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Patient perceptions of the quality of health services in South Africa

Quality Management Conference (in association with COHSASA)
29 May 2018 | Gallagher Convention Center | Johannesburg, South Africa

Carmen Christian

Outline

- Why do we care about patient perceptions of the quality of health services?
- Pitfalls of patient perceptions
- Evidence from two South African studies
- Take home: further work needed to reduce measurement challenges of patient perceptions of quality

Perceptions of health services quality and health-seeking behaviour

- Patient perceptions of quality drives acceptability of health services (Penchansky and Thomas, 1981).

- Services not acceptable → less likely to return for follow-up, less likely to seek healthcare, more likely to access private sector.
  - Bypassing of closest clinics (Burger & Christian, 2018; Rao & Sheffel, 2018).
  - Patients with low-quality perceptions of public healthcare services prefer to utilise private healthcare facilities (Burger *et al.*, 2010; Van der Berg *et al.*, 2010).

- Understanding quality of health services – from a user's perspective – is essential for health outcome improvements.

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Pitfalls of patient perceptions in the South African context

- Public system - patient disempowered because not paying.
- Many patients have little health knowledge.
- Many patient may have low expectations.
- Social desirability bias.
- Data biased if only collect info from those who choose to visit health facilities.
  - Vital to understand perspectives of those who do ***not*** go to health facilities.

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Acceptability of PHCs in South Africa

- Burger & Christian, 2018.
  - Forthcoming in *Health Economics, Policy & Law.*
- Data: South Africa's 2009 and 2010 General Household Surveys
  - n=190,164.
- We approximate acceptability with an indicator measuring share of community members bypassing their closest healthcare facility.
  - We argue that reported **healthcare provider choice is more reliable than stated preferences.**

Acceptability of PHCs in South Africa

- Acceptability constraints noted by only 10%.
  - But we found evidence of bias using this method.
  - Indicator assumes all individuals have available and affordable provider choices – an unrealistic assumption that inflates acceptability in poor, rural areas.
  - Our result may therefore be an underestimate/lower-bound estimate.
  - Recommend further work on measurement of acceptability in household surveys, especially considering this dimension's importance for health reform.

Inconsistencies in stated preferences

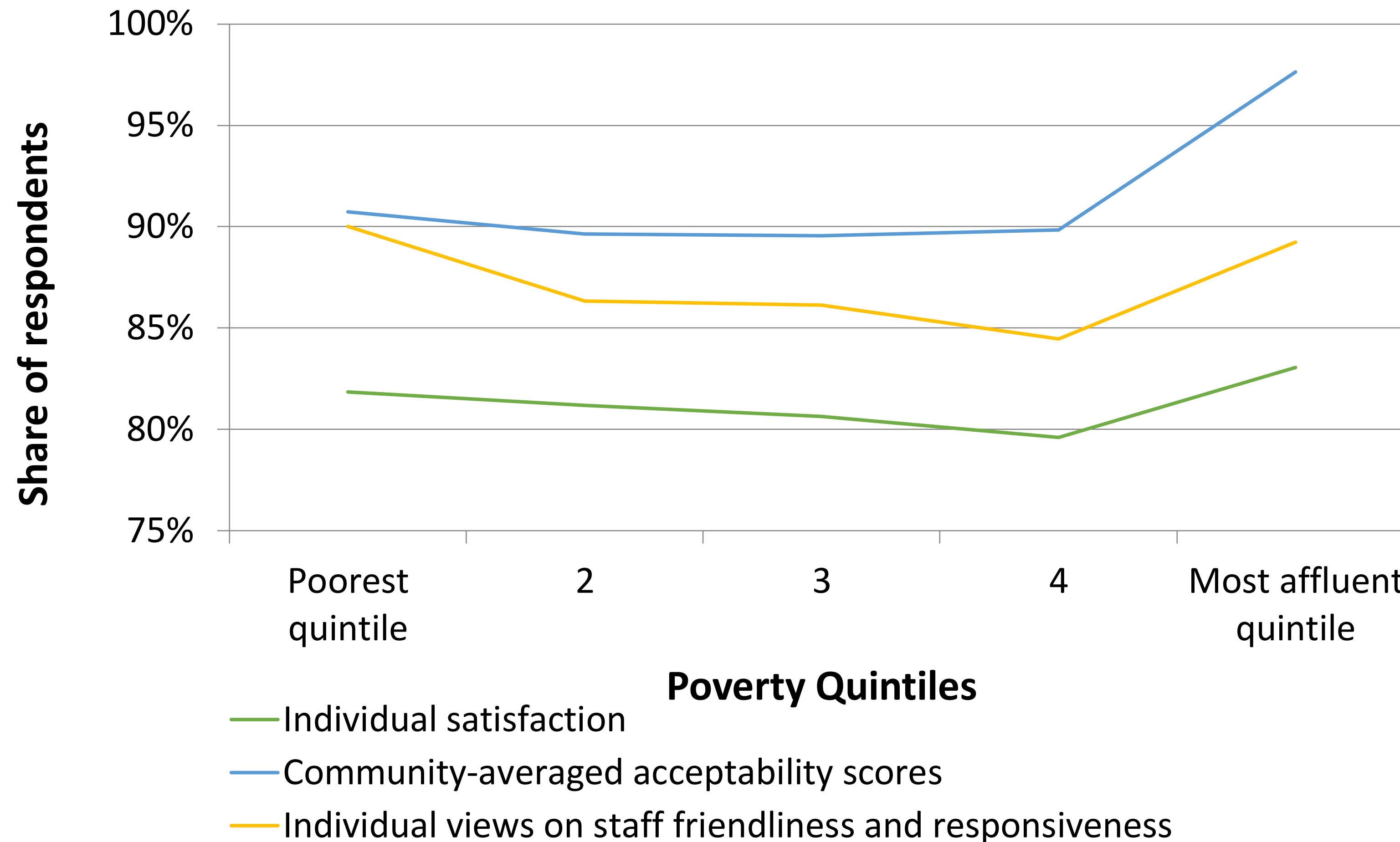
Table 1: Proportion of complaints in various health visit satisfaction categories, 2009–2010

	Long waiting times	Rude and uncaring staff	Medication not available
Very satisfied	20%	2%	6%
Somewhat satisfied	65%	18%	29%
Indifferent	78%	38%	47%

Source: Own calculations using GHS 2009/2010 data. Weighted by population.

Reducing bias in acceptability indicator

Figure 1: Socioeconomic status slopes of three acceptability indicators, 2009–2010



Source: Own calculations using GHS 2009/2010 data. Weighted by population.

Standardised patients sent to PHCs in South Africa

- Standardised patients (SPs) sent to PHCs as covert patients with scripted opening sentence and set of symptoms.
  - Should map to set of probes, diagnoses and treatment/next steps.
  - SPs trained to provide pre-determined, standardised answers to likely questions.
- Upon leaving PHC, relevant details of visit recorded on score sheet.
  - High level of data accuracy, even though recall-dependent (Das *et al*., 2015).
- Complicated to navigate ethics of concealment.
  - Balancing benefits/uniqueness of approach with risks.

Standardised patients sent to PHCs in South Africa

International Journal of *Environmental Research and Public Health*

Article

Measuring Quality Gaps in TB Screening in South Africa Using Standardised Patient Analysis

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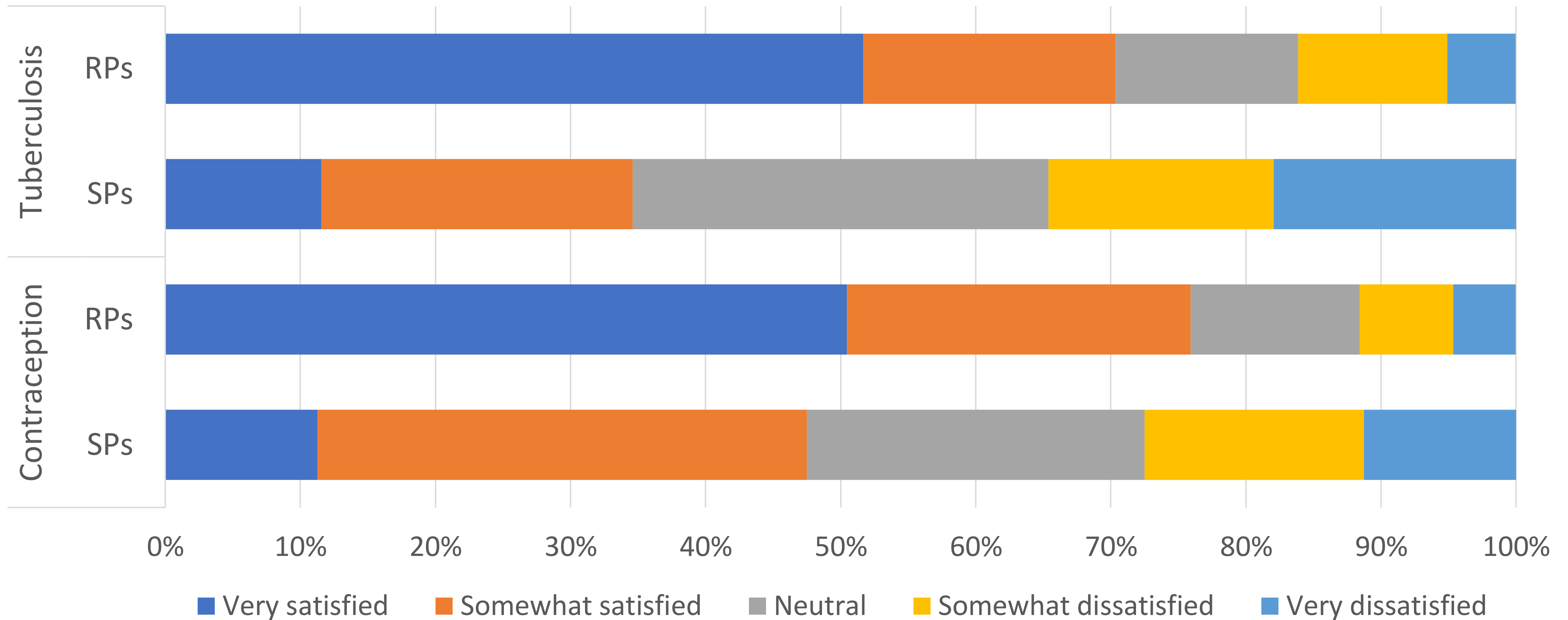
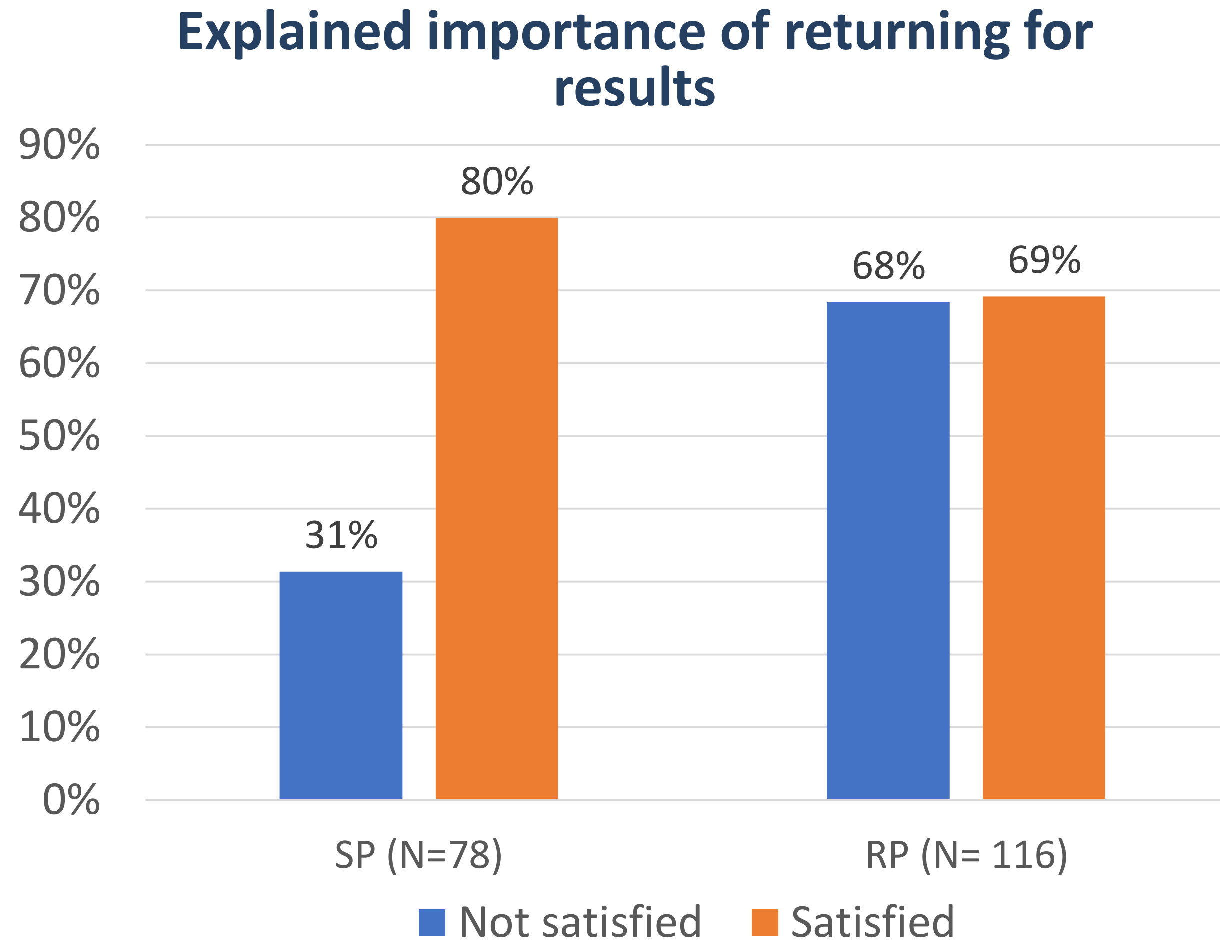
SP vs real patient (RP): Satisfaction



SP vs real patient (RP): Satisfaction compared to TB quality measures



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Further work needed to reduce measurement challenges of patient perceptions of quality

- Educate patients about what they should expect ito health services.
  - Coupled with patient empowerment.
- Introduce vignettes in household surveys.
  - Challenges with administering to lay public.
- Routine use of standardised (mystery) patients.
  - Compare with exit interviews for patients with similar conditions.

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Appendix

Empirical evidence: waiting times

- Alswat *et al.*, 2015: Waiting time = high opportunity costs. Waiting time a determinant of patient satisfaction?
- Daniels, 2015: Long waiting times influence perceived quality of care (Cape Town, RSA).
- Hasumi & Jacobsen, 2014: In GHS 2010, 34, 8% complained about long waiting times at last visit to public facility.
- Burger *et al.*, 2012: In 2002-2008 GHS, 40,7% reported long waiting times as main complaint about public facilities.

Empirical evidence: staff attitudes

- Rispel, 2016; Gilson & McIntyre, 2007: Healthcare workers' attitudes crucial for user's experience since it influences perceived quality of care.
- Burger *et al*., 2012: In 2002-2008 GHS, 10.7% of respondents complained about rudeness of healthcare workers.
- Gilson & McIntyre, 2007: Attitude and interpersonal skills of healthcare workers are important in influencing the health-seeking behaviour of patients, utilisation and overall health outcomes.
- Burger & Swanepoel, 2006: In 2003 GHS, 12.52% of users of public healthcare complain about healthcare worker rudeness.

Empirical evidence: cleanliness of facilities

- Markkanen *et al.*, 2009: clean healthcare facility is comforting to patients, provides an impression of good quality care.
- Burger & Swanepoel, 2006: In 2003 GHS, 6.64% of public healthcare facility users complained about facilities not being clean.

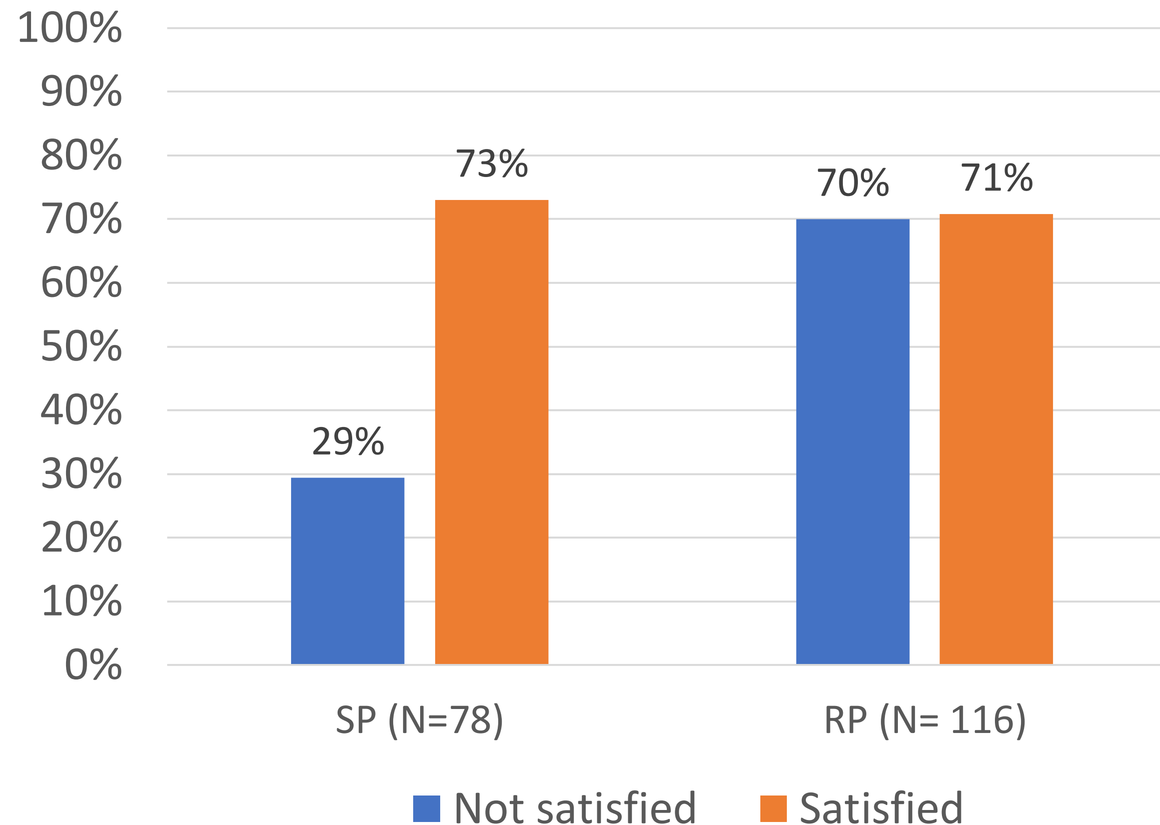
Empirical evidence: drug availability

- Mcintyre & Ataguba, 2017: From patient's perspective, availability of prescribed medicines is one of the most easily noticed signs of quality of care.
- Hasumi & Jacobsen, 2014: 14.1% of respondents complained about unavailability of prescribed drugs during last visit at public healthcare facility.
- Burger *et al.*, 2012: In 2002-2008 GHS, 14.1% public healthcare users complained about a problem of drug availability at facilities.
- Burger & Swanepoel, 2006: In 2003 GHS, 14.08% users of public healthcare facility complained about drugs unavailability.

Empirical evidence: hours of operation

- Hasumi & Jacobsen, 2014; Burger & Swanepoel, 2006: public healthcare users complain about opening times of health facilities not being convenient.

SP vs real patient (RP): Satisfaction compared to TB quality measures



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