guba's model which identifies four strategies of ensuring trustworthiness which are, truth value or credibility, transferability or applicability, consistency or dependability and neutrality or conformability.

Truth value or credibility

Credibility or truth value establishes how confident the researcher was with the truth of the findings based on the research design, informance and contexts. For a study to be credible it must enhance the believability of the findings, taking step to demonstrate credibility to external leader. Credibility is achieved to the extent that the research methods employed engender confidence in truth of the data and in the researcher's interpretations of the data Judd et al. 1991).

Prolonged engagement and persistent observation:

Through prolonged engagement and persistent observation the researcher was able to ensure credibility of data. The researcher invested sufficient time in data collection activities to have an in-depth understanding of culture, language and views of the group under study and to test for misinformation. Through engagement the researcher can also build trust and rapport with informants, which enables the researcher to obtain useful, accurate and rich information (Judd et al. 1991)

Transferability or applicability

According to Judd et al. (1991) transferability or applicability refers to the degree or extent to which the findings from the data can be applied to other contexts and settings. In order to ensure transferability the researcher applied the thick description strategy, where she collected sufficient detailed description of data in contexts and report them with sufficient detail and precision to allow judgement about transferability to be made by the reader.

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Dependability

Dependability refers to the stability of data over time and conditions (Babbie, 2008). In order to ensure dependability the researcher might provide evidence if the study is repeated with the same or similar respondents, in the same or similar contexts its findings might be similar.

Conformability

Judd et al. (1991) stated that conformability refers to objectivity or neutrality of data, i.e. the potential of agreement between two or more independent people about the accuracy, relevance or meaning of data. In order to ensure conformability the researcher went to the hospital management to find out if they are aware of the aspects raised by the respondents.

3.6 PLANS FOR DATA COLLECTION

In this study the researcher used unstructured interviews, which is described by Strydom et al. (2005) as an interest in understanding the experience of other people and the meaning they make of that experience. This allows the researcher and the participants to explore the issue and determine individuals' perceptions, opinions, facts and their reactions. An unstructured face-to-face interview was used to ask questions from each responded, one at a time. The interview took the form of in-depth unstructured interview. Each responded was interviewed for between 45 minutes to an hour using the interview guide.

The method was used because it attains high response rate, it yields less missing answers and gave the researcher a chance to make important observations, probe and make follow up questions aside from responses given to the questions asked. Notes were also taken just after the interview which helped the researcher remember and explore the process of interview. A tape recorder was also used to record the interview after the participants had given their permission as it allowed a much fuller record than notes taken during the interview.

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3.7 DATA ANALYSIS

Data analysis was conducted on interview transcripts based upon a six-phase thematic analysis approach as Cited in Phiri (2012). Themes identified using this approach formed the Evidence- base from which the conclusions in this study were drawn. A summary of the data analysis approach as undertaken is provided in Table 1.

Table 1: Summary of the six-phase thematic analysis process to be undertaken

Phase	Description of the process
1. Familiarize with data	Raw data transcribed, transcripts read and re-read
2. Generate initial codes	Segments were coded for as many features as necessary. Once all data was coded, data was collated by code. Final transcripts read and all segments of data were systematically coded for features
3. Search for themes	Lists of codes were produced and related codes were gathered into potential themes. All data relevant to each theme were then collated
4. Review themes	Data relating to each potential theme were considered in relation to other themes. The validity of themes was considered in relation to entire data set.
5. Define and name themes	A detailed analysis was conducted on each theme by organizing data into a coherent account, with narrative. Constructs were given to each theme for the written account.
6. Produce the report	The final analysis of themes were conducted and presented in the report

Source: Ross-Jones and Longhurst (2010) cited in Phiri (2012)

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3.8ETHICAL CONSIDERATIONS

The research proposal was presented to the Higher Degrees Committee of the School of Health Sciences, University of Venda and to the University Higher Degree Committee for quality control. It was also reviewed by the University Health, Safety and Research Ethics Committee. Permission was also asked from the Provincial Department of Health, Polokwane.

CONFIDENTLY AND ANONYMITY

The information obtained by the researcher remained confidential at all times. Only the researcher had access to the responds given by the respondents. Anonymity states that a participant's data should not be associated immediately and obviously with his or her name or any other identity (Bless et al., 2006). Participants' name did not appear on any of the documents used and the data recorded was not identified by the participants' name or identity. The data was kept confidential all the time and was discarded immediately on completion of the study.

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INFORMED CONSENT

Judd et al. (1991) and Babbie, (2008), argue that whatever the case when subjects are involved without their consent, right to self- determination is impaired. Consent forms were given to each respondent to be completed. The participants were informed that their participation is voluntary and should participants feel unable to continue with the study, they were be free to withdraw. The respondents each signed a consent form as a way of accepting responsibility to participate in the study.

NO HARM TO PARTICIPANTS

Social research should never injure the people being studied, regardless of whether they volunteered for the study or not (Babbie & Mouton, 2001). The researcher looked at possible dangers that the participants might encounter and guarded against them.

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3.9 SCOPE AND LIMITATION OF THE STUDY

The limitation to this study was that because the research was being conducted for degree purposes there was not enough time to cover a wide scope and it was not big. The study only contained a certain scope. Another limitation was the fact that only a few participants were used and was only based on Tshilidzini hospital only, and therefore the researcher might have been biased towards the issues she was seeking to study. Only one instrument was used and this instrument might have had faults.

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4.1 INTRODUCTION

The following chapter presents the results of the study. In this chapter, the results of the study were presented in line with the specific objectives of the study as follows:

- Demographic profile
- Main theme 1: Patients' access to hospital resources
- Main theme 2: Patients' relationship with health care providers
- Main theme 3: The rights of patients as clients in the hospital
- Main theme 4: Patients' view of medical treatment received at the hospital
- Main theme 5: Patients' recommendations of the changes that can be made at the hospital

The main themes were also divided into sub- themes

4.2 DEMOGRAPHIC PROFILE

As shown in table 2. The findings of the study revealed that of the 16 participants, most were above 55 years of age. The ages of the participants ranged from 18 to 65 years. All the participants in the study were Venda speaking people. Most of the participants were staying in rural areas, though there were two staying in a township

In this study there was equal number of male and female participants and most of the participants had not reached the educational level of grade 12, whereas 2 were still attending school. In the study most of the participants were unemployed, whereas 2 are receiving old age grant.

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Table 2. Demographic characteristics of the participants

	N= 18
Age distribution in years	
18-35	2
35-45	4
45-55	3
55-65	7
Gender distribution	
Females	8
Males	8
Educational status	
Tertiary	Non
Secondary level	10
Primary level	6
Employment status	
Employed	3
Unemployed	7
Self employed	1
Pensioners	5
Permanent residence	
Rural area	14
Township	2

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4.3 THE FACTORS THAT AFFECT PATIENTS' PERCEPTIONS ABOUT QUALITY OF HEALTH CARE IN THE HOSPITAL

In this study, the participants mentioned several issues regarding their perceptions of the quality of health care at the hospital. Under the subject of *the factors that affect patients' perceptions about quality of health care in the hospital* there were the following themes and sub- themes as listed in table 3.

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Table 3. FACTORS THAT AFFECT PATIENTS' PERCEPTIONS ABOUT QUALITY OF HEALTH CARE IN THE HOSPITAL

Main theme:	Sub- themes emerged:
Patients' access to hospital resources	• Means of transportation
	• Distance from home to hospital
	• Accessing hospital facilities
	• Expenditure on transport and medication
Patients' relationship with health care providers	• Patients' relationship with hospital staff
The rights of patients as clients in the hospital	• Patient's understanding of their rights
Patient's view of the medical treatment received at the hospital	• Negative view about treatment
	• Positive view about treatment
Patient's recommendations of the changes that can be made at the hospital	• Shortages of staff at the hospital
	• Provision of Physical staff for weak patients
	• Free access to medical care

4.3.1 MAIN THEME1: ACCESS TO HOSPITAL RESOURCE

Sub- theme 1: Means of transportation to hospital

The results of the study demonstrated that most of the participants had used their own transport to get from home to hospital, which were mostly either hired cars or relative's cars. One of the participants said:

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"I would rather take my chances in a car than rely on an ambulance. At least in a private car I have a chance of getting to hospital on time, with an ambulance you can call it and it comes hours later or sometimes it does not even bother to come. One can die waiting for an ambulance, those people don't care that you are in pain.

"When you call an ambulance to come and pick you up, you will sometimes be told that there are no available ambulances to come and pick you up and that when one is available it will come and pick you up. They don't even care how sick you are. These people do not care about the sick".

Further findings in the study revealed that most of the patients had no faith in the ambulances. They also indicated that even if they are being referred from the clinic by the nurses they do not receive any information or reassurance from the nurses about whether the ambulance is coming or not. One of the participants said:

"Even if the nurses at the clinic you are being transferred from are the once who called the ambulance, even they will tell you they don't know when the ambulance will arrive when you ask, and they say it in a rude way".

"Ambulances don't come when we call them or if they come they come after a long time. I once went to the clinic when I was giving birth. I was told I would have to be transferred to the hospital. When they call an ambulance it took hours to come and I was in pain".

In the study, findings indicated that some patients used public transportation no matter how sick they were. They could not afford the money to hire a private car and had no cars of their own. Those that needed to be carried by ambulances to hospital said that they could not wait for the ambulance since it is unreliable. One of the participants said that:

"I stay too far from the hospital and have to go for check-ups at the hospital every month but it's very expensive and I sometimes do not have money to pay for the taxi, I have to borrow from neighbours, it's hard but what I can do, I need my medication.

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Even in days where I feel too sick to use public transport I have to because I do not own a car and cannot afford to hire one".

Another one said: *"When I came to the hospital I was very sick and could hardly walk. I was forced to use a taxi because I could not afford to hire a car. My wife had to help me walk to the bus stop which is very far from my home".*

"When I came to the hospital, I was carried by a wheelbarrow to the bus stop. I could not walk because I was very sick".

"Taxi drivers are very rude and impatient if you are being slow. They will tell you to make it fast even though they can see that you are sick and struggling, and when you get to the hospital, they will just drop you at the gate not assisting you. They are always in a hurry", said another patient.

Another participant said, "If *you are sick and want to die, wait for an ambulance. It's a waste of time to call an ambulance. I would rather take my chances in a taxi".*

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Sub- theme 2: Distance from home to hospital

The results of the study demonstrated that some of the patients did not have trouble getting to the hospital since they stay in nearby villages. Though getting to the hospital on time is not a problem, it was also indicated that the service at the hospital is slow and this often leads to patients being assisted late even though they got to hospital on time. One of the in-patients said

"I do not stay far from the hospital so it is not difficult for me to get to the hospital. This makes it very easy for me in my condition".

Another participant said*: "I do not have a problem with getting to the hospital because I stay close by where I can even walk to the hospital. The problem is that even if I can get to the hospital on time, the hospital staffs are very slow and you will only be helped hours after arriving".*

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In the study, the patients indicated that they stay very far from the hospital. They indicated that hospital M was the closest to their villages and there was no other hospital close by. These patients further indicated that sometimes people stay at home even though they have received transfer letters to hospital from the clinic because the hospitals are too far and transportation is expensive.

"I stay very far from the hospital and when I called the ambulance it took three hours to come, I would have hired a car if I had money but I did not have money, I am unemployed".

Another undisclosed patient said: *"I stay very far from the hospital and hired a car to bring me to the hospital since I could not walk and was in too much pain and knew that the ambulance would probably take too long to get to come fetch me, this ambulances are not reliable, a person can die waiting for them. Hiring a car is very expensive but what could I do, I had to borrow R300 because that is how much the owner of the car said it would cost me to come to Hospital M".*

"I once went to the clinic and received a transfer letter to the hospital. Because I'm not working and the only source of income in our family is my two children's child support grant, I did not go because I could not afford it. A neighbour of mine gave me her pain medication because the pain was getting too much".

Sub-theme 3: Accessing hospital facilities

Findings in the study indicated that though most of the patients did not have trouble accessing the hospital resources in terms of transport, they did have challenges when they had to take their hospital files. They indicated that the lines are always too long and sometimes files get lost. Those who stay too far said that no matter how early they tried to wake up to go to the hospital, they always find the line already too long because they have to use buses since buses are much cheaper than taxis. An undisclosed participant said:

"This people who give files will tell you they cannot find your file. I don't know that if they are saying they cannot find my file, who should. I do not work at the hospital".

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"I stay very far away from the hospital, but I always try to get here in time so that I can get my file in time. No matter how early I get here the lines are always too long, and these people are very slow".

"What is the use of getting to the hospital early, those people start working late"?

The findings in the study further revealed that patients who come to the hospital and were unable to walk had to find wheel chairs themselves. They indicated that it's really hard if there is no one accompanying them. It was also indicated that it is often hard especially for elderly patients travelling alone to know where all the facilities are, such as where they should go for x-rays or eye tests. One participant said:

"Can you imagine if you are in pain and the taxis drop you off at the gate, it's very far from where we fetch files and if you have no one to fetch a wheelchair for u its hard".

"As you can see I am old, but sometimes the nurses just tell us to go for x-ray. No one even bothers to accompany you. For someone like me who stays alone at home it is hard because I have no one to accompany me to hospital".

The findings also revealed that most patients who were admitted in the hospital did not receive assistance from the nurses. It was indicated they were often ignored if they asked for assistance from the nurses or answered in a rude way. One of the participants who was admitted at the hospital said

"It's hard in here if you are unable to get to the toilet by yourself, if you mess on yourself this nurses will shout at you like you are a child".

Another one said: *"I was once very thirsty and called a nurse to ask for water, when the nurse came after a long time, she just passed me by and went to another patient, and sometimes people do not die from diseases here but from bad treatment".*

Further findings in the study indicated that patients do visit the hospital and leave without being seen by a doctor. These patients further indicated that at times they are

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booked to see a specialist e.g. an eye doctor but are given a date that is very far away. A participant said:

"I have a problem with my eyes. When I went to the hospital I was told that I would have to go and be treated at another hospital for my eyes. The date I was given was very far and I was in a lot of pain".

Sub- theme 4: Expenditure on transportation and medication

The results of the study indicated that most of the participants struggle with money for medicine and transport regardless of whether they stay near the hospital or far, especially those who have to visit the hospital regularly for check-ups. One of the participants said:

"I was told that I must pay my hospital bill, that no one is allowed to owe the government when I tried to explain that I did not have money to pay, I am not employed and even had trouble to pay the car I hired to come to the hospital, I don't know where I will get the money to settle the hospital bill when I get discharged, I don't want to face that woman of finance again, she is very rude".

Another one said, *"I was shouted at in front of people and told that I should not have come to the hospital if I did not have money to settle my hospital bill. It was very embarrassing. Those people do not care about patients at all".*

Whereas another patient said, *"The way in which they shout at us if we cannot pay our bills, I ask myself if the money we pay goes to them or the hospital. This is a government hospital, no one owns it but some of those people treat us like it's their hospital.*

The study further indicated that, patients that are pensioners do not pay for medication at the hospital. They are given free access to medical care. This is said to be of great assistance to the elderly whose old age grant is said to also cover for household expenses where they stay. As said by one of the undisclosed elderly participants:

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"I don't pay for medication at the hospital because I'm a pensioner. If I had to pay for medication, things would have been very difficult for me and my family".

4.3.2 MAIN THEME 2: PATIENTS' RELATIONSHIP WITH HEALTH CARE PROVIDERS

Sub-theme 1: Patients' relationship with hospital staff

The results indicated that most of the patients do not have a good relationship with the nurses. They said that most doctors treat them well and talk nicely to them. They said that if they have questions, doctors are willing to answer them but nurses are always rude when they answer or ignore them. One of the participants said that

"I have never been treated badly by a nurse but I once saw an elderly man being shouted at like a child that really broke my heart".

Another participant said, "*Doctors are very kind to us. They always give us time to ask them questions, and if there is something you don't understand they explain it to us.*

One participant said, *"All the hospital staff are rude, even the administration staff, it's like they were given birth by the same mother the way they all have bad attitudes".*

"Since I was admitted the nurses have been treating me very well. I have a very good relationship with them".

Whereas another participant said, *"The nurses will treat you well, as long as you do not talk too much and ask too many questions. If your relatives complain about the way you are being treated when they come to visit, then these nurses will start treating you bad, it's better to keep quite even if you are unhappy about the treatment".*

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4.3.3 MAIN THEME 3: THE RIGHTS OF PATIENTS AS CLIENTS IN THE HOSPITAL

Sub- theme 1: Patients' understanding of their rights

There was a wide variation amongst the patients regarding their understanding of their rights. Some of the patients knew about the rights since the nurses explained the rights to them when they were admitted. These patients felt that it was always advisable for one not to exercise their rights because they would be victimised if they did. One of the undisclosed participants said:

"I know my rights but if I tried to exercise those nurses will start treating me very badly. They don't like a person who thinks they know too much."

One participant who was admitted said *"If a person tries to make themselves as if they know too much, this nurses will treat you very bad, they don't like people who talk too much and thinks they know better".*

Further findings in this study indicated that some patients were not given information about their rights upon admission. Though it might be argued that the rights information sheets are displayed next to every hospital bed, further inspection indicated that some of the information sheets have either fallen or were removed from display since they are no longer there. What should also be taken into consideration is that some of the patients are either illiterate or might be too sick to take in their surroundings and notice things such as information sheets. One patient said:

"I have no idea what this rights are and they were never explained to me".

Another participant said: *"I cannot read. I left school at a very young age to go and look after my father's cattle, so all I see are papers, what is written in them I don't know".*

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4.3.4 MAIN THEME 4: PATIENT'S VIEWS OF THE MEDICAL TREATMENT RECEIVED AT THE HOSPITAL

Sub- theme 1: Negative views about treatment

The results in this study indicated that some of the patients felt that the medication they are given is ineffective and it is better to go to a private doctor if one wants to get better. Patients viewed the medication as ineffective because they felt that they are often not given the right medication for their illnesses, Shortage of medication was also viewed as one of the contributing factors in the ineffectiveness of treatment. One participant said that

"I am just thankful to be alive even if I have to pills every month. These pills do not heal a person completely; they just make the pain better for a little while".

Another said: *"This people sometimes just give you panado and not the pills for your disease, how can I get healed by panado. In fact one would even be lucky to get that panado because sometimes you will be told there is no medication. What kind of hospital stays without medication and expects its patients to get better. This government does not care for the people who vote for it".*

"These hospitals don't have medication, I don't know what kind of hospitals they are or how they expect us to get better if they do not have medication".

"Going to hospital sometimes is a waste of time because you can be told that there is no doctor, or you wait in the queue the whole day buy the doctor comes very late".

"One can think that these nurses where given birth by the same mother, they are all very rude".

Sub- theme 2: Positive views about treatment

Findings in the study also indicated that, there are also patients who found the medication to be effective and helpful. These patients indicated that they saw a

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difference between the ways they were when they came and how they were at the time the data was collected. One patient said:

"The medication is really working for me. If you had seen the way I was when I came to the hospital and now, you would notice a huge difference. One just needs to listen to the nurses and do what you are told, as well as always taking your medication. I'm so much better they are even discharging me today".

"A person must just take their medication the right way and work well with these nurses. Not all of them are rude. Others are very friendly and helpful".

"These hospitals are helping a lot, especially to people like me who cannot afford to go to a private doctor. Their medications have assisted me a lot".

4.3.5 MAIN THEME 5: PATIENT'S VIEWS OF HOW THE SERVICES THEY RECEIVE AT THE HOSPITAL CAN BE IMPROVED

Sub- theme 1: Shortages of staff at the hospital

Findings in the study indicated that, the hiring of more hospital nurses and doctors was viewed to be of top priority amongst the patients since there seemed to be a shortage of staff. Participants indicated that they arrive at the hospital early but only get to see a doctor late. Participants felt that it becomes a waste of time for them to come to the hospital if they are not going to be examined by a doctor or if the doctor will only examine them for a short time. Further findings indicated that doctors go for lunch leaving patients waiting in queues and this is said to inconvenience those patients using public transportation and sometimes making them go home without receiving treatment. One participant said:

"This place does not have enough nurses and doctors. I come early in the morning to see a doctor and will only be examined late in the afternoon. Even when I go in to see the doctor, he will only see me for two minutes. The government needs to hire more staff so that we do not waste our time coming to the hospital and not be examined".

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Another participant said, *"One can sit the whole day waiting to see the doctor and when you are close by in the queue the doctor tells you he is going for lunch. It's hard when you are using public transports because they get finished. I remember once where I even went home without receiving treatment after waiting the whole day because it was getting late".*

Sub- theme 2: Provision of Physical staff for weak patients

Other findings in the study revealed that it is hard for patients using public transportation and being dropped off at the hospital gate because sometimes they are in too much pain that they cannot walk. It was recommended by the participants that the hospital should have staff waiting at the gate to assist those using taxis and cannot walk.

One participant said: *"It is very hard if you are using public transport that will drop you off the gate and you are in pain. It would really help if there were hospital staff at the gate to assist us".*

"Hospitals should have people who assist the elderly. Some of eyes are very old as you can see. Even the eyes no longer see properly. We get lost a lot and even at the queues these younger ones pass us even if we came first".

Sub- theme 3: Free access to medical care

Findings in the study also indicated that some of the participants did not understand why other patients should pay for medical services while others did not pay whereas they are all from poor backgrounds and it's a government. Participants recommended that all patients should not pay for medical care since it was a government hospital and people who seek medical advice there were those from disadvantaged backgrounds. One of the participants said:

"Why should there be people who pay and those who do not pay when it's a government hospital. We should all not pay because we are all poor. I am not

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working now because of illnesses, where to they expect me to get the money to pay them", said another participant.

"Hospitals are supposed to be free because they belong to the government. What do they want to do with the money we pay, they want to put it in their pockets. These people care more about money than people's health. They should make health care free".

"How can they make us pay for treatment when the pills are always unavailable? We must get free treatment".

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CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter is divided into three sections as follows:

5.2 DISCUSSION

The demographic profile (Table 2) shows that most of the participants in the study were above the age of 55 years. All were Venda speaking and most staying in rural areas. There were an equal number of males and females and most participants had not reached the educational level of grade 12. Most participants were unemployed, whereas two were receiving old age grant.

In the study, transportation to hospital remains a challenge due to the cost and distance travelled to get to hospital, especially for the participants from disadvantaged background. This is supported be Nera et al (2012), by saying that, public transports services are reported to be inadequate and cabs too expensive. The difficulty in physically accessing health services was also raised by health care providers. According to The White Paper (1995), patients usually travel long distances from their various homes to get access to health care services. Though the South African medical care is free at public hospitals and clinics, patients usually have to spend a lot of money on transport. This is further supported by Gilmore et al. (2005).who says that, patients usually travel long distances from their various homes to get access to health care services. Though medical care is free at public hospitals and clinics, patients usually have to spend a lot of money on transport. Residents of rural areas face barriers in accessing health care services. Patients often have to travel long distances to seek care, made more difficult by a lack of reliable transportation. These factors contribute to their tendency to delay seeking care, which aggravates health problems and leads to more expensive interventions upon receiving care.

In the study access to hospital facilities, starting from taking a file, seeing a medical practitioner, getting medication and paying the hospital bill is a challenge. This is no exception for patients who have been admitted in the hospital. For them accessing basic services such as getting a glass of water or going to the toilet is a challenge. Seventy-two

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million Americans live in rural areas and depend upon the hospital serving their community as an important, and often only, source of care. The nation's nearly 2,000 rural community hospitals frequently serve as an anchor for their region's health-related services, providing the structural and financial backbone for physician practice groups, health clinics and post-acute and long-term care services. Rural hospitals provide their patients with the highest quality of care while simultaneously tackling challenges due to their often remote geographic location, small size, limited workforce, and constrained financial resources (The Patient Protection and Affordable Care Act of 2010). The poor supply of medicines limited access to services with patients having to travel long distances from one facility to another looking for drugs (Seitio-Kgokgwe1et al. 2014). According to Seitio-Kgokgwe1 et al. (2014), hospitals do not have resources and there is shortage of medical doctors. It is possible to be booked to see doctors after three months, when a patient comes they are told he/she is not available because he is alone. You find one doctor helping so many patients, or you are told he/she is still out to help other patients while your own illness progresses and finally you give up and go home without assistance. Perceived waiting time is a strong predictor of patient satisfaction. If waiting time is longer than what is expected or considered inappropriate, dissatisfaction will arise no matter how long the actual waiting time. Hana and Martin (2005) in Quality of Primary health Care in Saudi Arabia further say that, a huge quantity of supplied medicine and equipment is left unutilized and unconsumed due to poor management. Very often, it is alleged that doctors encourage the patients to purchase medicine from outside because of unawareness of the medical officer about availability and quantum of medicine stock in the store (Acker, 1998). Moreover, physicians are getting bribe from the private medicine suppliers. Lack of transparency in management creates the scope for the employees of the hospitals to sell drugs of hospital stores to outside pharmacies. Many pharmaceutical/drug shops admit of buying medicine from the hospital staff at cheaper rate. Many private clinics admit of procuring expensive equipment and supplies from the public sector supply system (Shaikh and Juanita, 2004). In the public sector, 'not having to pay' informs the choice of people using primary care, some as outpatients, and others as inpatients. Of household members who delay seeking care, most are the poorest unlike the richest and this is due to unaffordable transport costs. Transport costs are similarly a problem for people living in Eastern Cape and Limpopo. Unaffordable transport also obstructs immediate care for most people. Inability to leave work also prevents immediate care-seeking. For those who seek outpatient care, transport costs are catastrophic for the poorest, which also delays access to health care. Financially catastrophic transport costs occurred to those living in rural areas,

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and the unemployed. This often affects more black Africans than other groups, and only few whites. Access to health services depends on the availability of service (i.e. the availability of physicians, health centres, and hospitals) to the actual as well as potential users (The Patient Protection and Affordable Care Act of 2010). Major portion of population in the target area is poor and they are dependent on public hospitals. While getting treatment in public hospitals, people have to face a number of problems that are utmost necessary to be identified, inquired, analysed and presented for solution. In a majority of cases at public hospital there is delay response in case of emergency as there is high ratio of absenteeism among the hospital staff; including doctors, sweepers, nurses, etc. which constitute in a manner i.e. (5%;95%) to lower and greater extent accordingly and increases health hazards at public hospital. A shaking fact was found that Sweepers, medical technicians, nurses and even physicians have been reported to be absent for months, there is lack of availability of doctors and medical staff in case of emergency (Naz, 2012). According to The National Department of Health (2007), many quality problems in health care have been identified, in both the public and the private sectors. These include:

- Under-use and overuse of services;
- Avoidable errors;
- Variation in services;
- Lack of resources;
- Inadequate diagnosis and treatment;
- Inefficient use of resources;
- Poor information;
- An inadequate referral system;
- Disregard for human dignity;
- Drug shortages;
- Records not well kept; and
- Poor delivery systems.

These shortcomings endanger the health and lives of all patients, add costs to the health care system, and reduce productivity. On the 24th of May 1994, President Nelson Mandela announced in his State of the Nation address that all health care for pregnant women and children under the age of 6 years would be provided free to users of public health facilities. The free care policy at primary care level was extended to all users from 1 April 2006. A national survey of health inequalities conducted in June 1994 found that 12.5% of people

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reported that they had delayed seeking health care. Of these, two thirds (64.3%) – and three quarters (73.8%) of Africans – cited the cost of health care as the main reason for delay. By 1999, 86% of people using public PHC facilities reported that there was no health care fee – although half still incurred travel costs (Harrison D., 2009). The majority of the population of South Africa has inadequate access to basic services including health, clean water and basic sanitation. Statistics for 1994 suggest that between 35% and 55% of the population live in poverty. Fifty three percent of the populations live in rural areas the vast majority of whom are poor (seventy-five per cent of the poor live in rural areas) (Department of Health, 1997). Impoverished circumstances have a huge impact on patients' not only in their ability to access appropriate health care services but also in them getting nutritious food (Nera et al, 2012). According to Offei et al (2004) everyone should have access to quality health care. Access refers to the ability of the individual to obtain health services. Some of the factors that can affect access are:

- Distance: e.g. where health facility is sited far away or it is difficult to get transport to the facility access to quality health care becomes a problem.
- Financial: e.g. where people cannot pay for the services provided.

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In the study, findings further revealed that patients and health care providers often have a negative relationship, which was attributed to the fact that patients felt maltreated and not being given the necessary respect by health care providers. Hana and Martin (2005) on Quality of Primary health Care in Saudi Arabia agrees with this saying that health care providers are often seen as being rude and lacking in compassion by patients. This kind of negative treatment often makes patients to be unable to express their feelings for fear of being shouted at and been seen as someone who talks too much and this in turn affects the treatment received which becomes ineffective. Awino (2007) in patient perception of quality of care and service delivery emphasised the importance of a good relationship between a patient and health care provider by saying that, health care providers can influence patients to make healthier lifestyle choices, such as stopping smoking, increasing physical activity, making healthy dietary modifications, and complying with cancer screening recommendations. Capitalizing on this influential relationship depends, in part, on whether or not these two groups can effectively communicate with one another. Effective communication between patients and providers helps to optimize counselling interactions and

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has a significant influence on patient behaviours and health outcomes. Hana and Martin (2005) in Quality of Primary health Care in Saudi Arabia supports this indicating that, a patient must have confidence in the competence of their physician and must feel that they can confide in him or her. Hana and Martin (2005) in Quality of Primary health Care in Saudi Arabia further says that for most physicians, the establishment of good rapport with a patient is important. Some medical specialties, such as psychiatry and family medicine, emphasize the physician-patient relationship more than others, such as pathology or radiology. The quality of the patient-physician relationship is important to both parties. The better the relationship in terms of mutual respect, knowledge, trust, shared values and perspectives about disease and life, and time available, the better will be the amount and quality of information about the patient's disease transferred in both directions, enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Where such a relationship is poor the physician's ability to make a full assessment is compromised and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice. In these circumstances and also in cases where there is genuine divergence of medical opinions, a second opinion from another physician may be sought or the patient may choose to go to another physician (Hana and Martin, 2005 in Quality of Primary health Care in Saudi Arabia). The Patient Protection and Affordable Care Act of 2010, further says that, the quality of the patient-physician relationship is important to both parties. The better the relationship in terms of mutual respect, knowledge, trust, shared values and perspectives about disease and life, and time available, the better will be the amount and quality of information about the patient's disease transferred in both directions, enhancing accuracy of diagnosis and increasing the patient's knowledge about the disease. Anderleer (2001) says that where such a relationship is poor the physician's ability to make a full assessment is compromised and the patient is more likely to distrust the diagnosis and proposed treatment, causing decreased compliance to actually follow the medical advice. Desire for respectful treatment influences the health-seeking behaviour of almost a quarter attending private-outpatient services. For inpatients, anticipation of respectful treatment is twofold as important for private than public patients. Around four-fifths of main patients who used public-inpatient services in the past year reported being treated disrespectfully by health providers. Over half of patients feel that patients at public hospitals are ‘rarely treated with respect and dignity” (Anderleer, 2001).

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In the study most patients are still not fully aware of their rights as clients in the hospital. Department of Health (1997) says that most of the patients are from rural areas and therefore often illiterate. For these patients, unless they are told about their rights upon arrival in hospital, they remain unaware and there will never exercise those rights. Patients being unaware of their rights will mean they remain helpless and not know what to do or where to go when they experience unfair treatment from hospital staff. Even those who are aware of those rights through reading or being told about them feel unable to exercise them for fear of being victimised by health care providers. Educating patients about their rights upon their arrival in hospital or educating them is often neglected by health care providers and for those patients that are illiterate or too sick to consider notices on display, they remain unaware of their rights. The Department of Health (2003) reflects on this by saying that, patients should be treated courteously with dignity and respect. Before consenting to specific care choices they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to; coverage for qualified second options; timely referral and access to needed speciality care and other services, confidentiality of the medical records and communications with providers; and respect for their legal advanced directives or living wills. The Patients' Rights Charter lists the responsibilities of both providers and patients which further emphasizes the importance of patients' knowledge of their rights. According to this policy every patient has the right to:

- A healthy and safe environment.
- Access to health care.
- Confidentiality and privacy.
- Informed consent.
- Referral for second opinion.
- Exercise choice in health care.
- Continuity of health care.
- Participate in decision-making that affects his/her health.
- Be treated by a named health care provider.
- Refuse treatment.
- Knowledge of their health insurance / medical aid scheme policies.
- Complain about the health service they receive Department of Health (2002).

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In the study participants' views were influenced by the kind of treatment they received at the hospital. Some of the negative views given in the study were lack medication, shortages of staff, long queues and lack of respect by staff members. According to Friedman, (1993) nurses as the providers of health care can also have an influence on the way patients view the treatment they receive. If a health care provider is rude and lacking in compassion, chances are high that the treatment received will be seen as ineffective by the patient whether medication is available or not. Tateke et al, (2012) also says that, patients have explicit desires or requests for services when they visit hospital. However, many cases of patient dissatisfaction can occur due to inadequate discovery of their needs. A satisfied patient is more likely to comply with advice, and it is the patient's judgment on the care that has been provided, Moreover, there is growing consensus that assessment of the quality of hospital services should be based in part, on patients' perceptions of overall care and patient satisfaction. Satisfaction is also influenced by the manner with which health care is delivered. Merkouris et al, (2013) says that, participation in care is another parameter that is closely related to the provision of information. Indeed, patients expressed low satisfaction with the opportunities given to them for their participation in care. Nurses should be made more sensitive and aware of the importance of patients' information and autonomy as well as their rights in general. The time that nurses devote to their patients is another area where the latter showed their dissatisfaction. This, however, can be attributed to the work load that nurses have to deal with daily. On the other hand, the following question could arise: is just the lack of personnel the reason why nurses do not get closer to their patients? Deogonka (2004) agrees that, shortage of medication is still a challenge for most hospitals which lead to patients receiving medication which is inappropriate. The victims of poor medical care are those who have to rely on government hospitals, which are overcrowded, short staffed and have meagre funds to provide for medicines and health supplies. Moreover, syringes and surgical equipment are repeatedly used on different patients without adequate sterilization allowing further spread of deadly viral infections among unsuspecting patients. Worse still, medical waste is not disposed of properly and used medical equipment is scavenged outside hospitals only to be sold. Another issue that can affect patients' perceptions include shortage of health care practitioners. In March 2012, 165317 qualified health practitioners in both public and private sectors registered with the Health Professions Council for South Africa (HPCSA), the health practitioner watchdog body. This included 38236 doctors and 5560 dentists. The doctor-to-population ratio is estimated to be 0, 77

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per 1000. But because the vast majority of GPs- 73% work in the private sector, there is just one practicing doctor for every 4219 people (Department of Health, 2008). Gilmore et al. (2005) says that users of public health care services were more dissatisfied with day hospitals, government clinics and government hospitals. In a community survey in rural South Africa a low accessibility of primary health care: 78% felt that the medical services are poor. These were a significant relationship between not being member of a medical scheme, poor health status and availability of health care services. Medicines being out of stock in clinics, no water and bad attitudes of health care staff are also said to be some of the problems with the health care system in South Africa (Mashego and Peltzer, 2005). Long queue which is perceived as a sign of ineffective care, and anticipated disrespectful treatment, partly account for delayed care-seeking. Most commonly, delays are due to a belief that the illness is not serious enough to warrant immediate care. According to National Department of Health (2007) the active participation of patients in their care can improve the effectiveness of care as well as their satisfaction with their care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans. The patients' feelings are what matters even if the staffs' perception is different, since patient satisfaction evaluation is connected with their behaviour and can be used to improve nursing services (Merkouris et al 2013). Offei et al, (2004) indicates that, patients want services that: are delivered on time by friendly and respectful staff; are safe, produce positive result and that they can afford; provide them with adequate information about their condition and treatment; provide them with all the drugs they need; give privacy and are within their reach (distance) and given in a language they can understand. Patients' satisfaction plays an increasingly important role in the quality of care and health care delivery generally. Measuring patients' satisfaction has become an integral part of hospital/ clinic management strategies across the globe. Moreover, the quality assurance and accreditation process in most countries require that the satisfaction of patients be measured on a regular basis. Care for patients is the fundamental aim of health services. Although consumers in South Africa are increasingly aware of their rights, they often have no formal mechanism to have their voice heard (Department of Health, 2008). Waiting time is also still a huge challenge especially in public hospitals. Patients are often expected to wait for too long in the queue before they are attended to be a doctor. A patient who has had to wait for too long in the queue will have a negative view of the treatment they receive by the time they are attended to. It is not in all cases where medical

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treatment is viewed negatively or where patients are dissatisfied with the medical treatment received in hospital. There are instances where patients go to hospital and receive treatment that they feel is effective.

The study found that patients as clients in the hospital and the ones accessing medical care are in the best position to advice and give recommendations on how they think the services they receive in hospital can be improved. Merkouris et al. (2003) supports patients giving recommendations about health care by saying that, the patients' feelings are what matters even if the staff's perception is different, since patient satisfaction evaluation is connected with their behaviour and can be used to improve nursing services. Patients and the general public often complain about the poor quality of care in our health facilities. We often hear on the radio, television and even in the community about the poor quality of care that patients have received. Patients experience this poor quality in health facilities when they are sick complain about the poor quality of care in our health facilities. We often hear on the radio, television and even in the community about the poor quality of care that patients have received. Patients experience this poor quality in health facilities when they are sick.

In the study participants recommended that the hospital should hire more health care professionals. According to Meyer and Bishop, (2007) the shortage of health care professionals is a major issue facing the biggest licensed profession in the health care system. This shortage will affect health care more each day, as it appears not much is being done to avert it. Many emergency rooms have longer waiting times due to less nursing staff, and hospital floors are feeling the effect as well. This is affecting patient care because the number of patients to one nurse is increasing, therefore decreasing the quality of care. This shortage is being felt in hospitals, nursing homes and health care agencies (Meyer and Bishop, 2007). According to the Patient Protection and Affordable Care Act of 2010, the limited supply of health professionals in rural areas and difficulty recruiting professionals creates challenges for rural hospitals to secure and sustain adequate staffing. Health care professionals should put patients first by ensuring that health care services are accessible to patients at all times when the need arises. Patients should not be sent home without receiving medical care (White Paper, 1995).

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In the study Participants also felt that it will be of great assistance if the hospital can detail support staff at the hospital gate/entrance to help weak patients. This is supported by the White Paper, (1995) that states that health care scare professionals should put patients first by ensuring that health care services are accessible to patients at all times when the need arises. Offei et al, (2004) says that not all patients are in a position to can access hospital facilities on their own without assistance. This can be because of age or a patient being too sick to move around on their own. Patients using public transportation such as taxis face more of a challenge since taxis drop them off at the hospital entrance which is often a long distance to the hospitals main buildings.

The study also revealed that patients felt that access to medical treatment should be free for all patients regardless of age since most patients come from disadvantaged backgrounds and are unable to pay for medical treatment. Harrison, (2009) supports this stating that on the 24th of May 1994, President Nelson Mandela announced in his State of the Nation address that all health care for pregnant women and children under the age of 6 years would be provided free to users of public health facilities. The free care policy at primary care level was extended to all users from 1 April 2006. A national survey of health inequalities conducted in June 1994 found that 12.5% of people reported that they had delayed seeking health care. Of these, two thirds (64.3%) – and three quarters (73.8%) of Africans – cited the cost of health care as the main reason for delay. By 1999, 86% of people using public PHC facilities reported that there was no health care fee – although half still incurred travel costs.

In the study participants further recommended that the hospital should make sure that there is enough medication at all time. According to Seitio-Kgokgwe1et al. (2014), shortage and erratic supply of medicines was reported by hospitals across the country. This was mainly attributed to inefficient supply chain management systems. The poor supply of medicines limited access to services with patients having to travel long distances from one facility to another looking for drugs. In a study done by Mashego (2005) one of the respondents said, *"We are not satisfied with the outcome, we just tell ourselves that God will heal us because the drugs they ae giving us are just useless; they are not strong enough to cure patients. The nurses give us medication for other diseases, not for what we are really suffering from".*

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5.3 CONCLUSIONS

Based on the results of the study, the following conclusions were made:

- Access to transport from home to hospital is a challenge for most of the participants, especially since ambulances are viewed as unreliable and most of the participants do not own private transports.
- Accessing hospital facilities such as getting hospital files and having to wait in queues for a long time is a major problem, participants feel that they do not receive enough assistance from hospital staff.
- Cost of medical care is a problem since most patients accessing medical care in the hospital are from disadvantaged backgrounds and are unable to pay for the hospital bill as well as transportation.
- Relationships between participants and health care providers are of a negative nature since health care providers are seen as rude and lacking in compassion.
- Most participants are unaware of their rights as clients in the hospital and those who know them feel unable to exercise them for fear of being victimised
- Most participants view treatment as ineffective because of issues such as lack of medication in hospitals and a shortage of medical staff.
- Participants recommend that more staff should be hired and that there should be staff at the hospital entrance to assist those patients who are old or too sick.

5.4 RECOMMENDATIONS

Recommendations in this study are based on the conclusions of the study. The researcher proposes the following recommendations based on the study findings:

5.3.1 Recommendations to the Provincial department of health

- Ambulance services should be reliable and effective and the department should make sure that they are serviced regularly and always in good working condition. The department should also provide enough ambulances for each hospital to prevent shortages.

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- The Department of Health (DOH) should hire more doctors and nurses to increase patients' access to hospital services and to avoid nurses being overworked and in turn not delivering effective treatment.

- All patients' regardless of whether they are pensioners or not, should be able to obtain free medical care

- The DOH should organise workshops regularly for the hospital staff focusing on provider- patient relationship. The DOH should further make sure that there is an employee assistance practitioner at every hospital where the staff can go and discuss their issues whether personal or work related which will also improve their relationships with patients.

- The DOH should organize campaigns and road shows to educate patients about their rights so that the communities can be well informed even before they go to access services in hospitals.

- The DOH should conduct surveys on a regular basis in hospitals where they can gather information or on whether patients are satisfied with their services or not.

5.3.2 Recommendations to the hospitals' management

- The hospitals management should make sure that the ambulances in their hospitals are easily accessible to patients at all times and that they are being utilised for their purpose. The hospital management should on a regular basis go around the hospital wards to monitor how the staffs are interacting with the patients.
- Hospital management should make sure hospital facilities such as patients getting their medical files to seeing a health care practitioner are easily accessible to all patients and that waiting time is not too long.

- The hospital management should make sure that patients are not victimised because they are unable to pay their bills by

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- Interaction between patients and health care providers should constantly be monitored and all complaints by patients should be taken seriously.
- The hospital management should make sure that patients' rights are written in all official languages and displayed where they will be visible to every patient, Furthermore, they should make sure that this rights are always explained to patients.
- The hospital management should regularly engage with patients to hear how they view the treatment they are receiving at the hospital.

5.3.3 Recommendations to the nurses

- Nurses starting from those rendering services at PHC level should always assist in reporting irregularities in the way ambulances operate.
- Nurses should make patients stay in hospital as comfortable as possible, by making sure that patients are able to access all hospital resources with ease. They should assist in acting as guides for patients, by properly explaining to patients where they should go to access a service and where possible accompany the patient.
- Nurses should always practice the batho pele principles in order to improve the relationship with patients. They should always exercise patience since not all patients are literate or understand easily.
- Nurses should make is a priority at all times to explain patients' rights to every patient who enters the hospital and in a language that the patient will understand.
- Patients should always enquire how the patient is feeling, this will assist the nurse to determine whether the patient views the treatment they are receiving as effective or not and know where the patients' concerns lies.

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5.3.4 Recommendations to the hospital administrative staff

- The hospitals administrative staff should develop a better filing system that ensures that patients easily access their files.
- The administrative staff should always treat patients struggling with caution and respect as well as be empathetic towards them.
- The hospital administrative staff should make sure that no patient should be denied medical care or victimised because they are unable to pay for it. Hospital staff should always prioritise giving patients' medical care and not burden them with how much they owe.

5.3.5 Recommendations to the community

- Community leaders should also hold meetings with public transport associations to discuss how drivers should treat patients.
- Community leaders should hold meetings with community members to hear what challenges they are facing regarding accessing hospital facilities so that they can report it to hospital management.
- Community members should try and build a good relationship with hospital staff and listen to advice.
- Community members should always exercise their rights as clients in the hospital
- Community members should always voice their concerns to hospital management about the treatment they receive in hospitals or if they feel that the treatment they are receiving is ineffective.

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APPENDICES

APPENDIX A: RESEARCH INSTRUMENT

PROBING QUESTIONS

Section A: Access to hospital

1. How do you get to the hospital?
2. How long does it take you to get to the hospital from home?
3. How do you know where to access the different facilities in the hospital?
4. How much do you spend on transportation to and from the hospital and medication?

Section B: Relationship with health care providers

5. How would you describe your relationship with the hospital staff?
6. From the time you started taking medical treatment (medication) for your illness, how did you experience treatment both negative and positive from:
   - The administrative officers (clerks)
   - Auxiliary staff members
   - Nurses or Nursing staff
   - Medical doctors

Section C: Patients' perceived rights, views about care and recommendations

7. What is your understanding regarding your rights as a patient?
8. How do you view the medical treatment you are receiving at the hospital?
9. What changes/ recommendation do you have for hospital management for different aspects of your negative observation/experience?

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APPENDIX B: PARTICIPANT INFORMATION SHEET (THE PATIENTS)

Good day!

My name is Thelma Mugwena; and I am doing research for the purpose of obtaining a Masters in Public Health at the University of Venda. The focus of the study is on lived experiences of the patients at Tshilidzini hospital. Part of the research is to find out how patients regard the services they receive at Tshilidzini hospital and whether they are satisfied with this services. The reason for inviting you to take part in this study is because you are patients at Tshilidzini hospital and currently receiving medical care there. I wish to understand how you regard the services you receive at Tshilidzini hospital, whether you are satisfied with them and how you think the hospital can improve its services. After my findings I will have a meeting with the hospital management to discuss with them my findings.

Taking part in this study is voluntary and there will be no payment for participation. However a meal will be served on the interview. Should you choose not to participate, there will be no negative results for you. Participation means that I will have an interview with you and other fellow patients in order to learn more about how you regard the health care services you receive at Tshilidzini hospital, whether you are satisfied or not. The interview may last up to 30 minutes and refreshments will be provided. Should you give permission, a tape recorder will be used so that I can go over what you said during the interview and really understand your situation. All of your answers will be kept confidential and your identity will not be known or named in the report I shall be writing. Your answers will only be known to me and my supervisor and will be kept in safe custody. I will give feedback to you at the end of the interview so that you can confirm important points that have been captured for my report.

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APPENDIX C: CONSENT FORM

I, _____ consent to participate in the in-depth interview with Thelma Mugwena for her study on the patients' perceptions

I understand that

1. Participation is voluntary and will take the form of Focus Group Discussions.
2. The final report will contain no information that can be linked to me.
3. I have the right not to answer a question that I feel uncomfortable with answering.
4. I can withdraw from the study at any time with no negative results for me.
5. A tape recorder will be used during the interview.

Signed _____ Date_____

Participant

Signed _____ Date_____

Thelma Mugwena (Ms)

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OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS G.T. M.T. MUGWENA

SCHOOL OF HEALTH SCIENCES

FROM : PROF J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 22 APRIL 2014

DECISIONS TAKEN BY UHDC OF 13th MARCH 2014

Application for approval of Master's research proposal in Health Sciences:

Mugwena M.T: 11552998

Topic: "Patients' perceptions regarding health care services at Tshilidzini hospital, Vhembe District, Limpopo Province".

Supervisor:	UNIVEN	Prof. H.A. Akinsola
Co-Supervisor:	UNIVEN	Ms C.M. Phiri

UHDC approved Master's proposal

Prof J.E. CRAFFORD

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RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms MT Mugwena

Student No:
11552998

PROJECT TITLE: Patients' perceptions regarding health care services at Tshilidzi Hosptial, Vhembe District, South Africa.

PROJECT NO: SHS/14/PH/07/2807

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof HA Akinsola	University of Venda	Supervisor
Ms CM Phiri	University of Venda	Co-supervisor
Ms MT Mugwena	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: July 2014
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Mugwena MT
University of Venda
Private Bag X5050
Thohoyandou
0950

LIMPOPO PROVINCE
TSHILIDZINI HOSPITAL
RECEIVED / REGISTRY
2014 -10- 14
PRIVATE BAG X5050, THOHOYANDOU, 0945
DEPARTMENT OF HEALTH &

Greetings,

Patients perceptions regarding health care services at Tshilidzini Hospital, Vhembe District, South Africa

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.

Head of Department

12/09/2014
Date

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