

**PATIENTS' SATISFACTION WITH HEALTH CARE SERVICES PROVIDED IN
THE CITY OF JOHANNESBURG MUNICIPALITY CLINICS**

by

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DECLARATION

I declare that **PATIENTS' SATISFACTION WITH HEALTH CARE SERVICES PROVIDED IN THE CITY OF JOHANNESBURG MUNICIPALITY CLINICS** is my own work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

SIGNATURE

(Irene Ntebo Ramela)

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ABSTRACT

The study aimed at describing patients' satisfaction with health care services provided in the city of Johannesburg. The research sample consisted of adult male and female patients who visited region E clinics for health services. Questionnaires were used to collect data and descriptive statistics for data analysis. Findings indicated that patients were generally satisfied with health care services provided. Recommendations included ongoing staff training to improve quality of health care and public information and education campaigns to foster community awareness and understanding of health services, develop a sense of ownership thereof, and encourage positive participation.

Key terms:

Accessibility; complaint procedure courtesy; consultation; information and transparency and quality of health care redressing the wrongs; value for money.

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It is said that no feast comes to the table on its own feet, but requires loving attention and preparation, the work of many hours and often the effort of many hands ... and so it is with this dissertation.

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Dedication

To my mother and father, with love

and

to nurses everywhere in appreciation

CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

One of the main objectives of the Department of Health as stated in the White Paper on Transformation of Health System (WPTHS) in South Africa was to establish a District Health System (DHS) that would be implemented to offer an essential package of primary health care (PHC) services to cover all communities (Department of Health 1997:109).

PHC is a framework of services within the district in which health is promoted and delivered. It protects the public from being abused and exploited by health care providers. It does this by providing policies, which health care providers should use to deliver quality of health care.

PHC involves community participation in health matters. People should be given an opportunity to participate actively in various aspects of planning and provision of health care to point out issues that need improvement (Department of Health 1997:15). By so doing, health professionals are made aware of the importance of identified health needs of the community as patients to improve quality of health care services. Patients' needs should be the focus of interaction in PHC services. Patients should never doubt nurses' management of quality of care when referred to another professional.

The Department of Public Service and Administration (DPSA) (1997:24) introduced the White Paper on Transforming of Public Service Delivery (WTPSD), which includes the *Batho Pele Principles* as guidelines. These guidelines include accessibility, value for money, information, service standards, and transparency. To improve the quality of health care services in South Africa, the Department of Health (2001:23) introduced key strategies and policies as a guide for local government within which quality health care should be provided and measured. According to these guidelines, health care professionals should identify patients' needs and priorities, identify gaps for

improvement and set standards to improve the quality of health care services (Department of Health 2001:24).

Negative comments from community meetings, patients' letters to facility managers and the media, however, frequently seemed to indicate that patients were dissatisfied with health care services provided at clinics.

1.2 BACKGROUND TO THE PROBLEM

According to daily clinic admission registers, and patients' medical cards, some patients travelled long distances from their catchment's areas for provision of health service (Sandown clinic daily, admission registers 2005). One of the key elements of PHC services is that health services should be affordable and brought closer to the people. This implies that patients, who travel long distances from their catchment's areas seeking health care services, are indirectly paying for health care services out of their pockets.

Regarding health care services delivery, the Local Government Municipal Demarcation Act 27 of 1998, stipulates that PHC services should provide quality of health care that is affordable, accessible, effective, efficient and sustainable (South Africa 1998:38). These elements of PHC emphasise that health care professionals should put patients first by ensuring that health care services are accessible to patients as customers at all times when the need arises. Patients should not be sent home without being seen by health care professionals. Health care facilities should be available when needed. The community is encouraged to participate in health care facilities meetings and raise their concerns by pointing out issues that need improvement. Health care professionals then identify the concerns raised and prioritise them.

To maintain the standard of quality in PHC, the management of the district health care sets goals and priorities with regards to health care, taking into consideration recommendations from the community. It is often difficult for the health care facilities to maintain quality of health care services and patients' satisfaction due to overcrowding of patients and staff shortages, which have drastically increased nurses' workloads.

The Department of Health's (2006:108) comprehensive PHC package includes, the HIV/AIDS/STI and TB (HAST), INH prophylaxis to HIV/AIDS patients, and prevention of mother-to-child transmission (PMTCT) programmes. Curative and chronic health care services are a challenge to PHC services in an overcrowded environment, especially because patients have to wait for a long time.

The City of Johannesburg is divided into seven regions in order of A to G. These regions differ in size because of the population density, which is affected by informal settlements. There is no bypass fee paid by patients if they wish to visit the clinics outside their borders. They are free to visit any clinic of their choice and this makes health services difficult to render because the clinics become over crowded. Some clinics in the city operate for eight (8) hours daily while others operate for twenty-four hours to accommodate maternity patients.

There are ten (10) referral hospitals in Johannesburg where patients who attend municipal clinics are referred to. Each region has a referral hospital to accommodate the patient load. The people who mostly use municipal clinics are uninsured, which means they have no medical aid scheme and therefore cannot afford to pay for expensive medical healthcare services provided in the private sector.

According to the mid-year district health information statistics, the uninsured population in region E was 301 875 (District Health Information System Population Estimate 2006).

According to the geographical demarcation of regional borders, Region E where this study was done, is situated in the Northern side of Johannesburg further north is Tshwane/Pretoria to the East is OR Tambo (see Annexure E). It serves the community of Alexandra and its residential suburbs namely Woodmead, Wynberg, Sandton City, Mayibuye in Midrand, and Petervale near Bryanston, Bezvalley and Bruma on the East.

The number of clinics in region E is ten including one non-governmental organisations (NGO) clinic. Alexandra Health Care Centre is a NGO, 4th Avenue clinic, 8th Avenue clinic, Thoko Mngoma, Eastbank clinics are in Alexandra. Mayibuye clinic is in Midrand, Bezvalley clinic at Bezvalley in South of Johannesburg. Sandown, Petervale and Wendywood are residential areas in Sandton where people from different parts of Johannesburg work. Most of the patients who utilise the clinic services in those areas

are domestic workers and people working in the region and live in the townships or in other suburbs in Johannesburg.

This study was done in region E and there are no mobile clinics. Therefore the study was conducted in fixed clinics only. This study focussed on patients' satisfaction with health care services provided in the City of Johannesburg region E.

1.3 RESEARCH PROBLEM

A survey of municipal clinics in 2004 found that patients expressed dissatisfaction about provision of health care service delivery provided in the clinics. The emphasis according to the findings from the survey was that health care professional's lunch and tea breaks were too long (more than an hour) and staff not relieving one another during breaks. Patients had to wait too long before being attended to. The negative attitude from staff was also identified. Staff did not adhere to the norms and standards of the complaint procedure (Department of Health 2004:33).

According to the health norms and standards, each clinic should have a complaints procedure and the Patients' Rights Charter clearly displayed to inform the community about the steps to take when they experience problems (Department of Health 2001:33). Clinic records indicate that clinics are overcrowded with patients. Some clinics attend to about 2000 patients per month while others attend to about 4000. The clinics are managed by two to three professional nurses including an operations manager and provide comprehensive package of PHC services daily. The situation makes patients unhappy because they have to wait a long time before they are attended to.

The main problem is that the majority of these people are working and visits the clinics during their tea and lunch breaks and expects to be seen immediately because they need to go back to work. If not seen, they return to work without being seen by health care professionals. It becomes a problem because they have to wait in the line like other patients. These patients are unable to attend the clinic meetings during their working hours to raise their concerns.

There are, however, suggestion boxes available in every clinic which the patients could use. The majority of the residents living around these clinics can afford private health care services and are therefore not involved in municipal clinic matters like attending clinic meetings.

The researcher therefore conducted the study on patients' satisfaction with health care services provided in the City of Johannesburg focusing on the *Batho Pele Principles* and the Patients' Rights Charter.

1.4 SIGNIFICANCE OF THE STUDY

The study should be of benefit to the City of Johannesburg with regards to the patients' satisfaction with health care services provided. Community participation should improve quality of care in health services by indicating areas that need improvement. The study should also facilitate the implementation of programmes to meet and satisfy patients' needs.

1.5 PURPOSE OF THE STUDY

The purpose of this study was to identify and describe patients' satisfaction with health care services provided by clinics in region E City of Johannesburg in order to develop guidelines for health care professionals to ensure quality of health care services delivery and patients' satisfaction.

1.6 OBJECTIVES OF THE STUDY

The objectives of this study were to

- identify and describe patients' satisfaction with health care services
- recommend guidelines for health care professionals to improve health care delivery

1.7 THEORETICAL FRAMEWORK

According to Polit and Hungler (1999:111), a theoretical framework refers to a study based on theory, and a conceptual framework refers to a study based on conceptual models. A theoretical framework guides the researcher to formulate ideas for the research (Brink & Wood 1998:66). The theoretical framework for this study was based on national health policies, which emphasise provision of health care provided in the facilities. The policies include the WPTHs and the WPTPSD – *Batho Pele Principles*. This framework was used in developing a questionnaire for data collection (South Africa (Republic) 2003:2).

The WPTPSD emphasises the importance of building a public service capable of meeting the challenges of improved service delivery to all South Africans. A decent health care service would no longer be a privilege but the right of all South Africans (Department of Public Service and Administration 1997:2).

The Department of Public Service and Administration introduced the *Batho Pele Principles*, which put pressure on the systems, procedures, attitudes and behaviour within the public service including health services and reoriented them in customer services to address people's needs (Department of Public Service and Administration 1997:2). *Batho Pele* is the Sesotho for "People first" and emphasises a philosophy of a transformed people-oriented service. The eight *Batho Pele* service delivery principles are consultation, setting service standards, access, ensuring courtesy, information, openness and transparency, redressing the wrongs, and value for money. In this study the researcher used the *Batho Pele Principles* as criteria to measure patient's satisfaction.

- **Consultation**

Consultation refers to the involvement of the community in health matters. Members of the community including the local counsellor are invited to attend clinics meetings and to form committees. Meetings are chaired by the operations manager of the clinic. The aim of the meetings is to discuss clinic problems and recommendations are made and forwarded to the regional management for attention. There are also suggestion boxes at the clinics for the community to use to point out issues they think need improvement.

The clinic committees then open suggestion boxes, issues raised from the suggestion boxes are discussed and those pertaining to the clinics are solved locally. Issues that cannot be solved at the clinic level are then forwarded to management.

- **Setting service standards**

Service standards refer to the set level of health care services that satisfy the health care consumers (Department of Public Service and Administration 1997:2). Community health care professionals are first contact care, and are therefore expected to behave professionally and understand different cultural groups. The aim is that the nurses should meet the needs of different cultural groups of patients. Health care professionals are provided with in-service training to update them on the new developments of health care services skills required, so that they provide quality of patient care that will satisfy the patients.

- **Access**

According to the study access refers to patients being able to receive health care services from health care facilities when the need arises. All citizens are entitled to equal health services. That means patients should be attended to at all times at the clinics. No patients should be turned away or sent home from the clinic unattended. The *Batho Pele Principles* provide a framework for making decisions about delivering public services to all South Africans. Services should be geographically accessible and within a five to ten kilometre radius in the area where transport would be available. Accordingly patients should utilise the clinics within their catchment's areas of 5 to 10 kilometres radius (Dennill, King & Swanepoel 2003:3). Operations hours of the clinics and the health care services provided including the signages should be clearly displayed in all the clinics for the public to see. Ramps to accommodate disabled patients should be available.

- **Ensuring courtesy**

Health care providers should be empathetic when delivering services to the public to raise their level of good and positive behaviour (Department of Public Service and Administration 1997:2). In service training on customer services satisfaction as part of

induction is conducted to all the new employees. The aim is to empower employees on customer service satisfaction and to ensure that health professionals understand different cultural groups of patients and manage their needs with understanding. It is expected at the clinics that health care professionals treat patients as unique individuals with respect and dignity, and should:

- greet first when addressing the patient
- identify themselves to patients by wearing name tags at all times when dealing with patients
- talk to patients and give them advice in a friendly manner
- provide enough time for patients to make enquiries and listen to patients with positive attitude when asking questions that need clarity with regards to their illnesses
- understand and consider patients with special need such as the elderly or infirm (Department of Public Service and Administration 1997:2)
- **Information**

Communication between health care professionals and patients is an important factor in patient care in terms of satisfaction. In this study information and transparency refers to the communication of health care professionals between the patients and the health care professionals. Information in the form of signage's such as the type of health care services provided, the hours of operations should be clearly displayed where the public could see, Information also refers to the display of Patients' Rights Charter and the *Batho Pele Principles* and any other educational health care posters for patients to read. Health care professionals should at all times encourage patients to read information displayed. It is also expected that health promoters draw a programme for health education so that they are able to give health talks to patients whilst the patients are waiting in the waiting area to be attended to by health care professionals.

- **Openness and transparency**

Openness and transparency refers to the information that is given to the public by management of the health team (Department of Public Service and Administration 1997:2). Openness and transparency is similar to information. The management team

together with the local counsellors of different wards visits the clinics to reassure the patients at the clinics about issues that hamper the management of patients care resulting in for an example, increased waiting time period for the patients when nurses are on strike. Health professionals should be opened and transparent at all time. Issues such as the number of nurses at work for the day should be informed in writing and be clearly displayed to the patients so that they understand and be patient.

- **Redressing the wrongs**

Redressing the wrongs is the capacity to deal with and to take actions when things go wrong. The principle should be the ability to identify shortfalls below the set standard of promised services and the ability to intervene positively. Patients should be treated like customers and complaints raised should be acknowledged and apologies should be made. Complaints are to be reviewed and improved speedily, fairly, confidentially, and responsively. Not only the complaints should be raised even the good work done by the health care professionals should be acknowledged verbally or in writing by the patients. Complaints raised should be attended to:

- **Speedily**

Speedily refers to the time period within which patients' **complaints** are attended to. Patients' **complaints** should be attended to immediately. An immediate and genuine apology should be made to the patient verbally or telephonically, depending on the circumstances. Patients should be reassured about a solution to the problem (Department of Public Service and Administration 1997:2).

- **Fairly**

Complaints are fully investigated without bias to ensure patients' confidence in the health care providers and should be solved in such a way that patients gain trust in the provision of health care services (Department of Public Service and Administration 1997:2).

- **Confidentially**

Patients' confidentiality is expected to be protected. Patients should not be victimised but rather be protected and encouraged to trust the health care sectors. It is an ethical responsibility to maintain professional secrecy in terms of patients' complaints should not be discussed in public (Department of Public Service and Administration 1997:2).

- **Responsively**

Responsiveness is similar to redressing the wrongs in that an apology should be made to the complainant immediately when the problem has occurred.

Furthermore, a mechanism for review of complains is available in the clinics as a guide to solve problems. Health care professionals especially the nurses are expected to know and follow the guidelines provided should the patient complain (Department of Public Service and Administration 1997:2).

- **Value for money**

Value for money in the study refers to the efficiency and the effectiveness of the health care services provided by health care providers. The promised level of set standards should be maintained at all times. Health care providers should provide quality of health care services that will satisfy the patients' needs. It includes good communication to patients, health care professionals' skills, and the ability to assess, treat and care for the patient. Patients are unique individuals and should be respected at all times.

1.8 RESEARCH DESIGN

The research design is a plan or blueprint of how the research will be conducted (Polit & Beck 2004:55). For this study, the researcher selected a quantitative and descriptive design.

Quantitative methods attempt to measure a phenomenon on numerical scale. The data produced reflects the frequency with which the phenomenon occurs and the exact measure of the amount of the phenomenon occurring (Brink & Wood 1998:5).

Quantitative research is the systematic collection of numeric information usually under conditions of considerable control and the analysis of that information, using statistical procedures (Polit & Hungler 1999:200).

Descriptive research describes the phenomena in real situation and also accounts for accurate characteristics of that situation. In a descriptive study real meaning of what exist is described including the frequency with which something occurs and information is categorised (Burns & Grove 2003:27). The study uses the descriptive method as the phenomena in the real situation would be described in terms of frequency and the relationship of variables identified and classified categorised. The data collected will be statistically analysed and interpreted. The outcome of the described variables would be the recommendation to draw guidelines for health professionals to improve health care delivery.

1.9 POPULATION AND SAMPLE

The population consisted of male and female patients, 18 years and older, who attended the clinics for health care services.

The study was done at six clinics namely Sandown, Petervale, 4th Avenue, and 8th Avenue, Thoko Mngoma and Eastbank clinic.

A random sample of 134 patients was obtained. A questionnaire was used as a data-collection instrument. The questionnaire was a cost-effective tool for reaching the respondents because it was distributed at the facilities (Polit & Hungler 1999:167).

1.10 DATA ANALYSIS

As a quantitative and descriptive approach, statistics was used to analyse the differences and associations of opinions regarding identifying and describing patients' satisfaction by means of frequencies and percentages (Burns & Grove 2003:409). Recommendations to draw guidelines for health care professionals to improve health care services were made.

1.11 VALIDITY AND RELIABILITY

Validity and reliability determine the quality of a research instrument. Validity is the degree to which an instrument measures what it is intended to measure (Polit & Hungler 1999:308).

Reliability is the degree of consistency or dependability with which the instrument measures the attribute it is designed to measure. If reliability is considered using an indicator or a measuring tool, the results will be the same each time the test is repeated (Polit & Hungler 1999:308). The study used the Cronbach's alpha coefficient method to measure the reliability of an instrument. The alpha of a scale equal to 0.70 or greater is acceptable for items to be reliable. The **Cronbach's** alpha in each section of the questionnaire was above 0.70, it indicated that all the questionnaires were reliable (Polit & Beck 2004:416).

1.12 ETHICAL CONSIDERATIONS

Ethical consideration is the right to human dignity and moral. It pertains to people being treated like humans (Polit & Hungler 1999:73). Accordingly, the researcher upheld ethical considerations by:

- Requesting for permission to conduct a research (Annexure A).
- Obtaining permission to do the study from the Regional Manager of region E (Annexure B).
- Obtaining permission from the Research and Ethics Committee, Department of Health Studies, University of South Africa (Unisa) (Annexure C).
- Obtaining informed consent from the research respondents (Annexure D).
- Maintaining confidentiality and anonymity in data collection and presentation.
- Obtaining permission from the facility operations manager.

1.13 SCOPE AND LIMITATION OF THE STUDY

The study was done in the City of Johannesburg region E municipal clinics and focused on adult male and female patients who attended the clinics for health care services.

1.14 DEFINITIONS OF CONCEPTS

For the purposes of this study, the following concepts are used as defined:

- **Patient**

A patient refers to any client who receives medical attention, care, or treatment. The client may be ill or injured and in need of treatment by a physician or other medical professional. It includes clients visiting the physician for routine check. (Neuberger 1999:1756). In this study patients referred to all the clients utilising the region E municipal clinics for health care purpose.

- **Patient satisfaction**

According to Lindsey, Henley and Tyree (1997:31) patient satisfaction refers to “the result when patients accept and understand their health status and the logistics of care. It is also the perception that treatment will result in improved health.” In this study patients’ satisfaction refers to the acceptance of the set standards amongst others the value, the effectiveness and the efficiency of the health care services provided by the health care providers.

- **Clinics**

Clinics refer to health care services that are provided at a none hospital setup. The services could be provided in PHC clinics including NGOs. In this study clinics refer to the health care services that are provided at the PHC facilities and in NGOs (Department of Health 2001:22).

- **Fixed clinics**

Fixed clinics refer to the health care services that are provided at the facilities. The services are non-mobile and operate for twenty-four hours or for eight hours a day. (Department of Health 2001:22).

- **Health care services**

Health care services refer to the health care services delivered within the public and the private or non governmental or other health sectors or applied by their constitutional duties of the state to respect, protect, promote and fulfill (South Africa (Republic) 2003:12). According to the study the health care services refer to the services that are delivered at the PHC clinics.

- **Primary health care (PHC)**

PHC refers to health care services that are made universally accessible to individuals and families through full participation of community members. The services should be affordable, accessible and available and the community should benefit from them (Department of Health 2001:22). The study also refers to the PHC services as comprehensive in terms of management of all the programmes such as preventive and promotive and management of curative chronic diseases, HIV/AIDS and TB, including reproductive health. It should include services to handicapped people. According to the PHC the clinics should be 5 to 10 kilometres radius within the community and where transport would be available so that the health care services are affordable and accessible (Department of Health 2001:22).

- **Participation**

Participation is an essential element that is democratically based to reduce the domination from professionals. It helps to accurately respond to the challenges and encourage more rational use of health care services (Fry & Hasler 2000:862). According to this study participation refers to the community members given the opportunity to be involved in the health care matters to point out issues that need improvement.

- **Catchment area**

A catchment area refers to coverage of the provision of health care services by PHC. According to World Health Organization (WHO) the distance should be 5 to 10 kilometres radius (Dennill et al 2003:23).

- **Uninsured group**

According to the district health information system, an uninsured group is “a group of people that do not have medical aid and receive health services at local government health facilities” (District Health Information System 2006). In this study uninsured people referred to the people in the City of Johannesburg who mostly use municipal clinics and cannot afford the health care services that require medical aid schemes at private clinics.

1.15 OUTLINE OF THE STUDY

Chapter 1 describes the purpose and objectives of the study, the background to the problem, and the research design and methodology and defines key concepts.

Chapter 2 discusses the literature review conducted for the study.

Chapter 3 covers the research design and methodology.

Chapter 4 discusses the data analysis and interpretation.

Chapter 5 presents the findings and makes recommendations for practice and further research.

1.16 CONCLUSION

This chapter described the background to the problem, purpose and objectives of the study, and the research design and methodology, and defined key concepts.

Chapter 2 covers the literature review conducted for the study.

CHAPTER 2

Literature review

2.1 INTRODUCTION

The researcher conducted a literature review on patients' satisfaction with health care services provided. The literature review covered patients' satisfaction, PHC, challenges and factors affecting PHC.

2.2 PATIENTS' SATISFACTION

Nurses are accountable for provision of health care services in the PHC facilities. It is important for them to be aware of the guidelines on providing health care services, namely the *Batho Pele Principles* and the Patients' Rights Charter. When adhered to, these guidelines could lead to patients' satisfaction. Patients' satisfaction refers to the results when patients accept and understand their health status, and the logistics of care (Dennill et al 2003:6).

Lindsey, Henley and Tyree (1997:31) found that patients' satisfaction depends on the understanding and the belief of patients that the treatment given will be of help and will result in improved health.

In Sweden, Törnkvist, Gardulf and Strender (1999:74) found that the alleviation of physical symptoms, such as pain and discomfort, and the health professionals' skills, time management, knowledge and professionalism together with patients' participation in nursing care, confidence in the health system, regular source of care and accessibility, contributed to patients' satisfaction.

The interpersonal aspects of caring, such as individualised care, patients' needs, humanistic approach, commitment and concern by health professionals, are important aspects of patients' satisfaction with the health care system (Attree 2000:456).

Patients' satisfaction is subjective and means different things to different people (Walsh & Walsh 1999:307).

Nevertheless, patients' satisfaction depends on the fulfilment of the individual felt needs and the perception of the level of health care provided in the facility. Walsh and Walsh (1999:307) add further that patients cannot express their satisfaction by just making a tick on a Likert scale and that satisfaction should be measured with a tool that has a range of nursing care items that a patient can rate. These ratings should be aggregated to a score to measure patients' satisfaction with the nursing care provided and the questionnaire should cover all aspects of nursing care.

Regarding evaluation of patient satisfaction with PHC and quality of health care, Moll van Charante, Giesen, Mokkink, Oort, Grol, Klazinga and Bindels (2006:437) found that accessibility and continuation of health services, waiting time, consultation of patients by health care providers, availability of medicines, performance of doctors and nurses, laboratory investigations and level of privacy in the consultation rooms are dynamics in health care services and should be maintained at all times to enhance patients' dignity.

A customer service satisfaction survey done in the City of Johannesburg 2004 recommended that patients should not be left unattended due to facility problems (Department of Health 2004:33). Health care services should be accessible and available when needed. Clinics' operational hours should be extended to accommodate working patients who are unable to access health care services during the day due to work.

2.2.1 Measurement of patients' satisfaction

Patient's satisfaction surveys are frequently used to measure patient's quality of health care services from patients' perspective. Quality of health care services and patients' satisfaction are interrelated. Patients' satisfaction depends on the quality of health care services provided.

In a related study of gender and patients satisfaction Weisman, Rich, Rogers, Crawford, Grayson and Henderson (2000:657) found that women in terms of visits, were mostly satisfied with the information and the continuity of care, whilst men' overall

satisfaction depended mostly on individual attention they got from staff. The *Batho Pele Principles* measure patients' satisfaction as accessibility of health care services provided, ensuring courtesy, considering patients as unique individuals, adequate health information to patients, being able to answer questions asked by patients politely, redressing the wrongs with a positive attitude (Department of Public Service and Administration 1997:2).

Walsh and Walsh (1999:307) refer to Ovretveit (1992) that quality of health care is three fold, namely managerial, professional and client-based quality. The managerial quality of health care is measured against the cost effectiveness, availability and the use of resources while client-based quality is measured by patient satisfaction surveys.

The measurement of patients' satisfaction in terms of cost effectiveness refers to value for money, namely the way in which the costs of provision of health care are contained and properly utilised. The costs of provision of health care services should be monitored to avoid over- or under-spending so that human resources, structure and finance are available to manage the health care services correctly and cost effectively at all times.

The client-based quality of health care services is based on patients' perceptions of the services. The participation of patients in decision-making in health care improves quality of care and patients' satisfaction. Satisfied patients are willing to follow the professionals' advice and instructions and will always return to the same provider when they need health care service (Törnkvist et al 1999:74). Patients who are dissatisfied with health care do not return to the same provider, but go elsewhere for better health service.

The Department of Health introduced a policy for the development of a district health system (DHS) for South Africa. The DHS is a vehicle for the delivery of the PHC package. The strategies to plan the health care services delivery and Key Performance Indicators are set to measure quality of health care services and patients' satisfaction (Department of Health 2001:33).

2.2.2 Health workers' responsibility with regard to patients' satisfaction

The patient or customer is an important source of information in improving service delivery in the PHC system. Health professionals should increasingly aim to satisfy patients. Patients like to use health facilities that deliver satisfying health care. Patients' satisfaction reduces complaints from patients and their relatives. Complaints, criticisms and anger are raised when patients are not satisfied with the health care services provided (Sherman & Sherman 1999:376).

Health care workers' responsibility with regards to patients' satisfaction refers to "customer" concept that is, "people must come first". In competitive commercial market, private companies do not afford to ignore wishes of their customers if they wish to remain in business. Dissatisfied customers take their business elsewhere. In terms of the public health services, individual clients do not pay health care providers directly. Therefore the National and Provincial Departments of Health do not go out of business if the services standards fall below promised level (Department of Public Service and Administration 1997:13).

Customer satisfaction improves health care service delivery as in the provision of service for commercial gain. It implies that patients should be treated as customers by

- listening to their views and taking them in consideration when making decision with regards to health care services
- treating them with consideration and respect
- providing them with the promised levels of health care services
- responding to them with a positive attitude when promised level of health care services fall below the set standards (Department of Public Service and Administration 1997:13)

The framework of the *National Health Plan for South Africa* (African National Congress [ANC] 1994) stipulates that health care services should be provided to the public with dignity. The Department of Health stipulates that all clinics must display the Patients' Rights Charter, which clearly describes what standards of health care services patients should receive (Department of Health 2001:33). In addition, all clinics are expected to display the complaints procedure. The purpose of the complaints procedure and the

Patients' Rights Charter are to deal effectively with complaints and rectify service delivery problems. In so doing, management wishes to improve the quality of health care by raising awareness of the rights and responsibilities of patients, and empower patients to change their attitude by strengthening the relationship between them and the health providers. Patients' understanding and use of the Patients' Rights Charter should enforce the development of a mechanism by health professionals to improve health care services and patient satisfaction.

2.3 PATIENTS' RIGHTS CHARTER

According to the Patients' Rights Charter (Department of Health 2001:33), patients have the right to

- access health care
- a healthy and safe environment
- participation in decision making in the provision of their health care management
- confidentiality and privacy
- informed consent
- exercise choice in health care
- be treated by health care providers that have identified themselves
- continuity of health care
- refusal of treatment
- referral for a second opinion

The ANC's 1994 national health plan emphasises that every individual has the right to achieve optimal health. The Government is responsible for ensuring that health services are available to all South Africans and the ANC is committed to the PHC approach (ANC 1994:23).

2.4 PRIMARY HEALTH CARE (PHC) APPROACH

In 1978, the WHO Alma Ata Conference introduced and endorsed a philosophy of achieving universally available health care and attaining "health for all by the year 2000". Accordingly, PHC became a core policy for the WHO in 1978. In that regard PHC policies and programmes have dominated since then (Dennill et al 2003:2).

The legacy of apartheid in South Africa created large disparities amongst racial groups in terms of socio-economic status, education, occupation, health and housing. Apartheid policy created a fragmented health system, which resulted in inequitable access to health care. Institutions and health care facilities were built and managed to sustain racial segregation and discrimination in health care (ANC 1994:39). Consequently, there was little or no emphasis on health and its achievement and maintenance, but great emphasis on medical care and the dominant role of doctors in the health care system (ANC 1994:39).

In 1994, South Africa was faced with the challenge to design improved comprehensive health care programmes to reduce social and economic injustice. These programmes involved the complete transformation of the national health care delivery system to remove the inequities in the health sector (ANC 1994:39). The transformation of the health care system in South Africa would involve, among other things, emphasising health care services and not only medical care.

Since then the harmful effects of apartheid health care services have been redressed and health care services introduced in line with international norms to promote health for all South Africans. The fragmented departments of health care services have been replaced by a single Department of Health led by the Minister of Health. The Department of Health is advised by the National Development Committee together with the Ministers of Agriculture, Housing, Public Service and Administration and others (Dennill et al 2003:45).

The PHC approach promotes full participation of members of the community in the planning, provision, control and monitoring of health services. Community participation is recognised as an important component in the health care system. Respect for human rights and accountability to the users of health facilities and the public at large are emphasised (WHO 2003:6).

PHC is the first level of contact between health care services and the patient, the family, the community (Dennill et al 2003:3). The national health system ensures that health care is brought as close as possible to where people live and work and that the community can participate fully (Department of Health 2001:4). PHC is a compre-

hensive programme designed to redress social and economic injustice, eradicate poverty, reduce waste, and increase efficiency to promote greater control by communities and individuals over all aspects of their lives (Department of Health 2001:5).

The PHC package includes the following:

- **Education and training**

Refers to the understanding by professionals of health education information in terms of preventing, and controlling prevailing health problems. It should include issues such as establishment of a resource centre for provision and production of health education materials and information about resources elsewhere. Education should involve institutions and organisations to meet the needs of the community (Department of Health 2001:23).

- **Provision of food and proper nutrition**

Adequate nutrition is the basis of health and has reciprocal interaction with issues such as the economic situation, employment levels, commodity prices and the performance of agriculture. The supplementation of food forms the strategy and includes provision of food to deprived groups. Health education for promotion of correct nutrition is the basis of any programme and facilities must train health care workers to carry out the project of proper nutrition (Department of Health 2001:23).

- **Adequate supply of water and basic sanitation**

The water supply should be within walking distance and every one should have access to at least twenty litres per day is required. Sanitation should be safe with adequate toilets and adequate systems for the removal of household waste (Department of Health 2001:23).

- **Provision of maternal and child health services including family planning**

Promoting safe pregnancies, contraception and counselling, and monitoring growth and development in children, including promotion of school health and good nutrition and prevention of malnutrition, can reduce high mortality and morbidity. Priorities include controlling HIV/STI health-related problems (Department of Health 2001:23).

- **Immunisation against major infectious diseases**

Immunisation of children against communicable disease reduces morbidity and mortality in harmful cases such as measles, tetanus, poliomyelitis, pertussus, diphtheria, mumps and rubella. The Department of Health has embarked on national immunisation campaigns to ensure coverage, mostly in measles and polio (Department of Health 2001:23).

- **Prevention and control of local endemic diseases**

Endemic diseases refer to chronic diseases of life style, which can be monitored and controlled in a specific area such as community clinics. It is important to identify factors that influence the diseases' profile and to develop strategies to control chronic diseases (Department of Health 2001:23).

- **Appropriate treatment of common diseases and injuries**

Appropriate treatment of common diseases and injuries refers to management of minor injuries and ailments, taking into consideration the environment in which individuals live, as well as the age and the socio economic status of individuals and the family. Professional nurses without the help of doctors manage most health facilities. It is therefore important to develop professional nurses' skills to empower them to meet the patients' needs (Dennill et al 2003:38).

- **Provision of essential drugs**

The provision of essential drugs refers to the provision of safe, essential, effective and affordable medicine and vaccines to all who need them. The Department of Health

(2001:4) is committed to ensuring the availability of safe, efficient and quality drugs, including good dispensing and prescribing practices. Training is provided to professionals who manage the drugs.

- **Accessibility**

Access to PHC health care services is the key to ensuring that health care is responsive to the needs of individuals. It recognises that there are principles of best practices that should be evident in any mode of health services delivery.

Accessibility means the degree to which health care is easily available and obtained when needed. It indicates the level of patients' satisfaction with health services provided. Health services should be geographically accessible to all members of the community and where transport will be available. Accessibility in terms of operational times of health care services should be clearly displayed; financially accessible at a cost the community can afford, and functionally accessible in terms of appropriate type of care available to meet the needs of the community and should be sustainable (Dennill et al 2003:3).

- **Affordability**

Affordability of health care services refers to the cost of health care services that the community and the country can afford. This implies that all clinics should be within the reach of the community in the catchment's area of a five- to ten-kilometre radius. The distance the patients travel should be comfortable (Department of Health 1997:7).

- **Equity**

Equity refers to the distribution of health services to the entire population and one of the strategies of "health for all" in PHC. It is also a moral and social commitment of government and health service providers in the practice of PHC (Department of Health 1997:7).

- **Efficiency**

Refers to the successful strategy for implementing PHC. It is achieved by the distribution of resources proportional to the money, time and effort spent (Dennill et al 2003:7). It also refers to the extent to which the health care services provided cover to the population requiring them. In PHC facilities it would take into consideration how the money is spent

- **Effectiveness**

Refers to positive outcome of health care services rendered to patients by the health care providers. Effectiveness means that health care services should do what they are intended to do. Health care services should be effective if costs and quality are properly managed (Dennill et al 2003:7).

2.5 CHALLENGES

Health problems, such as the emergence of HIV and AIDS, increasing chronic conditions, high birth rates, and life style changes have brought about a change in the health status of the population. The population consists of more elderly people. Disease management has become increasingly complex and the workload in PHC services has increased accordingly.

In April 2006 the DoH introduced a five-year plan aimed at the reduction and impact of HIV/AIDS on communities. The plan includes long-term strategic interventions in partnership with communities and civil society, including non-governmental organisations (NGOs), to help prevent the spread of HIV/AIDS through community mobilisation and health education (Department of Health 2006:3).

2.6 FACTORS AFFECTING THE DELIVERY OF PHC SERVICES

Factors such as structure, limited resources, time, finance and training, rapid changes, and cultural factors and attitudes adversely affect the delivery of PHC services.

2.6.1 Structure

Structure refers to the infrastructure, staffing and supplies. The shortfall of one component has a negative impact on the whole process of health services delivery to patients, including the possibility of medical mismanagement, which may result in death (Clark & Mayben 1999:107).

The problems of infrastructure cause poor quality of health care services. Patients are at risk of not receiving the proper care they deserve, if problems such as lack of health facilities and inadequate referral systems, inequitable distribution of health care and of equipments, personnel and space to provide comprehensive health care services including equipment prevail (Dennill et al 2003:67).

2.6.2 Limited resources

Expanding health care services coupled with increased demands for health care services measured against a small workforce has a negative effect on the outcome of health care services provided (Clark & Mayben 1999:107).

2.6.3 Staffing

Adequate staffing is imperative for positive patient care outcome. Limited budgets put a strain on delivery of health care services including health personnel. Highly skilled professionals leave or emigrate for better conditions of services. Increased workloads and dissatisfaction result in burnout and job strain (Aiken, Clarke, Sloane, Sochalski, Buse, Clarke, Giovannetti, Hunt, Rafferty & Sharman 2001:53).

In Malawi, Chirwa (2002:10) found staff shortages and long working hours with poor conditions of service were among the problems managers had to deal with in assuring quality care. Aiken et al (2001:43) found staff shortages led to increased complaints and verbal abuse of nurses by patients and their families together with stress and burnout among the nurses. The need to retain skilled and qualified nurses in the competitive labour market requires employers to realise the importance of personnel policies and benefits (Aiken et al 2001:45).

In the Free State, due to the shortage of staff, nurses were no longer being shifted from hospitals to community clinics. At the same time, nursing staff bear the brunt of clinical health care services because of the shortage of doctors and this sometimes results in poor nursing care (Elgoni 2001:1).

2.6.4 Finance

Proper financial management of health care services is important. Staff benefits, equipment and provision of amenities are an effort to retain nursing staff for adequate patient care provision. Quality may be sacrificed in an attempt to reduce health care costs thus creating tension between quality and cost effectiveness (Aiken et al 2001: 45).

2.6.5 Time

Time spent on patient care is vital in building a therapeutic relationship between nurse and patient. In a study on patients' and relatives' experience of quality of care, Attree (2000:460) found that the respondents emphasised that patients should be treated as people. Health care workers should make them feel human by showing an interest in them.

2.6.6 Training and education

Inadequate training of health care professionals has a detrimental effect on patient care. If nurses are unqualified, they cannot provide adequate care that is up to standard (Carlson & Ansari 2000:166).

2.6.7 Rapid changes

The current and ever-changing health care service delivery system, which is characterised by downsizing, reorganisation and other health reforms including changes in the caring methods, lowers the quality of nursing care (Shongwe 2000:36). These changes, though good, affect the level of patient care because of the adaptation of health providers from one system to another.

2.6.8 Cultural factors and attitude

Cultural beliefs about attitudes towards health affect the delivery of health care services. Culture guides people how to view the world and how to behave in it in relation to other people, supernatural forces and the natural environment (McKenzie, Pinger & Koteckie 2005:586). For health care services to be effective, health professionals should be multicultural and understand the cultures of the community they are dealing with in order to guide and encourage them to change their attitude and cultural practices.

2.7 CONCLUSION

This chapter discussed the literature review undertaken for the study on patient satisfaction and participation, PHC, and factors that impact on health care services. The *Batho Pele Principles* and the Patients' Rights Charter were also discussed as the overall guidelines and framework within which health services should be delivered to ensure patients' satisfaction.

Chapter 3 describes the research design and methodology.

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CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter describes the research design and methodology, target population, sample and sampling and data collection process.

3.2 OBJECTIVES OF THE STUDY

The objectives of the study were to

- identify and describe patients' satisfaction with health care services
- recommend guidelines for healthcare professionals to improve health care delivery

3.3 RESEARCH DESIGN

A research design is a plan that describes when and where the data will be collected and analysed. It is the strategy to be followed when a research is conducted and researchers should therefore know what they intend to find out and also determine the best way to do it. In this study, the researcher selected a quantitative and descriptive design (Brink & Wood 1998:5).

3.3.1 Quantitative

Quantitative research is conducted within the context of previous knowledge. A literature review is conducted before data collection, as quantitative researchers strive to understand what is already known about the topic (Polit & Beck 2004:55). Quantitative research relies primarily on the collection of quantitative (numerical) data (Polit & Beck 2004:36). A quantitative approach uses structural procedures and formal instruments, such as a questionnaire, to collect data. Quantitative research also provides data that is easy to analyse as it is focused (Brink & Wood 1998:15). The

researcher used a structured questionnaire to collect data that could be transposed into numbers, tables, and graphs and statistically analysed.

3.3.2 Descriptive

Descriptive studies are undertaken to describe what exists in terms of frequency of occurrence. Descriptive research provides new information and uses interviews or questionnaires for data collection (Brink & Wood 1998:289).

Descriptive research has as its main objective the accurate portrayal of the characteristics of persons, situations, groups or the frequency with which the phenomenon occurs. For non-experimental studies, it is used to describe and document aspects of a situation (Polit & Hungler 1999:451).

Descriptive statistical techniques reduce data to manageable proportions by summarising them and also describe various characteristics of the data under study (LoBiondo-Wood & Haber 2006:358). In this study the descriptive study was used to describe patients' satisfaction with health care services provided and to recommend guidelines for health professionals to improve health care services. The *Batho Pele Principles* were used to measure patients' satisfaction.

3.4 TARGET POPULATION

The population includes all the individuals that meet the sampling criteria for inclusion in the target population (Burns & Grove 1999:278). Region E has nine fixed clinics and no mobile clinics. The number of patients who visit the clinics in region E per month is about 18 000. The population under study for this research consisted of 0.74%; (n=134) patients obtained from six out of nine clinics namely 4th Avenue, Sandown, Petervale, Eastbank and Mayibuye and Thoko Mngoma. Fourth Avenue, Eastbank and Thoko Mngoma clinics are situated in Alexandra Township; Sandown clinic is in Sandton, Petervale clinic is in Bryanston and Mayibuye clinic is situated in Midrand.

The criteria of the population in this study were male and female patients of all races aged 18 years and older who visited the clinics for health care services. One of the crucial points when deciding on the population would be to stipulate the limitations

pertaining to the population that will be selected (Burns & Grove 2003:83). Children, the frail, aged, and mentally handicapped persons were excluded from the study.

3.5 SAMPLE AND SAMPLING

A sample is a segment of the population with the same characteristics as the population on whom the study is conducted (Burns & Grove 2003:363). It was not possible to conduct a study on the whole population as the sample would be too large to control.

Sampling distinguishes who in a target population qualifies to be part of the research participants (Burns & Grove 2003:47; Polit & Beck 2004:56).

The researcher used probability random sampling to select the sample. Probability sampling reduces bias, and ensures a more representative sample, and the probability of each person in the population is known. All elements of the population have an equal opportunity of being selected to participate in the study (Polit & Hungler 1999:285). Polit and Beck (2004:508) define random sampling as the selection of a sample such that each member of a population had an equal probability of being included.

Accordingly, a sample was drawn from the population who met the criteria of interest for the study. A sample of 0.74 % (n=134) patients of all racial groups were selected by choosing every fifth adult patient from the admission register October 2007 (see 3.4 Target population).

In the study the assumption was that all adult male and female patients of all races 18 years and older who visited the clinics for health care services had equal chances of being included in the study.

3.6 DATA COLLECTION PROCESS

Burns and Grove (1999:423) describe data collection as a process of gathering data from subjects. The actual methods of collecting data are specific to each study and depend on the study design. Data may be collected by means of observation, questionnaires and interviews. The researcher may either collect data or supervise the collection of data (Burns & Grove 2003:423). In this study, the researcher collected data between 08:30 and 13:00 using a self-administered questionnaire.

3.6.1 Research instrument

The research instrument is a method used to observe or measure the research variables as accurately as possible (Polit & Beck 2004:50). The researcher developed a questionnaire for the respondents to express their satisfaction with the health care services provided at the clinics, using a five-point Likert scale (Burns & Grove 2003:289) (see Annexure F). The questionnaire had two sections. Section A consisted of demographical questions, including gender, age, place where patients live, level of education, employment status, and the frequency of clinic visits. Section B consisted of questions evaluating the Patients' satisfaction with health care services provided at the clinics. The Batho Pele Principles and questions relating to them were applied.

A covering letter accompanied the questionnaire, informing the respondents of the importance of expressing their true feelings in answering the questions, and ensuring their confidentiality.

3.6.2 Advantages of questionnaires

Polit and Hungler (1999:342) list the following advantages of questionnaires:

- They are cheaper to use, considering geographical area. They can be presented in a consistent manner, and therefore have fewer opportunities for bias than interviews.
- Anonymity is assured, as respondents do not have to identify themselves.
- They are self-administered therefore do not need the researcher's involvement.
- Questions provide a guide for people who cannot express themselves verbally as they would have to do in an interview.

In this study, the researcher made use of a questionnaire and collected data for a period of two weeks. This was a cost-effective method because the clinics were not far and the researcher administered the questionnaires herself. The advantage was that all the questionnaires were returned because the respondents were not allowed to take the questionnaires home.

3.6.3 Disadvantages of questionnaires

According to Polit and Hungler (1999:350), questionnaires have the following disadvantages:

- The response rate for the return of questionnaires is lower than interviews because the respondents can ignore the deadline with the intention of completing them in their own time. In this study the response rate was high as all the questionnaires were returned.
- The sample is not controlled as anyone can answer the questionnaire. The sample was under control as respondents completed the questions in the presence of the researcher
- Questions cannot be explained if respondents do not understand them, which could lead to erroneous conclusions and to some questions being left unanswered.

In this study questions were explained to the respondents who did not understand because the researcher was available while the respondents completed the questionnaires.

3.6.4 Distribution of the research instrument

Data in this study was collected by means of a survey, using a questionnaire. A survey is a system that obtains information from the population using self-report; that is, the people in the sample respond to a series of questions posed by the researcher (Polit & Hungler 1999:186).

The operational managers of the clinic were informed of the data collection in advance. At the clinics the researcher showed the letter of permission to conduct the study to the operational manager. A questionnaire was given to the operational manager to read and was also explained, when necessary.

The researcher introduced herself and explained the nature and purpose of the study to all the patients in the waiting area and that participation was voluntary. She also read

the covering letter to the patients to make sure that they all understood of the purpose of the study and their rights.

The researcher distributed the questionnaires to all the respondents, who completed them and returned them to the researcher. In the case of respondents who needed assistance to complete the questionnaire, the researcher assisted the respondents to complete the questions. The fact that the researcher distributed the questionnaire herself had a positive impact on the response rate. One hundred and thirty-four (134) questionnaires were distributed, completed and returned, giving a 100% response rate.

3.7 VALIDITY AND RELIABILITY

A data-collection instrument must comply with the requirements of validity and reliability.

3.7.1 Validity

Validity of the tool refers to the degree to which the instrument measures what it is supposed to measure (Polit & Hungler 1999:308). The questionnaire in the study was intended to measure patient satisfaction with health care services provided at the clinics. In this study, content validity was used.

3.7.1.1 Content validity

Content validity is concerned with ensuring that the instrument covers all the features of the particular concepts of the study (Parahoo 1997:304). Content validity refers to the degree to which the items in an instrument adequately represent the universe of content of the concept being measured (Polit & Beck 2004:497).

The questionnaire was based on the *Batho Pele Principles* and contained the variables related to the objective of the study, which was to determine patients' satisfaction with health care services provided at the clinics. A pre test was done on 20 patients and it was found that some of the questions had to be rephrased so that they would be simple to understand and be able to measure what it was supposed to measure namely "patients' satisfaction with health care services provided at the clinics."

3.7.2 Reliability

Reliability is the consistency, stability and homogeneity demonstrated by a research instrument when it is used to measure a variable or attribute that it was designed to measure (Brink & Wood 1998:47; LoBiondo-Wood & Haber 2006:319). The common measure of internal consistency of a questionnaire is Cronbach's alpha coefficient. It is based on inter item/question reliability, and considers the reliability over all items/questions. The Cronbach alpha was determined as follows:

$$\alpha = \left(\frac{n}{n-1} \right) \cdot \frac{SD^2 - \sum SD_i^2}{SD^2}$$

Where SD_i^2 is the variance of the i^{th} item or question, over all respondents, SD^2 is the variance of the total of the items/questions, and n is the number of items or questions (Anastasi & Urbina 1997:14).

The range of the alpha coefficient is from 0 to 1. As a rule of thumb, the alpha of a scale equal to 0.70 or greater is acceptable for items to be reliable. The Cronbach alpha in each section of the questionnaire was above 0.70 (see table 3.1). This indicated that all the questions were reliable and assessed the desired concept (Polit & Beck 2004:420).

Table 3.1 Reliability analysis of the questionnaire

Section of questionnaire	Number of questions	Cronbach alpha (Reliability coefficient)
Openness and transparency	6	0.743
Ensuring courtesy	8	0.878
Redressing the wrongs	2	0.787
Value for money/ Standard setting	4	0.806

3.8 ETHICAL CONSIDERATIONS

Ethics have to do with what is morally right and wrong and pertain to people being treated like humans (Polit & Hungler 1999:73) (see Annexure B). In this study, the

following ethical considerations were upheld: permission to conduct the study, voluntary participation, and respect for the person, safety of respondents, and Polit&Hungler 1999:75).

- **Permission to conduct the study**

The researcher requested and obtained permission to conduct the study from the Regional Manager of region E (see Annexure A). Permission to conduct the study was also granted by the Research and Ethics Committee, Department of Health Studies at Unisa (see Annexure C).

Permission to conduct a study was also asked from the operations managers of the clinics where study would be conducted. The researcher showed the Regional Manager's letter granting permission for the study. The researcher was introduced to the clinic staff and informed them that the study would not interfere with the daily routine of the clinic.

- **Principle of beneficence**

Principle of no harm is a fundamental principle. It refers to the safety of the respondents. The researcher should during the study strive to minimise harm to the respondents.

This principle protects the respondents from psychological and physical harm during the research process. The respondents were informed of the nature and purpose of the study and that participation was voluntary. The researcher also assured the respondents of the strictest confidentiality (Polit & Hungler 1999:75). Confidentiality promises respondents that any information they provide will not be publicly reported or made accessible to parties not involved in the research (Polit & Beck 2004:95). In this study, the respondents were not asked to put their names on the questionnaires and their responses could not be linked to their identities.

- **Principle of respect/autonomy**

Autonomy refers to the principle of self-determination and respect for human dignity. Respondents had the right for full disclosure. Respondents were considered as individuals not just as members of the group. Respondents were **not asked** to decide for themselves whether to participate in a study, therefore they had adequate information about the research to enable them to consent or decline participation (Polit & Hungler 1999:134; Polit & Beck 2004:93). Furthermore, the researcher informed the respondents of the purpose of the study and allowed them to ask questions related to the purpose of the study. The respondents were also informed that participation was voluntary, they would be protected, and they could leave the study at any time without any penalty should they wish to do so. The questionnaire did not have a consent form. The respondents were requested to volunteer to participate in the study by giving an informed consent. By completing the questionnaire, the respondents consent to take part in the research.

- **Principle of justice**

The principle of justice refers to fair and equal treatment of the participants. The participants' needs should be prioritised (Parahoo 1997:112). In the study, the respondents were treated equally without discrimination. All the respondents were made to feel comfortable and were free to ask questions to clarify issues that were not clear.

3.9 DATA ANALYSIS

Data analysis means breaking down data into small manageable patterns. The aim was to understand the relationship of the information given by the respondents (Polit & Hungler 1999:334). Statistics was drawn and analysed with the assistance of a statistician using the Statistical Package for Social Sciences (SPSS) V10 programme.

3.10 CONCLUSION

This chapter covered data collection, development of data collection instrument, validity and reliability and ethical consideration. Chapter 4 discusses the data analysis and interpretation.

CHAPTER 4

Data analysis and interpretation

4.1 INTRODUCTION

This chapter discusses the data analysis and interpretation. The satisfaction variables were analysed according to a three-point Likert scale (*satisfied, not sure* and *dissatisfied*) summarised from the five-point Likert scale (*strongly satisfied, satisfied, not sure, dissatisfied* and *strongly dissatisfied*) of the questionnaire. The numbers of respondents differed from item to item because not all the respondents answered each item of the questionnaire.

The main objective of the study was to identify and describe patients' satisfaction with health care services provided by clinics in the city of Johannesburg. The descriptive information about patients' satisfaction was discussed; there was no need to perform tests of statistical significance.

The data was analysed, using the Statistical Package for the Social Sciences (SPSS) version 10. The findings were presented in tables, pie charts, bar diagrams and percentages.

Section A of the questionnaire covered demographic data; and section B dealt with the evaluation of health care services provided at the clinics. The data analysis was discussed according to the questionnaire.

4.2 SECTION A: DEMOGRAPHIC DATA

The respondents' demographic data included gender, age, where they resided (lived), education level, employment status and frequency of clinic visits (see figures 4.1 to 4.6).

4.2.1 Item 1.1: Respondents' gender

Figure 4.1 indicated that of the respondents, 78% (n=105) were females and 22% (n=29) were males.

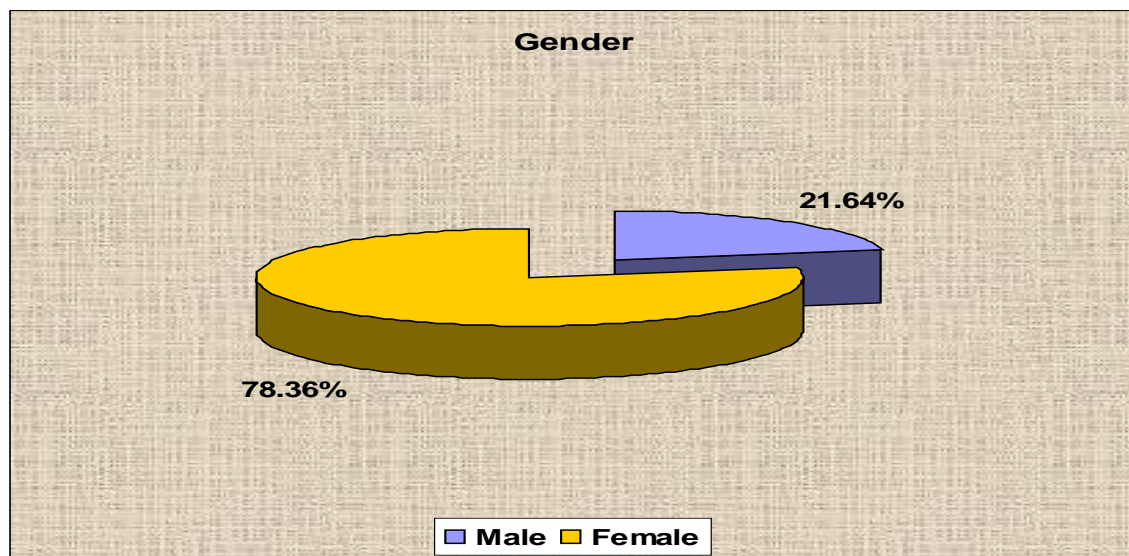


Figure 4.1 Respondents' gender (n=134)

More females attend health care facilities than males because the PHC core package is a supermarket approach, which means that all health care services should be provided on a daily basis. Therefore, besides the health conditions common to males and females, the services cater to specific female health aspects, such as pregnancy, mother and child health, and other female-related conditions. The *Batho Pele Principles* emphasizes that patients' health problems should be put first and that patients should not return from the health facilities unattended by health professionals due to facility-related problems.

The Johannesburg Growth and Development Strategy and Independent Development Plan (GDS and IDP) (2006:114) emphasises the implementation of the women's health programme at all fixed facilities. The programme ensures provision of family planning, comprehensive antenatal and postnatal care including immunization of babies, termination of pregnancy (TOP) services and strengthening of breast and cervical cancer screening for women. These are important women's health priority programmes that women need to attend, therefore health facilities should be accessible at all times.

4.2.2 Item 1.2: Respondents' age distribution

Figure 4.2 indicates the respondents' ages.

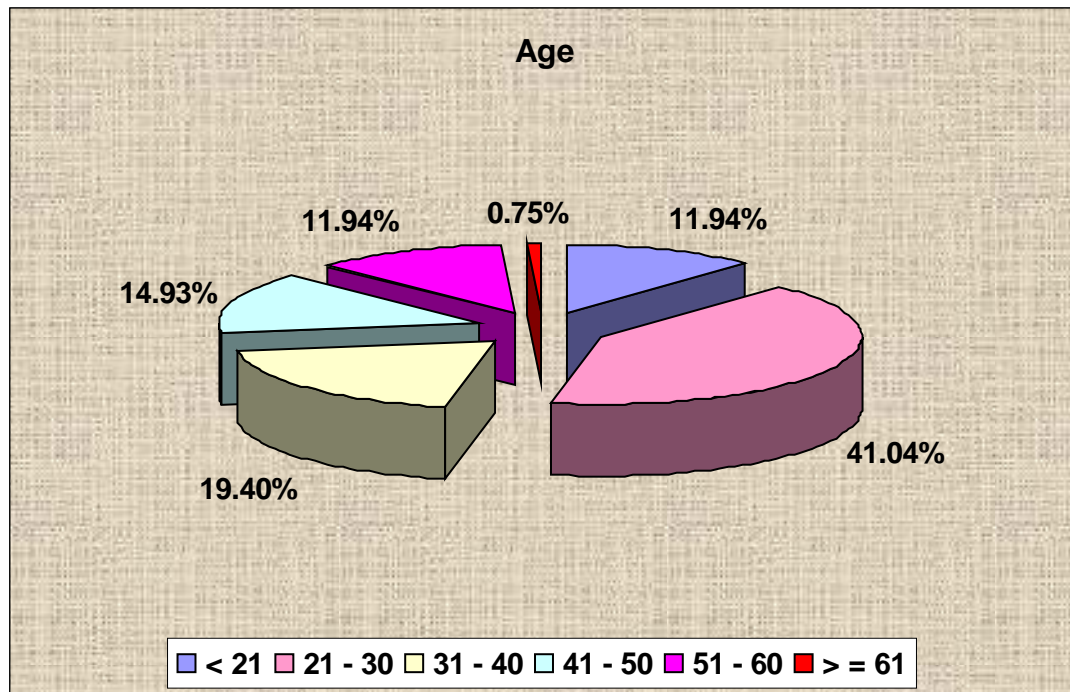


Figure 4.2 Respondents' age distribution (n=134)

According to the groups of respondents, 12% (n=16) were younger than 21 years, 41% (n=55) were between 21 and 30 years old, 19% (n=26) were 41 and 50 years old, 12% (n=16) were between 51 and 60 years old, and only 0.75% (n=1) was older than 61 years. Most of the respondents 60% (n=81) were between 21 and 40 years old. Most people in the age group of 21 to 40 years were falling in the working group.

4.2.3 Item 1.3: Respondents' living area distribution

Figure 4.3 indicated where the respondents lived (resided).

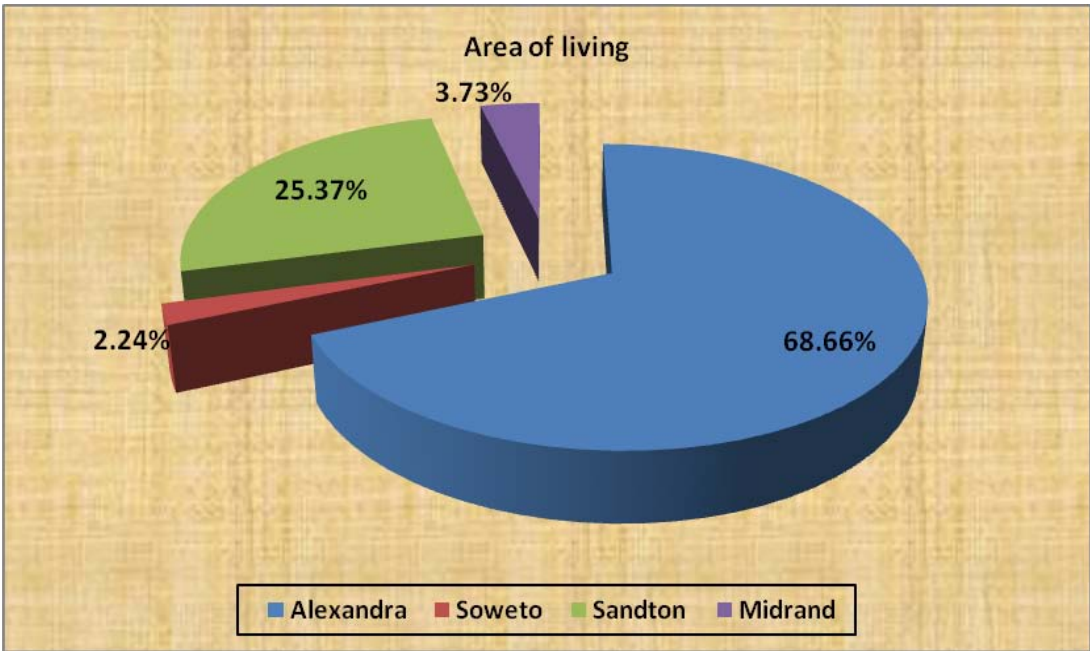


Figure 4.3 Respondents' living area (n=134)

Of the respondents, 94% (n=126) lived in Alexandra or Sandton. The majority of the respondents resided in the catchments area of the clinics surveyed. Figure 4.3 further indicates that the majority of the respondents live in Alexandra. The clinics in Alexandra are overcrowded with patients on daily basis. This overcrowding of patients coupled with shortage of staff, lower the standard of health care services provided at these clinics. Some patients return home unattended.

4.2.4 Item 1.4: Respondents' level of education

Figure 4.4 indicates the respondents' level of education.

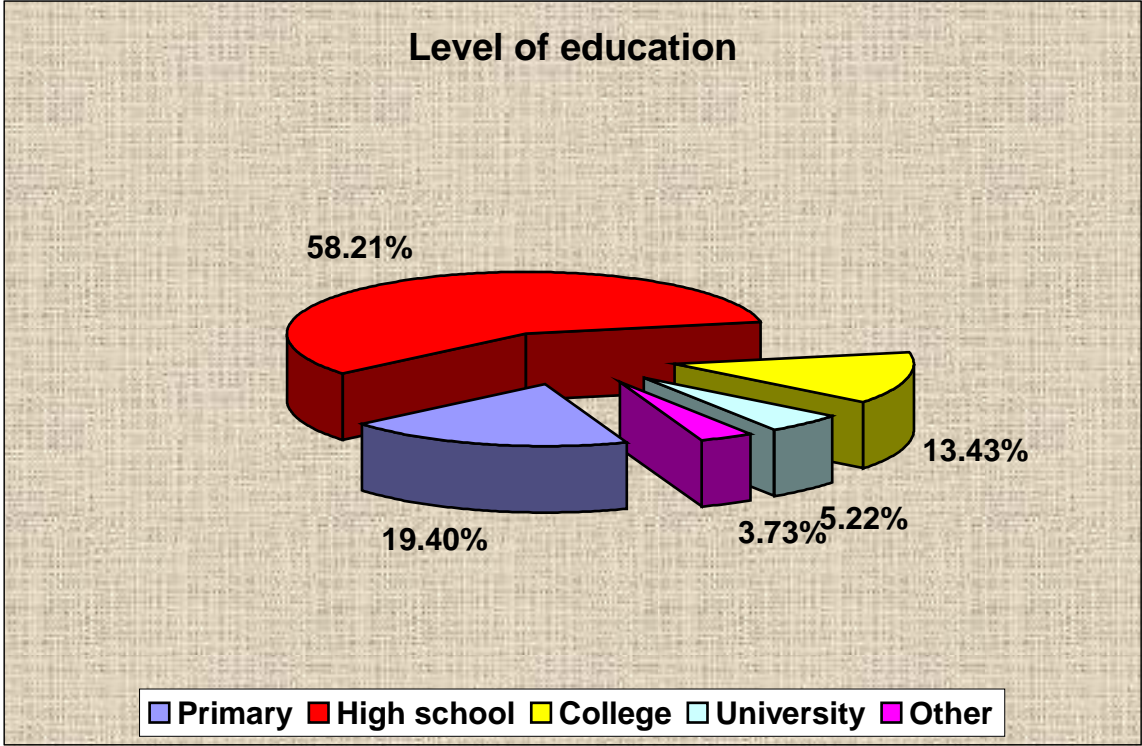


Figure 4.4 Respondents' level of education (n=134)

Figure 4.4 indicates that, of the respondents, 19% (n=26) had a primary school education; 58% (n=78) had a high school certificate, 14% (n=18) had a college diploma or certificate, 5% (n=7) had a university qualification, and 4% (n=5) had other qualifications. The majority of the respondents, (78%; n=104), then, had a basic education. Patients' educational background assists them to best understand what is expected of the health care provided in facilities and point out issues that need improvement. This, in turn, urges health care professionals to pay attention to, and deal positively with the complaints raised by patients so as to improve the quality of health care services. In this study, the respondents' educational background also assisted them to understand the purpose of the research.

4.2.5 Item 1.5: Respondents' employment status

Figure 4.5 depicts the respondents' employment status.

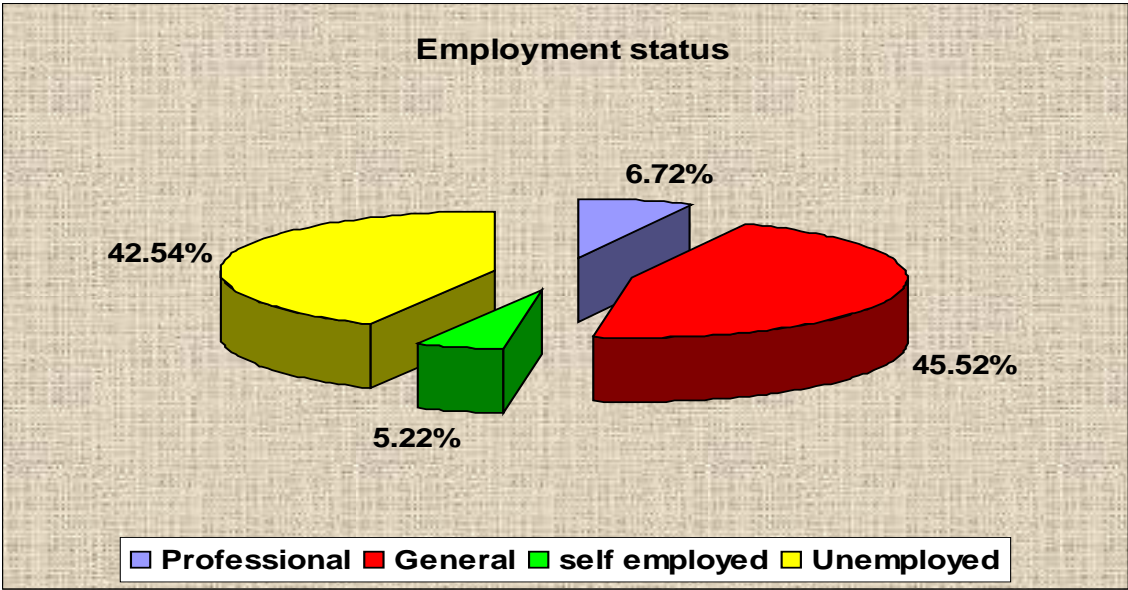


Figure 4.5 Respondents' employment status (n=134)

Of the respondents, 88% (n=118) were either generally employed or unemployed: 46% (n=61) were general workers and 43% (n=57) were unemployed. In addition, 5% (n=7) were self-employed, and 7% (n=9) were professionals. The general workers and unemployed were in the majority. Region E serves the community of Alexandra, Sandton, Petervale and Wendywood communities. Alexandra is a highly populated area affected by migrant people and informal settlements where most of the people are unemployed. The majority of the people have no medical aid schemes and therefore use the municipal clinics for health care services. Sandton City, Petervale and Wendywood are industrialised areas where most of the people attending the municipal clinics are labourers. Other people working in the area were general workers who came from different parts of Johannesburg to work.

4.2.6 Item 1.6: Respondents' frequency of clinic visits

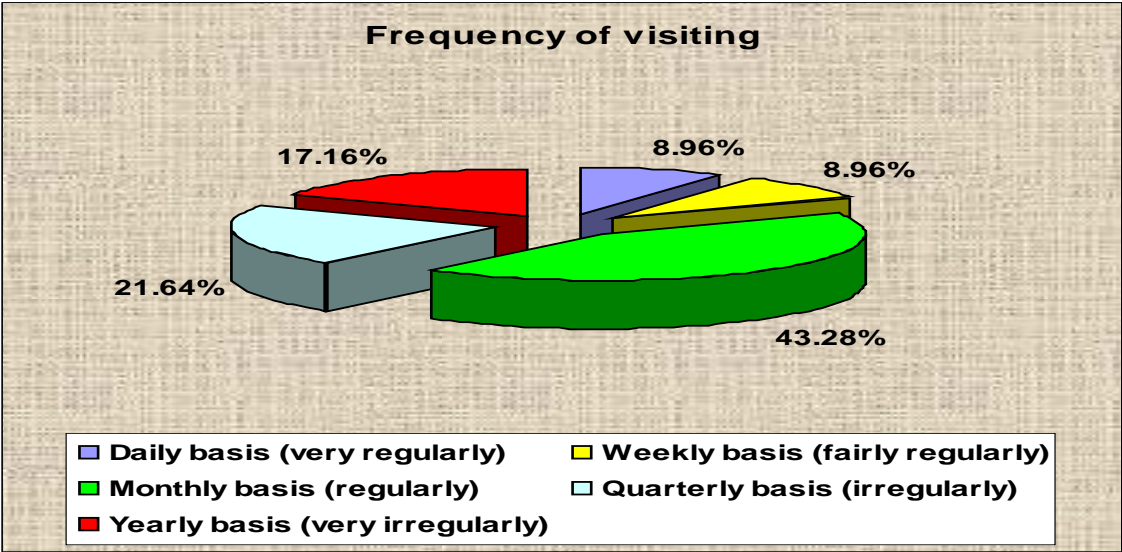


Figure 4.6 Respondents' frequency of clinic visits (n=134)

Figure 4.6 depicts that 43% (n=58) of the people who visited the clinic on monthly basis, were chronically ill patients. Nearly a fifth of the patients visited the clinic on a quarterly (22%; n=29) and yearly basis (17%; n=23), while nearly 10% of the patients made weekly and daily (9%; n=12) visits to the clinic. Patients who visit the clinics on daily basis would be TB patients on medication such as streptomycin injection, and the weekly, quarterly and yearly would be acutely ill patients.

4.3 SECTION B: IDENTIFICATION OF PATIENTS' SATISFACTION WITH HEALTH CARE SERVICES PROVIDED AT THE CLINICS

Frequency distributions of the respondents' satisfaction variables with the clinics and the services provided.

Tables 4.1 to 4.4 deal with the respondents' satisfaction with the clinics and the services provided. The total respondents were 134. It is, however, noted that the number of items in tables differs in counts, as some respondents did not respond to all the items. The counts vary between 115 and 134.

4.3.1 Item 2.1: Accessibility

4.3.1.1 Clinic within the area where you live

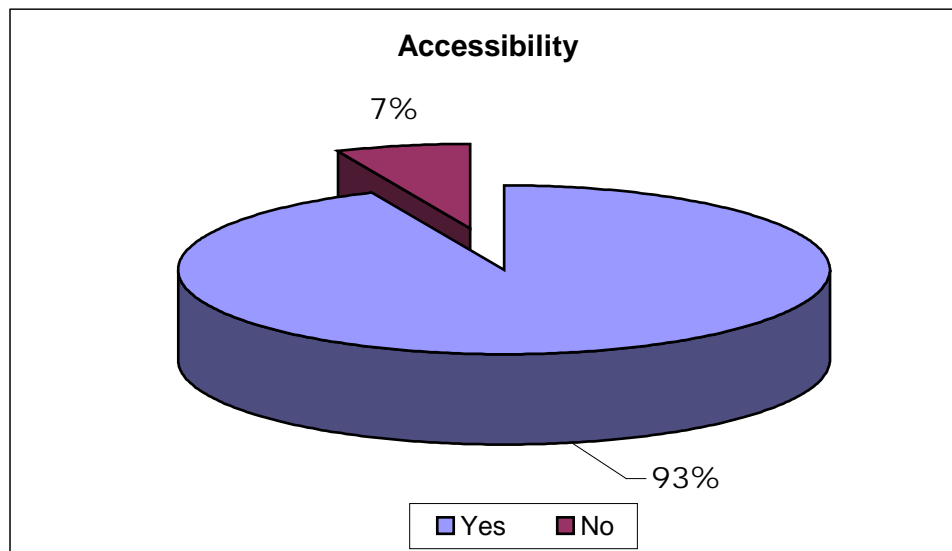


Figure 4.7 Satisfaction with accessibility (n=134)

Ninety-three percent (n=125) respondents lived near the clinics whilst 7% (n=9) did not live near the clinic. The majority of the respondents lived near the clinic and could access the health facilities.

Törnkvist et al (1999:67) revealed that home care patients were mostly dissatisfied with the possibility of reaching the district nurses on the telephone. Accessibility of health care services should be available at all times when needed.

Findings from a study done by Attree (2000:460) stated that patients and relatives commented that health care practitioners were available and approachable. The findings comply with attitude that is required in patients satisfaction with health care services provided in all the health care facilities.

4.3.1.2 Signages to show direction

Signages referred to the display of information clearly and where members of the public could see.

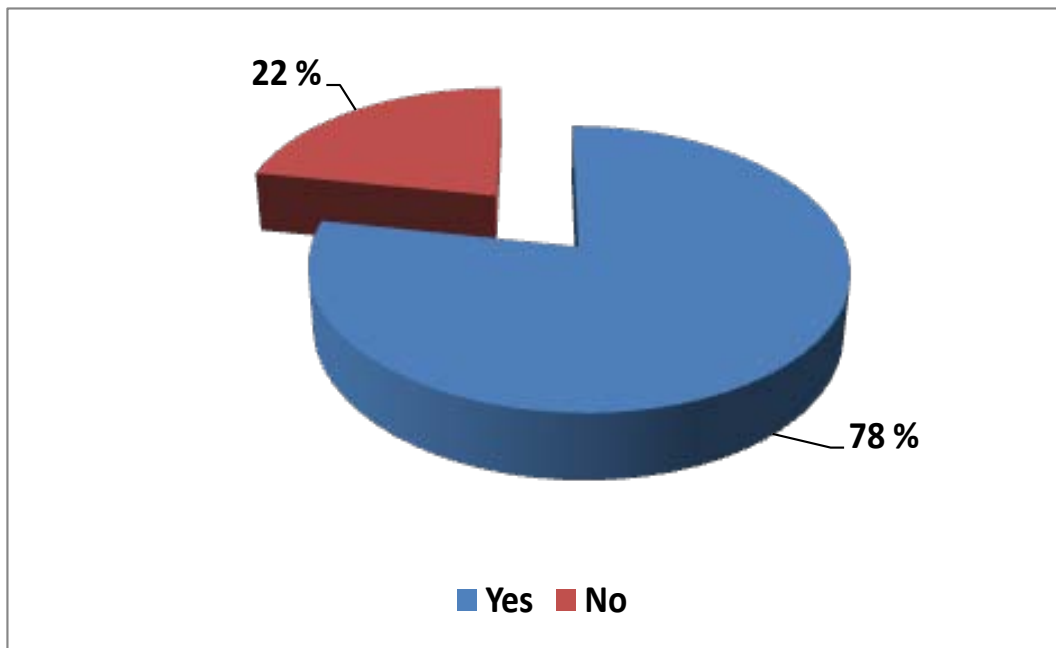


Figure 4.8 Satisfaction with signages (n=134)

The signage's information indicated the directions of the clinics and the operational hours and health care services provided. Of the respondents, 78% (n=104) were aware of the signage's that were clearly displayed whilst 22% (n=30) did not see the signages. Signages to show direction is part of accessibility whereby patients should not struggle to find the health care service centre. According to the findings most of the respondents were aware of the signages.

4.3.1.3 Operating hours/days of the clinic

Figure 4.9 deals with the respondents' satisfaction with the operating hours of the clinics/days convenience.

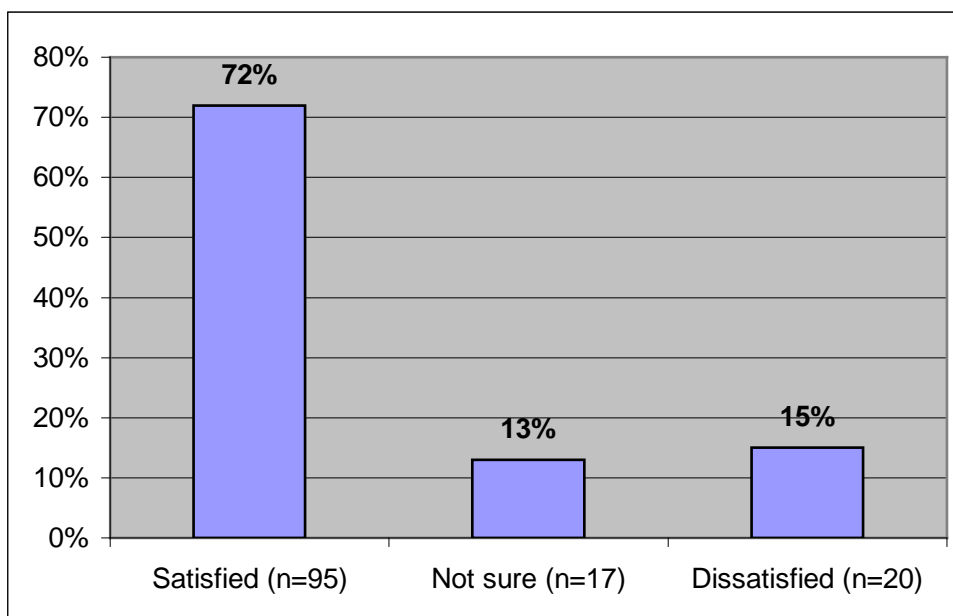


Figure 4.9 Operating hours of the clinics (n=132)

Operating hour's convenience was based on the principle of increasing access. The operating hours of the clinics in this study are 8 hours per day from 07:30 to 16:00. Of the respondents, 72% (n=95) were satisfied with the operating hours, 16% (n=20) were dissatisfied, and 13% (n=17) were not sure. According to the findings from the report, most patients were satisfied with accessibility of the health care services provided at the clinics. It is not known why 13% were not sure and 15% were dissatisfied. It could be that some of those who were not satisfied were employed and found it difficult to take time off from work for clinic visits.

Complementary comments about time were also mentioned in the study by Attree (2000:461) that health care practitioners should make time available for patients. It is reckoned that health care providers should not be too busy to attend to a patient.

4.3.2 Item 2.2: Information/openness and transparency

Table 4.1 Information/openness and transparency (n=115-133)

Information	Satisfied		Not sure		Dissatisfied		Total	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Information about the health care services provided at this clinic is displayed	96	73%	17	13%	19	14%	132	100%
Information about complaint procedure is displayed	71	53%	26	20%	36	27%	133	100%
Information about the Patients rights charter is displayed	92	71%	15	11%	23	18%	130	100%
The clinic communicates regularly Information on health and life style	71	54%	34	26%	27	20%	132	100%
The clinic empowers me through effective communication on health situation	95	83%	18	15%	2	2%	115	100%
The clinic provides sufficient health education to me as a patient.	100	77%	16	12%	14	11%	130	100%

Information/openness and transparency refer to the information that is given to patients by health care professionals at the clinics.

The respondents appeared satisfied with openness and transparency as they responded positively to most of the questions under this section, from health services information about the clinics are provided 73% (n=96), to the clinic provides sufficient health education to patients 77% (n=100). Of the respondents, just more than a half

(53%; n=71) were satisfied with the display of the information on the complaint procedure and 54% (n=71) with regular communication between the clinics and the patients. The shortfall was on the complaint procedure, patients seemed not satisfied about the display of information with regards to the complaint procedure, as only 53% (n=71) were satisfied.

Törnkvist et al (1999:74) in their study found that patients were satisfied with the information given by health professionals. The same study further emphasised that, information in health care services was important and regarded as vital to enhance the patient's self-control and as important, in the preparation for participation in individual health care. Richards et al (1987) as cited in Törnkvist et al (1999:74) stated that "nurses must change their attitude and learn to share the decision making in real meaningful way".

4.3.3 Item 2.3: Ensuring courtesy

Table 4.2 Ensuring courtesy (n=128-134)

Ensuring courtesy	Satisfied		Not sure		Dissatisfied		Total	
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage
Helpdesk staff welcome and greeted me in a friendly manner	96	72%	7	5%	30	23%	133	100%
Nursing staff welcome and greeted me in a friendly manner	99	77%	12	10%	17	13%	128	100%
Personal interest shown on me and my medical problems	102	77%	15	11%	16	12%	133	100%
Medical procedures and tests explained to me	98	73%	14	11%	22	16%	134	100%
Staff has adequate medical knowledge to answer my question	98	74%	14	11%	20	15%	132	100%

Ensuring courtesy	Satisfied		Not sure		Dissatisfied		Total	
Examination treatment and care provided by staff at this clinic	93	69%	20	15%	21	16%	134	100%
Staff always gives me individual attention	106	79%	14	11%	14	10%	134	100%
Staffs usually respond positively to my request.	86	65%	25	19%	22	16%	133	100%

In this study courtesy refers to the friendly manner in which help desk and nursing staff welcome patients. It includes staff giving individual attention to patients, explaining the procedures to be done on patients, and being able to answer politely questions asked by patients. The respondents indicated overall satisfaction with the courtesy in the clinics. For example, of the respondents, 77% (n=99) rated the nursing staff welcome; 72% (n=96) rated the help desk staff welcome and 79% (n=106) were satisfied with individual attention from staff.

4.3.3.1 Identification of staff



51 %

49 %

Yes No

Figure 4.10 Staff wearing name tags (n=69)

There was dissatisfaction of patients with staff wearing name tags as only 49% (n=69) did agree that staff wear name tags. Identification of health care providers comply with the Patients' Rights Charter that indicates that patients have the right to be treated by health care providers that have identified themselves (Department of Health 2001:33). It is important that patients know the names of the health care providers attending to them.

4.3.4 Item 2.4: Redressing the wrongs

The health care professionals to handle patients' complaints with a positive attitude.

Table 4.3 Redressing the wrongs (n=131-132)

Redressing the wrongs	Satisfied		Not sure		Dissatisfied		Total	
Staff showing positive attitude towards my complaint	66	50%	35	27%	30	23%	131	100%
Staff has apologised to me towards my complaint	59	45%	49	37%	24	18%	132	100%

Redressing the wrongs refer to the capacity of the health care professionals to deal with problems when promised level of standards fall below the set standards.

Concerning redressing the wrong, the respondents were not satisfied although there was no evidence that they had complained. Of the respondents, only 50% (n=66) received a positive attitude to their complaints and 45% (n=59) received an apology to their complaints from staff.

Quality of health care services and patients' satisfaction are based on patients' perception of health care services that the patients have received (Department of Public Service and Administration 1997:13). According to the respondents, it seems that "Redressing the wrongs" was not satisfactorily managed, as the percentage of respondents who were satisfied was low compared to other variables.

4.3.5 Item 2.5: Value for money

Table 4.4 Value for money (n=134)

Value for money	Satisfied		Not sure		Dissatisfied		Total	
Professional behaviour of the staff	85	64%	26	20%	21	16%	132	100%
Your expectation being met from the health care services that you have received from the clinic	83	62%	25	19%	25	19%	133	100%
The overall patient care that you have received during today's visit at this clinic overall patient care	96	73%	17	13%	19	14%	132	100%
Recommendation of health care services to my relatives and friends	87	65%	21	16%	25	19%	133	100%

Value for money refers to the effectiveness and the efficiency of the health care services provided to patients.

Regarding value for money, 64% (n=85) of the respondents, were satisfied with the professional behaviour of the staff and 73% (n=96) were satisfied with the overall patient care received at the clinic, 65% (n=87) would recommend the health services to their relatives and friends.

4.3.6 Item 2.6: Consultation

An open-ended questionnaire was asked on this section. This question asks; "How could the health care services at the clinics be improved?"

A total of 128 out of 134 patients responded to this question. Twenty respondents (16%). Indicated that they had no suggestions for improvements while 39% (n=50) suggested that staff should be increased. More than a quarter (29% n=37) suggested that staff should change their attitude. Some respondents (16% n=21) suggested that the clinics be opened on Saturdays to increase the clinics operating hours and that they could be able to visit the clinics when they are off duty.

The question indicated that shortage of staff was the main problem followed by the suggestion that the clinics should be opened on Saturdays. Patients had expressed that

nurses should change their attitudes, lunch and tea breaks of the staff were too long as such they had to wait too long before they were being attended to.

4.4 CONCLUDING REMARKS

It was seen that patients were satisfied in most of the aspects of the health care services as the percentages scores of satisfaction were between 53% and 83%.

From tables 4.1 to 4.6, it is evident that the respondents were satisfied with the quality of health care provided. Of the respondents, 72% (n=95) with the convenience of the operating hours of the clinics. Operating hours of the clinics were convenient for the patients as they were able to visit the clinics during their working hours. Operating hours of the clinic were also suitable for the unemployed patients. It was also noticed that patients were satisfied with the individual attention they received from staff as the score was 79% (n=106). Satisfaction with the welcome of the helpdesk staff was 72% (n=96) while 73% (n=96) indicated that the health services information about the clinic was displayed, and 73% (n=100) indicated that health education was provided to them. Of the respondents, 64% (n=85) were satisfied with the professional behaviour of the staff and 65 (n=87) were willing to recommend the health services to their relatives and friends.

However, some of the respondents appeared to be dissatisfied. Of the respondents, just over a half 53% (n=71) were satisfied with the display of the information on the complaint procedure and with regular communication between the clinic and the patient. Concerning the section of redressing the wrongs, only 50% (n=66) of the respondents received a positive attitude to their complains and 45% (n=59) received an apology to their complaints from staff.

Figure 4.8 indicates that patients were well directed to the clinics where, 104 (78%) answered positive to the question that signage's to show direction were clear. Patients were less satisfied (49% n=65) with staff wearing their name tags; hence patients' did not identify the names of the staff who attended to them.

4.5 CROSS-TABULATION OF SATISFACTION VARIABLES WITH DEMOGRAPHIC PROFILES

This section, describes the relationship between demographic aspects and respondents' satisfaction. That is, the cross tabulation of gender, age group, area of living, level of education, employment status and frequency of visit including all the satisfaction questions will be discussed. **According to the researcher, Courtesy is the most satisfying aspect of patient satisfaction in the health care services as such, the cross tabulation will be discussed in relation to the following variables.**

- staff always gives me individual attention
- personal interest shown on me and my medical problems
- adequate medical knowledge of staff to answer my questions

Tables 4.5 to 4.22 below provide these relationships.

4.5.1 Gender and satisfaction

Table 4.5 Gender and satisfaction with individual attention received from staff

Gender		Satisfied		Not sure		Dissatisfied		Total	
Male	Count	25	86%	1	3.0%	3	11%	29	100%
Female	Count	81	77%	13	12%	11	11%	105	100%

Table 4.5 shows that patients were cared for individually and were satisfied with the attention they received from staff. Approximately 86% (n=25) of males and 77% (n=81) of the female's respondents were satisfied with individual attention they received from staff.

Weisman, Rich, Rogers, Crawford, Grayson and Henderson (2000:657) stated that men's overall satisfaction is more dependent on personal interest shown in them by health care providers whereas women were dependent on informational content, continuity of care and multidisciplinary aspects of care.

Table 4.6 Gender and satisfaction with attention to my medical problems

Gender		Satisfied		Not sure		Dissatisfied		Total	
Male	Count	21	72%	4	14%	4	14%	29	100%
Female	Count	81	78%	11	8%	12	90%	104	100%

Table 4.6 indicates that males 72% (n=21) and females 78% (n=81) were satisfied with the attention to their medical problems.

Table 4.7 Gender and satisfaction with staff has adequate medical knowledge to answer my questions

Gender		Satisfied		Not sure		Dissatisfied		Total	
Male	Count	19	68%	1	3%	8	29%	28	100%
Female	Count	79	76%	13	12%	12	12%	104	100%

Table 4.7 indicates that 68% (n=19) male and 76% (n=79) female respondents, respectively, were satisfied with the adequate knowledge of the medical staff at the clinics. Women are always on the majority and according to Weiseman et al (2000:661) women who visited health care facilities for their routine check and have the opportunity to ask questions more than men.

4.5.2 Age and satisfaction

Table 4.8 Age and satisfaction with individual attention from staff

Age		Satisfied		Not sure		Dissatisfied		Total	
< 21	Count	12	75%	2	13%	2	2%	16	100%
21 – 30	Count	40	73%	8	15%	7	13%	55	100%
31 – 40	Count	19	73%	4	15%	3	12%	26	100%
41 – 50	Count	20	100%	0	0%	0	0%	20	100%
51 – 60	Count	14	88%	0	0%	2	12%	16	100%
> = 61	Count	1	100%	0	0%	0	0%	1	100%

Table 4.8 indicates that patients in the age group younger than 21 years 75% (n=12) were satisfied with individual attention from staff. Also patients in the age groups of 21-30 years 73%; (n=40) were satisfied with individual attention from staff, 31-40 years

73% (n=19) were also satisfied with individual attention from staff, 41-50 years 100% (n=20) indicated that they were satisfied with individual attention from staff, 51-60 years 88% (n=14) were satisfied with individual attention from staff and older 61, 100% (n=1) was also satisfied with the individual attention from staff. The satisfaction level in terms of individual attention from staff was high, all above 73% and not associated with age. In general patients were satisfied with individual attention they received from staff.

Table 4.9 Age and satisfaction with attention to my medical problems

Age		Satisfied		Not sure		Dissatisfied		Total	
< 21	Count	8	50%	5	31.3%	3	18.8%	16	100%
21-30	Count	40	74%	5	9%	9	17%	54	100%
31-40	Count	21	81%	2	8%	3	11%	26	100%
41-50	Count	19	95%	1	5%	0	0%	20	100%
51 – 60	Count	13	81%	2	13%	1	6%	16	100%
> = 61	Count	1	100%	0	0%	0	0%	1	100%

In table 4.9 shows that patients seem to be satisfied about the way the staff gave attention to their medical problems. Age group younger than 21 years (50%; n=8) indicated that they were satisfied with attention to their medical problems. Patients with the age group of 21-30 years 74% (n=40) were satisfied with the individual attention to their medical problems, age group of 31-40 years (81%; n=21) also indicated that they were satisfied with individual attention to their medical problems, patients in the age groups of 41-50 years 95% (n=19), 51-60 years (81%; n=13) and the age groups of 61 years (100%; n=1) also indicated that they were satisfied with attention to their medical problems. This table indicated that patients of all age groups were satisfied with attention to their medical problems.

Table 4.10 Age and satisfaction with adequate knowledge of medical staff

Age		Satisfied		Not sure		Dissatisfied		Total	
< 21	Count	11	69%	1	6%	4	25%	16	100%
21 – 30	Count	35	66%	8	15%	10	19%	53	100%
31 - 40	Count	20	77%	2	8%	4	15%	26	100%
41 - 50	Count	17	85%	2	10%	1	5%	20	100%
51 - 60	Count	14	88%	1	6%	1	6%	16	100%
> = 61	Count	1	100%	0	0%	0	0%	1	100%

Table 4.10 indicates that patients in the age group of younger than 21 years 69% (n=11) were satisfied with the adequate knowledge of staff. The age group of 21-30 years 66% (n=35) were satisfied with adequate knowledge of staff, age group of 31-40 years 77% (n=20) were satisfied with adequate knowledge of staff and 41-50 years 85% (n=17) were satisfied with the adequate knowledge of staff. The table also indicated that the patients in the age groups of 51- 60 years 88% (n=14) and older than 61 years 100% (n=1) were satisfied with adequate knowledge of staff. In general patients were satisfied with the adequate knowledge of staff.

4.5.3 Residential area and satisfaction

Table 4.11 Living area and satisfaction with individual attention from staff

Living area		Satisfied		Not sure		Dissatisfied		Total	
Alexandra	Count	70	76%	11	12%	11	12%	92	100%
Soweto	Count	3	100%	0	0%	0	0%	3	100%
Sandton	Count	29	85%	2	6%	3	9%	34	100%
Midrand	Count	4	80%	1	20%	0	0%	5	100%

In table 4.11 indicates that patients living in Alexandra, Soweto Sandton and Midrand seem to be satisfied with the individual attention given to them by staff. The patients living in Alexandra 76% (n=70) were satisfied with individual attention from staff those patients living in Soweto 100% (n=3) were satisfied with individual attention from staff. Patients living in Sandton 85% (n=29) also indicated that they were satisfied with the individual attention from staff. While patients living in Midrand 80% (n=4) also indicated that they were also satisfied with individual attention from staff. In general patients seem to be satisfied with the attention received from staff. The living area did not affect the individual attention from staff. Individualised patients care is ethical and should be maintain at all times to ensure respect.

Table 4.12 Living area and satisfaction with attention to my medical problems

Living area		Satisfied		Not sure		Dissatisfied		Total	
Alexandra	Count	66	73%	12	13%	13	14%	91	100%
Soweto	Count	2	67%	1	33%	0	0%	3	100%
Sandton	Count	29	85%	2	6%	3	9%	34	100%
Midrand	Count	5	100%	0	0%	0	0%	5	100%

According to table 4.12 patients that live in Alexandra (73%; n=66) were satisfied with attention to their medical problems. Patients living in Soweto 67% (n=2) were satisfied with attention to their medical problems. The respondents residing in Sandton 85% (n=29) indicated that they were satisfied with attention to their medical problems and patients who live in Midrand were 5 and all were satisfied with attention to their medical problems 100% (n=5). It is indicated in table 4.11 that the patients were satisfied with medical attention they received from staff and were not influenced by their places of living.

Table 4.13 Living area and satisfaction with adequate knowledge of medical staff

Living area		Satisfied		Not sure		Dissatisfied		Total	
Alexandra	Count	64	70%	11	13%	16	17%	91	100%
Soweto	Count	3	100%	0	0%	0	0%	3	100%
Sandton	Count	27	82%	2	6%	4	12%	33	100%
Midrand	Count	4	80%	1	20%	0	0%	5	100%

Table 4.13 shows that satisfaction level with adequate knowledge of medical staff was well above 60% for all 4 areas where the patients attending the clinics live. Patients living in Alexandra 70% (n=64) indicated that they were satisfied with the adequate knowledge of staff. Patients living in Soweto were 3 and they were all satisfied with the adequate knowledge of medical staff 100% (n=3). Patients living in Sandton 82% (n=27) and Midrand 80% (n=4) indicated that they were satisfied with the adequate knowledge of staff. Living area was not associated with adequate medical knowledge of staff. Staff is encouraged to be multicultural and should ask for assistance if not sure with the questions asked.

4.5.4 Educational level and satisfaction

Table 4.14 Level of education and satisfaction with individual attention from staff

Level of education		Satisfied		Not sure		Dissatisfied		Total	
Primary	Count	22	84%	2	8%	2	8%	26	100%
High school	Count	63	81%	8	10%	7	9%	78	100%
College	Count	13	72%	2	11%	3	17%	18	100%
University	Count	5	72%	1	14%	1	14%	7	100%
Other	Count	3	60%	1	20%	1	20%	5	100%

Table 4.14 indicates that the satisfaction level was high between 60% and 84%. Patients with primary level of education 84% (n=22) were satisfied with individual attention they got from staff. Patients with high school level of education 81% (n=63) were also satisfied with individual attention from staff. Patients with college level of education 72% (n=13) also indicated that they were satisfied with individual attention from staff. Patients with the university level of education 72% (n=5) and other levels of education 60% (n=3) were satisfied with individual attention from staff. However, the patients' level of education was not associated with the individual attention from staff.

Table 4.15 Level of education and satisfaction with attention to my medical problems

Level of education		Satisfied		Not sure		Dissatisfied		Total	
Primary	Count	22	84%	2	8%	2	8%	26	100%
High school	Count	61	79%	10	13%	6	8%	77	100%
College	Count	12	67%	2	11%	4	22%	18	100%
University	Count	4	57%	1	14%	2	29%	7	100%
Other	Count	3	60%	0	0%	2	40%	5	100%

Table 4.15 indicates that the satisfaction level were 60% and above. Patients with primary level of education 84% (n=22) were satisfied with attention to their medical problems. High schools 79% (n=61) were also satisfied with attention to their medical problems. Patients with college level of education 67% (n=12) indicated that they were satisfied with attention to their medical problems. Patients with university qualification 57% (n=4) and other levels of education 60% (n=3) were satisfied with attention to their

medical problems. It seems as if the higher the level of education the less satisfied they became with attention to their medical problems.

Table 4.16 Level of education and satisfaction with adequate knowledge of medical staff

Level of education		Satisfied		Not sure		Dissatisfied		Total	
Primary	Count	20	77%	3	11%	3	12.2%	26	100%
High school	Count	59	78%	6	8%	11	14%	76	100%
College	Count	12	67%	4	22% ⁴	2	11%	18	100%
University	Count	4	57%	0	0%	3	43%	7	100%
Other	Count	3	60%	1	20%	1	20%	5	100%

Table 4.16 indicates that patients were satisfied with adequate knowledge of medical staff. Patients with primary level of education 77% (n=20) were satisfied with adequate knowledge of staff. Patients with high school level of education 78% (n=59) were also satisfied with adequate knowledge of medical staff. Patients with College level of education 67% (n=12) university level of education 57% (n=4) and others 60% (n=13) indicated that they were satisfied with adequate knowledge of staff. University levels of education were less satisfied with adequate knowledge of medical staff.

4.5.5 Employment status and satisfaction

Table 4.17 Employment status and satisfaction with individual attention from staff

Employment status		Satisfied		Not sure		Dissatisfied		Total	
Professional	Count	6	67%	1	11%	2	22%	9	100%
General	Count	53	87%	6	10%	2	3%	61	100%
Self-employed	Count	4	57%	2	29%	1	14%	7	100%
Unemployed	Count	43	75%	5	9%	9	16%	57	100%

According to table 4.17 the percentage satisfaction of employment status of the patients indicated that the patients were satisfied with individual attention from staff. Professionals 67% (n=6) were satisfied with individual attention from staff. General 87% (n=53) were also satisfied with individual attention from staff. Self employed 57%

(n=4) and unemployed 75% (n=43) indicated that they were satisfied with individual attention given by staff. In general patients were satisfied with individual attention from staff irrespective of their employment status.

Table 4.18 Employment status and satisfaction with attention to my medical problems

Employment status		Satisfied		Not sure		Dissatisfied		Total	
Professional	Count	5	56%	1	11%	3	33%	9	100%
General	Count	56	92%	3	5%	2	3%	61	100%
self employed	Count	2	33%	4	67%	0	0%	6	100%
Unemployed	Count	39	68%	7	12%	11	20%	57	100%

Table 4.18 indicates that not all the respondents were satisfied with attention to their medical problems. Self employed were not satisfied with medical attention to their problems 33% (n=2) it is not known why self employed were not satisfied with attention to their medical problems. Professionals 56% (n=5) were less satisfied with attention to their medical problems, General workers 92% (n=56) were satisfied with attention to their medical problems and unemployed also indicated that they were satisfied with attention to their medical problems 68% (n=39).

Table 4.19 Employment status and satisfaction with adequate medical knowledge

Employment status		Satisfied		Not sure		Dissatisfied		Total	
Professional	Count	3	33%	2	22%	4	45%	9	100%
General	Count	51	85%	5	8%	4	7%	60	100%
self employed	Count	5	71%	0	0%	2	29%	7	100%
Unemployed	Count	39	70%	7	12%	10	18.%	56	100%

Table 4.19 indicates that professionals were not satisfied with adequate knowledge of medical staff 33% (n=3). It could be assumed that the professionals were not satisfied because health professionals and health promoters including lay counsellors who have limited level of medical knowledge do health education at clinics. However, general workers 85% (n=51) were satisfied with adequate knowledge of medical staff, self-

employed 71% (n=5) were satisfied, and unemployed 70% (n=39) indicated that they were satisfied with adequate knowledge of medical staff.

4.5.6 Clinic visits and satisfaction

Table 4.20 Visiting frequency and satisfaction with individual attention from staff

Visiting frequency		Satisfied		Not sure		Dissatisfied		Total	
Daily basis (very regularly)	Count	9	75%	1	8%	2	17%	12	100%
Weekly basis (fairly regularly)	Count	8	67%	0	0%	4	33%	12	100%
Monthly basis (regularly)	Count	43	75%	8	14%	6	11%	57	100%
Quarterly basis (irregularly)	Count	26	90%	1	3%	2	7%	29	100%
Yearly basis (very irregularly)	Count	16	69%	5	22%	2	9%	23	100%

Table 4.20 shows that the satisfaction levels were high 67% and 90%. Patients visiting the clinic daily 75% (n=9) were satisfied with individual attention from staff. Patients visiting the clinics weekly 67% (n=8) were satisfied with individual attention from staff. Patients that visited the clinic monthly 75% (n=43) were also satisfied with individual attention from staff. Patients that visited the clinics quarterly (90%; n=26) and yearly (69%; n=16) indicated that they were satisfied with individual attention from staff. Generally patients were satisfied with frequency of clinic visits and individual attention from staff.

Table 4.21 Visiting frequency and satisfaction with attention to my medical problems

Visiting frequency		Satisfied		Not sure		Dissatisfied		Total	
Daily basis (very regularly)	Count	9	75%	1	8%	2	17%	12	100%
Weekly basis (fairly regularly)	Count	8	67%	0	0%	4	33%	12	100%
Monthly basis (regularly)	Count	43	75%	8	14%	6	11%	57	100%
Quarterly basis (irregularly)	Count	26	90%	1	3%	2	7%	29	100%
Yearly basis (very irregularly)	Count	16	70%	5	22%	2	8%	23	100%

Table 4.21 indicates that patients were satisfied with their visit to the clinics. Patients that visited the clinics daily 75% (n=9) were satisfied with attention to their medical problems. Patients that visited the clinics weekly 67% (n=8) were satisfied with attention to their medical problems. Patients visiting the clinics monthly 75% (n=43) were also satisfied with attention to their medical problems. Patients that visited the clinics quarterly 90% (n=26) and yearly 70% (n=16) indicated that they were satisfied with attention to their medical problems. Generally patients were satisfied with their visit to the clinics and that their medical problems were attended to satisfactorily irrespective of the frequency of their visits.

Table 4.22 Visiting frequency and adequate knowledge of medical staff

Visiting frequency		Satisfied		Not sure		Dissatisfied		Total	
Daily basis (very regularly)	Count	8	67%	3	25%	1	8%	12	100%
Weekly basis (fairly regularly)	Count	4	33%	4	33%	4	34%	12	100%
Monthly basis (regularly)	Count	46	79%	5	9%	7	12%	58	100%
Quarterly basis (irregularly)	Count	24	83%	1	3%	4	14%	29	100%
Yearly basis (very irregularly)	Count	16	70%	1	4%	6	26%	23	100%

Table 4.22 indicates that patients on different visits were satisfied with adequate knowledge of staff except those who visited the clinics weekly 33% (n=4). It is not known why patients that visited the clinics weekly were not satisfied with adequate knowledge of medical staff. However patients that visited the clinics daily 67% (n=8) were satisfied with adequate knowledge of medical staff. Patients who visited the clinics monthly 79% (n=46) were also satisfied with adequate knowledge of medical staff and patients that visited the clinics quarterly 83% (n=24) and yearly 70% (n=16) also indicated that they were satisfied with knowledge of medical staff.

4.6 CONCLUSION

This chapter discussed the data analysis and interpretation. The respondents’ satisfaction with the services provided by the clinics was examined and measured according to satisfaction variables and demographic information (see tables 4.1 to 4.22).

The respondents all had at least a basic (primary) level of education. Accordingly, they were literate, understood what they expected from the health care facilities, and could read and complete the questionnaire. Professionals, 33% (n=2) seemed not satisfied with adequate knowledge of medical staff. It is assumed that health education at the clinics is also done by lay counsellors with a limited medical knowledge. Self-

employed, satisfaction rating was 33% (n=2) not satisfied with the attention with medical problems. Generally patients were satisfied with health care services provided.

Chapter 5 concludes the study, discusses its limitations, and makes recommendations for practice and further research.

CHAPTER 5

Findings, limitations and recommendations

5.1 INTRODUCTION

This chapter concludes the study, briefly discusses its findings and limitations, and makes recommendations for practice and future research.

A problem of overcrowding of patients in the City of Johannesburg resulted in negative comments from community meetings, patients and the media, seemed to indicate that patients were not satisfied with health care services provided. Patient's perceptions and satisfaction was researched.

5.2 PURPOSE OF THE STUDY

The purpose of the study was to identify and describe patients' satisfaction with health care services provided by clinics in region E of the City of Johannesburg in order to develop guidelines for health care professionals to ensure quality of health care.

5.3 OBJECTIVES OF THE STUDY

The objectives of the study were to

- identify and describe patients' satisfaction with health care services
- recommend guidelines for health professionals to improve health care delivery

Accordingly, the study was conducted on a random sample of 134 male and female patients, 18 years old and older, who attended the region E clinics in Johannesburg for health services. Region E clinics serve the community of Alexandra and its residential suburbs namely Woodmead, Wynberg, Bruma, Sandton City, Mayibuye in Midrand, Bezvalley and Petervale near Bryanston.

5.4 SUMMARY OF FINDINGS

The findings were presented within the framework of the research objectives, according to demographic data and evaluation of health care services at the clinics. The *Batho Pele Principles* and the Patients' Rights Charter were used to measure patients' satisfaction.

5.4.1 Demographic data

With regard to gender, the study found that the sample selected consisted of more females 78% (n=105) than males 22% (n=29). The highest age group was between 21 and 40 years old 60% (n=81) and respondents between 21 and 30 years old were 41% (n=55) between 51 and 60 years old were 12% (n=16) and 61 years old was 0.75% (n=1). Of the respondents, 88% were generally employed or unemployed. Self-employed were 5 % (n=7) and 7% (n=9) were professionals. The criterion for the study was all male and female patients of all races aged 18 years and older who visited the clinics for health care services.

Regarding the respondents' level of education, 78% had a basic education, 14% (n=18) had a college diploma and 5% (n=7) had a university qualification.

Respondents with regards to frequency of visits were 43% (n=58) visited the clinic on monthly basis most of whom are chronically ill patients. Respondents that visited the clinics daily were 8.9% (n=12) weekly 9% (n=12).

Region E serves the communities of Alexandra and Sandton hence most of the respondents were from Alexandra 69% (n=92) and Sandton 25% (n=34) and few were from Midrand.

5.4.2 Evaluation of health care services at the clinics

- **Access**

Accessibility was based on the convenience of the operating times of the clinics. Of the respondents, 72% (n=95) indicated that they were satisfied with the operating times of the clinics, 13% (n=17) were not sure and 16% (n=20) were dissatisfied with the times.

- **Openness and transparency**

Generally, the respondents were satisfied with the openness and transparency at the clinics with regard to health services information of the clinics 73% (n=96) and health education provided at the clinics 77% (n=100).

- **Redressing the wrongs**

The respondents were not satisfied with the redressing of wrongs. Of the respondents, only 45% (n=59) received an apology from staff, and 50% (n=66) were satisfied with the complaint procedure and regular communication between the clinic and the patients 54% (n=71). This indicated that redressing the wrongs was generally not satisfactorily addressed.

- **Courtesy**

Regarding the courtesy received from the professionals, 72% (n=96) of the respondents were satisfied with the help desk staff welcome and 79% (n=106) received satisfactory individual attention from staff.

- **Value for money**

Of the respondents, 62% (n=83) indicated that the health professionals met their expectations 73% (n=96) were satisfied with the overall patient care that day, and 65% (n=87) would recommend the clinic services to their relatives and friends. This indicated satisfaction with the level of services standards.

Summary

With regard to patient satisfaction the study consistently found a high level of satisfaction in all areas except the redressing of wrongs and staff wearing name tags. The respondents were generally satisfied with the quality of health care services provided at the clinics and indicated that their problems were managed individually and confidentially.

5.5 LIMITATIONS

The researcher identified the following limitations in the study:

- The questionnaire contained closed ended questions with options on a five-point Likert scale therefore the respondents could not elaborate on or give reasons for their feelings on some of the factors.
- The results of the study could not be generalised, as the study was limited to the municipal clinics in region E of Johannesburg.

5.6 RECOMMENDATIONS

The recommendations were based on the consultation from the questionnaire where by respondents were asked to give recommendation as to how could the health care services at the clinics be improved. Some patients did not have recommendations 16% (n=20). Some patients suggested that staff should change their attitude 29% (n=37). Another recommendation was that the clinics be opened on Saturdays so that those who are working could visit the clinics when they are off duty 16% (n=21) and 39% (n=50) recommended that staff should be increased.

5.6.1 Guidelines for health professionals to improve the quality of health care services

- **Staff training**

Skills assessment should be done annually to identify staff training needs. Staff should be trained in customer care and emphasis should be on the *Batho Pele Principles* so that issues such as redressing the wrong should be understood. All new recruits should undergo staff induction with regards to patients' satisfaction. Ongoing in-service training should be provided and staff upgrading encouraged by means of formal studies at university and/or college.

- **Staffing**

Recommendation was that the reasons for staff turnover should be identified and be solved for an example nurses salaries should be increased to attract them not to resign. This would also reduce the nurses' workload.

- **Opening of the clinics on Saturdays**

Opening of the clinics on Saturdays was implemented at some of the clinics, as all clinics were not opened on Saturdays. Sandown clinic, 8th Avenue clinic and Mayibuye clinic operate on Saturdays from 08:00 to 12:00.

5.6.2 Further research

The researcher recommends further research on the following topics:

- A comparative study of patients' satisfaction with health care services provided by clinics in the City of Johannesburg.
- Patients' satisfaction with health care services provided at community health centres (CHCs).
- Health professionals' perceptions of health care services provided at clinics.
- Professional nurses' perceptions of clinic patients' health care service needs.

5.7 CONCLUSION

This study described patients' satisfaction with health care services provided in the City of Johannesburg region E. Even though the satisfaction score was high, the main shortcomings appeared to be in the area of redressing the wrongs. Consequently, the researcher made recommendations to improve practice, which should foster better relations and service.

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
Faculty of Human Sciences
CLEARANCE CERTIFICATE

Date of meeting: 31 March 2005 Project No: 0645-270-1

Project Title: PATIENTS' SATISFACTION WITH HEALTH CARE SERVICES
PROVIDED IN THE CITY OF JOHANNESBURG

Researcher: Ms IN Ramela

Supervisor/Promoter: Mrs EN Monama

Joint Supervisor/Joint Promoter: -

Department: Health Studies

Degree: MA (Cur)

DECISION OF COMMITTEE

Approved



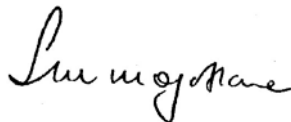
Conditionally Approved



Date: 31 March 2006



Prof TR Mavundla
RESEARCH COORDINATOR



Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

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List of abbreviations

ANC	African National Congress
AIDS	Acquired immunodeficiency syndrome
COJ	City of Johannesburg.
DHS	District Health System
DPASA	Department of Public Service and Administration
GDS	Growth and Development Strategy
HAST	HIV/AIDS/STI and TB
HIV	Human immunodeficiency virus
IDP	Independent Development Plan
INH	Isoniazid
MEC	Member of Executive Committee
NGOs	Non-governmental organisations
PHC	Primary health care
PMTCT	Prevention of mother-to-child transmission
SPSS	Statistical Package for Social Sciences
STIs	Sexually transmitted infections
Unisa	University of South Africa
WPTHs	White Paper on Transformation of Health System
WPTPSD	White Paper on Transformation of Public Service Delivery
WHO	World Health Organization

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ANNEXURE A

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ANNEXURE E

A map of region E

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ANNEXURE D

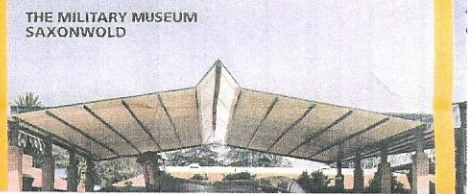
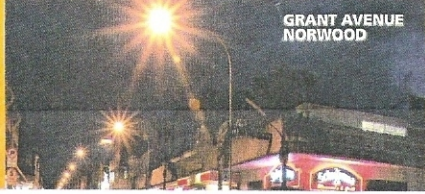
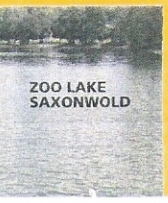
Covering letter for patients

ANNEXURE E

A map of region E

ANNEXURE F

Questionnaire in English

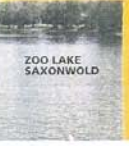
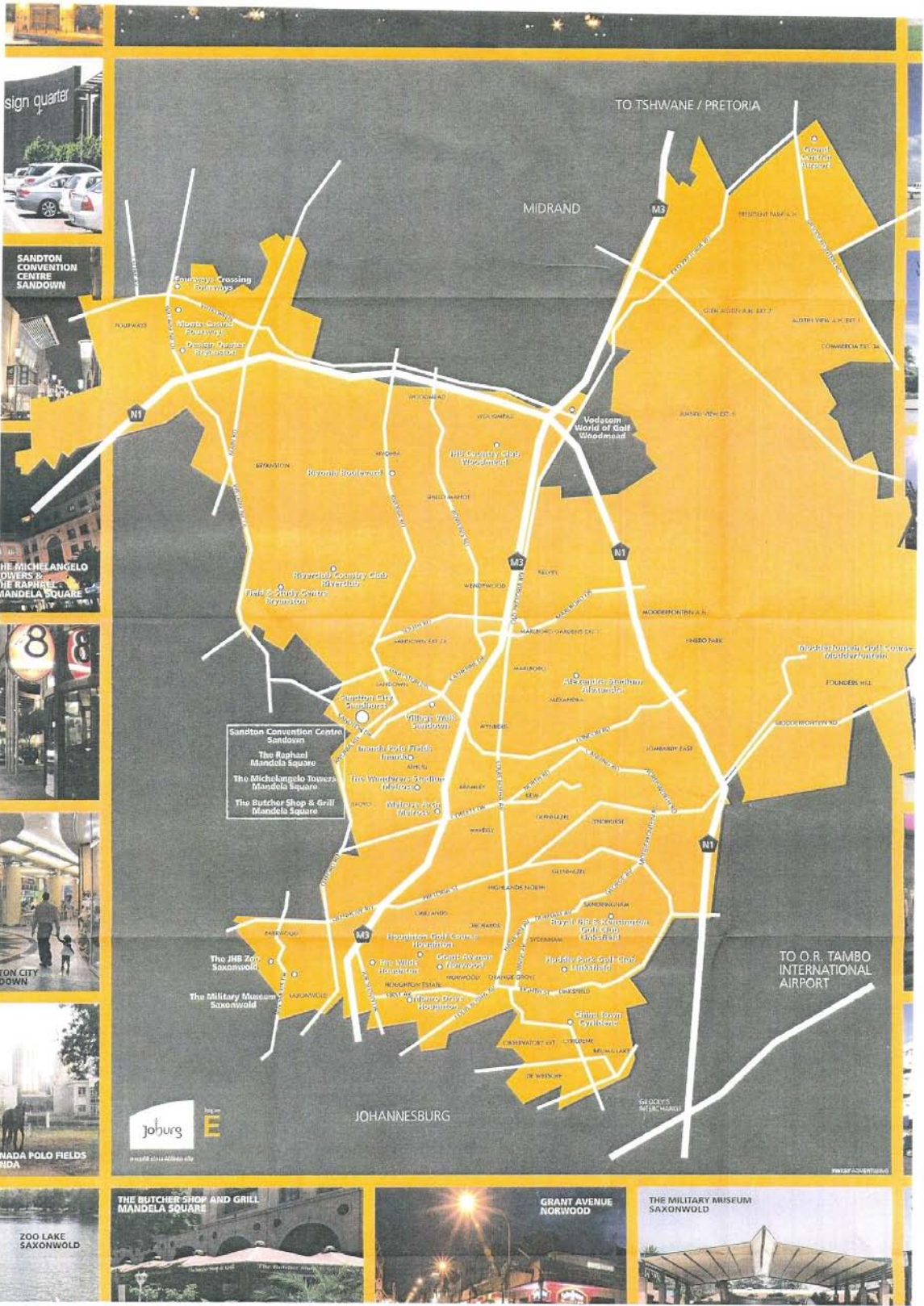


ZOO LAKE SAXONWOLD

THE BUTCHER SHOP AND GRILL MANDELA SQUARE

GRANT AVENUE NORWOOD

THE MILITARY MUSEUM SAXONWOLD



Joburg

JOHANNESBURG

TO TSHWANE / PRETORIA

MIDRAND

TO O.R. TAMBO INTERNATIONAL AIRPORT

Sandton Convention Centre Sandown
 The Raphael Mandela Square
 The Michelangelo Towers Mandela Square
 The Butcher Shop & Grill Mandela Square