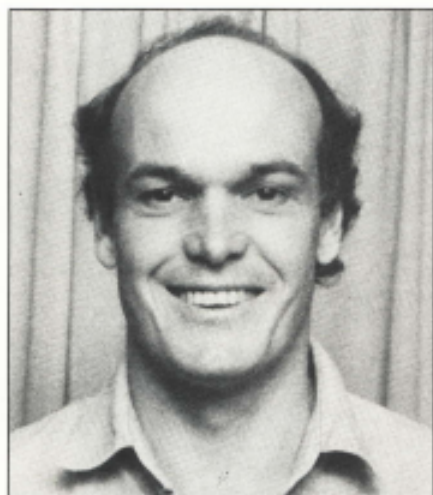


Private versus State Health Care: Patient Perceptions — Dr Brian Wood



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Curriculum vitae

Brian was born in Cape Town, and obtained the MBChB at UCT in 1982. He completed his internship at Victoria Hospital, Wynberg. From 1985 to 1990 he worked in rural KwaZulu, mainly at Charles Johnson Memorial Hospital in Nqutu, then at Hlabisa Hospital. In mid 1990 he joined the Family Medicine department at Medunsa. He completed the MPraxMed in 1991, and at present is appointed as a Family Practitioner and Lecturer at Medunsa. He is responsible for the department's programme for final year medical students. He is married to Judy and they have two children.

Summary

The perceptions of a rural population of the local public sector health facility is compared to their views of the available private facility. The most surprising reason identified for choosing the private sector is the reduced likelihood of being referred to a tertiary hospital. Waiting times, perceived likelihood of receiving an injection, and cost factors are important, but continuity of care is not apparently available at either venue.

S Afr Fam Pract 1993; 14: 300-5

KEYWORDS:

Physicians, Family; Patient Satisfaction; State Medicine; Private Practice; Research.

Introduction

Many people living in rural areas of South Africa have only recently had access to private medical services, and are increasingly making use of such facilities. This has had a noticeable impact on the outpatients departments of some hospitals, which, however, continue to experience considerable demand for their services. The reasons why patients prefer the available private or public services under local circumstances do not appear to have received attention.

The research conducted predominantly in a Western context concerned with patient satisfaction, identified a number of factors which contribute to patients' perceptions of the care which they are receiving. It

has repeatedly been demonstrated that patients prefer continuity of care to episodic care.^{1,2,3} Patients expect to receive care of a high technical standard,³ and expect to be listened to, taken seriously, and understood.^{4,5} They feel uncomfortable if they get the impression that the doctor is rushed and doesn't have time for them.⁶ Services are expected to be easily accessible, whether by appointment or open access systems and a recurring theme of frustration relates to long periods spent waiting to see the doctor.^{7,8,9,10,11} Financial charges have been shown, some of the time, to affect attitudes to care received, but patients appear to be happy to pay more for a service which they believe to be superior.^{12,13} It does not seem to have been explored whether a higher charge may actually encourage such a belief. Patients also prefer an attractive waiting area, with air-conditioning where appropriate, and up-to-date magazines.² The relevance of these findings to a rural population is somewhat debateable, but it would be surprising if rural attitudes and expectations were completely different.

Rural black patients are widely perceived to expect an injection as part of any medical treatment. This was confirmed by Mfenyana among a rural Xhosa population in the Transkei, in 1988.¹⁴ Nearly 90% of the patients surveyed would be dissatisfied with a consultation which did not include an injection.

Hlabisa is situated in Northern Natal, in one of the more rural and remote parts of KwaZulu. The population in the district is estimated at 120 000. The hospital was started by the American Lutheran Church, but now falls under the KwaZulu health department. The local private facility

... Private vs State Health Care

is a branch of a practice based in the nearest Natal town and at the time of the study had been open in Hlabisa for 6 months and provided a consultation service in the mornings from Tuesday to Friday. The motivation for this study came from the hospital doctors, but the private practitioners were also interested to learn how they are perceived by patients.

Method

Hypothesis:

It was expected that the following factors would be important:

1. The patients in the area expect to wait longer at the hospital outpatients department than they would wait to see a private General Practitioner (GP).
2. Patients' desire for injections would affect health service utilization in that they would perceive the GPs as more likely to give an injection.
3. Cost would be perceived to be lower at the hospital, encouraging utilization of the hospital services.
4. Continuity of care would be greater in the private sector, a

factor leading patients to prefer private care.

Study design and sample:

A cross-sectional design was chosen with a stratified sample. Two patient groups were studied, consisting of a group of patients waiting to see the GP and a group of patients waiting at the hospital. A consecutive sample was taken on two days, a Tuesday and a Wednesday. This is because a different GP was present on those

GPs are less likely to refer

days. On Tuesday the GP was a very fluent Zulu speaker, but new to the area. The doctor on Wednesday was not such a good Zulu speaker, but well known in the area. The doctor in the hospital OPD was not predictable. The Zulu fluency of the four hospital doctors varied from moderate to nil. On each day the interviewer started at the GP practice and interviewed as many patients as possible, up to 25. The same interviewer then interviewed the same number of patients at the hospital. In this way a total of 88 patients was obtained.

Data collection:

A structured interview was used, with a combination of open and closed questions. The open questions preceded the closed. Simple demographic information was collected. The questionnaire was translated into Zulu for the patients' benefit by the interviewer who wrote down their replies in English. The chi-square test of association was used in analysis of the results, and the results were analyzed with the help of EPI5.

Results

Demographic information:

A total of 88 patients, or the adult accompanying an ill child, were interviewed (Hospital: 46, GPs: 42). There were no significant differences between the groups seen on Tuesday and Wednesday and they are analyzed together. No patient refused to participate.

Waiting time:

There was good agreement between the groups, that patients expected to wait longer at the hospital (see Table 1). The group seeing the GP expected to be seen earlier. In answer to the open question, "Why did you come to see the GPs today?", 3

Table 1. Venue at which patients would expect to wait longer to see the health care provider. ($\chi^2 = 4,72$; $df = 2$, $P = 0,09$)

	GP rooms	Hospital	Unsure
GP patients	1	31 (74%)	6
Hospital patients	4	27 (59%)	14

Table 2. Patient desire for an injection. (Yates corrected $\chi^2 = 0,66$; $df = 1$; $P = 0,81$)

	I want an injection	I don't want an injection
GP patients	39 (93%)	3
Hospital patients	41 (89%)	5

... Private vs State Health Care

Table 3. Perceptions concerning whether patients would receive an injection had they attended the other venue. ($\chi^2 = 35,19$; $df = 2$; $P = < 0,001$)

Would you get an injection at the other venue?	Yes	No	Unsure
GP patients	14 (33%)	18 (43%)	10 (24%)
Hospital patients	43 (94%)	1 (2%)	2 (4%)

patients specifically mentioned the expectation of a shorter waiting period than was expected at the hospital.

Injections:

Both groups showed a strong desire that treatment include an injection (Table 2), but a large number of the patients attending the GPs doubted that they would receive an injection at the hospital, whereas the hospital patients had no doubt that the GPs would give them an injection if they attended there. (Table 3.) In response to the first open question, the most common answer was that patients were seeing the GPs because they would be given an injection. Other patients, while not specifically mentioning injections, also stated that the medications of the GPs produced good results. On the other hand, the hospital patients did not mention injections at all as a reason for attending the hospital. One patient felt that the hospital doctors were more competent than the GPs because, "They know when you need more than an injection".

Costs:

Both groups also expected to pay more to see a private practitioner than a hospital doctor (Table 4). An

open question about charges revealed that in general, patients were not unhappy about fees. 45 of the 46 hospital patients felt that the hospital fees were reasonable, 1 objected to the concept that charges should be related to income. The GP patients were less unanimous. 28 patients felt that charges were reasonable, 6 felt that they were excessive, and 8 had no comment. In answer to another

We go to the GP because he gives an injection

open question, 7 hospital patients mentioned specifically that one of their main reasons for attending the hospital rather than the GPs was the lower fees at the hospital.

Continuity of care:

There was little evidence that either group of patients were expecting to see a specific care giver. The hospital patients had the greatest uncertainty, with 24 expecting to see "any" doctor, and the other 22 expecting to see either a nurse only, or a nurse first. The GP patients were less uncertain, all expected to see the doctor, but only 6 (14%) expected to

Table 4. Patient expectation about where costs would be higher. ($\chi^2 = 0,57$; $df = 2$; $P = 0,75$)

	GP rooms	Hospital	Unsure
GP patients	31 (73%)	4	7
Hospital patients	37 (80%)	3	6

see a particular doctor (Table 5). In an open response 1 patient stated that he was attending the GPs because he was certain not to be seen by a nurse.

Other findings:

It was thought that other factors might play a role, and although these were not formally stated as hypotheses other possibilities were explored as well. Both groups felt that the doctor they were about to see was a better speaker of Zulu than the doctor at the other venue although here the hospital patients were less confident (see Table 6). Patients were also asked specifically about their attitude to referral to the nearest secondary care institution, Ngwelezana Hospital in Empangeni. A significantly larger group of the patients seeing the GPs would not have agreed to being transferred had this been recommended (see Table 7). The open questions also produced corroboratory evidence, with 5 patients stating specifically that they were seeing the GPs as they were less likely to be admitted by them. On the other hand 6 hospital patients stated that one of their reasons for attending the hospital was because of the facilities available there, including theatre, investigation and admission.

The answers to the open questions

... Private vs State Health Care

are not reported in full, but the agreement between the responses to the closed questions and those to the open questions was good.

Discussion

The results obtained are supportive of three of the hypotheses. Both groups of patients believe that the waiting period to see the GP will be shorter than at the hospital, injections, which are strongly desired by both groups, are believed to be more readily given by the GPs, and the costs of seeing

Hospital doctors know when you need more than an injection

the GPs are consistently believed to be greater than at the hospital. The only hypothesis which was not supported was that concerning continuity of care. As has been mentioned, the GP practice had been open in Hlabisa for about six months at the time that the study was conducted, and the utilization pattern, particularly of chronically ill patients, may not have been fully established. This would be likely to lead to an underestimation of the component of continuity of care

Table 6. Perceptions concerning the doctors' ability to communicate with patients in Zulu. ($\chi^2 = 5,86$; $df = 2$; $P = 0,053$, nearly significant)

Better Zulu speakers	GPs	Hospital	Unsure
GP patients	21 (50%)	6 (14%)	15 (36%)
Hospital patients	12 (26%)	13 (28%)	21 (46%)

available at the GP practice. In the British context, the private sector is not able to provide adequately for the chronically ill, and this may be true in the Hlabisa situation as well, principally because of cost factors.¹⁵ It is interesting to note that certain patients at the hospital reported in the open-question responses that they believed that their diseases "needed" the hospital. These people appeared to be suffering from diseases like TB and diabetes: chronic and costly to treat.

Possibly the most important finding was the greater tendency of the GP patients to resist referral. The GPs do not refer from Hlabisa directly to Empangeni, but to the Hlabisa Hospital, whereas it is regularly necessary for the hospital to refer patients for investigation, opinion or surgery to either Ngwelezana or King Edward VIIIth Hospital. It is common, for very understandable

reasons, for patients to be reluctant to go the long distances involved, to places often new to them. Patients seem to feel safer seeing the GPs who do not refer so far away. This presumably reflects concern that once they have allowed themselves to be absorbed into the "system", patient autonomy is difficult to maintain, particularly for a patient who is disadvantaged by communication difficulties as well as by the strangeness of the situation.

However the design of the study needs to be considered when assessing the information obtained. The sample was consecutive and no attempt at randomization was made. It was also obtained on only two days. Patients using the hospital for emergencies after hours are not represented. It is therefore possible

Patients feel safer with a GP who does not refer them far away

Table 5. The care giver expectations of the two groups.

Patients expect to see:	Any Doctor	Own Doctor	Nurse Only	Nurse & Doctor
GP patients	36 (86%)	6 (14%)	—	—
Hospital patients	24 (52%)	—	11 (24%)	11 (24%)

that it is not adequately representative of the population which it was intended to study. However, at neither of the two venues are patients divided into any predetermined groups. Patients with any problem

... Private vs State Health Care

Table 7. Attitudes to referral. ($\chi^2 = 5,35$; $df = 2$; $P = 0,02$)

Would you agree?	Yes	No	Unsure
GP patients	13 (31%)	26 (62%)	2
Hospital patients	28 (61%)	18 (39%)	—

were free to come on any day, so it is felt that the sampling method was not unreasonable. A similar sampling method has also been used by a number of studies referred to in the literature survey, and although it has limitations, particularly related to generalizability, it is a simple, cheap method, which is particularly attractive because the patients studied are clearly those using the health services.^{16,17}

The interviewer was crucial to this study. She was expected to translate the questionnaire into Zulu and the patients' answers back into English. Answers were not taken down in Zulu and therefore the accuracy of the translation cannot be checked. She was chosen for the task partly because of her competence in English

Hospital doctors make patients wait too long

and Zulu, but errors may well have occurred and cannot be identified at this stage. This method of cross-language questionnaire administration is quite commonly used for small studies, and an effort was made to reduce potential for the translation of the questionnaire to be spontaneous and unsystematic, by careful explanation of the intended

meaning of each question.^{18,19} The answers obtained from the open and closed questions showed good agreement suggesting good internal consistency of the instrument.¹⁷

Information regarding the financial position and educational standards of the patients was not obtained. The absence of such information does not invalidate the perceptions expressed, but its presence may have provided additional insight into why the patients' views were those obtained. Furthermore, it should also be remembered that this is not a wealthy community, and the range of incomes is probably relatively small between the richer and poorer members. Other studies have shown conflicting results with regard to the relationship between patient satisfaction and sociodemographic factors, including income.²⁰ Kloos showed, however, that in Addis Ababa, the more affluent patients did prefer private care.²¹ No patient in this study had medical aid cover.

Conclusion

Hospital doctors particularly, face a huge challenge in the area of waiting times. For too many years patients have been kept waiting most of a day, sometimes even overnight, and patients are influenced by their perceptions of expected waiting time. Solutions are not easy, but the area deserves attention.

The area of medication remains difficult, with the great majority of patients expecting to receive an injection. It appears that there is already a patient perception in Hlabisa that the hospital doctors are less likely to give an injection than the GPs, and a small minority of patients appreciate this approach. Hopefully with a consistent policy and explanations appropriate for local people, patients can be taught greater understanding of how medicines work and more sophisticated expectations. The dilemma for the

Patients need greater understanding of how medicines work, and how injections are part of it

GP is more acute, as his livelihood may be dependent on continuing a liberal injection policy. It seems that these expectations are likely to take a long time to change, but it is suggested that such change should be anticipated, and it should not always be assumed that all patients will expect an injection. (7% and 11% of patients seeing the GPs and the hospital respectively, didn't want an injection.)

Patients clearly believe that costs are higher in private medicine. This study has not demonstrated that this prevents all patients from using private facilities, but it seems to be a problem for some. Moves to place access to governmental institutions entirely in the control of the private sector seem likely to prejudice the poorer group of patients, and those with chronic diseases.

Continuity of care is rare in both

... Private vs State Health Care

practices, and this also deserves closer attention in the light of clearly established patient preference for continuity. Again this constitutes a major challenge for pressurised public facilities; possibly advances in this area could be more easily achieved by giving patients continuity of care at the nurse practitioner level.

The finding that patients chose a health care provider who is less likely to refer them is cause for concern, as it may also be a factor in late presentation. Where referral is necessary it should be carefully explained, and every effort needs to be made not to pressurize patients into doing what they do not believe is best for themselves. Here many doctors need to be reminded that they are very powerful in the doctor-patient relationship, and this power must frequently be deliberately curtailed in the interests of patient autonomy.

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