UNIVERSITY OF KWAZULU NATAL

DEVELOPING A CONCEPTUAL MODEL TO IMPROVE PATIENT EXPERIENCE AS A STRATEGY TO ENGAGE PUBLIC HEALTH SECTOR REFORM IN SOUTH AFRICA

By

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DECLARATION

I, Hope Padayachee do hereby declare that this dissertation is the result of my investigation and research and that this has not been submitted in part or full for any degree or for any other degree to any other University

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H. Padayachee Date

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ABSTRACT

Patient Experience is well recognized in health quality improvement initiatives within developed countries due to the reforms that result thereof. Developing a conceptual model to improve patient experience in South Africa is undertaken in this study. The study consists of a qualitative (nine nursing service managers participated in semi-structured interviews) and quantitative component (three hundred patients were included in a survey). A one hundred percent response rate was noted for the qualitative interviews and a 93.3 percent response rate was noted for the surveys that were conducted. Data for the quantitative study was analyzed using the Statistical Package for Social Sciences and a thematic analysis using NVIVO was applied to the qualitative data.

The results from the qualitative component highlight the need for patient experience to be incorporated in the drive for quality improvement and stress the value of a patient experience model. Nursing managers support that the patient experience is positive in the primary health clinic but the survey findings reveal that the majority of respondents reported a negative patient experience. The overall patient experience satisfaction variable indicates that more than 50% of the respondents are dissatisfied with the overall patient experience. The Kruskal-Wallis analysis reveals a significant association with age and race on the overall patient experience satisfaction. Older patients are more accepting of health service delivery as compared to younger patients who are more critical. Patients show agreement with more than 50% of respondents indicating that the fifteen domains as per the Conceptual Framework are influencers of their patient experience. Nursing managers showed support for all fifteen domains. A latent factor analysis revealed that Information, Communication, Management Effectiveness towards Producing Positive Outcomes and Patient Centered Care were not statistically significant towards influencing the patient experience.

The conceptual model was developed by incorporating the remaining eleven domains that influence the patient experience and the positive reforms that result thereof. Given the changing landscape in SA, it was necessary to develop a model to improve patient experience in order to improve the quality of service delivery thus engaging sustainable positive reform.

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LIST OF ACRONYMS

African National Congress	ANC
Batho Pele Principles Framework	BPPF
Department of Health	DoH
District Health System	DHS
Gross Domestic Product	GDP
Health Consumer Assessment of Health Care Provider and Systems Survey	HCAHCPS
Human Resources for Health	HRH
Institute of Medicine	IOM
Kwa-Zulu Natal	KZN
National Department of Health	NDoH
National Health Insurance	NHI
Patient Centred Care	PCC
Patient Experience Framework	PEF
Primary Health Care	PHC
Public Health Sector	PHS
Quality Improvement	QI
South Africa	SA
Statistics South Africa	STATS, SA
United Kingdom	UK
United States Dollars	USD
United States of America	USA
World Health Organisation	WHO

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CHAPTER 1:

INTRODUCTION

1.1 Introduction

Patient experience feedback should be distinguished as an essential component to guide quality improvement (QI) in health care. However, the role of patient experience in public health systems (developing countries) is insufficiently researched. In comparison high income countries have invested heavily in patient experience studies thereby highlighting its' relevance in the field of QI. Thus far, notwithstanding the applicability of patient experience in addressing QI, research within the African continent has been scarce.

Scant literary evidence has consequently created an opportunity that compels research of this nature within South Africa (SA). The study is therefore conducted with a novel view to assess the current patient experience in SA clinics, determine domains of patient experience and the positive reforms that support QI. This chapter provides a discussion of the rationale for the study which is followed by a description of the problem statement. The research aim, objectives and the significance of the study are clearly articulated. A description of the format of the study provides an overview of the dissertation.

1.2 Background to the Problem

The health system in SA was divided prior to 1994, being mostly attributed to the apartheid system of governance (Jackman,2015:4). As a consequence thereof, health care was administrated within a system whereby 14 separate departments were responsible for managing the health needs of the different racial groups (Naidoo,2012:149). Therefore, the quality of healthcare service delivery among the different race groups showed a lack of standardisation with regards to best care practices. For example public health services for the white population were perceived to be better than those for the black population. In particular, the black population groups residing in urban areas experienced better health access in comparison to the rural black population (South African Department of Health Annual Report,2015:10). As part of a response to address the racial inconsistencies noted in health care service delivery, the African National Congress (ANC) restructured the health system in SA. This culminated in the National

Department of Health (NDoH) assuming responsibility for the public health management of SA at large (South African Department of Health Annual Report,2015:14). However, despite the restructuring of the health system, there still remain numerous problems that plague the public system. SA's high unemployment and poverty levels are well known contributors to the majority of South Africans who are medically uninsured. As a result, almost 80% of the South African population rely on "no fee" primary health clinics (National Audit for Health Facilities Baseline Summary Report,2012:23). However, the quality of health care has declined despite the significant healthcare spends of almost three hundred and fifty dollars per public healthcare user (World Bank,2015:5). Even further, the quality of South African health care is evidenced by the World Economic Forum, who indicated that SA's public health system ranked 132nd out of 144 member countries (Jackman,2015:18).

The significance of quality health care can correspondingly be linked to the finding that quality health care is an important factor contributing to the development of any nation in the world (Mgijima,2010:2). As indicated in the preceding section, there is a significant dependence of the majority of South Africans (80%) on the public health sector. This highlights the relationship offered by Mgijima that sub-standard health care could have serious implications for the socio-economic development of the country. This understanding is based on the inference that an efficient and effective public health system contributes to the life span of its citizens and respectively, the productivity of a nation (Mgijima,2010:3). The decline in healthcare quality in SA was further substantiated by an audit of clinics in 2012 which revealed a poor representation of the delivery of health care across the nine provinces of SA (National Audit for Healthcare Facilities Baseline Summary Report,2012:27). The evidence above substantiates a need for change.

In this regard, the ANC were prompted to develop a new approach to healthcare called the National Health Insurance (NHI) Model (NHI Policy Paper,2011:34). The NHI model has received much evaluation since its development and pilot implementation, already highlighting potential inefficiencies in the model and its implementation (Jobson,2015:24). Therefore, there exists a suggestive possibility that the NHI model may not be able to produce the desired vision of "Quality healthcare for all" despite the government's assurance that the model is capable of achieving a better health system for all South Africans. From a business perspective, health in its

strictest sense is considered a service therefore patients are viewed as consumers of the healthcare market just as conventional consumers are viewed as end users in the economic market. However, whilst marketing strategies to improve the conventional consumers' experience are based on the explicit and implicit view from the consumer, health strategies in contrast have been based on what the leadership of the country deem necessary based on the economic sustainability of the strategy. This point is well substantiated by the government's commitment towards NHI despite the evidence that contradicts the effectiveness of the NHI applicability in SA. In an effort to develop a health system that is both effective and efficient, Andrews (2013:34) recommends that the general public who are active users of the system should be "encouraged to engage in the decision making and planning of health services". This type of public reform offered by Andrew's, draws from the use of the New Public Service approach which places the citizen at the centre of the change strategy. This approach as applied to the Public Health System is intended to positively influence the patient experience for the benefit of the entire community and to ensure that there is a sustained quality of service provision based on the right service, in the right place, at the right time. When citizens are placed at the very core of public sector reforms, consideration is needed in the design and sustainability of reforms (Andrews, 2013:28).

One such effort that places the patient at the centre of its reform efforts is that of England's National Health System (NHS), which is based on the Picker Principles (Model adopted in England to support a positive patient experience). It has been suggested that the assessment of the patient experience is more effective in evaluating the patient's perspective of health care. From this perspective, patient experience is noted for its role in engaging QI (Vadhana,2012:13). Emerging evidence shows that patient experience is increasingly recognised as central to improving quality in developed countries (Australian Institute of Health and Welfare,2014:7). Therefore this study seeks to obtain a more accurate and comprehensive picture of patient experience and QI. The merits of the study are addressed below.

1.3 Rationale of the Study

1.3.1 Contribution to Body of Knowledge

The public sector in SA utilises just over 11 percent of the budget available to government for health. This is higher than the 5 percent of Gross Domestic Product (GDP) recommended by the

World Health Organisation (WHO) and is reflective of the high costs carried by the public sector in SA (Jobson,2015:33). The increased expenditure towards an already failing health system combined with the increased demand due to the quadruple burden of disease demands a change initiative. The quadruple burden of disease is explained by the epidemic of the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) alongside a high burden of Tuberculosis (TB), high maternal and infant mortality rates, high levels of violence related injuries and the rise in non-communicable diseases (Hossain, Ferdousi, Biswas, Mahfuz and Biswas,2012:74). The change initiative is especially fundamental for a country such as SA where the majority of the population is dependent on the use of primary health clinics. The study can assist in the development of a conceptual model to enhance patient experience by investigating patient experience from the perspective of the patient (consumer) and Nursing Service Mangers (leaders of clinics). The proposed model may also be used to potentially engage QI reforms for the healthcare systems in SA and in other developing countries with similar economic and social environments.

1.3.2 Implications for South Africa

Statistics South Africa (Stats SA) (Stats SA,2016:13) conducted a survey which reported that nearly seven in every ten households used the primary health clinic as their first point of access. In comparison, the percentage of South Africans utilizing facilities within the private health sector has declined since 2004. Whilst SA's private health sector is regarded among the best in the world there are only a small percentage of South Africans that use a private clinic, private hospital or private doctor. This is presumably due to the fact that most South Africans lack the financial means to frequent a private health facility because private healthcare costs are considerable. Over the past two decades, costs in the private health sector have risen 59 percent due to the following:

- private hospital costs have almost doubled (oligopoly of 3 hospital providers);
- specialist prices have increased by approximately 70% (continuous shortage of specialists);
- general practitioner prices have increased by 20% (shortage of general practitioners); and

- medicine and medical technology costs are rising worldwide (Still,2015:76).

With this in mind, it is evident that even the few South Africans that were able to access the private health care system in the past, may now be unable to afford this luxury. The implication of the rising costs may therefore result in an even higher percentage of the nation seeking usage of the Public Health System when medical aid benefits have been exhausted or are insufficient to obtain the necessary health care.

Therefore, there is a need for primary health clinics to perform with efficiency and effectiveness in order to provide quality health care that can benefit the nation at large. This sentiment is shared by the DoH: "the failure to achieve the level of efficiency and effectiveness as per the Batho Pele Principles (A political initiative that was introduced by the Mandela Administration to promote better delivery of goods and services in public institutes) could present as a potential dilemma for SA where the burden of disease has been well documented" (DoH,2015:4). Measuring patient experience is an indispensable step toward the effective provision of care. Patient experience data can be used as follows:

- standardising hospital service outcomes;
- evaluate the effectiveness of interventions;
- set rankings in the hospital; and
- Generate revenue for research and innovation.

Patient experience measures can bring to light relevant solutions and improve the quality of health care (Hossain et al.,2012:74).

1.4. Statement of the Problem

The health objective of the government in SA is the provision of quality health care for all South Africans (DoH,2015:5). However, there have been numerous complaints levelled against the public health system, thus highlighting the challenges that plague the system. Transformation within large public systems can be difficult as these systems are often resistant to change. Therefore choosing the right change strategy to support positive reform is critical (Berman, Pallas, Curry and Bradley,2011:34). Public Service Models should support change strategies that place the patient at the centre of the reform effort (Robinson,2015:11). Historically, a top down

bureaucratic approach has been utilised in developing the change strategies of SA's health system. However, SA continues to struggle in its objective towards the provision of quality care. In keeping with the findings of Robinson and Berman et al. this study will add a new dimension to traditional approaches using a bottom up approach incorporating the perspective of the patient and the Nursing Service Managers towards patient experience and QI.

1.5. Research Aim

The study aims to develop a conceptual model that can be used to improve patient experience as a change strategy to engage public health service reform in SA.

1.6. Research Objectives

- To evaluate the current patient experience in the primary health clinic.
- To examine the patients' contribution on patient experience domains and positive reforms in the primary health clinic.
- To examine the clinic managers' opinion of the patient experience domains and positive reforms in the primary health clinic.
- To develop a conceptual model to improve the patient experience as a change strategy to engage public health service reform in South Africa.

1.7 Research Questions

- What is the current patient experience in primary health clinics?
- What are the patients' contribution on the patient experience domains and positive reforms in primary health clinics?
- What are the clinic managers' opinion on the patient experience domains and reforms in primary health clinics?
- How can a conceptual model be developed to improve the patient experience as a change strategy to engage public health service reform in SA?

1.8 Format of the Study

The study format is discussed below:

- **Chapter 1 - Introduction**

Chapter 1 presents the research problem followed by the research objectives. The significance of the study is outlined.

- **Chapter 2 - Literature Review (Part A)**

Chapter 2 discusses relevant literature through an exploration of literary sources. The study of patient experience is still relatively new and an in-depth discussion of the benefits and role of patient experience is needed.

- **Chapter 3 - Literature Review (Part B)**

Theoretical frameworks and health models that are used in other countries and SA are discussed. The conceptual framework for the study is developed in accordance with the various frameworks that are discussed.

- **Chapter 4 - Research Methodology**

This chapter describes the research methodology applied in the study. A mixed method methodology for the study is explained.

- **Chapter 5 - Statement of Quantitative Results**

Chapter 5 presents the statistical analysis of data based on the survey responses of the participants. Information is presented in the form of tables.

- **Chapter 6 - Discussion and Interpretation of Quantitative Results**

The quantitative findings are explained and analysed using literature in this chapter.

- **Chapter 7 - Statement of Qualitative Results**

Chapter 7 presents the qualitative analysis of data obtained from the interview responses of the facility manager participants.

- **Chapter 8 - Discussion and Interpretation of Qualitative Results**

The information was categorised into themes and presented accordingly. The overall chapter provides a detailed understanding of patient experience as perceived by the facility managers.

- **Chapter 9 - Conclusions and Recommendations**

This chapter provides conclusive statements relative to the research objectives. This is accompanied by the development of a conceptual model.

1.9 Conclusion

Chapter one provides an overview of the healthcare in SA as pertaining to the study. The history and restructuring is discussed in conjunction with the problems that plague the health sector in SA. The research problem provides the platform for understanding the need for a patient experience model and the rationale for the study provides a brief discourse of the benefit of patient experience. The research objectives lay the foundation succinctly. Finally, the format of the study provides an explanation of the chapter organisation in the dissertation. Chapter two that follows provides a discussion of the relevant literature.

CHAPTER 2:

LITERATURE REVIEW

2.1 Introduction

Public Health Systems across the globe are seeking out innovative strategies that improve the quality of their health services, with an emphasis on the disadvantaged. The new scenario in high income countries boasts that the patient has become central to QI strategies. Unfortunately, African countries are lacking in this regard and SA is no exception. There are significant challenges that plague the South African health system, but evidence on how best to stimulate QI is lacking. The literature review is introduced with an overview of healthcare in the African Continent and SA. Health care models implemented in SA and other countries are explained to obtain a comprehensive understanding of health systems on a global level. The status of healthcare in the African continent is discussed in the section that follows.

2.2 A Perspective of Health Care within the African Continent

A recent Ebola health crisis in West Africa highlighted inefficient health systems. The outbreak raised an awareness of the insufficiency of basic medical supplies and healthcare staff in countries affected by the Ebola outbreak. The questionable level of quality was evident as a result of the insufficient health resources (Ly, Sathananthan, Griffiths, Kanjee, Kenny and Gordon,2016:17). Okpokoro (2013:2) states "that every nation should be interested in the health of its citizens as the health index of any nation is closely linked with the economic and social growth of the nation". This statement highlights the importance that has been placed on ensuring the effectiveness of a health system.

- **Nigeria and Zambia**

The situation in Nigeria and Zambia presents a dismal outlook for citizens who are dependent on the public health system. The health-care quality ranking of Nigeria is reported at position 187 out of 200 countries and the country has found a place among other countries whose health indicators are progressively worsening (National Population Commission (NPC) [Nigeria],2014:5). There are approximately 23 640 health facilities in Nigeria, with 85.5 percent

of these being public facilities serving the majority of the population (Nnebue, Ebenebe and Adogu,2014:235). However, despite the extensive network of public facilities, Nigeria lacks the capacity to provide basic and cost-effective services. The following factors have been credited to Nigeria's healthcare problems:

- health facilities are poorly equipped;
- human resource shortages;
- roles and responsibilities are not clearly defined;
- political commitment is inadequate; and
- accountability from all stakeholders is lacking.

Nigeria like SA also experiences a shortage of health professionals. As a consequence thereof, Nigerian healthcare workers are offered training irrespective of their capacity to cope with the transfer of knowledge (Okpokoro,2013:11). Under-skilled and unqualified health workers are over bombarded with training initiatives to prepare them for the following global health issues:

- human immune-deficiency virus (HIV)/Acquired Immune-Deficiency Syndrome (AIDS);
- malaria; and
- Tuberculosis.

The resultant effect is that many of the healthcare workers struggle to cope with the duties that need to be performed for patients that present with these global health issues. In Zambia, HIV/AIDS is a significant health problem that places a huge burden on the already compromised healthcare system. The effects of a poor health system are evidenced by statistics that show for the "majority of families that suffer the loss of the household head due to HIV/AIDS, an 80 percent drop in monthly income can be experienced" (Okoli, Eze-Ajoku, Oludipe, Spieker, Ekezie and Ohiri,2016:6). This statistical finding is in keeping with Okpokoro (2013:2) with regard to the negative impact of poor health on socioeconomic growth and development.

- **Rwanda and Ghana**

Mills (2014:552) states that "Rwanda is frequently referred to as a country that has achieved remarkably high voluntary insurance coverage, although the depth of coverage is limited and there is still insufficient financial protection for the poorest groups". This presents a major

problem for Rwanda as the highest health burdens are noted in the population groups of a lower socio-economic status. Simply stated, the majority of citizens who need the healthcare are unable to access it. Ghana in comparison to Rwanda has made considerable attempts towards increasing access to health coverage. Ghana also utilizes a national health insurance with free healthcare for population members that are unable to afford healthcare costs. Therefore all members of the population are catered to should they require health care. Literary evidence investigating the effectiveness of the Ghanaian health care system is insufficient and requires further investigation.

- **Botswana**

Botswana utilizes the "Integrated Health Services Plan to deliver the services of the Essential Health Service Package"(Government of Botswana [Ministry of Health],2010:207). According to Setlhare (2014:6) primary health clinics in Botswana suffer from resource constraints which impact on the quality of care. Clinics are supported by nurses who serve as consultants and primary diagnosticians, in spite of the understanding that the nurse practitioners, are not adequately qualified to consult and treat patients. Traditionally, poor quality in health care service delivery had been associated with the lack of training among health workers. A recommendation that has been put forth in this regard, is for the various departments of medicine and nursing in Botswana to work together to streamline the training for healthcare professionals. (Government of Botswana [National Health Policy],2012:41). The problem of poor quality is still evident and continues to impact on the achievement of health objectives for Botswana.

In many developing countries within the African continent there is a rising trend where citizens demonstrate high utilization of primary health clinics and a correspondingly poor quality of health service delivery can be observed. The above healthcare systems in African countries are failing in their objectives to provide quality health care for their citizens. Consequently, the importance of a strong health care system is highlighted, especially in relation to the socio-economic development of the nation. SA much like the other African countries has also experienced challenges.

2.3 A Perspective of Healthcare in South Africa

South Africa's health care system has experienced considerable changes post-apartheid juxtaposed with an increased focus towards the Primary Health Care approach in the public sector. (DoH,2016:24). The Primary Health Care Approach is discussed further in the section that follows.

2.3.1 The Primary Health Care Approach in South Africa

As defined by the Conference in the Declaration of Alma Ata (WHO, 2011:23):

"*Primary Health Care is essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service."*

The Declaration of Alma-Ata suggests that the focus of primary health care work is based on the following five principles:

- *"active public participation;*
- *accessibility;*
- *health promotion and chronic disease prevention and management;*
- *the use of appropriate technology and innovation (including knowledge, skills and information), and*
- *intersectoral cooperation and collaboration."* (Dookie and Singh,2012:67).

The term "Primary Health Care" in SA relates to the following:

"Primary health care is a public health strategy derived from the social model of health and is based on the philosophy that health gains are better obtained when people's basic needs are met first" (Dookie and Singh,2012:68).

The principles of the approach include the following as recommended by Dookie and Singh (2012:69)

- "*equitable service delivery;*
- *access to appropriate and affordable services;*
- *people empowerment; and*
- *sustaining service provision*".

A point of note, is that "active participation" which has been recommended as per the Declaration of Alma Ata and the "empowerment of people" as recommended by Dookie and Singh can be translated in real life application to embracing the patient's input in the strategy for QI in health service delivery. The patient's input as included in the development and implementation of strategy can be identified as achieving the following benefits (Wong, 2013:268):

- "*improved patient outcomes;*
- *cost reductions;*
- *increased efficiencies;*
- *lowered hospitalisation rates;*
- *reduced health inequities;*
- *increased patient satisfaction; and,*
- *improved health outcomes".*

The benefits are clearly outlined and can be translated to support a higher quality of health care being meted out to patients (Wong,2013:35). Even further, the benefits are not restricted to the

patient but also hold potential benefits for healthcare workers and the government. The legislative mandates provide clarity on the constitutional relationship towards healthcare in SA and are discussed in the section that follows.

2.3.2 Legislation of the South African Health System

The South African Constitution (Act No. 108 of 1996 guides the Department of Health through the following sections*:*

"Section 27(1): Everyone has the right to have access to ... health care services, including reproductive health care.

Section 27 (2): The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

Section 27(3): No one may be refused emergency medical treatment.

Section 28(1): Every child has the right to …basic health care services…

Schedule 4 list health services as a concurrent national and provincial legislative competence."

In terms of the South African Constitution (Act Number 108 of 1996, as amended):

"*citizens have the right to health care that is caring, free from harm and as effective as possible*".

Every individual should have the ability to obtain health, and the state is responsible to ensure the realisation of this right as reflected by the following constitutional mandates:

"Section 195: Public administration must be governed by the democratic values and principles enshrined in the Constitution.

Section 195 (1b): Efficient, economic and effective use of resources must be promoted.

Section 195 (1d): Services must be provided impartially, fairly, equitably and without bias.

Section 195 (1h): Good human resource management and career development practices, to maximize human potential must be cultivated."

In keeping with the legislation adopted by the Constitution, the mission of the DoH through the use of the PHC approach is stated as follows:

"To improve the health status through the prevention of illness, disease and the promotion of healthy lifestyles, and to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability" (South African Department of Health Annual Report,2014:23).

The areas that have been highlighted towards QI are included in the conceptual framework to ensure that the model being developed is in keeping with the constitutional mandates and the mission of the DoH.

2.3.3 The Status of Public Health Care

Batho Pele Principles guide patient care in SA (DoH,2016:45). However the quality of service rendered has been continuously scrutinised on various public platforms. There have been claims that the quality of service rendered and inequitable service delivery have been influenced by the availability of resources. These claims may be substantiated by the fact that the state provides approximately 40 percent of all healthcare expenditure, but the public sector serves more than 80 percent of the population (DoH,2016:12; Statistics SA,2014:55). The problem of poor quality and inequitable service delivery has therefore become a challenge as noted by the finding that each province of SA receives a standard of care that is proportional to the economic positioning of that province. For example, due to the skewed distribution of economic resources, poorer provinces, such as the Eastern Cape, have on offer a lower standard when compared to richer provinces such as Gauteng and the Western Cape (DoH,2016:15). In addition to this skewed distribution of economic resources, there is much question that surrounds the efficient use of the economic resource allocation. Human and financial resources are inequitably distributed, and imbalances are evident between the rural and urbanised provinces.

Resource constraints, ineffective management and the decline in the physical state of the infrastructure do not support quality health service delivery (National Audit for Health Facilities Baseline Summary Report,2012:27). A dichotomy between the Batho Pele Principles and the service delivery actually meted out to patients is evident (Sebugwawo,2012:7). This suboptimal delivery of healthcare is unacceptable in light of the ANC's mandate to provide healthcare that is accessible, equitable and affordable as envisioned by the NHI model (DoH,2016:18).

According to Jobson (2015:12) the NHI will be gradually implemented using a 14 year period in SA. The pilot project will commence in 10 districts which are primarily based in rural areas. The government has organized a national audit of facilities in preparation for the gradual completion of the NHI model. (National Audit for Health Facilities Baseline Summary Report,2012:13). The government is eager to implement the NHI model as a means to overcome the challenges that currently plague the public sector. However the findings of the audit have revealed that the facilities are not capable of supporting the successful implementation of the NHI model. In particular the National Audit for Health Care Facilities Baseline Summary Report (2012:14) revealed the following:

- "*A negative patient experience is common: facilities scored poorly relative to compliance with vital measures against priority areas;*
- *Access to services is variable across provinces, as reflected in indicators of accessibility, such as antenatal first visits before 12 weeks of age (Health Systems Trust, 2013/2014);*
- *Patients' total waiting time in clinics ranges from two to seven hours;*
- *Infrastructure in clinics is often inadequate; in all, 80 percent of clinics are not fit for purpose;*
- *Essential (medical) supplies are often missing at clinic level, because of a poorly responsive supply chain. For example, requisition for a non-standard stock item (NSSI) may take up to 63 days;*
- *A lack of strong financial management causes many facilities to run out of funds early in the year; and*
- *Implementation of improvement initiatives is uneven, partly as a result of inadequate institutional arrangements between provinces and national government."*

There is serious concern, as to whether facilities are capable of supporting the NHI model (Jobson,2015:4; Van Weel and Maeseneer,2012:148). The factors above which have been highlighted in the national audit are included in the development of the research instrument for this study.

In a response to the national audit of facilities, the former President of SA, Mr. Jacob Zuma supported the development of the "Operation Phakisa" initiative in line with the principles of Batho Pele to ensure that, "by 2019, every one of South Africa's public health facilities displayed the elements of the Ideal Clinic" (National Audit for Health Care Facility Baseline Summary Report, 2012:72). Operation Phakisa was developed and implemented as the mechanism through which the "Ideal Clinic" could be attained to support the successful implementation of the NHI model. Simply stated, the "Ideal Clinic" is government's approach towards improving the quality of healthcare and inequitable service delivery in SA.

An Ideal Clinic is defined as follows:

- "*a clinic with good infrastructure;*
- *appropriate staffing levels;*
- *sufficient quantities of medicines and supplies;*
- *good administrative processes; and*
- *adequate bulk supplies;*
- *Applicable clinical policies, protocols, guidelines as well as stakeholder support is used to ensure the provision of quality health services to the community"* (National Audit for Health Facilities Baseline Summary Report,2012:74).

Four strategic themes for achieving Ideal Clinics include the following:

- *"Patient-centric approach:focusing on patient health, patient experience and ensuring that patients are treated with dignity".*
- *"Back to basics in the clinics:ensuring all clinics have acceptable infrastructure and are equipped for service and maintained over time".*
- *"Career of choice:ensuring the best and brightest come and work in the facilities".*
- *"Effective processes:ensuring all processes are streamlined and focused on improving the outcomes of the system and the experience of patients and staff".*

The four themes described above are relevant as they are central to the change effort being implemented through Operation Phakisa to achieve the Ideal Clinic status. In particular, the theme of the patient centric approach is included in the development of the research instrument

for the study as it emphasises the role of patient experience. The Batho Pele principles aim to prioritise the needs of the people in SA and play a critical role in the approach to service delivery (Jardien-Baboo, Van Rooyen, Ricks and Jordan,2016:397). The section that follows outlines and explains the norms and standards that are developed from the Batho Pele Principles for the primary health clinics.

2.3.4 Standards for Primary Health: Batho Pele Principles

The Department of Health (DoH,2016:38) has outlined standards for the Primary Health Clinic.

1. *"The clinic renders comprehensive integrated Primary Health Care services using a one-stop approach for at least 8 hours a day, five days a week;*
2. *Access, as measured by the proportion of people living within 5km of a clinic, is improved;*
3. *The clinic receives a supportive monitoring visit at least once a month to support personnel, monitor the quality of service and identify needs and priorities;*
4. *The clinic has at least one member of staff who has completed a recognised PHC course;*
5. *Doctors and other specialised professionals are accessible for consultation, support and referral and provide periodic visits;*
6. *Clinic managers receive training in facilitation skills and primary health care management;*
7. *There is an annual evaluation of the provision of the services to reduce the gap between needs and service provision using a situation analysis of the community's health needs and the regular health information data collected at the clinic.;*
8. *There is an annual plan based on this evaluation;*
9. *The clinic has a mechanism for monitoring services and quality assurance and at least one annual service audit;*
10. *Community perception of services is tested at least twice a year through patient interviews or anonymous patient questionnaires."*

The standards give a clear indication and expectation of how a clinic in the public sector should be operated based on the Batho Pele Principles. These standards are set to ensure that the services provided across the nine provinces of SA are of the same level and quality. The Patients Rights' Charter was developed as a baseline for health care in SA and is discussed in the section that follows.

2.3.5 Patients Rights' Charter

1. The following serves to identify the aims and objectives of the charter:

- *"deal effectively with complaints and rectify service delivery problems and so improve the quality of care;*
- *raise awareness of rights and responsibilities;*
- *raise expectations and empowerment of users;*
- *change attitudes by strengthening the relationship between providers and users;*
- *improve the use of services and develop a mechanism for enforcing and measuring the quality of health services and*
- *Each clinic displays the Patients Rights' Charter and patient responsibilities at the entrance in local languages"* (DoH,2016:39).

2. According to the patient rights charter, the patient should at the basic level be afforded the following:

- "*a healthy and safe environment;*
- *access to health care;*
- *confidentiality and privacy;*
- *informed consent;*
- *be referred for a second opinion;*
- *exercise choice in health care;*
- *continuity of care;*
- *participation in decision making that affect his/her health;*

- *be treated by a named health care provider;*
- *refuse treatment; and*
- *knowledge of their health insurance/medical aid scheme policies;"* and,

3. *There is provision for the special needs of people such as a woman in labour, a blind person or a person in pain;*
4. *Services are provided with courtesy, kindness, empathy, tolerance and dignity;*
5. *Information about a patient is confidential and is only disclosed after informed and appropriate consent;*
6. *Informed consent for clinical procedures is based on a patient being fully informed of the state of the illness, the diagnostic procedures, the treatment and its side effects, the possible costs and how lifestyle might be affected. If a patient is unable to give informed consent the family is consulted;*
7. *When there is a problem the health care user is informed verbally of the health rights charter with emphasis on the right to complain and the complaints procedure is explained and handed over;*
8. *The clinic has a formal, clear, structured complaint procedure".*

The Patients Rights' Charter, Batho Pele Principles and Standards for primary health clinics provide the baseline reference for the acceptable standard of service and are therefore integral to identifying the picture of a positive patient experience within SA. Developing sustainable models to provide services for marginalized groups are challenging for any sector, but it is particularly necessary in the area of health.

2.3.6 The Status of Private Healthcare

Approximately 120 billion rand is spent in the private health sector per annum (to cover 16.2 percent of the population). There are just over 110 medical schemes that provide medical cover for 3.4 million principal members. In SA there are more than enough private hospitals that cater to private patients (188-urban areas; 50-rural areas) (Jobson,2015:7). Healthcare professionals

provide private services to patients and are compensated via medical aid payment. Based on the above information, one can clearly see that the private sector should be well resourced and adequately provisioned for a high standard of healthcare as compared to the public sector. Yet, there have been accounts of questionable health service quality in the private health sector.

A general consensus has alluded to the understanding that the public sector could benefit from the success of the private healthcare sector in SA, however there is insufficient anecdotal evidence that supports this proposition. The issue of poor quality in healthcare service delivery is therefore not confined to any one sector and indicates the need for a paradigm shift. Simply stated, SA's healthcare system is in need of significant change to adapt its healthcare strategy to engage reform. The areas that require reform is clearly highlighted in the discussion that follows.

2.4 Challenges in the Public Health Sector

2.4.1 Access to Care

Access is defined "as the opportunity or ease with which consumers are able to use appropriate health services in proportion to their needs" (Levesque, Harris and Russell,2013:18). In SA, access, has been constitutionally mandated as a basic human right (Constitution of SA Section 2.3.2). The failure of the preceding mandate leads to vulnerable populations characterized by unsatisfactory health care outcomes.

An investigation and "exploration of the experiences of vulnerable groups can provide information on their access to, and satisfaction with, health care services" according to Scheffler, Visagie and Schneider (2015:820). This study focuses on patients in order to obtain information about their experience with access to and within primary health clinic facilities. Firstly, the availability of skilled human resources is a critical component of providing quality service delivery to the health consumer. In this way the patient's needs and expectations can be adequately met as staff are appropriately skilled to provide quality health care. Secondly, the adequacy and acceptability components work closely in ensuring that the patient is provided with services that are in keeping with basic standards and meet the users' expectations and health needs.

Thirdly, the proximity of clinics to its users ensures that the patient is able to access the clinic and services that are needed without delays that could affect the outcome of their health needs. Based on the ACCESS Framework the "dimensions of availability, accessibility, adequacy and acceptability" are relevant to the concept of patient experience and is included in the conceptual framework of the study. The clinics provide their services for free (Jobson, 2015:3) therefore, affordability is not included in the study.

Table 2. 1: ACCESS Framework

Dimension	**Definition**	
"Availability	*The existing health services and goods meet clients` needs.*	*Adequate supply of services, goods and facilities, including types of services, sufficient skilled human resources*
Accessibility	*The location of supply is in line with the location of clients.*	*Proximity, means of transportation and travel time*
Affordability	*The prices of services fit the clients' income and ability to pay.*	*Direct and indirect costs of accessing health care*
Adequacy	*The organization of health care meets the clients' expectations.*	*Organization of services, including the standard of the facilities and meeting user expectations*
Acceptability	*The characteristics of providers match with those of the clients.*	*Ethical standards and the appropriateness of services, goods and facilities to address cultural and gender differences and life-cycle requirements; to improve outcomes; and to ensure confidentiality, effective communication and facilitating attitudes"*

Source: Balen, Liu, McManus (2013:2350); Scheffler, Visagie, Schneider (2015:821)

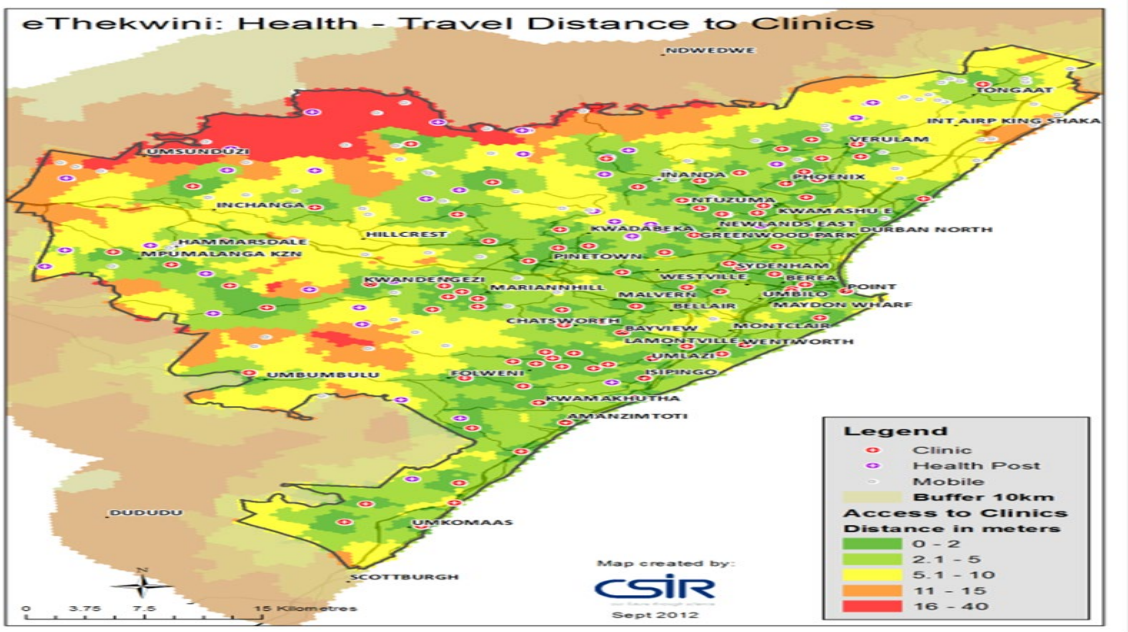

Figure 2. 1: Approximate Distance to Health Clinics in the eThekwini Municipality

Source: DoH (2016:40)

The majority of clinics can be accessed within the 0-5 km radius. However, as denoted by the regions highlighted in red, yellow and orange, the outer lying areas have difficulty in accessing health posts and mobile clinics which may also be inadequate to cater for certain service provision. This necessitates that the patient will have to be referred to a clinic which may well exceed the 40 km radius. This highlights the problem with access to quality health care within the eThekwini region for rural areas and offers a potential interest for further investigation.

2.4.2 Physical State of the Infrastructure

According to Jobson (2015:3) clinics are the foundation of the public health system as they are "first line of access for people needing healthcare services". Findings by the NDoH (National Audit for Health Care Facilities Baseline Summary Report,2012:34) show that "less than 20 percent of the clinics have an infrastructure that is fit for its purpose". A report by the NDoH and the Health Systems Trust (DoH,2015:20) indicates that the "physical state of the infrastructure in clinics in SA is inadequate, owing to unequal development and the general lack of maintenance". These inadequacies may contribute to a negative patient and health worker experience.

The physical state of the infrastructure is implicated for its role in worker efficiency and effectiveness. In keeping with the findings of the report of the Health Systems Trust, Burge's

“Sick Building Syndrome” (SBS) highlights the following symptoms as related to an unhealthy work environment. The group of symptoms comprise "headaches and lethargy which can reduce productivity and increase absenteeism from work" (Huisman, Morales, Hoof and Kort,2012:70). Kupperschmidt, Kientz, Ward and Reinholz (2010:21) explain that work environments should be healthy and safe for supporting the health and motivation of health professionals towards delivering safe and effective patient care. There is limited research that has investigated the effect of the SBS on healthcare workers and this presents an area for further research.

When evaluating the infrastructure, Marshall, Kiston and Zetiz (2012:2664) noted that the "standardisation of patient rooms and equipment made routine tasks simpler and decreased errors" thus increasing the efficiency and effectiveness of the staff. The physical state of the infrastructure is therefore relevant to how effective and efficient staff can be when providing health services. In addition to the "physical layout, natural and electrical light is also an important aspect to consider for avoiding errors" (Marshall et al., 2012:2665). Reducing and avoiding the incidence of errors is important and could indicate the difference between life and death.

Physical Comfort is another component when examining the physical state of the infrastructure. Mittler, Martsolf, Telenko and Scanlon (2013:2002) highlighted the importance of physical comfort with specific reference to acoustic comfort whereby the improved acoustics in the facility had a positive effect on the patient's psychosocial environment thereby creating a positive patient experience. In comparison, the negative effects of noise pollution are closely associated with increased levels of stress (Stiff, Speller, Foster, Anas and 2013:191). As a result, good layouts, ventilation, lighting and physical comfort are necessary when trying to ensure a positive patient experience. In addition to the physical infrastructure of the facility, cleanliness which is discussed next, is also an important aspect of health care service delivery.

“South Africa is failing in terms of cleanliness” according to the Operation Phakisa Report (2015:38). Less than half of the clinics comply with infection control and cleanliness standards in SA. Although the percentage of clinics that are compliant in waste management is still not up to standard, there are more clinics (83 percent) that are compliant in waste management processes as compared to the clinics that comply with infection control and cleanliness standards (National Health Care Audit for Health Care Facilities Baseline Summary Report,2012:52).

Infection control is an important aspect of maintaining an infection-free environment for staff and patients especially near high risk patients (Mittler et al.,2013:2003). The area of cleanliness in public health care facilities demands greater attention.

2.4.3 Quality in Healthcare

Quality has three dimensions as reflected in Figure 2.2: clinical quality (SAFE), management quality (EFFECTIVE), and patient experience (PATIENT CENTRED). Patient experience can significantly contribute towards QI strategies for the safe and effective delivery of health. However, certain studies question the role of patient experience in this regard according to Papp, Markkanen and Von Bonsdorff (2014:262). The use of patient experience offers the public health system of SA a sound opportunity to address shortcomings to the extent that all factors impeding service delivery can be minimised. It should also be stated, that the use of a patient experience framework highlights key areas on how to improve service delivery. Whilst patient experience does hold the potential to contribute to quality improvements in health care, it cannot guarantee positive health outcomes for all patients. However, a positive patient experience can aid in the health journey that patients undertake at public health facilities. The present study addresses a gap in the existing literature by incorporating both the patient and the nursing service managers' perspective on the quality of care.

Figure 2. 2: Components of Quality

Source: Pickers Principles (2014:14)

"Patient centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers" (Australian Institute of Health and Welfare,2014:10). Its underlying principles include the following:

•*"treating patients, consumers, caregivers and families with dignity and respect;*

•*encouraging and supporting patients, caregivers and families to participate in shared decision-making;*

•*communicating and sharing information with patients, caregivers and families;*

•*encouraging collaborations with patients, caregivers, families and health professionals in the development of programs and in the delivery and evaluation of health services".*

Patient Centred Care promotes the quality of care as patients receive care that is tailored to meet their needs by ensuring "patient safety, cost effectiveness and satisfaction for the patient, family and staff" (Australian Institute of Health and Welfare, 2014:15). Thus patient experience can useful for QI and monitoring purposes.

This study seeks to obtain information from the patients in order to investigate how patient experience can be enhanced. Apart from the use of the Patient Experience to direct quality improvement, the Lean Six Sigma and Studer approaches have been used. Common improvements from implementing lean principles are listed as the following:

- "*time savings;*
- *cost reductions;*
- *reductions in errors;*
- *improved staff and patient satisfaction;*
- *improved staff engagement and collaboration and*
- *Reduced mortality* "(Stiff et al.,2013:191).

However, one of the criticisms levelled against lean thinking is that "senior leaders create a culture receptive to lean thinking in order for the lean initiative to be sustainable"(Stiff et al., 2013:192). Therefore the system is dependent primarily on how well the senior managers are

able to facilitate the necessary culture change. "Six Sigma has a customer-driven approach and is considered data-driven because it uses quantitative data to measure quality parameters, and dig deeper than other QI approaches to find the root causes, while reducing costs" (Stiff et al.,2013:193). There is insufficient literary evidence that has investigated the use of the Six Sigma approach within the public health setting and this presents an area for future research initiatives.

The Studer Approach consists of "passion, principles and pillars". However the use of these principles has not been adopted within a public health setting due to the extensive change effort required in its' implementation. "QI has become an important issue in healthcare settings" (Anderson,2013:5) and the role of the consumer are gaining impetus. The issue of quality and QI in SA is currently managed by the Public Service Commission (PSC) in SA which is mostly achieved through the inspections of service delivery sites. In 2009/10, the PSC conducted inspections to evaluate the compliance of the clinics to the Principles of Batho Pele, and the availability of resources (DoH,2016:25). The outcome of the inspection revealed a lack of adherence to Batho Pele Principles and inadequately provisioned facilities. Therefore, the need for QI strategies that place the citizen at the heart of the reform effort is greatly needed within the PHS of SA.

2.4.4 Patient Centeredness

The subject of patient centeredness which has been highlighted for its role in the area of quality is significant in the patient experience. Therefore this subject has been identified independently for its contribution to the patient experience. This train of thought has also been applied in the Picker Principles and IOM Framework. Patient centeredness seeks to provide healthcare that places the patient at the centre of the health treatment plan by incorporating the process of engagement, empowerment and decision. "Patient engagement can occur with patients and families when an individual is receiving direct care or involve patients or public improving health services through policy planning and process improvements" (Coulter,2011:10).

- **Patient Engagement**

Carman, Dardess, Maurer, Sofaer, Adams, Bechtel and Sweeney (2013:223) presented a continuum of engagement. At the patient level, this could comprise the following:

- diagnosis information;
- patient preference;
- treatment decisions (preference based); and
- access to medical evidence.

Parsons, Winterbottom, Cross and Redding (2010:12) explains that at the management level this could comprise the following:

- organization-wide surveys to evaluate care experience;
- patients included as advisors and patients contributing towards safety; and
- patients being involved in quality improvement committees.

There has also been an increase in healthcare consumers making verbal representations of their patient experiences as patients are more informed of their rights as patients. Most providers and organizations view complaints with the incorrect perspective, as complaints may serve as a useful resource in pinpointing the improvements that are needed. According to Hsieh (2012:435) organizations have begun to consider the value of complaints as shown in the example, where a thematic analysis was conducted on 101 patient complaints identifying "communication, wait times and clinical experience" as major themes. Although one may argue that the findings are specific only to the hospital in Hsieh's study, the benefit of using complaints are that it can be systematically incorporated to "develop policy and improve clinical practice for all health care systems" (Corner, Wagland, Glaser and Richards,2013:18). According to Hsieh (2012:439) and Carman et al. (2013:226) timely feedback to staff and management is needed when using the complaints feedback system. This study has used a quantitative survey to obtain feedback from patients that highlights the relevant domains of patient experience and positive reforms thereof.

- **Patient Empowerment**

"Health literacy has been defined as the ability to read, understand and act upon health information, essential skills for making appropriate health decisions" (Stiff et al.,2013:194). Ricciardi, Mostashari, Murphy, Daniel and Siminerio (2013:376) found that patients, who subscribe to electronic health sources, are better equipped to manage their health care and appointments. Patients are more empowered because health literacy provides the patient with a better understanding of what is happening in their bodies. According to the Kings Fund Report, the most common cause of patient dissatisfaction is identified as patients with insufficient

information about their primary diagnosis and management of the condition. Patients who receive relevant information about their diagnosis and management report a positive experience of care. "Informed patients are more likely to engage in preventive behaviours and manage their conditions as compared to their counterparts who are three times more likely to have unmet medical needs and unnecessary hospital visits"(Kings Fund Report,2013:15).

- **Decision Making**

According to Stiff et al. (2013:195) "shared decision-making is the process by which patients and clinicians jointly review the best medical evidence as well as patients' preferences and values." According to the Ontario Ministry of Health and Long-Term Care: Excellent care for All Act of 2012 it is important for doctors to involve patients in decisions that pertain to their health needs and management. Patients that were involved in decisions that pertain to their needs showed a significant association with cost reduction according to a study conducted by Friedberg, Van Busum, Wexler, Bowen and Schneider (2013:268).

2.4.5 Role of Medication

The issue of medication has become one wrought with challenges. In SA, officials found that in 2010 there was a shortage of medicines (36 percent of the clinics that were inspected held sufficient medication) (Consolidated Report on Inspections of Primary Health Care Delivery Sites: Department of Health, 2010:38). When there are shortages in medication, patients make repeat visits to the clinics on separate occasions or are requested to purchase medication that is in short supply through private pharmacies. The patients that frequent clinics for repeat visits, to collect medication not previously available, can create higher workloads and administrative challenges. Therefore, repeat visits create the problem of inefficient system processing which creates bottlenecks in the dispensing of medication. In the case of patients being asked to obtain the medication privately, there is little evidence to suggest that this instruction is being followed.

Another challenge related to medicines is identified as the physical collection of medication by patients. Through Operation Phakisa the DoH developed and implemented innovative dispensing techniques for chronic patients:

- "*The first is through a system, either with direct delivery to the patient or to a pick-up point where the patient can collect it;*
- *The second option for receiving medication by patients would be via simple direct delivery to them; and*
- *Finally, the delivery of medication is possible via a mobile pharmacy. Here, a mobile unit arrives in terms of a pre-determined route, date and time. This service can also take the form of an outreach where a certain community is offered the service in a predetermined area for a pre-determined period".*

As a result of this initiative, chronic patients only need to visit primary health clinics every six months to obtain a new prescription, subject to changes or the relocation of a patient. It is hoped that the long waiting times and patient traffic will be reduced in time (Operation Phakisa Report, 2015:14). However, the efficacy of these new dispensing systems has yet to be evaluated and presents an area for further investigation.

2.4.6 Role of the Doctor

The doctor plays an important role in the delivery of health care as he/she is responsible for making a diagnosis based on clinical knowledge and the symptomatic presentation of the patient. However, studies show that patients are concerned with more than just a good or accurate diagnosis from the doctor thereby highlighting various aspects that affect the doctor patient interaction or experience (Devanny,2015:25). The relative importance of compassion, communication and referrals may differ especially where the radiance effects of these factors are concerned.

- **Compassion**

According to Devanny (2015:26) when patients seek counsel from their doctors, it is usually during a stressful point in their lives. Patients want to know that they can trust their doctors with the responsibility of keeping them informed and empowered. In addition to clinical soundness from the doctor they expect the doctor to be caring and compassionate during their time of need. Regardless of the health outcome, patients need doctors that provide care with compassion.

- **Communication**

According to Levinson, Lesser and Epstein (2010:1311) the role of communication is strongly associated with the effectiveness of the doctor. Earlier research (Arora,2003:791; Epstein and Street,2007:805) shows the importance of communication towards supporting important outcomes such as the adherence to treatment plans and better self-management. An added benefit as noted by Robinson, McCallister, Berry and Dearing (2008:602) and Janglang, Gunningberg, and Carlsson (2009:200) is that communication influences the experience of care Inappropriate communication between professionals and patients can result in poor patient experiences (Nadzam,2009:186). When doctors are unable to communicate effectively, it has a negative influence on the doctor-patient relationship thus contributing to a negative patient experience. The invaluable art of communication and the importance of sound discussion between patients and doctors are clear.

However, good communication should focus on identifying patient needs and improving shared decision making rather than seeking to solely addressing patient concerns. In addition to effective communication between the doctor and the patient, non-verbal cues are also deemed relevant to the patient experience as revealed in studies conducted in developed countries. Based on the study conducted by Devanny (2015:24) more than half of United States (US) and United Kingdom (UK) patients (68%) expect eye contact, a handshake and good verbal communication when consulting with the doctor. The patients in the study were of the viewpoint that these factors contribute the most to an overall positive experience.

- **Consultation and Confidentiality**

In Germany, privacy during the consultation was most significant to the patient and this was followed by communication, and eye contact. Poor compliance to patient confidentiality on the part of the health professional may influence the patient's ability to provide an honest account of their health needs. Patients expect confidentiality and doctors that listen when they talk (Devanny,2015:30). Whilst the emphasis has shifted towards reducing waiting times and improving productivity, the primary goal should always be to develop a strong bond between the patient and the doctor.

Experienced doctors often say: “it’s not the amount of time that is actually spent on the patient, but rather, it’s the perception of time spent that matters most to patients” (Levinson et al., 2010:1315). For example, when the doctor remains near the door during the consultation, the

patient may feel rushed from a psychological perspective, but when a doctor sits near the patient, maintaining eye contact, and shows a willingness to know more from the patient, the visit appears longer.

- **Referrals**

The sense of being rushed not only negatively impacts patient experience but, it can create the impression that the patient is not priority and influences whether a positive recommendation will be made for the doctor. In Devanny's study more than half of the German patients (68 percent) use a family or friend's recommendation when choosing potential doctors. Similarly patients in the US (52%), and UK (24%) agree that their choice of a health worker is influenced by a past experience of a friend or family member (Devanny,2015:34). Whilst the percentage of patients showing agreement in the UK is considered to be much lower than that of German and American patients, it is clear that this is an important point for patients. Therefore the role of the doctor-patient relationship does not only influence the experience of the patient that is in the doctor's room's but also impacts on future potential patients. If the patient in the consulting room has had a negative patient experience, then it is possible that they will be less inclined to recommend the doctor of note to a friend or family member. Based on the statistics provided in Devanny's study this could hold negative implications for the doctor who has elicited a poor or negative patient experience.

- **Availability of Skilled Doctors**

Longmore and Ronnie (2014:369) evaluated the insufficiency of human resources in healthcare (HRH). It is evident that the supply and demand balance of current and future doctors are ineffective which translates to human resource constraints within the public health sector in SA. Although the government has recognised that human resource constraints affect the overall functioning of the health system and provision for this constraint has been accounted for in 10-point strategy plan (DoH,2016:33) there is a concern that the efforts are misguided and inadequate to cater to the issues timeously (Longmore and Ronnie, 2014:369).

Only 30 percent of health professionals in SA work in the public domain in spite of the high volumes of patients that frequent public centres (80%) (DoH,2016:24). There is less than 1 doctor for every thousand people, compared with an average of more than three doctors in

developed countries (Jackson,2015:3). Even further, less than five percent of medical students who graduate willingly proceed towards rural areas (Robinson,2015:11). A further issue facing SA and other low and middle income countries is "brain drain". The issue of "brain drain" has been brought to the attention of platforms such as the WHO and also through the negotiation of bi-laterals with developed countries. Government statistics indicate that there is a vacancy total of 10 860 for doctors (DoH,2016:30). Many of these posts have been frozen due to meagre financial resources, yet the government has been ineffective in its effort to address the problem. To compound the issue of the shortage of health workers, the Health Professions Council of South Africa (HPCSA) increased the requirements for foreign trained professionals to serve as independent practitioners in SA (Health Professionals Council South Africa (HPCSA,2016:4).

Another challenge as highlighted by the DoH (2015:5) is that of the role of HIV which has affected the health worker population and impacted patient workloads. Occupational health hazards are increasing in health facilities. Tuberculosis among SA health workers is rising. Health workers have a higher exposure to contagious diseases and when they are affected, it affects their ability to work because the roles are now reversed. The consequences of inadequate staffing have important implications for the patient. One of these being that the patient may be required to wait longer before they are attended to. In addition, by the time that the patients have been attended to, there is every possibility that the health worker may be so fatigued by the extra work load that their judgement could be impaired.

This type of scenario could only lead to potential malpractice and patient negligence. In particular, doctors that are over-worked are unable to communicate effectively and will not be able to offer the type of service that patients should receive. Doctors will want to work quickly just so that the workload can be completed and this may encourage verbal and non-verbal cues that are not reflective of empathy or compassion for the patient. Simply stated the situation where there are insufficient doctors could potentially elicit a negative patient experience.

The response of the DoH by 2018/19 is to possess suitably trained healthcare staff that possesses the required capabilities will deliver quality health care. If this is achieved, it will mean that the following positive health reforms will be achieved:

- " *No patient goes home unattended due to a lack of staff;*

- *No employee feels that going the extra mile is not worthwhile;*
- *All workers are engaged and ready to perform at their best; and*
- *No clinical professional is overburdened with administrative tasks"* (DoH,2016:41).

These aspirations seem noble at first glance but one has to wonder whether it is achievable for the short and long run.

2.4.7 Role of the Nurse

There is a general consensus that health professionals especially nurses are dissatisfied and are being "pushed" into greener pastures. Nurses, who mostly manage the primary health clinics, are citing an unpleasant work environment and poor wages for leaving the public sector (Taylor, Machta, Meyers, Genevro and Peikes,2013:8). Kumar, Ahmed, Shaikh, Hafeez and Hafeez (2013:4) state that work satisfaction affects various aspects of the worker's personal life but more importantly plays a role in their work performance. Therefore it is imperative that health worker concerns are not dismissed by officials in management, and the necessary measures to address the problems are taken. Human resources play a significant role in the provision of quality healthcare. Therefore an emphasis should be placed on staff motivation in order to produce higher levels of employee satisfaction that contribute towards increased effectiveness and efficiency. Staff who displays high levels of satisfaction can positively contribute to service delivery in the primary health clinic.

Pelzang, Wood and Black (2010:186) identified an association between human resource insufficiency and a negative patient experience. Pelzang et al.(2010:190) also indicated that by strengthening a positive organisational culture, the patient experience improved. The link between patient experience and health professionals has been explained and highlights the role of these professionals in eliciting a positive patient experience. The role of the nurse has been identified as important to patient experience and is therefore included in the development of the research instrument.

2.4.8 Information, Communication and Education

- **Information**

The "Batho Pele Principles of Access and Information require information to be readily available to citizens in order to empower them and to address their needs" (Dookie and Singh,2012:69). The lack of the right information at the right time will affect the patient's ability to be empowered. This disempowerment is not conducive to ensuring that service delivery is meted out in the highest quality. Therefore the need for a patient experience model can aid in highlighting the need for patients to be properly educated and informed about the delivery of healthcare. The information regarding the patient's condition, treatment and clinic operations needs to be communicated in a manner that ensures that the message is appropriately received and interpreted.

- **Communication and Education**

According to the report (National Health Care Facilities Baseline Audit,2012:25) "*mechanisms to communicate consistently and systematically with patients and to share with communities the results and the progress of quality improvement initiatives are lacking*".

This has the potential to leave the patient feeling neglected by the government. Patients can become confused when communication channels are lacking especially when changes have taken place in the process or service rendered. Patients are easily frustrated when procedures that have been followed in the past are amended without them being notified of the changes. Even further patients are irate when the changes are implemented but they strongly believe that the “old system” worked better in their opinion.

According to Coulter (2012:80), before changes are made patients should be consulted about what works and what does not, especially since they are impacted by the changes that are implemented. Patients need to be included because they do matter and their opinions should count. The common error is that health professionals have the perception that patients are unrealistic in their expectations and demands. This incorrect perception needs to change so that patients are included and empowered in the change efforts that influence them. If patients are not

included in the process of information sharing they can become non-compliant and this can also lead to them “shopping around”.

2.4.9 Coordination and Continuity of Care

Schang, Waibel and Thomson (2013:11) states that "care coordination can be seen as part of a broader strategy to improve quality in health care delivery and, ultimately, to strengthen the performance of the health system".

It is needed in the following three contexts:

- within organisations;
- between organisations; and,
- At the patient level, to enable patients to have access to care delivered by appropriately trained professionals.

Roseman, Osborne-Stafsnes, Amy, Boslaugh and Slate-Miller (2013:232) explain that the potential benefits of care coordination include the following:

- hospital stays are reduced;
- the quality of the management protocol is improved ;
- patient satisfaction is improved; and
- The access to specialty care is improved.

Ewing (2013:258) identified an inconsistency with regard to the definition of coordinated care and the coordination activities that were most useful. White, Carney, Flynn, Marino and Fields (2014:63) define care coordination as:

"*the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of*

information among participants responsible for different aspects of care" (Berry, Rock, Smith, Houskamp, Brueggeman and Tucker,2013:188).

According to Shaw, Rosen and Rumbold (2011:14) integrated care addresses fragmentation in patient services, thus enabling coordinated and more continuous care.

The referral system in primary health clinics is problematic. Based on the findings of the National Audit (National Audit of Health Facilities Baseline Summary Report,2012:34) 23% of facilities do not have referral guidelines. There is a lack of standardization in referral policies and the mechanisms for referral are deemed inadequate. The lack of an effective referral system does not support co-ordinated care and creates frustration for the patient. In comparison, the benefit of an effective referral system ensures that people do not have to travel far beyond their primary residence. According to the DoH (2015:54) an effective referral process requires the following:

- "*Timely access to relevant patient information;*
- *Effective communication between all organisations along the continuum of care;*
- *Available resources (human and other) across the continuum of care;*
- *Universal implementation of the process, using the system tools".*

The "National Patient Referral Policy of 2008" is still being developed and to date there is no policy that has been implemented which serves as a potential barrier to the continuation and co-ordination of care.

Table 2. 1: Integrated Care and Integration

What is integrated care?	What is integration?
"Impose the patient perspective as the organizing principle of service delivery" (Lloyd and Wait,2005:7).	It includes all the means which facilitate integrated care. (Leutz,1999:77).

Integrated care works on improvements in care through better coordination. (Taylor et al., 2013:11). Further research is needed to develop policies that support integrated care. The "WHO's Framework for Action on Inter-professional Education & Collaborative Practice"(Gilbert, Yan, and Hoffman,2010:196) highlights collaborative teamwork for the

delivery of effective health care. "Collaborative practice occurs when health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings" according to Pelzang et al.(2010:915). This definition emphasises the multi-disciplinary approach and incorporates the involvement of friends/family members.

2.4.10 Welcoming the Involvement of Family and Friends

Boyle (2015:10) explains that communication with the family requires the following:

- Identify one person who can relay information to other members;
- Verbal communication and body language is important when communicating;
- Address members of the family with respect and ensure that the name of patient is known;
- Communication should seek to develop a bond of trust;
- Be sensitive about the family beliefs and value systems;
- Avoid unrealistic expectations, and
- Avoid providing a response to questions where you are unfamiliar with the correct answer.

The multi-disciplinary team should work together with the patient's family to decide on the appropriate care plan for the patient in the short and long term. The family and friends may not hold a degree in medicine or have a supporting healthcare background, but their opinion is still important. Once again the theme of communication is highlighted but in this instance the interaction also includes the family. Patient visitors may present with other implications that include the transmitting of infections and disrespect towards hospital policies and protocols. However, there are no conclusive studies that support the association between higher infection rates and visiting times. The concept of welcoming family and friends has not been investigated within the health care environment in SA and the present study adds new knowledge in this regard.

2.4.11 Patient Waiting Times

Waiting time contributes towards the patient experience. In SA, three quarters of patients wait beyond a two hour time frame, and in extreme cases, there have been marginal groups of patients where the waiting time exceeded seven hours. (National Health Care Facilities Baseline Audit,2012:66). Waiting for such long periods draws attention to inefficient operational processes in the facility. According to Vadhana (2012:22) waiting time was shown to be a major factor that caused the greater part of the study sample to complain about their care in the clinic. Whilst the majority of the respondents in Vadhana's study were positive toward the quality of the services, they indicated disappointment with the waiting time.

There are various factors that affect or influence the waiting times in the public health sector. Firstly, the appointment systems currently in use are poorly managed. Whilst some type of appointment system has been developed in the primary health clinics there is a lack of standardization and the systems have many shortcomings. According to the report (National Health Care Facilities Baseline Audit,2012:32) ppatients' are given a date on which to present themselves at the clinic but no appointment time is given. The problem with this system is that most patients all arrive at the same time at the start of the day. Another point of concern is the lack of integrated care which results in multiple appointments by multiple health workers for patients with co-morbid conditions on different days. Patients receive appointments only when they are physically present at the clinic and the lack of a reminder system results in many missed appointments. There is no flexibility or choice afforded to patients in the setting of their appointments.

The DoH has determined to implement an appointment system for patients since April 2015 (Operation Phakisa Report,2015:24). The initiative aims to reduce waiting times, by affording patients an opportunity to be included in the setting of their appointment date and time. An SMS-based platform including appointment reminders will help control the workload and waiting times. Appointment reminders will also useful in reducing missed or forgotten appointments. The system will allow for the cancelling of appointments and patients will be able to comment on the quality of care received. Government is confident that waiting times and contributors of high waiting times will be reduced with the use of this system. However, the progress regarding this system is unclear and the same challenges prevail.

Secondly, patients may travel to clinics unnecessarily to receive advice that could have obtained via the telephone. Patients constantly frequent clinics because they are concerned with minor side effects as they have been uniformed of the potential effects of certain medication at the time of dispensation. An initiative that comprises that development of a call centre can be used as a means to increase the contact between the patient and the system. The avoidance of physical clinic visits which may be accompanied by long waiting times can be encouraged through the use of the system where patients may ask questions or explain their symptoms. Call centre's can also provide information that reduce patient congestion and improve patient experiences (Operation Phakisa Report,2015:28).Thirdly, long waiting times affects the patient's ability to receive the care that is needed when it is needed and in the place that it is needed. The call centre initiative still remains in the proposal stages of development. Another recommendation put forth by Operation Phakisa suggested the use of a separate queue to fast-track service needs. "The Ideal Clinic pilot sites showed a decrease in the median total time spent by chronic patients (30%) by implementing some of these guidelines" (Operation Phakisa Report,2015:32).

Fourthly, filing systems are inefficient thus creating implications in the record keeping based on the findings of the National Audit. Finally, there are inconsistencies noted in the patient experience and waiting time measures among the different primary health clinics across the various provinces. The use of different measurement instruments also adds to the inconsistencies, making the investigation of patient experiences across facilities almost impossible. Without the use of a standardized research instrument, facilities lack the systematic and standardized collection of data. More than half (70%) of the clinics are unable to provide reliable feedback for the challenge of waiting time and on improvements that have been achieved (National Health Care Baseline Facility Audit, 2012:41). Therefore it has been recognized that waiting times should be addressed in order to address the issue of inconsistency.

According to the National Audit the following objectives should have been achieved by March 2018, as follows (National Health Care Baseline Facility Audit, 2012:43):

- "*Patients will wait for less time, both before and between receiving services. The target is two hours maximum waiting time;*
- *Patients will spend less time in total at the clinic. The target is three hours maximum spent at the clinic;*

- *Patients will be satisfied with waiting times. The target is that 90% will be satisfied with their waiting time at the clinic; and*
- *Patients will report a positive experience of care. The target is that 80% will report a positive experience with reference to the waiting time".*

If these targets can be attained then it will improve the overall patient experience and reduce waiting times. Patient waiting time is closely associated with patient experience and has been included in the research instrument.

2.4.12 Outcomes and Effectiveness

Managers are important in promoting the effectiveness of service delivery as highlighted in a study conducted by Kaufman and McCaughan (2013:53) who contend that leaders set the platform for the behaviour of the multidisciplinary team. Therefore leaders need to address poor work practices in the clinic so as to develop the correct work practices that support a positive patient. Managers need to ensure that patients receive care that is "safe, efficient, equal and patient centred care"(Frojd, Swenne, Rubertsson, Gunningberg and Wadensten,2011:228). Therefore the role of the health facility manager is important and has been included in the collection of data for the study at hand.

Papastavrou, Andreou, Tsangari and Merkouris (2014:13) explain that the combined lack of resources and uncaring healthcare workers led to negative outcomes for patients. Insufficient or inadequate resources impeded the provision of quality care and this contributed to higher death rates. However, it should also be stated that the patient may display poor outcomes in their health which may not be attributed to poor quality of service delivery. Therefore there needs to be a close examination of factors that contribute to poor outcomes and this presents a future area for further research.

2.5 Patient Experience

2.5.1 Global Perspective of Patient Experience Themes

According to the Beryl Institute patient experience is defined as follows:

"*The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care*"(Beryl Institute,2015:14).

Patient experience is also explained as "the influence of various health events on patients and the extent to which patients needs are met"(Health Foundation Inspiring Movement, 2013:5). The entire path that the patient follows from the entrance of the clinic all the way through to the exit and everything in between should be included in the experience of care (Institute of Medicine (IOM),2001:32). For the purpose of the study, the definition of patient experience as offered by the Beryl Institute is applicable to the study. According to the National Institute for Health and Clinical Excellence (2010:12) the experience of care does not exist in isolation, but, is in fact influenced by a number of factors or domains based on the services rendered, healthcare professionals and the patient as an individual. These factors have also been included in the conceptual framework for the study.

Measuring patient experience benefits the process of service delivery improvement, supports better clinical outcomes and reduces costs (De Silva,2013:18). Furthermore, patient experience is associated with improved adherence to medication especially in the case of chronic conditions. Another benefit of patient experience is reported as the reduction in employee turnover. Developing a comprehensive strategy for measuring patient experience entails what factors/domains should be measured and how (De Silva,2013:25). Therefore the study adds new knowledge by highlighting the domains of patient experience that are relevant to patients within the context of healthcare in SA.

Research conducted by the WHO (2010:14) outlined the following areas for addressing experience of care:

- "*providing a suitable environment for people and health professionals";*
- *"care co-ordination";*
- *"care teams that have a multi-disciplinary approach";*
- *"patient education, family involvement, self-management and counselling";*
- *"standards and incentives for high quality, safe services";*
- *"developing new models of care"; and*
- *"developing the right leaders to support a positive patient experience".*

There is a gap that exists within the public health sector in SA with reference to developing new models of care as supported by WHO (2010:16). This gap presents opportunities for research into developing models of care that support a positive patient experience. This study, in particular seeks to develop a conceptual model to improve patient experience as a strategy to engage Public Health Service reform in SA.

The Picker Institute in Europe (Boyd,2007:210) reported the following top elements as priority to the experience of care:

1." *The doctors know enough about my medical history and treatment";*

Patients want doctors that are informed and knowledgeable about the diagnosis and management thereof. This requires that doctors take the initiative to further develop and equip themselves with new knowledge.

2. "The doctors can answer questions about my condition and treatment in a way that I can understand";

The art of communication is once again emphasised as patients need doctors that are not only knowledgeable but can also communicate this knowledge so that the sharing of knowledge can take place.

3. "I have confidence and trust in the hospital staff that treats me";

Patients require health staff that are appropriately skilled and are able to treat them with patient safety as a priority.

4. "The doctors wash or clean their hands in between touching patients;

Hygiene is very important to patients. Therefore hygiene and infection prevention protocols have to be adhered to.

5. "The nurses know enough about my medical history and treatment";

It is clear that patients expect not only the doctors to be knowledgeable but also place a demand on the nursing staff to hold similar knowledge.

6. "Before my operation or procedure, I get a clear explanation of what will happen";

Patients can be anxious about procedures and require emotional support. When health staff provide an explanation for the patient it helps the patient to prepare for what is going to happen and they are less likely to become fearful during the procedure.

7. "The risks and benefits of my operation or procedure are explained to me in a way that I can understand";

It is insufficient for a patient to be informed that a procedure is needed without the information regarding the procedure. This is needed to help gain a patient's commitment towards the procedure.

8. "The nurses wash or clean their hands between touching patients";

The emphasis on hygiene protocol indicates that patients need to be reassured that the health worker is not going to transmit any infections in the process of the consultation.

9. "The rooms and ward are clean";

Cleanliness in a facility that provides medical care should at its very core support cleanliness as a primary objective.

10. "The doctors and nurses are open with me about my treatment or condition".

With the advancements in technology patients have been clearly given the means of accessing information about medical conditions. It is pointless to assume that patients are incapable of processing information that relates to their treatment or condition. On, the contrary, health staff should actually make an effort to provide patients with information in order to support the patient's education and understanding thereof.

An earlier international study by Grol (1999:503) reported that the five priorities for a good patient experience in a United Kingdom general practice are as follows:

1. "*A doctor should be able to provide a quick service in case of emergencies;*

2. during the consultation a doctor should have enough time to listen, talk and explain to me;

3. A doctor should guarantee the confidentiality of information about all his/her patients;

4. A doctor should make me feel free to tell him or her my problems; and

5. A doctor should tell me all I want to know about my illness".

The patient experience themes that have been identified in Table 2.3 are included in the development of the Conceptual Framework for the research instrument.

Table 2. 2 : Themes for Patient Experience

Theme	Explanation
Knowing the patient as an individual	Every patient is unique and needs to be consulted accordingly
Essential requirements of care	"Health is not merely the absence of disease" according to the WHO (2016). Therefore the importance of viewing the whole patient in respect of the emotional, mental and social aspects.
Tailoring healthcare services for each patient	Treatment plans and protocols need to be organised according to the patient's needs.
Continuity of care and relationships	The patient needs to be referred to other relevant professionals to support a multi-disciplinary approach.
Enabling patients to actively participate in their care	The patient needs to have a voice in the decision making process of treatment management.

Source: National Institute for Health and Clinical Excellence (2010:14)

The themes support patient experience and are relevant to the study. A recent survey (Figure 2.3) conducted by the DoH based the dimensions of patient experience as follows:

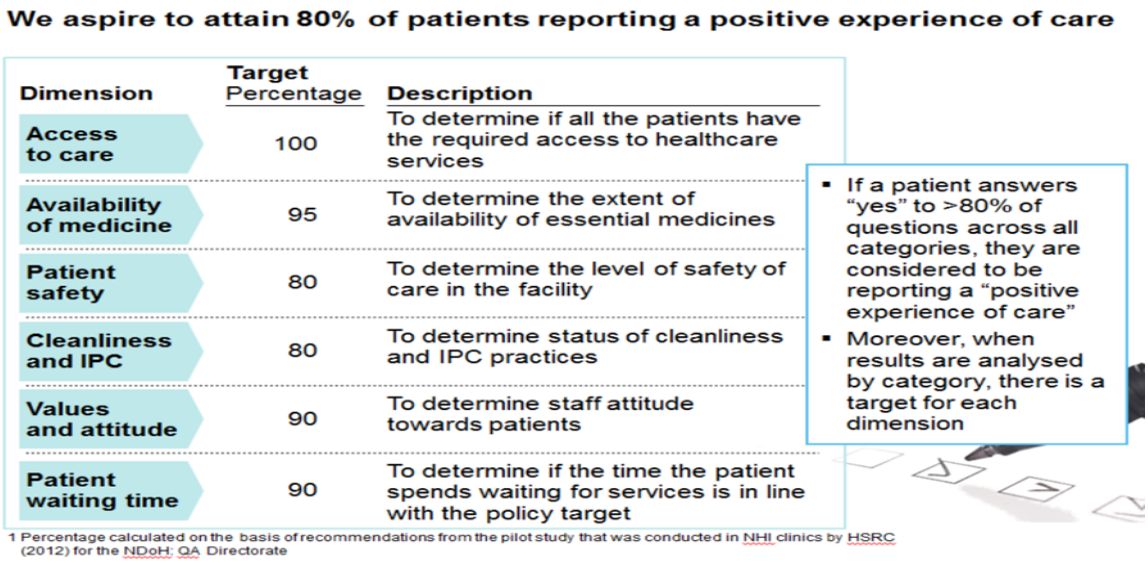

Figure 2. 3: Dimensions of Patient Satisfaction according to the DoH

Source: NDoH (2015:36)

However, the DoH has not provided a comprehensive overview of how patient experience should be evaluated. Therefore the study is relevant as it addresses the shortcomings of how patient experience has been evaluated in the past. The need for other domains is evident based on the literary support provided in the preceding sections.

2.5.2 Patient Experience and Patient Satisfaction

In the past, the evaluation of health care has primarily been achieved through patient satisfaction surveys. Satisfaction can be explained as the gap between what patients expect and what they experience. According to Coultzer, Fitzpatrick and Cornwall (2009:7) patient satisfaction "is sometimes treated as an outcome measure (satisfaction with health status following treatment) and sometimes as a process measure (satisfaction with the way in which care was delivered)". Researchers (Fenton, Jerant, Bertakis and Franks,2012:405; Greaves Ramirez-Cano, Millett, Darzi and Donaldson,2012:251) explain that "patient experiences cannot be reliably measured by asking questions such as: How satisfied were you with your care in hospital X?". Therefore there is a shift taking place which has highlighted the role of patient experience in QI.

The satisfaction ratings are based on the following:

- "*the personal preferences of the patient;*

- *the patient's expectations;*
- *response tendencies due to personal characteristics; and*
- *The quality of the care received "*(Luxford, Gleb and Delbanco,2012:510).

The initial focus of satisfaction surveys has lacked the ability to obtain consequential responses that support QI programs. Simply stated, the use of patient satisfaction is insufficient to address QI. Needham (2012:255) provides support to the preceding statement with the following: "the focus on patient satisfaction alone is short-sighted and that best practices from other industries should be adopted into health care to move beyond satisfaction to deliver a more complete patient experience". Therefore satisfaction data has been limited in this regard thus sounding the call for information on the patient's experience of care (Luxford et al., 2012:511). According to Price, Cleary, Elliot, Zaslavsky, Hays, Lehrman, Rybowski and Edgeman-Levitan (2014:522) patient experience reports reflect the experience with the health system, facility or service provider and provides valuable data from the patient's perspective. This understanding of patient experience was also supported by other researchers (Browne, Roseman, Shaller, and Edgeman-Levitan,2010:921; Wolf,2015:14) but there are other researchers that devalue the use of patient experience.

One such example is that of Manary, Boulding, Staelin, and Glickman (2013:368) who opposed the use of patient experience as shown by the following:

- The credibility of patient feedback is questionable as the patient has not received formal medical training
- In the evaluation of the patient experience, patients who are by their nature easily influenced, can allow non health related events to influence their experience of care.
- The other concern that is raised, is focussed on, patient need gratification rather actual benefit to the patient.

Whilst these concerns are valid, one has to bear in mind that the patient, though not formally qualified as a health practitioner can provide valuable information on the quality of the service delivery by identifying bottlenecks in the system that may not be recognized by the practitioners that are delivering the care. It is possible that patients may present with unrealistic expectations

that are unsustainable within the public sector, but this should not serve as a deterrent from using the patient in the process of developing QI initiatives.

2.5.3 The Role of Patient Experience

2.5.3.1 Patient Experience Measures for Quality Improvement

In a study by Manary, Staelin, Kosel, Schulman, and Glickman (2015:12) and a Beryl Institute (2014:11) report, most managers supported the role of patient experience in addressing QI. This is a considerable turnaround as the general perspective offered by managers did not link patient experience in this regard. The Beryl Institute "found that improving the patient experience was the top priority by over 70% of the managers" (Beryl Institute,2014:14). However, there still remains uncertainty on the methods that are most appropriate to apply the data towards QI.

Measurement of patient experience is important and relevant in the current healthcare environment to achieve the following:

- "*identify gaps in service;*
- *to gain insights into issues that are causing negative effects on patient care; and*
- *To innovate and/or redesign processes in order to better deliver care with patients".* (Lehrman, Silvera and Wolf,2014:9; Luxford et al.,2012:18).

Patients have exclusive knowledge about important aspects of care, and measuring patient experiences can be used for quality improvement (Wolf,2015:15; Bjertnaes, Sjetne and Iversen, 2012:39).

According to Ahmed, Burt and Roland (2014:15) the change towards using patient experience in developing policies to support QI is gaining momentum throughout the world. The benefits of incorporating patient experience into policies are as follows:

- "*understanding current problems in care delivery;*
- *informing continuous improvement and redesign of services;*
- *helping professionals reflect on their own and their team's practice;*
- *monitoring the impact of any changes;*

- *facilitating benchmarking between services/organisations;*
- *comparing organisations for performance assessment purposes;*
- *informing referring clinicians about the quality of services;*
- *informing commissioners and patients about the quality of services;*
- *informing patients about care pathways;*
- *helping patients choose high quality providers; and*
- *Enabling public accountability"* Ahmed et al. (2014:15).

England, USA Australia, Canada, New Zealand and other European countries have moved towards the use of patient experience (Robert and Cornwall,2013:67; Lombarts, Rupp, Vallejo, Sun˜ol and Klazinga,2009:28). The results of patient experience surveys have far-reaching consequences, as these are often used as a management tool and as a basis for political decision-making. Measures of patient experience are important information and should be a priority for health care managers. However, there are significant challenges with regard to analyzing and interpreting data, thus practitioners must be cautious when using the information in quality assessment and in decision-making processes (Sandager, Freil, Knudsen and Lehmann,2016:17). "The use of patient experience information can be an important strategy to use in driving system transformation" (Browne et al.,2010:921) which supports patient experience in QI.

2.5.3.2 Patient Experience and Clinical Outcomes

Luxford and Sutton (2014:16) explain "that organizations cannot address clinical outcomes or the quality and safety efforts that shape them in isolation". The key to improving clinical outcomes as part of the overall patient experience strategy is to identify the key dimensions or domains of patient experience that are most relevant to the patient experience phenomenon. Achieving excellent clinical outcomes cannot be prioritized in lieu of the quality and safety of health service delivery. Therefore the patient experience objectives should be developed so that all service delivery in the health sector is provided such that there is negligible compromise of safety or quality. Once the domains of patient experience have been identified, health leadership can develop appropriate health policies and regulations that incorporate these domains into the provision of service delivery in order to effect the required change.

Browne et al. (2010:922) explain "that health care providers cannot achieve positive health outcomes without commitment and action from patients". Research by Luxford and Sutton (2014:19) demonstrated a positive association between patient experience data and the clinical outcomes of patients; while another positive association with reduced hospital admission stays, improved patient safety and compliance to treatment protocols are noted (Doyle, Lennox, and Bell,2013:4).

2.5.3.3 Patient Experience and Financial Outcomes

Patient experience is also recognised for its role in financial outcomes. The benefits that result from this association can be found in the reduction of health care costs, increased efficiency and effectiveness at the health facility (Stanowski, Simpson and White,2015:268; Zhao,Haley, Spaulding, and Balogh,2012:309). This is also supported by Boulding Glickman Schulman, Staelin and Manary (2011:12) and Trzeciak, Gaughan, Bosire and Mazzarelli (2016:6), who show that patient experience was positively associated with the performance of the health organisation, patient retention, reduced provider malpractice risk, and increased health staff satisfaction. In an earlier study conducted by Nelson, Zahorik, Rose, Batalden and Siemanksi (1992:12) "patients' perceptions of quality explained nearly 30 percent of the variation in hospital financial performance". In a country such as SA there is an emphasis to reduce financial wastage and improve the financial viability. The high burden of disease has placed a significant constraint on the availability of resources and has the potential to undermine the financial sustainability of the system in SA.

2.5.3.4 Patient Experience and Consumer Loyalty

According to Wolf (2015:3) the inability to elicit a positive patient experience has implications for patient loyalty. In fact, Arab et al. determined that:

"The patient's experience has a strong impact on the outcome variables like willingness to return to the same hospital and reuse its services or recommend them to others."

In a country such as SA where the prevalence of communicable diseases is high, a positive patient experience is needed for patients to develop an unwavering commitment to the health facility, services and staff.

2.5.3.5 Patient Experience and Community Reputation

Healthcare organizations are a prominent presence in communities and the experiences that result thereof are more likely to be communicated within the community (Stanowski et al., 2015:269). The reputation of an organisation will influence the patient's decision to seek healthcare from that specific organisation. Simply put, if the facility has a good reputation then there is a greater probability that individuals will choose to frequent that particular facility. There is limited research that addresses the link between patient experience and community reputation which provides a new area for further research.

2.5.3.6 Patient Experience and Safety Outcomes

Stein, Day, Karia, Hutzler and Bosco (2015:21) noted an association between patient safety outcomes and patient experience measures. Kvist, Voutilainen, Mantynen and Vehviläinen-Julkunen (2014:11) also associated patient experience scores with job satisfaction among nurses. The link between job satisfaction and patient safety is evidenced by improved effectiveness of the health worker when the motivation levels are high. Safety outcomes are important especially when one considers the rising costs of malpractice lawsuit cases that can be levelled against the public health sector. With an already alarming incidence of patients who are dissatisfied with the quality and safety of healthcare delivery the need to improve safety outcomes has increased.

2.5.3.7 Patient Experience and Employee Outcomes

According to Browne et al. (2010:923) a positive patient experience contributes to employee satisfaction (Figure 2.4) thereby reducing turnover. When the health professional provides reputable service it provides a sense of fulfilment that they are doing a good piece of work. The employee is better motivated and is able to function well within the work environment thus also reducing employee turnover. This type of scenario will lead to improved levels of satisfaction and motivate them to be better employees. This highlights the need for health facility managers to ensure the operational functioning. The benefits for improving patient experience with regard to the impact on employee satisfaction and turnover is clear whilst the case for good business is evidenced in previous studies according to Brown et al (2010:923). Whilst the literature supporting the link between patient experience and employee satisfaction is limited in this regard, the evidence for improving the employee level of satisfaction through patient experience should not be minimized. It is well known that health professionals have been experiencing low

levels of job satisfaction which has in turn influenced the quality and effectiveness of service delivery (Dieleman and Hammejer, 2010:6). Therefore as reflected in Figure 2.4 there is a need for employees to experience need satisfaction so that they can be perform better within the work environment and in so doing there should be justifiable rewards that reinforce the need satisfaction.

Figure 2. 4: Basic Motivational Model

Source: Cronje, du Toit, Marais and Motlatla, 2012:223

The area of job satisfaction presents a potential area for further research.

2.6 Conclusion

The chapter has outlined the health system efficacy in African countries and SA in particular. The Batho Pele Principles in its application to the Primary Health Care approach has been discussed. The standards and norms that support the Ideal Clinic are explained. The challenges that influence the public health sector are outlined. Picker Principles and the IOM Framework provide an understanding of patient experience themes as applied in developed countries. Patient Experience and the associated benefits are explained. The chapter that follows provides an understanding of the different health models and frameworks

CHAPTER 3:

MODELS AND FRAMEWORKS

3.1 Introduction

Primary health care clinics still face a challenge in bridging the gap between patient expectations and the actual service that they receive. Therefore the role of the patient has become necessary in the evaluation of the quality of health service delivery. QI initiatives in high income countries clearly outline how patient experience is a key component of the change strategy. Therefore, developing a conceptual model to improve the patient's experience of health services may be a key component to engage positive health reform in SA. The chapter provides a discussion of the different models of health that are implemented in health systems across the world. Patient Experience Frameworks are also explained in the chapter and outline the different domains of patient experience.

3.2 Models of Health

The following models of health have been described according to Wallace (2013:41):

A) The Bismarck Model

Countries that ascribe to this model include Japan, France, Belgium, Switzerland, Japan, and Latin America. In this health model the "providers and payers are private therefore private insurance plans are financed jointly by employers and employees through payroll deduction". The plan aims to provide cover with no profit incentive. In order to achieve this, the plan is strictly controlled to ensure that costs are appropriately managed. (Wallace,2013:42). The countries who apply the model are explained as follows:

- **The Model is applied in France as follows:**

France has been rated first for its application of the Bismarck Model in the country's healthcare system. France provides public health cover for all of the country's 64 million residents. Funding is pooled from social contributions that are paid in by the worker and the company. Whilst the

healthcare provided is not restricted, the plan requires pre-payment for services by the patient. The patient is then reimbursed for the payment made but there is no assurance that a full refund will be provided for.

- **The Model is applied in Japan as follows:**

According to Ellis, Chen and Luscombe (2014:14) Japan has a four tier health system that includes the following : tier one for salaried employees, tier two for unemployed persons, alternative employment and low income grouping, and tier three that is specifically designed for the elderly. Individuals that do not qualify for inclusion within tier one to three receive health within the tier 4 insurance. In this way all members of the population are catered to using the Bismarck model. The model as applied in Japan also provides additional benefits to those who are categorised as disabled or geriatric.

B) The Beveridge Model

This model was named after William Beveridge and inspired Britain's National Health System. Healthcare is funded by the government in the form of tax contributions as the emphasis is on providing a service to the public. Therefore the health costs are minimized as the model does not account for private providers (Wallace,2013:46). This "socialized medicine" model is currently applied in Great Britain, Brazil, Spain, Australia and New Zealand.

The model as applied in Australia is discussed as follows:

According to the Australian Institute of Health and Welfare (AIHW) (2014:34) "most health care in Australia is provided in primary health care settings". The primary health care system allows patients to receive care either from one provider or a multi-disciplinary approach but it has been described as 'fragmented' and 'fractured' (AIHW,2014:36). The Patient Centred Care Approach is also applied in Australia. The socialized model allows for the population to receive primary health care at the lowest level of healthcare.

The model as applied in Brazil is discussed as follows:

According to Binge (2010:1) the Brazilian Unified Healthcare System is based on three principles which comprise the following:

- "*Firstly, access to healthcare is universal and free at the point of use to the whole population;*
- *Secondly, free healthcare is provided at all levels, from preventative care to complex hospital treatments;*
- *Thirdly, the funding and provision of healthcare is shared between the three tiers of government, federal, state and municipal, with an increasing trend towards managerial decentralisation";*

Municipalities have the responsibility for health services delivery and provision, which can vary widely across states and municipalities.

The Family Health Programme is implemented in Brazil and due to its success has been expanding. Binge (2010:3) explains that the " programme is part of a shift from a model based on curative care in hospitals towards a focus on primary and preventative care, with the first point of contact shifted to local communities". This model is cheap and technologically simple and may be ideal for use in developing countries. (Binge,2010:3).

The increase in coverage has improved health outcomes in Brazil (Binge,2010:3). Rocha and Soares (2010:126) "showed that the implementation of the programme was associated with significant reductions in mortality throughout the age distribution, but particularly at early ages". The evidence for the poorest regions suggested that the "programme was correlated with lower fertility rates, increased female labour supply and improved school enrolment". The above information indicates that the healthcare model has proven to be successful in Brazil.

According to Mackinko, Starfield and Shi (2014:831) significant progress has been made in terms of improving health and human development in the Region of the Latin America and the Caribbean. Whilst SA displays economic and social similarities with Brazil, SA is lagging far behind in its delivery of healthcare.

The model as applied in the United Kingdom is discussed as follows:

The model is applied through the "Patient and Family-Centred Care Programme". The program focus aims to improve the patient's experience by ensuring that providers and health facilities meet the requirements for quality service provision. These aims are encapsulated as follows:

- "*Patients should have confidence that they are receiving high quality care;*

- *Patients participate in their care with healthcare providers; and*
- *Patients have care that is designed to deal with their holistic needs".*

"Each organization investigates new tools to measure patient experience. Information is gathered by shadowing patients throughout their journey" (Health Foundation Inspiring Improvement, 2013:35).

C) The National Health Insurance (NHI) Model

The countries that ascribe to this model include Canada, Taiwan and South Korea. Health care providers are considered to be private. The model "is a government-run insurance program that every citizen pays into and has considerable market power to negotiate lower prices" according to Wong (2013:15). Costs can be controlled through the limitation of services rendered or by controlling the period of wait for services by the patients.

The model as applied in Canada is discussed as follows:

According to Wong (2013:15) primary health care is the foundation of Canada's health care system. A strong foundation has the potential to produce positive population health outcomes including the following:

- *"increased knowledge about health and health care;*
- *reduced risk,*
- *duration and effects of acute and episodic conditions ; and*
- *Reduced risk and effects of continuing health conditions"* (Hollander,Kadlec and Hamdi, 2009:30).

Patients who worked with a regular provider produced the following positive outcomes (Mazowita and Cavers,2011:18):

- improved medication adherence ;
- reduced use of emergency services;
- shorter hospital stays; and

- Lower overall health-care utilization.

Tregillus and Cavers (2011:14) have shown that those with a chronic disease who have a regular provider have lower health system costs. However, despite all the positive outcomes Canadians have become increasingly concerned about their health system. Two of the more pressing concerns worthy of note, relate to the access and the quality of their care from family physicians, whether for a first contact or for routine care. Increasing dissatisfaction with workloads, higher compensation for specialists versus family physicians, an increasingly complex family physician workload, and fiscal and cost restraints that affected health care service delivery across the country have affected the access and quality of care according to Mazowita and Cavers (2011:20). Canada is therefore also in a prime position for reform with regard to improving its health quality and access.

The NHI Model has also been strategically developed for implementation in SA. It is interesting to note that Canada is already concerned with the effectiveness of the NHI health system and has pointed out a number of obstacles.

D) The Out of Pocket Model

In certain rural regions within Africa, India, China, and South America there is a “no-system” approach to healthcare. The patient must pay for services rendered and this has implications for the poor who are unable to afford these payments. There is a lack of government intervention. "In rural regions of Africa, India, China, and South America, hundreds of millions of people go their whole lives without ever seeing a doctor" (Wallace,2013:49).

In comparison to the "no system" approach, other parts of these developing countries have a system in place but there is evidence to suggest that the systems are lacking.

Das and Hammer (2014:525) explain that "*a study in India found that providers on average spent 3.6 minutes with a patient, completing only one third of recommended history and physical exams. Diagnoses were provided in only 36% of cases, and only 12% of these were correct. Harmful or unnecessary treatments were more common than correct ones (42% vs. 30%)".*

"*In China, clinicians completed only 18% of items on a recommended checklist, provided a correct diagnosis in just 26% of patients, and dispensed unnecessary or harmful medications in nearly 70 % of interactions*" (Sylvia, Shi, Xue, Tian, Wang, Liu,2014:1).

These findings reflect that there are areas of concern in China and India (Ndhambi,2012:21)

It is apparent that there is a diverse implementation of health models in countries around the world. However the positive outcomes that can be produced with a successful primary health care system still outweigh the problems facing many countries. Cuba, Chile, Costa Rica, US, Canada, and Great Britain have improved their health care services to fit the population's needs by using the primary health care approach as suggested by Chimezie (2015:208).

The section that follows describes the development and advancements of Public Sector Improvement Frameworks and how the framework can be used to engage positive reform within any public sector.

3.3 Public Sector Improvement Theories and Frameworks

The Public Health Sector in SA can benefit from the use of Public Sector Improvement Frameworks. The theories that have been used in the past to support improvements in the Public Sector range from the Old Public Administration to the innovative Public Sector Improvement Framework. The change in the approach to improving the Public Sector is clearly outlined and highlights the need for incorporating the citizen at the heart of the change effort. This is especially relevant within the South African context where the public sector has been wrought with inefficiencies and challenges that impair the quality of service delivery. Through an analysis of the different approaches towards public sector improvement, the study outlines the relevance of the New Public Service approach and its applicability within the South African context.

3.3.1 The Old Public Administration

The prevailing approach for much of the 20th century "drew on a model of bureaucracy based on the twin principles of hierarchy and meritocracy" (Robinson,2015:8). This approach to public administration was introduced around the world under colonial rule (Rowe and Chapman,2015:17). However, governments quickly realized that the approach of command and

control was limited at best and needed to be adjusted. This heralded in the New Public Management Approach.

3.3.2 The New Public Management

The New Public Management (NPM) emerged in a number of countries in the 1980s. The NPM model was developed in response to gaps identified with the old public administration application in a competitive market economy (Rowe and Chapman,2015:20). In practice NPM reforms in developing countries were limited as many of these countries favoured a command and control approach (Cheung,2011:656). McCourt (2013:22) provides an example of a developing country such as India who used the NPM reform to improve government responsiveness. However, studies that investigated the effectiveness of the reform are inconclusive. Another example offered by McCourt included tax administration programmes that used the NPM model within Uganda, Tanzania and Zambia. The use of NPM reforms are mostly highlighted for its application in the financial sector reforms. Its' application in health sector reforms has received little attention.

3.3.3 The New Public Governance

The New Public Governance (NPG) approach by Osborne, Radnarand and Nasi (2010:14) is contrasted with the bureaucratic hierarchy (old public administration) and the managerial discretion (NPM) approaches, as it places citizens at the centre of its frame of reference (Robinson,2015:21). The NPG approach also speaks to a democratic type of governance where the citizens of the land are entitled to determine who the powers of authority should be. However, it can be argued that the citizen should not be the only shareholder included in the frame of reference that seeks to improve the public sector. This type of sentiment led to the development of the New Public Service Approach which is discussed in the section that follows.

3.3.4 The New Public Service

The New Public Service (NPS) approach starts with the premise that the focus of public management should be citizens, community and civil society. In this conception the primary role of public servants is to help citizens articulate and meet their shared interests rather than to

control or steer society (Robinson,2015:22). However, these approaches are largely grounded in developed countries therefore their applicability in developing countries may be criticized. In this respect Andrews (2013:12) highlights that approaches should be tailored to each country but the emphasis should always place the citizen at the centre of public sector reform efforts

In keeping with this ideal, health care in Europe was transformed through the use of the NPS approach in the development of the Public Sector Improvement Framework (PSIF) which was founded on the needs of the citizens being served. The PSIF has been applied in Scotland in the public health arena with positive results in the experiences reported by patients (Rowe and Chapman,2015:24). The PSIF holds great potential if it can also be applied within the SA context to cultivate a culture of continuous improvement in every department that is managed through government. This framework has the potential to support the sustained achievement of a positive patient experience when applied within the public health sector. According to the public sector approaches that have been explained, it is evident that the need for a bottom up approach is more applicable in developing QI initiatives when catering to the citizens' needs. The importance of placing the citizen at the heart of the health care reform effort is also highlighted within the QI frameworks that can be applied within the healthcare context. The section that follows explains the different frameworks that have applicability within the healthcare context.

3.4 Frameworks of Quality Improvement

Edward Deming (2000:5) writes,

"*Quality should be aimed at the needs of the customer, present and future*".

Based on the above, there is a clear instruction of how QI should be developed. It reinforces the understanding that within the healthcare context, the patient should be the driving force in the QI movement. However, there is much contention and debate surrounding this approach within SA. Understanding the definition of quality and QI highlights the role of the patient in directing positive reforms. SA should be focused on developing frameworks that support QI through the eyes of its most valuable asset, being the patient.

The IOM "defines quality in healthcare (medicine) as the extent to which health services increase the likelihood of desired health outcomes consistent with current professional knowledge for individuals and citizens" (Sorian,2006:11; Sollecito and Johnson,2011:14).

The role of information in healthcare is imperative to understanding how and why healthcare service delivery has been lacking.

"*A quality improvement approach refers to a deliberate and organised set of actions within a practice*

*Or organisation involving planning, implementation and assessment designed to improve the safety and quality of care" (*AIHW,2014:20).

According to the AIHW (2014:24) QI processes usually rely on information and feedback care to understand the reasons for variations in quality, and to identify where quality can be improved. This sentiment was shared by Wong as stated:

'A well-constructed survey offers a window into patients' perceptions that is otherwise unavailable. Patients are uniquely positioned to report on their care experiences and they are often the only common thread across disparate health care settings' (Wong,2013:14).

Most health facilities are reliant on patients for valuable feedback after a change has been implemented, but there is a current change in the trend, whereby countries are relying on patients for initiating and developing programmes to improve the quality of service delivery. This viewpoint is especially relevant within SA where the health services are inequitable across the provinces despite the standardization of norms for healthcare facilities and the use of the Batho Pele Principles (National Health Facilities Baseline Audit,2012:55). The need for incorporating the patient's experience is critical to the process of QI in healthcare. One may question why; and the response: The patient has historically been misunderstood as a discontented entity, regardless of the service delivery meted out to them. This type of flawed perception has inappropriately placed the patient in a position of disempowerment and disengagement. Looking ahead, the ultimate objective should seek to work with and not against the patient.

3.4.1 European Foundation for Quality Management (EFQM)

According to Ismail, Darestani and Irani (2011:35) the EFQM helped European companies to be competitive in international markets. The model accepts that EFQM gives better results for private organizations in comparison with public organizations (Nour-Mohammad and Yaghoubi,2011:71).

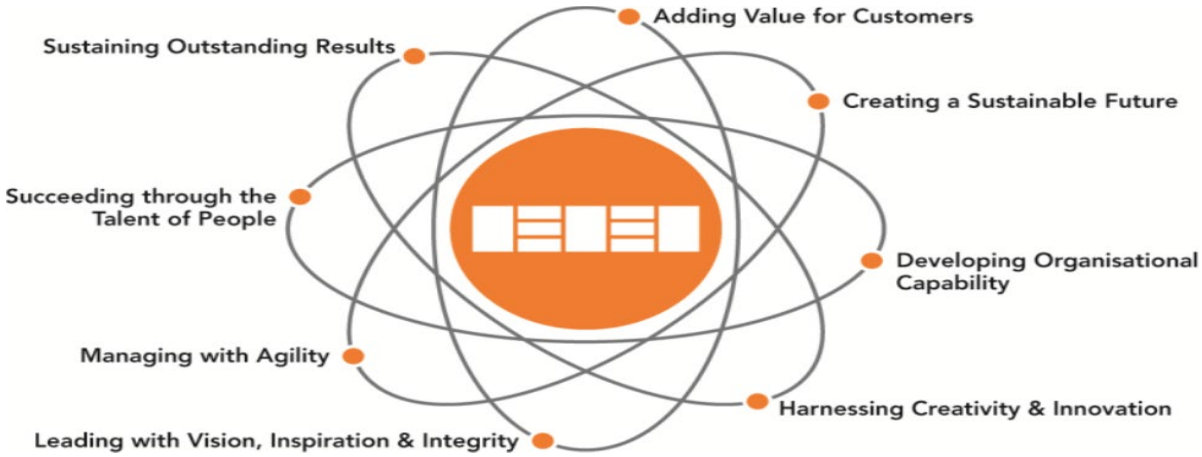

Figure 3. 1: Fundamental Concepts of the EFQM

Source: Nour-Mohammad and Yaghoubi (2011:73)

As shown in Figure 3.1 there are 8 Fundamentals Concepts (EFQM,2012:5):

- Adding value for customers;
- Creating a sustainable future:;
- Developing organizational capability;
- Harnessing creativity and innovation;
- Leading with vision, inspiration and integrity;
- Managing with agility;
- Succeeding through the talent of people; and,
- Sustaining outstanding results.

Whilst the fundamental concepts of EFQM could potentially be translated to develop QI initiatives within the public health sector, the use of the model has not proven to be

successful in major public reform initiatives (Nour-Mohammad and Yaghoubi,2011:74). Therefore this model is not applicable to the study. In the context of public healthcare the use of Patient Experience Frameworks has received accolade with respect to its role in QI.

3.4.2 Patient Experience Frameworks of Healthcare as a QI Initiative

"Patient care is defined as an approach and philosophy to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships among providers, patients, and families" (Abraham and Moretz,2012:44).

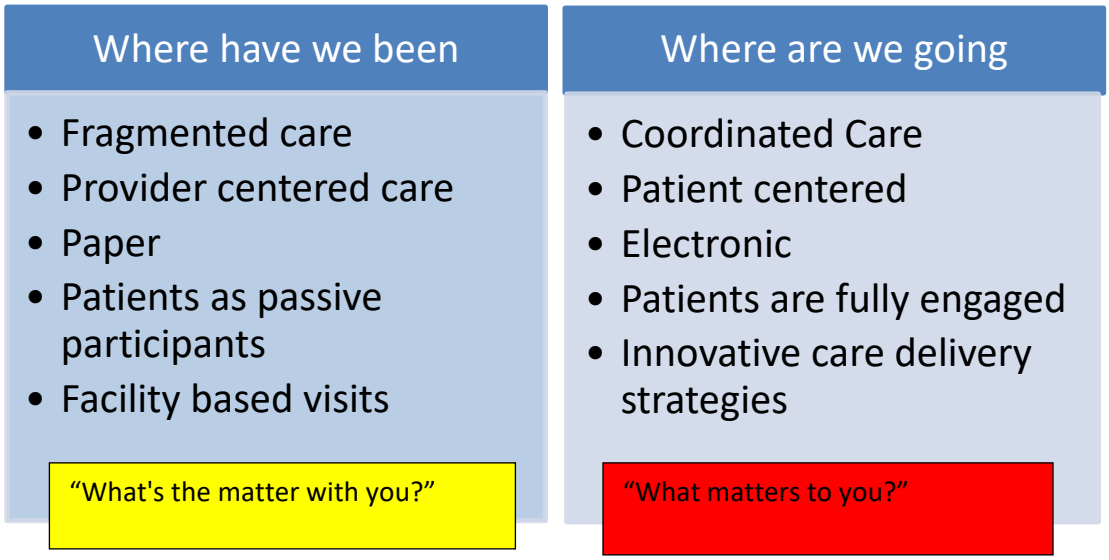

Figure 3. 2:**Paradigm shift towards Improving Patient Experience**

Source: **Barry and Edgeman-Levitan (2012:780)**

It is evident that health care is moving towards emphasising patient experience in the care approach. In highlighting the role of patient experience where patients are more engaged and health care is delivered using innovative strategies, the health care system is able to provide quality health care. By investigating the patient experience of care the health system is able to identify the different aspects of health service that needs to be improved and in this way it can direct QI initiatives.

The IOM framework and the Picker Principles place the patient at the core of the health directive. Experience of care is highlighted as important in the framework to improve quality of health care due to its associations with "improved patient satisfaction, better health

outcomes, and cost-effective care"(Cosgrove, Fisher, Gabow, Gottlieb, Halvorson, James, Kaplan, Perlin, Petze, Steele, and Toussaint,2013:321).

Anhang-Price, Cleary, Zaslavsky and Hays (2014:10) found that positive experiences of care were associated with care practices that prioritised the patient's needs. However, changing the culture, high implementation costs and the maintenance of new practices have limited the move towards care that focuses on the patient (Luxford et al.,2012:512). The models of the experience of care are discussed further in the section that follows:

3.4.2.1 Picker Principles

The Picker Institute (Europe) pioneered the use of carefully designed survey instruments to obtain detailed reports of patient experience and identify areas for improvement in the public health system (Picker Institute Europe,2014:12). These survey instruments differ from patient satisfaction surveys which have a more subjective focus.

"Patient centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers" (ACSQHC,2013:11). Its underlying principles include the following:

- treat all stakeholders including the patient with dignity and respect;
- encourage and supporting patients, carers and families to participate in shared decision-making;
- communicating and sharing information with patients, carers and families; and
- encourage collaborations with patients, carers, families and health professionals in the development of programs and in the delivery and evaluation of health services.

The cornerstone for assessing patient centred care is to understand how patients experience their care. The link between patient experience and patient centred care is thus revealed. This work of understanding patient experience is commonly guided by the Picker framework. The Batho Pele Principles which are used in SA is closely related to the principles of patient care as depicted by the Picker Principles.

3.4.2.2 Institute of Medicine

The Institute of Medicine (IOM) was established in 1970 and is the health arm of the National Academy of Sciences. In 2001 the IOM published a report 'Crossing the Quality Chasm: A New Health System for the 21st Century' (Institute of Medicine,2001:5). The report outlined 6 major aims for all health care organisations, stating that health care should be; safe, effective, patient-centred, timely, efficient and equitable. Care was described as encompassing qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient. Care properties are described in Table 3.1 and also show the relationship between how these properties can be achieved when incorporated in the health care system and in the professional patient relationship.

Table 3. 1: IOM and Picker Care Properties, by Target Area.

Care properties, by target area.	**Health care system**	**Both - Professional-patient relationship and health care system**
Alleviation of fear/Anxiety	Collaboration between disciplines towards goal of healing	Medical terminology is standardised to improve communication
Provision of Factual information	Long term	Communication about care
Education/Shared knowledge	Coordinated and integrated care	Culture supporting positive interaction between patients & caregivers
Emotional/Psycho-social support	Creates new standards/evolves	Equitable treatment for all
Enhancing Dr/patient relationship	Effective professional resources for people who can't manage their own health	Free flow/accessibility of information
Holistic	Focus on expected patient outcomes vs. departmental needs. Incorporate art (music, visual etc.) into patient care	Incorporating prevention/health promotion
Personalization	Incorporate massage/human touch	Involvement of family/friends
Partnership among professionals, patients and families	Infrastructure supports administration, training, information financing and quality improvement	Patients understanding & Participation in goal of healthier society
Patient control	Integrate alternative/complementary practices	Respect for patient needs/customized care
Participate in own care	Patients participation in financing & incentives for healthcare	Respect for patient preferences/wants
Patient responsibility for health	Simplifying care at the bedside	Respect for patient values
Physical comfort	Team management of health professionals	Quality
Reaching agreement about managing illness	Transition planning	Patients' values guide clinical decisions

Adapted from 'Putting Patients First'- Health professional-patient relationship

Stiff et al. (2013:610) states that there are commonalities between patient centred care and patient experience. Still explains that "Patient experience is seen as a measure of patient centeredness, and can be used to ensure organizations are delivering patient centred care". Dr. Susan Frampton, President of Planetree, also noted that patient experiences were not only a measure of the patient-centred approach used at health facilities but also provided valuable feedback on how to promote quality. Therefore patient experience not only indicates the degree of patient centeredness but also indicates how patients view the entire process of healthcare. For this reason, the study has drawn its attention to patient experience as a whole rather than patient centeredness.

3.5 Health Systems that Adopt the Patient Frameworks for Improving the Experience of Care

3.5.1 Canada (British Columbia)

British Columbia a province in Canada has a vision for achieving a health care system in which:

a) The patient`s voice

• is anchored in all behaviours and drives all activities of the health system.

b) A culture of patient-centeredness

• is self-evident across the health system and is integrated into existing health care programs.

c) Health care programming

• is built upon the patient-centred care principles throughout planning, implementation, and evaluation (Shaller,2013:6).

3.5.2 Sweden

Jönköping (Sweden), healthcare system is recognized for focused care based on the patients needs, expectations, preferences and anxieties. The Program coordinates care and ensures that patients flow well through the system and between sectors. The goal is that services are assessed and provided by looking through the patient's eyes and is associated with decreased wait times and costs and more effective treatment (Davis, Wackerberg, Fuge, Harris, Barrett-Lee, Matthias, 2012:15; Baker, MacIntosh-Murray, Porcellato, Dionne, Stelmacovich and Born,2008:10)

3.5.3 United States

Medical College of Georgia (MCG) Health System focussed on key elements as follows:

- *"Committed leadership;*
- *Vision;*
- *Participation and involvement of patients and families;*
- *Work environments that are supportive;*
- *Feedback and measurements that are systematic; and*
- *Quality of built environment*".

As a result the MCG Medical Centre patient care experience ratings improved in a short period of time with a reduced employee turnover (Shaller,2013:8).

3.6 Conceptual Framework for the Study

The Batho Pele Principles provides a baseline with regard to what the patient can and should expect at a primary health clinic in SA. The Picker Principles and the Institute of Medicine (IOM) Framework provides an outline of how patient experience can be improved. The principles of Batho Pele is also clearly linked to the concept of patient experience as noted by the commonalities with the IOM framework and the Picker Principles and is therefore relevant in the study as a point of reference to improve patient experience in SA. The three frameworks together with the PSIF are used to develop the conceptual framework for the study to provide a point of departure on how to enhance patient experience in the PHS and are discussed below. The PSIF supports the understanding that the patient is at the centre of the reform initiative and this sets the platform for the study. Based on the framework, the survey is designed to obtain a comprehensive understanding of the current patient experience in the primary health clinic and to determine the domains that patients in SA agree to be relevant to the patient experience. The various themes highlighted in the Batho Pele Principles, Picker Principles and IOM Framework is evaluated to determine themes that are applicable to patient experience. In addition the PSIF is used to determine the positive reforms that can result with the use of the proposed model.

Consultation
"Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered".

Batho Pele Principles note that the principle of consultation requires the inclusion of patients when evaluating the quality of services that are delivered within the healthcare context. Essentially, the inclusion of patients in the assessment of quality is closely linked to the Patient Experience Frameworks.

Service Standards
"*Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect".*

Batho Pele explains that it is imperative that patients are informed and Patient Experience frameworks support that the patient be included in the setting of standards.

Access
"All citizens should have equal access to the services to which they are entitled;"

Batho Pele explains that citizens should be able to freely access health services. Patient Experience Frameworks also support that access is an important factor.

Leadership and Direction
Good leadership is one of the most critical ingredients for successful organisations. (DoH,2016:12).

Batho Pele Principles explain "that organisations who do well in serving their customers can demonstrate that they have leaders who lead by example, who set the vision, and ensure that the strategy for achieving the vision is owned by all and properly deployed throughout the organisation. They take an active role in the organisation's success" (DoH, 2012).

Customer Impact
"*Impact means looking at the benefits we have provided for our customers both internal and external – it's how the nine principles link together to show how we have improved our overall service delivery and customer satisfaction. It is also about making sure that all our customers are aware of and exercising their rights in terms of the Batho Pele principles"* (DoH,2016):13

This is an important aspect that incorporates how the service comes together to provided benefit for the patient.

Openness and Transparency
"Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge";

According to Batho Pele Patients should be well informed of the organisational structure and hierarchy.

Redress
"*If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when the complaints are made, citizens should receive a sympathetic, positive response".*

According to Batho Pele the patient is at the centre of the entire health service. When a patient complains, it is important that they are given the attention that is needed and should not be dismissed as being difficult or unappreciative. When someone complains there needs to be an investigation that seeks out to identify the root of the problem so as to prevent the repeat incidence (Batho Pele). Patients should therefore be encouraged to participate in the process of identifying bottle necks or problem areas within the health system.

Involvement of family and friends
"Involvement of and support for family and carers"

According to Picker Principles "*this includes the accommodation of family and friends, involving family in decision-making, supporting the family as care-giver and recognizing needs of the family"***.**

According to the IOM "*this includes accommodating family and friends on whom patients may rely, involving them as appropriate in decision making, supporting them as caregivers, making them welcome and comfortable in the care delivery setting, and recognizing their needs and contributions".*

Courtesy and Respect
"*Citizens should be treated with courtesy, consideration, empathy and respect"*

According to Picker Principles the quality of life, involvement in decision making, dignity, needs and autonomy.

According to IOM "*each patient's wants, needs, and preferences; gives patients opportunities to be informed and involved in medical decision making; guides and supports those providing care in attending to their patients' physical and emotional needs; care is customized and incorporates*

cultural competence. Patients' preferences are likely to change over time and to depend on the clinical problems in question"

Emotional Support
Emotional support—relieving fear and anxiety.

According to Picker Principles "anxiety *over clinical status, treatment and prognosis; impact of the illness on self and family; and the financial impact of the illness need to be considered*."

According to IOM "*suffering is more than just physical pain and other distressing symptoms; it also encompasses significant emotional and spiritual dimensions".*

Physical Comfort		
Attention to physical and environmental needs		

According to Picker Principles this includes the surroundings and hospital environment.

According to IOM "the *attention to physical comfort implies timely, tailored, and expert management of symptoms such as pain, shortness of breath or other discomfort".*

Co-ordination and Integration
Continuity of care and smooth transitions.

According to Picker Principles" *information on discharge, continuing care that is organized, continuing support and who to call for help is important*".

According to IOM "*the requirement to ensure that accurate and timely information reaches those who need it at the appropriate time; addresses the need to manage smooth transitions from one setting to another or from a health care to a self-care setting".*

Information
Citizens should be given full, accurate information about the public services they are entitled to receive;

According to Batho Pele the right to information is an important aspect of Batho Pele.

According to Picker Principles "*information, communication and education to support clinical status, progress and prognosis; processes of care; facilitate autonomy, self-care and health promotion are needed".*

According to IOM "*people want to know what is wrong (diagnosis) or how to stay well, what is likely to happen and how it will affect them (prognosis), and what can be done to change or*

manage their prognosis. They need answers that are accurate and in a language they understand. Common to all such interactions is the desire for trustworthy information (often from an individual clinician) that is attentive, responsive, and tailored to an individual's needs"

Value for Money
Public services should be provided economically and efficiently in order to give citizens the best possible value for money;

According to Batho Pele the emphasis of Bath Pele is service delivery with high quality.

According to Picker Principles: Health workers should provide quality care.

Encouraging Innovation and Rewarding Excellence
"*Innovation can be new ways of providing better service, cutting costs, improving conditions, streamlining and generally making changes which tie in with the spirit of Batho Pele. It is also about rewarding the staff who "go the extra mile" in making it all happen"*

Innovation according to Batho Pele seeks to identify ways of making improvements that support the general well being of the patient. It therefore is in keeping with the motivation to develop a patient experience model. The principles that have been discussed are used to identify potential domains of patient experience.

The Batho Pele Principles have been contrasted with the Picker Principles and Institute of Medicine (IOM) Framework to identify commonalities that can influence the patient experience. The Picker Principles and the IOM Framework provides an outline of how patient experience can be improved in developed countries and by itself, the frameworks may not be well accepted in the South African context. Therefore the contrast ensures that the factors influencing patient experience based on the theoretical analysis of the frameworks are culturally acceptable for application in SA.

The following domains of patient experience that have been included in the study based on the frameworks of Batho Pele, Picker Principles and IOM are as follows:

Table 3. 2: Development of the Domains of Patient Experience

DOMAINS	FRAMEWORK
1. Access	Batho Pele explains that citizens should be able to freely access health services.
2.The physical state of the infrastructure	According to Picker Principles this includes the surroundings and hospital environment. According to IOM "*attention to physical comfort implies timely, tailored, and expert management of symptoms such as pain, shortness of breath or other discomfort".*
3. Involving my family and friends in my care	According to Picker Principles*" this includes the accommodation of family and friends, involving family in decision-making, supporting the family as care-giver, recognizing needs of the family "* According to the IOM" *this includes accommodating family and friends on whom patients may rely, involving them as appropriate in decision making, supporting them as caregivers, making them welcome and comfortable in the care delivery setting, and recognizing their needs and contribution"*
4.Waiting time	According to Batho Pele the emphasis of Bath Pele is service delivery with high quality. According to Picker Principles: Health workers should provide quality care.
5.The quality of care	According to Batho Pele the emphasis of Bath Pele is service delivery with high quality. According to Picker Principles: Health workers should provide quality care.
6. Information	According to Batho Pele the right to information is an important aspect of Batho Pele. According to Picker Principles "information, communication and education on clinical status, progress and prognosis; on processes of care; to facilitate autonomy, self-care and health promotion".
7. Education	According to IOM "people tend to want to know (1) what is wrong (diagnosis) or how to stay well, (2) what is likely to happen and how it will affect them (prognosis), and (3) what can be done to change or manage their prognosis".
8. The role of the doctor	According to Batho Pele the emphasis of Bath Pele is service delivery with high quality. According to Picker Principles: Health workers should provide quality care.
9. Management effectiveness towards positive outcomes	Batho Pele Principles" explain that organisations who do well in serving their customers can demonstrate that they have leaders who lead by example, who set the vision, and ensure that the strategy for achieving the vision is owned by all and properly deployed throughout the organisation."
10.The role of medication	According to Batho Pele the emphasis of Bath Pele is service delivery with high quality.
11. Communication	"Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect."
12. Patient centred care	Batho Pele Principles note that the principle of consultation requires the inclusion of patients when evaluating the quality of services that are delivered within the healthcare context.
13. The role of the nurse	According to Batho Pele the emphasis of Bath Pele is service delivery with high quality. According to Picker Principles: Health workers should provide quality care.
14. Cleanliness in the clinic	"Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect."
15.Co-ordination and continuity of care	According to Picker Principles" information on discharge, continuing care organized, continuing support who to call for help." According to IOM "the requirement to ensure that accurate and timely information reaches those who need it at the appropriate time; addresses the need to manage smooth transitions from one setting to another or from a health care to a self-care setting"

3.7 Conclusion

The various health models that are in use globally are explained. The NHI model has been reviewed in Canada and significant concerns have been raised. The QI frameworks in healthcare have been described and the use of Patient Care Frameworks that emphasise Patient Experience is recognised as useful to measure quality in healthcare. Differences between the concepts of patient experience and patient satisfaction are addressed. Despite the reluctance surrounding the use of patient experience, the phenomenon is fast gaining momentum in the healthcare industry. This chapter concludes with a conceptual framework for the study providing a description of the domains that have been developed for further investigation in the study. The chapter that follows discussed the methodology that was adopted in this study.

CHAPTER 4:

RESEARCH METHODOLOGY

4.1 Introduction

The preceding chapter presented the review of the Health Care Models and Patient Care Frameworks. This chapter outlines the research methodology applied in the study. A mixed method approach was utilised in the study. The quantitative component of the study focussed on patients and the qualitative aspect of the study focussed on nursing service managers. The research philosophy, design and sampling strategies are explained.

4.2 Rationale for the Methodology

Patient experience data is mostly obtained using surveys but it can also be obtained using the method of interviews or focus groups (Ahmed et al.,2014:20). In this study, the patients' views were obtained using a survey in order to obtain a comprehensive understanding of the current patient experience, domains of patient experience that were outlined in Chapter Three and positive reforms. The study also used face to face interviews to obtain the views of the nursing service manager on how best to improve the patient experience. The benefit of the mixed method approach increases the reliability, validity and trustworthiness of the findings as the weaknesses of one research method can now be balanced by the strengths of the other method incorporated in the study.

4.3 Research Design

Wilson (2014:115) "...explains that research design is a framework for the gathering and analysing of data". The three common approaches to conducting research are quantitative, qualitative and mixed methods. "Measuring patient experience can be accomplished using a mixed methods approach whereby the quantitative and qualitative approaches" are both utilized in the collection of data (LaVela and Gallan,2014:28). The present study adopted a mixed approach that drew on both positivism and phenomenology to overcome the gaps that rise from using only one of the approaches. Some of the common forms of research designs are explained.

- According to Wilson (2014:120) "*exploratory research is usually based on an inductive approach where there is a lack or very little published work or knowledge on a certain topic*".
- According to Sekaran and Bougie (2013:97), "*descriptive research gathers data concerning individual characteristics, activities or situations regarding demographic details and satisfaction ratings*".

The study adopted research designs that supported the mixed method research approach. In keeping with the rationale for the methodology, the qualitative aspect of the study ascribed to the exploratory research design and the quantitative aspect of the study ascribed to the descriptive research design. The exploratory research design obtained data from the Nursing Service Managers with regard to patient experience. There is a dearth of literature on the subject of patient experience in SA and the exploratory research design is suitable to cases where there is little published work or knowledge on the subject. The descriptive research design gathered data from patients who provided valuable information with reference to the experience of care. The use of this design enables the study to obtain data that can be analysed to produce information on what is required in order to develop a conceptual model that improves the patient experience of care in SA.

4.4 Research Philosophy

4.4.1 Positivism

Positivism is focused on neutrality, objectivity, measurement and validity (Demetrius and McClain,2012:1; Campbell,2012:3). The justification for the use of the quantitative research approach in the collection of data from the patients is explained herein. The use of the quantitative data provided reliable data that was used to determine the patient experience of care from the perspective of the patient.

4.4.2 Phenomenology

"Phenomenology is based on the study of occurrences in their natural surroundings" (Saunders and Lewis,2012:105). The justification for the use of the qualitative approach is discussed herein. The use of the interview provided an opportunity to obtain an in-depth understanding of patient

experience as viewed from the perspective of the Nursing Service Manager. The interviews allowed the NSM's to describe experiences and perceptions. In doing so, the interview elicited a deeper understanding of patient experience. The qualitative research provided depth and breadth to the understanding of patient experience from a management perspective. Therefore the qualitative approach was used. The benefits that arise from using either the quantitative or the qualitative paradigm are clearly outlined above and further support the justification for the use of a mixed method study. Through the mixed method, the study has provided a comprehensive analysis of the factors that influence patience experience and how these factors can be included in a model to improve the patient experience of care.

4.5 Target Population

4.5.1 Geographical Setting of the Study

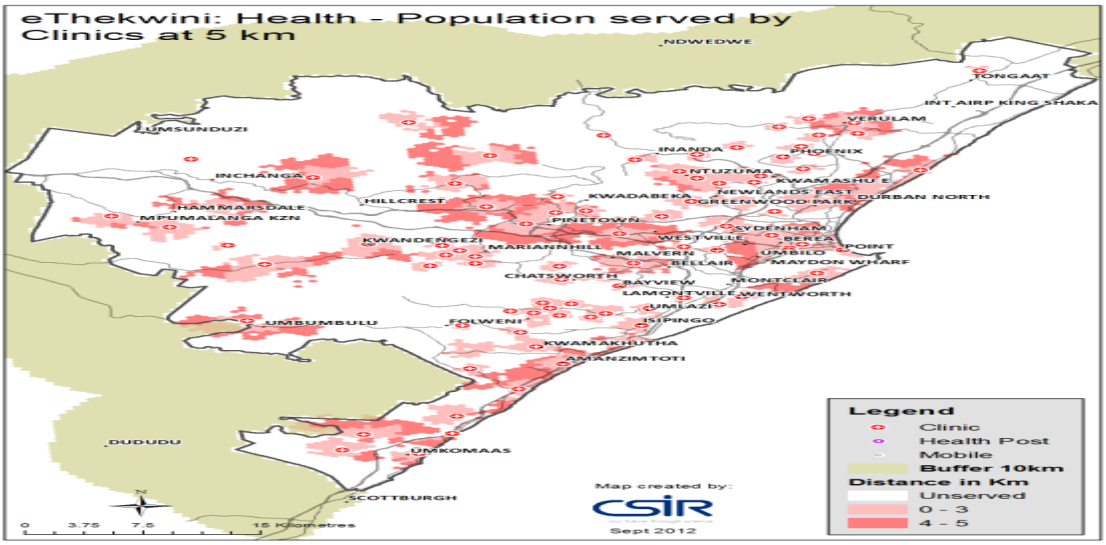

Figure 4. 1: Geographic Presentation of the Health Population in eThekwini

Source: DoH (2016:23)

The Province of KwaZulu-Natal (KZN) is one of the poorest provinces yet it comprises about 20% of the total population of SA with over 3 million people who live in the EThekwini District making it the second most densely populated district in SA (Stats SA,2015:28). The eThekwini District comprises of 103 urban, rural and peril-rural wards (DoH KZN,2015:4). Many areas have limited access to services and equity in KZN despite the growing urbanisation of the province. The EThekwini District is one such district with a significant spread of rural communities in the province of KZN and was included in the study.

4.5.2 Population Groups in the Study

According to Gravetter and Forzano (2009:129), "a target population is the group defined by the researcher's specific interest, and they specifically share one characteristic".

In the study, the mixed method approach has been justified. Therefore, two population groups were included in the study as follows:

In the survey segment of the study, the population comprised all households within a 2 km radius of the Waterloo, Grove-End and Stonebridge clinics within the EThekwini district of KZN. These suburbs were chosen because there is a close proximity to primary healthcare clinics and the suburbs though not varied in its demographic profile, are representative of the major race groups in SA. The use of a 2km radius was employed in the study to incorporate patients that walked to the clinic and patients that used transportation to the clinic. In addition the 2km radius was applied to obtain the required sample population with ease of convenience. Patients were able to provide comprehensive information related to their experiences at the primary health clinic. There were 1500 houses in total within the 2km radius included in the study. This data was, drawn from the EThekwini Housing Department based in Unit 20, Phoenix. In the qualitative section of the study, all 169 Nursing Service Managers of the primary health clinics in the EThekwini Metropolitan Municipality of KZN were included in the population group.

4.6 Sampling Strategy

"Sampling is a process of selecting cases to represent the entire population so that inferences about the population can be made" (Polit and Beck,2012:275). As illustrated in Figure 4.2 the sample can be explained as a subset of the population (Sekaran and Bougie,2013:263).

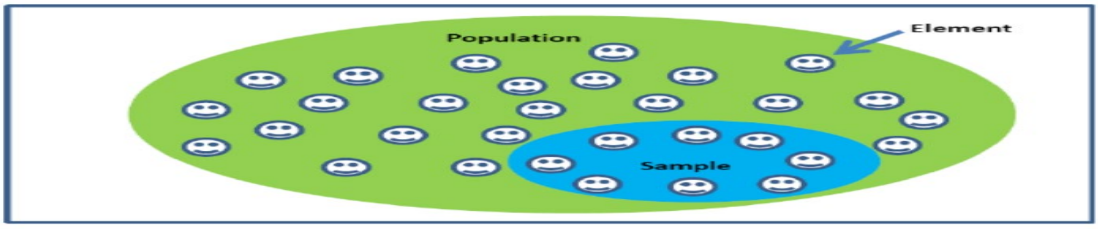

Figure 4. 2:The Population and Sample

Source: Saunders et al. (2015:211)

4.6.1 Probability Sampling

A method where members have an equal chance of being selected is widely used (Sekaran and Bougie,2013:245). The techniques applicable to the probability sampling method are as follows:

- **Simple Random Sampling**

This technique can be expensive but allows each member to be equally selected

- **Systematic Sampling**

This sampling technique "draws every nth constituent in a population with an element between 1 and n which is randomly selected"(Sekaran and Bougie,2013:248).

- **Stratified Sampling**

This technique involves separating the population into groups.

- **Cluster Sampling**

"Cluster Sampling groups elements in the population where the target population is first divided into clusters". (Sekaran and Bougie,2013:250).

- **Justification of the Sampling used for the Quantitative Component**

For the survey, a probability sampling technique with systematic sampling was, applied to the study. (Demetrius and McClain,2012:2). The use of systematic sampling was the most economical and efficient technique to employ for the household survey. The advantage of using the systematic sampling technique is the assurance that the population will be evenly sampled however, caution must be exercised to ensure that the sampling technique is not compromised. A survey was conducted in the EThekwini District with specific reference to the three suburbs, covering an area of a 2 km radius where the sampling interval of every 5^{th} house was included in the survey until the sample of 300 had been reached. To reduce selection bias, a random method was applied to determine the first sample member. The total number of houses was determined through a map of the region and a sample of 300 was obtained based on the sample size table in Saunders et al. (2015:156).

4.6.2 Non-Probability Sampling

According to Sekaran and Bougie (2013:245) techniques of non-probability sampling are explained as follows:

- **Quota Sampling**

"Quota sampling provides for certain characteristics in the selected population. This sampling technique is used as a substitute in probability sampling when a sampling frame is not available" Saunders and Lewis (2012:137).

- **Purposive Sampling**

Purposive sampling is adaptable to small samples for qualitative studies (Saunders and Lewis,2012:137).

- **Snowball Sampling**

The first sample member is identified and then the earlier sample members identify subsequent members, as it may be difficult for the researcher to access a suitable sample. Therefore, the researcher depends on other members to guide the sample selection (Saunders and Lewis,2012: 140).

- **Self-selection Sampling**

This technique incorporates the participant as the identifier for sample selection. (Saunders and Lewis,2012:140).

- **Convenience Sampling**

Saunders and Lewis (2012:140) explain that this technique is rarely used because it does not always support the reliability of the study.

- **Justification of The Sampling Method used in the Qualitative Component**

A non-probability sampling method was, used to conduct the interviews with the nursing service managers using the purposive technique. Purposive sampling can be justified when selecting cases related to the study goals. The advantage of purposive sampling can be noted in the ease

with which generalisations can be made about the sample however, caution must also be exercised in the use of purposive sampling as the use of this technique can be prone to selection bias. According to Demetrius and McClain (2012:3) 6 to 12 participants may be common in a qualitative study as compared to the quantitative study where the sample size is much more significant. As a result, qualitative research tends to have less statistical power than quantitative. This is not seen as a limitation as the aim of the study is to obtain value added and rich information that can add a new dimension. For the study a total of 9 participants served as the sample from the target population of 169 and the sample size was based on data saturation which is in keeping the use of thematic analysis. Permission was obtained from the EThekwini Municipality Health Manager for the study to be conducted at the respective clinics. The clinics that were included in the study were as follows:

- Caneside;
- Grove end;
- La Lucia;
- Ottawa;
- Redcliffe;
- Redhill;
- Stonebridge;
- Trenance park;
- Verulam; and
- Waterloo.

4.6.3 Sample Size

Sample size and selection are important points of consideration when designing a survey. Sample size can be determined by using the following factors:

- the size of the population;

- desired level of confidence; and,
- The availability of resources.

The total number of houses for the survey was determined through a map of the region and a sample size table was applied to obtain the sample of 300 at a 95% confidence level and a 5% margin. Based on sound scientific literary sources (Jebreen,2012:162; Demetrius and McClain, 2012:4) and the use of data saturation, the sample size for the qualitative component of the study was set at 9. Qualitative studies do not require large sample sizes as is seen in quantitative studies.

4.7 Research Instruments

4.7.1 Interview – Qualitative

Interviews are widely recognised for its role in qualitative research studies. Jebreen (2012:168) "...states interviews offer a widely used tool that is primarily used to tap into the first hand experiences of people, their emotions, inner attitudes and their unique perception of reality". The advantages of using interviews are noted by the high response rates that can be achieved and they allow for more detailed questions to be asked. Interviews can become very time consuming and costly so the use of interviews has to be carefully considered. There are different types of interviews that can be used in the study, such as structured, semi-structured and unstructured interviews. This type of research tool focuses on gathering mainly verbal data rather than measurements.

Semi structured interviews were, conducted with the managers in the study to achieve the following:

- Provide clarity and insight into how patient experience can, be enhanced.
- To develop a model that can be used to enhance the patient experience of care

Semi-structured interviews offer flexibility through, the use of open-ended questions. The open-ended nature of the questions provided opportunities to discuss certain topics in more detail. (Please refer to the interview schedule – Appendix F). Face-to-face interviews were, conducted and the conversation was, audio recorded and transcribed. Due to the nature of patient experience

and the influential role played by the manager, the use of face-to-face interviews proved invaluable in obtaining the required data.

4.7.2 Survey - Quantitative

Questionnaires are widely used in business and management research (Saunders et al., 2015:416). An extensive and thorough literature search was conducted to identify research instruments that assess patient experience. The Consumer assessment of Healthcare Providers and Systems which is primarily used in the USA is well recognized for its reliability and validity. However, based on the fact that the questions may require adjustment within the South African context, the instrument was carefully analysed. The Primary Care Assessment Tool originally developed at the Johns Hopkins University has been documented as being well able to support cross cultural health systems that exist outside of the USA with specific reference to China and can hold relevance to the South African context of healthcare (Wang, Wong, Wong, Wei, Wang, Li, Tang, Gao, and Griffiths,2013:517). In addition to the Primary Care Assessment Tool the National Health System (NHS) developed the patient experience survey which has been widely used throughout the United Kingdom. The three surveys described above were used to develop a survey that would be relevant within the South African context and was used to conduct the survey. The demographic details were strategically placed at the beginning of the questionnaire to ensure that the respondents completed these sections to support the analysis of data. The questionnaire (Refer to Appendix G) was developed following an intensive literature search that identified key indicators of patient satisfaction and experience. The questionnaire comprises four sections as follows:

Section A: Demographic details

Section B: Current patient experience with the public health sector

Section C: Factors that influence the patient experience

Section D: Positive Reforms

4.8 Data Administration and Collection

4.8.1 Interview

Data to support the qualitative research design was, collected via the use of semi structured face-to-face interviews. A date and time was, arranged to conduct the interviews with each hospital manager (Refer to Appendix B). The interviews were captured by audio-recordings in order to accurately preserve the participant's words (Ritchie, Lewis, Nicholls and Ormston,2013:13). Observational data was collected by the researcher on an on-going basis, which included the non-verbal behaviour of interviewees. This data was useful in enhancing the understanding of the participants' response beyond verbal explanation and was recorded in the form of field-notes by the researcher soon after the interview (Padgett,2012:147; Polit and Beck, 2012:220).

4.8.2 Survey

For the quantitative study, participants were given a Letter of Consent (Please refer to Appendix A), and were requested to sign an informed consent form that acknowledged their willing participation. The participants then completed the survey which took approximately 30 minutes to finish.

Field researchers completed the survey over a period of four weeks from Monday to Friday (8am–4pm). The survey team consisted of 10 individuals comprising 1 field co-ordinator, 1 data entry person, 1 driver and 7 interviewers.

The following guidelines were adhered to in the field survey:

- Every effort was made to follow the prescribed list of households selected.
- Houses that were unoccupied at the time of a visit, was revisited.
- If occupants declined to participate/ failed to meet the inclusion criteria, then the next household was visited.
- The exclusion criteria included any household that had not experienced care at a primary health clinic.

All of the responses were securely maintained in a designated office with strict access control for the appropriate time. The data was then exported to a computer aided software package that is explained in the data analysis.

4.9 Data Analysis

4.9.1 Data Analysis for the Qualitative Component (Interview)

Qualitative research focuses on the subjective experiences of a social reality; it is an inductive and exploratory method which assimilates and analyses contextual data from participants and is able to uncover meaning from the insider perspective (Holloway and Wheeler,2010:115). Qualitative data can be analysed either through the deductive or inductive approach (Burnard, Gill, Stewart, Treasure and Chadwick, 2008:429). The deductive analysis approach was, used to analyse the qualitative data.

Tesch's eight-step procedure of data analysis was applied (Tesch, cited in Creswell, 2009:142) as follows:

• "*Interviews were transcribed verbatim and analysed by the researcher.*

• *The researcher read the transcripts and compared them with the audio-taped interviews.*

• *The researcher read the transcript for the second time so as to identify the underlying meaning.*

• *The researcher selected the most interesting and informative interview and notes were made in the margins of the transcribed interview. The process was repeated for the rest of the interviews.*

• *Similar topics were clustered together under topics.*

• *From the topics, the researcher formed themes and sub-themes.*

• *Literature was reviewed to verify the findings*".

The collected data for the qualitative research design component was, analysed using the NVIVO, statistical data analysis software package (Saunders et al.,2015:214).

4.9.2 Data Analysis for the Quantitative Component (Survey)

The quantitative data was analysed through the use of the Statistical Package for Social Sciences (SPSS) and the use of descriptive and inferential statistics was used in the study. Descriptive statistics were, presented using percentages, frequencies, and measures of central tendency. According to Sekaran and Bougie (2013:283) "*frequencies refer to how often different sub-categories of a particular occurrence take place resulting in the calculation of the percentage and the cumulative percentage of the phenomena*". Descriptive statistics were, performed for the evaluation of the patient experience, domains of patient experience and the positive reforms of improving patient experience. According to Wilson (2014:254), "inferential statistics draw inferences about the population from the studied sample and can be used for estimation, forecasting, measuring associations, differences and assessing the strength of relationship between variables". A factor analysis test was, conducted to develop a summary variable (overall patient experience satisfaction). Factor analysis was also used to identify the domains that influence patient experience. Kruskal-Wallis tests were also performed to determine the association of age, gender and frequency on the domains of patient experience and the perception of patient experience.

4.10 Pilot Study

Welman, Kruger and Mitchell (2011:148) explain that, "*a pilot study sets out to administer the research instrument, which is the questionnaire to a limited number of respondents from the same population*". The sample for the pilot study can comprise 10% of the sample population (10% of 300) (Denscombe,2010:106). A sample of 30 was used in the pilot study. The questionnaire was assessed for its suitability to the South African context and its reliability. Only the quantitative questionnaire was piloted in the study. There were no revisions made as the questions were clear and unambiguous.

4.11 Validity and Reliability

For the quantitative component of the study, validity and reliability were obtained as follows:

Saunders et al.(2015:271) recommend using the following tests to ensure validity:

- Construct validity is defined as the extent to which a test measures what it claims to measure. The research instrument was developed by working with three validated research instruments that investigated patient experience and this supported the construct validity.

- Content validity is defined as the degree to which an instrument represents all facets of a given construct. Through the application of three research instruments measuring patient experience, the study was able to achieve high content validity for all the constructs investigated.

- Internal validity for the survey was achieved as the questions were closely developed with similar patient experience research instruments. According to Welman et al. (2011:19), "reliability refers to the constant measurement of data". The research instrument was carefully developed to answer the research questions. "Cronbach's Alpha internal consistency reliability is a measure of internal regularity, which signifies how closely associated a set of objects are, as a group" (Melville and Goddard,2008:61). This test was, applied in the study to ensure the reliability of the study. The results of the Cronbach's Alpha test in the study suggested a high measure of internal regularity.

For the qualitative component of the study, the following principles are discussed:

Based on Polit and Beck (2012:210) principles of trustworthiness include "credibility, dependability, confirmability and transferability".

- The interview process was thorough thus supporting credibility. Field notes were completed and the tape recorder was used to collect data. Data was transcribed and the transcribed notes were a true reflection of the participants' response (Jardien-Baboo et al.,2016:400)
- The research findings were confirmable. This was achieved with the accumulation of data from the interviews, the field notes, and the transcript.
- To facilitate transferability, a clear description of the context, participant selection, data collection and data analysis was completed (Babbie,2014:277) and "through dense description of the research results, supported with verbatim quotations from the participants" (Polit and Beck,2012:185).

4.12 Elimination of Bias

This was, achieved as follows:

- Gender-neutral words were used when conducting the interviews and interacting with the respondents.
- Every respondent was, given an opportunity to participate in the study regardless of race, gender or ethnicity.
- All language used was respectful towards all groups of members of the population
- The study did not discriminate against any person based on their age and all members of the population will only be excluded based on the exclusion criteria

4.13 Limitations of the Study

The study is limited to the eThekwini Municipality within the province of Kwa-Zulu Natal. It would have been more suitable for the study to be conducted across all nine provinces in SA in order to gain a more representative sample. The qualitative study does not facilitate the use of a large sample size and this could be viewed negatively with respect to the reliability of the findings. However the emphasis of the study was to obtain rich and in-depth information about the current service delivery standard that is being practiced within the primary health clinic. Resource constraints also served as a limitation to the study.

4.14 Ethical Considerations

When undertaking research many ethical considerations were highlighted.

Permission to conduct the study was obtained from the KZN Department of Health Manager and a letter of support was provided for the research undertaking (Refer to Appendix D). Approval was obtained from the Humanities and Social Sciences Research Ethics Committee with Protocol Reference number: HSS/0126/017D (Refer to Appendix H). Basic ethical principles were adhered to at all times.

- **Ensuring participants have been given formal consent**

The researcher ensured that the study was, fully explained to the participants and participants had fully consented to their participation in the study.

- **Ensuring no harm to participants**

This was be done by ensuring that risk to participants were minimised throughout the study.

- **Ensuring that anonymity is maintained**

An assurance was, given to the participants on their anonymity and confidentiality in writing by the researcher when the research was, administered. It is, noted that all participants were anonymous in this study

- **Ensuring that permission is obtained**

The Department of Health and the Research Ethics Committee provided letters of permission to conduct the research.

- **Ensuring that participation is voluntary**

Participants were volunteers in the study. The researcher endeavoured to ensure that the participants were not coerced into participating.

4.15 Conclusion

Chapter four provided a detailed understanding of the rationale for the methodology. Based on the objectives for the study the research design comprised a mixed method approach and incorporated the positivist approach to conduct the survey to determine the patients' perception of patient experience in the primary health clinic. The questionnaire was developed based on surveys that have been used in USA, United Kingdom and China. The semi structured interview was developed based on an extensive literature search of patient experience in the public health systems in other countries. A pilot study was conducted to assess the reliability of the questionnaire and no revisions were deemed necessary. The population groups and sampling was explained in the chapter and the procedures used for the collection of data were outlined. Data collection for the survey was completed at the point of distribution which supported a high

response rate. The interview data was recorded and transcribed to facilitate the analysis of data. The limitations of the study and the elimination of the bias were explained with concluding remarks on the ethical considerations that were adhered to. The chapter that follows details the quantitative results of the study.

CHAPTER 5:

QUANTITATIVE RESULTS

5.1 Introduction

This chapter presents the quantitative findings of the study. Each question in the questionnaire is accompanied by a response together with a diagrammatic illustration or table of the response where applicable. The results provide an understanding of the domains of patient experience that are considered relevant and appropriate to users of the primary health clinics. The domains and reforms are used in the development of the conceptual model.

5.2 Response Rate

When the response rate exceeds 60%, the study is both credible and reliable. In the study, 300 questionnaires were, used to obtain a 95% level of confidence (Saunders et al.,2015:271). Twenty questionnaires were, excluded due to the questionnaire being, incorrectly completed. There were 280 questionnaires used in the data analysis, which yielded a response rate of 93.3%. Therefore, the results can, be considered both valid and reliable.

5.3 Presentation and Discussion of Quantitative Results

Section 5.4 provides the demographic representation of the patients that participated in the survey from the total number of the households. The age, gender and details pertaining to the clinic visit are explained. The data is presented in tables to reflect the percentage. In the reading of the results, the strongly agree and agree percentages are aggregated and represented in the Frequency distribution column. Similarly the strongly disagree and disagree percentages are also aggregated through calculation and recorded for the purpose of analysis.

Section 5.5 presents the findings of the current patient experience and a Kruskal-Wallis analysis is presented in subsequent tables. The domains that influence patient experience are presented thereafter and a Kruskal-Wallis analysis is presented in tables. A principal components based exploratory analysis is presented in tables and the frequency analysis of the positive reforms follows.

5.4 Demographics

Table 5. 1: Demographic Summary of the Respondents

Variable	Category	Percent
A1: Age	<20 years	6.1%
	21-25 years	14.6%
	26-30 years	15.7%
	31-35 years	21.8%
	36-40 years	17.5%
	41-45 years	8.2%
	46-50 years	7.9%
	50+ years	8.2%
A2: Gender	Male	32.6%
	Female	67.4%
A3: How many times do you attend clinic per year	1-6 times	16.8%
	7-12 times	45.0%
	13-18 times	21.4%
	19-24 times	13.6%
	25-30 times	3.2%
A4: What is your approximate distance from the clinic?	1-2 km	16.1%
	3-4 km	10.4%
	5-6 km	36.4%
	7-8 km	28.9%
	9-10 km	6.4%
	11+ km	1.8%
A5: How do you travel to the clinic?	Taxi	60.4%
	Bus	10.0%
	Private Car	16.4%
	Hired Transport	5.7%
	Walk	7.5%
A6: What is your main reason to visit the clinic?	Monthly Consultation	41.4%
	Collection of Medication	15.7%
	Treatment of an Acute Condition	13.2%
	Treatment of a Chronic Condition	18.6%
	Maternal	11.1%
A7: Race	Black	38.9%
	Indian	61.1%

The demographic summary reveals that 21.8% of respondents belong to the 31-35 age interval and two thirds of the sample were of the female gender (67.4%). There was a high frequency (45%) of patients that visit the clinic on average between 7-12 times in the year. More than one third of patients (36.4%) live within the 5-6 km distance from the clinic therefore they are reliant on public taxi transport. The respondents frequent clinics for monthly consultations at a

percentage of 41.4%. The patients in the survey who are of Indian ethnicity (61.1%) have an edge over Black patients that comprise 38.9%.

5.5 Objective One: Evaluating Patient Experience in the Primary Health Clinic

Table 5. 2: Patient Perception of the Experience of Care

Current patient experience in the Public Health Sector N=280		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
	% Strongly Disagree +Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree + Strongly Agree	Mean	Std Dev	
1 The clinic is easily accessible	75.3%	69.6%	5.7%	10.7%	2.9%	11.1%	13.9%	1.80	1.37	0.854
2 The clinic has a good infrastructure to provide quality health care	69.3%	64.%	5.0%	16.4%	2.5%	11.8%	14.3%	1.93	1.40	0.930
3 I observe protocols for cleanliness in the clinic	70.0%	65.0%	5.0%	13.2%	4.3%	12.5%	16.8%	1.94	1.44	0.943
4 The management of the clinic is effective in	69.3%	63.9%	5.4%	16.1%	2.9%	11.8%	14.6%	1.93	1.41	0.971
5 The doctors provide quality care	69.3%	62.9%	6.4%	15.0%	2.5%	13.2%	15.7%	1.97	1.44	0.964
6 The nurses provide quality care	68.6%	61.1%	7.5%	16.4%	2.5%	12.5%	15.0%	1.98	1.42	0.962
7 There is good communication in the clinic	71.1%	62.9%	8.2%	15.7%	1.4%	11.8%	13.2%	1.91	1.38	0.961
8 I am educated about my health management	71.8%	63.9%	7.9%	15.0%	2.1%	11.1%	13.2%	1.89	1.37	0.941
9 I am informed about my health management	73.2%	66.1%	7.1%	12.9%	1.1%	12.9%	13.9%	1.88	1.41	0.894
10 The clinic gives my family and friends an opportunity to be involved in my care	75.3%	68.9%	6.4%	12.1%	2.5%	10.0%	12.5%	1.78	1.33	0.867
11 The medication I receive is properly dispensed	70.4%	64.3%	6.1%	13.9%	3.6%	12.1%	15.7%	1.93	1.42	0.929
12 There is co-ordination and continuity of care	68.5%	62.1%	6.4%	16.8%	2.1%	12.5%	14.6%	1.96	1.42	0.947
13 I receive a good quality of care	68.9%	62.4%	6.5%	15.1%	2.5%	13.6%	16.1%	1.99	1.45	0.944
14 I receive patient centred care	68.2%	62.5%	5.7%	15.4%	1.8%	14.6%	16.4%	2.00	1.47	0.944
15 The waiting time is appropriate to deliver quality health care	72.1%	66.4%	5.7%	16.1%	2.9%	8.9%	11.8%	1.82	1.31	0.902
Summary Variable	70.75%						14.51%			
Chronbach's Alpha								0.989		

A) Descriptive Analysis of Current Patient Experience

According to the findings, the majority (75.3%) of respondents disagree that the clinic is easily accessible. Respondents (69.3%) disagree that the clinics have good infrastructure to provide quality healthcare. More than two thirds of the respondents (69.3%) are disagreeable that the

management of the clinic is effective in providing quality care. Almost 70% of patients (69.3%) disagreed that the doctors provide quality care. Similarly, 68.6% of patients disagreed that the nurses provide quality care. Most patients (71.1%) disagree that there is effective communication in the clinic. With regards to the issue of being educated about their health management, most patients (71.8%) are disagreeable and patients (73.2%) are also disagreeable about being informed about their health management. The majority of patients (75.3%) disagreed that there was a welcomed involvement of family/friends, and 70.4% of patients disagree that the medication they receive was properly dispensed to them. Patients (68.5%) also disagree that there is co-ordination and continuity of care. The findings show that 68.9% of patients disagreed that the care that they received translated to good quality care, or patient-centered care (68.2%). Waiting time is considered to be inappropriate to deliver quality health care as indicated by 72.1% of patients. Cronbach's Alpha is a test of the consistency of the respondents' answers to all the test items in an instrument (Sekaran,2013:205). All other factors held constant, the value of alpha will be higher for longer tests than shorter tests. The frequency distribution of the patient experience items presented in Table 5.2 shows that the questionnaire items had very high internal consistency (Cronbach's Alpha=0.989) hence a summary variable (latent factor) for patient experience satisfaction can be created using the principal component analysis. Higher values of this factor would depict higher levels of satisfaction while lower values would depict dissatisfaction.

B) Tests to Determine the Current Patient Experience Data Distribution

In order to decide on the appropriate statistical test to use for assessing the effects of the demographic variables on the patient experience a test of normality was carried out. The results presented in Table 5.2.1 show that there is a significant departure from normality in the measure for overall patient experience satisfaction (Kolmogorov-Smirnov statistic=0.304, df=280, p-value<0.001, Shapiro-Wilk statistic=0.721, df=280, p-value<0.001). Because there is a significant departure from normality, non parametric tests are more appropriate in testing for the effects of demographic variables on patient experience.

Table 5.2.1: Test of Normality

Tests of Normality						
	Kolmogorov-Smirnov			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Overall Patient Experience-Satisfaction	0.304	280	<0.001	0.721	280	<0.001
a. Lilliefors Significance Correction						

Table 5.2.1 indicates that the data does not present with normal distribution.

C) Test for the Effects of Age, Gender or Race on Patient Experience

The Kruskal-Wallis test was used to test if age, gender or race were significant factors affecting patient experience.

- **Age and Patient Experience**

The results show that age significantly affects patient experience (H=18.525, df=7, p-value =0.010). The age group with the lowest level of patient experience is the 36-40 age group (mean rank =119.98) with the 46-50 age group having the highest level of patient experience (mean rank =170.89).

Table 5.2.2: Age and Overall Patient Experience Satisfaction

	Ranks				Kruskal-Wallis Test		
	Age	N	Mean Rank	Order of Satis.	Statistic	df	p-value
Overall Patient Experience Satisfaction	< 20 years	17	137.35	3	18.525	7	0.010
	21-25 years	41	164.11	6			
	26-30 years	44	140.33	5			
	31-35 years	61	121.99	2			
	36-40 years	49	119.98	1	Age is a significant factor affecting overall patient experience		
	41-45 years	23	137.96	4			
	46-50 years	22	170.89	8			
	50+ years	23	167.35	7			

B) Gender and Overall Patient Experience-Satisfaction

The results show that gender does not significantly affect the overall patient experience-satisfaction

Table 5.2.3: Gender and Overall patient Experience-Satisfaction

	Ranks				Kruskal-Wallis Test		
	Gender	N	Mean Rank	Order of Satis.	Statistic	df	p-value
Overall Patient Experience-Satisfaction	Male	91	140.16	1	0.003	1	0.957
	Female	189	140.66	2			
					Gender is not a significant factor affecting overall patient experience.		

C) Race and Patient Experience

The results show that race significantly affects patient experience (H=6.467, df=1, value = 0.011) with Black respondents having a significantly lower mean rank of patient experience.

Table 5.2.4: Race and Overall Patient Satisfaction

	Ranks				Kruskal- Wallis Test		
	Race	N	Mean	Order of Satis.	Statistic	df	p-value
Overall Patient Experience Satisfaction	Black	109	126.40	1	6.467	1	0.011
	Indian	171	149.49	2			
					Race is a significant Factor affecting overall patient experience		

5.6 Objective two (PART A): Domains that Influence Patient Experience in SA

Table 5. 3: Patients Perspective of Domains that Influence Patient Experience

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
	%Disagree+ Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
1 Access to the clinic influences my patient experience	0.4%	0.4%	0.0%	4.6%	15.7%	79.3%	95.0%	4.74	0.58	0.886
2 The physical state of the infrastructure influences my patient experience	1.4%	1.4%	0.0%	2.5%	16.4%	79.6%	96.0%	4.73	0.65	0.796
3 Involving my family and friends in my care influences my patient experience	1.1%	1.1%	0.0%	4.6%	15.7%	78.6%	94.3%	4.71	0.66	0.871
4.Waiting time influences my patient experience	0.7%	0.7%	0.0%	8.6%	16.1%	74.6%	90.7%	4.64	0.70	0.944
5 The quality of care influences my patient experience	0.4%	0.4%	0.0%	7.5%	15.7%	76.4%	92.1%	4.68	0.64	0.910
6. Information influences my patient experience	0.0%	0.0%	0.0%	2.1%	15.7%	82.1%	97.8%	4.80	0.45	0.739
7. Education influences my patient experience	0.7%	0.7%	0.0%	3.9%	15.4%	80.0%	95.4%	4.74	0.60	0.729
8. The role of the doctor influences my patient experience	2.1%	0.7%	1.4%	3.6%	14.6%	79.6%	94.2%	4.71	0.67	0.723
9. Management effectiveness towards positive outcomes influences my patient experience	3.2%	1.1%	2.1%	6.1%	13.9%	76.8%	90.7%	4.63	0.78	0.781
10.The role of medication influences my patient experience	2.1%	2.1%	0.0%	6.1%	16.1%	75.7%	91.8%	4.63	0.78	0.820
11. Communication influences my patient experience	0.4%	0.4%	0.0%	7.1%	15.4%	77.1%	92.5%	4.69	0.63	0.817
12. Patient centred care influences my patient experience	0.4%	0.4%	0.0%	6.1%	15.4%	78.2%	93.6%	4.71	0.61	0.840
13. The role of the nurse influences my patient experience	1.8%	1.8%	0.0%	6.4%	13.9%	77.9%	91.8%	4.66	0.75	0.807
14. Cleanliness in the clinic influences my patient experience	2.9%	2.9%	0.0%	6.4%	14.6%	76.1%	90.7%	4.59	0.85	0.821
15.Co-ordination and continuity of care influences my patient experience	2.9%	2.9%	0.0%	6.1%	14.6%	76.4%	91.0%	4.62	0.84	0.781
Summary Variable	1.36%						93.17%			
							Chronbach's Alpha	0.936		

A) Domains that Influence Patient Experience

According to the results, 95% of participants agree that the access to the clinic influences the patient experience. The influence of the physical state of the infrastructure of the clinic is, highlighted with 96.0% of participants showing agreement. Participants respond that welcoming the involvement of family friends is an important area that influences the patient experience with

an agreement of 94.3%. Another area of influence on the patient experience is, noted by waiting time as the results reflect that 90.7% of patients showed agreement. The quality of care and its influence of patient experience has, been confirmed with 92.1% of participants showing agreement.

There is a strong agreement (97.8%) that information influences the patient experience. Participants (95.4%) agree that education influences the patient experience and 94.2% of participants are in agreement that the doctor influences their patient experience. Respondents (90.7%) are agreeable that management's effectiveness towards positive outcomes influences the patient experience and the role of medication and its influence on the patient experience is evident as indicated by 91.8% of participants who agree.

On the point of communication and its influence on patient experience, 92.5% of participants are agreeable. Patient centred care and its influence on patient experience is agreed upon by participants (93.6%). Respondents agree (91.8%) that the role of the nurse influences the patient experience. Respondents (90.7%) agree that cleanliness in the clinic influences the patient experience and are agreeable (91.0%) that co-ordination and continuity of care also influences the patient experience. The Cronbach's alpha value shown in Table 5.3 is 0.936. This suggests that there is high internal consistency reliability which is consistent with long tests.

B) Factor Analysis of the Domain Variables to Patient Experience

The domains of patient experience include 15 items which can be subdivided into sub-domains using principal components based exploratory factor analysis. Three sub-domains of patient experience were found according to the results in the Table 5.3.1. The first sub-domain comprises of Waiting Time, Quality Care, Access, Family Involvement, Physical State Infrastructure and Communication. The suggested name for this sub-domain is “Communication, Access and facility quality”. The items in this sub-domain have high internal consistency (Chronbach's Alpha=0.911) hence high reliability. The second sub-domain comprises of Clinic Cleanliness, Coordination/ Continuity Care, Nurse Role and Patient Centred Care. The suggested name for this sub-domain is “Nurse/clinic care”. The items in this sub-domain have high internal consistency (Chronbach's Alpha=0.931) hence high reliability. The third sub-domain comprises of Doctor’s role, Education, Medication Role, Management Positive Outcomes and Information.

The suggested name for this sub-domain is "Doctor and management". The items in this sub-domain have high internal consistency (Chronbach's Alpha=0.870).

Table 5.3.1: Factor Analysis of Patient Experience Domains

Domains of Patient Experience (Conceptual Framework)	Principal Components (Latent factors)		
	Factor 1	Factor 2	Factor 3
Waiting Time	0.914		
Quality Care	0.853		
Access	0.745		
Family Involvement	0.722		
Physical State Infrastructure	0.714		
Communication	0.596		
Clinic Cleanliness		0.943	
Coordination/ Continuity Care		0.943	
Nurse role		0.882	
Patient Centred Care		0.639	
Doctor role			0.970
Education			0.898
Medication Role			0.854
Management Positive Outcomes			0.637
Information			0.443
Chronbach's Alpha	0.911	0.931	0.870
Suggested sub-domain name	Communication, access and facility sub-Domain	Nurse/Clinic care sub-Domain	Doctor's/management sub-Domain

C) Effects of Demographic Variables

- **Test for normality of the Patient Experience Domains, Sub-Domains and overall domain**

In order to decide on the appropriate statistical test to use for assessing the effects of the demographic variables on the Patient Experience Domains and sub-domains, a test of normality was carried out. The results presented in Table 5.3.2 show that there is a significant departure from normality in the sub-domains (p-values<0.001 for both the Kolmogorov-Smirnov and the Shapiro-Wilk tests). Because there is significant departure from normality, non-parametric tests are more appropriate in testing for the effects of demographic variables on sub-domains. The Kruskal-Wallis test was used to test for the effects of age, gender or race on sub-domains.

Table 5.3.2: Tests of Normality

Tests of Normality						
	Kolmogorov-Smirnov			Shapiro-Wilk		
	Statistic	df	p-value	Statistic	df	p-value
Sub-domain: Access and facility quality	0.513	280	<0.001	0.344	280	<0.001
Sub-domain: Nurse/clinic care	0.526	280	<0.001	0.342	280	<0.001
Sub-domain: Doctor and management	0.508	280	<0.001	0.312	280	<0.001
Overall PED Domain	0.480	280	<0.001	0.466	280	<0.001
Significant departure from normality						

There is a significant departure from normality.

- **Test for the effect of age, gender or race on Patient Experience Sub-domains**

The Kruskal-Wallis test was used to test if age, gender and race were significant factors affecting sub-domains.

Table 5.3.3: Age and Sub-domains

Sub-domain	Ranks				Kruskal-Wallis Test		
	AGE	N	Mean Rank	Order	Statistic (H)	df	p-value
Sub-domain: Communication, Access and facility quality	up to 30 years	102	136.94	1	1.769	2	0.413
	31-45 years	133	144.12	3			
	46+ years	45	137.89	2	**No significant Age effect**		
Sub-domain: Nurse/clinic care	up to 30 years	102	129.28	1	12.777	2	0.002
	31-45 years	133	148.76	3			
	46+ years	45	141.53	2	**Significant Age effect**		
Sub-domain: Doctor and management	up to 30 years	102	131.15	1	10.177	2	0.006
	31-45 years	133	148.82	3			
	46+ years	45	137.10	2	**Significant Age effect**		
Overall PED Domain	up to 30 years	102	143.18	3	0.464	2	0.793
	31-45 years	133	139.32	2			
	46+ years	45	137.90	1	**No significant Age effect**		

The results show that age is not a significant factor for the sub domain: Communication, Access and Facility Quality and the overall Patient Experience Domain. Age does however have a significant association with Nurse/Clinic Care sub-domain (H=12.777, df=2, p-value = 0.002) and the Doctor/ Management sub-domain (H=10.177, df=2, p-value =0.006).

Table 5.3.4: Gender and Sub-domains

Sub-domain	Ranks				Kruskal-Wallis Test		
	Gender	N	Mean Rank	Order	Statistic (H)	df	p-value
Sub-domain: Communication, Access and facility quality	Male	91	148.07	2	4.084	1	0.043
	Female	189	136.86	1	**Significant gender effect**		
Sub-domain: Nurse/clinic care	Male	91	150.92	2	8.515	1	0.004
	Female	189	135.48	1	**Significant gender effect**		
Sub-domain: Doctor and management	Male	91	148.87	2	5.150	1	0.023
	Female	189	136.47	1	**Significant gender effect**		
Overall PED Domain	Male	91	143.53	2	0.470	1	0.493
	Female	189	139.04	1	**No significant gender effect**		

Gender has a significant effect on all three sub-domains with the most significant effect on the sub-domain: Nurse/Clinic Care.

Table 5.3.5: Race and Sub-domains

Sub-domains	Ranks				Kruskal-Wallis Test		
	Race	N	Mean Rank	Order	Statistic (H)	df	p-value
Sub-domain: Communication, Access and facility quality	Black	109	136.87	1	1.247	1	0.264
	Indian	171	142.82	2	**No significant race effect**		
Sub-domain: Nurse/clinic care	Black	109	138.59	1	0.380	1	0.538
	Indian	171	141.72	2	**No significant race effect**		
Sub-domain: Doctor and management	Black	109	138.57	1	0.361	1	0.548
	Indian	171	141.73	2	**No significant race effect**		
Overall PED Domain	Black	109	129.44	1	8.306	1	0.004
	Indian	171	147.55	2	**Significant race effect**		

Race has no significant effect on the three sub-domains but does have a significant effect on the overall patient experience domains (H=8.306, df=1, p-value =0.004).

5.7 Objective Two (PART B): Positive Reforms Associated with a Positive Patient Experience

Table 5. 4: Positive Reform in Access to Care

		Frequency Distribution						Descriptives		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
1 Improved access to healthcare	%	1.4%	0.0%	6.8%	13.9%	77.9%	91.8%	4.67	0.73	0.978
2 Improved availability of services, goods and facilities	%	1.4%	0.0%	7.1%	12.9%	78.6%	91.4%	4.67	0.73	0.973
3 Improved willingness of staff to assist patients	%	4.6%	0.7%	6.8%	12.9%	75.0%	87.9%	4.53	0.99	0.774
	Chronbach's Alpha							0.929		

The positive reforms show that patients (91.8%) agree on improved access to healthcare. Patients (91.4%) agree on improved availability of services, goods and facilities and there is a strong agreement whereby 87.9% of patients agree that staff will be more willing to assist the patient. The latent factor analysis reveals that improved access to care (0.978) and the improved availability of goods, services and facilities (0.973) are significant positive reforms linked to the access of care. The improved willingness of staff to assist patients (0.774) is less significant when compared to the other positive reforms. The Cronbach's alpha value is 0.929.

Table 5. 5: Positive Reforms in the Physical Infrastructure of the Clinic

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
D9.1 Patients will able to use ablution facilities when needed	%	0.7%	0.0%	2.1%	10.4%	86.8%	97.1%	4.83	0.52	0.972
D9.2 Patients will be confident to use the ablution facilities	%	1.1%	0.0%	1.8%	10.4%	86.8%	97.1%	4.82	0.56	0.945
D9.3 Patients will be more willing to participate in the consultation	%	0.7%	0.0%	2.1%	10.4%	86.8%	97.1%	4.83	0.52	0.972
D9.4 Patients will feel less frustrated to wait	%	1.1%	0.0%	1.8%	10.0%	87.1%	97.1%	4.82	0.56	0.892
D9.5 Patient safety will be improved	%	0.7%	0.0%	5.7%	9.3%	84.3%	93.6%	4.76	0.62	0.851
							Chronbach's Alpha	0.946		

Mostly patients (97.1%) agree that they will be able to use ablution facilities when needed and 97.1% of patients agree on being confident to use the ablution facilities. Patients (97.1%) agree on being more willing to participate in the consultation and 97.1 % of participants agree on being less frustrated to wait. It is evident from the results that participants (93.6%) agree on patient safety being improved. The latent factor analysis explains which positive reform is most significant for the patient within the domain of the physical infrastructure of the clinic. Participants place significance on the reforms concerning the ablution facilities (0.972) and the participation during consultation (0.972). The alpha value is 0.946.

Table 5. 6: Positive Reforms in the Clinic Cleanliness

		Frequency Distribution						Descriptives		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
E6.1 Improved hygiene protocols	%	0.0%	0.7%	5.4%	7.1%	86.8%	93.9%	4.80	0.56	0.966
E6.2 Reduction in the transmission of infection	%	0.0%	0.0%	5.4%	7.9%	86.8%	94.6%	4.81	0.51	0.993
E6.3 Patients are more compliant	%	0.0%	0.0%	5.4%	7.9%	86.8%	94.6%	4.81	0.51	0.993
E6.4 Improved willingness for patients to attend the clinic	%	0.0%	0.0%	5.0%	8.2%	86.8%	95.0%	4.82	0.50	0.973
							Chronbach's Alpha	0.984		

Participants agree with 93.9% on improved hygiene protocols and most patients (94.6%) agree on a reduction in the transmission of infection. Similarly, patients being, more compliant elicits a 94.6% agreement and participants (95%) agree that patients would be more willing to attend the clinic. Based on the latent factor analysis all the above constructs regarding the positive reforms for the domain of cleanliness are significant. The reduction in the transmission of infection and patients being more compliant are significant reforms associated with the domain, Clinic Cleanliness. Patients being, more willing to attend the clinic is a point of importance (0.973) when considering the positive reforms related to the cleanliness of the clinic. The Cronbach's alpha value shown is 0.984.

Table 5. 7: Positive Reforms in the Quality of Care

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
F8.1 Improved quality of care	%	0.4%	0.0%	5.7%	9.6%	84.3%	93.9%	4.78	0.58	0.974
F8.2 Quality care that is timeously delivered	%	0.4%	0.0%	5.7%	10.4%	83.6%	93.9%	4.77	0.58	0.980
F8.3 Quality care that is delivered with patient safety	%	0.4%	0.0%	6.1%	10.4%	83.2%	93.6%	4.76	0.59	1.000
F8.4 Patient-centred care	%	0.7%	0.0%	5.7%	10.4%	83.2%	93.6%	4.75	0.62	0.981
							Chronbach's Alpha		0.991	

An improved quality of care receives strong support (93.9%) and quality care that is timeously delivered receives similar support (93.9%). Quality care that is delivered with patient safety at its core, is reflected by 93.6% of participants and the high percentage of 93.6% of patients agree that the care delivered will amount to patient-centred care. Based on the latent factor analysis, quality care that is delivered with patient safety (1.00) holds the most significance for the patient in the domain of Quality Care. Similarly the positive reforms of quality care that is delivered timeously and patient centred care are also significant as they are closely related to the quality of care domain (0.981). the improved quality of care being improved is also a significant reform to this domain. The alpha value shown is 0.991.

Table 5. 8: Positive Reforms in Patient Centred Care

		Frequency Distribution						Descriptives		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
G8.1 Patient centred care	%	0.4%	0.0%	5.4%	13.2%	81.1%	94.3%	4.75	0.58	0.996
G8.2Public participation in policy development	%	0.4%	0.0%	5.4%	13.2%	81.1%	93.9%	4.73	0.62	0.949
G8.3 Improved Patient engagement	%	0.4%	0.0%	5.4%	13.2%	81.1%	94.3%	4.75	0.58	0.996
G8.4 Improved healthcare staff accountability	%	0.4%	0.0%	5.7%	13.2%	80.7%	93.9%	4.74	0.59	0.984
							Chronbach's Alpha		0.992	

Participants (94.3%) agree on patient-centred care and 93.9% of participants agree that there would be more public participation in policy making. There are a significant percentage of

participants (94.3%) who agree that patients will be more engaged in the healthcare process. An improved accountability by healthcare staff (93.9%) is noted. The latent factor analysis indicates that the most significant positive reforms related to the domain of Patient Centred Care include patient centred care, and improved patient engagement (0.996). The alpha value is 0.992.

Table 5. 9: Positive Reforms in the Role of the Doctor

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
H8.1 Improved confidence in the doctors ability to treat effectively	%	10.0%	2.1%	7.1%	11.1%	69.6%	80.7%	4.28	1.30	0.994
H8.2 Improved relationships between the doctor and the patient	%	10.0%	2.1%	6.1%	11.4%	70.4%	81.8%	4.30	1.29	0.999
H8.3 Patient has improved control in the management of their condition	%	10.0%	2.1%	6.1%	11.4%	70.4%	81.8%	4.30	1.29	0.999
H8.4 Improved adherence to treatment	%	10.0%	2.1%	6.1%	10.7%	71.1%	81.8%	4.31	1.29	0.999
H8.5 Improve Doctor Patient Communication	%	10.0%	2.1%	6.1%	10.0%	71.8%	81.8%	4.31	1.29	0.997
							Chronbach's Alpha		0.999	

Participants agree (80.7%) on improved confidence in the doctors ability to treat effectively with 81.8% of participants who agree on an improvement in the relationship between the doctor and the patient. Similarly 81.8% of participants agree on improved control in the management of their condition. There are 81.8% of participants who agree on an improvement in patients' adherence to treatment. Also, 81.8% of participants agree on an improvement in doctor patient communication. The latent factor analysis shows that the positive reforms that are closely related to the Role of the Doctor are an improved relationship between the patient and the doctor, patients have improved control in the management of their conditions and an improved adherence to treatment (0.999). The improvement in the communication between the doctor and the patient is also important (0.997) and the improved confidence in the doctor's ability to treat effectively (0.994) are noted. The alpha value is 0.999.

Table 5. 10: Positive Reforms in the Role of the Nurse

		Frequency Distribution						Descriptives		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
I6.1 Improved nursing care	%	1.1%	0.0%	7.1%	10.7%	81.1%	91.8%	4.71	0.69	0.972
I6.2 Improved emotional support for patients	%	1.1%	0.7%	5.7%	9.6%	82.9%	92.5%	4.73	0.70	0.993
I6.3 Improved relationships between patients and nurses	%	1.1%	0.0%	7.1%	10.0%	81.8%	92.5%	4.73	0.67	0.997
I6.4 Improved nurse satisfaction	%	1.1%	0.0%	6.4%	9.6%	82.9%	92.5%	4.73	0.67	0.997
							Chronbach's Alpha		0.993	

There are 91.8% of participants who agree that improved nursing care and emotional support for patients would be improved (92.5%). Similarly, 92.5% of patients are agreeable that the relationship between nurses and patients would be improved and it is clear that a high percentage of patients agree (92.5%) that the nurses' level of satisfaction would increase. The latent factor analysis shows that the improved relationships between nurses and patients as well as an improved satisfaction with nurses are the most statistically significant reforms associated with the role of the nurse (0.997). The alpha value is 0.993.

Table 5. 11: Positive Reforms in Information, Communication and Education

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
J14.1 Improved patient knowledge of conditions	%	0.0%	2.9%	6.8%	10.7%	79.6%	90.4%	4.67	0.73	0.991
J14.2 Improved patient communication	%	0.0%	2.1%	6.1%	11.4%	80.4%	91.8%	4.70	0.68	0.934
J14.3 Patients are more informed of changes	%	1.1%	2.1%	5.7%	11.4%	79.6%	91.1%	4.66	0.77	0.983
J14.4 Improve the health education of the general public	%	0.7%	2.1%	6.1%	11.4%	79.6%	91.1%	4.67	0.75	0.988
							Chronbach's Alpha		0.979	

Based on the results presented, patients agree on positive reforms such as an improvement in the patient's knowledge of their conditions. Patients are agreeable (90.4%) on the preceding point and there are 91.8% of patients who agree on an improvement in the communication with the

patient during the health process. On the point of patients being more informed of the changes that take place within the clinic, 91.1% of patients are agreeable and patients agree (91.1%) on an improvement in the health education of the general public. The latent factor analysis reveals that the improved patient knowledge of conditions is a significant reform linked to the domains of Information (0.991) and the improved health education of the general public is a significant reform associated with the Education Domain. Lastly the improved patient communication is a significant reform associated with the Communication Domain.

The alpha value is 0.979.

Table 5. 12: Positive Reforms in the Co-ordination and Continuity of Care

		Frequency Distribution						Descriptives		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
K9.1 Improved continuity of care	%	0.4%	0.0%	5.7%	12.1%	81.8%	93.9%	4.75	0.59	0.996
K9.2 Improved co-ordination between healthcare staff in service delivery	%	0.4%	0.0%	5.7%	12.1%	81.8%	93.9%	4.75	0.59	0.996
K9.3 Patient centred care	%	0.4%	0.0%	5.7%	11.4%	82.5%	93.9%	4.76	0.59	0.998
K9.4 Effective referral system	%	0.4%	0.0%	5.7%	11.4%	82.5%	93.9%	4.76	0.59	0.998
							Chronbach's Alpha	0.999		

Participants (93.9%) are agreeable on an improvement in the continuity of care and participants are confident that the co-ordination between healthcare staff would be improved with 93.9% showing agreement. Participants agree on more patient centred care with 93.9% being agreeable. Also, 93.9% of respondents are agreeable on an effective referral system. The latent factor analysis reflects that patient centred care and an effective referral system (0.998) are most significant positive reforms related to the Co-ordination and Continuity of Care. An improved co-ordination between healthcare staff in service delivery and improved continuity of care is also significant (0.996). The alpha value is 0.999.

Table 5. 13: Positive Reforms in the Role of Medication

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagre1e	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
L9.1 Streamline medicine dispensing processes	%	0.4%	0.0%	6.1%	7.5%	86.1%	93.6%	4.79	0.58	0.968
L9.2 Reduce the incidence of drug overdose	%	0.4%	0.0%	5.7%	7.5%	86.4%	93.9%	4.80	0.57	0.984
L9.3 Improve the pharmaceutical education of patients	%	0.4%	0.0%	5.7%	7.5%	86.4%	93.9%	4.80	0.57	0.984
L9.5 Increase the adherence towards treatment	%	0.0%	0.0%	5.7%	7.5%	86.8%	94.3%	4.81	0.52	0.965
							Chronbach's Alpha		0.986	

Participants agree (93.6%) on positive reforms whereby the medicine dispensing process is streamlined. Participants are confident that the incidence of drug overdose will be reduced as shown by 93.9% who agree. Another positive reform agreed upon, is that of improved pharmaceutical education of patients with 93.9% of participants in agreement. Participants also agree on an improved adherence towards treatment intervention as shown by a 94.3% agreement. The latent factor analysis shows that the improved pharmaceutical education of the patients and the reduction in the incidence of drug overdose is most significant (0.984) in the domain of the role of medication. Streamlining the medicine dispensing process (0.968) and the increased adherence towards treatment (0.965) is noted. The alpha value is 0.986.

Table 5. 14: Positive Reforms in the Involvement of Family and Friends

		Frequency Distribution						Descriptives		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
M5.1 Improved emotional well-being of the patient	%	0.7%	0.0%	5.4%	11.1%	82.9%	93.9%	4.75	0.62	0.994
M5.2 Improves the family involvement in the medical management	%	0.7%	0.0%	5.4%	11.1%	82.9%	93.9%	4.75	0.62	0.994
M5.3 Reduces patient anxiety	%	0.7%	0.0%	5.4%	11.1%	82.9%	93.9%	4.75	0.62	0.994
M5.4 Improves family understanding of the patient's medical management	%	0.9%	0.0%	5.2%	11.1%	82.9%	93.9%	4.75	0.62	0.994
M5.5Improves the family/ friend involvement	%	1.2%	0.0%	5.3%	11.1%	82.5%	93.6%	4.74	0.68	0.924
							Chronbach's Alpha		0.985	

An improved emotional well being of the patient where 93.9% of participants are in agreement is noted and improved family involvement in the patient's medical management where 93.9% of

participants agree is noted. Participants agree (93.9%) on a reduction in patient anxiety with improvements in the welcoming of family and friends. Participants are agreeable (93.9%) on an improvement in the family's understanding of the patients' medical management. There are 93.6% of patients who agree on an improvement in the family/friend involvement. According to the results of the latent factor analysis, the improved emotional well being of the patient, reduction in patient anxiety, improved family involvement in the medical management and the improved understanding of the family with regards to the patient medical management (0.994) are the most significant positive reforms related to the friend/family involvement domain. The alpha value is 0.985.

Table 5. 15: Positive Reforms in Waiting Time

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
N7.1 Improved efficiency at the clinic	%	0.0%	0.0%	5.0%	8.2%	86.8%	95.0%	4.82	0.50	1.000
N7.2 Increase in patient satisfaction	%	0.0%	0.0%	5.0%	8.2%	86.8%	95.0%	4.82	0.50	1.000
N7.3 Increase in employee satisfaction	%	0.0%	0.0%	5.0%	8.2%	86.8%	95.0%	4.82	0.50	1.000
N7.4 Improved staff effectiveness	%	0.0%	0.0%	5.0%	8.2%	86.8%	95.0%	4.82	0.50	1.000
							Chronbach's Alpha		1.000	

Improved efficiency and staff effectiveness at the clinic obtain an agreement of 95%. Similarly, a notable increase in patient and employee satisfaction as noted by the 95% of patients that, are agreeable. Based on the latent factor analysis, all of the above positive reforms are significant in the domain of waiting time. The alpha value is 1.

Table 5. 16: Positive Reforms in Outcomes and Effectiveness

		Frequency Distribution						Descriptive		Latent Factor (Principal component) Coefficient
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	%Agree/ Strongly Agree	Mean	Std Dev	
O7.1 Improved patient participation	%	9.3%	0.7%	5.7%	6.8%	77.5%	84.3%	4.43	1.23	0.991
O7.2 Improved patient engagement	%	9.2%	0.8%	5.6%	6.2%	78.2%	84.4%	4.43	1.23	0.992
O7.3 Improved patient empowerment	%	8.9%	0.7%	6.1%	6.1%	78.2%	84.3%	4.44	1.22	0.999
O7.4 Improved commitment by management to support positive patient	%	8.8 %	0.7%	6.5%	6.1%	77.9%	83.9%	4.43	1.22	0.992
O7.5 Improve commitment by management to support effectiveness of service delivery	%	8.7%	0.7%	6.6%	7.5%	76.4%	83.9%	4.42	1.22	0.989
Chronbach's Alpha									0.997	

Improved patient participation as shown by the 84.3% agreeable responses and participants (84.4%) agree on improved patient engagement. On the point of improved patient empowerment, 84.3% of patients are agreeable. It is also agreed on by 83.9% of patients that an improved commitment from management to support positive patient outcomes is recognised as a positive reform. Patients agree (83.9%) on management being more committed to support the effectiveness of service delivery. The latent factor analysis shows that the improvement in patient empowerment is the most significant reform related to this domain (0.999). This is closely followed by improved patient engagement (0.992), improved commitment by management to produce positive outcomes and improved patient participation (0.991). The improved commitment by management to support the effectiveness of service delivery is an important reform within this domain (0.989). The alpha value shown is 0.997.

5.8 Conclusion

The chapter presents the findings of the patient survey. The current patient experience is presented and a Kruskas-Wallis analysis is conducted to determine the effects of age, gender and race on the overall patient experience satisfaction. The domains that influence patient experience are presented using a descriptive table and a factor analysis is conducted. Three sub-domains are noted. The sub-domains are analysed using the Kruskas-Wallis test to determine the effect of

age, gender or race on the factors that influence the patient experience. The positive reforms that can result are presented using frequency tables.

CHAPTER 6:

DISCUSSION FROM THE QUANTITATIVE STUDY

6.1 Introduction

Chapter 5 presented the data collected via the survey. The data gathered from the responses were analyzed using SPSS. Chapter 6 provides a discussion based on the survey findings in chapter 5 of the study. The findings are corroborated with supporting literature to identify common literary threads. The discussion includes the current patient experience in clinics, domains that are deemed relevant to patient experience and the associated positive reforms. The demographic analysis is discussed next.

6.2 Analysis and Discussion of the Quantitative Data

6.2.1 Demographic Analysis

Most respondents belong to the Indian ethnic grouping and the remaining respondents belong to the Black ethnic grouping. Bearing in mind that the three suburbs that are included in the survey are traditionally Indian based suburbs, the findings of the study are in keeping with the racial demographics of the areas. The 31 to 35 year age group has an edge over the other age groups. The age grouping (31-35) demographics is in keeping with the age demographics of the patient populations in KZN (DOH KZN (2015:32). This could also be attributed to the understanding that patients start presenting with symptoms for more serious conditions around this age grouping. Female respondents mostly attended the clinic with a frequency of 7 to 12 visits. Abdulraheem et al. "assumed that more females than males present for treatment in primary health care centres since it has been shown that women have significantly higher mean number of morbidities than men" (Abdulraheem et al.,2011:14).

The results also show that few respondents lived within 2 km of the clinic with the highest percentage of patients having to travel the distance of 5-6 km. According to statistics, for the eThekwini municipality, the majority of clinics can be found within the 0-5 km radius (DoH,2016:8) therefore, the findings of the study are in close alignment with recent statistics.

However, there are more than one third of patients who live beyond 7 km from the clinic which can affect the access to healthcare. The majority of patients travel to the clinic using public transport, whilst one fifth of patients travel using either a hired or private vehicle. Few patients walk to the clinic, which is plausible based on the findings that less than one fifth of patients live within 1-2 km of the clinic and the highest percentage of patients are found in the 5-6 km distance grouping. Based on the finding that more patients are older than 50 years of age, it is more likely that patients travel by public or private transport as compared to walking. This is an important point, as the money spent on transportation can be significant when one considers that patients frequent the clinic between 7-12 visits but this can also increase when the patient has to fetch medication that is unavailable at the time of collection. Whilst most patients frequent the clinic for a monthly consultation to visit with the doctor for their health needs, there are a significant percentage of patients who are categorised as needing care for chronic conditions.

KZN is identified as having a population with a high incidence of chronic diseases. Chronic disease places a heavy burden on the public sector. The implication of, the finding suggest that more health initiatives are needed to reduce the incidence of chronic diseases. For example Diabetes and Hypertension have been linked to dietary patterns, physical activity and sleep patterns (International Diabetes Federation,2013:5). Experts estimate that many South Africans have Type 2 Diabetes Mellitus as a result of lifestyle choices. A study by WHO explains that the incidence of Type 2 Diabetes Mellitus is minimised with an intensive lifestyle intervention. (WHO,2010:1). Based on the above, a lifestyle intervention programme can be productive for South Africans with Diabetes Mellitus.

Table 6. 1: Chronic diseases in the KZN and SA Population

	Hypertension	Arthritis	Diabetes	HIV/AIDS	Asthma	Other	Cancer
KZN	6.2%	3.4%	3.3%	2.7%	2.6%	1.6%	0.3%
SA	7.5%	2.5%	2.8%	1.9%	2.5%	2.2%	0.4%

Source: DOH KZN(2015:32)

6.2.2: Patient Experience in the Primary Health Clinics

6.2.2.1 Current Patient Experience according to the Picker Principles, IOM Framework, Batho Pele Principles of Care and the Ideal Clinic Framework.

The results show that the current patient experience as per the Picker Principles, IOM Framework and Batho Pele Principles is generally dissatisfactory. According to Mr. Jacob Zuma, former President of SA, public health facilities are required to possess particular characteristics that support the Ideal Clinic Initiative (SA Government,2014:19). The discussion that follows regarding the evaluation of the patient experience is outlined according to the standard expectations that patients are entitled to in terms of the Ideal Clinic.

The Ideal Clinic "should be staffed by health care providers who treat people with dignity, and observe the Batho Pele principles of Access, Consultation, Courtesy, Information, Service Standards, Openness and Transparency, Redress and Value for Money "(SA Government, 2014:19). Access is "defined as the opportunity or ease with which consumers or communities are able to use appropriate health services in proportion to their needs" (Levesque et al., 2013:18). The finding of the study reveals that most respondents disagree that the clinic is accessible which aligns with the demographic finding that the highest number of respondents were 5-6 km away from the clinic. From general commentary with the patient, field researchers noted that most patients used family and friends' to house (within the 2km radius) them during clinic visits. In addition, researchers have pointed out that challenges to healthcare service provision in SA included transport to the clinic, distances from their homes to the clinic, a loss of time (long waiting times) and increased cost as being specific barriers to access (Cooke, Couper, and Versteeg,2011:107; Gaede and Versteeg,2011:99).

According to, the South African Human Rights Commission Economic and Social Rights Report 2006-2009 "insufficient access for vulnerable groups such as women, pensioners and older persons is evident"(Seokama and Mukendi,2009:17). Most respondents in the older age groups indicated that they were dependent on public transport. The rising transport costs and increased difficulty in accessing the various modes of transport present as a significant barrier to access.

The costs associated with referral visits can also be significant for these patients belonging to vulnerable groups and in the long run, these patients may be less willing to follow through with the referrals. Therefore, clinic accessibility is important for patients in terms of the proximity to clinic and the availability of services/goods within the clinic.

The chi-square analysis conducted for the study showed an association between age and the perception of access, with older patients indicating inaccessibility. Therefore the findings of Seokama and Mukendi dovetail with the findings of the study. Whilst gender did not have a significant association with the perception of access, the chi- square analysis revealed that race had a significant effect on the perception towards accessibility. Dulgerler, Etem and Ozer (2012:2729) also found no significant association with gender and patient perception while an earlier study refutes the finding of the present study and Dulgerler et al. (Islam and Jabbar,2008:55). Studies investigating gender as a, predictor of patient perception are inconclusive and presents an opportunity for further research. In the study, Black respondents were less agreeable as compared to Indian respondents regarding the accessibility of clinics. This could well be attributed to the fact that traditionally labelled "Indian suburbs" have benefitted from health infrastructure in the past whereas their Black counterparts were disadvantaged in this regard. This finding adds new knowledge, as there are limited studies that address the influence of demographic predictors on clinic accessibility. The finding of the study confirms that participants are disagreeable on the clinic being easily accessible.

The Ideal Clinic should provide community-based health promotion and disease prevention programmes in collaboration with the community (SA Government,2014:19). Most respondents are disagreeable that they are educated or informed about their health management. "The Batho Pele Principles of Access and Information require information to be readily available to citizens in order to empower them and to address their needs", (Dookie and Singh,2012:71). Patients need information to be empowered and should be educated about what services are available. The chi-square analysis showed that age has a statistically significant effect on the perception of being educated and informed. Younger and older patients were more agreeable to being educated about their health whilst older patients were more agreeable to being informed about the healthcare process. A common thread with older patients appears consistently in that they are

generally more agreeable when responding to health service evaluation questions. Authors of patient satisfaction studies have expressed that older patients (Afzal, Rizvi, Azad, Rajput, Khan, Tariq,2014:154), particularly patients that were above 60 demonstrated higher levels of satisfaction when asked to evaluate health services (Ahmad, Nowaz, Khan, Khan, Rashid and Khan,2011:183). Maseko and Harris (2018:27) explain that patients have become more accepting of the service received because they are reluctant to experience victimisation. This could present as a probable reasoning towards older patients being more accepting and agreeable. Gender was not statistically significant in either of the issues.

The findings reveal that patients perceive a lack of patient centred care. The chi-square analysis shows a significant association with age and race towards the perception of care being patient centred. Indian patients' were more agreeable as compared to Black patients and older patients were mostly agreeable that the care delivered amounted to patient-centred care. Afzal et al. (2014:155) indicated that the level of patient satisfaction increased with the age of the patient. However, the finding of this study indicates that patients older than 46 years of age are more agreeable whereas patients in Afzal's study were older than 55 years of age. It may be anticipated that the age at which patients are becoming more accepting of the patient care appears to be decreasing.

The Ideal Clinic "should be very clean, promote hygiene and take all precautionary measures to prevent the spread of diseases" (SA Government,2014:19). Most respondents indicate that they did not observe cleanliness protocols being followed in the clinic environment. Cleanliness has become a point of contention in many health facilities (DoH,2016:5). The chi square analysis indicated that race and age had a significant effect on the perception of cleanliness. Younger (<30) and older patients (>46) were agreeable to cleanliness protocols being followed with Indian respondents also showing more agreement than Black respondents. There are limited studies that focus on age and race towards the perception of cleanliness in the clinics.

A report by the NDoH and the Health Systems Trust (DoH,2016:20) "indicates that the physical state of the infrastructure in health care facilities in SA is poor, owing to unequal development and the general lack of maintenance". Respondents also indicate that the physical state of the infrastructure was not conducive to providing quality care. Marshall, Kiston and Zetiz (2012: 2260) noted that the standardisation of rooms and equipment simplified routine tasks and

reduced staff errors. In addition to the physical layout, light is important for avoiding errors (Marshall et al.,2012:2664). However, in SA, due to infrastructure constraints and a lack of standardisation across the various clinics' structural design the problem of medical errors could escalate. The lack of a suitable infrastructure and a clean environment not only serves as a deterrent towards repeat visits to the clinic for patients but could potentially impact health worker performance and motivation levels. Age and race has a significant effect on the patients' perception of the clinics' infrastructure. Patients in the younger and older age groups were more positive about the physical state of the infrastructure. Similarly, Black respondents were more agreeable with the state of the infrastructure. Gender did not have a significant effect on the perception of the physical state of the infrastructure. Gangai (2015:49) noted that both gender and age showed no statistical significance with patient satisfaction levels. Whilst Gangai's finding about age differs from the finding of the present study, the findings of gender are in agreement with the present findings. There are limited studies that examine age and race for its effect on the perception of the physical state of the infrastructure.

The Ideal Clinic "should have reasonable waiting times, and community members do not have to sacrifice their entire working day to seek health care" (SA Government,2014:19). The respondents in this study have clearly indicated that the waiting time is not appropriate to deliver quality health care and it has been emphasised that waiting time is an important area that needs to be improved. Similarly, Amatya et al. (2017:276) reported that the waiting time in the clinic had a negative effect on patient care. A recent study from Nepal has also stated that longer waiting times are associated with higher dissatisfaction rates (Mehata, Paudel, Dariang, Aryal, Paudel, Mehta, King and Barnett,2017:319). A study conducted in Congo listed waiting time as a barrier to accessing public health care (Lutala, Kwayla, Basagila, Watongoke and Mupend,2010:468). It is an important point to note that waiting time has also been identified as a barrier to access thereby highlighting how the domains of patient experience are inter-connected. In a South African study conducted by Vallabhjee (2011:44) long waiting times and bottlenecks is an indication of poor leadership in clinics. This also highlights another domain where waiting time ties in with management effectiveness.

The chi square analysis indicated that age and race had a significant effect on the perception of waiting time. Older patients are less agreeable that the waiting time is appropriate with more

Black respondents agreeing on the waiting time being appropriate over Indian respondents on this point. Maseko and Harris (2018:23) supported that race was noted for its influence on the perception of care in SA with white patients generally more positive towards healthcare in SA as compared to Black patients. The findings of this study contrasts with Maseko and Harris. A potential explanation of this could be linked to the fact that the majority of Black patients use the clinics out of necessity rather than choice and are more tolerant of longer waiting times. Against the standards of the Ideal Clinic and other literary findings, the results of the present study converge. Long waiting times do not support a positive patient experience.

The Ideal Clinic "should provide a comprehensive package of good quality health services every day, and community members do not have to return on different days for different services" (SA Government,2014:19). On the point of doctors providing quality care most respondents are disagreeable. The chi square analysis revealed a statistically significant association with age and the perception that doctors provide quality care. Interestingly, patients in the younger age group who are less than 30 years of age were most agreeable. Younger patients tend to prefer a walk in walk out service and do not want to spend a lot of time with the doctor. Older patients in comparison want to spend time with the doctor to ensure that they are well informed about their conditions and treatment options. In the association of race, Indian patients were more agreeable than Black patients that doctors provide quality care. Devanny (2015:34) suggested that the different factors affecting patients' perception of the doctor can provide valuable insight into possible reasons for the racial differences and presents an opportunity for further research that examines cultural backgrounds towards health evaluation.

Respondents mostly disagree that nurses provide quality care. The most reliable method to improve patient experience comprises the provision of "consistent, personalized, and reliable care for the patients, which especially includes the nursing care delivered" (Kutney-Lee McHugh, Sloane, Cimiotti, Flynn, Neff and Aiken,2009:123). Therefore, nurses play an integral role in the delivery of quality care. Lupo (2016:468) "defined the quality of care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". According to WHO, “quality health care is defined as that care which consists of the proper performance according to standards” (WHO,2010:8). The findings of the study are in agreement with that of Lupo and the

WHO as most participants indicate that the quality of care delivered from healthcare workers is not in keeping with desired health outcomes. Most respondents indicated that the care they received did not translate to good quality care. The chi -square analysis revealed a significant association with age and race on the perception of quality care. Older patients are more agreeable that the care delivered amounts to good quality care. Kvist, Voutilainen, Mäntynen and Vehviläinen-Julkunen (2014:466) also agree that older patients are generally more satisfied with the quality of care. Indian patients were more agreeable than Black patients that the quality of care is good.

Respondents are disagreeable that the management of the clinic is effective in providing quality care. Bleich (2015:297) supports that the commitment and engagement of management, has the potential to create a shared vision that can unite health workers, and transform the facility. The manager therefore needs to be goal oriented towards providing quality care (Delmatoff and Lazarus,2014:245; Smith,2015:47). The finding of the study suggests that care is not being delivered according to standards as laid out by the Ideal Clinic Initiative, Bleich and others.

Most respondents disagree that communication in the clinic is effective. Research by Mohammed, Nolan, Rajjo, Shah, Prokop, Varkey and Murad (2014:7) identified communication as one of the ten "characteristics patients identified as important in a quality health care delivery system". Effective communication between patients and caregivers is, known to have improved the patient experience as well as the health outcomes for patients (Kourkouta and Papathanasiou,2014:65). Therefore, ineffective communication will most likely contribute to a negative patient experience as reflected in the findings of the study.

The Ideal Clinic "should have the basic necessities available, such as essential medicines" (SA Government,2014:19). Medicines are seen as an essential building block in health systems; therefore countries that aim to strengthen their health systems need to deliberate carefully on issues pertaining to medicines (Bigdeli, Peters and Wagner,2014:11;WHO,2018:10). Participants mostly disagree that the medication they receive was properly dispensed to them. This finding is in keeping with an earlier study in SA, where 20% of patients who frequented public health facilities were unable to receive medicines due to stock outs and shortages (Wagenaar, Gimbel, Hoek, Pfeiffer, Michel, Manuel, Cuembelo and Quembo,2014:791). The problem of long waiting is also noted in the dispensation of medication (Du Plessis,2008:103) thus rendering the process

inefficient as many patients who are unable to wait in the long queues leave prior to the collection of the medication. A similar South African study investigating waiting time and medicine dispensation showed a contrasting finding in that more than 70% of respondents' reported that the service was delivered in a quick and efficient manner (Munyaka, Senekal, Mafuya and Davids,2010:25). Whilst the study of Munyaka et al. does refute the findings of the present study, there is an overwhelming support of literary evidence that supports long waiting times and medicine dispensation. Medicine shortages and inefficient dispensation processes do not support a positive experience of care. Furthermore, patients may not always return to fetch medicines when they do become available which creates ripple effects especially in the case of chronic patients who are dependent on the medicines.

The Ideal Clinic "should refer people to higher levels of care timeously when this is required" (SA Government,2014:19). When respondents commented on co-ordination and continuity of care the findings show that, respondents are disagreeable indicating that people are not timeously referred for higher care when needed. According to WHO (2010:76) interventions that support the continuity and coordination of care has the potential to improve the care experience of patients who require chronic support, support health worker satisfaction, improve health outcomes and promote the performance of health systems. Low and middle- income countries with health care worker shortages and with many dispersed, remote communities look towards informal care, family support, community health workers, donor funding and social innovation for continuity and coordination. This highlights the importance of the clinic's interaction with diverse stakeholders.

The Ideal Clinic "should work together with the community it serves, with diverse stakeholders, in promoting health and socio-economic development" (SA Government,2014:19). The majority of respondents disagreed that there was a welcomed involvement of family/friends. The involvement of family and friends with chronically ill adults proved effective in supporting day-to-day self-management, via emotional support and the facilitation of healthy behaviours (Sayers, Riegel, Pawlowski, Coyne, Samaha, 2008:70; Rosland, Heisler, Choi, Silveira and Piette,2013:98). Age is statistically significant with the perception of the involvement of family and friends. The chi-square analysis indicate that patients younger than 30 years of age are more agreeable that the clinic encourages family/friend involvement, with the middle age and older

age groups sharing similar lower levels of agreement. Older patients may require more involvement from family/friends as compared to their younger counterparts for various reasons.

The conclusion of the current patient experience shows that < 50% (14.51%) of patients are satisfied with the patient experience thus indicating an overall dissatisfaction in terms of the current status of patient experience. It is clear from the findings of the study that the current level of patient experience is not in keeping with the objectives of the Ideal Clinic as promoted by the former President, Mr. Jacob Zuma. Also, the findings of the study provide a dismal picture of patient experience as investigated through Picker Principles, IOM, Batho Pele Principles of Care and the Ideal Clinic Initiative and this highlights the need for the patient experience model as relevant to SA, to be developed.

6.2.2.2 Age, Gender or Race Chi Square Analysis with the Summary Variable of Overall Satisfaction of Patient Experience

The frequency distribution shows that the questionnaire items had very high internal consistency (Cronbach's Alpha=0.989) hence a summary variable (latent Factor) for patient experience-satisfaction was created using the principal component analysis. Higher values of this factor would depict higher levels of satisfaction while lower values would depict dissatisfaction.

The summary variable was developed and named "overall patient experience satisfaction" based on the feedback from the current evaluation of patient experience in the primary health clinic. The chi square tests reveal a significant association with the overall patient experience satisfaction towards age and race. The age group with the lowest level of patient experience satisfaction is the 36-40 age group (mean rank = 119.98) with the 46-50 age group having the highest level of patient experience satisfaction (mean rank = 167.35). Afzal, Rizvi, Azad, Rajput, Khan, Tariq,2014:154) supports this finding as noted by a similar outcome from the study they conducted. Lower expectations or the reluctance to communicate a negative patient experience may justify why the older patient is more accepting of the level of care delivered. In another study Vuong, Vuong, Ho and Nguyen (2017:5) evaluated the effect of age on patient perception of service delivery, "older people who were widowed or divorced and those with friends or relatives who had experienced or were experiencing prolonged treatment tend to be more critical in evaluating the quality of services they receive. However, young people, married or unmarried

people, and those surrounded with people in stable health conditions were more likely to express positive feelings on health care quality.

Keller and Lehrmann on the other hand, "proved that younger people are more critical in assessing the quality of medical care" (Keller and Lehmann,2008:117). The findings of the study align with the findings of Keller and Lehrman in that younger people in the study indicated that there was an overall dissatisfaction with the patient experience. However, older participants in the study were less critical as noted by their overall satisfaction with the patient experience. The findings of this study are refuted by Vuong et al. with respect to how older patients perceive the quality of service.

The results show that race significantly affects patient experience (H=6.467, df=1, p-value = 0.011) with Black respondents having a significantly lower mean rank of patient experience when compared to Indians. Racial differences in patient experience, that include levels of satisfaction and trust are noted but the findings are inconclusive (Dovidio, Penner, Albrecht, Norton, Gaertner and Shelton,2008:478; Klonoff,2009:48; Musa, Schulz, Harris, Silverman and Thomas.,2009:1293; Saha, Arbelaez, and Cooper,2003:1713)

However, the association between gender and the overall patient experience satisfaction was not statistically significant. A study conducted by Campbell et al. (2001:94) expresses that gender was not significant in influencing patients' perceptions of the care received. Janicic et al. (2011:1705) found no significant difference in gender groups for satisfaction of healthcare whereas Afzal et al. (2014:156), Gajovic et al. (2012:4185) and Dulgerler et al. (2012:2734) reported that gender showed no effect at all on the patient satisfaction score in their research. Overall, studies show that gender is not a demographic predictor of patient perception.

6.2.3 Domains of Patient Experience: Patient Perspective

The discussion that follows groups the domains into three sub-domains according to the Factor Analysis 'Communication, Access and Facility quality', 'Nurse/clinic care' and 'Doctor and Management'.

6.2.3.1 Communication, Access and Facility Quality

The Kruskal-Wallis analysis showed no significant association with age and race toward this grouping. Gender has a statistically significant association with this grouping. Female respondents were less likely to report that the waiting time, physical state of the infrastructure,

communication quality of care, access and family/friend involvement influence their experience of care whereas male respondents were more likely to report that the above domains were significant predictors of patient experience. These findings provide new knowledge, as other studies have not investigated demographic predictors on the domains that influence patient experience.

- **Waiting Time**

The majority of respondents agreed that waiting time influenced their patient experience. The factor analysis revealed that waiting time is a significant domain to patient experience as the latent factor value exceeds 0.7. Salam, Alshakiera, Alhadi, Ahmed and Mohamed (2010:1) support that whilst the experience of the quality of care is influenced by technical components such as equipment, it is mostly influenced by non-technical elements such as waiting time and health worker attitude. Similarly, an earlier study (Vadhana,2012:22) "showed waiting time to be a significant factor that caused the majority of the respondents to feel uncomfortable with the services provided". More than three quarter of the respondents from Vadhana's study showed a positive opinion towards services provided in the department but they were disappointed with the very long waiting time to receiving services. These studies support the findings of the present study. Therefore waiting time is included in the development of the conceptual model.

- **Quality of Care**

The majority of the respondents agreed that the quality of care influenced the patient experience. The factor analysis revealed that quality of care is a significant domain to patient experience as the latent factor value exceeds 0.7. Quality of health care meets the health needs of the patient at the lowest cost and within the expected professional standards and regulations (Amatya et al., 2017:270). "The patients' satisfaction with the quality of care is the degree to which, the desired expectations, goals and or preferences are met by the health care provider and or service" (Nnebue, Ebenebe, Adinma, Iyoke, Obionu, Ilika,2014:595**)**. If a gap exists between the patient's expectation and the provision of quality care, it can have a negative impact on the patient's experience of care. According to Khumalo (2010:1), Batho Pele Principles seek to ensure that public servants are service-orientated and strive for excellence. Simply stated Batho Pele emphasises quality and holds public servants accountable for the lack thereof. Importantly there is also a close relationship between quality and waiting time, as reflected in the study by

Vadhana (2012:25), where patients had a positive opinion towards the quality of services but felt that the long waiting time elicited a negative experience. Quality of care is included in the development of the conceptual model.

- **Access**

The majority of respondents agree that access influences their patient experience. The factor analysis revealed that access is a significant domain to patient experience as the latent factor value exceeds 0.7. In SA, "access, has been constitutionally mandated as a basic human right, and government should aim to provide universal and equitable access to high quality health care services throughout the nine provinces" (Levesque et al.,2013:12). A survey of public views of the health system showed that patients reported difficulty in accessing care (Stremikis, Schoen and Fryer,2011:4). A failure of government to provide accessible healthcare also leads to vulnerable populations who present with unsatisfactory health care outcomes when compared with the general population. Access is included in the development of the conceptual model.

- **Family/ friend Involvement**

The frequency analysis revealed that the majority of respondents agreed that welcoming family/friend involvement influenced their patient experience. Whilst the concept of welcoming family and friends is not investigated within the health care environment in SA, the factor analysis revealed that family/friend involvement is a significant domain to patient experience as the latent factor value exceeds 0.7. Therefore, the lack of family/friend involvement can elicit a negative patient experience. According to Rosland, Piette, Choi and Heisler (2011:37) whilst little is known about the level of family/ friend involvement in the healthcare visits of patients and how that involvement affects the experience of patients, their study showed a different perspective of welcoming the involvement of family/friends. The findings of Rosland's study showed that patients were not always comfortable with the presence of the third party in the private consultation and indicated that too much of their personal information, had been divulged. Whilst these findings do not support the involvement of family / friend, the present study supports the involvement of family/friends in the management of the patient. It may also, be argued that in the case of vulnerable populations such as the elderly, children and pregnant women, the use of additional assistance in the form of a friend or family member can help

lighten the load of care management. The involvement of family/friend is included in the development of the conceptual model.

- **Physical State of the Infrastructure**

The majority of the respondents indicated that the state of the physical infrastructure influenced their patient experience. The factor analysis revealed that the physical state of the infrastructure is significant to patient experience as the latent factor value exceeds 0.7. This finding is justified by the findings of Ahmad et al. where the physical environment in a public health facility is a major determinant influencing the experience of care (Ahmad et al.,2011:183). The Health Care Facilities Baseline Audit indicate that less than one fifth of health facilities have a suitable infrastructure and these inadequacies therefore lead to sub-standard delivery of care and may contribute to a negative patient and health worker experience. The physical state of the infrastructure is included in the development of the conceptual model.

- **Communication**

The finding of the study shows that the majority of respondents' indicated that communication influences the respondents' experience of care. However, the factor analysis showed that communication, as an individual domain is not significant as it yielded a value less than 0.7. The factor analysis results can be attributed to the understanding that communication serves as a key aspect within the role of the doctor, role of the nurse, education of the patient, role of medication and the involvement of family/ friend. Therefore, its significance as an individual domain influencing patient experience is less weighty. According to the National Health Care Facilities Baseline Audit (2012:45), "mechanisms to communicate consistently and systematically with patients and to share with communities the results and the progress of quality improvement initiatives are lacking". Bearing in mind that most of this communication takes place through the medium of health professionals, the role of the doctor and nurse is highlighted. Robinson, Callister, Berry and Dearing (2008:602) support communication in its role for a better patient experience. Whilst, communication is noted by other authors for influencing patient experience it is not included in the conceptual model as an individual domain.

6.2.3.2 Nurse/Clinic care

The Kruskal-Wallis analysis finding shows that race did not have a statistically significant association with this grouping. Age and gender has a statistically significant association with this grouping. The younger patients (<30) were less likely to report that the domains in this grouping influenced their patient experience. As the age of the patient increases, the influence of the domains in this grouping on patient experiences increases correspondingly. More male respondents report that the domains in this grouping influence their experience of care. These findings provide new knowledge, as other studies have not investigated demographic predictors on the domains that influence patient experience.

- **Clinic Cleanliness**

The majority of respondents indicated that cleanliness influenced their patient experience. The factor analysis showed that clinic cleanliness is significant as it yielded a value greater than 0.7. "South Africa is failing in terms of cleanliness" according to the Operation Phakisa Report (2015:38). The issue of cleanliness is one that demands attention taking into consideration the transmission of infection. Dirty environments and unhygienic toilet facilities are a common occurrence in government hospitals, and contribute towards patient dissatisfaction (Saini, Singh, Parasuraman and Rajoura,2013:114). There is a convergence of the study findings with other authors regarding the state of cleanliness. Cleanliness is included in the development of the model.

- **Coordination and Continuity of Care**

Almost all the patients have agreed that this domain influences the patient experience. The factor analysis showed that coordination and continuity of care is significant as it yielded a value greater than 0.7. According to Picker Principles the information on discharge and organizing the continuing care as well as whom to call for help supports co-ordination and continuity of care. According to IOM, "the requirement to ensure that accurate and timely information reaches those who need it at the appropriate time..." also merges with the above statement (IOM,2001:14). Patients often receive insufficient information about vital aspects of the care management such as progressive steps in their care plan, activities of daily living, side effects or complications for procedures that have been completed, and follow up queries.

On the other hand, information overload can affect the patient's ability to remember and apply the information when needed (Jencks, Williams and Coleman,2009:1418). Schang et al. (2013:21) states that "care coordination can be seen as part of a broader strategy to improve quality in health care delivery and, ultimately, to strengthen the performance of the health system". According to Shaw, Rosen and Rumbold (2011:14) "integrated care is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems". The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care. Ho (2014:12) also worked on patient co-ordination and integration at "to improve waiting time and operational clinic flow by optimising the process and rearranging the time. The turn-around time reduced, the percentage of patients seen by the doctor increased and the waiting time reduced ". The benefits of integrated care are clear as reflected by the various literary sources. The domain is included in the development of the conceptual model.

- **Role of the Nurse**

The majority of respondents indicated that the nurse's role influenced their patient experience. The factor analysis showed that the role of the nurse is significant as it yielded a value greater than 0.7. In SA healthcare staff are, burdened with the high workloads (DoH,2016:20) and the current patient experience finding indicates that nurses do not provide quality care. Pelzang, et al. (2010:186) explained that the shortage of staff and overworked employees worked against a positive patient experience. The role of the nurse is included in the development of the model.

- **Patient Centred Care**

The majority of patients revealed that receiving patient centred care influenced their patient experience. The factor analysis provided a contrasting finding in that the domain of patient centred care is not significant as it yielded a value less than 0.7. According to Picker Principles "this includes the accommodation of family and friends, involving family in decision-making, supporting the family as care-giver and recognizing needs of the family". According to the IOM "this includes accommodating family and friends on whom patients may rely, involving them as appropriate in decision making, supporting them as caregivers, making them welcome and

comfortable in the care delivery setting, and recognizing their needs and contributions". The above definitions link patient centered care closely with the involvement of family/friends. This link could possibly explain why patient centered care is not significant as an individual domain influencing patient experience. Patient Centred Care is not included in the development of the model.

6.2.3.3 Doctor and Management

The Kruskal-Wallis analysis revealed that age and gender had a significant association with this grouping. More specifically the patient experience of respondents in the 31-45 age category were mostly influenced by the role of the doctor, education, information, management effectiveness towards producing positive outcomes and the role of medication. Male respondents also reported that the domains in this grouping were influencers of their patient experience. These findings of the present study provide new knowledge, as other studies have not investigated demographic predictors on the domains that influence patient experience.

- **Role of the Doctor**

The majority of respondents indicated that the role of the doctor influenced their patient experience. The factor analysis showed that the role of the doctor is significant as it yielded a value greater than 0.7. According to Devanny (2015:26) patients want to know that they can trust their doctors with the responsibility of translating clinical data into explanations and treatment options that make sense. Other studies have also highlighted the importance of practitioner-patient interaction, and its influence on the experience of care (Odhayani and Khawaja,2014:24; Sodani, Kumar, Srivastava and Sharma,2010:52; Muhondwa et al.,2008:67). Galhotra, Sarpal, Gupta and Goel (2013:240) "reported that less than two thirds of patients were satisfied with the advice they received, and 72% felt that the practitioner’s medical skills were satisfactory". A study carried out at by Islam and Jabbar (2008:56) suggested,"81% of patients were satisfied with the responsiveness and patience of the doctors, but 49% were dissatisfied with the lack of explanation or clarity regarding their prescribed treatment". The doctor plays an important role in the patient's experience of care and is included in the model.

- **Education**

The majority of patients indicated that being educated about their health influenced their experience of care. The factor analysis showed that the domain of education is significant as it yielded a value greater than 0.7. Educating the patient holds benefits for the patient, service provider and health facility. When patients are educated about the health condition, processes that they will follow and general management of their well-being, they are better positioned for producing positive outcomes (Jha et al.,2017:37). Education of the patients is included in the model.

- **Role of Medication**

The frequency statistics revealed that the more than ninety percent of patients agreed that the role of medication influenced their experience of care. The factor analysis showed agreement with the preceding finding in that the role of medication is significant as it yielded a value greater than 0.7. In SA, officials found that only one third of the clinics that were inspected had sufficient medication (Consolidated Report on Inspections of Primary Health Care Delivery Sites: Department of Health, 2010:25). The unavailability of medicines is a significant barrier to patients gaining access to much needed essential medicines in South Africa (Magadzire, Budden, Ward, Jeffery and Sanders,2014:520.). In the event of shortages or unavailable medicines, South African health facilities give the patient a date on which they are to return to the facility to check and collect their medicines if they are available at that visit which translates to additional visits to the health facility (Bateman,2013:600; Magadzire et al.,2014:521). The findings of other authors' have clearly presented the case for the importance of medication in the patient's experience. The role of medication is included in the model.

- **Management Effectiveness Towards Producing Positive Outcomes**

The majority of patients agree that managers play an important role in supporting effective health care with positive outcomes. The factor analysis showed that management effectiveness towards producing positive outcome is not significant to patient experience as it yielded a value less than 0.7. Whilst Kaufman and McCaughan (2013:53) "contend that leaders cannot be seen to turn a blind eye to poor practice, as this sets the pattern of behaviour for the whole team", the entire health care approach is a team driven approach and requires commitment from every team member. This statement is, not meant to detract from the importance of the leader, as he/she is an

important member of the health team. "Managers are essential participants in improving healthcare quality, and they need to participate in ensuring that patients receive safe, efficient and equal care" (Frojd, Swenne, Rubertsson, Gunningberg and Wadensten,2011:228). Whilst the patients do agree that this is an important aspect of their experience, the latent factor analysis provides a contrasting finding to that of the respondents' perspective and to other authors in this field of study. This could be attributed to the fact that management is not solely responsible for the effective functioning of the clinic or the positive outcomes for the patient. Management Effectiveness towards producing positive outcomes is not included in the development of the conceptual model.

- **Information**

The majority of patients' reported that information influenced their experience of care. The factor analysis showed that the domain of patient centred care is not significant to patient experience as it yielded a value less than 0.7.The results contrast each other and the findings of other studies. One train of thought supports the importance of providing the patient with adequate information to enhance the health service experience (Dookie and Singh,2012:67) whilst an opposing viewpoint submit that patients may suffer from information overload. This can cause patients to feel overwhelmed and inundated at the point of information reception, which may have the opposite effect to that of the desired positive experience (Jencks et al.,2009:1418). Information is not included in the development of the model.

6.2.4 Positive Reforms

- **Access to Care**

"Understanding the experiences of the patients in relation to the domain of access can assist in changing the provision of health care to enhance health outcomes" (Scheffler et al.,2015:820). Participants reported the associated positive reforms within the Access domain. The majority of patients agree on an increase in access to healthcare, coupled with an improved availability of services, goods and facilities. Patients mostly agree on an increase in the willingness of staff to assist patients in accessing the healthcare services, goods and facilities that are needed. The latent factor analysis revealed that the increased access to healthcare was the most significant reform related to Access. When patients evaluate the access of care and their feedback is use to

implement QI strategies that address the bottlenecks towards access, positive reforms such as the above reforms become evident.

- **Physical State of the Infrastructure**

According to Picker Principles the physical state of the infrastructure includes the surrounding areas to the hospital environment and not just the hospital environment. The benefits of a safe environment have also been associated with a reduction in errors and improved patient safety (Johnson,2014:22). Mostly patients agree that reforms associated with this domain include using ablution facilities when needed. Clearly, the majority of patients agree that they are confident to use the ablution facilities without the fear of acquiring infections that has a negative impact on patient safety. Sharma et al. (2014:12) found that participants graded the toilet facilities and found them to be lacking with respect to cleanliness. The participants of Sharma's study also explained that dirty toilets served as a disincentive for patients frequenting public health facilities. The finding of this study coincides with Sharma's study as patients also associated positive reforms with this domain that encouraged repeat visits to the clinic due to improved ablution facilities. Kupperschmidt et al. (2010:33) associated patient safety and the health workers state of being with the state of the physical environment. This finding is suggestive that the physical state of the infrastructure holds implications not only for the patient but also for the healthcare worker. A high percentage of participants in the study agree that as a positive reform, patients will be more willing to participate freely in the consultation when they are more physically comfortable and are able to consult where privacy is not an issue. In an inspection report of health clinics in SA, patients complained about the personal medical details being discussed among health workers thus infringing on their patient right to patient confidentiality (National Health Care Facilities Baseline Audit Summary Report,2012:47). Such practice, contravene the provisions of the National Health Act, which states that:

"*All information concerning a user, including information relating to his or her health status, treatment or stay at a health establishment is confidential*" *(*Republic of South Africa. National Department of Health. The National Health Act, 2004).

When patients are uncomfortable in an environment, they are more likely to rush through the consultation so that they can leave. This in turn, has implications for the health service provider who is forced to rush during the consultation because the patient is uncomfortable. Participants

mostly agreed that patients are less frustrated to wait if the physical state of the infrastructure was good. According to IOM, "The attention to physical comfort produced positive outcomes in patients". Whilst the positive outcomes have not been further elaborated on, it is clear that improving the physical state of the infrastructure has many associated positive reforms. The result of the latent factor analysis reveals that patients placed the highest significance on two reforms being the improved ablution facilities and participation in the consultation. In the past patients were considered to be merely passive recipients in the health process (Nordgren, 2009:18). However, emerging data indicates a change in this regard.

- **Cleanliness**

In the 1990s' Nepal suffered from an under-utilisation of health facilities, despite a substantial investment of state funds into the maintenance of these facilities. The under utilisation of these health facilities remained low because of negative perceptions towards cleanliness (Sheikh and Gilson,2014:29). Positive reforms associated with the cleanliness domain include improved hygiene protocols and a reduction in the transmission of infection. Further, patients are more compliant and willing to attend the clinic, which are identified as the most significant positive reforms for the cleanliness domain. Most participants in a South African study felt that more members of the public would willingly access public facilities if improvements were made and there was visible proof of positive change (Maseko and Harris,2018:22).

- **Quality of Care**

Patients agree that the most significant positive reform associated with an improved quality of care contributes to patient safety. The WHO "defines patient safety as the prevention of errors and adverse effects to patients associated with health care" (WHO,2018:14). The Beryl Institute findings show that patient safety influences the patient experience (Wolf and Palmer,2013:33). Evidence suggests that when patients identify poor and unsafe practices it has the potential to enhance effectiveness and safety (Doyle, Lennox and Bell,2013:1570). A high percentage of patients agree on positive reforms whereby the care delivered will amount to patient-centred care. According to Amatya et al. (2017:270) one of the main challenges of health services in developing countries is in finding ways to make the services more patient-oriented. The improved quality of care that is timeously delivered is agreed upon by the majority of the participants.

- **Patient Centeredness**

Luxford and Sutton (2014:20) explain that the statement of :"nothing about me without me in health care, emphasises the need to understand the current experience of patients as well as partner with patients to drive improvement in health care". The importance of communication in promoting patient engagement is highlighted (DeLao,2015:26; Manary, Boulding, Staelin, Glickman,2013:201). A high percentage of patients agree on more public participation in policy-making. Patients agree on positive reforms with a move towards patient-centred care. Patients agree on a positive reform whereby patients will be more engaged in the healthcare process. According to Stiff et al. (2013:111), shared decision-making is the "process by which patients and clinicians jointly review the best medical evidence as well as patients' preferences and values." According to the Ontario Medical Association (Ontario Ministry of Health and Long-Term Care: Excellent care for All Act,2012) physicians should "share decision-making with patients about all aspects of their health care." Through shared decision-making, treatment costs can be lowered as the patient and health worker find a solution that suits the patient (Friedberg, Van Busum, Wexler, Bowen and Schneider,2013:268). Patients agree on a positive reform whereby patients are more educated and informed. These reforms are not included in the development of the model as the latent factor analysis indicated that this domain did not significantly influence patient experience.

- **Role of the Doctor**

Patients agree on an improved confidence in the doctors' ability to treat effectively. Patients need reassurance that their doctor has the required skill set to produce positive health outcomes (Devanny,2015:30). If doctors, are able to improve on their professional skills then patients are able to develop a good doctor patient relationship built on trust. Experienced doctors often say: "it's not the amount of time that is actually spent on the patient, but rather, it's the perception of time spent that matters most to patients" (Levinson et al.,2010:1315). The majority of patients' agree on an improvement in the relationship between the doctor and the patient. Janglang et al., (2009:201) as well as Doyle conducted a study that linked clinician-patient communication and adherence to medical treatment. Participants agree that the adherence to treatment is an associated positive reform. Literary evidence (Arora,2003:806; Epstein and Street,2007:89) "shows that good doctor communication has a positive impact on important outcomes, including

patient satisfaction, adherence to recommended treatment, and the self-management of chronic disease". An improvement in patients' satisfaction would be an expected positive reform, which is, supported by Epstein and Street. The majority of patient complaints to health worker regulatory associations are linked to a breakdown of communication between patients and health workers (Sambo and Lewis,2010:194). Respondents agree that the patient has improved control in the management of their condition.

- **Role of the Nurse**

According to Batho Pele the emphasis is service delivery with high quality. According to Picker Principles health workers should provide quality care. Public sector health workers in SA are often described as ‘cruel’ or ‘uncaring’ with little or no regard for patient confidentiality (Maseko and Harris,2018:24). Mostly respondents agree on improved nursing care and a significant percentage of patients agree that the emotional support for patients would be improved. According to IOM "suffering is more than just physical pain and other distressing symptoms; it also encompasses significant emotional and spiritual dimensions". Similarly, patients are agreeable that the relationship between nurses and patients would be improved. Patients are agreeable that the nurses' level of satisfaction is improved. Kumar et al. (2013:4) associated work satisfaction with the personal aspects of the individuals inter and intra- personal relationships. Worker motivation is also influential in service delivery. Skilled health workers support positive outcomes and patient experiences (Wanjau, Muiruri and Ayodo,2012:118).

- **Information , Communication and Education**

According to Batho Pele the right to information is an important aspect of Batho Pele. According to Picker Principles" information, communication and education on clinical status, progress and prognosis; processes of care; self-care and health promotion is important". According to IOM "people want to know (1) what is wrong (diagnosis) , (2) what is likely to happen and how it will affect them (prognosis), and (3) what can be done to change or manage their prognosis". Patients need to be informed with correct information about the diagnosis, prognosis and management protocol. Apart from the provision of information communication should be simple enough to ensure that the patient does understand and is educated about their health concerns (Papp et al.,2014:280). The reforms associated with information are not included in the development of the model.

According to the National Health Care Facilities Baseline Audit (2012:49) communication, mechanisms are lacking. High-quality communication between care team members and patients has been shown to have a positive influence on patient health outcomes (Gordon et al.,2015:20). It is seen that clear communication helps to build relationships that are built on trust (Manary et al.,2013:201). According to Voung (2016:2935) "when the quality of health communication rises, people receive more information, both in quality and quantity; their assessment will be more informed and reasonable instead of being characterised by flawed remarks due to a lack of information, which leads to a lack of empathy for medical staff, who usually work in a stressful environment". Positive reforms associated with communication are not included in the development of the model.

According to Coulter (2010:10), before changes are made patients should be consulted about what works and what does not, especially since they are impacted by the changes that are implemented. "Evidence suggests that when patients identify poor and unsafe practices it enhances effectiveness and safety" (Doyle et al.,2013:122). Papp et al. (2014:279) explains that health workers support the health education of the public.

Based on the results, patients agree on positive reforms whereby there is an improvement in the patient's knowledge of their conditions. Patients are agreeable that there would be an improvement in the patient's participation of the health process. On the point of patients being more informed of the changes that take place within the clinic, patients are agreeable. Patients agree that they could expect an improvement in the health education of the general public should more education initiatives be implemented.

- **Co-ordination and Continuity of Care**

White, Carney, Flynn, Marino and Fields (2014:63) define care coordination as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services". Patients expect positive reforms with an improvement in the continuity of care and in the co-ordination between healthcare staff.

Communication that is courteous and compassionate can affect patient satisfaction and influence patient-health worker interactions (Cahnman,2014:114, Groene et al,2015:142). The provision of appropriate instructions upon discharge can support the patient's commitment to the treatment protocol and ensures that the patient is engaging in safe care practices (Doyle et al., 2013:124). Patient's associate patient centred as a positive reform.

Based on the findings of the National Audit (National Baseline Audit of Health Facilities, 2012:34) 23% of facilities do not have referral guidelines. According to the DoH (2016:21) an effective referral process requires patient information which can be accessed with ease; communication between all stakeholders; and resources. Similarly, patients agree that an effective referral system should be developed and implemented.

- **Medication**

Patients agree on positive reforms whereby the medicine dispensing process is streamlined. Through Operation Phakisa the DoH developed and implemented innovative ways of dispensing medication for patients with chronic conditions to suit their own convenience without them having to go to the clinic each month, depending on the geographic locations of the patients. Patients are confident that improvements in the medication delivery can contribute towards a positive patient experience.The options that are available include direct delivery to the residential address or to a pick-up point where the patient can collect it or the use of a mobile pharmacy (Operation Phakisa Ideal Clinic Realisation and Maintenance Final Report,2015:35). Patients also agree on an improved adherence towards treatment intervention.

The factors that contribute to the problem of medicine stock outs in SA comprise an "inadequate health workforce particularly pharmacy personnel, poor medicine stock management, and inefficient communication between suppliers, depots and health facilities" (Bateman,2013:602). Patients are confident that the incidence of drug overdose is reduced. Another positive reform is that of improved pharmaceutical education. In the instance of medicines being unavailable, it can result in a lack of trust toward that country's health system (Magadzire et al.,2014:520; Wagenaar et al.,2014:794; Honda, Kuwahara, Nakagawa, Yamamoto, Hayashi and Mizoue,2015:1004).

- **Welcoming the Involvement of Family and Friends**

Patricia Reid-Ponte and Dana Farber also added, “If patients and families are involved, you’re bound to get it right the first time” (NHS,2011). Patients expect positive reforms whereby the emotional well being of the patient is improved. Patients expect a reduction in patient anxiety with improvements in the welcoming of family and friends. Patients agree on an improvement in the family's understanding of the patients' medical management. A recent study highlights the importance of family involvement and the role of effective communication between the practitioner-family interaction (Carlsson, Carlsson, Prenkert, and Svantesson,2016:50) Effective engagement also entails giving stakeholders/patient’s family members the opportunity to participate in care-giving and express choices. An improvement in the family involvement in the patient's medical management is reported.

- **Waiting Time**

The patients agree on shorter waiting times before being attended to at the clinic. Mostly patients agree that there should be shorter waiting times before consultation. Similarly there are patients who agree that the waiting times between services should be shorter and there should be a total reduction in waiting time at the clinic. Patients agree on empathy from the staff during the waiting time. When patients are required to wait for long periods, they can become reluctant to endure the long wait and opt to avoid going for treatment (Decroo, Telfer, Biot, Maikere, Dezenbro, Cumba, Da Dores, Chu and Ford,2011:40). Reegon (2010:6) identified long waiting time as a point of contention among health workers and patients. Patients agree on improved efficiency and staff effectiveness at the clinic with a reduction in waiting times. Similarly, the patients agree on an increase in patient and employee satisfaction. These improvements are supported by literature.

- **Outcomes and Effectiveness**

Managers bear a great burden in ensuring that the healthcare quality exceeds patient expectations (Frojd et al.,2011:228). Jha et al. (2017:39) highlighted the need for managers, and health care workers to prioritise patient experience for improving healthcare effectiveness as reflected by the following statement “...when leaders and staff are not focused on the experience that the patients have, that trust is diminished, and the effectiveness of healthcare is substantially reduced.” Patients are confident that a positive reform that can be realised is that of improved patient

participation. There are patients that agree on improved patient engagement as a positive reform. On the point of improved patient empowerment, patients agree that this could be an expected positive reform. The use of a patient safety law (SFS,2010:659) has been recommended to improve the effectiveness of healthcare and patient safety. Patients are confident that a positive reform that can be realised is that of improved patient participation. There are patients that agree on improved patient engagement as a positive reform. On the point of improved patient empowerment, patients agree that this could be an expected positive reform. Research suggests an association between the experience of care and clinical effectiveness (Doyle et al.,2013:8). The reforms associated with this domain are not included in the development of the conceptual model.

6.3 Conclusion

The chapter discusses the quantitative findings of the study. The overall patient experience is negative. The association between age and race with the overall patients experience is significant. As patients get older, they are more accepting of the service delivery regardless of the quality. Indian patients are more acceptable of the service delivery and report a more favourable patient experience. The participants reported that all the domains are important to their experience of care. However, the latent factor analysis showed that information, communication, patient centred care and management effectiveness that produce positive outcomes were not statistically significant. Positive reforms outlined according to each domain have also been discussed. The chapter that follows presents the qualitative findings.

CHAPTER 7:

QUALITATIVE RESULTS

7.1 Introduction

The preceding chapter presented the discussion and interpretation of the quantitative data analysis. Chapter 7 follows with the results of the qualitative data that was obtained from the facility managers via the semi-structured interview. There were a total of nine, Nursing Service Managers (NSM) that were identified for the sample and participated in the study. The biographical data of the respondents are outline in the section that follows to provide a background to the respondent.

7.2 Biographical Data of Respondents

The respondents' biographical information is provided for as follows:

Table 7. 1: Biographical Data of Respondents

Respondent	Race	Gender	Age	Position
A	Indian	Female	48	Nursing Service Manager
B	Black	Female	46	Nursing Service Manager
C	Indian	Female	43	Nursing Service Manager
D	Black	Male	42	Nursing Service Manager
E	Black	Female	45	Nursing Service Manager
F	Indian	Female	47	Nursing Service Manager
G	Black	Female	45	Nursing Service Manager
H	Black	Female	58	Nursing Service Manager
I	Coloured	Female	50	Nursing Service Manager

7.3 Thematic Analysis of Qualitative Data

7.3.1 Theme 1: The Experience of Care as an Indicator for Evaluating the Quality of Health Delivery

Sub Theme: The Experience of Care as a Measure for Quality and QI

Patient Experience is recognised as an important aspect of healthcare. The measure of Patient Experience can be useful in identifying areas of service delivery that do not meet the required standards. Consequently, the feedback from patients provides a valuable baseline from which quality can be measured and appropriate QI initiatives can then be developed and implemented. The feedback offered, by the respondents are expressed as follows:

Respondent B:

It is an excellent measure and it is the only way that I can think of to use the information to help provide a better experience of care. For example when the patient feels that the staff has a bad attitude or they feel violated in any way then they tell me by way of the experience, complaints process or feelings of dissatisfaction then I am able to make changes that support positive reform. Otherwise if they do not complain I will not know what improvements need to be made and how to make these improvements. I will not know what is wrong or what is right. I will not know if the patients are experiencing good quality health care.....

Respondent D:

It is very important because time and again it must be checked to see how the service is being perceived by patients. We need to know what patients think because they are the customer and the customer is always right.

Respondent H:

Patient experience is useful because the patient can guide us in telling us what is working and what is not. Especially when the quality of health delivery is not good sometimes we don't know until the patient tells us. It also makes the patient feel more involved when we respond to their feedback and we act on it. I think that it is necessary for us to use the feedback from the patient in developing our QI programs.

However, whilst there is an overwhelming support of respondents for patient experience as relevant as a measure of quality and QI, Respondent A in particular offers a contrasting viewpoint.

Respondent A:

Patient surveys are done but sometimes the patients are either very true or not true at all. Based on this I feel that the audits done internally and externally are a better feedback mechanism.

Respondent C also shared the viewpoints of Respondent A by highlighting the following:

Respondent C:

.....In other words the internal team makes sure that the facility has what is needed in order to provide quality care based on the "Ideal Clinic". The external audit teams are from the national department of health to audit national core standards of the entire clinic.

Sub Theme: Patient Experience to Drive Quality Improvement and Positive Reform

Patient Experience is recognised for its role in stimulating quality and quality improvement initiatives in developed countries. Patient Experience has a place in developing countries, however, there needs to be a committed buy in to the role of patient experience as a driver for QI and positive reform within the public health sector.

Respondent F:

In the past we did not encourage the use of the patient's feedback in order to gauge our services. But times have changed and now the patient's opinion is used in everything. I can understand this because at the end of it all the patient is the person who is at the receiving end of the amendments to policy and regulations made at the National and Provincial level. At the end of the day the patient has to accept the service based on what government says. But what about what the patient has to say. What if the changes made at government level are not benefitting the patient. How will we know if we do not ask the person who it affects? Other countries use patient experience to guide their health care initiatives but we are lacking in SA. We need to use the patient experience in all our initiatives because they are important to understand whether the initiatives are working or not. Yes, I think it is important to use patient experience to promote

quality improvement in SA. Through this then we will be able to see positive change and reform in the way that our health service is being delivered

Respondent G:

Patient experience can be used to evaluate the quality improvement programs because the patient is the person at the receiving end. They are the ones that get the care so they know whether the care is good or bad. The patient wants change and we need to fill the gap from where our services are to where the patient expects our services to be.

Respondent I:

It is a good indicator to check the quality improvement programs of health service delivery. Patients are our customers and as in the business world we also want to please our customers and improve the standard of care by getting response. When patients give responses we are able to use the responses for our Quality Improvement Programs that benefit the community we serve.

7.3.2 Theme 2: Patient Experience Policies

Patient Experience policies are currently lacking within developing African countries and SA is no exception. In SA, the Ideal Clinic Policy and the Clinic Committee Policy are currently in use within public healthcare clinics as per the Operation Phakisa Initiative. However, in spite of this initiative and the use of the Ideal Clinic Policy the respondents have still highlighted potential problems and inefficiencies that exist within the delivery of healthcare.

Respondent C

The Ideal Clinic Policy guides how the clinic should be run and what staff should be able to do in the clinic. In this way the government or department of health has worked to help the clinics and the managers have a guideline of what to do so that we can deliver good service to the patients.....

The clinic committee policy is a mandate from the NDoH to encourage members of the community to get involved in ensuring the well-being of the public. The chair is the ward councilor for the ward that the clinic falls under. But this policy can cause a lot of problems

because the public do not know how to contribute to the clinic committee meetings and they can become quite disruptive.

Respondent F

The Ideal Clinic policy is developed to help us run the clinic with the best possible outcome. This is not specifically designated for patient experience but the overall idea is to encourage the best level of care that is provided with efficiency and effectiveness. There is no specific model that has been developed or implemented that is directed towards patient experience. So this research that you are doing can be very helpful especially if the primary health clinic is going to improve the level of patient experience. I am looking forward to this new model of patient experience.....

Respondents F, G and H shared similar viewpoints with reference to the Ideal Clinic Policy and the role of the policy.

Respondent I

The Ideal Clinic Policy is used as a framework to guide what we should be doing in the clinic and what patients should be able to expect from us when they walk in the door, but really there is confusion about the level of service delivery that patients should receive. The ideal clinic policy is not as yet effective. There are budgetary as well as human resource constraints.

Respondent E

National Policy on Management of Patient waiting in out-patient departments and the Clinic Committee Policy are in use.

However members in the clinic committee are not trained. As a result of the lack of training there is a problem because members do not understand their role and meetings are not always productive. Sometimes they want to take over and do not completely understand their roles. At that point I step in to ensure that the clinic functioning is not affected.

7.3.3 Theme 3: Patient Experience Frameworks

The IOM and Picker Principles framework are used in developed countries in order to create a basic understanding of Patient Experience, the factors that influence it, and the implications

thereof. There is at present, no specific framework or model that has been instituted by the Department of Health that specifically addresses patient experience in SA.

Respondent G

……We do not have a patient experience model so it has not been implemented.

Respondent A

There is the Ideal Clinic Realisation and Maintenance Program. This document is used in conjunction with the Batho Pele Principles Framework (BPPF) to guide client satisfaction. So from an administrative perspective it gives NSM's clear guides on how to perform their duties……

The BPPF is the framework that guides how staff should function in their roles as health care professionals within the clinic. Batho Pele (BP) training was previously included in the annual staff training and it was also a part of orientation even before the staff began performing their duties. Now, it is not happening.

Respondent C

……Batho Pele training is no longer done and this has affected the way that the staff works with patients.

Respondent B

Mostly we use the challenge model, or also called the fishbone model. This has been provided for in the operation plan for the Ideal Clinic Realisation and Maintenance program. The NDoH is using this model. It works for us. We like to identify issues and call it challenges and not a problem. When you say that it is a problem it means that now you have created a wall and you cannot do anything about it. But when you say it's a challenge there is something that you can do about it.

7.3.4 Theme 4: Benefit of Measuring Patient Experience

The benefit of measuring Patient Experience can be felt by the patient, the health professional, the health facility and the public health sector at large. The importance of understanding whether

the patient experience has been positive or negative based on the service that has been offered is, key to identifying areas for change and inciting positive reforms.

Respondent C

It can be beneficial but I get some feedback sometimes that makes me wonder whether patients understand the level of pressure that we as the service providers are under. Patients forget that we are trying to do our best in spite of the constrained resources. But if patients are being realistic and are willing to provide constructive criticism then the patient experience feedback can help staff to provide a better service.

Respondent G

Yes the patient experience is useful because it can help to increase accountability of healthcare staff and to stimulate quality improvements.

Respondent I

Yes the patient experience measure is useful…… it helps to create positive patient experiences.

Respondent D (Respondent H offers similar viewpoints)

Yes it is very beneficial. It gives patients an opportunity to have a say in the running of clinics and hospitals. Management of clinics and hospitals also get an opportunity to identify patient's complaints and engage with staff and develop quality improvement plan to remedy the situation

Respondent F

Yes the patient experience is useful as I mentioned earlier. It helps us to see how the policies are working at grassroots level and we are able to recommend changes where necessary so that we can also support quality improvement with regards to policy making. We need to have a bottom up approach so that the public health sector can be productive and better utilized to meet the needs of the nation.

7.3.5 Theme 5: Measuring Instruments for Patient Experience

Research instruments are a necessary and important component of data collection. The type of instrument that is used will influence the quality of Patient Experience data that is obtained.

- Questionnaires

Respondent C

I think that surveys are a good way to get a quick feedback. But sometimes the surveys don't give patients a chance to add on their views so the surveys should be restructured so that the patient can explain in detail where the problems lie and how they feel that service can be improved.

Respondent I

…….we need to conduct patient experience surveys that provide patients with the opportunity to provide constructive feedback. These surveys should be done independently so that patients are free to express their views. I would recommend that they be conducted every 3 months.

A contrasting viewpoint to that offered above is given by Respondent A:

Respondent A

If we are looking at the surveys, what is generally found is that the feedback or responses on the questionnaires, will not talk to one another one for the following reasons:

- *Disinterested patients are not willing to provide an accurate picture of the experience of care;*
- *No value for the patients themselves directly, so patients feel it is not worth it to complete the questionnaire;*
- *No feedback provided by the patients because they do not have the time to fill out the patient or waiting time survey;*

- *Inaccurate reflection because patients have high expectations of service delivery based on private healthcare standards;*
- *Deviations and irregularities in the data analysis which do not yield reliable data that can be utilized in the development of quality improvement plans.*
- Suggestion Box/Complaints Book

Respondent B favoured the use of a suggestion box or book in combination with a complaints process. This system was traditionally in use and proved favourable according to the respondent.

Respondent B

When they complain or make suggestions……..

- Patient Focus Groups

Respondent E

Yes. We can use patient surveys and we can also do patient focus groups to get information from the patients.

Respondent E suggested the use of patient focus groups which are well known for obtaining information rich feedback that provides an in depth understanding of what the problems may be and potential ways in which the problems can be solved to improve the experience of the patient.

- Patient Forums

Respondent F

I think that patients need to be included in a forum where the voice of the patient can be heard. Patient surveys are useful. Patients should also get involved at the district, national and provincial level. I believe that patients must be given an opportunity to comment at all levels.

7.3.6 Theme 6: Domains of Patient Experience (Perspective of the NSM)

Patient Experience can be linked to domains. The identification of the domains that influence patient experience enables health professionals and policy makers to develop policies that support a positive patient experience.

Respondent A, C, D, H and I shared the same response as follows:

The six domains are adequate to determine the quality of the patient experience of care.

However, only respondents F and G proposed the importance of the quality of care and the inclusion of family or friends in the experience of care.

Respondent F

……These are the domains that are offered by the department of health but I think that there are more domains that need to be investigated. As you are talking to me I am thinking about the quality of care and the inclusion of family and friends. I am also thinking about the other domains that can be related to the patient experience.

Respondent G

Attitudes of staff, Waiting Times, Cleanliness of the facility, Availability of basic medicines/ supplies, Safety and security of the facility, Quality of Care, Involving family and friends

These are the domains that are offered by the department of health but there are more domains.

Respondent E

Values and attitudes of the staff if staff attitudes are poor then patients are constantly complaining and it's hard to change staff attitudes when staff show disrespect to their jobs and the patients.

7.3.7 Theme 7: Domains of Patient Experience - (Conceptual Framework)

Sub Theme: Clinic Access and Patient Experience

Patient Experience can be influenced by the ease with which patients are able to access the health service. When patients experience great difficulty in obtaining the health service it can cause patients to become frustrated and this can elicit a negative patient experience. Access is not only limited to how patients get to the clinics but also incorporates how the patient accesses the different services within the clinic and between health facilities.

Respondent A

I think that it's not applicable. The majority of patients have noted that they don't mind travelling because the service delivery is what matters most. If patients have a good experience of care delivered in the clinic then they are willing to travel even if it exceeds 10 km. For example I have patients that are willing to travel as far as 20 km because they appreciate the quality service delivery. But patients expect the staff to have good attitudes and to communicate properly with them when they are accessing services in the clinic. They tell us that the staff is hindering their access to services when the staff does not assist them. Sometimes we have staff shortages and we cannot deliver all the services so the access to these services is affected by the lack of skilled staff. This makes the patient have a bad or negative experience.

Respondent B

Yes access is very important. We can lose patients to other facilities because of location. Patients from MT Moriah have to take two taxis. Patients from the Redberry suburb think that Gandhi Hospital is near and they do not want to walk far. But they can't just go to a level two hospital. We need to screen the patients. Patients comment on the accessibility. Even patients go to other facilities because of convenience and we are losing patients from our catchment area. Even when they go to the hospital they get chased away. They need to come to the clinic. The system won't work if we allow every tom, dick and harry to just go to the clinic.

Respondent I

Yes access to the clinic is an important point. We see patients that live well beyond the ten km mark. These patients use taxis and hire transport just so they can get medical attention. Clinics are sometimes unable to deal with the high burden of patients and this can also affect their access to the clinic. Services are rendered but when there are a lot of patients the staff is slower and sometimes cannot see all the patients even though they have a need. There is an inadequate supply of services and this causes the patient to have a negative experience. Sometimes patients are asked to come back on different days and this can be a costly point especially for patients who live far away. Patients get frustrated when they need to come back. It's understandable and that is why we try to help all the patients but resource constraints are beyond our control. We do the best we can with the little we have. I think that if we can improve the patient's experience

then we can see positive reforms with better access to services and good service delivery. Patients will then have a better experience and staff will also be more satisfied and willing to help.

Sub Theme: Physical Environment and Patient Experience

The Physical Environment in which patients receive care should be conducive to the delivery and receipt of health care services. There is a need for the physical environment to support effective and efficient service delivery.

Respondent C

Patients have provided comments that support the good physical environment so this makes me think that the physical environment does affect patient experience. Patients do not want to wait in rooms that have other patients with contagious and infectious diseases especially patients with TB. They want separate waiting rooms and the ventilation must be good to ensure that the clinic is well ventilated. Patients want to wait in well lit areas and there must be privacy when they're being consulted. I think that if we can improve the patient experience then we can begin to see positive changes whereby there is more participation and involvement from the patient. Patients will be safer because the clinic is clean and supports hygiene.

Respondent F and I shared similar viewpoints

An untidy clinic is not good for the patient experience. Especially if the waiting area has funny smells or odours then it becomes difficult for the patients to wait in the clinic. Good toilet facilities are important for patients because they need to be able to use the facilities without being afraid that they are going to pick something up that is an infection. Patients need toilets that work and are clean. This helps them to have a positive experience. They also want good ventilation especially when people are coughing. They don't want to be around people who are coughing because everyone is afraid of getting TB. That is why I have also split the waiting areas so that infectious patients do not wait in the same area.

Respondent G

I have noticed that the state of clinics in different provinces is different. In some provinces the clinics are neat and have a good structure but other places have very untidy and unsafe

facilities. Patients that frequent these untidy facilities have commented in the media that they would rather die than go to these facilities. This means that they do not have a good patient experience when they go to facilities that do not have a good physical environment. Even us, as staff do not want to work in a clinic that is untidy and dirty. I will not feel safe if the clinic is falling apart and the ventilation is poor. I can also pick up infectious and contagious diseases if the clinic is not well ventilated. Patients need well ventilated clinics to have a positive experience. If we can improve the clinics then even staff can be happier at work.

Sub Theme: Cleanliness and Patient Experience

The cleanliness of the facilities in which patients receive health care has been highlighted. A clean facility supports the basic objectives of healthcare service delivery.

Respondent D

Cleanliness is next to Godliness. I cannot work in a dirty environment so how can I expect my patient to be treated in one. This is not acceptable to have a clinic that is dirty. My staff knows that I support cleanliness and all staff and equipment must be clean. Nurses and doctors must practice hygiene protocols when consulting with our patients. Patients deserve to be treated with respect and we have a responsibility to do this for them. When the staff practices hygiene protocols then patients want to be touched and are not afraid of what germs they may pick up. Then staff can treat and patients want to be treated.

Respondent F

When the clinic is dirty it will support the transmission of infection and my patients will not get better. Then this will affect my outcomes and my clinic status. I need to make sure that my clinic is clean to give the patient a positive experience. Then I will see that my patients are listening and they do not get angry or frustrated with us. Patients are willing to wait if the clinic is clinic and they complain less.

Sub Theme: Quality of Care and Patient Experience

The quality of care meted out to patients can be an important factor that influences the patient experience. Patients are able to identify when the level of quality is substandard and can quickly become frustrated when they are subjected to poor standards of healthcare service delivery.

Respondent A

Patients know their rights and have technology to check on google.com. Also professional patients and health professionals use the clinic services so these patients have high expectations. What happens, patients are having access to medical aids but come for the antenatal clinic on their first visit and then switch over to private. Or the other way around where patients start with private and then come over to PHS. Patients that have medical aids have an experience of care that is based on private sector service delivery and availability of resources. The quality of care that is delivered is expected to be high with these types of patients. These patients want care that is effective and efficient. They do not want to wait. They want the care to be timeous, but this is not always possible you know.

Then there are some patients who do not have medical aid at all, and do expect to be treated well as in with respect and dignity but do not have as high expectations when compared with those patients who are professionals or come from the private sector. Quality is differently perceived between the two groups. Private patients' expectations are higher and do not want to wait, demand is high, complaints are higher versus patients who are fully reliant on the PHS. These patients (non-medical aid) are more accepting of the clinic standards and service delivery as long as they get their treatment. We need to make sure that all patients receive good quality of care by giving all patients a positive experience.

Respondent B

People from the Indian community value quality. They will complain. In a non-Indian community it is different. At Amaoti clinic we do not have the same complaints. In an Indian community people complain about everything. But in the black community there are fewer complaints and they are satisfied that they have received care. Whereas in the Indian community it is not the same. I do not care about racial things but this is what I have experienced as a nurse. If you can check the complaints register you will see who complains the most (the complaints register was revealed to reflect the complaints and race grouping). Indian patients feel that black nurses treat black patients differently, then they tell me that they want equal care. I think this is about staff. If the staff can give good service all the time and do not make patients wait then patients are happier because they can see that they do not have to wait long and they are getting good service so they will see that race is not the point here.

Respondent C

Quality is differently perceived between patients. So from my experience quality care is perceived differently based on age and cultural backgrounds. It does affect the patient experience of care because if patients feel that the quality of care is not good, you can see on their faces that they are unhappy. Even if they do not complain about the poor quality of care we can see that they are upset. Sometimes I think that the older patients do not complain because they do not want to be victimized by staff when they come back for their next treatment.

Respondents D, E, F and G have clearly indicated that the quality of service is very important to patients.

Respondent I

The quality of care that the patient receives will determine whether the patient will return to the facility especially in respect of chronic care and immunization. They want to be seen as individuals and they want to be the unique patient. Then they have a positive patient experience. Otherwise if the quality of care is not good, it can increase the burden of disease because they are not receiving their chronic care as they do not come back for treatment. They can also discourage other patients from coming to the clinic. They complain to the ward councilors who also are involved in the clinic management team.

Sub Theme: Patient Centeredness

Patient centered care is becoming important in the context of service delivery and quality care. Patients need to be seen at the centre of the healthcare process in order to provide quality health care that supports positive outcomes.

Respondent E

Today's patients are different. They ask questions and they ask about treatment options because they are more informed. A lot of patients use google.com and they learn about everything. They want us to tell them everything that is happening. They need to be included and respected. If our staff can help the patient like this then our patients will feel important because we are including them in our treatment protocol.

Respondent H

My patients want to tell me what they think about the quality of care even if I don't ask them, they will tell me. Patients want to participate in their care, and they give me ideas on how to make the service delivery better. They also let me know which staff is not performing well and they expect me to address these issues and they will come back and ask me what was done. They follow up when there is a problem. If I do not consider their thoughts there will be a problem, but when I consider their thoughts I see that patients are more willing to be understanding when there are problems. The patients want staff to deliver good service all the time and they do not want to be treated like cattle. You know, they want staff to see them and not a patient number. We have a long way to go with this one because we have a lot of staff issues.

Respondent I

The community want, more opportunities with the clinic committee. They want to be involved in any changes that are taking place. The patients will also form their own whatsapp chat groups with members of the committee in order to communicate their needs for healthcare. I always see that patients have something to say and they want to be heard. If we can make this clinic committee work then the patient can feel like they are being heard.

Sub Theme: Role of the Doctor

Doctors can play a significant role in the type of experience the patient has. The understanding of what factors influence the patient experience from their interaction with the doctor needs to be better understood.

Respondent C has indicated how the role of the doctor impacts on future referrals. They will advise other patients accordingly according to Respondent C.

Respondent C

The doctor is a very influential person to the patient and the patient can have a very good experience if the doctor plays his part. By this I mean that the doctor needs to be courteous and patient. Patients want to know that the doctor is listening and that he cares. They want to feel like they are important to the doctor and that they matter. If the doctor is rude or disrespectful patients have a negative experience and they will complain about the doctor to other patients. Sometimes we will hear patients discussing a particular doctor and warning other patients about

how that doctor can be and how they (the patient) should be so that the doctor does not push them around or take advantage of them. When the doctors is good, hey, I'm telling you that the patient is tops. Then the patient is having a good relationship with the doctor and they follow with their treatment protocol.

Respondent A provides a very contrasting viewpoint from Respondents B, C and E by stating that patients do not complain even if there is a need to complain because they feel intimidated.

Respondent A

A very small percentage of people complain about doctors even if there is a need to complain. They (patients) tend to accept and respect doctors. If doctors are late for example they will complain to me and not to the doctor. Even if the doctor is not delivering the quality level of care that they expect patients do not complain. Maybe the patient is afraid to complain because they feel that if they need help, then the next time the doctor will not help them. This is especially true for patients that are reliant on the clinics in the community. This is why if our doctors can treat the patients well, then the patient can be more satisfied with this doctor and be happy with the way the doctor is treating them.

Respondent D and I supports the viewpoint that doctors carry a higher status than nurses and as such patients are willing to take note of what the doctor is saying in comparison to nurses who are considered to have a lower status.

Respondent I

Doctors are very important in ensuring the patient has a good experience at the clinic. Especially for the elderly who want to be attended to at least every six months the doctor is almost like a "God" in the clinic. His word is final and the patients wait for the doctors to give them a diagnosis and indicate their management. They want the doctor to listen to what their complaints are and to pay attention to them. Sometimes the doctors are busy and are unable to spend that quality time with the patient. Patients will complain to me that the doctor was disinterested and they don't like how he works with them. Also when the doctor does not answer their questions patients feel as though the doctor thinks that they are not smart enough to understand his responses.

Respondent F has suggested that patients are quickly receptive to non-verbal cues and take note of doctors who show that they are unwilling to touch the patient because they feel dirty. The importance of a doctor who is caring and understanding cannot be overemphasised.

Sub Theme: Role of the Nurse and Patient Experience

The role of the nurse is important in the type of experience that a patient has. Patients require a positive attitude, confidentiality, good communication, personal contact and respect from the nursing staff. The role of the nurse has been undervalued in the past.

Respondent A

The nurse plays a great role in the patient experience of care. The positive attitude of the nursing staff and good human relations, little gestures such as smiling, how they (patients) get information and receive attention and know that someone (nurse) is there to help them. When they (patients) enter the facility they (patients) want to see face value from the nurse. When they receive that face value, they do compliment the staff. They expect dignity and confidentiality and privacy. Before you (nurse) can even go into the consulting room for examining and treating them (patients), if you have treated them well, then 50 % of your job has already been done for the consultation. How the nursing staff carry themselves is also important to the patients. Staff uniforms help identify the staff and portray a good image which also shows respect for the patient. Good communication and eye contact are valued by patients. Patients want nurses who communicate well. If we can do all this then the patient can comment that they are happy with the nursing care and they can have better relationships with the nursing staff

Respondent C

Good communication and eye contact are valued by patients. It seems that there is a greater expectation from nurses as compared to the doctors. Nurses can cause the patient to leave feeling good or feeling worse than before they came in. I have heard patients complain about nurses who are disrespectful and rush the patients. They want nurses who embody what good nursing should be. They will often express how nurses used to be and how nurses have changed. They also complain when the nurses do not practice good hygiene. This creates a very strong impression that nurses play an important role in influencing patient experience care. Good nursing care will elicit a positive patient experience. I think if we work for a better a patient

experience then, there are positive outcomes like better nurse patient relationships and nurses will be more satisfied. Then the nurses will also be more empathetic and give our patients more emotional support.

Respondent I

The nurse is the patient's advocate and sometimes they have a better rapport with the nurses than with the doctors. Patients will ask nurses questions as well especially when the doctors do not provide answers that meet their satisfaction. Patients get irritated when nurses rush them or are impatient. Sometimes cultural differences between patients and nurses can become a problem. Patients want equitable treatment and they sometimes perceive that due to cultural and racial differences, a particular race group of patients is getting prioritized care. Arguments do arise between nurses and patients but we try to keep the environment conflict free in order to avoid issues.

Sub Theme: Provision of Information with Patient Experience

Informing patients about aspects of healthcare that influence or affect their personal health and wellbeing is well understood. The lack of information can cause patients to become confused and disorientated. Therefore patients need to well informed and when they are well informed it will help to facilitate a positive patient experience.

Respondent A

Patients want information given to them. They want to know what is happening in the clinic, if changes are made, why these changes are made. They want to be informed because it affects them. Also in the treatment process, for instance the process of consulting for the patient is completed when the patient knows what the diagnosis is at the end of the consultation. Treatment will be provided and this gives him confidence in knowing what is wrong and how to take care of himself. But when someone examines them and does not tell the patient what is going on they feel violated. It is an expectation that they want to know.

Respondent D

Health education and Communication go a long way in reducing complaints. If it has been explained well to clients why there is a long waiting period, shortage of staff before they can even start to complain then there would probably be no complaint.

The link between information, education and communication with a positive patient experience is clearly outlined with the response offered by the following respondent:

Respondent F

The patient has a better experience when they are given information about their condition and subsequent management. They are able to understand what the condition means and they feel empowered to make lifestyle changes. They are also knowledgeable about their condition so that they know what they need to manage their condition better. Even when the medication is given to them they are able to follow their regimes without defaulting. This helps to make their experience even better because they see the benefits of working with the staff to get better health outcomes. This means that the patient listens and participates in the relationship to better health for all.

Respondent I

Pamphlets help keep the patients educated about conditions. Even if they do not have the condition but they get informed and empowered so that they can help other people in their families or communities. In this way the message spreads and patients can help other patients to make informed decisions about their health needs because they are informed about the conditions.

Sub Theme: Education of Patients and Patient Experience

Education is an important and powerful weapon that can be used to support healthcare objectives for the patient, health professional and the PHS. Patient education is beneficial in that it makes patients more accountable and responsible for their health and well being.

Respondent A

For example, the local newspapers have articles about awareness health programmes. Part of health awareness for the clinic is to have an article about the health condition and the other thing that the department has initiated is the antenatal programme called MUM connect where they (mothers to be) receive messages from the NDoH that communicates about every stage of

the pregnancy till the child is 6 years old. For example: "Please take you baby to the clinic for vaccine" or "Signs of labour". Posters and pamphlets are available and they are useful because patients read up and ask questions. Patients enquire if there are no pamphlets available. So we have found that patients value awareness and education about their conditions and their management. Some patients even like to learn about conditions that they may not necessarily have so it goes to show how being educated is so important to them.

Respondent G

In the hospital we have pamphlets that we give to patients but we do not have pamphlets for all conditions. Sometimes patients ask for more information and we cannot give them anything. There needs to be more media usage to help improve the patient experience. Patients need information and we should be educating the patients. They should not have to look at google.com. They must know that if they need to know more we can help them. There is technology and we must use it for the good of the patient.

Respondent F

Patients want to understand what their condition means and what the treatment means. This way they are able to relate to what they are going through. Patients tell me that they feel better prepared when they are dealing with something that they understand than when they are dealing with something that they have no understanding about. They tell me that even if it is not good news then they are able to be positive and take it one step at a time and keep going forward. They tell me that they also use it as an opportunity to encourage and advise other people. For example when a patient was informed about diabetes he then explained it to members of his community and encouraged them to test their blood sugar levels. This made him feel good because some people were diabetic and did not even know. So you see, education is not stagnant. If you educate one person you educate a family, if you educate a family, you educate a community, if you educate a community, and you educate a nation. Patients feel good when they are a part of something that is bigger than them.

Sub Theme: Communication and Patient Experience

The role of communication is important within the healthcare setting. Healthcare staff needs to communicate effectively with the patients and vice versa. The lack of effective communication can lead to an array of problems which can elicit a negative patient experience.

Respondent E

Communication is the key to running a good clinic. In my time as the manager I have learnt that if people don't communicate we have a lot of problems. Especially between the staff and the patients. Oh the patients get upset when staff does not tell them what is going on. Especially when we are short staffed and we do not tell the patients that the waiting times will be longer. Also sometimes we make changes in the clinic and we need to communicate this to patients because they know how the system works and get confused when there are changes that we don't tell them about. Also staff must communicate well with the patients. This communication must be good because the patients need to understand and be able to ask questions so that they are satisfied should they have any concerns.

Staff also needs to communicate in a respectful manner with a calm voice. Body language is very important and patients watch how the staff is communicating with their bodies. Sometimes they will tell me that the staff was impatient because they were not even facing them when they were talking. There was no eye contact and they were shouting or used a loud voice. Even privacy should be maintained whilst communicating. Patients don't want people to know everything that they are discussing and sometimes staff does not know how to maintain confidentiality and privacy when they are communicating. Patients will appreciate that the staff is communicating well to them.

Respondent A

Communication is very important. When you communicate all the time there are fewer complaints and there is smooth sailing with regards to the clinic operation. However, I have noticed when there is a lack of communication between staff and between the patients and staff the level of complaints seems to increase.

The end result is indicated according to the response offered by Respondent G who explains that that ineffective communication contributes to a negative patient experience.

Respondent H

The staff does not always communicate with patients and I see how this affects the patient experience. Patients get upset because they feel that the staff does not value them enough to offer information when asked or when they are concerned about what is happening. For example if the patient is being given an injection they want the nurse to tell them what is happening so that they can follow what to do and make the process as smooth as possible so that they can have a good patient experience.

Sub Theme: Co-ordination and Continuity of Care and Patient Experience

Whilst the issue of referrals stands as a point of contention between facilities and healthcare professionals, there is also a significant problem that lies with the patients. Patients are reluctant to complete referral visits because they feel that it is a waste of their time for the following reasons offered by Respondent A:

Respondent A

There is a Guided Referral Policy Standard Operating Procedure. A community health clinic has certain criteria for referrals and what cases can come to them. Even though there is co-ordination between the healthcare professionals because they are accompanied by a referral letter, the doctor may consult further and then patients want to know how long they have to wait. Patients want to be seen at the facility and then they get annoyed because they have to use additional transport to get to the referral facility or the queues are too long at the referral facility. I find that the issue is more that patients are not willing to be referred rather than the issue of co-ordination between health care.

Respondent C

Patients do not want to be referred in the first place because they want all their care in one place. This should perhaps be looked at by the department of health because when the patient is referred they do not actually go for treatment. Also when patients are referred they have to get familiar with the other facility and the staff may not be able to co-ordinate their care well. This

can result in clashes with treatment dates and other problems which can affect the overall well-being of the patient. Patients get negatively affected when there is poor co-ordination of their care and management.

Respondent E

Co-ordinated care means that patients know where they are supposed to be and staff, know which patient they need to be attending to. I say this because one department can send the patient to another department but the patient does not know where the department is or who they are supposed to be meeting with. I think that the staff needs to communicate better so that patients are fully aware of where the department is and who they need to speak to in that department. This reduces the feeling of uncertainty and confusion. Staff also know that a patient has been referred to them and so they know who to expect and when. This will also enable the receiving staff to plan their departments so that they are able to provide efficient and effective care. When patients are moved around either in the clinic or from one clinic to a hospital they can become very frustrated when people at the receiving centre have no knowledge of them and they have to start from scratch explaining what is going on and why they are there. This is why we need a better referral system, so that there is better co-ordination.

Respondent H

Management needs to train staff on how to co-ordinate care because patients are not impressed when staff push them from pillar to post and make them run around the clinic and there is no way forward.

Sub Theme: Role of Medication and Patient Experience

It is important that the medication is dispensed according to protocol in order to ensure that the patient fully understands what the medication is, what it should be used for, how it should be administered, when and how many should be administered. If medication is not properly dispensed it have serious consequences not only for the patient, but also for the health professional and the health facility that the patient has attended.

Respondent A

Medication is very, very important. Patients are advised and educated as per protocol from the NDoH. Compliance of patients to taking their medication is checked regularly. A test is done and patients are assessed on how the meds are taken. This gives us an idea of how patients take their medication when they are at home and to ensure that they are taking their medication properly. Older patients tend to be more enthusiastic about these tests to check if the medication is being taken properly and they are willing to sit and listen to the instruction of the pharmacy assistant. Then these older patients are more educated about their medicines. Younger patients are very hasty; do not want to have a consult. Always hasty. They are not willing to even wait to pick their medication up. We need to make a system that helps these younger patients so that they can learn everything but do not have to wait long. So I have noticed that the older patients value the proper medication dispensing but the younger patients are not really interested or concerned.

Respondent E

Patients dispensing is key to our treatment plan. If the patient does not know how to take the medication and does not understand what the medication is for then they will not take the medication. This is a big problem especially for our diabetic, TB, hypertensive and HIV patients who need to take their medicine regularly. I have seen how patients who do not understand about the medicines because it was not dispensed properly will default and then end up with multi drug resistant TB and this problem is largely due to dispensation. Let me tell you that the pharmacist and assistants need to take their time. I always say to them to ask the patient to bring a relative or friend especially when the patient is elderly. It's not easy to remember everything that you are being told and sometimes the patients get overwhelmed. But if we can explain everything, the patient can take their medication properly and finish their course of treatment.

Therefore dispensing forms an important aspect of the role of medication with patient experience according to Respondent G.

Respondent H

The medication must be available so that it can be dispensed at the right time to the right person. When medication is not available then we have to make the patient come back. This is not good because the patient does not like to go back and forth. They want to get everything done on one

day. I can understand this because it costs money to go up and down. Also patients need to be explained on how to take their medication properly so that they understand what needs to be done. If they do not take their medication properly then they will be hurting themselves and wasting money. It is not good for the clinic because the patient will tell people that the clinic did not help them if they do not feel better. This is why management needs to intervene and ensure that patients have good outcomes from being in the clinic. Our staff must be effective in their jobs so that patients know that we are doing a good job.

Sub Theme: Emotional Support and Patient Experience

The provision of emotional support is conducive to a positive patient experience. Positive attitudes, a welcoming look and smile and friendly service help the patient feel more at ease and want to participate in the care process.

Respondent F

Patients need to know that they are being cared for because someone wants to do what is right for them. Patients complain and they will often say "It is their job to help sick people. How can you help sick people if you cannot show love and care? What kind of a doctor or nurse are you if you have no sympathy for people who come to the clinic. You should not have joined the medical profession" Patients feel strongly about staff that does not provide emotional support for the patients. They show me that it is unacceptable because I watch their body language and you can see that this has caused them to have a bad experience.

The staff is also reluctant to show emotional support because they feel they are overworked and underpaid but this is not right and the patients will tell them that they are here to do a job and they should do it properly. If they can't do the job then they should go look for another job where they do not have to interact with people. Patients are not shy when it comes to expressing themselves. Sometimes they will address the problem before it even gets to me and I then have to resolve the conflict. So you can see how important it is to patients.

Respondent H

Even when management talks to patients they must show care and support towards the patients' complaints or problems. All patients need to know that they are important and that they are not just another number in the system.

Respondent I

Clinic staff are generally lacking in this area as workloads are high. But when staff does provide emotional support we feel the difference in the clinic. The atmosphere is completely different and patients are willing to follow queues and wait for the staff to get to them. They are less easily frustrated and irritable and will even help to quiet other patients that are getting too rowdy or negative.

Sub Theme: Inclusion of family/friends and Patient Experience

The inclusion of family friends and its influence on the patient experience needs to be better understood in SA. There are contrasting views that are offered with regards to whether family/friends should be included and the extent to which their inclusion should be facilitated. The feedback offered by respondents highlights the controversy of this domain.

Respondent G

This is a new concept that is being looked at because in the past family and friends were always excluded and they were asked not to ask the doctor questions because the patient's confidentiality was affected. Now it is different, doctors will discuss with the family as long as the patient is comfortable with that. Patients want their family and friends involved so it means that this is important to them having a good experience.

Respondent C

Patients value their family and friends and will also view their involvement in the treatment as important. This means that patients will feel good about the involvement of their family and friends. There is also a sense of comfort that patients display when they have family members around I notice that they are happier and are willing to wait in the queues without complaining.

Respondent H

I feel that patients are comfortable when they have their company around them. This makes them feel like they are not alone and that they have someone who is watching out for them. They also feel like they have some kind of protection while they are in the clinic so they don't have to be afraid of what is being done. It can be good but it can also be bad. Sometimes friends and family tend to interfere negatively with the treatment and staff can get irritated. Then problems can arise which can affect the functioning of the clinic. I suppose we have to strike a balance.

Patients that need assistance require the inclusion of family/friends in order for them to have a positive experience of care according to Respondent F.

However, Respondent A notes that it is not always easy to get the help of family/friends when needed. Respondent B highlights that Indian families tend to be more involved than with other race groups.

Respondent A

Whilst I find that the inclusion of family and friends is relevant, it is hard to get. Even in the provision of health services sometimes patients need more assistance but they are unable to get it from their friends or family. I have to encourage the staff to get family and friend involved through communication with the patients but there is little enthusiasm shown. I think that the patient would want family and friends to help them and they would appreciate it if we could also work with them .....

Sub Theme: Waiting Time and Patient Experience

Waiting time refers to the time that a patient has to wait before service is rendered. In SA the waiting time has received much attention in the media. Waiting time can influence the patient experience. The feedback offered by the respondents explains the link between patient experience and waiting time.

Patients do not want to wait for long periods of time as noted by the following responses:

Respondent C

Waiting time is a major problem. No matter how much you try to avoid it, when patients have to wait for a long time they become irritable and restless. They do not want to wait for a long time especially when they have to get back to work. Also some patients need to eat or use the toilet

more frequently than others and they get frustrated because they have to wait for so long in the clinic. Long waiting times creates a negative patient experience.

Respondent E

Patients do not want to wait for a long time. We get elderly patients who can't sit for long and they get tired quickly. We have workers who need to get back to work. We have children who get restless and can't wait for long. We have mothers who have to go back home for other children. There are a lot of social activities that affect why the patients do not want to wait. It is not just that patients do not want to wait. They have urgent matters that need to be attended to. Sometimes the workers get into trouble because their bosses think that they are lying that the wait is so long. They ask for a letter from the clinic to tell them about the waiting time. I also feel bad when I see patients wait for a long time but sometimes it is not anyone's fault. Patients get upset when they have to wait for long. They also want service that is effective and efficient. They feel that if they are waiting for long they are not getting a good service and they also get fed up and leave. So waiting time is an important point of patient experience. It is one of the greatest challenges that we face in the clinic.

Respondent B explains that the availability of more staff would ease the load of patients for each staff member and help to reduce the waiting times.

Respondent F

Waiting time is my major problem. Somehow I cannot fix this and you know that the patient they are always complaining about waiting time. My staff will try to help the patients but the time is a problem. It is very important to the patient for them to wait less in the clinic. They want to do other things. Patients tell me that on their clinic days they can't do anything else because the wait is so long and then they get tired and then they need to rest. They get upset when the wait is long and they are happy when the wait is short. This means that the waiting time does affect the patient experience.

Sub Theme: Outcomes and Effectiveness

It is important that the clinic management ensure that the outcomes for good health delivery are being achieved. This also translates to effective health care delivery within the clinic.

Respondent A

As the manager I am committed to good health care, but sometimes the patients are too sick and they do not get better, but I make sure that I am giving them the best care together with my staff. My staff knows that they need to do a good job because this is what they are here to do and I check that they are providing a good service. When they do not provide a good service then it is my responsibility as the manager to address this and see what the problem is especially when the patients have poor outcomes. I check with my patients about their health and I find out how they are doing. Sometimes I see that the patients are not good emotionally and they look depressed and I will offer support through counsellors and a psychologist or social worker.

Respondent D

If we can improve patient experience by showing the patient that we as managers' care, then the patients will also be committed to do things that are good for their health. They will be more involved in their care. We as managers will also feel good because our patients are doing well and we will be more committed to support positive outcomes and service delivery.

7.3.8 Theme 8: Positive Reforms

Managers in the clinic are working hard to elicit positive patient experiences. Whilst patient experience is not yet a phenomenon that is set out by the DoH, there are definite efforts that have been made towards positive patient experiences. Managers that are at grass root levels understand and acknowledge the importance of patient experience and how it can contribute towards positive reforms in the PHS. Respondent A indicates that there are positive outcomes in the clinic which include the following:

Respondent A

Improved management of time for staff and waiting times are reduced for patients. Patients are satisfied. Staff (Doctors and nurses) Attitude has improved and there is more respect shown to the patient. Staff communication skills are improved. The patients know what is happening in the clinic especially with changes. Staff are more willing to assist patients to access the services and patients have a positive experience. Now our patients keep coming back because the quality of

care is so good and they also educate their friends and families in the community about services that we offer.

Respondent B

I have seen the graph from zero percent to somewhere. I feel I am going somewhere. I have seen the staff change in attitude, and I think that they are more committed to their work and duties. Enjoy what you are getting paid to do. When you are getting your salary you need to make sure that you have done your job and you have not robbed municipality. I have organised that culture here. But if you come as a manager when everything is not done, then you do not know where to start. We communicate a lot and they know what I expect. I tell them that even if I am not here then they must not just do their work anyhow. Even the cleaning staff know that the whole clinic must be clean and that the toilet must be hygienic for the patients. My patients are okay to wait because they get good service delivery and my staff are number one. They practice their hygiene protocols.

Respondent C

When the patient has a positive experience it causes positive ripple effects. Staff feels more motivated and is eager to provide quality service delivery. Patients have a chance to be more involved in their care now and the staff has the patience to answer the questions. Patients are more informed and educated. The atmosphere in the clinic is good and other patients tend to buy in to that supportive atmosphere. The clinic can function with efficiency because there is less pressure and strain.

Respondent G

The patients are more comfortable and they understand what needs to be done for them. They are less resistant and are willing to do what the staff says. Doctors and nurses are good now, they have a good attitude and they explain to the patient. They have a good relationship with my patients. We even include family to help the patient and the patient is happy about this.

There is a better atmosphere in the clinic and there is better organisation.

The staff are motivated and they want to come up with new ideas on how to improve and make things better. Even myself, as a manager I am more satisfied and I am committed to my role as the manager.

7.3.9 Theme 9: Using Patient experience as a Management Tool to Stimulate Positive Reform

Patient experience can be used as a measure for performance monitoring. This enables health managers and policy makers to identify key areas for change and stimulates QI. When QI initiatives are developed and implemented, it requires both the patient and the healthcare professional to work together in order to ensure its success. This is beneficial as it promotes positive reform within the PHS and encourages better health care for all.

Respondent A

My negative or low scores tell me that there is a problem or bottle neck somewhere. I then investigate the different aspects of why patients have waited long for example by checking with staff and then I look at what strategies can be used by working with the staff. For example can we most probably not separate the patients and then screen patients differently to reduce queues. The booking system does help a bit as a positive reform that was initiated and we provide a fast lane for collection of medication where the maximum time that patients wait is up to 5 minutes. Medications also come pre packed for certain patients on chronic medication who are then redirected to chronic clubs where they can use a facility close by to just fetch their medication. Understanding what makes patients feel unhappy and why they feel unhappy is useful in guiding positive reforms.

Respondent C

I listen to the comments or challenges that patients have when they come to my doorstep as the manager. This is generally an indicator that something is not working somewhere. When patients complain it's usually because something is not going according to plan. Then I implement changes that help to reduce complaints.

Respondent F

Patients are always expressing their views and when they do they want to see a change and action. This tells them that I listened and I cared enough to do something. They also get happy when they know that something they commented on was the reason for the change. I listen to the patient and they know that I listen to them. I do something that will make their experience better and this also brings about good changes for everybody even the staff. I do not do something when I hear the patient comments that make the staff feel bad or when I hear the staff does something that makes the patients feel bad. I do something that is for everyone's benefit. I do not want to pick sides but I want a balance. At the end of the day I want my clinic to be top and I want the patients to sing my praise. It does not matter what stars I get from my audits, for me I get my stars from the patient.

7.3.10 Theme 10: Challenges towards Positive Patient Experience

There are many challenges that can affect patient experience. Human Resources have proven to be quite a challenge in ensuring that patients have a positive experience of care at the clinic. Another challenge is the resource constraint that, plague the PHS. Whilst other challenges do exist these two areas are quite prominent.

Respondent A and C share similar viewpoints

Human resources are a problem. Sick leave and absenteeism is the challenge that affects the service delivery and creates a negative patient experience. When staff is absent there is a problem of capacity and we are unable to get work done efficiently and effectively. The remaining staff also gets frustrated and feels overworked and they are less enthusiastic about working with a compassionate attitude.

Respondent F

I have challenges with staff shortages and medicine shortages. It is not easy to work with half a staff complement and then I am also working with the team. When there are staff shortages I have so much of challenges. Waiting time is increased and there is insufficient staff to see to the patients. We do not deliver quality services because we are trying to see to a lot of patients in a short space of time. This is not good when we deliver poor quality service because staff makes

mistakes and this leads to more problems. The staff feels bad to make the patient come back so they try to work faster but it cannot be done. Then with the medicine shortage we cannot provide medicines on time when the patient needs it. This means that the patient must come back and then they get upset and don't come back which means that they default. This is not good for TB patients and for my hypertensive and diabetic patients.

Respondent I

Staff has a poor attitude towards patient complaints. Staff feels that patients are complaining but there is no real reason for the complaint. They feel that patients are not understanding towards the resource constraints and the fact that they are overworked.

Staff should be positive in their approach to patients, evaluating their needs, correcting misinformation and giving each patient a feeling of always being welcome.

7.3.11 Theme 11: Recommendations

It is important to obtain the nursing service manager's feedback with regards to potential recommendations that can be used to improve the patient experience and support positive reform. These managers interact closely with patients and are well aware of what is needed to support positive reform in the PHS.

- **Recommendation for a Patient Centred Model**

Respondent C

There needs to be a model that is developed that addresses patient experience in particular. There are aspects that are covered by the department of health but I feel that there are more domains that can be used in investigating patient experience.

Respondent H

Better communication via the bottom up approach where patients can tell us what they need to bring about positive change and not just the top down policies that we see.

Respondent F

I feel that there needs to be an entire shifting in the model for the primary health care clinic. The patient needs to be at the centre of this model and the government needs to understand that we are the staff that see to the patient and that work with the patient. We know that the patient is not happy about certain things because we see things on the ground

Respondent A

Attitude of staff needs to improve so that the delivery of care will improve holistically. The patients will be more satisfied. They will have a better experience. The doctors will be able to help the patients and the patients will appreciate the doctors. Even if there are challenges patients will be more understanding. They will complain less. Nurses will provide more support for the patients and in turn they will also feel better about the jobs that they are doing.

Respondent G

I think we need to focus on improving the efficiency of our staff so that they can work better and help the patients. They can improve their clinical effectiveness. The quality of care will be more efficient and effective and it will encourage a positive patient experience. The care delivered will be safe for the patients.

7.4 Conclusion

The respondents recognise the importance of patient experience as a measure of quality and QI. However, the viewpoint that the patient feedback is neither credible nor reliable is also proposed. Patient experience has been found to be useful in the drive for QI and Positive Reform. When feedback is provided by the patient, the QI initiatives are better suited to bringing about the change that is needed and consequently support positive reform. At present, there are no patient experience policies that have been developed or implemented in the PHS. There are also no patient experience frameworks or models that have been developed or implemented within the PHS of SA.

The use of patient experience can be beneficial to the patient, health professional and health facility in the PHS. Upon deeper investigation of the domains that were cited in the Picker Principles and IOM Framework, it is noted that respondents agree that there are additional domains that influence the patient experience of care. The challenges that oppose the provision

of a positive patient experience are discussed and the recommendations that support a positive patient experience are explained. The chapter that follows provides a discussion and interpretation of the qualitative data.

CHAPTER 8:

DISCUSSION FROM THE QUALITATIVE STUDY

8.1 Introduction

The preceding chapter provides the results of the qualitative data based on the responses from the Nursing Service Managers (NSM) via the semi structured interview. This chapter presents the discussion of the qualitative data analysis. The chapter is organised according to the thematic analysis to link the findings within themes and subthemes. The discussion highlights the findings of the study in relation to the literature reviewed in chapters two and three.

Themes and categories emanating from the interviews were cross-referenced with the Patient Experience Models presented through the Picker Principles and the Institute of Medicine Framework searching for commonalities (co-occurrences) and patterns to inform categories forming the basis of the codes created by studying and reviewing interviews. In addition, the Batho Pele Principles as the existing framework for service delivery in SA is also cross referenced to ensure that the dominant themes contributing to a positive patient experience is in keeping with the objectives laid out by the Batho Pele principles to support positive reform. These co-occurring categories were then coded as groups and this iterative process continued as fine-tuning and distilling the thought process and coding continued.

8.2 Discussion of Themes

8.2.1 Theme 1: The Experience of Care as an Indicator for Evaluating the Quality of Health Service Delivery

Sub Theme: The Experience of Care as a Measure for Quality and Quality Improvement

When the patient provides feedback on patient experience, it enables the NSM to have a better understanding of the processes that work and those that do not. Hence the feedback enables the management team to ascertain if the quality of health delivery is at the required standard. The respondents also indicate that the feedback on patient experience measures enables the NSM to identify areas that need to be positively reformed and the systems that need to be redesigned to support the provision of quality health care. Hence the feedback allows for the management team

to develop and implement QI programs and initiatives that can improve the quality of service delivery and support positive reform. There is an evident understanding and appreciation of the role of patient experience as a measurement tool.

According to the National Institute for Health and Clinical Excellence (2012:10) the role of patient satisfaction in evaluating quality has been minimised. According to Needham (2015:255) the degree of satisfaction is inadequate to drive positive change for the experience of care. Researchers are of the belief that the inconsistencies related to patient's background and health conditions cannot be adequately investigated with satisfaction rating question (Fenton et al.,2012:1678). There is therefore a gap that has been identified specifically within the healthcare context. The move away from patient satisfaction is in agreement with the Care Quality Commission (2011:10). An example of this is seen in UK's National Health System (NHS) where a patient experience survey is used in the evaluation of service delivery and patient experience. As a consequence, the survey data of patient experience is providing insight into areas of healthcare that require focused improvement and positive reform. According to IOM there is a general agreement that in developed countries patient experience within the health care context is a "practically, managerially, and clinically important concept to measure" (IOM, 2001:32). The majority of the respondents' viewpoints are in keeping with the viewpoint offered by the Beryl Institute (2014:15) and the IOM where the measurement of patient experience is important and relevant in the current healthcare environment. The findings of the present study which highlight the benefits of measuring patient experience are in agreement with the benefits cited by the Beryl Institute's which are as follows (Beryl Institute,2015:16):

- "*identify gaps in service;*
- *to gain insights into issues that contribute towards negative effects on patient care; and,*
- *To innovate and/or redesign processes in order to better deliver care with patients".*

Whilst the benefits are clear, there still exists an opposition to the use of patient experience data. Patients may have a tendency to provide feedback that may not be reliable or credible and the uses of audits that are performed by the DoH provide a more reliable form of feedback. However, upon delving further into the DoH audit process, it is noted that the patient is excluded from participation in the audit process. Therefore the feedback is based primarily on officials that are from the DoH who perform an evaluation of the clinic based on predetermined criteria

(PSC,2010:19). This type of scenario can present an opportunity for poor service delivery to go unnoticed especially when promotions and performance reviews of healthcare professionals are at stake. In addition the problem of colluding among healthcare staff at the clinic and the official inspectors may hinder the process of inspection and work against the objectives of the National Health Inspection Authorities in SA.

This viewpoints offered, where the concept of measuring patient experience is counterproductive, is in agreement with the findings of Manary et al. who supported the notion that patient feedback is not credible. However, the reasons cited for the lack of credibility in the Manary et al. study were attributed to the fact that patients lacked formal medical training and the understanding that the actual patient experience could be potentially influenced by factors outside of the health service process (Manary et al.,2013:368). Whilst it is probable that the patient's experience can be potentially influenced by external variables that do not necessarily encompass the health experience, De Silva (2013:198) explains that measuring patient experience is beneficial in both the clinical and business case. De Silva further suggested the need for greater support in the collection and use of patient experience data especially in developing countries.

The Batho Pele Principle of Customer Impact which clearly outlines the need for evaluating the benefits that have been provided for customers both internally and externally states as follows:

"It's how the nine principles link together to show how we have improved our overall service delivery....." (DOH,2016:12),

This principle in particular highlights the need to monitor improvements in service delivery within the public sector. Therefore, the evaluation of services from the patient's perspective to determine quality and QI is receiving stronger support from the NSM's as reflected in the findings of the present study. The findings reveal that patient experience can be a useful measure in quality and QI.

Sub Theme: Patient Experience to Drive Quality Improvement and Positive Reform

Respondents have indicated that measuring patient experience enables them to develop QI programs. Through an evaluation of the patient's experience they are also able to determine whether the QI programs are actually improving the experience of the patient or not. The

respondents have also indicated that when the QI programs developed from the patient experience data are implemented, it has the potential to promote positive changes in the clinic that translate to positive reforms. This is noted by De Silva who makes mention "that measuring patient experience is important not only to guide quality and service improvement, but also because people's experiences of care may be linked to clinical outcomes and costs" (De Silva, 2013:199).

Therefore incorporating patient experience in the drive for QI and positive reform is relevant within the context of the public sector. For example, when considering the aspect of clinical outcomes, patient experience has been well linked with the patient's commitment to medication and treatment protocols. In the case of SA where there is a high burden of disease, there is a need for patients to commit to the health process to support better health for all and to also reduce the burden in the long run. For example, patients that are diagnosed with Tuberculosis (TB) are required to complete the full course of TB medication in order to reduce the incidence of Multi Drug Resistant (MDR) TB. When the patient does not complete the full course of medication and develops MDR TB, the patients' management now places a greater economic burden on the health system and the risk of infection spread among family and friends may increase. Studies show that when patients have a negative experience, they become non compliant in the management of their conditions and this has the potential to reduce the clinical outcome of the patient (Sa´nchez-Piedra, Prado-Galbarro, Garcıa-Perez,2014:147).

In the case of organisational costs, patient experience is a useful measure to also understand transient changes in cost and management accounting within various aspects of the health organisation. For example, De Silva found a positive association between experiences of care employee retention (De Silva,2013:200). According to Browne et al. (2010:923) efforts to improve patient experience also result in greater employee satisfaction thereby reducing turnover. Costs related to employee turnover can be felt by all stakeholders. Inadequate staffing places an undue burden on staff to perform in stressful work conditions. This can lead to job dissatisfaction and also may affect the way in which the healthcare staff interacts with the patients and with their colleagues. Within the public sector, the problem of employee turnover and healthcare worker migration has received much attention. Therefore, this is an important

finding as it shows that patient experience can be linked to employee retention. This link highlights how patient experience influences the cost component.

According to Ahmed et al. (2014:15) collecting experience of care data to stimulate QI is becoming popular. The data collected through patient experience surveys are acknowledged as an important parameter of quality (Lehrman, Silvera and Wolf, 2014:10). Based on the feedback of the present study, the measure of patient experience is important in the drive for QI and positive reform. Therefore the findings of the study are in agreement with Ahmed et al. and Lehrman et al. which show the importance of patience experience in the drive for QI. There are various reasons why feedback from patients may be considered useful in the quest for QI and positive reform. The finding of the present study is in agreement with the findings of Robert and Cornwall. The authors explain that these can include but are not limited to the following:

- "*understanding current problems in care delivery;*
- *informing continuous improvement and redesign of services;*
- *helping professionals reflect on their own and their team's practice;*
- *monitoring the impact of any changes;*
- *facilitating benchmarking between services/organisations;*
- *comparing organisations for performance assessment purposes;*
- *informing referring clinicians about the quality of services;*
- *informing commissioners and patients about the quality of services;*
- *informing patients about care pathways;*
- *helping patients choose high quality providers; and*
- *enabling public accountability* "(Robert and Cornwall,2013:67)

In addition to the findings of Robert and Cornwall, the standards and norms of the DOH (2016:27) state the following with regards to the perception of services:

"*Community perception of services should be tested at least twice a year through patient interviews or anonymous patient questionnaires*".

Simply stated, the patients within the community should be given an opportunity to provide feedback that speaks to driving QI via the experience that they have previously encountered. However, the questionnaire presently in use by the DoH to obtain patient feedback, has not taken

into consideration the various domains that influence the experience of care, but is rather designed to evaluate patient satisfaction which has been shown to be outdated and less valuable when the issue of quality is raised (National Institute for Health and Clinical Excellence, 2012:10). Based on the Picker Principles and the IOM Framework there is evidence to suggest that there are other domains that need to be included when evaluating the experience of the patient (Picker Principles,2014; IOM Framework,2001).

The questionnaire presently in use caters for just six domains that influence patient satisfaction and is lacking in this regard. The domains are as follows:

- Attitudes of staff;
- Waiting Times;
- Cleanliness of the facility;
- Availability of basic medicines/ supplies;
- Safety and security of the facility; and
- Quality of Care.

Questionnaires are given to patients as part of the service delivery evaluation process but the relevance of the questions included in the questionnaire is also questionable. The importance of the right questions being asked so that the right information can be obtained to aid in the QI process is key, to quality care. The present questionnaire in use is lacking in this regard which creates a gap in terms of obtaining the right information. Hence the need for this study has been further highlighted. Through the study, the domains of patient experience as deemed relevant by both the NSM and the patient is determined. Therefore patient experience is identified as a valuable measure for quality and the QI process within the healthcare environment. There is a definite agreement between the respondents that support the drive for QI and positive reform. The literature presented also supports the need for incorporating patient experience in the drive for QI and positive reform.

8.2.2 Theme 2: Patient Experience Policies

The respondents have clearly indicated that there is no patient experience policy at the National or Provincial level that has been developed or implemented and are of the viewpoint that the development of a patient experience policy will prove beneficial in ensuring a positive

experience of care. The respondents agree on the use of the Ideal Clinic Policy and the Clinic Committee Policy to support service delivery at a level deemed appropriate for quality health care. Whilst the above policies are not specifically designed for the patient experience of care, respondents have identified the policies as the nearest to patient experience.

The Ideal Clinic Policy has been well identified by the respondents as the policy that is implemented within healthcare facilities in order to support good service delivery as per the Operation Phakisa initiative mandated by the former President Jacob Zuma. Respondents clearly stated that the Ideal Clinic policy is not as effective as was envisioned, due to resource constraints. The issue of resource constraints is a problem that is constantly raised and may well continue to pose as a potential problem in the near future especially in light of the NHI implementation (Jobson,2015:22). It is evident from the preceding statement, that merely developing initiatives that mandate good service delivery is insufficient to create the positive experience of care that is sorely needed in SA. One needs to bear in mind that the aim of such initiatives is directed towards providing a service to the masses rather than one unique patient.

Another point of concern that surfaced from the interviews remains, where the NSM does not subscribe to one policy and may favour the use of policies that are outdated or not in keeping with the current objectives of the NDoH. This lends itself to inconsistencies in the service delivery and the quality of care. Therefore the drive towards standardised service delivery with a positive patient experience of care across all nine provinces is clearly unmet. Evidently, the need for a patient experience policy of care is needed as a separate initiative to achieve this strategic objective as there are contrasting viewpoints on the effectiveness of the Ideal Clinic Policy as reflected by the respondents feedback.

Apart from the Ideal Clinic Policy, the respondents agreed on the use of the Clinic Committee Policy which ultimately serves as a vehicle to empower the community. This is in keeping with the Patients' Rights Charter (No.1) which is as follows:

"*The purpose and expected outcome of the Patients Rights' Charter and complaints procedure is to deal effectively with complaints and* ***rectify service delivery problems*** *and so improve the* ***quality of care,*** *raise awareness of rights and responsibilities,* ***raise expectations and empowerment of users,*** *change attitudes by strengthening the relationship between providers*

and users, ***improve the use of services and develop a mechanism for enforcing and measuring the quality of health services."*** (DoH,2016:28)

The Clinic Committee Policy seeks to actively engage and empower the community by providing a forum whereby members of the community can provide feedback on the experiences of patients that have received care at the same clinic. It also provides the community with an opportunity to participate in shared decision making processes regarding proposed changes at the clinic. Through this committee members of the public are afforded an opportunity to become involved in the decision making process which supports the Batho Pele Principle of Consultation whereby:

"*Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered*". (DoH,2016:29)

There is evidence that the respondents do not value the clinic committee policy because they are of the opinion that the general public are unable to productively contribute to the engagement process and as such the policy needs revision. Respondents indicated that due to the lack of training for these committees the meetings tend to be non-productive and do not support the objectives for which the policy was implemented. These challenges have contributed to a less than successful committee. This presents an opportunity for further research as there is a definite need to include the community in the governance of the clinics.

There is no Patient Experience Policy developed for SA. As such there is limited understanding of how to improve the patient experience to drive QI to support positive reform. Respondents also share conflicting approaches on the policies that they feel are relevant in the management of the clinic. This also expresses the inconsistencies that are prevalent within management teams and how the quality of service delivery can vary from one clinic to the next due to the lack of standardization. There is therefore an evident need for a Patient Experience Policy that promotes a consistent positive patient experience within public facilities in SA. This policy will also ensure that there is standardization in terms of the experience that a patient should have from one clinic to the next. The respondents are also in agreement that there needs to be a change in focus, which emphasises the role of a National Patient Experience Policy to drive QI and promote positive reform in the PHS in SA.

8.2.3 Theme 3: Patient Experience Framework/Model

There is no specific framework or model to date that has been instituted by the DoH that specifically addresses patient experience in SA. The respondents agree in this regard. The Batho Pele Principles and the Ideal Clinic Program that are currently in use are identified as frameworks that the respondents use to promote patient satisfaction. The Batho Pele Principles aim at service delivery within the public sector and guides the manner in which service should be delivered and managed within this sector (DoH,2016:11). The Ideal Clinic Framework has been designed to provide the manager with an overview of what should be done and how it should be done to ensure that there is standardised quality in the delivery of health care.

Clearly, there is a place for the above frameworks, but both the frameworks discussed above do not specifically address the issue of patient experience and have also been criticised by respondents. Respondents explain that they did not think that the Ideal Clinic was successful as patients were still providing negative comments about service delivery in the clinic. The NSM's were non-specific as to the nature of the service delivery challenges which can be attributed to the fact that the respondents do not want to be noted for experiencing challenges in their clinics. Respondents also indicated that the lack of Bath Pele training has resulted in staff not facilitating the delivery of care according to these principles. In short, Batho Pele has lost its value in the current practical setting. Seemingly, the development of a patient experience model demonstrates relevance in SA.

8.2.4 Theme 4: Benefit of Measuring Patient Experience

In a study by Manary et al.(2015:201), improving the patient experience is important in the health care reform which has also gained increasing popularity from 2013 to 2015, as reported by the Beryl Institute (2015:14).

The respondents have clearly expressed that the measure of patient experience is useful and beneficial. In addition to better service delivery, respondents indicated that patient experience feedback could be used to stimulate QI. The results of the respondents are in keeping with Browne et al. "where the use of patient experience information can be an important strategy to

use in driving system transformation" (Browne et al.,2010:921) and are discussed as follows:

- Positive reforms in service delivery (Respondent C);
- Increase in accountability of healthcare professionals (Respondent G);
- Stimulate quality improvement (Respondent G);
- Increase in patient engagement and inclusion (Respondent D);
- Favours a bottom up approach (Respondent F);
- Increase in productivity within the PHS; and
- Creating positive patient experiences (Respondent I).

Research by Luxford and Sutton (2014:10) showed an association between patient experience scores and clinical outcomes. Doyle et al. (2013:114), together with Berger et al. (2014:142) showed a positive association with patient experience to "patient safety, decreased length of stay, and adherence to treatment by patients within the clinical setting". Whilst these benefits were not specifically highlighted by the respondents one can see that the use of patient experience is beneficial to the patient, health professional and the country at large. The respondents also highlight particular challenges that surrounded the measure of patient experience. These management challenges are discussed in further detail in Section I. Respondent C offers the viewpoint that patients can become unrealistic in their expectations of service delivery, but there is evidence to suggest that the commitment to good service delivery on the part of healthcare staff has been questionable according to the Operation Phakisa Report (2015:23).

It is a point of significance that the respondents agree that there are definite benefits to measuring patient experience in spite of the concerns that are expressed above. The benefits of measuring patient experience have been documented through earlier studies to support positive reform based on Robert and Cornwall. Therefore, the role of patient experience in supporting positive reform is a significant one.

8.2.5 Theme 5: Measuring Instruments for Patient Experience

The NHS first implemented a nation-wide survey for measuring patient experience in 2001, followed by the USA who developed the "Hospital Consumer Assessment of Healthcare Provider and Systems" survey (HCAHPS). Other developed countries such as "Australia, Canada, New Zealand and many European countries" also evaluate patient experience at a national level (Robert and Cornwall,2013:67). In SA the survey or questionnaire, is a common method of investigation. However, there are issues that were raised by the respondents. The surveys that are currently in use do not provide in-depth qualitative information about where the problems lie and how they can be improved. Respondent C is of the opinion that the current survey falls short in this regard. Respondent A, on the other hand does not support the use of patient surveys or questionnaires based on the viewpoint that patients do not provide accurate information due to unrealistically high expectations. In addition, some of the patients do not fill in the questionnaires correctly or the patients do not completely fill the questionnaire. This renders the questionnaire invalid in the process of data analysis and is a significant waste of resources. These challenges also present an opportunity for the use of different measurement tools to, be considered in acquiring data on the patient experience and presents a potential area for further research.

The current research instrument as recommended by the NDoH is a questionnaire that comprises six areas of health and is mostly quantitative in nature (DoH,2017:24). The questionnaire falls short in terms of the comprehensive overview of other domains of patient experience that are excluded from the questionnaire. The respondents indicated that questionnaires or surveys are conducted upon request from the NDoH or the Provincial DoH, thus implying that the tests are not performed at regular quarter intervals. The respondents have recommended using the questionnaire or the survey but they have also suggested that the surveys be conducted at regular quarterly intervals and to include other domains of patient experience. This enables the managers to obtain four individual experience survey data that can be used to implement changes throughout the year and to make preparations in advance for the impending year. In the spirit of objectivity, respondents also suggested that the surveys should be conducted independently by an outside research consulting service in order to encourage patients to be open and honest. This ensures that the feedback will be both credible and reliable.

Another research instrument tool was offered by Respondent B who favoured the use of a suggestion box or book in combination with a complaints process. This system was traditionally in use and proved favourable according to the respondent. Respondents further suggested the use of patient focus groups which are well known for obtaining information rich feedback that provides an in-depth understanding of what the problems may be and potential ways in which the problems can be solved to improve the experience of the patient. Respondents also present a valid suggestion with reference to a patient forum. Patients need to be included at the various levels so that they are able to provide feedback at all levels. This will not only support a bottom up approach but will also enable patients to be involved in the decision making processes at levels where policies are being developed and implemented. Patients who are able to be involved at all levels will be able to experience first-hand how the policies are being developed and evaluate the success of the policy implementation. The recommendation for a patient focus group and forum is a new and innovative idea that can prove to yield valuable data, which can be used to drive QI and promote positive reforms. The concept of the patient forum is also in keeping with the Batho Pele Principles, Picker Principles and the IOM framework (DoH,2017:15;Picker Principles,2017:12;IOM,2001:15). The Public Sector Improvement Framework which places the citizen at the heart of the reform initiative is also closely linked with the idea of the patient forum (Robinson,2015:198). However, there needs to be a national level initiative such as a Patient Experience Policy that supports the use of the focus groups and forums.

Most organisations collect a great deal of patient feedback in different ways, including:

- "*national patient surveys;*
- *ward-level surveys;*
- *interviews and focus groups;*
- *patient forums;*
- *informal feedback to PALs;*
- *formal complaints;*
- *comments on websites (NHS Choices);*
- *feedback on the performance of individual clinicians for appraisal or revalidation purposes; and*

- *Complaints/ Suggestions"* (National Institute for Health and Clinical Excellence, 2012:35).

The important point of note lies not in the method that is used but rather the information that is needed. The importance of obtaining both qualitative and quantitative information has a place in the phenomenon of patient experience. There are a range of research instruments that can be used, and it would be impractical to suggest the use of only one method regardless of how successful the method may seem.

8.2.6 Theme 6: Domains that are Deemed Relevant from the Perspective of the NSM

The respondents identified the six domains that would influence patient experience based on a patient satisfaction survey that was developed by the NDoH and further, were of the viewpoint that these domains were adequate to evaluate the patient experience.

- Availability of medication;
- waiting times;
- infection and prevention and control;
- attitudes of staff;
- patient safety; and
- Cleanliness.

It is key to note that these are the very same domains that are investigated by the DoH through the patient satisfaction surveys. Respondents partially committed to the ideology that possibly including other domains was relevant to the patient experience of care. However, there is also a general understanding, given, that respondents are unwilling to go against the norm and challenge anything that has been put in place by the NDoH. The respondents offer minimal input with regards to identifying the possible inclusion of other domains that should be investigated when interviewed, but they did indicate the importance of other domains when specifically asked about these various domains further long in the interview. This shows that the respondents do believe that the questionnaire is lacking in terms of the domains that are investigated, but they are unwilling to express this. This could possibly be due to fear of their job security or position in the clinic. The IOM framework describes the domains that influence patient experience of care as encompassing qualities of compassion, empathy, responsiveness to the needs, values, and

expressed preferences of the individual patient (IOM,2001). According to the Picker principles "physical comfort, emotional support, respect, welcoming the involvement of family and friends" as well as information and communication were identified as domains that significantly influenced the patient experience (Beryl Institute,2011:11). When compared against the six domains that are used in the NDoH surveys it is clear that the emphasis needs to change (DoH, 2017:14). Bearing this in mind, both the IOM framework and the Picker Principles have highlighted domains that are deemed significant when investigating the patient experience of care. Therefore the findings of the study are in disagreement with the Picker Principles and IOM framework which have highlighted the importance of other domains of patient experience.

Sub Theme: Clinic Access and Patient Experience

When investigating the influence of access to the clinic as a domain of patient experience, two contrasting viewpoints were raised. Both Respondent A and C are of the viewpoint that access is secondary to a positive experience of care. Simply put, patients are willing to travel provided that they have a good experience of care. Respondent A has already identified patients who reside beyond the 20 km radius but are willing to travel and wait in the queues to receive that quality care. "Geographical access was ranked as an important aspect of the quality of primary care, among patients and professionals alike" (Papp et al.,2014:158). The question that still remains is whether, access is secondary to the quality of care or vice versa. Whilst studies such as Papp et al. have investigated the importance of access, there are few studies that examine the domain of access against the domain of quality care. The identified gap presents an area for potential research.

Whilst respondents agree that patients who experience good care at the clinic may not be negatively influenced poor access to the clinic, there remains the issue of patients who do not have private transport or the financial resources to travel. In the latter scenario, patients with financial restraints will most likely be influenced by the proximity of their homes to the clinic (Papp et al.,2014:158). The implication of this is that many patients with poor access to the clinic will be reluctant to follow their clinic schedules due to the financial restraints thereby influencing health outcomes poorly. It can also be proposed that patients who lack the financial resources will subject themselves to health facilities with better access although the closer facilities may

offer a poor quality of care, simply because the patient's financial situation limits their freedom of choice.

Patients who experience poor access to the clinic willingly choose to go to clinics where they have better access even though they are not allowed to do so as explained by the respondents. This refers to the importance of patients following the primary health care approach before referral to subsequent tiers. Patients in this scenario value the role of the proximity dimension of ACCESS to the clinic and this implies that it does influence the patient experience of care. Patients that complain about the access to the clinic will therefore have a negative patient experience. Scheffler et al. (2015:820) highlights the Acceptability dimension of the ACCESS Framework as follows:

"*Ethical standards and the appropriateness of services, goods and facilities to address cultural and gender differences and life-cycle requirements; to improve outcomes; and to ensure confidentiality, effective communication and facilitating attitudes."*

Based on Scheffler's standpoint of acceptability, it is understandable that patients would be willing to travel far distances in order to work with staff that are willing to provide a good service with the right attitude and demeanour. However, the converse of this statement is also true based on Scheffler, where patients who experience bad service, staff with a poor attitude and demeanour will be less willing to attend a clinic, even if the clinic is nearby their place of residence.

Respondents have noted that when the proximity of access is poor, the patients offer more complaints and are generally dissatisfied which has a negative influence on their experience of care. Respondents further add that when the clinics are burdened with high volumes of patients, staff is unable to cope and this also influences the patients' access to services within the facilities. This brings in a very important point that access is not merely limited to how the patient gets from their place of residence to the clinic and vice versa, but also incorporates how the patient moves from point a to point b within the clinic and how easily services within the facility can be accessed.

As indicated by Scheffler et al. (2015:820), the ability to ensure good access also rests on the understanding that the clinic is able to provide appropriate services that are specific to

individuals which reflects that the acceptability of access may still be lacking. The ultimate aim of the clinic should be to encourage a positive experience of care and this can be achieved by providing services that reflect good quality through staff that have facilitating attitudes and can communicate effectively. Accessibility in time which is defined as the "shortest possible time to reach primary care services was found to be another important aspect. Patients wish to reach their doctors immediately when needed, which can be translated to quick and easy access with short waiting times. Such high patient expectation generally leads to frustration among health professional" as revealed by Papp et al. (2014:159).

According to the ACCESS framework, the dimension of availability, states as follows:

"*Adequate supply of services, goods and facilities, including types of services, sufficient skilled human resources" (*Scheffler et al.,2015:820).

When the dimension of availability is well catered to, patients benefit from improved access as they are not restricted or limited in terms of their supply of services, goods and facilities. Translated within the health clinic context, this means that there is sufficiently skilled staff who can efficiently and effectively provide quality care without stressing the patient unnecessarily and there are well resourced facilities that support the provision of adequate goods and services. Respondents have indicated that patients who have poor access to the clinic will make arrangements to attend the clinic on one day for all that they need because of the extra strain that is placed on them to attend on different days especially when there is poor proximity. The end result is that sometimes patients do not come back to the clinic when they are unable to obtain all that they need on the one day. This has serious health implications for the patients. "All citizens should have equal access to the services to which they are entitled" based on the principles of Batho Pele. However, this is not the case, as highlighted by respondents, but there is a concerted effort made on the part of leadership, where arrangements to accommodate the unique needs of patients are made. Tailoring the services to meet the unique needs of patients is key to a positive experience according to NICE. According to the DoH (2016:19) as referenced by the Batho Pele Principle of Leadership and Direction "Good leadership is one of the most critical ingredients for successful organisations". Therefore it is evident that health facility managers play an important role in accessing services and to determine whether the patient experience is positive or negative.

The adequacy dimension of the ACCESS framework focuses on the organisation of services, including the standard of the facilities and meeting user expectations. NSMs will have to ensure that services in the clinic are organized and offer a positive experience of care. As reflected by Respondents, the entire clinic should have one main objective and that is to work towards a positive experience of care. Respondents' make arrangements and organizes services such that the patient does not have to make repeat visits unnecessarily. This understanding is in keeping with the National Institute for Health and Clinical Excellence (2012:17) theme of "tailoring healthcare services for each patient" which is as follows:

"*Patients wish to be seen as an individual within the healthcare system. This requires health services to recognise the individual and therefore to tailor services to respond to the needs, preferences, and values of the patient. Advice on treatments and care, including risks and benefits, should be individualised as much as possible*".

The access domain has been discussed as per the ACCESS framework offered by Scheffler et al. and there are contrasting viewpoints. However, based on the arguments presented, it is sufficient to state that access is an important domain of patient experience.

Sub Theme: Physical Environment and Patient Experience

The respondents indicate that the clinic's physical environment should be neat and clean with a well organised patient flow and physical structure. Respondents note that patients want to have a welcoming experience and they want to be advised of where to go and what to do. The patient is unhappy when they experience a physical environment that is not conducive to their well-being. Dirty and unhygienic facilities especially in the context of a healthcare facility are unacceptable. This creates a breeding ground for germs and bacteria and contradicts the objectives of the NDoH. Also the physical environment should be comfortable and cater for seating so that patients can be seated when they are awaiting their turns. It needs to be noted that patients waiting time can go up to a three hour waiting period and it is not acceptable for the clinic to be without proper seating for that period. Especially in the case of pregnant women and frail patients there needs to be special consideration given. Another point of view is offered by Respondent H who explains that some patients may not be adversely influenced by the physical environment provided that they receive good quality care, but it is still essential that the physical environment be suitable for the provision of healthcare.

According to the Operation Phakisa Report (2015:24),"dirty, unhygienic and unsafe facilities adversely impact on patient and staff experiences". The finding of the present study is in agreement with the findings of the Operation Phakisa Report. An inspection of SA clinics (PSC,2010:22), "found that 25% of the clinics visited were dilapidated and required urgent attention which suggests that the safety of officials and patients during consultation was at risk". In addition, during the interviews that were conducted at the nine different clinics the general observation of the physical environment indicated that clinics were small and overcrowded with limited seating within the clinic. Patients waited outside the clinic for a long period without any protection from the elements of nature. It is also noted through observation that administrative duties were conducted by other healthcare staff whilst the nurse or doctor was consulting with the patient which translates to an infringement of privacy and as such works against the rights of the patient according to the Patient Charter. Certain clinics had an overflow of medical waste which constitutes a health risk as it could easily spread infections. Currently, there still exists the challenge of facilities that do not have the best physical infrastructure to support a positive patient experience.

According to the Public Service Commission Report (2010:19) "the quality of the working conditions play an important role in both increasing the productivity of the health workers as well as providing a welcoming environment for the patients". Ablution facilities need to be clean and in proper working order. Patients are discouraged when the ablution facilities are not in good working order. They are unable to use the facilities and they are afraid that they will pick up an infection. This is also problematic, because some patients may need to do a urine test for which a sample is required. If patients are reluctant to use the ablution facilities then the clinic will not be able to get a sample and this will hinder the diagnostic process. Patients may then undergo unnecessary and expensive treatments simply because the ablution facilities were not in good working order. The findings of the study are in agreement with the findings of the Operation Phakisa Report and the Public Service Commission Report, highlighting the point that the physical environment is an important dimension of patient experience.

The recommendations that have been put forth according to the Operation Phakisa Initiative emphasise the importance of the physical infrastructure by highlighting the issues of cleanliness, spacing and security (Operation Phakisa Report,2015:29):

- "*The clinic should be clean, organised and convenient to accommodate the needs of patients' confidentiality and easy access for older persons and people with disability;*
- *Every clinic should have a house keeping system to ensure regular removal and safe disposal of medical waste, dirt and refuse.;*
- *Every clinic should be able to provide comprehensive security services to protect property and ensure safety of all people at all times;*
- *The clinic should have a supply of electricity, running water and proper sanitation;*
- *The clinic should have a written infection control policy, which is followed and monitored, on protective clothing, handling of sharps, incineration, cleaning, hand hygiene, wound care, patient isolation and infection control data".*

Despite the recommendations that have been put forth based on the Ideal Clinic Initiative it is disheartening to note that these recommendations have not been properly implemented within the clinic setting.

Patients are concerned about infectious diseases such as Tuberculosis (TB) and they are reluctant to wait in the same waiting areas as those patients with TB. Even further, patients have a need to attend a clinic that is clean, well ventilated, properly spaced and organized to support infection control and hygiene. Whilst the Batho Pele Principles do not specifically consider the role of the physical infrastructure in eliciting a positive patient experience (DoH,2017:10), the IOM (IOM,2001:12) and Picker Principles (Beryl Institute,2011:20) have highlighted the importance of physical comfortability as an important dimension of patient experience in developed countries. Ensuring the patient is physically comfortable when attending the clinic is necessary to elicit a positive patient experience. For example it was observed during the conducting of interviews that pregnant patients stood while awaiting their turns for treatment. The pregnant patients also waited in the same waiting areas as the other patients with infectious conditions such as TB. (Refer to respondents C, D and E who commented on similar scenarios). The waiting times were long and the clinic was not well ventilated with patients complaining of the heat. This type of scenario is a clear indicator for a negative patient experience.

Sub Theme: Cleanliness

The importance of a clean healthcare facility needs little discussion as the very nature of healthcare demands that the environment is a clean one. However, "South Africa is failing in terms of cleanliness" according to the Operation Phakisa Report (2015:38). Almost half of the clinics included in the Report are non-compliant to infection control and cleanliness standards with 17% of clinics being non-compliant in waste management processes (The National Health Care Facilities Baseline Audit, National Summary Report,2012:24). Respondents are of the viewpoint that patients are concerned about the state of cleanliness in the clinics and that the neatness of the clinic does indeed impact on the patient experience in a negative way. The NSMs' have indicated clearly that patients complain when the clinic is dirty and the patients become physically uncomfortable especially when there are odours. Therefore the respondents note that the level of cleanliness does indeed influence the patient experience of care and should be identified as a domain of patient experience.

Sub Theme: Quality of Care and Patient Experience

Clinical quality and patient experience are both widely used to evaluate the quality of health care, but the relationship between these two domains remains uncertain (Llanwarne, Abel, Elliott, Paddison Lyratzopoulos, Campbell and Roland,2013:467). However, recent studies show that when the quality of care is sub standard, there is an associated negative patient experience (Groene et al.,2015:10).

There are various factors identified by the respondents in their discussion of the quality of care and patient experience. Based on the feedback from respondents, it is clear that that the NSM is of the opinion that the perception of quality is influenced by whether or not the patient has been on a medical aid and has accessed private health care facilities. This is inextricably linked to the socioeconomic status of the patient. Respondents are of the viewpoint that patients who have been on medical aids and thus were entitled to visit privately funded health professionals compare the quality of the service received in the primary clinics against the quality of the service rendered in the private facilities.

The patients that were able to access private health care facilities through the aid of a medical aid hold higher expectations of service delivery. In comparison to the findings of the present study, there is evidence that individuals of lower socio-economic status (SES) tend to be less satisfied with their care and face substantial barriers including lack of insurance coverage and unaffordable costs (Arpey, Gaglioti and Rosenbaum,2017:174). The findings of the present study is therefore refuted by the earlier findings of Campbell, et al. (2001:93) and recent findings of Arpey et al. where the individuals with a lower SES "differed from the more advantaged individuals in reporting less favourable assessments of primary care". Based on the earlier study conducted in 2001 against the recent study of 2017, the outcomes seem to be consistent in the correlation between lower SES and the perception of quality of care. Particular race groups such as that of Indian Ethnicity hold higher expectations of the quality of care when compared to Black Ethnicity groups and this comment is based on the personal experiences of respondents. Respondents of both Indian and Black ethnic origin commented alike in this regard. The implication of the response is that patients of the Indian race generally comment that they have had a poor patient experience even if they have been given good service because they hold such high expectations of health care service provision. "Non-white ethnic minority respondents reported less favourable assessments of care than white ethnic majority respondents" in the study conducted by (Campbell et al.,2001:93). According to the authors, further research is needed in identifying the ethnic associations within healthcare service delivery. Older patients tend to be more accepting of the quality of care as compared to their younger counterparts. Respondents also explain that in addition to the race group of the patient influencing their perception of quality, the age of the patient also influenced their perception.

An earlier study conducted by Campbell et al. (2001:95) "in 2001 has shown significant differences between people of varying age and ethnicity with respect to their assessments of primary care using a reliable and valid instrument to measure patients' views". Patients' perceptions of "quality of care have been found to be significantly different where older patients consider quality of care to be higher than do younger patients" (Kvist et al.,2014:466). The findings of the present study reveals that older patients tend to be more accepting of treatment regardless of the quality of the service being rendered and are less inclined to complain because they do not want to affect their ability to receive the basic services necessary for their well-being.

The findings of the present study are in keeping with the evidence offered by Campbell et al.(2001:95). The earlier study conducted by Campbell et al. against the recent study of Kvist et al. shows a growing trend over the past decade where the older patient rates their experience of care more favourably. The findings of the present study show agreement with this trend.

Younger patients in comparison who are more informed about their rights are much more critical in terms of the quality of service delivered. Patients that are well informed of their patient rights expect the quality of care as determined by the DoH. More specifically, respondents expressed that when the patient receives good quality they are less likely to complain and more likely to complement, which highlights the relationship between quality and patient experience. If patients experience good quality in their visits to the clinic then they are more likely to have a good patient experience. When patients experience good quality then they are more willing to listen to the instruction of the staff and participate in the health process. Respondents explain that poor quality also incites the patient to share their negative experiences with other patients and discourages the return of patients for further treatment, which is detrimental to the health of the patient. Patients that have chronic conditions requiring regular treatment and intervention are impacted the most by the negative patient experience when they decide to discontinue going to the clinic. Isaac et al. (2010:1024) "reported a strong link between high levels of health care quality measures and high levels of patient experiences among patients". Simply, stated the higher the quality of care, the better the level of patient experience. From a literary perspective, factors influencing the perception of quality within the healthcare setting requires an in depth analysis and this presents a potential area for further research.

Sub Theme: Role of the Doctor

"A number of studies about patient experience demonstrate that a gap often exists between what patients want and what doctors think patients want" (Lee, Hulsman and Sepucha,2010:563). Therefore the role of the doctor presents as an important aspect of patient care. Respondents are of the viewpoint that if the doctor communicates well, is courteous, patient, understanding and respectful then the patient is more likely to have a good patient experience and complain less. Based on the study conducted by Devanny (2015:24) it was found that 68 % of UK patients and US expect everything from eye contact and a handshake to verbal communication when they

visit their doctor, and are of the viewpoint that these factors contribute the most to an overall positive experience. The manner in which the doctor interacts and communicates with the patient therefore influences the patient experience. The findings of the study are in agreement with that of Devanny.

There is an abundance of literature highlighting the importance of good communication between healthcare professionals and patients. According to Levinson, Lesser and Epstein (2010:1311), "communication skills are fundamental to the effectiveness of the doctor". According to Nadzam, anti-social behaviour patterns have a negative influence on the patient (Nadzam, 2009:186). The findings of this study are in keeping with the findings offered by Levinson et al. and Nadzam. According to Papp et al. (2014:268) patients' require compassion, empathy and sympathy during their consultation with health care staff. The time spent by the healthcare professional during the consultation was raised as a point of concern among patients in Papp's study. The respondents in this study note that communication contributed to a climate of confidence and thus led to a good doctor-patient relationship. The communication between the doctor and the patient should be simple, understandable and clear according to the respondents. The doctor should also spend time explaining the situation to his patients based on the respondent feedback. The findings of the present study are in agreement with the findings of Papp et al.

The respondents explain that when patients have a negative experience with the doctor they tend to complain to other patients about the doctor and will also warn other patients of potentially "bad" staff in the clinic. In Germany, 68 % of people rely on a family or friend’s recommendation when selecting their doctor, followed by 52 % in the US, and 24 % in the UK (Devanny, 2015:34). When the doctor does not show empathy, is discourteous and impatient, it can have an impact on future referrals. There is a real threat of health service seekers bypassing service providers based on the perception of low quality (Amatya et al.,2017:276). Other patients will "pass the message about the doctor" through the informal grapevine and this hinders the effectiveness of care. Even though the doctor may be skilled, poor patient interaction and communication will reduce his ability to provide good quality care thereby eliciting a negative

patient experience. The findings of the study are in agreement with Devanny (2015:34) and Amatya et al. (2017:276).

However, respondents clearly indicate that patients do not complain to the doctor or about the doctor for fear of being intimidated or victimised. Another respondent also indicated that patients perceive doctors to be of a higher status as compared to nurses and are therefore less reluctant to complain about the doctor even if they have had a negative patient experience. There are limited studies that address these findings in the present study. However, the importance of these statements should not be marginalised in light of the scant literature surrounding the findings. There is a need for further studies to be conducted in view of the above statements.

Sub Theme: Role of the Nurse and Patient Experience

Nurses are unable to provide the level of care that is expected of them in relation to their job descriptions and patient expectations. This is largely due to the staff shortages and extensive administration burden based on the feedback from the respondents. The shortage of nurses has become a significant problem according to feedback offered by the respondents. Pelzang et al. (2010:186) found that "the shortage of staff, dissatisfied staff and overworked employees were the main barriers to eliciting a positive patient experience observed in the practical setting". "Job satisfaction can be defined as the extent to which employees like their jobs "(Szecsenyi, Goetz, Campbell, Broge, Reuschenbach and Wensig,2011:508). It is further explained "as an emotional state that is enhanced by achieving desired results at work and the feeling of belonging to an efficiently functioning work community" (Aiken, Sloane, Clarke, Poghosyan , Cho, You, Finlayson, Kanai-Pak and Aungsuroch,2011:357). When there is staff shortages it creates extra work for the remaining staff and this can reduce the nurses' ability to deliver a good nursing service. Based on the definition offered by Aiken et al. (2011:357), this scenario can lead to job dissatisfaction. The findings of the study are in agreement with the findings of Pelzang et al. The lack of job satisfaction is a problem that is prevalent in SA and can potentially contribute to negative patient experiences.

"One of the most significant factors that influences job satisfaction and nurses' evaluations of the quality of care provided at the unit level is the practice environment and the availability of

adequate resources" (Hinno, Partanen and Vehviläinen-Julkunen,2011:255). The respondents note in the section:"Physical Environment and Patient Experience" that the working conditions have a significant impact on the level of staff satisfaction and productivity. This finding of the present study is also in agreement with the findings of Hinno et al. SA is constantly faced with challenges regarding the availability of adequate resources and the lack of resources has been well linked with the substandard service delivery in SA. Based on Hinno et al. (2011:255), the lack of resources will also impact the level of satisfaction among nurses. Higher levels of job dissatisfaction can be associated with poor service delivery based on Pelzang et al. (2010:187).Therefore the role of the nurse is an important domain in understanding patient experience of care.

Skilled nurses are also vital to the patient experience. Respondents indicate that patients want nurses who know their jobs, perform their jobs efficiently and effectively. Patients are very observant and watch when nurses are not performing their jobs properly. Patients are quick to identify when nursing staff lack the necessary skills to perform procedures or tasks. The skilled nurse also speaks to the issue of quality. If the nurses lack the necessary skills that are needed to perform their jobs in a safe and clinically responsible manner, then the issue of low quality and patient safety may be raised. The findings of the present study are in agreement with Groene et al. (2015:1147) where substandard quality is associated with a negative patient experience of care. The importance of a skilled nurse is therefore key to ensuring service delivery at the required levels of quality and in eliciting a positive patient experience.

Whilst patients may appear to hold the doctor in a more favourable light as compared to the nurse, respondents have noted that there is a greater expectation from patients towards nurses as compared to doctors. Patients value nurses that are patient and show empathy and this seems to be a common theme that is consistently highlighted when discussing the role of healthcare staff. The respondents note that patients expect nurses to provide emotional support to them and when patients observe nurses that lack in care, patience and consideration, they complain about the nurses and they comment on their dissatisfaction with nurses. According to the IOM framework (2001):

"Suffering is more than just physical pain and other distressing symptoms; it also encompasses significant emotional and spiritual dimensions."

Therefore, nurses play an important role in eliciting a positive patient experience according to IOM Framework (2001). Respondents explain that patients complain when nurses do not behaviour in a manner that is becoming of a health professional. Good communication and eye contact is key to developing a good rapport with the patient and providing emotional support according to respondents, a good rapport will help to reduce complaints from patients. Again the theme of communication and emotional support is highlighted in the role of healthcare staff and stresses the importance of communication in the patient experience of care. There is sufficient evidence according to the Public Service Commission Report (2010:18) that the interaction between health care staff and patients is less than desirable. Therefore initiatives according to the DoH (DoH KZN,2015:13) have been introduced at various hospitals to address challenges related to the interaction between nursing staff and patients, which include the following:

- *"War on Attitude Campaign;*
- *Greeting with a smile month;*
- *Staff member of the month; and*
- *Infection control monthly awards".*

The “Walk like a Nurse” project at Edendale Hospital involved nurses "addressing problems and challenges relating to poor staff attitude in service delivery". The Department hosted the Health Care Professionals Summit with the purpose to re-inculcate the ethos and values of health care professions and bring back the white uniform, using the theme “My Profession, My Pride!” The NDoH have identified various challenges that relate to the human resource component of service delivery and are attempting to inculcate transformation through the various projects highlighted above. The evaluation of the effectiveness of these projects also presents an area for future research.

Sub Theme: Provision of Information and Patient Experience

There is an evident problem that shows the lack of communication between healthcare professionals and patients in the PHS. Based on the feedback from Respondents it is noted that patients want to be informed and educated on matters that pertain not only to their health needs but also to the clinic operation. The importance of communicating unanticipated changes when

they arise due to operational incapacity is highlighted by respondents who explain that the problem of patient complaints can be mitigated with proper communication of bottlenecks that are evident in the clinic. The respondents explain that patients want problems related to operational incapacity communicated to them so that they can be prepared and organised. It is well known that bottle necks in the system can create longer waiting times that impact on the patient. Some patients wait for long periods of time only to be told that the service delivery cannot take place due to insufficient capacity. It would be more suitable for staff to communicate to the patient that there are capacity problems and give them a choice as to the best way forward. This means that patients want to be informed when changes are being made and have been implemented. The findings of the study are in keeping with the findings of the 2012 Audit.

According to the National Health Care Facilities Baseline Audit (2012:18) "mechanisms to communicate consistently and systematically with patients and to share with communities the results and the progress of quality improvement initiatives are lacking". Patients are especially concerned with the provision of information in respect of their diagnosis and subsequent management. It is understood that this clearly influences the type of patient experience that they have as expressed through respondents. The problem that emanates from the lack of communication between health care professionals and the patient indicates that patients suffer from a negative experience when they are not informed and communicated to about the diagnosis and subsequent management of the condition. "There is evidence that patients frequently do not receive important information on their condition and options for self-management, and that there is insufficient involvement of patients in developing quality goals" (Groene et al.,2015:1137). The findings of this study are in agreement with Groene et al. The failure to inform and communicate with the patient can lead to increased resistance from the patient towards the treatment process according to respondents. The presence of resistance does not reflect a positive patient experience and can also hinder the effectiveness of the treatment process thereby negatively influencing the clinical outcomes for the patient. This sentiment was also expressed by Luxford and Sutton (2014:11).

Health literacy has been defined as the “ability to read, understand and act upon health information, essential skills for making appropriate health decisions” (Stiff et al.,2013:14).

Ricciardi et al. (2013:376) "found that patients, who use e-health resources, respond that they are more prepared for appointments, ask more relevant questions about their care and are more likely to take the initiative to improve upon their health". Patients are more empowered because health literacy encourages the patient to develop a greater understanding of the condition and the treatment plan. The lack of information about patient conditions and treatment offerings cause a high degree of dissatisfaction among patients whereas patients who are more informed have positive care experiences. Patients who receive sufficient information about their condition and treatment options "engage in behaviours such as screening, healthy eating and exercise and manage their conditions, while less activated patients are three times more likely to have unmet medical needs and unnecessary hospital visits". (Kings Fund Report,2013:14).

There is a community forum that provides the public with an opportunity to be informed of the proposed changes and to provide feedback. This community forum is in keeping with the Batho Pele principles but there is a lack of commitment towards these community initiatives. The respondents indicated that the meetings with the community forum generally conclude in great conflict and chaos. According to Coulter (2010:10), before changes are made patients should be consulted about what works and what does not, especially since they are impacted by the changes that are implemented. This is reflected clearly in the feedback provided by Respondent. Whilst the community forum is a useful forum that allows patients to be more informed of proposed changes and new developments, respondents have a negative attitude towards the role of the forum and the findings of the present study are refuted by Coulter (2010:10).

Sub Theme: Education of Patients and Patient Experience

It is well known that educating patients hold a plethora of benefits for the patient, healthcare professionals and healthcare facilities. Respondents clearly indicate that the DoH has taken an initiative to educate patients especially in vulnerable groups such as maternal and child healthcare. Respondent G is of the opinion that there needs to be more education offered through technology at hospital and clinic sites. The pamphlets that are provided are not comprehensive and get finished over time. They are always in short supply. If technology can be used then patients can be more educated about all the different conditions, causes, symptoms and possible treatment options.

The use of MUM connect provides information for pregnant women on what will happen at every stage of the pregnancy and what they need to eat to be healthy. This system also ensures that mums are well educated on the importance of vaccinations and the times when they are taking place. Technology has proved useful in educating this type of patient according to respondents. Moriates and Shah (2014:1693) explain that "patients struggle to remember what they are told and one study showed that patients only recalled 40% of the information they were given, and almost half of what they thought they remembered was incorrect". This highlights the importance of educating patients so that they understand what is going on with their bodies and what they need to do to promote good health. Patients that are educated are more willing to make healthier lifestyle changes that aid in the management of their conditions. According to the respondents, when patients are, they are empowered to improve their well being.

Patients have a need to be educated as seen through the feedback offered by respondents. The patients are willing to use Google in order for them to be more knowledgeable about their conditions and the treatment that they are receiving. Knowing what is going on also helps the patient to be at ease and they are more relaxed. Posters and pamphlets are also used in the clinics. Some patients enjoy the read to be more informed and educated on different conditions. The positive spin off is that these patients go back into their families and communities and they are able to take the knowledge to the street. In addition to the posters and pamphlets that are available, there are workshops and programs that are available and seek to educate the patients on conditions that prevalent within their communities. In the past patient education has been taken for granted, however, there is a move towards increasing the health education of patients. According to the IOM Framework (2001) and Picker Principles (2013), when patients are educated they are able to also become more responsible for their health and can contribute to shared decision making. Therefore, educating patients encourages patient engagement and holds benefits for the patient and the health care professional.

Sub Theme: Communication and Patient Experience

Communication is not only to be limited between the staff and the patient but can also include communication between patients which can also present with its own set of challenges according to the respondents. Respondents agree that in order for the communication between patients to be effective it needs to be done in a respectful manner taking into account that non verbal cues

speak louder than words. Whilst healthcare staff cannot control what patients say to each other and the manner in which they communicate, healthcare staff should be observant and keep watch for any potential conflict that may arise from communication that is non-productive. Healthcare staff should also be willing to step in to mediate before patient to patient communication becomes negative. The benefit of effective verbal and non-verbal communication between patients as expressed by respondents suggested that it contributed towards smoother operations within the clinic and produced fewer complaints. The converse of this is also true as the respondents indicated that ineffective communication between patients contributed to higher levels of complaints. There is insufficient literature that examines the role of patient to patient communication and this presents a potential area for further research.

Respondents highlighted the importance of proper communication between the staff and the patients. Communication is therefore significant in the type of experience that the patient has. When the communication is ineffective between staff and patients then the type of patient experience can be viewed as negative. However, if the communication between the staff and the patient are effective then the patient will have a positive patient experience. According to Torpie, (2014:7) clinical, interpersonal and communication skills to ensure that the patient is safe, comfortable, cared for and included in treatment planning are necessary to elicit a positive experience of care and patients are more grateful towards health care professionals. Grateful patients are also more likely to be loyal patients and this holds implications for their adherence to treatment. In the same token staff who, are rewarded by the gratitude of patients and management are more likely to deliver good service. The findings in the study are in agreement with that offered by Torpie.

Respondents have raised a valid point in that language can present as a potential barrier to communication. This is a challenge in SA as there are eleven official languages and not all staff may be able to communicate fluently with patients who communicate in a different language. Staff also tends to communicate less when the clinic is short staffed. The problem of language barriers and an unwillingness to communicate on the part of the healthcare staff can lead to a lot of problems in the clinic because the patient wants the staff to communicate and when they do not communicate well for whatever reason, be it language or staffing issues, patients get frustrated. "High-quality communication between care team members and patients has been

shown to have a positive influence on patient health outcomes" (Gordon et al.,2015:23). Therefore there is a need for healthcare staff to develop good communication skills.

Sub Theme: Role of Medication and Patient Experience

"Medication error is an error that occurs during the process of drug prescription, dispensation, preparing and administering that involves giving medical advice regardless of whether such prescriptions can lead to harm" (Brady,2009:679) When medication is dispensed according to regulation, then patients are well aware of the medication, its use and how it should be administered. This is especially important to prevent the incidence of medication error in patients who suffer from chronic conditions and infectious conditions. It is vital that these groups of individuals are committed to taking their medication as recommended in order to reduce the incidence of complications such as the development of MDR TB in cases of TB patients who do not complete their course of medication and place family members at risk of TB according to the respondents. The importance of proper medication dispensing is important to ensure that patients do not suffer the consequences of medication errors. As reflected in Figure 8.1 there are four possible causes that contribute to medication errors. In SA, the problem of understaffing is prominent, which places an undue burden on the staff that is present leading to fatigue, stress and burnout. This creates the potential for errors to take place. Therefore, there is a need for medication to be dispensed according to regulation in order to reduce the incidence of medication errors.

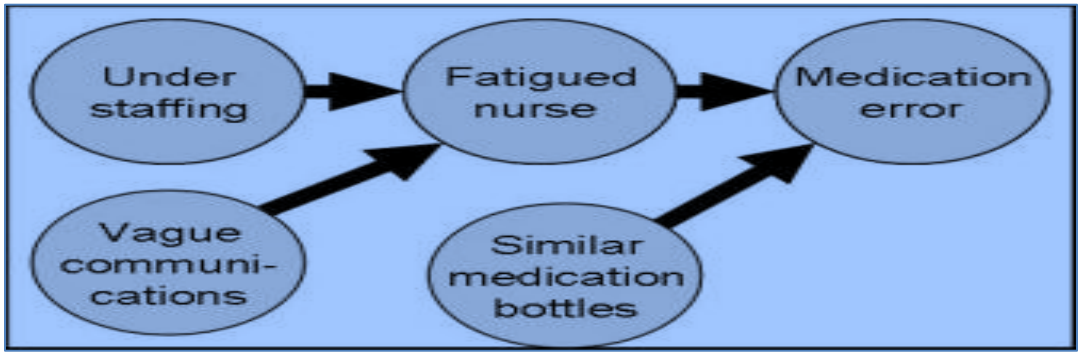

Figure 8. 1: Four Possible Causes of Medication Errors and their Relation

Source : Farrokh-Alemi(2010:132)

Respondents note that younger patients are impatient in their wait for the medication dispensing according to the regulations laid out. They want to pick up and go, whereas the older patients want to be informed about the medication and what they need to do when administering the medication. Respondents further note that proper medication dispensing is important to the type of experience that the patient has. Patients that are able to experience the proper dispensing of medication will benefit because it will reduce the incidence of medication error and enable the patient to have a positive patient experience. It is equally important for elderly patients who experience difficulties with remembering all the information around medication dispensing to bring in a family member or friend that is able to assist them when they are at home. Respondents also stress the importance of patients knowing how to administer the medication. According to Phillips (2013:59) a retrospective analysis "found that the most common types of errors were from administering the improper dose; overdose, the wrong drug and the wrong route of administration. The most common causes of errors were performance and knowledge deficits and communication errors". In the case of the younger patient and the older patient improper administration of medication can lead to medication errors.

The role of medication is an important aspect affecting patient experience. The availability of medication in the right place at the right time and in the right quantities is critical to ensure a positive patient experience. Patients are not willing to go back and forth for treatment that can be delivered on one day. It adds to their clinic costs and patients may experience financial limitations that prevent them from returning to the clinic. This creates a problem as they are unable to fetch their medication and use it as prescribed in the management of their conditions. In SA, officials found that in 2010 there was a shortage of medicines, with only 36% of the clinics that were inspected holding sufficient medication (Consolidated Report on Inspections of Primary Health Care Delivery Sites: Department of Health, 2010). When there are shortages in medication, patients have to make repeat visits to the clinics on separate occasions or they may be requested to purchase medication that is in short supply through private pharmacies. The patients that frequent clinics for repeat visits in order to collect medication that was not previously available can create higher workloads and administrative challenges. Therefore, repeat visits create the problem of inefficient system processing which creates bottlenecks in the dispensing of medication. In the case of patients being asked to obtain the medication privately, there is little evidence to suggest that this instruction is being followed.

Patients who have adequate access to medicines when needed will be able to have a positive experience of care as compared to patients who are told to come back on the next clinic date for the prescribed medication or to source the medication from somewhere privately. Patients that are uneducated about the medication that has been prescribed for them will be less motivated to commit to completing the course of medication even though it may be exactly what is needed to help them have positive health outcomes. The medication also needs to be dispensed so that the patient is well aware of what to do and how to do it in order to reduce the incidence of medication errors. Eslamian, Taheri, Bahrami, and Mojdeh, (2010) reported that in the US alone approximately one hundred thousand drug errors resulted in one thousand and one hundred deaths. The role of medication is clearly outlined and the association to patient experience is explained.

Sub Theme: Co-ordination of Care and Patient Experience

According to Papp et al. (2014) "patients had a strong need for the continuity and co-ordination of primary care and pointed out the importance of long standing personal relationships with their doctor. Patients have a need for their doctor to coordinate their care and the services provided by other professionals, in other settings and at other levels of the health care system". Respondents have indicated that there are problems in terms of the co-ordination between clinic staff and external healthcare providers in other facilities. This is noted from past experience when patients who required intervention at district and tertiary hospitals were referred from the clinic. This is why there is a move towards assisting the patient within the clinic and reducing the need for referrals out of the clinic. Based on the findings of the National Baseline Audit of Health Facilities (2012:34) it was found that 23% of facilities do not have referral guidelines. The lack of an effective referral system does not support co-ordinated care and creates frustration for the patient.

Unlike the findings of Papp et al (2014) which illustrate the importance of co-ordination of care, the South African health workers are of the opinion that reducing the referrals is the key solution to the problem. Whilst this may prove fruitful in the short run, this is hardly a long time solution. One just has to consider the fact that not all health care facilities are able to offer the same level of service and patients that require these services will have to be referred to facilities that can

provide the service. The findings of the present study which supports the idea behind reduced referrals is contradictory to the support offered by Papp et al. (2014). Schang et al. (2013) states that "care coordination can be seen as part of a broader strategy to improve quality in health care delivery and, ultimately, to strengthen the performance of the health system". The findings of the study are also in disagreement with the study of Schang et al. (2013). All patients should be referred to the next level of care when their needs fall beyond the scope of clinic staff competence according to the NDOH policy (2016:67). This is indicated as follows:

- "*Patients with a need for additional health or social services should be referred as appropriate.*

- *Every clinic should be able to arrange transport for an emergency within one hour.*

- *Referrals within and outside the clinic should be recorded appropriately in the registers.*

- *Merits of referrals should be assessed and discussed as part of the continuing education of the referring health professional to improve outcomes of referrals.*

-*There is a functioning community health committee in the clinic catchment area that links with the community health committee, civic organisations, schools, workplaces, political leaders and ward councillors in the catchment area".*

Poor coordination can also make care more expensive than it needs to be. Respondent C recommends that the government or rather the NDoH intervene and revisit the referral of patients as it has been noted that patients who are referred do not follow up on their visits which takes up the time allocation that another patient could use. When patients are referred to other facilities the treatment dates clash with the treatment dates at the clinic and this creates chaos for the patient especially when they have to fetch their medication for chronic conditions at the clinic. This can cause a negative patient experience.

Respondents make note of the problem where patients are not referred for services within the facility that can benefit the patient. Referral protocols should be well documented and rehearsed so that staff is well aware of any other services that the patient can benefit from. Patients also are well aware of services because they talk with other patients who will express potential services that can benefit the patient. Respondents note that the services within the clinic should be well organised and structured so that patients and staff know what is needed and when. They need to

be well aware of the patients they receive and what needs to be done before the patient even arrives. Respondents note that patients tend to become frustrated when the staff are unaware of why there are there and re-examine them or request a history all over again. "Additionally, better communication, more integrated care delivery processes, and decrease in service delivery gaps are appreciated" (Dabney and Tzeng,2013). "There is an increasing body of evidence that shows consumers and caregivers who are engaged, well informed, and who communicate effectively with their health care providers are more likely to receive preventive care and adhere to prescribed treatments" (Brown, Peikes, Peterson, Schore, and Razafindrakoto,2012:1056).

There are mixed viewpoints that are offered in this examination of co-ordinated care and patient experience. One viewpoint offers the understanding that the problem rests with the patient and not with the staff. This viewpoint expresses that the patient does not follow through with referral visits because it is an inconvenience for them. Apart from the inconvenience of additional costs and time wastage, patients get frustrated with having to continuously repeat their problems to different service providers. This can create a negative patient experience especially when patients experience conflicts in their treatment dates for the clinic and for the additional facilities. The other train of thought that is offered explains that staff lack basic skills when co-ordinating care and need to better equipped through training in order to refer the patient as and when is needed within the facility and out of the facility.

There is a well substantiated recommendation that is put forth by respondents who suggests the use of training to improve the co-ordination of care because the lack of co-ordinated care can elicit a negative patient experience. Patient experiences are also considered important in improving coordination of services and to increase transparency and improve information access for patients. According to the Picker Principles (2013), there is a need to ensure that the co-ordination of care is a seamless transition of care and that the patient benefits comprehensively through the co-ordinated care. The findings of the present study are in agreement with the Picker Principles (2013).

Sub Theme: Inclusion of family/friends and Patient Experience

"Patient engagement can be defined as involvement of patients, their families or representatives, in working actively with health professionals at various levels across the healthcare system (direct care, organizational design and governance, and policy making) to improve health and

healthcare services" (Carman et al.,2013:223). "Effective engagement also entails giving stakeholders/patient's family members the opportunity to participate in care-giving and express choices". This creates a respectful, empathic environment where individuals feel valued and cared for (Luthra,2015; Peters,2015). The move to including family and friends is new according to Respondent G. This was largely due to the issue of doctor patient confidentiality. However the new understanding is that a long as the patient is accepting of the family member and permits the doctor to discuss their diagnosis and subsequent treatment, and then it is acceptable. Respondent G indicates that the inclusion of family/friends helps the patient to have a positive experience. "Patient-centred care provides a mechanism to allow involvement of patients and families in their care" (Zimlichman, Rozenblum, and Millenson,2010).

"Patient-centered care must not only be focused on the patient, but the emphasis should be designed by the patient and for the patient with the best interest of the patient and family at its heart" (Grob,2013). "Patients and family have also been identified in this strategic approach as an invaluable asset and resource for improving patient safety" (Newell, Jones and Hatlie 2010:63). The benefit of including family/friends is seen especially in the elderly patients, chronic condition patients, HIV patients and TB patients according to respondents. Respondents note that patients with family/friends included in the treatment process are happier and complain less. However, respondents offer a different viewpoint that illustrates the problems that can arise when friends/family interfere negatively with the health care process. When the clinic is overcrowded the clinic is unable to accommodate the extra family/friends that come in and sometimes they are asked to wait outside. This can also lead to conflict and cause the patient to have a negative experience. The viewpoint that allowing patients and families an opportunity to be included in the healthcare process would be disruptive to patient care routines has been shown to be incorrect and in fact, actually promoted better service delivery and can lead to additional innovations and care improvements. "The involvement of family and friends has proven to reduce the adverse events in hospitals by the identification of barriers to quality care" (Berger et al.,2014).

The inclusion of family friends is important in the type of experience that the patient has based on the feedback obtained from the NSM's. For organizations to adopt patient- and family-centred care, several attributes and processes are required, as follows:

- "*committed leadership,*
- *focused strategic vision,*
- *active communication strategies,*
- *adequate resources to support staff and providers,*
- *Accountabilities and incentives to support adoption, and involvement of patients and families in the design of the processes*" (Luxford et al.,2011).

However, there still exists the potential for conflicts to arise when family/friends do not respect the rules and regulations of the clinic. There are a number of areas that need to be addressed in order to welcome the involvement of family/friends. These include the necessity to" change the culture, cost of the implementation process, the necessity for all staff to adopt these processes, and the requirement of more staff to maintain these practices" (Luxford et al.,2011). The benefits with the inclusion of family/friends are significant and needs to be considered.

Sub Theme: Waiting Time and Patient Experience

A recent study from Nepal published in 2017 states that longer waiting times are associated with higher patient dissatisfaction rates (Mehata et al.,2017). When patients are made to wait then every effort should be made to ensure that patients are kept informed and apologies are offered. There are different reasons for why patients do not want to wait. These can include but are not limited to work requirements, eating needs or toilet needs. Respondents explain that elderly patients are unable to sit for long periods and children get restless when they have to wait for immunisations. Patients who are also mothers may need to rush home so that they can see to other children who maybe at school. Respondents on the other hand explain that patients do not want to wait because they want a walk in walk out service. Respondents offer another explanation for long waiting times which is attributed to guidelines and protocols that need to be followed by healthcare professionals in their management of the patient. These two specific issues raised with regards to waiting time have not been adequately researched and warrants further investigation.

Patients get upset when they have to wait for a long time, because they want to receive service that is efficient and effective. With long waiting times, patients are of the opinion that they are not receiving a good service and this causes them to have a negative patient experience. In SA,

three quarters of patients wait can exceed two hours, and a minority of patients being under 10% could exceed seven hours. On average patients may lose approximately four hours due to the waiting time challenge (National Health Care Facilities Baseline Audit, 2012:54). According to the National Health Care Facilities Baseline Audit (2012:55) the lack of proper planning has led to the problem of long waiting times. More specifically the appointment system in place does not indicate a time slot and only provides a date on which the patient should report to the clinic. This leads to patients all arriving in the early hours of the morning causing the problem of overcrowding and longer waiting periods.

Waiting time has a definite influence of the patient experience as offered by the various respondents. When the waiting time is long, the patient has a negative experience, and vice versa. "As many as 70% of clinics are unable to report reliably on waiting times and on any improvements achieved", (National Health Care Baseline Facility Audit, 2012:56).

8.2.7 Theme: Management Use of Patient Experience to Guide Positive Reform

"Good leadership is one of the most critical ingredients for successful organisations". (DoH,2015). This was highlighted in a study conducted by Kaufman and McCaughan (2013:53) "who contend that leaders cannot be seen to turn a blind eye to poor practice, as this sets the pattern of behaviour for the whole team". Respondents indicate that patient surveys help identify areas where there are problems or potential bottlenecks in the system. Staff is then invited to participate in the process of identifying what factors contributed to the problem and how to bring about positive reform in the health facility. Patients' feedback is useful in guiding positive reforms according to respondents. Browne et al. (2010:922) explain that health care providers cannot achieve positive health outcomes without commitment and action from patients. This finding of the present study is in agreement with the stalwarts of patient experience such as the National Institute for Health and Clinical Excellence and Browne et al.

Respondents explain that they use the patient experience to develop QI programs by focusing on the complaints made by patients. When the QI programs have been developed, the NSM together with the staff monitor the effectiveness of the QI program. The implementation of QI programs generally necessitates that healthcare staff realign their attitudes and behaviour in order to support the QI program. Other positive reforms that occur can include the following:

- harmonious working environment;
- improved interaction between staff and patients;
- reduction in waiting times;
- reduction in errors by staff;
- improved job satisfaction of healthcare staff;
- improved clinical effectiveness;
- improved patient safety; and
- positive patient experience.

Sometimes the monitoring of QI programs are done formally through the use of a survey, but when there are resource constraints, the monitoring is done through an informal evaluation of the QI program. Nursing staff will query with the patients to ascertain about the effectiveness of the QI program. This seems to work well for these respondents because they base their initiatives on what the patients have commented on regarding the experience of care.

The viewpoint offered by respondents explain that patients are free to express their views and there is a need to implement changes that support a better experience of care not only for the patient but also for the staff as well. There is an emphasis on implementing changes that are of benefit to the entire clinic. "Tying the patient experience to financial incentives has demonstrated benefits in improved patient experiences, efficiency, safety, hospital reputation, outcomes of care, and performance" (Stanowski et al.,2015; Zhao et al.,2015). Even further, the respondent highlights the fact that the evidence of good practice is not based on audits that are conducted but rather are based on the stars that are received from the patients. This highlights the value that the respondent places on patient experience.

However the respondents are confident that the use of patient experience either through the process of complaints or through self suggestion has proved beneficial to develop and implement QI programs that support positive reform. According to Hsieh (2012:435) "some organizations have begun to consider complaints to be a resource to be used to improve the quality of service that the organization provides". It is well documented by respondents that the changes that are implemented bring about good or positive reform for all parties concerned. According to Hsieh (2012:439) "in order to effectively use complaints, qualitative data and patient experience data there is a requirement for standardized collection, continual and consistent analysis and timely

feedback to staff and management to ensure any problems are addressed and to improve the facility and processes in an ongoing effort". "Healthcare organizations are highly visible parts of their communities and their standing comes not just from event sponsorships or presence, but also from the very outcomes they offer and the stories these generate in the communities they serve "(Stanowski et al.,2015).

8.2.8 Theme: Management challenges identified in encouraging Positive Patient Experiences for Positive Reform

The major challenges facing primary health care include the following according to Dookie and Singh (2012:67):

- "*adequate political, financial, human and material commitments;*
- *optimal use of available resources;*
- *changing management techniques including decentralization; and*
- *Ensuring effective community participation and inter-sectoral collaboration".*

Human Resource Challenges

- **Absenteeism and Sick Leave**

Respondents note that there are problems with excessive absenteeism and sick leave. When staff is not present, it increases the workload on the remaining staff and this affects their ability to give off their best. It also has implications for the patients who may have to wait for longer periods because there are insufficient nurses to assist them. Despite the initiatives by government to assist staff that exhibit frequent absenteeism, it still remains a problem based on feedback by respondents. This problem of frequent absenteeism affects the patient, other health professionals, and the management in the facility.

- **Poor Staff Attitude**

Nurses and doctors are, overwhelmed by patient numbers according to the findings of Moosa and Gibbs (2014:147). Respondents also highlight the implications of human resource challenges and further postulates that when staff is overworked they are less likely to work with a compassionate attitude. Respondents indicate that the healthcare staff need to help the patients by

communicating in a compassionate way and not being rude or being unconcerned with how patients feel. Patients need that extra love and support, especially with vulnerable groups like patients with HIV and AIDs. Clinic staff are generally lacking in the area of emotional support area as workloads are high. But when staff do provide emotional support there is a notable difference in the clinic. The atmosphere is completely different and patients are willing to follow queues and wait for the staff to get to them. They are less easily frustrated and irritable and will even help to quiet other patients that are getting too rowdy or negative as offered by respondents.

- **Lack of Emotional Support for Patients**

The staff is also reluctant to show emotional support because they feel de-motivated and underpaid but this is not right and the patients will tell them that they are here to do a job and they should do it properly. If they can't do the job then they should go look for another job where they do not have to interact with people. Patients are not shy when it comes to expressing themselves. Sometimes patients address the problem before it even gets to management based on feedback from respondents. This sentiment is also expressed by Kourkouta and Papathanasiou whom explain, "Effective communication between patients and caregivers improves the patient experience as well as outcomes" (Kourkouta and Papathanasiou,2014:65). Studies also confirmed that the "nurses' dissatisfaction with their working environment, staff shortages and poor management negatively impacted on patients' safety and quality of care" (Schubert, Clarke, Aiken and De Geest,2012:230).

- **Staff Shortages**

Staff shortages can be attributed to the high number of nurses that have migrated from the public to the private sector and from SA to other parts of the world. The problem of unfilled posts due to insufficient funding has also affected the availability of staff within the PHS. In an effort to encourage professionals to return to SA, the NDoH has proposed the Bring Back our Professionals Campaign including the following:

- "*Revised financial incentives, following the example of other countries (notably Turkey) that offer salary increases if professionals switch to a family practice track.*

- *Flexible and more attractive working arrangements, including part-time work for those in private practice, increased training opportunities, dedicated research time, and protocols that allow work in other private and public sector facilities.*
- *Improved management of doctors, including improved performance management and career development systems".*

- **Lack of a Patient Centred Approach**

Another challenge facing the public sector is that healthcare professionals did not practice patient centeredness. Whilst the concept of patient centeredness has not fully entered into SA, there is a definite move towards allowing the patient the freedom to become more involved in the health process. Patients are more informed and want to be given more freedom to voice their opinions and participate in shared decision making. Health professionals need to embrace this change rather than resist it.

- **Waiting Time**

The waiting time challenge is also quite significant. "Waiting times negatively impact on patients' costs in seeking care and this was reported in a study exploring the reasons for non-adherence to HIV treatment in Uganda, Tanzania and Botswana."Lost wages due to long clinic waits and transport costs impacted on adherence to treatment", (Umar, Oche and Umar, 2011:20). There are various factors that contribute to the excessive waiting time within the PHS and as such there demands a multipronged approach that takes all of these factors in consideration. The following section provides a brief overview of these factors:

1. Based on the findings of the Operation Phakisa Report (2015:47), the existing appointment systems that were developed as an initiative to reduce waiti1ng times reveals that the systems are poorly managed and health care services are fragmented. Whilst most clinics have developed some type of appointment system, these suffer from various shortcomings. The following shortcomings with regards to the system are noted:

- Patients are given an appointment date but there is no appointment time. Most patients will present at the clinic from the morning and this causes overcrowding and unnecessary queues;

- The appointment system lacks a reminder function and this results in many patients missing their appointments;
- Patients are only able to obtain an appointment if they are physically present at the clinic due to technological inefficiencies;
- Healthcare staff provides multiple appointment dates for different services required by the patient. This is not only a costly venture for the patient but also increases the possibility that the patient may not receive the comprehensive care that is needed.
- As many as 70% of clinics are unable to report reliably on waiting times and on any improvements achieved (National Health Care Baseline Facility Audit, 2012:57)

2. The problem with overworked human resources contributes to the waiting time problem. Most respondents are of the opinion that increased staff would solve the problem of the longer waiting times in the clinic.

3. Problems with queuing of patients (Reagan and Igumbor,2010:590). Respondents have noted that patients are easily frustrated when they have been asked to wait in an incorrect queue. There is a need for healthcare staff to direct the patient from the moment that they walk through the door in order to reduce the problem associated with patients waiting in the wrong queues. Respondents also note that patients become easily angered when the nursing staff allow patients to "cut the queue" and this emphasises the importance of nurses adhering to a high standard of professional ethics in their delivery of healthcare.

4. High influx of morning patients. Due to the ineffective appointment system in place, the problem of overcrowding in the mornings especially creates delays throughout the clinic. Respondents note that when patients arrived in the morning, staff was insufficient to direct them and to attend to the patients and in a timeous and effective manner. Patient responses to resource constraints in the clinic may not always be positive. This can create tension and conflict within the clinic environment because patients express a negative experience.

5. Medicine shortages are another problem that contributes to a negative experience. Patients are generally called back to the clinic on a separate occasion in order to collect the medication but this creates two problems. Firstly the patients may not come back to the clinic to collect the medication which means that the management of the patient is compromised. This is especially

challenging in cases where patients have TB. The second problem is that patients lack the financial means to come back to the clinic on another day and when the access to the clinic is poor then this confounds the problem of not collecting the medication.

6. The problem of a poor staff attitude is highlighted. This creates challenges in creating a positive patient experience. However, staff need to ensure that their attitude is professional and supports the provision of good healthcare as reflected by Respondent I. Training and positive corrective action is lacking in the public sector. "It's critical that nurses continue to focus on providing the best possible care to their patients in the current stressful healthcare environment, finding ways to organize care efficiently and effectively while maintaining a trusting nurse-patient relationship and upholding the values of the nursing profession is paramount" Yetter,2010:5).

8.2.9 Theme: Positive Reforms Obtained Through a Positive Patient Experience

"Provinces and districts are inconsistent in the level of health care delivery due to inequalities in the coverage and quality of health services", (Dookie and Singh,2012:69). The IOM Framework and Picker Principles have indicated that the use of patient experience can facilitate the standardisation of service delivery and levels of quality. Patient involvement and patient experience in QI is part of a wider trend towards a more bottom-up approach of service planning and provision. Based on Figure 8.2 the use of patient experience data can be used to set benchmarks, conduct comparative analyses within facilities and between facilities, and between provinces. The information can be communicated to all relevant stakeholders in order to develop action plans.

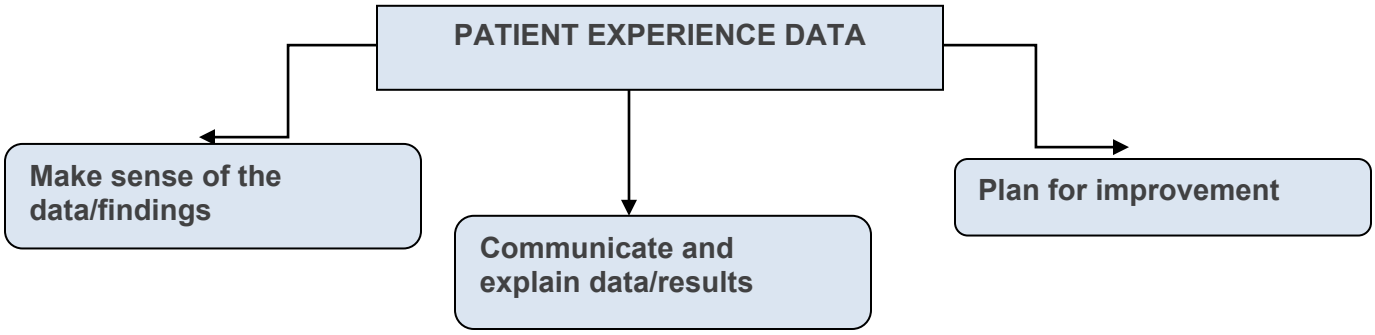

Figure 8. 2: **A framework for understanding and using patient experience data to improve health care quality.**

Source: Kumah, Osei-Kesse and Anaba (2017:31)

"Patient centeredness, shared decision making, and patient experiences are presented as vital dimensions of improving healthcare quality in practice and for empowering patients"(Ocloo and Fulop,2011:1369). The Norwegian government expects healthcare services to increase the use of patient experiences as part of QI and states that patients are an unexploited resource in the QI. This viewpoint is also supported by Wiig, Storm, Aase, Gjestsen, Solheim, Harthug, Robert and Fulop (2013:206) "where the drive for enhanced patient involvement is attributed to the improved outcome in which the incorporation of patient experiences is a means for improving quality QI programs that are designed to improve patient experience are promoting positive reforms". Respondent B provides a detailed account of the problems that were experienced when trying to elicit a positive patient experience. Staff, were not committed to their duties and the work environment suffered as a result. The manager engaged in QI programs that were designed to address some of the issues that patients raised due to the staff displaying a poor attitude and lack of commitment. Through the QI programs, the manager notes that the staff changed in their attitude toward work and the patients, there was a positive reform in the organisational culture. Patients that follow their treatment protocols are patients that are committed to supporting the objectives of good health. The atmosphere or environment in the clinic is conducive to working and Respondent G reiterates the point by explaining that patients are less resistant and are willing to do what the staff states. Staff are more motivated and they work together to develop innovative solutions.

The leader needs to serve as a change agent developing a culture that supports the success of change strategies (Delmatoff and Lazarus,2014:141; Smith,2015:47; Stichler,2011:21). Simultaneous to serving as a change agent, the leader needs to work on improving staff motivation levels and promote good care practices (Laschinger and Fide,2015). Leaders are required to develop a sense of commitment, accountability and responsibility towards the change effort in order for the organisation to move towards the direction of change (Van Gorder, 2014:16). Health care requires an environment of change in order to ensure that health delivery is continuously undergoing transformation (Parsons and Cornett,2011). When management talk to patients' they must show care and support towards the patients' complaints or problems. All patients need to know that they are important and that they are not just another number in the system as offered by respondents. Healthcare professionals are now committed to their jobs and they are willing to work hard to create a positive patient experience. The organisational culture

has improved for the better and the spin offs are felt throughout the organisation. This encourages efficiency and effectiveness within the clinic according to respondents.

In the UK the role of compassion has been emphasised in the delivery of nursing care (Health Service Ombudsman,2011; Department of Health,2015; Francis,2013). "Duffy's Quality Caring Model" merges medical and nursing models and "theorizes that nurses who develop caring relationships with their patients influence positive patient outcomes". SA aims to provide quality health care from the perspective of the patient, health care provider and the community by 2018/19". There are definite positive reforms that develop as patient experience improves. Patient experience has the potential to encourage positive reforms.

8.2.9 Theme: Recommendations for a Positive Patient Experience

- **Recommendation for a Patient Experience Model**

According to Luxford and Sutton (2014:21), "even with customer focus as a key domain of quality, health care has not yet fully embraced using patient feedback as a driver of quality improvement". Respondent C and F express the need for a change that does not only cater to one aspect of care but rather that comprises all the dimensions and domains of care that help to contribute to a positive patient experience. These managers highlight the need for a model that addresses patient experience as reflected by respondents and a model where the patient is at the centre of the model as reflected by respondents. The lack of standardisation and inconsistencies in the experience of care merits the case for a Patient Experience Model. According to the Operation Phakisa Report (2015:48):

"*There is also lack of agreement on the definitions and clear metrics of what constitutes an optimal patient experience and optimal waiting times across the PHC clinics in SA. This makes it very difficult to measure consistently and to implement appropriate improvements. The use of different tools also results in inconsistencies, making comparison of patient experiences across facilities difficult. Without standardised tools, facilities face the challenge of choosing the appropriate ones".*

A comprehensive review of the literature confirmed that little empirical evidence exists regarding how patient experience data is used to drive QI in organizations and clinical services (Kumah et al.,2017:27). Therefore, the need for the development and implementation of a patient

experience model is critical when one considers the benefits and positive reforms that are associated with the use of patient experience feedback.

- **Human Resource Training and Development**

There is an overwhelming support of respondents with respect to developing and training the staff. High on the list of priorities is the need for a change in the staff attitude. In other words, the way in which the staff communicates, interact and deliver service. This includes their level of commitment, compassion, emotional support and empathy for the patient. Respondents reiterate this sentiment. Respondents explain that a change in staff attitude is also needed with respect to the staff approach and issues of punctuality. The benefits of these changes will definitely bring about positive reforms such as improved waiting times at the clinic and a positive patient experience. This will improve service delivery and elicit a positive patient experience. Apart from that, there will be positive reforms that will be encouraged such as shown by respondents.

Managers also need training so that they are better equipped on how to deal with challenges and problems that occur in the clinic. When managers are not properly trained they will experience difficulty in leading the clinic with efficiency and effectiveness.

- **Conducive Working Environment**

Aiken et al. (2008:11); and Kupperschmidt et al. (2010:21) "contend that healthy work environments are essential for healthcare workers well-being, and safe and effective patient care". It is important that the working environment support the objectives of the clinic, patients and the staff. If the physical environment is not conducive to working then staff are unable to perform their jobs properly. Patients are also unable to be physically comfortable.

- **Increase staff capacity**

Research conducted by Longmore and Ronnie (2014:369) regarding the insufficiency of human resources especially doctors explain the current situation in SA. Nurses are citing an unpleasant work environment and poor wages as primary reasons for leaving the state sector (Taylor, 2012:17). There is a need to develop the staff capacity. Respondents generally are of the opinion that increasing staff at the clinic will enable the clinic to function more efficiently and effectively in order to improve the patient experience. If more staff, is added to the clinic, the understanding

is that patient care will be more clinically effective and safe. Waiting times will also be reduced and no patient will go home without being attended to.

- **Technology**

Respondents feel that technology is needed to educate patients and to keep them informed of changes and services that are available. Technology can also be used to set up appointment times and reminders so that patients know when to come to the clinic. The Operation Phakisa Report (2015:16) "indicates that in order to drive improvements in patient and staff experience and to reduce waiting times, an appointment system will ensure that every patient avoids unnecessary visits, and ensures they are referred to the right level of care". This will reduce the waiting times as patients will work by appointment and in so doing improve the patient experience. The development of call centres at a provincial level has also been envisioned as a means to reduce the unnecessary burden on clinics.

There is a completely different viewpoint offered by Respondent B who feels that everything that needs to be done has been done. Respondent B is of the opinion that the DoH has developed the policies that are necessary and needed to ensure a positive patient experience.

An important recommendation put forth by the above respondent looks at Community caregivers that aid in reaching the community and helping the people within the community to improve their management of the disease and health outcomes. This is an important point that can aid in reducing the workload within the clinic structure.

8.3 Conclusion

The qualitative data has been discussed and interpreted in this chapter. The feedback provided by the NSM reveals that Patient Experience is a useful measure in determining quality levels and developing QI programmes. The domains that influence patient experience have been explained according to the perspectives of the respondents. The qualitative data for the identification of domains will be analysed against the quantitative data that has been collected through the household survey. The chapter that follows provides the conclusions for the present study and outlines the recommendations thereof.

CHAPTER 9:

CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

The quantitative and qualitative findings discussed in the previous chapters, are concluded as related to the research objectives. Recommendations are made based on the conclusions drawn from the quantitative and qualitative components of the study. Areas of future research are recommended and the limitations of the study are explored.

9.2 Conclusions and Recommendations of the Study

9.2.1 Current Patient Experience

Conclusions

The current patient experience as per the Picker Principles, IOM Framework and Batho Pele Principles was generally poor as reflected by a predominantly negative experience. Based on the findings, less than 50% of patients overall agree on a positive patient experience against the fifteen domains developed as per the Conceptual Framework. There was a significant association found between the overall patient experience satisfaction with race and age. Older patients are more accepting of the care that they receive with Indians being more accepting of the patient experience. NSMs' indicated that Indian patients were expectant and demanding of quality services.

NSMs' strongly supported the use of patient experience as a measure for quality and QI overall. The managers support the use of patient experience to drive quality improvement and positive reform in the public health sector. Presently no policy or framework is in place that specifically addresses the concept of patient experience. Whilst the Ideal Clinic Policy (model) and the Ideal Clinic Realisation and Maintenance Program (Framework) has been adopted for use in primary health clinics as per the NDoH, managers are not fully committed to the model and framework in place. The study concludes that the managers perceive the policy to be ineffective towards eliciting a positive patient experience. Furthermore, the lack of standardisation in terms of the

framework and models applied by the different managers contribute to varied patient experiences across SA.

Recommendations

More emphasis should be placed on eliciting a positive patient experience. To achieve this end, the study recommends the development and implementation of a Patient Experience model within the public health sector as there is no such model in place. The model can be used to develop suitable policies that can be implemented to support the standardisation of patient experience across all primary health clinics in SA. Training and development ensures that all health workers are well educated and informed on how to utilise the different domains of Patient Experience to elicit a positive patient experience.

9.2.2Domains of Patient experience and Positive Reforms

Conclusion: Domain - Access to Care

Access influenced the patient experience of care. Positive reforms included increased access to healthcare, improved availability of services, goods and facilities, increased willingness (staff) to assist patients in accessing services, goods and facilities. Patients offered more complaints and were generally dissatisfied when the access was poor which had a negative influence on their experience of care. NSM's concluded that access was secondary to a positive experience of care. Patients with financial restraints would most likely be influenced by the proximity of their homes to the clinic. Patients who experienced poor location access to the clinic chose to go to clinics where they had better location access even though they were not permitted to frequent these clinics. NSM's agreed on positive reforms including improved access to services and goods, improved staff satisfaction and patient satisfaction. The study concluded that from all of the positive reforms explored, the improved access to healthcare services and goods was an important positive reform related to access as indicated by the patient and the NSM

Recommendations: Domain-Access

It is recommended that Access to Care be included in the conceptual model to improve patient experience. It is recommended that mobile clinics with comprehensive services be systematically dispatched to areas experiencing poor access to improve the access to healthcare services and goods.

Conclusion: Domain- Physical State of the Infrastructure

The physical state of the infrastructure influenced the experience of care. Positive reforms where patients were confident to use the ablution facilities without the fear of acquiring infections, participated freely in the consultation and improved patient safety were deemed relevant. NSM's supported that the clinic's physical environment should be neat and clean with a well organised patient flow and physical structure. NSM's noted positive reforms such as improved patient safety and staff were more satisfied to come to work. Facilities do not have the best physical infrastructure to support a positive patient experience. The study concluded that from all of the positive reforms that were explored both the patient and the NSM agree on improved patient safety.

Recommendations: Domain-Physical State of the Infrastructure

It is recommended that the Physical State of the Infrastructure be included in the conceptual model to improve patient experience. Adequate maintenance programs should be developed and implemented with monitoring mechanisms. This will ensure that the health facility is capable of providing a healthy environment that speaks to patient safety.

Conclusion: Domain-Cleanliness

Patients perceived cleanliness to influence the experience of care. Positive reforms indicated by the patients included improved hygiene protocols, reduction in the transmission of infection, patients being more compliant and there was an improved willingness for patients to attend the clinic**.** Dirty and unhygienic facilities, were unacceptable. Patients were concerned about the state of cleanliness in the clinics and the lack of cleanliness affected the patient experience in a negative way. Patients were troubled by ablution facilities that do not work, dirty clinics and odours. Positive reforms included by the managers were an increased confidence that hygiene protocols are followed, patients being more willing to wait, and patients who complained less. The positive reform that was most significant to the domain from the perspective of the NSM and the patients was the improved confidence that hygiene protocols were followed.

Recommendations: Domain Cleanliness

It is recommended that Cleanliness be included in the conceptual model to improve patient experience. Cleaning has been outsourced at many of the public facilities but the level of cleanliness lacks standardisation. This study recommends that a formal cleaning policy be

developed that is implemented throughout all public health facilities. Checks by healthcare managers are also needed to ensure that the clinic is being cleaned as per the guideline. Any failure regarding the cleaning policy should be addressed and the contracts revisited to ensure that all cleaning personnel understand the importance of cleanliness.

Conclusions: Domain-Quality of Care

The quality of care influences the patient experience of care. Positive reforms such as an improved quality of care delivered with patient safety at its core; quality care that is timeously delivered and patient centred is noted. The perception of quality was influenced by socioeconomic and demographic variables. Patients that possessed a medical aid membership held higher expectations of care. Particular race groups such as that of Indian Ethnicity hold higher expectations of the quality of care when compared to Black Ethnicity patients. The age of the patient influenced perception with the quality of care with older patients being more accepting. Positive reforms (managers) include patients returning for treatment and communicating a good report to other patients. This supported the continuity of care especially for chronic patients. There was no particular positive reform that has been agreed upon by both the NSM's and the patient in this domain.

Recommendations: Domain- Quality of Care

The quality of care is recommended in the development of the conceptual model to improve patient experience. Training and Development is a key recommendation to support the provision of quality health care. Incentives should be offered to health workers as a means to encourage learning so that skills are upgraded.

Conclusions: Domain-Patient Centeredness

Patient-centred care does not significantly influence patient experience based on a latent factor analysis. Positive reforms (patients) included the move towards patient-centred care, public participation in policy making; patients were engaged in the healthcare process, with an increase in educated and informed patients. The Clinic Committee Policy which has been recommended at the National level seeks to actively engage and empower the community by providing a forum whereby members of the community can provide feedback on the experiences of patients that have received care at the same clinic. NSM's do not value the clinic committee policy because

they believe that there is insufficient training on how the clinic committee should be managed. Managers agree that positive reforms such as more patient inclusion in the decision making process for deciding on the treatment protocol is possible and patients may be more understanding when there are problems. Improved patient engagement was the most significant reforms related to this domain.

Recommendations: Domain: Patient Centeredness

Patient centeredness is not recommended for inclusion in the model. The clinic committee policy needs to be revisited as suggested by the NSM's. NSM's and community stakeholders need to be trained on how best to manage the committee so that patients and given an opportunity to express their opinions and patients will see that they are treated with a unique approach.

Conclusions: Domain-Role of the Doctor

The role of the doctor is important to the experience of care. Positive reforms (patients) where there is an improved confidence in the doctors ability to treat effectively, communicate effectively, improved relationship between the doctor and the patient, improved adherence to treatment, and an improved doctor patient communication. Communication, courtesy, understanding, patience and respect shown by the doctor was, more likely to influence a positive patient experience and patients complained less. Doctors played a role to bring about positive reforms where patients were more satisfied with the doctor and they followed through with their treatment protocol. The improved adherence to treatment was an important positive reform indicated by the patient and the NSM's.

Recommendation: Domain-Role of the Doctor

It is recommended that the role of the doctor be included in the conceptual model. Doctors are required to complete courses towards their continuous professional development as mandated by the HPCSA. It is recommended that doctors attend courses to train them in the art of good communication on an annual basis just as they are required to complete ethics and first aid training.

Conclusions: Domain-Role of the Nurse

The role of the nurse is an important domain that influences the patient experience. The positive reforms included improved nursing care, improved levels of satisfaction in the nurses' level of

satisfaction, improved emotional support and interaction between nurses and patients improvement in the nurses level of satisfaction. Nurses were unable to provide the level of care expected of them in relation to their job descriptions and patient expectations, due to the staff shortages and extensive administration burden. Skilled nurses were vital to the patient experience and patients wanted nurses who knew their jobs, performed their jobs efficiently and effectively. Nurses that were patient, showed empathy and provided emotional support brought about a good nurse patient relationship. Improved relationship between the nurse and patient was noted as positive reforms by the NSM's and the patients.

Recommendation: Domain Role of the Nurse

The domain is recommended for the conceptual model to improve patient experience. In order to support a better relationship between the nurses and the patients, there is a need to recruit qualified nurses rather than using enrolled nursing assistants

Conclusions: Domain-Information, Communication and Education

Information and communication are statistically insignificant to the experience of care. Education influences the experience of care. Positive reforms (patients) such as improved knowledge of conditions and improvement in the health education of the public were reported. Patients wanted to be educated on matters that pertain not only to their health needs but also to the clinic operation. Patients who were better informed were more willing to participate and this was seen as a positive reform.

Recommendations: Domain-Information, Communication and Education

Information and Communication are not included in the development of the conceptual model. Education is included in the development of the conceptual model. The study recommends that more education be offered with technology at health facilities. E- Health resources can benefit the general public at large and at a fraction of the cost that is spent on marketing campaigns and printed media.

Conclusions: Domain-Co-Ordination and Continuity of Care

The domain is important to the patient experience. Positive reforms included the effective continuity of care, co-ordination between healthcare staff, and patient-centred care. Patients have a need for their doctor to coordinate their care and the services provided by other

professionals. There were problems in terms of the co-ordination between clinic staff and external healthcare providers in other facilities. This is why there is a now a move towards assisting the patient within the clinic and reducing the need for referrals out of the clinic. Whilst this may prove fruitful in the short run, this is hardly a long time solution. Patients do not follow through with referral visits because it was an inconvenience for them (additional costs, time wastage, patients get frustrated with having to continuously repeat their problems to different service providers). The other train of thought that was offered explains that staff lack basic skills when co-ordinating care and needed to be better equipped through training in order to refer the patient as and when is needed within the facility and out of the facility. An effective referral system is a positive reform that is agreed upon by both the patient and the NSM's.

Recommendations: Domain-Co-ordination and Continuity of Care

This domain is recommended for the conceptual model for patient experience. The multi-disciplinary approach within the primary health care setting to reduce the need for out of facility referrals is needed. This recommendation can reduce the problem of un-kept referral appointments, reduce patient costs and ensure holistic care for the patient. Referral protocols should be well documented and rehearsed so that staff, are well aware of any other services that the patient can benefit from.

Conclusions: Domain- The Role of Medication

Medication plays an important role in determining the type of patient experience. Positive reforms whereby the medicine dispensing process was streamlined, drug errors were reduced, pharmaceutical education was improved, medication delivery was improved and adherence towards treatment intervention was improved. Younger patients are less willing to wait for the medication to be dispensed according to the regulations laid out. They want to pick up and go, whereas the older patients want to be informed about the medication and what they need to do when administering the medication. NSM's stress the importance of patients knowing how to administer the medication. Patients who are uneducated about the medication prescribed for them will be less motivated to commit to completing the course of medication. The medication also needs to be dispensed so that the patient is well aware of what to do and how to do it in order to reduce the incidence of medication errors. There are fewer issues with patients because they know what to do and they complete their medication course. Improving the pharmaceutical

education of patients and reducing the incidence of drug overdose are indicated as positive reforms that are associated with this domain as concluded in the findings from the patient and NSM's.

Recommendations: Domain: Role of Medicine

The role of medication is included in the conceptual model. It is recommended that elderly patients who experience difficulties with remembering all the information around medication dispensing bring in a family member or friend that is able to assist them. The availability of medication in the right place at the right time and in the right quantities is critical to ensure a positive patient experience. Patients are not willing to go back and forth for treatment that can be delivered on one day. It adds to their clinic costs and patients who use the public health sector may experience financial limitations that prevent them from returning to the clinic. This creates a problem as they are unable to fetch their medication and use it as prescribed in the management of their conditions. Therefore the study recommends the use of appropriate supply chain channels to ensure that medication is available for dispensing.

Conclusions: Domain-Welcoming the Involvement of Family and Friend

Family members or friend involvement is important to their experience of care**.** Positive reforms included improved emotional well being of the patient, reduction in patient anxiety, improvements in the welcoming of family and friends and an improvement in the family's understanding of the patients medical management. NSM's agreed that the move to including family and friends was new due to the issue of doctor patient confidentiality but they did agree that it helped the patient to have a positive experience. However they also were wary of problems that could arise when friends/family interfered negatively with the health care process.

Recommendations: Domain- Welcoming the Involvement of Family/Friends

The inclusion of this domain for the development of the conceptual model is recommended. NSM's are reluctant to involve family friends because they are of the opinion that family/friends are a hindrance to the treatment process. The recommendation is therefore for NSM's to be educated on how family friend involvement can be beneficial to the smooth operation of the clinic and the patient experience. The inclusion of community stakeholders at a national level will also help to improve the buy in of health workers and the public towards the Clinic Committee policy.

Conclusions: Domain-Waiting Time

Waiting time is an important domain that influences their patient experience. According to Stats SA, (2015:12) "households (93,5%) chose to visit the nearest health facility but for those households who preferred to travel further to access health facilities, 14,7% of the households indicated that long waiting periods motivated their decision to travel further". Positive reforms included improved staff efficiency, and effectiveness at the clinic. The waiting times were significantly reduced there was a notable increase in patient and employee satisfaction. Certain groups of patients needed an express service of care (elderly patients, children and mothers). Patients did not want to wait because they preferred a walk in walk out service. Both the NSM's and patients agreed on a positive reform whereby the waiting time was reduced.

Recommendations: Domain-Waiting Time

Waiting time is included in the development of the conceptual model. The study recommendation offered by the NSM's to institute an express service for vulnerable population groups to support a reduction in waiting time is advocated. Streamlining processes to reduce potential bottle necks in the system can also aid in reducing waiting time. Waiting time objectives should be set to ensure that patients are not waiting for more than three hours. The use of an appointment system which has been proposed should be developed and implemented.

Conclusions: Domain-Outcomes and Effectiveness

Management's support towards positive outcomes is not statistically significant in the patient's experience of care. Positive reforms included improved patient participation, patient engagement, patient empowerment and an improved commitment from management to support positive patient outcomes. Management was more committed to supporting the effectiveness of service delivery. Managers were committed to good service delivery, however there restraints and challenges affected their ability to perform efficiently and effectively. Managers were unable to interact more with patients due to the administrative burden that they bear. This was the main challenge that managers believe affects their ability to know what is happening at the grassroots level. Positive reforms that are seen included, motivated managers that are willing to support positive outcomes.

Recommendations: Domain: Outcomes and Effectiveness

This domain is not recommended for inclusion in the model. NSM's are recruited based on nursing qualifications primarily. However, there is a lack of management qualifications that accompany this post requirement. The recommendation is therefore to incorporate a management qualification as a core requirement for new NSM's.

9.2.3 Development of a Conceptual Model to Improve the Patient Experience in the PHS as a Strategy to Engage PHS reform.

The identification of the domains and associated positive reforms are useful in the development of the patient experience model. In essence, patient experience is enhanced by addressing the domains that are considered for inclusion in the model. Through a consideration of improving the various domains, positive reforms result. It is important to note as suggested by the Beryl Institute that patient experience is a sum of all the interactions which places an emphasis on the understanding that change is not only effected by influencing one of the domains. There is a need to bring about change through each of the domains.

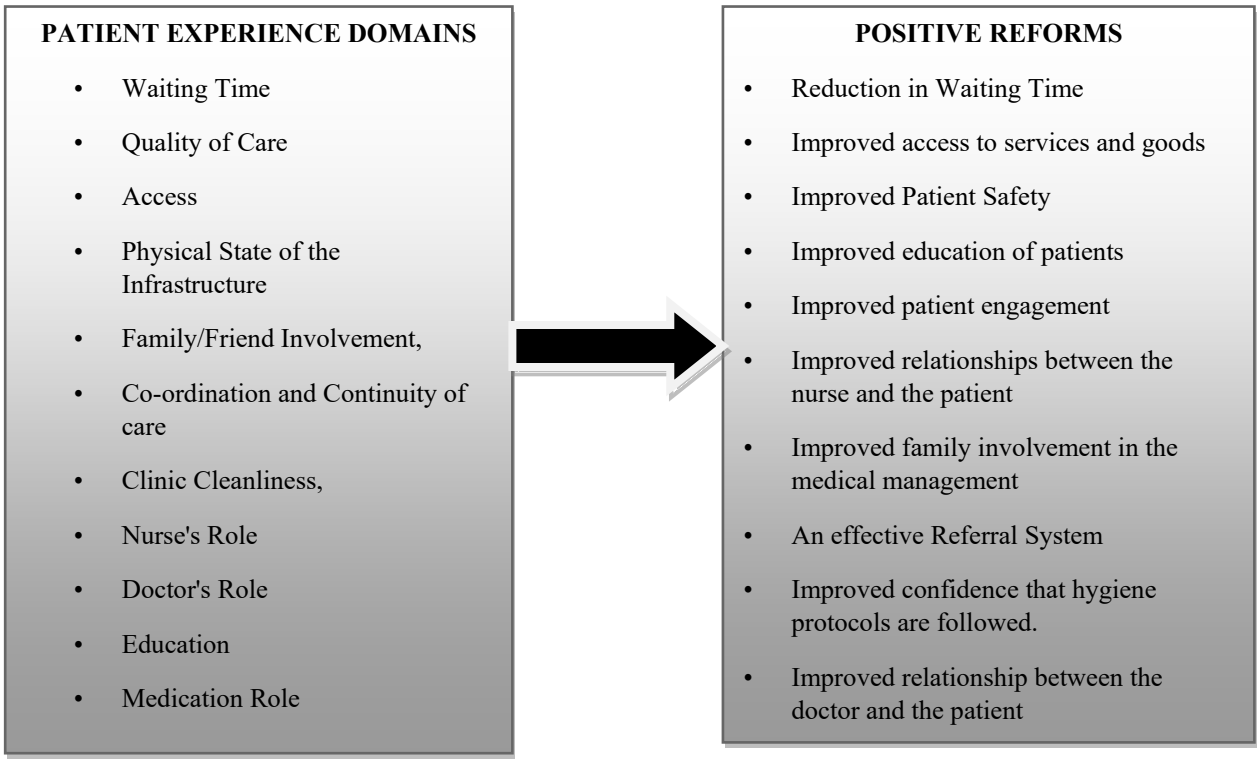

Figure 9. 1: Patient Experience Model: Domains and Positive Reforms

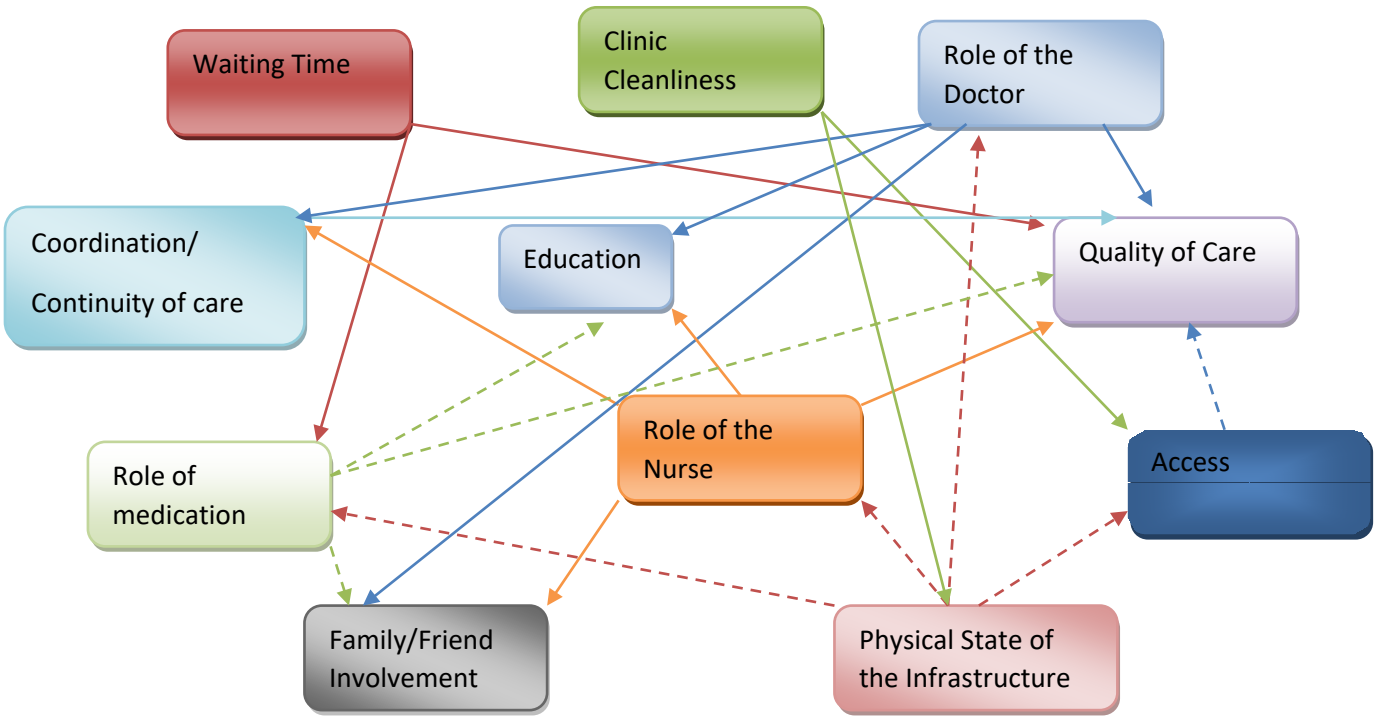

Figure 9. 2: Relationship between the Domains

The diagram reflects the interconnectedness of the various domains in the influence on patient experience. It emphasises the need for the model to address each of the 11 domains. The role of the doctor (Doctor and Management), clinic cleanliness (Clinic/Nurse Care) and waiting time (Access and Facility) were most significant within the three latent factor analysis grouping.

9.3 Recommended Research for the Future

The need to conduct further research in the healthcare setting is important in light of the dynamic nature of the health landscape within Africa. One such particular area of interest is the "setting of patient expectation" which has been cited by Keys as being able to achieve the following:

- help in preparing patients to wait,
- reducing complaints and
- To reduce levels of frustration and irritation among patients (Keys,2012).

However, many healthcare workers and organisations have been reluctant to engage in research of this nature due to the fear of not being able to meet patient expectations thereby highlighting the workers inability to function efficiently and effectively. This in turn may have adverse consequences for the workers themselves and this increases the resistance towards studies of this nature. However the benefits as illustrated by Keys (2012) in setting patient expectation justify the need for future research to be done on this topic.

It is well known that dirty, unhygienic and unsafe facilities may adversely impact on patient and staff experiences. Currently, there are neither guidelines on cleaning nor standardized cleaning materials and equipment in place SA. This highlights a gap in the existing literature which can be addressed through further study.

There is limited research that addresses the link between patient experience and community reputation. Community involvement as another key area in health decision making that requires further attention and investigation. Clinic committees are also an important aspect in the concept of patient experience. There is an evident lack of community involvement in this regard due to implementation challenges between the community and health facility managers. The need for further research is important in this regard.

It is well known that health professionals have been experiencing low levels of job satisfaction which has in turn influenced the quality and effectiveness of service delivery (Dieleman and Hammejer, 2010:6). Therefore there is a need for employees to experience need satisfaction so that they can be perform better within the work environment and in so doing there should be justifiable rewards that reinforce the need satisfaction. It is for this reason that the area of job satisfaction be explored in order to gain better insight thereof. This presents a potential area for further research.

9.4 Limitations of the Study

The study was conducted in a small community within the eThekweni Municipality. It would have benefitted the study to be conducted on a larger scale. However due to insufficient financial resources the study was limited in this regard. The race groups that dominated the study were confined to Indian and Black patients. The study would have benefited from a more

representative demographic profile in keeping with the demographics of SA. However, the communities that were included in the study are known to be predominantly populated by Black and Indian groups. The study used a sample that was adequate for a quantitative research approach. The study would have benefitted from a larger quantitative sample. The study utilised a quantitative approach to obtain data from the patients regarding the patient experience. The use of a qualitative approach would have added to the data regarding patient experience. This can be adopted in further studies. The study was limited to patients and nursing service managers due to time and cost constraints. However, the inclusion of health professionals such as doctors and nurses would have benefitted the study. These health professionals work closely with patients and would be able to provide valuable information that is pertinent to patient experience.

9.5 Summary

The chapter provides the conclusions and recommendations to the study. The domains of patient experience as indicated by the public health users and the NSM within the PHS are concluded. A conceptual model to improve patient experience as a change strategy to encourage positive reform is developed. The need for further research is explained and appropriate recommendations are made accordingly. The limitations of the study are explained.

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11.APPENDICES

Appendix A: Letter of Informed Consent for the Survey
UNIVERSITY OF KWA-ZULU NATAL (UKZN)

Dear Respondent,

Doctoral Research Project

Researcher: H. Padayachee (0718951414)

Supervisor: Prof. M. Hoque (031- 260 1111)

I, Hope Padayachee am a registered Doctoral student, at the Graduate School of Business at the UKZN in Durban.

The title of the study is as follows: "**Developing a Conceptual Model to Improve Patient Experience as a Strategy to Engage Public Health Service Reform in South Africa".**

The study will require the completion of a questionnaire .Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this survey. Confidentiality and anonymity of records identifying you as a participant will be maintained at all times. If you have any questions or concerns about participating in this study, you may contact me or my supervisor at the numbers listed above. The completion of the questionnaire should take about 15 minutes to complete.

I……(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT **DATE**

……

Investigator's signature_____

Appendix B: Letter of Informed Consent for the Health Facility Manager
Dear Respondent,

Doctoral Research Project

Researcher: H. Padayachee

Supervisor: Prof. M. Hoque (031- 260 1111)

I, Hope Padayachee am a registered Doctoral student, at the Graduate School of Business at the UKZN in Durban.

The title of the study is as follows: "Developing a Conceptual Model to Improve Patient Experience as a Strategy to Engage Public Health Service Reform in South Africa".

The study will require the completion of a face to face interview .Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this survey. Confidentiality and anonymity of records identifying you as a participant will be maintained at all times. If you have any questions or concerns about participating in this study, you may contact me or my supervisor at the numbers listed above. The completion of the interview should take approximately 2 hours to complete.

I……(full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT _____

DATE_____

Investigator's signature_____

Appendix C: Request for Permission to Conduct the Study at the Primary Healthcare Clinics in EThekwini.

ATT: Rochelle Peters

Research Administrator

EThekwini Municipality

RE: Letter of Support

I am a doctoral student conducting research to develop a patient experience model. The title of the study is as follows: "Developing a Conceptual Model to Improve Patient Experience as a Strategy to Engage Public Health Service Reform in South Africa". The study is a mixed method study and I require permission to interview the facility managers with regards to how best to improve patient experience. This is only an interview with the manager. I will not be interviewing patients at the clinic.

The clinics that I will include in the study are as follows:

- Newlands west
- New Germany
- Caneside
- Grove end
- La Lucia
- Ottawa
- Pinetown
- Redcliffe
- Redhill
- Stone bridge
- Trenance park
- Verulam
- Waterloo

Kind regards

Mrs H. Padayachee

Appendix D: Approval from EThekwini Municipality

22 June 2017

Dear Researcher,

Subject: Approval of a Research Proposal

The research proposal titled: **Developing a Conceptual Model to improve Patient Experiencing as a strategy to Engage Public Health Service Reform in South Africa,** was reviewed by the eThekwini Municipal Health Department research Committee. The study is hereby **approved at the following facilities, Newlands West, New Germany, Caneside, Grove End, La Lucia, Ottowa, Pinetown, Redcliffe, Redhill, Stonebridge, Trenance Park, Verulam, and Waterloo.**

The following conditions need to be noted:

- Submission of the indemnity form obtainable from the EThekwini Municipality Health Unit before commencement of the study.
- Prior arrangements to be made with the facility and an assurance that all services will not be disrupted.
- No staff member should be used for collecting data for the researchers.
- Progress reports to be provided and the final report of the study to the eThekwini Municipality Health Unit or emailed to: rochelle.peters@durban.gov.za
- Obtain permission from the eThekwini municipality health department for press releases and release of results to communities/stakeholders.
- The department has to receive recognition for the assistance given.
- Any amendment to the study must be communicated with the eThekwini Municipality Health Unit and the relevant amendment form obtainable from the unit to be submitted.
- Withdrawal of permission to conduct research will be left to the discretion of the eThekwini Municipality Health Unit.

Yours faithfully

(DR. AYO OLOWOLAGBA)

Head of Health

Appendix E: Semi Structured Interview

1. What is your viewpoint of using the measure of patient experience as an indicator for evaluating the quality of health delivery?
2. What policies do the Department of Health at a national and provincial level provide as guidelines to elicit a positive patient experience?
3. What has the Department of Health used as a framework or model to elicit a positive patient experience? Has it been effective in its implementation
4. In your professional opinion can the measure of patient experience be beneficial to the Public Health Sector (PHS) and how can this be achieved?
5. In your opinion what are the different domains that influence the experience of the patient
6. In your opinion, does the access to the clinic affect patient experience?
7. In your opinion, does the physical environment of the clinic affect patient experience
8. In your opinion, how does the quality of care provided influence the patient experience
9. In your opinion, how does the role that the doctor plays influence patient experience
10. What role does the nurse play in influencing patient experience
11. How is the patient's experience influenced by the provision of information about their condition and subsequent management?
12. How does the education of patients about the condition and subsequent management through the use of media influence the patient experience
13. How does the communication between the clinic staff and the patient influence patient experience
14. What is the role of proper medication dispensing to the patient experience
15. How does the co-ordination of care between healthcare professionals influence patient experience
16. How does the provision of emotional support by clinic staff influence the patient experience
17. How does the inclusion of friends and family in the provision of care influence the patient experience
18. How does the waiting time influence patient experience
19. How do you as a manager use patient experience to guide positive reforms in the delivery of quality health care
20. What challenges have you noted in trying to ensure a positive patient experience
21. What benefits or positive reforms has the institute experienced from ensuring a positive patient experience
22. What are the recommendations that you propose can elicit a positive patient experience and through these recommendations what are the positive reforms that can be expected in the delivery of health care in the PHS

Appendix F: Patient Experience Questionnaire
SECTION A: DEMOGRAPHIC DETAILS

A1. What is your age group?

1. Less than 20 years	2. 21-25 years	3. 26-30 years	4. 31-35 years	5. 36-40 Years	6. 41-45 years	7. 46-50 years	8. 50 years And older

A2. What is your Gender? 1. Male 2. Female

A3. How many times do you attend clinic per year?

1. 1-6	2. 7-12	3. 13 - 18	4. 19-24	5. 25-30	6. 31-36	7. 37-42	8. 43 or more

A4. What is your approximate distance from the clinic?

1. 1-2 km	2. 3-4 km	3. 5-6km	4. 7-8 km	5. 9-10 km	6. 11 or more

A5. How do you travel to the clinic?

1. Taxi	2. Bus	3. Private car	4. Hired Transport	5. Walk	5. Cycle

A6. What is your main reason to visit the clinic?

1. Monthly consultation	2. Collection of medication	3. Treatment of an acute Condition	4. Treatment of a Chronic Condition	5.Maternal

A7. What race group do you belong to?

1.Black	2.Indian	3.Coloured	4.White	5.Other

Section B: Patient Experience

B. 1Current Patient Experience in the Public Health Sector

Current patient experience in the Public Health Sector	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
1 The clinic is easily accessible					
2 The clinic has a good infrastructure to provide quality health care					
3 I observe protocols for cleanliness in the clinic					
4 The management of the clinic is effective in producing positive outcomes					
5 The doctors provide quality care					
6 The nurses provide quality care					
7 There is good communication in the clinic					
8 I am educated about my health management					
9 I am informed about my health management					
10 The clinic gives my family and friends an opportunity to be involved in my care					
11 The medication I receive is properly dispensed					
12 There is co-ordination and continuity of care					
13 I receive a good quality of care					
14 I receive patient centred care					
15 The waiting time is appropriate to deliver quality health care					

B. 2: Domains of Patient Experience

Domains of Patient Experience	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
1 Access to the clinic influences my patient experience					
2 The physical state of the infrastructure influences my patient experience					
3 Involving my family and friends in my care which influences my patient experience					
4.Waiting time influences my patient experience					
5 The quality of care influences my patient experience					
6. Information influences my patient experience					
7. Education influences my patient experience					
8. The role of the doctor influences my patient experience					
9. Management effectiveness towards positive outcomes influences my patient experience					
10.The role of medication influences my patient experience					
11. Communication influences my patient experience					
12. Patient centred care influences my patient experience					
13. The role of the nurse influences my patient experience					
14. Cleanliness in the clinic influences my patient experience					
15.Co-ordination and continuity of care influences my patient experience					

SECTION C

DOMAIN 1: ACCESS TO CARE

Which positive reforms can be expected if the access to care is improved	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
C.1 Improved access to healthcare					
C.2 Improved availability of services, goods and facilities					
C.3 Improved willingness of staff to assist patients					
C.4 Positive patient Experience					

SECTION D **DOMAIN 2: PHYSICAL STATE OF THE INFRASTRUCTURE**					
	1	2	3	4	5
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
D9 Which positive reforms can be expected based on the above					
D.1 Patients will be able to use ablution facilities when needed					
D.2 Patients will be confident to use the ablution facilities					
D.3 Patients will be more willing to participate in the consultation					
D.4 Patients will feel less frustrated to wait					
D.5 Patient safety will be improved					
D.6 There will be Positive patient experience					

SECTION E **DOMAIN 3: CLEANLINESS**					
	1	2	3	4	5
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
E6.1 Improved hygiene protocols					
E6.2 Reduction in the transmission of infection					
E6.3 Patients are more compliant					
E6.4 Improved willingness for patients to attend the clinic					
E6.5 Positive Patient Experience					

SECTION F **DOMAIN 4:QUALITY OF CARE**					
F8Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
F8.1 Improved quality of care					
F8.2 Quality care that is timeously delivered					
F8.3 Quality care that is delivered with patient safety					
F8.4 Patient centred care					
F8.5 Positive Patient Experience					

SECTION G **DOMAIN 5 :PATIENT CENTREDNESS**					
G8 Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
G8.1 Patient centred care					
G8.2Public participation in policy development					
G8.3 Positive Patient Experience					
G8.4 Improved Patient engagement					
G8.5 Improved healthcare staff accountability					

SECTION H **DOMAIN 6: ROLE OF THE DOCTOR**					
H8Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
H8.1 Improved confidence in the doctors ability to treat effectively					
H8.2 Improved relationships between the doctor and the patient					
H8.3 Patient has improved control in the management of their condition					
H8.4 Improved adherence to treatment					
H8.5 Improve Doctor Patient Communication					

SECTION I **DOMAIN 7: ROLE OF THE NURSE**					
	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
I6Which positive reforms can be expected based on the above					
I6.1 Improved nursing care					
I6.2 Improved emotional support for patients					
I6.3 Improved relationships between patients and nurses					
I6.4 Positive patient Experience					
I6.5 Improved nurse satisfaction					

SECTION J **DOMAIN 8 : INFORMATION,COMMUNICATION AND EDUCATION**					
J14Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
J14.1 Improved patient knowledge of conditions					
J14.2 Improved patient communication					
J14.3 Patients are more informed of changes					
J14.4 Improve the health education of the general public					
J14.5 Positive Patient Experience					

SECTION K **DOMAIN 9: CO-ORDINATION AND CONTINUITY OF CARE** **K9. Which positive reforms can be expected based on the above**	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
K9.1 Improved continuity of care					
K9.2 Improved co-ordination between healthcare staff in service delivery					
K9.3 Patient centred care					
K9.4 Effective referral system					
K9.5 Positive patient experience					

	1	2	3	4	5
SECTION L **DOMAIN 10 : Medication**	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
L9Which positive reforms can be expected based on the above					
L9.1 Streamline medicine dispensing processes					
L9.2 Reduce the incidence of drug overdose					
L9.3 Improve the pharmaceutical education of patients					
L9.4 Positive patient experience					
L9.5 Increase the adherence towards treatment					

SECTION M **DOMAIN 11 :Welcoming the involvement of family and friends**					
M5. Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
M5.1 Improved emotional well-being of the patient					
M5.2 Improves the family involvement in the medical management					
M5.3 Reduces patient anxiety					
M5.4 Improves family understanding of the patient's medical management					
M5.5Improves the family/ friend involvement					
M5.6 Positive patient experience					

SECTION N **DOMAIN 12: WAITING TIME**					
N7. Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
N7.1 Improved efficiency at the clinic					
N7.2 Increase in patient satisfaction with Waiting time					
N7.3 Increase in employee satisfaction					
N7.4 Improved staff effectiveness					
N7.5 Positive patient experience					

Section O **DOMAIN 12: OUTCOMES AND EFFECTIVENESS**					
O7. Which positive reforms can be expected based on the above	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
O7.1 Improved patient participation					
O7.2 Improved patient engagement					
O7.3 Improved patient empowerment					
O7.4 Improved commitment by management to support positive patient outcomes					
O7.5 Improve commitment by management to support effectiveness of service delivery					
O7.6 Positive patient experience					

Appendix G: Data Analysis Tables

Table A1: Age and Perception of Clinic Accessibility

Clinic is Accessible	AGE			Chi-square Test			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	69	110	32	12.700	4	0.013	Significant
Neutral	12	9	9				
Agree/Strongly Agree	21	14	4				
% Agree/Strongly agree by age group	**20.6%**	**10.5%**	**8.9%**				

The results in Table A1 show that, age has a significant effect on the perception of the clinics' accessibility (Chi-square=12.700, df=4, p-value=0.013). The results show that the younger patients (30 years or younger) (20.6%) have a higher percentage of those who agree or strongly agree that the clinic is accessible while the older one gets (10.5% for the 31 to 45 age group and 8.9% for those 46 years or older), the less they agree to the accessibility of the clinic.

Table A2: Age and the Perception of the Infrastructure of the Clinic

Clinic has Good infrastructure	AGE			Chi-square Test			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	68	104	22	16.843	4	0.002	Significant
Neutral	16	15	15				
Agree/Strongly Agree	18	14	8				
% Agree/Strongly agree by age group	**17.6%**	**10.5%**	**17.8%**				

Age has a significant effect on the patients' perception of the clinics' infrastructure (Chi-square=16.843, df=4, p-value=0.003) according to the results presented in Table A2 As far as infrastructure is concerned, the younger patients (30 years or younger) and the oldest patients (46 years or older) seem to have a higher rate of approval (17.6% and 17.8% respectively) than the middle aged patients (31 to 45 years) with an approval rate of 10.5%.

Table A3: Age and Perception of Observing Cleanliness Protocols at the Clinic

Clinic observes Cleanliness	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	68	105	23	17.677	4	0.001	Significant
Neutral	15	9	13				
Agree/Strongly Agree	19	19	9				
% Agree/Strongly agree by age group	**18.6%**	**14.3%**	**20.0%**				

The results in Table A3 show that, age has a significant effect on the perception of cleanliness protocols being followed (Chi-square=17.677, df=4, p-value=0.001). The results show that the younger patients (18.6%) (30 years or younger) have a higher percentage of those who agree or strongly agree that the clinic observes protocols for cleanliness and the oldest patients (46 years and older) have an approval rate of 20%. However, the lowest rate of approval is noted in the middle aged patients (14.3%).

Table A4: Age and the Perception of Management's Support toward Positive Outcomes

Management supports positive outcomes	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	68	105	21	25.653	4	<0.001	Significant
Neutral	13	15	17				
Agree/Strongly Agree	21	13	7				
% Agree/Strongly agree by age group	**20.6%**	**9.8%**	**15.6%**				

Age has a significant effect on the patients' perception of management's effectiveness in producing positive outcomes (Chi-square=25.653, df=4, p-value<0.001). According to the results presented in Table 5.6 the younger patients (30 years or younger) and the oldest patients (46 years or older) seem to have a higher rate of approval (20.6 % and 15.6 % respectively) than the middle aged patients (31 to 45 years) with an approval rate of 9.8%.

Table A5: Age and the Perception of the Quality of Doctor Care

Doctors give Quality Care	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	66	105	23	17.488	4	0.003	Significant
Neutral	16	12	14				
Agree/Strongly Agree	20	16	8				
% Agree/Strongly agree by age group	**19.6%**	**12.0%**	**17.8%**				

The results in Table A5 show that, age has a significant effect on the perception of doctors providing quality care (Chi-square=17.488, df=4, p-value=0.003). The results show that the younger patients (19.6%) (30 years or younger) have a higher percentage of those who agree or strongly agree that the doctors provide quality care compared with the oldest patients (46 years and older) who have an approval rate of 17.8%. However, the lowest rate of approval is noted in the middle aged patients (12%).

Table A6: Age and the Perception of the Quality of Nursing Care

Nurses give Quality Care	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	67	104	21	23.240	4	<0.001	Significant
Neutral	15	14	17				
Agree/Strongly Agree	20	15	7				
% Agree/Strongly agree by age group	**19.6%**	**11.3%**	**15.6%**				

Age has a significant effect on the patients' perception of nurses providing quality care (Chi-square=23.240, df=4, p-value <0.001). As far as nurses providing quality care is concerned, the younger patients (30 years or younger) and the oldest patients (46 years or older) seem to have a higher rate of approval (19.6 % and 15.6 % respectively) than the middle aged patients (31 to 45 years) with an approval rate of 11.3%.

Table A7 Age and the Perception of the Quality of Clinic Communication

Clinic has Good Communication	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	69	108	22	20.634	4	<0.001	Significant
Neutral	18	11	15				
Agree/Strongly Agree	15	14	8				
% Agree/Strongly agree by age group	**14.7%**	**10.5%**	**17.8%**				

The findings of Table A7 provide the chi square results for age and communication in the clinic. Age has a significant effect based on the results (Chi-square=20.634, df=4, p-value <0.001). The oldest patients (17.8%) (46 years and older) are agreeable that there is good communication in the clinic whilst the younger patients (30 years or younger) and the middle-aged patients (31 to 45 years) show lower rates of approval respectively (14.7% and 10.5%).

Table A8: Age and the Perception of Being Educated on Individual Health Management

Educated Health Management	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	70	109	22	24.770	4	<0.001	Significant
Neutral	14	12	16				
Agree/Strongly Agree	18	12	7				
% Agree/Strongly agree by age group	**17.6%**	**9.0%**	**15.6%**				

The results in Table A8 show that, age has a significant effect on the perception of patients being educated about their health management (Chi-square=24.770, df=4, p-value < 0.001). The results show that the younger patients (17.6%) (30 years or younger) have a higher percentage of those who agree or strongly agree that they are educated about their health management compared with the oldest patients (46 years and older) who have an approval rate of 15.6%. However, the lowest rate of approval is noted in the middle-aged patients (9%).

Table A9: Age and the Perception of Being Informed about Individual Health Management

Informed Health Management	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	74	105	26	9.004	4	0.06	Not Significant
Neutral	15	11	10				
Agree/Strongly Agree	13	17	9				
% Agree/Strongly agree by age group	**12.7%**	**12.8%**	**20.0%**				

Age does not have a significant effect on the patients' perception of being informed about their health management as reflected in the results of Table A9 (Chi-square=9.004, df=4, p-value=0.06).

Table A10: Age and the Perception of the Involvement of Family/friend

Family Friend Involvement	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	72	111	28	16.675	4	0	Significant
Neutral	15	7	12				
Agree/Strongly Agree	15	15	5				
% Agree/Strongly agree by age group	**14.7%**	**11.3%**	**11.1%**				

There is a significant association between age and the perception of the clinic's willingness to involve family and friends in patient care (Chi-square=16.675, df=4, p-value <0.001). The results show that the younger patients (14.7%) (30 years or younger) have a higher percentage of those who agree or strongly agree that the clinic involves family/friends while the older one gets, the less they agree to the clinic's willingness to involve family/friends in the care of the patient (11.3% for the 31 t0 45 age group and 11.1% for those 46 years or older).

Table A11: Age and the Perception of the Dispensation of Medication

Proper Dispensation Medication	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	66	107	24	15.129	4	0.004	Significant
Neutral	15	14	10				
Agree/Strongly Agree	21	12	11				
% Agree/Strongly agree by age group	**20.6%**	**9.0%**	**24.4%**				

Age has a significant effect on the patient's perception of medication being properly dispensed as reflected by the results in Table 5.13 (Chi-square=15.129, df=4, p-value=0.004). The older patients (46 years and older) and the younger patients (30 years and younger) have higher rate of approval (24.4%and 20.6% respectively). The middle-aged patients (9%) (31to 35) have the lowest rate of approval concerning medication being properly dispensed.

Table A12: Age and the Perception of the Co-ordination/Continuity of Care

Coordination Continuity of Care	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi- Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	64	105	23	19.332	4	0.001	Significant
Neutral	23	10	14				
Agree/Strongly Agree	15	18	8				
% Agree/Strongly agree by age group	**14.7%**	**13.5%**	**17.8%**				

The findings of Table A12 provide the chi square results for age and the perception of care co-ordination and continuity in the clinic. Age has a significant effect based on the results (Chi-square=19.332, df=4, p-value=0.001). The oldest patients (17.8%) (46 years and older) have the highest rates of agreement whilst the younger patients (30 years or younger) and the middle-aged patients (31 to 45 years) show lower rates of approval respectively (14.7% and 13.5%).

Table A13: Age and the Perception of the Quality of Care

Good Quality	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	64	107	22				
Neutral	19	10	13	20.219	4	<0.001	Significant
Agree/Strongly Agree	19	16	10				
% Agree/Strongly agree by age group	**18.6%**	**12.0%**	**22.2%**				

Age has a significant effect on the patient's perception of receiving a good quality of care as reflected by the results in the above table (Chi-square=20.219, df=4, p-value <0.001). The older patients (46 years and older) and the younger patients (30 years and younger) have higher rate of approval (22.2%and 18.6% respectively). The middle aged patients (31to 35) have the lowest rate of approval (12%) with regards to the quality of care.

Table A14: Age and the Perception of Care being Patient Centred

Patient Centred Care	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	63	106	22				
Neutral	22	9	12	20.801	4	<0.001	Significant
Agree/Strongly Agree	17	18	11				
% Agree/Strongly agree by age group	**16.7%**	**13.5%**	**24.4%**				

The findings of Table A14 provide the chi square results for age and the perception that patients receive patient centred care in the clinic. Age has a significant effect based on the results (Chi-square=20.801, df=4, p-value <0.001). The oldest patients (46 years and older) have the highest rates of agreement (24.4%) whilst the younger patients (30 years or younger) and the middle-aged patients (31 to 45 years) show lower rates of approval respectively (16.7% and 13.5%).

Table A15: Age and the Perception of Waiting Time being Appropriate

Appropriate waiting Time	AGE			Chi-square Tests			
	up to 30 years	31-45 years	46+ years	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	66	111	25				
Neutral	18	11	16	25.370	4	<0.001	Significant
Agree/Strongly Agree	18	11	4				
% Agree/Strongly agree by age group	**17.6%**	**8.3%**	**8.9%**				

There is a significant association between age and the perception that waiting time is appropriate to deliver quality health care (Chi-square=25.370, do=four, p-value <0.001). The results show that the younger patients (17.6%) (30 years or younger) have a higher percentage of those who agree or strongly agree that the waiting time is appropriate for quality health care while the 46 years or older and the 31 to 45 age group show lower rates of approval (8.9% and 8.3% respectively).

- **Chi-Square Tests for the Effects of Gender and Race on Perceptions of Patient Experience**

The results show that the effects of gender on the perceptions of patient experience are not significant when analysing all the domains.

Chi-square tests were conducted to test the effect of race on the perceptions of patient experience. The results that follow describe the association.

Table A16: Race and the Perception of Clinic accessibility

Clinic is Accessible	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	93	118	13.425	2	0.001	Significant
Neutral	3	27				
Agree/Strongly Agree	13	26				
% Agree/Strongly agree by race group	**11.9%**	**15.2%**				

The results in Table A16 show that, race has a significant effect on the perception of the clinics' accessibility (Chi-square=13.425, df= 2, p-value=0.001). The results show that Indians (15.2%) have a higher percentage of those who agree or strongly agree that the clinic is accessible when compared to Blacks (11.9%). There are also a higher number of Indians who were neutral.

Table A17: Race and the Perception of Physical Infrastructure

Clinic has Good infrastructure	RACE		Chi-square Test			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	91	103	31.547	2	<0.001	Significant
Neutral	1	45				
Agree/Strongly Agree	17	23				
% Agree/Strongly agree by race group	**15.6%**	**13.5%**				

The results in Table A17 show that, race has a significant effect on the perception of the clinics' accessibility (Chi-square=31.547, df= 2, p-value <0.001). The results show that Blacks (15.6%) have a higher percentage of those who agree or strongly agree that the clinic has a good infrastructure to provide quality health care when compared to Indians (13.5%). There are also a higher number of Indians who were neutral.

Table A18: Race and the Perception of the Clinic Cleanliness

Clinic has Cleanliness	RACE		Chi-square Test			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	92	104	26.185	2	<0.001	Significant
Neutral	1	36				
Agree/Strongly Agree	16	31				
% Agree/Strongly agree by race group	**14.7%**	**18.1%**				

The results in Table A18 show that, race has a significant effect on the perception of the clinics' protocols for cleanliness being followed (Chi-square=26.185, df= 2, p-value <0.001). The results show that Indians (18.1%) have a higher percentage of those who agree or strongly agree that the clinic does observe protocols for cleanliness when compared to Blacks (14.7%). There are also a higher number of Indians who remain neutral and are disagreeable.

Table A19: Race and the Perception of Management Support towards Positive Outcomes

Management support positive outcomes	RACE		Chi-square Test			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	92	102	31.390	1	<0.001	Significant
Neutral	1	44				
Agree/Strongly Agree	16	25				
% Agree/Strongly agree by race group	**14.7%**	**14.6%**				

The results in Table A19 show that, race has a significant effect on the perception of management's effectiveness towards producing positive outcomes (Chi-square=31.390, df= 2, p-value <0.001). The results show that Blacks and Indians have a similar percentage of those who agree or strongly agree towards management's effectiveness towards producing positive

outcomes (14.7% and 14.6% respectively). There are also a higher number of Indians who were neutral and disagreeable.

Table A20: Race and the Perception of the Quality of Doctor Care

Doctors Quality Care	RACE		Chi-square Test			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	91	103	23.476	2	<0.001	Significant
Neutral	3	39				
Agree/Strongly Agree	15	29				
% Agree/Strongly agree by race group	**13.8%**	**17.0%**				

The results in Table A20 show that, race has a significant effect on the patient's perception of the doctors being able to provide quality care (Chi-square=23.476, df= 2, p-value <0.001). The results show that Indians (17%) have a higher percentage of those who agree or strongly agree when compared to Blacks (13.8%). There are also a higher number of Indians who were neutral.

Table A21: Race and the Percpetion of the Quality of Care from Nurses

Nurses Quality Care	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	91	101	24.028	2	<0.001	Significant
Neutral	4	42				
Agree/Strongly Agree	14	28				
% Agree/Strongly agree by race group	**12.8%**	**16.4%**				

The results in Table A21 show that, race has a significant effect on the perception of the nurses providing quality care (Chi-square=24.028, df= 2, p-value <0.001). The results show that Indians (16.4%) have a higher percentage of those who agree or strongly agree when compared to Blacks (12.8%). There are also a higher number of Indians who were neutral and disagreeable.

Table A22: Race and the Perception of the Communication in the Clinic

Clinic Good Communication	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	92	107	23.565	2	<0.001	Significant
Neutral	3	41				
Agree/Strongly Agree	14	23				
% Agree/Strongly agree by race group	**12.8%**	**13.5%**				

The results in Table A22 show that, race has a significant effect on the perception of the communication in the clinic being good (Chi-square=23.565, df= 2, p-value <0.001). The results show that Indians (13.5%) have a higher percentage of those who agree or strongly agree when compared to Blacks (12.8%). There are also a higher number of Indians who were neutral on this subject.

Table A23: Race and the Perception of Being Educated on Health Management

Educated Health Management	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	93	108	25.196	2	<0.001	Significant
Neutral	2	40				
Agree/Strongly Agree	14	23				
% Agree/Strongly agree by race group	**12.8%**	**13.5%**				

The results in Table A23 show that, race has a significant effect on the perception of the patients' being educated about their health management (Chi-square=25.196, df= 2, p-value <0.001). The results show that Indians (13.5%) have a higher percentage of those who agree or strongly agree when compared to Blacks (12.8%). There are also a higher number of Indians who remain neutral in this regard.

Table A24: Race and the Perception of Being Informed on Health Management

Informed Health Management	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	92	113	19.921	2	<0.001	Significant
Neutral	2	34				
Agree/Strongly Agree	15	24				
% Agree/Strongly agree by race group	**13.8%**	**14.0%**				

The results in Table A24 show that, race has a significant effect on the perception of patients being informed about their health care management (Chi-square=19.921, df= 2, p-value <0.001). The results show that Indians (14%) have a higher percentage of those who agree or strongly agree when compared to Blacks (13.8%). However, the difference is negligible. There are also a higher number of Indians who are neutral with respect to this subject.

Table A25: Race and the Perception of the Involvement of Family/Friend

Family Friend Involvement	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	92	119	21.138	2	<0.001	Significant
Neutral	1	33				
Agree/Strongly Agree	16	19				
% Agree/Strongly agree by race group	**14.7%**	**11.1%**				

The results in Table A25 show that, race has a significant effect on the perception of the clinics' willingness to involve family/friends in the patient's care (Chi-square=21.138, df= 2, p-value <0.001). The results show that Blacks have a higher percentage of those who agree or strongly

agree (14.7%) when compared to Indians (11.1%). There are also a higher number of Indians who were neutral and disagreeable.

Table A26: Race and the Perception of the Proper Dispensation of Medication

Proper Dispensation of Medication	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	93	104	27.806	2	<0.001	Significant
Neutral	1	38				
Agree/Strongly Agree	15	29				
% Agree/Strongly agree by race group	**13.8%**	**17.0%**				

The results in Table A26 show that, race has a significant effect on the perception of the proper dispensation of medication (Chi-square=27.806, df= 2, p-value <0.001). The results show that Indians (17%) have a higher percentage of those who agree or strongly agree when compared to Blacks (13.8%).

Table A27: Race and the Perception of the Co-ordination/Continuity Care

Coordination Continuity of Care	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	91	101	29.558	2	<0.001	Significant
Neutral	2	45				
Agree/Strongly Agree	16	25				
% Agree/Strongly agree by age group	**14.7%**	**14.6%**				

The results in Table A27 show that, race has a significant effect on the perception of the clinic providing care that is co-ordinated and continuous (Chi-square=29.558, df= 2, p-value <0.001). The results show that both Blacks and Indians have a similar percentage of approval (14.7% and 14.6% respectively). More Indians are neutral on this subject when compared to Blacks.

Table A28: Race and the Perception of the Quality of Care

Good Quality	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	91	102	23.929a	2	<0.001	Significant
Neutral	3	39				
Agree/Strongly Agree	15	30				
% Agree/Strongly agree by age group	**13.8%**	**17.5%**				

The results in Table A28 show that, race has a significant effect on the perception of quality of care being good(Chi-square=23.929, df= 2, p-value <0.001). The results show that Indians (17.5%) have a higher percentage of those who agree or strongly agree when compared to Blacks (13.8%). Indians provide more neutral responses when compared with Black patients.

Table A29: Race and the Perception of Patient Centred Care

Patient Centred Care	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	91	100	30.410	2	<0.001	Significant
Neutral	1	42				
Agree/Strongly Agree	17	29				
% Agree/Strongly agree by age group	**15.6%**	**17.0%**				

The results in the table above show that, race has a significant effect on the perception of the care being patient centred (Chi-square=30.410, df= 2, p-value <0.001). The results show that Indians (17%) have a higher percentage of those who agree or strongly agree when compared to the Black patients (15.6%). There are a higher number of Indians who are neutral in comparison to the Black patients.

Table A30: Race and the Perception of Appropriate Waiting Time

Appropriate waiting Time	RACE		Chi-square Tests			
	Black	Indian	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	92	110	26.819	2	<0.001	Significant
Neutral	2	43				
Agree/Strongly Agree	15	18				
% Agree/Strongly agree by age group	**13.8%**	**10.5%**				

The results in Table A30 show that, race has a significant effect on the perception of the waiting time being appropriate to deliver quality health care (Chi-square=26.819, df= 2, p-value <0.001). The results show that Black participants (13.8%) have a higher percentage of those who agree or strongly agree when compared to their Indian counterparts (10.5%). There are a higher number of Indians who were neutral.

- Chi Square Analysis of Gender and the Evaluation of the Current Patient Experience (Research Objective One)

Table A31: Gender and the Accessibility of the Clinic

Clinic is Accessible	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	68	143	0.298	2	0.862	Not Significant
Neutral	11	19				
Agree/Strongly Agree	12	27				
% Agree/Strongly agree by age group	**13.2%**	**14.3%**				

Gender does not have a significant effect on the perception of clinic being easily accessible (Chi-square=0.298, df=4, p-value=0.862).

Table A32: Gender and the Physical Infrastructure of the Clinic

Clinic has Good Infrastructure	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	62	132	0.140	2	0.932	Not Significant
Neutral	15	31				
Agree/Strongly Agree	14	26				
% Agree/Strongly agree by age group	**15.4%**	**13.8%**				

Gender does not have a significant effect on the perception of the clinic having a good infrastructure to provide quality health care (Chi-square=0.140, df=4, p-value=0.932).

Table A33: Gender and Clinic Cleanliness

Clinic_Cleanliness	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	66	130	0.410	2	0.815	Not Significant
Neutral	11	26				
Agree/Strongly Agree	14	33				
% Agree/Strongly agree by age group	**15.4%**	**17.5%**				

Gender does not have a significant effect on the perception of the clinic protocols for cleanliness being followed (Chi-square=0.410, df=4, p-value=0.815).

Table A34: Gender and the Support of Management towards Positive Outcomes

Management supports positive outcomes	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	63	131	0.387	2	0.824	Not Significant
Neutral	16	29				
Agree/Strongly Agree	12	29				
% Agree/Strongly agree by age group	**13.2%**	**15.3%**				

Gender does not have a significant effect on the perception of management's effectiveness in producing positive outcomes (Chi-square=0.387, df=4, p-value=0.824).

Table A35: Gender and Quality Care from Doctors

Doctors give Quality Care	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	65	129	0.651	2	0.722	Not Significant
Neutral	14	28				
Agree/Strongly Agree	12	32				
% Agree/Strongly agree by age group	**13.2%**	**16.9%**				

Gender does not have a significant effect on the perception of doctors providing quality care (Chi-square=0.651, df=4, p-value=0.722).

Table A36: Gender and Quality Care from Nurses

Nurses give Quality Care	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	63	129	1.187	2	0.552	Not Significant
Neutral	17	29				
Agree/Strongly Agree	11	31				
% Agree/Strongly agree by age group	**12.1%**	**16.4%**				

Gender does not have a significant effect on the perception of nurses providing quality care(Chi-square=1.187, df=4, p-value=0.552).

Table A37: Gender and Communication in the Clinic

Clinic has Good Communication	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	63	136	3.480	2	0.176	Not Significant
Neutral	19	25				
Agree/Strongly Agree	9	28				
% Agree/Strongly agree by age group	**9.9%**	**14.8%**				

Gender does not have a significant effect on the perception of the clinic having good communication (Chi-square=3.480, df=4, p-value=0.176).

Table A38: Gender and Being Educated on Individual Health Management

Educated Health Management	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	66	135	0.713	2	0.7	Not Significant
Neutral	15	27				
Agree/Strongly Agree	10	27				
% Agree/Strongly agree by age group	**11.0%**	**14.3%**				

Gender does not have a significant effect on the perception of patients being educated about their health management (Chi-square=0.713, df=4, p-value=0.7).

Table A39: Gender and being informed on Health Management

Informed Health Management	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	70	135	1.230	2	0.541	Not Significant
Neutral	9	27				
Agree/Strongly Agree	12	27				
% Agree/Strongly agree by age group	**13.2%**	**14.3%**				

Gender does not have a significant effect on the perception patients being informed about their health management (Chi-square=1.230, df=4, p-value=0.541).

Table A40: Gender and the Involvement of Family/Friend

Family_Friend_Involvement	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	68	143	0.763	2	0.683	Not Significant
Neutral	13	21				
Agree/Strongly Agree	10	25				
% Agree/Strongly agree by age group	**11.0%**	**13.2%**				

Gender does not have a significant effect on the perception of the clinic being welcoming to the involvement of family and friends (Chi-square=0.763, df=4, p-value=0.683).

Table A41: Gender and Proper Dispensation of Medication

Proper Dispensation Medication	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	62	135	0.407	2	0.816	Not Significant
Neutral	13	26				
Agree/Strongly Agree	16	28				
% Agree/Strongly agree by age group	**17.6%**	**14.8%**				

Gender does not have a significant effect on the perception of medication being properly dispensed (Chi-square=0.407, df=4, p-value=0.816).

Table A42: Gender and the Co-ordination/Continuity of Care

Coordination Continuity of Care	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	61	131	0.148	2	0.929	Not Significant
Neutral	16	31				
Agree/Strongly Agree	14	27				
% Agree/Strongly agree by age group	**15.4%**	**14.3%**				

Gender does not have a significant effect on the perception of clinic providing care that is co-ordinated and continuous (Chi-square=0.148, df=4, p-value=0.929).

Table A43: Gender and Quality of Care

Good Quality	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	61	132	0.709	2	0.701	Not Significant
Neutral	16	26				
Agree/Strongly Agree	14	31				
% Agree/Strongly agree by age group	**15.4%**	**16.4%**				

Gender does not have a significant effect on the perception of the patient receiving a good quality of care (Chi-square=0.709, df=4, p-value=0.701).

Table A44: Gender and Patient Centred Care

Patient Centred Care	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	60	131	1.162	2	0.559	Not Significant
Neutral	17	26				
Agree/Strongly Agree	14	32				
% Agree/Strongly agree by age group	**15.4%**	**16.9%**				

Gender does not have a significant effect on the perception of the care being patient centred (Chi-square=1.162, df=4, p-value=0.559).

Table A45: Gender and Appropriate Waiting Time

Appropriate waiting Time	GENDER		Chi-square Tests			
	Male	Female	Chi-Square value	Degrees of freedom	p-value	Comment
Disagree/Strongly Disagree	61	141	1.866	2	0.393	Not Significant
Neutral	18	27				
Agree/Strongly Agree	12	21				
% Agree/Strongly agree by age group	**13.2%**	**11.1%**				

Gender does not have a significant effect on the perception of waiting time being appropriate to deliver quality health care (Chi-square=1.866, df=4, p-value=0.393).

- **Chi-Square tests with Domains of Patient Experience**

Table A 46: Age and Access

PED_Access	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	0	0	11.555	4	0.021
Neutral	10	2	1			
Agree/Strongly Agree	91	131	44			
% Agree/Strongly agree by age group	89.2%	98.5%	97.8%	Comment:	Significant	

Table A 47:Age and Physical State of the Infrastructure

PED_Physical_State_Infrastructure	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	3	0	7.863	4	0.097
Neutral	5	0	2			
Agree/Strongly Agree	96	130	43			
% Agree/Strongly agree by age group	94.1%	97.7%	95.6%	Comment:	Not significant	

Table A48:Age and the Involvement of Family /Friend

PED_Family_Involvement	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	2	0	14.576	4	0.006
Neutral	11	2	0			
Agree/Strongly Agree	90	129	45			
% Agree/Strongly agree by age group	88.2%	97.0%	100.0%	Comment:	Significant	

Table A49:Waiting Time and Age

PED_Waiting_Time	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	1	0	2.539	4	0.638
Neutral	11	8	5			
Agree/Strongly Agree	90	124	40			
% Agree/Strongly agree by age group	**88.2%**	**93.2%**	**88.9%**	**Comment:**	Not significant	

Table A50: Age and Quality of care

PED_Quality_Care	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	0	0	2.586	4	0.629
Neutral	9	8	4			
Agree/Strongly Agree	92	125	41			
% Agree/Strongly agree by age group	**90.2%**	**94.0%**	**91.1%**	**Comment:**	Not Significant	

Table A51: Age and Information

PED_Information	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Neutral	4	1	1	2.767	2	0.251
Agree/Strongly Agree	98	132	44			
% Agree/Strongly agree by age group	**96.1%**	**99.2%**	**97.8%**	**Comment:**	Not Significant	

Table A 52: Age and Education

PED_Education	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	1	12.459	4	0.014
Neutral	9	1	1			
Agree/Strongly Agree	93	131	43			
% Agree/Strongly agree by age group	**91.2%**	**98.5%**	**95.6%**	**Comment:**	Significant	

Table A53: Age and the Role of the Doctor

PED_Doctor_role	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	5	1	0	12.014	4	0.017
Neutral	6	1	3			
Agree/Strongly Agree	91	131	42			
% Agree/Strongly agree by age group	**89.2%**	**98.5%**	**93.3%**	**Comment:**	Significant	

Table A54: Age and Management Effectiveness towards Producing Positive Outcomes

PED_Management_Positive_Outcomes	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	5	2	2	12.219	4	0.016
Neutral	12	3	2			
Agree/Strongly Agree	85	128	41			
% Agree/Strongly agree by age group	**83.3%**	**96.2%**	**91.1%**	**Comment:**	Significant	

Table A55:Age and the Role of Medication

PED_Medication_Role	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	5	1	0	15.876	4	0.003
Neutral	12	3	2			
Agree/Strongly Agree	85	129	43			
% Agree/Strongly agree by age group	**83.3%**	**97.0%**	**95.6%**	**Comment:**	Significant	

Table A56: Age and Communication

PED_Communication	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	0	6.634	4	0.157
Neutral	12	5	3			
Agree/Strongly Agree	90	127	42			
% Agree/Strongly agree by age group	**88.2%**	**95.5%**	**93.3%**	**Comment:**	Not significant	

Table A57: Age and Patient Centered Care

PED_Patient_Centered_Care	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	0	1	14.612	4	0.006
Neutral	12	3	2			
Agree/Strongly Agree	90	130	42			
% Agree/Strongly agree by age group	**88.2%**	**97.7%**	**93.3%**	**Comment:**	Significant	

Table A58: Age and the Role of the Nurse

PED_Nurse_role	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	3	1	1	10.595	4	0.032
Neutral	12	3	3			
Agree/Strongly Agree	87	129	41			
% Agree/Strongly agree by age group	**85.3%**	**97.0%**	**91.1%**	**Comment:**	Significant	

Table A59:Age and Clinic Cleanliness

PED_Clinic_Cleanliness	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	6	1	1	14.883	4	0.005
Neutral	12	3	3			
Agree/Strongly Agree	84	129	41			
% Agree/Strongly agree by age group	**82.4%**	**97.0%**	**91.1%**	**Comment:**	Significant	

Table A60:Age and Coordination/Continuity of Care

PED_Coordination Continuity Care	AGE			Chi-square Tests		
	up to 30 years	31-45 years	46+ years	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	6	1	1	13.877	4	0.008
Neutral	12	4	2			
Agree/Strongly Agree	84	128	42			
% Agree/Strongly agree by age group	**82.4%**	**96.2%**	**93.3%**	**Comment:**	Significant	

Table A61:Gender and Access

PED_Access	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	7.096	2	0.029
Neutral	0	13			
Agree/Strongly Agree	91	175			
% Agree/Strongly agree by gender	**100.0%**	**92.6%**	**Comment:**	Significant	

Table A62: Gender and the Physical State of the Infrastructure

PED_Physical_State_Infrastructure	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	2	2	3.971	2	0.137
Neutral	0	7			
Agree/Strongly Agree	89	180			
% Agree/Strongly agree by gender	**97.8%**	**95.2%**	**Comment:**	Not significant	

Table A63: Gender and the Involvement of family/friend

PED_Family_Involvement	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	2	6.565	2	0.038
Neutral	0	13			
Agree/Strongly Agree	90	174			
% Agree/Strongly agree by gender	**98.9%**	**92.1%**	**Comment:**	Significant	

Table A64: Gender and Waiting Time

PED_Waiting_Time	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	2	4.061	2	0.131
Neutral	4	20			
Agree/Strongly Agree	87	167			
% Agree/Strongly agree by gender	**95.6%**	**88.4%**	**Comment:**	Not significant	

Table A65:Gender and Quality of care

PED_Quality_Care	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	2.389	2	0.303
Neutral	4	17			
Agree/Strongly Agree	87	171			
% Agree/Strongly agree by gender	**95.6%**	**90.5%**	**Comment:**	Not significant	

Table A66: Gender and Information

PED_Information	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Neutral	0	6	2.952	1	0.086
Agree/Strongly Agree	91	183			
% Agree/Strongly agree by gender	**100.0%**	**96.8%**	**Comment:**	Not significant	

Table A67: Gender and Education

PED_Education	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	1	3.111	2	0.211
Neutral	1	10			
Agree/Strongly Agree	89	178			
% Agree/Strongly agree gender	**97.8%**	**94.2%**	**Comment:**	Not significant	

Table A68:Gender and the Role of the Doctor

PED_Doctor_role	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	2	4	4.994	2	0.082
Neutral	0	10			
Agree/Strongly Agree	89	175			
% Agree/Strongly agree by gender	**97.8%**	**92.6%**	**Comment:**	Not significant	

Table A69:Gender and Management Effectiveness towards Positive Outcomes

PED_Management_Positive_Outcomes	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	3	6	8.721	2	0.013
Neutral	0	17			
Agree/Strongly Agree	88	166			
% Agree/Strongly agree by gender	**96.7%**	**87.8%**	**Comment:**	Significant	

Table A70: Gender and the Role of medication

PED_Medication Role	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	2	4	8.719	2	0.013
Neutral	0	17			
Agree/Strongly Agree	89	168			
% Agree/Strongly agree by gender	**97.8%**	**88.9%**	**Comment:**	Significant	

Table A71: Gender and Communication

PED_Communication	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	0	12.304	2	0.002
Neutral	0	20			
Agree/Strongly Agree	90	169			
% Agree/Strongly agree by gender	**98.9%**	**89.4%**	**Comment:**	Significant	

Table A72:Gender and Patient Centered Care

PED_Patient_Centered_Care	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	9.262	2	0.010
Neutral	0	17			
Agree/Strongly Agree	91	171			
% Agree/Strongly agree by gender	**100.0%**	**90.5%**	**Comment:**	Significant	

Table A73:Gender and the Role of the Nurse

PED_Nurse_role	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	4	9.766	2	0.008
Neutral	0	18			
Agree/Strongly Agree	90	167			
% Agree/Strongly agree by gender	**98.9%**	**88.4%**	**Comment:**	Significant	

Table A74:Gender and Clinic Cleanliness

PED_Clinic_Cleanliness	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	2	6	9.618	2	0.008
Neutral	0	18			
Agree/Strongly Agree	89	165			
% Agree/Strongly agree by gender	**97.8%**	**87.3%**	**Comment:**	Significant	

Table A75:Gender and Coordination/Continuity of Care

PED_Coordination_Continuity_Care	GENDER		Chi-square Tests		
	Male	Female	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	2	6	9.618	2	0.008
Neutral	0	18			
Agree/Strongly Agree	89	165			
% Agree/Strongly agree by gender	**97.8%**	**87.3%**	**Comment:**	Significant	

Table A76: Race and Access

PED_Access	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	8.858	2	0.012
Neutral	10	3			
Agree/Strongly Agree	99	167			
% Agree/Strongly agree by Race	**90.8%**	**97.7%**	**Comment:**	Significant	

Table A77: Race and Physical State of the Infrastructure

PED_Physical_State_Infrastructure	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	3	1.311	2	0.519
Neutral	4	3			
Agree/Strongly Agree	104	165			
% Agree/Strongly agree by Race	**95.4%**	**96.5%**	**Comment:**	Not significant	

Table A78:Race and Involvement of Family/Friend

PED_Family_Involvement	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	2	1	13.115	2	0.001
Neutral	11	2			
Agree/Strongly Agree	96	168			
% Agree/Strongly agree by race	**88.1%**	**98.2%**	**Comment:**	Significant	

Table A79:Race and Waiting Time

PED_Waiting_Time	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	1	1.478	2	0.478
Neutral	12	12			
Agree/Strongly Agree	96	158			
% Agree/Strongly agree by Race	**88.1%**	**92.4%**	**Comment:**	Not significant	

Table A80:Race and the Quality of Care

PED_Quality_Care	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	1.338	2	0.512
Neutral	10	11			
Agree/Strongly Agree	99	159			
% Agree/Strongly agree by Race	**90.8%**	**93.0%**	**Comment:**	Not significant	

Table A81:Race and Information

PED_Information	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Neutral	1	5	1.278	1	0.258
Agree/Strongly Agree	108	166			
% Agree/Strongly agree by Race	**99.1%**	**97.1%**	**Comment:**	Not significant	

Table A82:Race and Education

PED_Education	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	1	4.37	2	0.112
Neutral	1	10			
Agree/Strongly Agree	107	160			
% Agree/Strongly agree by Race	**98.2%**	**93.6%**	**Comment:**	Not significant	

Table A83:Race and the Role of the Doctor

PED_Doctor_role	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	5	1.665	2	0.435
Neutral	3	7			
Agree/Strongly Agree	105	159			
% Agree/Strongly agree by Race	**96.3%**	**93.0%**	**Comment:**	Not significant	

Table A84:Race and Management Effectiveness towards Positive Outcomes

PED_Management_Positive_Outcomes	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	9	12.963	2	0.002
Neutral	12	5			
Agree/Strongly Agree	97	157			
% Agree/Strongly agree by Race	**89.0%**	**91.8%**	**Comment:**	Significant	

Table A85:Race and the role of Medication

PED_Medication_Role	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	5	8.686	2	0.013
Neutral	12	5			
Agree/Strongly Agree	96	161			
% Agree/Strongly agree by Race	**88.1%**	**94.2%**	**Comment:**	Significant	

Table A86: Race and Communication

PED_Communication	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	1	0	5.682	2	0.058
Neutral	12	8			
Agree/Strongly Agree	96	163			
% Agree/Strongly agree by Race	**88.1%**	**95.3%**	**Comment:**	Not Significant	

Table A87: Race and Patient Centered Care

PED_Patient_Centered_Care	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	1	8.205	2	0.017
Neutral	12	5			
Agree/Strongly Agree	97	165			
% Agree/Strongly agree by Race	**89.0%**	**96.5%**	**Comment:**	Significant	

Table A88: Race and the Role of the Nurse

PED_Nurse_role	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	5	9.164	2	0.010
Neutral	12	6			
Agree/Strongly Agree	97	160			
% Agree/Strongly agree by Race	**89.0%**	**93.6%**	**Comment:**	Significant	

Table A89: Race and Clinic Cleanliness

PED_Clinic_Cleanliness	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	8	10.983	2	0.004
Neutral	12	6			
Agree/Strongly Agree	97	157			
% Agree/Strongly agree by Race	**89.0%**	**91.8%**	**Comment:**	Significant	

Table A90: Race and Coordination/Continuity of Care

PED_Coordination_Continuity_Care	RACE		Chi-square Tests		
	Black	Indian	Chi-Sq value	Degrees of freedom	p-value
Disagree/Strongly Disagree	0	8	10.983	2	0.004
Neutral	12	6			
Agree/Strongly Agree	97	157			
% Agree/Strongly agree by Race	**89.0%**	**91.8%**	**Comment:**	Significant	

Appendix H: Ethical Clearance for the Study

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

2 August 2017

Mrs Prunella Rosanne Padayachee 9800398
Graduate School of Business and Leadership
Westville Campus

Dear Mrs Padayachee

Protocol reference number: HSS/0126/017D
Project title: Developing a Conceptual Model to Improve Patient Experience as a strategy to Engage Public Health Service Reform in South Africa

Full Approval – Expedited Application

In response to your application received 1 February 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Dr M Hoque
cc. Academic Leader Research: De E Mutambara
cc. School Administrator: Ms Zarina Bullyraj

Humanities & Social Sciences Research Ethics Committee
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Appendix I: Turnitin Report

Turnitin Originality Report

- Processed on: 14-Dec-2018 3:30 PM CAT
- ID: 1046560528
- Word Count: 92539
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R Hodes, I Price, N Bungane, E Toska, L Cluver. "How front-line healthcare workers respond to stock-outs of essential medicines in the Eastern Cape Province of South Africa", South African Medical Journal, 2017
<1% match (student papers from 26-Sep-2016)