A holistic service quality framework for the delivery of patient-centred primary healthcare

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ABSTRACT

Internationally, governments have recognised the constraints facing their citizens with regards to access to affordable, quality healthcare services. This development is evident in South Africa where the majority of the population have limited access to affordable, quality healthcare due to the healthcare inequality between the insured and uninsured. To address this lack of access to quality healthcare, medical experts recommend a focus on patient-centred primary healthcare as opposed to the current system of provider-centred healthcare. This research aims, through the development of a patient-centred framework, to assist in advising healthcare systems for the delivery for patient-centred primary healthcare.

In order to develop a holistic view, all stakeholders involved in the delivery of healthcare were considered in answering the main research question. The study comprised of 43 interviews in total, of which 28 interviews were with uninsured patients who use healthcare facilities in South Africa and 15 medical expert interviews. This information was then consolidated into a framework, and further refined through the literature collected, to form a holistic service quality framework that allows for the delivery of patient-centred primary healthcare.

The holistic service quality framework acts as a mechanism to ensure that the delivery of patient-centred primary healthcare has a positive impact on patient satisfaction. Patient satisfaction can be improved or increased through the levers, available to the providers, identified in the framework. This allows healthcare systems to improve the service quality of the healthcare delivered.

Keywords: Service Quality, Patient-centred, Primary Healthcare
DECLARATION

I declare that this research project is my own work. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration at the Gordon Institute of Business Science, University of Pretoria. It has not been submitted before for any degree or examination in any other University. I further declare that I have obtained the necessary authorisation and consent to carry out this research.

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“DEDICATED TO THE THINGS THAT HAVEN’T HAPPENED YET AND THE PEOPLE WHO ARE ABOUT TO DREAM THEM UP”

-Cornerstone at Stanford Graduate School of Business
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1 Chapter 1: Introduction to Research Problem

1.1 Background to Research Problem
There has been a global focus to reach the Millennium Development Goals set out by the World Health Organisation, however many goals have still not been achieved. Governments have been urged by the United Nations General Assembly resolution, adopted in December 2012, to provide all people with access to affordable and quality healthcare services (WHO, 2014).

Ki-Moon (2013) indicated in the United Nations General Assembly report that there are still a large number of people who face serious deprivation in healthcare and education. Although policies supporting universal free access to quality primary healthcare for women and children have reduced child mortality in some countries in Sub-Saharan Africa, much work still needs to be done (WHO, 2014). Improvement is still needed in healthcare by addressing the areas of universal healthcare coverage, access and affordability (Ki-Moon, 2013).

There are four major issues that governments, healthcare providers, payers and consumers currently face, which are inhibiting the population’s access to affordable, quality healthcare services. These issues include; aging populations and chronic diseases, cost and quality, access to care and technology (Deloitte, 2014).

South Africa is currently experiencing healthcare issues similar to those experienced worldwide (Benatar, 2013). As a result, the government spending on healthcare “is expected to exceed R492-billion over the next three years as South Africa strengthens its healthcare system in preparation for the implementation of a National Health Insurance (NHI) scheme” (SouthAfrica.info, 2014, p.1).

Although the priority of healthcare in South Africa is evident, “the health and well-being of most South Africans remain plagued by a relentless burden of
infectious and non-communicable diseases, persisting social disparities and inadequate human resources to provide care for a growing population” (Mayosi & Benatar, 2014, p.1344). Subsequently, a patient-centred primary healthcare system is seen as a solution, which will enable equitable access to quality healthcare. This approach will place the patient at the centre of the complex delivery system, allowing for the development of a framework suitable to the South African context.

1.2 Quality, Cost and Access to Care

Across the globe, rising healthcare costs make healthcare unaffordable, and therefore, unsustainable. Rising healthcare costs adversely impact patients, as well as providers and insurers, and these higher costs do not necessarily correlate to better results or higher quality care (Deloitte, 2014). Warshawsky (2014) reported that government data has shown that “health costs are the biggest driver of income inequality in America today.”

Access to healthcare is a global issue with one billion people facing lack of access to healthcare (Shah, 2014). Access to healthcare and the improvement thereof, is a goal of governments and a centrepiece of many healthcare reforms around the world (Deloitte, 2014). Population growth is leading to an increase in demand for healthcare. However, access to healthcare is limited due to workforce shortages, patient locations and infrastructure limitations, in addition to rising costs (Deloitte, 2014). The limitation of access to healthcare also directly affects the quality of healthcare, and, as a result, affects many countries as they strive to meet their quality standards.

Quality, because of its very nature, is difficult to define. Healthcare’s complex nature, its many stakeholders with varying interests in healthcare delivery and ethical considerations add to the difficulty of defining quality (Mosadeghrad, 2013). Stakeholder groups have different perspectives, interests and definitions. Therefore, to determine healthcare quality, a multi-dimensional approach is required that encompasses various healthcare stakeholder needs and expectations.
1.3 Healthcare in South Africa

South Africa currently experiences huge healthcare inequality (Burger, Bredenkamp, Grobler & van der Berg, 2012). South Africa has the largest healthcare market in Africa, with the allocation of expenditure between public and private healthcare at 48 per cent to 52 per cent, respectively, of the total healthcare spend (Deloitte, 2014). However, despite the private healthcare expenditure being slightly larger than the public expenditure, only 17 per cent of the population benefits from access to private healthcare via medical schemes (Deloitte, 2014). When out-of-pocket expenditure is taken into consideration, the estimated figure increases to 28 to 38 per cent of the population making use of private healthcare facilities (Deloitte, 2014).

The roll-out of the NHI scheme is expected to extend quality healthcare to the poor, because the majority of the South African population is currently unable to afford the high costs associated with private healthcare (Zuma, 2014). South Africa’s public healthcare system is characterised by inefficiency and inequality. “In the public sector inefficiency is brought upon by the glaring poor quality of healthcare…. In the private healthcare sector it is bought upon by exorbitant fees… this brings a lot of inefficiency” (Mapumulo, 2014, p.2). Effective implementation of the NHI is expected to raise life expectancy, reduce HIV infection in young people and create efficient health systems that provide quality healthcare to all (Mapumulo, 2014).

South Africa, like many other developing countries, is suffering from a double burden of diseases. Communicable diseases are putting strain on the healthcare system, alongside growing instances of non-communicable diseases (Deloitte, 2014). HIV/AIDS is a key focus area within communicable disease, with an estimated 6.4 million people, or 12.2% of the population, being HIV positive in 2012 (Shisana, Rehle, Zuma, Simbaya, Jooste & Pillay-van-Wyk, 2013). The drivers, from a non-communicable disease perspective include an aging population and rising incidence of chronic disease (Deloitte, 2014).

Chronic diseases are another shared demographic trend with the rest of the world, which creates an increase in demand for healthcare (Levitt, Steyn, Dave
& Bradshaw, 2011). Chronic disease is seen as the leading cause of mortality in the world, representing 63 per cent of all deaths (Deloitte, 2014). It has been found that the cost of treatment for diabetes and other chronic diseases is expected to compel a more intense focus on disease education and prevention by governments and healthcare practitioners (Deloitte, 2014).

There has been a push by governments globally to position primary care as the way to transform health systems and improve quality and access to care and contain costs (O'Shea & Palmer, 2014). Primary, or preventative, healthcare has to become the mainstay in the long-term management of patients, such as those with diabetes, heart failure or chronic lung diseases (Khoo Lim & Vrijhoef, 2014).

1.4 Patient-centred Primary Healthcare
Primary healthcare would incorporate primary medical treatment services, education on preventative healthcare and health (O'Shea & Palmer, 2014). It is however not possible to create effective primary care system using a one size fits all approach as the development of the system would not only be shaped by the health problems the country faces, but also the country’s historical background, social beliefs and values (Khoo et al., 2014).

Therefore, patient-centred primary healthcare has been recognised as a solution, to increase the quality of care, by shaping the delivery of care around the complexities of each country (Edvardsson and Innes, 2010). Patient-centred care, therefore, allows for the healthcare system to be designed around the complex interaction between patient, provider and their environment (Stiglitz, 2012).
1.5 Research Motivation

1.5.1 Purpose of the Research

This research answered the main research question:

What is a holistic service quality framework for the delivery of patient-centred primary healthcare for the uninsured?

The roll-out of the NHI is in response for the need to ensure that all South Africans have access to quality care (Zuma, 2014). The majority of South Africans are uninsured as a result of the high costs associated with private medical care (Deloitte, 2014). The NHI scheme therefore aims to ensure that all South Africans, whether insured or uninsured have access to quality care. A patient-centred approach to delivering healthcare has been found to ensure that the patient receives high quality care. This high quality care is a result of the patient being satisfied with the level of service as well as having positive health outcomes. It is therefore necessary to develop a framework that will allow for the delivery of patient-centred primary healthcare to South Africans, which can be used as a mechanism to help with the improvement of primary healthcare clinics in the private and public sectors.

1.5.2 Academic Motivation

While research around service quality and the variables that make up functional and technical quality have been conducted before, each country’s complexities and history will influence each variable differently. Thus, in order to develop a framework, one needs to determine the variables, their impact on patient satisfaction as well as the factors that are inhibiting the delivery of quality care.

The research aims to contribute to the theory base of patient-centred primary healthcare, using service quality as a foundation and building on it through stakeholder engagement. This will allow the complexities facing the South African healthcare system to be captured and analysed.
1.5.3 Research Scope

The research will focus on developing a patient-centred primary healthcare delivery framework, through an exploratory analysis based on interviews with 28 patients using healthcare facilities and 15 experts involved in the delivery of healthcare. It will include patients who are currently medically uninsured and experts who operate in the private and public sectors.
2 Chapter 2: Literature Review

2.1 Introduction
This chapter will review the literature regarding the importance of primary healthcare with specific emphasis on a patient-centred approach to improve quality and accessibility of the uninsured. The dimensions of service quality will be analysed from a technical and functional point of view. The functional aspects will be determined from the literature surrounding patient satisfaction and the SERVQUAL model. The technical aspects will be formed through the collection of literature surrounding the importance of employee competence when delivering quality healthcare. Finally, all stakeholders within the primary healthcare sector will be classified in an attempt to define the parameters of stakeholder involvement.

2.2 Healthcare Reformation
Healthcare systems are under pressure to control their increasing costs, to better adapt to evolving demands, to improve the quality and safety of care and ultimately to ameliorate the health of their populations. In addition, healthcare systems are in dire need of reform to control increasing costs, better adapt to evolving demands and improve the quality and safety of care (Denis & Forest, 2012). A key strategy to reform healthcare is to integrate primary care and public health to serve the underserved communities that cannot afford medical insurance (Pinto, Wall, Yu, Penido & Schmidt, 2012).

2.2.1 Primary Healthcare
Health systems that have a strong primary healthcare sector, such as Cuba and Costa Rica, are generally more effective, efficient and generate better patient outcomes than those with a weak primary healthcare sector (Starfield, Shi & Macinko, 2005). Primary or preventative care has become an increasingly important aspect of healthcare delivery due to the contemporary challenges of increased rates of chronic and preventable diseases, new treatments becoming available and the rising cost of healthcare (Dadich & Hosseinzadeh, 2013).

Starfield (2008, p.8-9) defines primary healthcare as the “level of a health service system that provides entry into the system for all new needs and
problems, provides person focused care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere or by others”. This research will use primary healthcare as the main system of healthcare being studied.

Traditionally, healthcare systems focused on acute, episodic care, addressing the needs of inpatients. However, countries, namely the United Kingdom, Denmark, The Netherlands, Japan, Australia, Sweden, the United States, Austria and Germany are now moving towards a more holistic care model, which considers the aging population as well as the corresponding increases in chronic diseases (Khoo et al., 2014). A global push by governments has seen primary healthcare positioned as the means to transform current healthcare systems and improve the quality and accessibility whilst maintaining costs (O’Shea & Palmer, 2014).

2.2.2 Healthcare for the Uninsured
Gulley, Rasch & Chan (2011), documented how being uninsured can adversely affect persons with chronic conditions and disabilities. Unlike individuals who require simple routine care and screening, adults with chronic conditions have needs that may persist over time, often leading to costly healthcare services. Persons with chronic conditions frequently have multiple long-term conditions and may develop acute conditions over time (Gulley et al., 2011).

Health insurance is viewed as a necessity to ensure that people have access to medical care and protection against the risk of costly and unforeseen medical events (Rhoades & Cohen, 2006). The implementation of a National Health Insurance (NHI) scheme is a healthcare reform that is set to ensure that all “citizens and legal residents benefit from healthcare financing on an equitable and sustainable basis” (McLeod, 2012, p. 636). The implementation of a NHI scheme is implemented due to the burden that the uninsured would form on the country’s safety net infrastructure and without additional allocation many of those structures would collapse (Stephens & Ledlow, 2010).
When an uninsured person is ill, and aware of the costs of care and their inability to pay, the individual would wait to seek care until such a time that the acuity or severity of the problem increases (Stephens & Ledlow, 2010). At this stage, the cost to care for the patient is greater than the cost incurred had the person sought medical treatment at the onset of the problem. Furthermore, lack of health insurance influences the health behaviours of the uninsured (Stephens & Ledlow, 2010). They are less likely to obtain screenings and participate in other health promotion exercises.

The combination of uninsured individuals with chronic or episodic conditions puts a “Herculean” burden on healthcare systems due to the lack of continuity of primary care and over time, this problem will become larger and more complex (Stephens & Ledlow, 2010, p. 100). Primary care coverage for the uninsured is the first necessary step to reform and can be more cost effective and tolerable than a major system reform (Stephens & Ledlow, 2010).

2.3 Patient-centred Healthcare

2.3.1 Introduction

There is a growing recognition that complex interaction between healthcare, environment and social context determine an individuals’ health and wellbeing (Stiglitz, 2012; Wilkinson & Picket, 2010; Lynch, Baker & Lyons, 2009). Therefore, due to the different circumstances of each country, it is not possible to have a single recipe or practice that would allow the implementation of a primary healthcare system. A country’s disease burden, historical background and the social beliefs and values will shape the development of a primary healthcare system (Khoo, et al., 2014).

2.3.2 Importance of Patient-centred Healthcare

DuPree, Anderson and Nash (2011, p. 813) explained patient centeredness as a “means that care should be designed around the interest and needs of patients and their families and that quality should be measured by the extent to which those interest and needs are met.” Previously, healthcare was seen to be dominated by a provider-focused system. However, recent research (Wilde-Larsson, Inde, Carlson and Rystedt, 2014; Christensen, Dorrance,
Ramchandani, Lynch, Whitmore, Borsky, Kimsey, Pikulin & Bickett, 2013; Lusk & Fater, 2013) highlights the need to move to a patient-centred delivery model.

Kern, Edwards & Kaushal (2014), conducted a three-year cohort study of primary care physicians. The authors used a longitudinal study to compare quality of care provided by patient-centred medical facilities against physicians not using patient-centred medical facilities. The results concluded that those physicians who implemented patient-centred care “were performing significantly better… on 8 of 10 quality measures” (Kern et al., 2014, p. 745).

The recognition of patient-centred healthcare as a solution to increase the quality of care has led to an increased interest in related concepts like patient focused care, patient closer care and person centred care (Edvardsson and Innes, 2010). There is, however, a dominating theme that there is no accepted patient-centred care definition (Hobbs, 2009; Marshall, Kitson & Zeitz, 2012; Mitchell, Closson, Coulis, Flint & Gray, 2000) and without a common definition or model, healthcare providers tend to ascribe different meanings (Wilde-Larsson et al., 2014).

Patient-centred initiatives include the use of health information technology, measurement of patient perception of care and patient-provider communication (DuPree et al., 2011). The primary construct for the determinants of quality healthcare in South Africa, for this research, will be service quality. The idea of patient perception, concerning patient-centeredness, will be analysed in determining the variables to which patient satisfaction is affected within the healthcare industry in South Africa.

2.4 Service Quality

2.4.1 Introduction

The quality of goods or services is an important dimension in production and operations management (Azam, Rahman, Talib & Singh, 2012). Establishing quality levels of goods and services and assuring that those levels are maintained are vitally important tasks for virtually all businesses and organisations. As a result, businesses need to be able to measure and
understand the dimensions of what determines high quality levels of goods or services. Although quality levels are easily determined for goods, it is more difficult to determine and measure quality levels in services (Mosadeghrad, 2013).

Services, by nature, are intangible, heterogeneous and inseparable (Naidu, 2009). Due to these characteristics, the ability to measure the level of service quality is difficult. Parasuraman, Zeithaml & Berry (1985) defined service quality as the difference between predicted or expected service (customer expectations) and perceived service (customer perceptions). However, many definitions of service quality revolve around the identification and satisfaction of customers' needs and requirements (Cronin & Taylor, 1992; Parasuraman, Zeithaml & Berry, 1988; Rashid & Jusoff, 2009).

Owusu-Frimpong, Nwankwo & Dason (2010) depict service quality in service encounters as the outcome of an interactive process between the service provider and the service receiver. Therefore, the interactive features of service quality in service encounters are crucial to the ultimate outcome. Patient satisfaction is a result of the influence the provider has over the receiver (Padma, Rajendran & Sai, 2009). There is much debate around the concepts of patient satisfaction and service quality and whether they are seen to be separate constructs or whether patient satisfaction is a construct of service quality (Gill & White, 2009; Faezipour & Ferreira, 2013; Naidu, 2009; Owusu-Frimpong et al., 2010).

Naidu's (2009, p. 372) results depicted that “quality is positively correlated with satisfaction, however, the direction and strength of the predictive relationship between quality and satisfaction remain unclear”. Counter to this, however, Gill & White (2009, p. 12) point out that “with regard to health services, the focus should be on measuring technical and functional (how care is delivered) quality and not patient satisfaction”. Owusu-Frimpong et al. (2010, p. 206) analyses on Anderleeb & Conway (2006) results showed that “service quality could be viewed as the whole family picture album, while satisfaction is just one snapshot".
Rashid & Jusoff (2009) divide service quality into two categories, namely technical and functional quality. Technical quality in the healthcare environment is defined primarily based on the technical accuracy of the diagnosis and procedures (Miranda, Chamorro, Murillo & Vega, 2010). Functional quality refers to the manner in which the service is delivered to the patient (Miranda et al., 2010). Furthermore, “satisfaction is dependent on the ability of the supplier to meet the customers’ norms and expectations” (Padma et al., 2009, p.167). Therefore, this research will use patient satisfaction as a factor of functional quality.

2.4.2 Demand-Side: Functional Quality
In the healthcare industry, patients usually rely on the functional aspects, rather than technical aspects of quality, as the patients often do not have the knowledge to evaluate the quality of the diagnosis and therapeutic intervention process effectively (Rashid & Jusoff, 2009). Thus, the dimensions of the functional aspects of quality will be determined from the patients’ perspective, or demand side.

2.4.2.1 The Service Quality Scale Dimensions
The Service Quality (SERVQUAL) model, developed by Parasuraman et al. (1988), provided an instrument to measure service qualities across a broad range of services. The SERVQUAL model led to the development of five dimensions of service quality that is applicable, in general, to service-providing organisations. These dimensions, adapted from Rashid & Jusoff (2009), are:

1. Reliability: the ability to perform the required service reliably and accurately.
2. Responsiveness: the willingness to help customers and provide prompt service.
3. Empathy: caring, individualised attention provided to customers.
4. Assurance: the knowledge and courtesy of employees and their ability to inspire trust and confidence.
5. Tangibility: the appearance of personnel, equipment and the physical facilities.
Butler, Oswald and Turner (1996) questioned the applicability of the SERVQUAL model to healthcare. A number of authors (Fowdar, 2005; Sohail, 2003; Zineldin, Hatice Camgöz-Akdağ & Vasicheva, 2011) have modified their study by adding relevant or dropping irrelevant dimensions. It is normal practise to adapt the SERVQUAL dimensions as required (Parasuraman et al., 1988).

de Jager & du Plooy (2011) investigated two of the dimensions associated with SERVQUAL, namely; tangibility and reliability, in a public hospital in South Africa. Their findings indicated that there were clear gaps concerning the customers’ perceptions and expectations within the two dimensions. de Jager & du Plooy (2011) recommend that the variables tested should be broken down into individual components in order to arrive at a better understanding of what is expected by the patients.

2.4.2.2 Patient Satisfaction
Pascoe (1983, p. 189) defines patient satisfaction as “a healthcare recipient’s reaction to salient aspects of the context, process and results of their service experience.” Faezipour and Ferreira (2013) further refine patient satisfaction to represent patient fulfilment concerning cost, accessibility to resources and services, and patient wellbeing. There is a desired need for a measurement of patient satisfaction within the healthcare industry for all stakeholders due to it being one of the articulated goals of healthcare delivery (Gill & White, 2009).

Lochman (1983) identified factors that have the most noticeable relationship to patient satisfaction including the accessibility of medical care, the organisational structure of clinics, treatment length, perceived competence of physicians, clarity and retention of physicians’ communication to patients, physicians’ affiliated behaviour, physicians’ control and patients’ expectations. Tucker & Adams (2001) determined which factors would lead to patient satisfaction, including care, empathy, reliability and responsiveness. In contrast, Crowe, Gage, Hampson, Hart, Kimber, Storey and Thomas (2002) identified 138 studies investigating determinants of satisfaction. The authors agreed that the definitive conceptualisation of satisfaction within healthcare has yet to be achieved and that the understanding process by which patients become
satisfied or dissatisfied is yet to be answered. Hawthrone (2006) further emphasised the point that patient satisfaction suffers from the inadequate conceptualisation of the construct.

Naidu (2009) however, identified the dimensions that affect patient satisfaction within the healthcare industry through a review of 24 articles from international journals, identifying dimensions of patient satisfaction. These factors include access, care quality, cost, physician role and behaviour and tangibles (physical facilities) (Naidu, 2009). These are similar to the general service quality dimensions identified by Rashid & Jusoff (2009) such as reliability, responsiveness, empathy, assurance and tangibles.

2.4.3 Supply Side: Technical Quality
Technical quality, in the healthcare context, is defined based on technical accuracy of the medical diagnosis and procedures or the compliance of professional specifications (Rashid & Jusoff, 2009). Naidu (2009) established that patients might be unable to assess medical services technical quality. de Jager & du Plooy (2011) added that technical quality is the actual output of the service that can be measured objectively. Rashid & Jusoff (2009) defined technical quality further, referring to the competence of the staff as they go about performing their routines including clinical and operating skills of the doctors and the nurses’ familiarity with the administration of drugs.

Eiriz and Figueiredo (2005) believed that the complexity of healthcare services and the patients’ lack of technical knowledge must allow for the incorporation of broader healthcare quality measures such as financial performance, logistics and professional and technical competence. Isaac, Zaslavsky, Cleary & Landon (2010), study on the relationship between patients’ perception of care and measures of hospital quality and safety established that there were consistent relationships between patient experiences and technical quality. It is thus vitally important to ensure that there are technical quality initiatives in place to result in an increase in patient satisfaction.
In addition to this, the study by Alexander, Hearld, Jiang & Fraser (2007), investigating how various quality methods are applied concluded that regardless of the method, success is related to internal factors. This is supported by Leggat, Bartram, Casimir & Stanton (2010) whom declared that prior to a Quality Initiative (QI) implementation program managers should focus on enhancing employee skills. This notion of the need for provider competence as the base to technical quality is supported by Rashid & Jusoff (2009).

Khan & Ramachandran (2012, p. 921), define competence as “an ability to do something successfully or efficiently.” In the clinical setting, competence is the ability to make satisfactory and effective decisions or to perform a skill in a specific setting or situation (Khan & Ramachandran, 2012).

Healthcare providers not only need to possess the necessary technical skills to practise but must also be proficient in other competencies that influence their professional practise. Providers must be able to educate others effectively, critically evaluate their own professional practice and have good communication skills (Rowe, Frantz & Bozalek, 2012).

The changes in demographics require that multicultural factors be considered in the delivery of quality patient-centred care (Hammerich, 2014). Cultural competency is a broad concept used to describe a variety of interventions that aim to improve the accessibility and effectiveness of healthcare services. It was developed in response to the recognition that cultural and linguistic barriers between healthcare providers and patients could affect the quality of healthcare delivery (Truong, Paradies & Priest, 2014). Cowan (2009), evaluation on cultural competence determined that there was a lack of consensus on how cultural competence can be defined. However, Cowan (2009), found that it was apparent that some agreement exists on the need for the components of cultural awareness, cultural knowledge, cultural skill and cultural sensitivity.

Truong et al. (2014), study resulted in the findings that “seven of the nine reviews that examined patient/client related outcomes generally found evidence of some improvement in health outcomes due to the training of providers in
culture of those they provide too. Due to the improvement in outcomes found in Truong et al. (2014), it is evident that cultural competency needs to exist in order to ensure that patient-centred healthcare is being practised.

Figure 1: A comprehensive model to understand healthcare services (Naidu, 2009).

Figure 1, above, adapted from Naidu (2009), is a comprehensive model to understand healthcare services. It depicts the relationship between the healthcare provider and the patient and how that relationship affects health service quality. The involvement of the patient is an inherent feature in healthcare services whereby he or she influences outcomes quality through compliance, describing the right symptom and physically undergoing treatment.
2.5 Holistic Approach

2.5.1 Introduction
In the previous section, the construction of quality healthcare came from the constructs of both technical, as well as functional aspects. Mosadeghrad (2013) categorised these two aspects into demand and supply-side. Functional aspects are categorised under demand-side quality, as this approach defines quality as “satisfying customer expectations and needs” (Mosadeghrad, 2013, p.205). Technical aspects are shown to be categorised under supply-side quality as this approach defines quality as “conformance to specifications, requirements or standards” (Mosadeghrad, 2013, p.205).

A holistic approach emphasises the importance of the system as a whole, as well as the independence of the parts within the framework (van Gemert-Pijnen, Nijland, van Limburg, Ossebaard, Kelders, Eysenbach & Seydel, 2011). Through stakeholder engagement, a holistic approach encompasses both demand side and supply side aspects of quality healthcare with particular emphasis on the constructs of which they consist. In order to establish the variables affecting patient satisfaction, a holistic approach is used allowing for the engagement of all stakeholders.

2.5.2 Stakeholders
Chen (2009, p. 1782) referred to a stakeholder as “any group or individual who can affect or is affected by the achievement of the organisation’s objectives.” Freeman (1984) stated that stakeholder theory ensures that the organisation is responsible for the well being of its stakeholders such as customers, suppliers, employees, investors and communities who are identified by their interest in the organisation. Thus, an organisation ought to be “managed in the interest of its stakeholders” (Freeman, 1994, p. 417).

Primary stakeholders are directly related to the outcomes and operations of the organisation, while secondary stakeholders are not directly related to the organisation, even though they are able to influence and be influenced by its operations and outcomes (Hillman & Keim, 2001). The primary stakeholders involved in the delivery of healthcare are those who take an active role in its
delivery. In healthcare, different stakeholders have different perspectives, definitions and interest and therefore a multidimensional analysis that encompasses all stakeholders is required (Mosadeghrad, 2013).

Herald, Alexander, Beich, Mittler & O'Hora (2012) identified physicians, hospitals, insurers, employers and other purchasers and consumers as stakeholders. In addition to these, Lauvergeon, Burnand & Peytremann-Bridevaux (2012) added the ministry of health in various provinces, the department of public health, medical associations and patient organisations. In addition, Hinchcliff, Greenfield, Westbrook, Pawsey, Mumford & Braithwaite (2013), identified accreditation agencies and health professional colleges and associations as stakeholders.

For the purpose of this research, the stakeholders to be considered are those that shape healthcare delivery, as well as those who take an active approach in improving the accessibility to patients. The stakeholder groups identified include providers, clients, regulators, payers and professional medical associations.

These stakeholders (adapted from Mosadeghhard, 2013 & Lauvergeon et al., 2012) are illustrated in Figure 2 below.
2.5.3 Payers

Payers can be classified as private individuals or parties, such as insurance companies and the government (Lenert, 2009). The South African public sector’s aim is not to make a profit. However, the goals are more diverse with various external stakeholders (de Jager & du Plooy, 2011). The public sector is funded by general tax (Rowe & Moodley, 2013); this implies that both taxpayers as well as government can be classified as payers of healthcare, although government takes an active role in distributing the funds. It is found that South Africa has out-of-pocket payers who can self-fund their primary healthcare, but would rely on state funded institutions for secondary and tertiary healthcare (Rowe & Moodley, 2013). Certain South Africans depend entirely on private medical scheme cover, which would give them exclusive access to private healthcare (Rowe & Moodley, 2013).

For the purpose of this research, payers will be classified as government, individuals and private medical insurance schemes. This will ensure that all payers are included in this stakeholder group.
2.5.4 Clients
Clients, or patients, can be defined differently depending on what perspective they are analysed through. A consumerist model may view patients as consumers, whereas, a socialist model may view patients as beneficiaries or entitled users (Rowe & Moodley, 2013). The consumerist model has resulted in privatisation, which promotes competition with resultant quality improvement and cost containment (Rowe & Moodley, 2013). This research will define patients from the consumerist perspective, where patients consume health and providers are accountable to the patients in providing quality healthcare at an affordable cost.

2.5.5 Providers
Saksena, Xu, Elovainio & Perrot (2012) broadly classified healthcare providers as government, private and non-governmental organisations (NGO). Therefore, providers may be divided between private and public (government) healthcare providers. Furthermore, Kumar, Ghildaya & Shah (2011), classified providers as doctors, allied health professionals, hospitals and other healthcare facilities.

The South African population makes use of both formal and informal health services (Knight & Maharaj, 2009). The use of traditional healers, or informal health services, is common in South Africa (Finlay, Lancaster, Holtz, Weyer, Miranda & van der Walt, 2012). Finley et al. (2012) reported that the reasons for the use of traditional healers include continuity of care and preventative care. It is thus important to include informal, as well as formal, healthcare providers as subjects in this research, due to the roles they play in primary healthcare. These two channels are illustrated in figure 3 below.
2.5.6 Regulators

Regulatory agencies or regulatory boards can be classified as state, provincial, planning commission or national medical or nursing boards, (Rooney & Van Ostenberg, 1999). Further to this, Owusu-Frimpong et al. (2010) determine that the state holds the regulatory powers within the healthcare industry.

The South African regulatory agencies include the Department of Health (DoH) (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009), the Health Professions Council of South Africa (HPCSA) (Peer & Fagan, 2012), the South African Medical Association (SAMA) (White, 2010 ) and the Hospital Association of South Africa (HASA) (Matsebula & Willie, 2007).

2.5.7 Professional Medical Associations

Professional Medical Associations (PMA) bring together “physicians in the same speciality or subsequently, make many distinctive contributions to advancing the quality of medical care” (Rothman, McDonald, Berkowitz, Chimonas, DeAngelis, Hale, Nissen, Osborn, Scully Jr, Thomson & Wofsy, 2009, p. 1367). PMA’s play a vital role in medical education, issuing detailed practise guidelines that set the standards for efficient and effective patient care and they advocate for the particular interests of their members, for patients and for what they believe to be the best interests of society (Rothman et al., 2009).
2.6 Conclusion

The global crises of increasing rates of chronic and preventable diseases have seen the importance of primary healthcare rising. The uninsured are unable or unwilling to access primary healthcare due to the costs associated with the treatment and prevention of certain conditions. This puts immense strain on the second and tertiary institutions (Stephens & Ledlow, 2010). As a solution, healthcare reform includes the implementation of a National Health Insurance scheme to ensure equitable access and care is available to all. In addition to this, a holistic model that positions the patient at the centre of the primary healthcare delivery system is seen, by governments, as a means to transform the current healthcare system, thus improving quality and accessibility (O’Shea & Palmer, 2014).

Due to the complexity and context of each country, it was found that it is not possible to have a single solution to implement changes to solve healthcare problems in the respective countries. This is due to the circumstance of a country, including its current health problems, historical background and social beliefs and values that will shape the interactions between providers and users (Khoo, et al., 2014). A solution was found for dealing with the complexity and context within each country, which is a patient-centred approach (Wilde-Larsson et al., 2014).

Further, this chapter unpacked the literature around service quality and the dimensions in which it is determined within the healthcare sector. It was found that service quality is constructed from two categories, namely technical and functional quality (Rashid & Jusoff, 2009). It looked at the idea of patient satisfaction and found that it is the determining construct of functional quality. The factors of patient satisfaction were analysed and found to be similar to the general service quality dimensions identified by the SERVQUAL model (Naidu, 2009).

The technical quality aspect of service quality was unpacked from the literature and it was found that due to the complexity of healthcare services patients often do not have the technical knowledge to assess the quality received. The
inability of patients to determine the level of technical quality supports the notion of incorporating quality measures within the delivery system. However, Alexander et al. (2007) concluded that regardless of the method, success was related to internal factors. Competence was found to be the internal factor affecting the delivery of technical quality.

Competence was defined, and it was established that employees need to have both cultural competence as well as the correct skills necessary to perform the required tasks. The importance of cultural competency was established in order to understand the multicultural patients and allow the delivery of quality patient-centred care (Hammerich, 2014).

Due to the nature of service quality being influenced by functional and technical aspects and the inability of the patient to determine the level of technical quality a holistic approach was recommended. Thus, stakeholder engagement allows the ability to develop a holistic framework encompassing both the demand and supply side aspects of healthcare. The stakeholders groups were identified, and include providers, clients, regulators, payers and professional medical associations.
3 Chapter 3: Research Question

3.1 Introduction
In the previous chapter, the importance of a patient-centred approach to primary healthcare was established and the need to determine the variables affecting patient satisfaction was discussed. Additionally, the importance of a holistic approach was established, ensuring that all stakeholders are involved in the processes leading to the improvement of patient satisfaction for the uninsured citizens of South Africa. This is important due to the current South African government’s policy of instituting a National Health Insurance scheme, with the goal of ensuring that all South Africans will have equitable access and care.

The purpose of this research is to establish the variables and the extent to which they currently affect patient satisfaction of the uninsured in South Africa. Furthermore, using medical expert opinions, the external factors that affect the delivery of quality healthcare satisfying the patient. Finally, a framework will be developed as a means for service providers to improve patient satisfaction within their primary healthcare clinic.

3.2 Research Questions
The following main research question has been developed from the literature review and in alignment with the research objectives set out in the first chapter. The main research question will be answered by research questions 1 and 2.

3.2.1 Main Research Question
What is a holistic service quality framework for the delivery of patient-centred primary healthcare for the uninsured?

3.2.2 Research Question 1
Which variables affect the delivery of functional quality patient-centred primary healthcare for the uninsured?

3.2.3 Research Question 2
Which factors affect the delivery of technical quality patient-centred primary healthcare?
4 Chapter 4: Research Methodology

4.1 Introduction
The previous chapter stated the main research question, as well as the two questions that were tested in this research to answer the main research question. The purpose of this chapter is to discuss and articulate the research methodology used to gather and analyse the data set obtained.

4.2 Method
The research questions were addressed through exploratory qualitative study. An exploratory approach is used to deduce emerging themes from the data and to develop theoretical perspectives (Saunders, Lewis and Thornhill, 2009). Moreover, qualitative research was adopted as it is “designed to tell the researcher how (process) and why (meaning) things happen as they do” (Cooper and Schindler, 2014, p. 144). Qualitative research enables the researcher to get a better understanding of the different meanings that people place on their experiences. It helps the researcher delve deeper into people's hidden interpretations, understandings and motivations (Cooper and Schindler, 2014).

Some qualitative researchers promote a purely inductive approach, which allows for the emergence of new meanings, without the interference of prior theory and propositions (Saunders et al., 2009). However, in this research, a framework was formulated and then refined through an induction-deduction approach whilst remaining open to new meanings and realities (Saunders et al, 2009). Perry (2000) supports this notion by outlining the importance of an induction-deduction approach and states, “pure induction without prior theory might prevent the researcher from benefitting from existing theory, just as pure deduction might prevent the development of new and useful theory” (Perry, 2000, p. 309).

4.3 Rationale for the Research Method
An exploratory approach was used to provide the researcher with an opportunity to conduct in-depth interviews and to probe for answers and explanations where clarity was sought in establishing the variables currently
affecting patient satisfaction of the uninsured in South Africa. Additionally it allowed the experts to give their opinions on which factors are currently affecting the accessibility and equitable care. Finally, their expertise and input was used to build a framework in order to improve the accessibility of quality healthcare to the population.

4.4 Population
According to Struwig & Stead (2001), a population refers to a complete set of data, including all possible respondents in a research project and is used to draw a sample for testing. The population of this research included patients who are currently uninsured, as well as providers, payers, regulators and professional medical associations that are involved in the delivery of primary healthcare within the South African context. The population was defined in Chapter 2 by adapting the literature of Mosadeghard (2013) & Lauvergeon et al. (2012).

4.5 Sampling
To get rich information and different perspectives, this research consisted of five sample categories. Within these five sample categories, two distinct sampling methods were used that were judgement and purposive sampling.

The composition of the sample categories was as follows:

Sample 1: Consisted of uninsured users of both private and public primary healthcare facilities (Patients).
Sample 2: Consisted of providers of primary healthcare both on behalf of the government as well as private practises or clinics (Providers).
Sample 3: Consisted of third party payers, private payers and government who pay for the healthcare service (Funders).
Sample 4: Consisted of individuals involved in the implementation of regulation within the South African government (Regulators).
Sample 5: Consisted of individuals working in professional medical associations (PMAs).
Sample 1:

Non-probability, purposive sampling techniques were used when selecting individuals who used primary healthcare facilities and were uninsured. Specifically, judgement sampling was used in order for the researcher to select “sample members to conform to some criterion” (Cooper and Schindler, 2014, p. 359). In this case, the sample member’s chosen must have frequented a primary healthcare facility or practice whilst uninsured.

Sample 2-5:

Non-probability sampling techniques, such as purposive and snowballing sampling were used to select the individuals or institutions in the healthcare sector. Purposive sampling was used, because it allowed the researcher to choose “participants arbitrarily for their unique characteristics or experience, attitudes or perceptions” (Cooper and Schindler, 2014, p. 152). Snowball sampling was used due to the researcher’s need to penetrate a specialised area (Saunders et al. 2009).

i. Selection Criteria for Sample 1

In order to ensure that only patients who served the purpose of this research were selected, in a sequential order, the following criteria was utilised to select patients:

1. The patients selected used either public or private primary healthcare facilities in both formal and informal sectors; and
2. The patients had used any of the facilities within the last year; and
3. The patients did not have medical insurance at the time of treatment; and
4. The facilities patients used were based in Gauteng.

ii. Selection Criteria for Sample 1

The selection criteria for the other stakeholders was:
1. People from organisations that were involved in the delivery of primary healthcare, either as providers, regulators, payers or medical associations.

### 4.5.1 Sample Size:

Table 1: Sample sizes

<table>
<thead>
<tr>
<th>Sample Category</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample 1: Patients</td>
<td>28</td>
</tr>
<tr>
<td>Sample 2: Providers</td>
<td>9</td>
</tr>
<tr>
<td>Sample 3: Payers</td>
<td>3</td>
</tr>
<tr>
<td>Sample 4: Regulators</td>
<td>1</td>
</tr>
<tr>
<td>Sample 5: PMA</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

### 4.6 Unit of Analysis

The unit of analysis was the experience and insight of the individuals who were identified as stakeholders in the delivery of primary healthcare within the South African context.

### 4.7 Data Collection

An interview schedule was developed and used to guide the conversation. The interview schedule was designed using the key aspects and specific research questions pertinent to the research that emanated from the literature review (Cooper & Schindler, 2014). Five different interview schedules were designed for each sample category and are shown below:

- Appendix 1: Interview Guide for User of Primary Care Facilities.
- Appendix 2: Interview Guide for Providers of Primary Care.
- Appendix 3: Interview Guide for Third Party Funders
- Appendix 4: Interview Guide for South Africa Regulators
- Appendix 5: Interview Guide for Professional Medical Associations

The interview schedule was composed of open-ended questions and included sections for note taking during the interview. A voice recorder was used to record the discussions during the interview schedule.
4.7.1 Pilot study on the Interview Schedule
A pilot test of the interview schedule was conducted in order to detect weaknesses in design and instrumentation (Cooper & Schindler, 2014). This allowed the interview schedules to be conducted ensuring that there was no ambiguity and that the questions could be easily understood. The interview schedules were pretested on patients and individuals who were knowledgeable about the area being researched.

The following was accomplished through this process:

• The structure and the questions, including the interview schedule, were finalised. This included linguistic changes to the questions; and
• The wording of the questions were tested to ensure that they could be understood by the interviewee; and
• Allowed interviewing techniques to be practised; and
• The recording device was working properly; and
• The interview session would be completed within the allotted time frame.

4.7.2 Data Collection Method
An interview was the primary data collection technique for gathering data in qualitative methodologies (Cooper & Schindler, 2014). The researcher chose to collect data using semi-structured interviews, which allowed for a few specific questions to be asked and was followed by the interviewer probing the interviewee’s lines of thought. Semi-structured interviews made it possible for the interviewee to draw on their knowledge and experiences whilst allowing for probing questions where the interviewee’s response was not clear.

There were two means used when conducting the interviews. Face-to-face as well as Skype interviews were conducted. Face-to-face interviews were held at either the interviewees’ place of work or convenient and conducive public places. Three interviews were held over Skype, as the interviewee was not able to meet face-to-face. Interviewees’ were given the freedom to choose the time and date that was convenient for them.
The researcher firstly conducted the interview by explaining to the interviewee the purpose of the research and that the respondents were not required to divulge information they preferred to withhold. The researcher then explained what was expected from the interviewee, including the amount of time that would be required. The interviewee was notified that their participation was voluntary and that they may withdraw at any time without fear or negative ramifications. It was then explained how the interviewee’s confidentiality would be protected. Confidentiality will be further explored in Chapter 5.

The interview was interactive, and as a result, the researcher formulated each subsequent question based on the respondent’s personal experiences and willingness to answer. This however was done in accordance to the interview schedule (Annexure 1-5) developed. As opposed to quantitative methods where the interviewee is forced to choose from fixed responses, the qualitative study allowed the interviewee the opportunity to respond in their own words (Saunders et al, 2009). The researcher used a minimal response technique, along with paraphrasing, summarising and clarifying techniques (Saunders et al, 2009). This allowed the researcher to test his own understanding and to sharpen the focus of vague comments.

The following data collection method was followed for each interview (Miles & Huberman, 1994; Patton, 2005; Saunders et al, 2009 and Welman & Kruger, 2001):

1) The researcher conducted the interview
2) The researcher transcribed the interview from the recordings and notes taken. These first two steps created a platform for a qualitative analysis.
3) The researcher acknowledged any insightful and analytical aspects from the notes taken during the interview for use in future interviews and analysis.
4) The researcher then combined and organised his notes into themes. A record was taken of any new themes emerging and therefore adjusted to the interview schedule (Appendices 1-5) accordingly to allow for further investigations of the new themes.
5) The researcher repeated the above steps for subsequent interviews.
The researcher used the above stated data collection method to achieve reliability and generalizability in the collection of qualitative data (Miles & Huberman, 1994 and Srnka & Koeszeg, 2007). The collection of data was designed in a structured manner and processed according to the above procedures (Srnka & Koeszeg, 2007). The collection of data, using an inductive approach, allowed for the essence of the new phenomenon to be captured, which therefore increased the validity of the study (Srnka & Koeszeg, 2007). The transcribing of the interviews took two to three hours per interview to ensure that all information was collected.

4.8 Data Analysis

Data analysis allows the process to bring order, structure and meaning to vast amounts of data collected (Lal, 2001). The need for meticulous documentation and concise disclosure of the entire analysis process, including all stages and immediate outputs is necessary, due to the absence of detailed information on the procedure of qualitative research (Srnka & Koeszeg, 2007).

The following stages have been identified by Srnka and Koeszegi (2007) in conducting data analysis within a qualitative study:

1) **Unitisation** allows for the unit of analysis from the transcriptions to be divided into different themes and patterns using content analysis.

2) **Categorisation** develops a framework of categories relevant to the themes and patterns that have emerged. It is necessary for this framework to be significant to the research question.

The data will be analysed through content, narrative and comparative analysis. Content analysis is a way of systematically analysing the data collected from the interviews by identifying the occurrence of themes and how they have been portrayed (Welman & Kruger, 2001). Content analysis will lead to two major outcomes, which are new theoretical insights and coded data (Srnka & Koeszeg, 2007). Narrative analysis allows the richness of the data to be retained, allowing patterns to develop (Saunders et al, 2009). Comparative analysis will be used to compare the units of analysis across all semi-structured interviews (Yin, 2003).
4.9 Limitations

4.9.1 Researcher Bias
Due to the nature of a qualitative study, the researcher influences the results, which causes the research to be subjective and relative. The researcher, in this research, has limited experience in research and thus in order to mitigate the inexperience the researcher sought the advice of a more experienced researcher.

4.9.2 Geographic Bias
Due to the area in which the research was conducted, a geographical bias may be evident. The research was conducted on patients living in an urban environment in Gauteng, South Africa. Their satisfaction could be completely different to those living within a rural environment or in different provinces around South Africa.

4.9.3 Validity and Reliability
Validity is important in research as it is concerned with whether a researcher is measuring what needs to be tested and if the results are credible and can be applied elsewhere (Yin, 2003 & Saunders et al, 2009). A consistency matrix, showing how the research questions are being addressed, was compiled in order to improve the validity of the research.

Qualitative research does not pursue a statistical generalisation across a population but rather concerned with a phenomenon in a definite time and place. To improve external validity, the interviews need to be replicated across other samples (Saunders et al, 2009).
5 Chapter 5: Results

5.1 Introduction
The previous chapter explained the methodology used to test the main research question highlighted in Chapter 3. This chapter will present the findings of the research.

5.2 Sample Description

Sample 1: 28 patients were interviewed with ages ranging from 24 years old to 54 years old. Of the 28 patients interviewed, 16 were males and 12 were females. All these individuals were selected as being uninsured patients, which was in line with the screening criteria. The interviews were conducted in three districts around Johannesburg, namely; Ferndale, Kempton Park and Randburg. Table 2, below, shows the make-up of the patients interviewed as well as the areas in which the interviews were conducted.

<table>
<thead>
<tr>
<th>Area</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferndale</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Kempton Park</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Randburg</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Total:</td>
<td>16</td>
<td>12</td>
</tr>
</tbody>
</table>

Sample 2: The sample of providers was made-up of nine interviews, consisting of seven private practices and two public institutions. The providers of healthcare included two clinical nurses from a private clinic (Clinical Nurse 1 and 2), three hospital owners/managers (Hospital Owner/Manager 1, 2 and 3) and two private (Doctor 1 and 4), as well as two public (Doctor 2 and 3) medical doctors. The researcher experienced difficulty in interviewing public clinic nurses due to the inability to get permission from their seniors in the required time. Table 3, below, illustrates the positions the providers held and the sector in which they practised.
Table 3: Composition of the providers interviewed including their position and the sector in which they practise.

<table>
<thead>
<tr>
<th>Position</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Nurse 1</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Clinical Nurse 2</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital Owner/Manager 1</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital Owner/Manager 2</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital Owner/Manager 3</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Doctor 1</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Doctor 2</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Doctor 3</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Doctor 4</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Sample 3:** The third party payers consisted of two employees from two of South Africa’s leading medical aid companies, as well as a manager of government clinics within the Ekurhuleni District in Gauteng. Medical Aid 1 represented the largest and most prominent medical aid administration and healthcare management company in South Africa. Medical Aid 2 represented a company that is seen as the global thought leader in wellness behavioural change and its integration with health, life and short term insurance. The clinical manager is responsible for 36 primary healthcare facilities within the Ekurhuleni District in Gauteng. Table 4, below, illustrates the interviewees and the sector in which they practised.

Table 4: Composition of the third party payers and the sector in which they practise.

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Aid 1</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Medical Aid 2</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Clinical Manager</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Sample 4:** An interview with one regulator was conducted (Regulator 1); the interviewee was the same person who was interviewed as a third party payer as a manager of the 36 primary healthcare facilities. A second interview was conducted where the interviewee was interviewed as a regulator.
Sample 5: The sample was comprised of two specialists (Specialist 1 and 2) who work for an organisation whose vision is to give “everyone the best care and health possible.” The organisation specialises in working with health systems, countries and other organisations on improving quality, safety and value in healthcare. The first interviewee is based in the United States but has lived and worked in South Africa for 7 years, working closely with the Department of Health in an attempt to improve the healthcare quality. The second interviewee is a South African doctor who works for the organisation consulting to the Department of Health.

5.3 Confidentiality
For the purposes of confidentiality, the identities of the organisations or individuals interviewed have intentionally not been disclosed in the research findings. This is in line with the research methodology outlined in Chapter Four. Ensuring confidentiality in this research is ethically responsible and assisted in obtaining unbiased and informative responses from the interviewees. Confidentiality was ensured by coding the actual interviewee’s name with a fictional name such as Interviewee one, two or Doctor one, two etc. The quality and content, however, have not been altered.

5.4 Results

5.4.1 Research Question 1: Which variables affect the delivery of functional quality patient-centred primary healthcare for the uninsured?
Patient satisfaction is affected by five variables, namely:

- Access
- Physicians' Role and Behaviour
- Care
- Cost
- Tangibles

In Table 5, below, it lists the five variables affecting patient satisfaction and shows how many interviewees cited each variable as being the significant factor.
affecting their satisfaction. The commentary following the table will provide more detail on each driver, with particular focus on the interviewees’ responses.

Table 5: Variables of patient satisfaction.

<table>
<thead>
<tr>
<th>Variables</th>
<th>No. of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>12</td>
</tr>
<tr>
<td>Physicians Role and Behaviour</td>
<td>9</td>
</tr>
<tr>
<td>Care</td>
<td>4</td>
</tr>
<tr>
<td>Cost</td>
<td>2</td>
</tr>
<tr>
<td>Tangibles</td>
<td>1</td>
</tr>
</tbody>
</table>

Two of the 28 interviewees frequented a traditional healer although they did not seek a traditional healer for primary care and rather visited for “other issues” they were experiencing.

5.4.1.1 Access:
Access was found to be the biggest frustration patients were currently experiencing. This adversely affected their satisfaction in receiving healthcare and was a driver to move from public care, where healthcare was free, towards private care. As shown in Table 4, 12 of the 28 patients interviewed stated that access was the most critical variable affecting their satisfaction.

*Interviewee 12:* “I used to have to get to the clinic at 5 o’clock in the morning to try and be seen as early as possible. Sometimes I would wait until 1 or 2 o’clock before I was seen. My boss wasn’t happy for me to take a half a day to have my check up and so I was forced to go to a private clinic. This was better though. I had to pay but I was seen quickly and now am able to work much quicker.”

*Interviewee 6:* “we have to travel far to the hospital and we sometimes don’t get seen after waiting the whole day and are told to come back the next day. We can’t do this (miss work). I never went back.”

*Interviewee 10:* “I asked to please make an appointment for a time within the next three days as I needed to get back to work but was told that I needed to wait. I only ended up leaving at 15h00.”

*Interviewee 20:* “for me, the most important thing is that I do not have to wait a long time. I cannot afford to sit the whole day waiting. Now I go to a pharmacy and buy the medicine when I am not well. I don’t need the hospital anymore.”

*Interviewee 16:* “I was sick so I went to X but was told I shouldn’t be here after I waited for a long time. I asked them ‘where should I go?’ This is a hospital and I am sick, you should treat me. They said ‘no, you are not in the right place. Because you live there
you must go to X. I just left and went to the private clinic. They treated me right away
and I was happy for that. It cost me money but I was happy.”

Interviewee 5: “I was at Y and was waiting there for two hours. I then see this man
come to the nurse. He give [gave] her 50 bucks and he goes [went] straight in. This
isn’t right, we all waited there for a long time. I wanted to complain but then I was
scared they would never help me.”

5.4.1.2 Physicians Role and Behaviour:
9 of the 28 patients stated that the physicians’ role and behaviour had a major
impact on their satisfaction. The bad attitudes of the doctors or nurses forced 6
of the 9 patients to leave the public clinic and move to a private clinic, even
though a cost was associated with the private clinic.

Interviewee 2: “The nurses are not nice. They shout at you. They [are] not good
people. I was in hospital and a lady was there and the baby was coming. She shouted
for the nurses to come as the baby is coming. The nurse shouted to her to hold on.
She could not hold on. She could not stop and eventually the baby came on the bed.
There was no nurse or doctor. I was very afraid as to when my baby was going to
come.”

Interviewee 11: “I use to go to the government hospital or clinic. I don’t go anymore. All
the workers there treat you badly. It does not matter where you go, they all the same. I
now go to a private doctor. I pay but I know that the nurse will be caring for me and my
problems.”

Interviewee 24: “I only go to private doctor now, the nurses are completely different to
government, they really care about me.”

Interviewee 7: “I used to use a traditional healer in Zim [Zimbabwe] for my health
problems but the traditional healers here (South Africa) only want the money, they
don’t care about the problems.”

Interviewee 25: “for me, the most important thing is that the doctor gives me time to
understand what is wrong with me. All the time you going through quickly, quickly, how
do I know if they understand my problem?”

5.4.1.3 Care:
4 of the 28 patients stated that care was the biggest influence affecting their
patient satisfaction.

Interviewee 4: “I will always be willing to pay for private healthcare as it is worth every
cent if they can cure the sickness right away”.

Interviewee 23: “I had the tooth problem. I was in a lot of pain. I went to the hospital but
the line was too long. I then went to the private clinic where I had to pay. The pain was
too much. They helped me very quickly but the pain did not go away. I was not happy as I paid money but I was still in pain. That pain was too much and they couldn’t help.”

Interviewee 19: “I went to the traditional healer with a problem, she did not help my problem. I still need to sort it out.”

5.4.1.4 Cost:
Two of 28 interviewees found that cost adversely affected their satisfaction.

Interviewee 17: “I used to go to the private clinic but the cost was too much. At that place the nurses are better, they help me quicker, the medicine is correct but it is too much (the cost).”

5.4.1.5 Tangibles
1 of the 28 interviewees found that the tangibles affected satisfaction the most.

Interviewee 14: “I have to take my daughter to the clinic twice a month due to her disability. The place is not nice. There is a hole in the wall. There is blood all over the bathroom. There is [are] no seats to wait. I changed clinics and now it is much better. The floor is clean, there is [are] magazines whilst we wait there. It’s very nice.”

5.4.1.6 Conclusion to Research Question 1
In conclusion, the major variable currently affecting patient satisfaction was the lack of access. The public healthcare facilities where the uninsured seek treatment have a reputation of having long queues and an inadequate number of staff to support the demand. The inaccessibility has led to a bad reputation associated with the public facilities where patients have come to terms with waiting a whole day to be treated.

The physicians’ behaviour was of particular concern to several of the interviewees. There was a general perception that the providers in the public healthcare facilities are not concerned with the wellbeing of the patient. The patients indicated a lack of trust in the system, where patients would not trust the physicians that treated them. This lack of positive behaviour could be associated with the overburden that the current system faces. Due to the long waiting queues, providers are forced to rush through the examination of the patient or develop bad attitudes towards the patients due to their personal frustrations.

Public facilities have developed a reputation for inadequate access and bad attitudes of the physicians. This reputation has forced the uninsured to seek healthcare elsewhere. The majority of the patients interviewed had sought
treatment from a private healthcare facility due to the lack of satisfaction. This was even though they had to pay out of pocket for the treatment as opposed to receiving it free at a government facility.

5.4.2 Research Question 2: Which factors affect the delivery of technical quality patient-centred primary healthcare?

Results from the expert interviews indicated that competence, in line with the literature, and two other factors affect the delivery of technical quality, which is affecting patient satisfaction. The constructs identified by the experts affected technical quality are shown below:

- Cultural Competencies
- Skills Competencies
- Accountability and Education
- Legislation and Litigation

5.4.2.1 Cultural Competencies

The theme of cultural competencies was evident in the majority of the expert interviews. One interviewee questioned the ability of the managers of third party payers to understand the cultural dynamics of the patient.

*Medical Aid 1*: “Cross cultural competence is very important. Currently the decision makers are white males. How do they know the needs of a poor black lady? There needs to be a greater understanding of the patients.”

*Specialist 2*: “There are very real cultural problems. Certain patients’ cultures dictate that they should not question someone older or in greater authority than them [they]. Providers need to understand this so they are able to ensure the patient gets the best service they deserve.”

*Hospital Owner/ Manager 1*: “We send out questionnaires after a patient has been treated in our practice where we try to determine their level of satisfaction particularly if their religious aspects where taken into account.”

Both clinical nurses interviewed supported the notion of cultural competencies.

*Clinical Nurse 2*: “It is very important to ask probing questions. Certain cultures are not going to ask questions and you must ensure that they understand the process of treatment and how exactly to take their medication and why.”

*Clinical Nurse 1*: “It is very important to understand the patient’s value system. This will certainly have an impact on their care. You need to treat them with dignity and respect...”
and speak to them on their level in order for them to understand you. Ultimately, you must be knowledgeable about the patient’s circumstances.”

5.4.2.2 Skills Competencies

The skill level across the board was seen to not be adequate to the level expected by the experts. This was due to the lack of constant training and development or upskilling of providers, as many experts deemed necessary in ensuring quality outcomes for the patient.

Medical Aid 1: “There is a need for constant training and up skilling of the doctors who are contracted to the third party payers. The third party payers currently hold a large amount of power within the private healthcare industry in South Africa. The patients of the funders are restricted to only see the providers who are contracted to by the funders. They however play no role in up skilling the providers, keeping them relevant or passing on new knowledge in the treatment of patients. This would certainly help the uninsured patients who are paying out of pocket to see a private doctor.”

Clinical Manager: "There is a need for constant training and up skilling of all providers so they are competent and are able to do their job properly and effectively. It is also very unfair to rely on someone to do a job that they have never received training on. It is unfair to both the patient and the provider as the patient will get inadequate care and the provider will feel that they are inadequate in their job which will affect their motivation.”

5.4.2.3 Accountability and Education

The lack of accountability towards the patient is a factor affecting the technical quality outcome. The consensus of the experts was that all stakeholders should be held accountable to the patient.

Doctor 2: “Establishing accountability regulation is an important step in improving patient satisfaction. Doctors should be held to account by the population on the quality outcomes. Doctors also need to support professionalism as a training to moderate them and get their peers to moderate them too. The importance of promoting professionalism is due to the inability to easily manage quality rules.”

Doctor 1: “The current process in place only allows providers to be accountable to third party payers. This is done through the release of a report in which they compare doctors within their network. Each doctor is analysed on his or her performance in terms of costs per treatment. The doctors will then be penalised if their costs are not in relation to their peers. There is however a flaw in the system in that they are only worried about the financial outcomes rather than the quality based outcomes each doctor is achieving.”

Doctor 3: “There is no accountability in the public sector. No one is accountable to anyone, not the patient, not the government and not their superiors. There is a serious lack of leadership within the public healthcare system.”
Medical Aid 1: “Data can be used to hold practitioners accountable. The practitioners do not currently understand the long-term implications that they make and the affect this will have on the patient. There should be financial penalties should the doctor not perform adequately. Performance outcomes should be linked to 20-30% of capitation fees.”

The idea of accreditation and licensure as a means of holding providers accountable was questioned by two of the experts.

Specialist 2: “Of course there are accreditation and licensure policies in place but in my opinion they are not doing what they supposed to be doing. Having a basic set of standards is not enough to hold the practitioner accountable and then there is the enforcement to talk about. They are not being enforced by the institutions.”

Medical Aid 2: “we have an accreditation process in place in selecting our providers before we reach a financial agreement. We however have been quite soft in implementing the process, even if people did not meet the threshold, we did not exclude them from our network. They would still go through the accreditation process but whether they meet the threshold or not, it didn’t matter.”

The patients’ lack of technical knowledge adversely affected the provider being held accountable to the patient. The experts identified the need for patients to be educated in the healthcare treatment they are receiving in order to improve the technical quality of healthcare received. This would help in improving the accountability towards the patient.

Doctor 1: “The patient needs to understand and appreciate what care they are getting. This way the patient is able to set expectations which allow the doctor to become accountable to the patient, giving the patient more say in the care they are getting.”

Medical Aid 1: “A scientific view on outcomes is not enough and the patient needs to understand and appreciate what care they are getting.”

Clinical Nurse 1: “It is very important to educate the patient to alter their value system. By educating the patient, they become part of the preventative or curing process and this will influence the outcome of care in a positive manner. This will only benefit the quality of care they receive.”

Specialist 2: “It is important to give more information to the patients. Currently certain diseases and sicknesses are stigmatised in the communities and therefore the ability to treat or cure the patient gets affected. Look at Ebola, education is a key driving factor, that the powers that be seek, as a solution to slow or stop the spread of the virus. Access to information and educated patients will bring about accountability, as people will start to demand services rather than rely on the provider to solve all their problems.”
There was, however, a counter argument to the process of educating the patient by Doctor 4 and Hospital Owner 3, and the ability for the patient to see value in something that could only affect them in five years.

*Doctor 4:* “Doctors do not get paid to educate, they only get paid on curing acute illnesses. Do you think the patient will see value in being educated on something that can only affect them in 5 years? Would they be willing to pay for that? I don’t think so.

*Hospital Owner 3:* “Educating the patient is not what doctors are paid for. Doctors are paid for treating acute symptoms when the patient is in pain or discomfort. How would a patient see value in being educated about a future condition?”

### 5.4.2.4 Legislation and Litigation

The experts highlighted the current legislation of South Africa as a contributing factor to the inability to deliver quality technical healthcare. Although this was not found in the literature, the finding is unique to South Africa.

*Medical Aid 2:* “The current legislation is the most serious challenge facing our current healthcare system. The current system does not allow a doctor to be employed or salaried in the private sector. This is fragmenting the industry and driving up costs. An example of this is that caesarean section procedure in South Africa is the most expensive in the world.”

*Hospital Owner/Manager 2:* “The Health Professionals Code of Practise legislation is a major factor holding back the delivery of quality healthcare. The inability of a doctor to be salaried results in them only earning on the procedures they perform. This drives up costs of those procedures. Look at the caesarean section, it is the most expensive in the world.”

*Hospital Owner/Manager 3:* “The current legislation does not allow a doctor to be hired by a business owner or manager. I have to rent out my premises to the doctors within my hospital. Think about how that works in GP’s private practices, that is why there is such fragmentation within the industry. There are just a million little GP practices scattered around the place.”

The experts noticed a current trend that is sweeping across the South Africa healthcare landscape. There is an increasing trend in the use of litigation regarding the malpractice. This litigation process is forcing providers to take extra precaution, driving up costs in both the private sectors, for the patient, and the public sectors, for the government.

*Hospital Owner/Manager 1:* “The litigation around poor practise is definitely affecting quality of care. It used to be very rare to hear of a doctor being sued, but now it is becoming common practise. Doctors are therefore taking extensive precautions by..."
doing all the possible tests that they relate to the symptoms in an attempt to avoid getting sued.”

Doctor 4: “I have been sued and it is the perfect case of once burnt twice as shy. There was a patient who came in the other day who was complaining of chest pains, however, there was nothing pointing to a heart attack but I sent him for all the tests possible. Lucky he was on medical aid as the costs were very high. I don’t know how I would have gone about this if he had to pay it out of pocket.”

Regulator 1: “There has certainly been an increase in litigation around poor practise and more and more patients are trying to sue the government for malpractice. As opposed to the private sector, the providers working in the public sector are not directly sued. This has major financial implications on the government. Lawyers are using this litigation to win cases on behalf of patients in order to enrich themselves rather than for the best interest of the system.”

5.4.2.5 Conclusion to Research Question 2

It is interesting to note that, in addition to the cultural and skill competencies that are necessary in delivering quality healthcare accountability and education, legislation and litigation were contributing factors. Cultural competencies were highlighted as an important factor. This is even more important due to the large cultural diversities in South Africa. The ability of the provider to understand the cultures of his or her patient is important in delivering patient-centred healthcare.

Skills competencies were highlighted with particular emphasis being placed on the continued training and development of the providers. The up skilling of providers is important to keep them current and up to date with the latest treatment procedures or practises. This will result in the improvement of quality healthcare, from a technical perspective, for the patient.

Accountability and education come hand in hand. Currently, the providers are not being seen as accountable to the patients either from a particular stakeholder holding too much power or from the lack of knowledge on the patient’s behalf. Educating the patient was seen as a means of bringing about accountability. A patient, who is knowledgeable, is able to question and be part of the process of treatment and care. As a result, the provider becomes accountable to the patient leading to the implementation of a patient-centred treatment plan.
The current legislation of South Africa and the litigation around malpractice are having an impact on the delivery of quality care. The legislation is creating a fragmented system in South Africa leading to the ineffective delivery of healthcare. This is due to the inability of a doctor to be salaried in the private sector, which therefore leads to multiple private practices each with a single provider. The litigation is influencing the delivery of care from a provider’s perspective. The ability to easily sue a provider for malpractice is forcing providers to take extra precaution by testing excessively, which is driving up costs.

5.4.3 Main Research Question: What is a holistic service quality framework for the delivery of patient-centred primary healthcare for the uninsured?

The main research question is answered by building a framework from the findings of research questions 1 and 2. This way a holistic approach, through stakeholder engagement, is used to determine the framework, which can be used to deliver healthcare in a patient-centred approach. The top of the framework, as shown in Figure 1, starts with the patient, because the patient is at the centre of a patient-centred delivery framework. The variables that are having the most impact on patient satisfaction of the uninsured were found to be the lack of access and the role and behaviour of the physicians.

The experts identified four factors leading to the inability to provide technical quality healthcare. These four factors are:

1. Legislation and Litigation
2. Accountability and Education
3. Skills Competencies
4. Cultural Competencies

In order to improve the satisfaction of the patient and provide patient-centred primary healthcare these four factors need to improve to ensure the adequate access to physicians with the correct roles and behaviours.
5.4.3.1 Access

In order to bring about patient-centred care, access needs to be addressed. The lack of access is causing dissatisfaction amongst the patients interviewed. This lack of access was found to be linked to two factors identified by the experts in their interviews. These factors are the current legislation and litigation as well as accountability and education.

The current legislation does not allow a doctor to be salaried in a private practise. This entails that a doctor is only able to earn an income through the tests or treatments they provide. As a result, the fees associated with private doctors are high, as was made evident by the experts Medical Aid 2 and Hospital Owner/Manager 2 discussing the cost of caesarean sections. The uninsured patients then have a choice to either pay high out of pocket expenses of private healthcare or to utilise the free services of a public facility. The inability to pay the exorbitant fees of the private practitioners takes the choice away from the patient and forces them to use the public institution. This in turn adds strain to the public healthcare system due to sheer volume of patients seeking care. This causes the long waiting times as experienced by the majority of patients interviewed. The inaccessibility for the patient does not allow for a patient-centred approach to delivering healthcare.

The litigation has a similar effect on patient satisfaction as the legislation, which is driving up of costs of private practitioners. The practitioners fear being sued by the patient for malpractice as was pointed out by Doctor 4: “once burnt, twice as shy.” They therefore, are testing for everything associated with the patient’s condition in order to cover their bases. This in turn results in the high costs associated with private healthcare, forcing the uninsured to either pay those high out of pocket expenses or seek public healthcare. The public healthcare facility becomes over burdened with patients, thus, negatively affecting accessibility.

The lack of provider accountability and healthcare knowledge is also affecting access to healthcare. The complete lack of accountability, as pointed out by Doctor 3, in the public sector is affecting accessibility. Providers are found to be
“lazy, uninterested and uncaring” resulting in poor accessibility. This is due to the “bad attitudes” of the providers not caring or worrying about how long the patients wait for. This brings about confusion and misunderstanding on the patient’s behalf as they “don’t know where they are supposed to go or who they supposed to see.” This lack of accountability affects the possibility of providing patient-centred care because the providers just do not care about the patients at all.

The lack of knowledge by the patients affects access to healthcare facilities. This is due to the inability to self-treat, self-diagnose or practise preventative measures in order not to get ill. This inability to self-treat or self-diagnose can often lead to a delay in the patient seeking treatment resulting in the worsening of their condition. This then leads many patients to seek health intervention at a much later stage of their sickness putting strain on the system. A patient-centred approach would educate the patient on current practises of preventative healthcare as well as self-treatment.

5.4.3.2 Physicians’ Role and Behaviour
The behaviour and role of the physician is currently causing dissatisfaction of the patients. Through the expert interviews, three of the four factors are said to improve the role and behaviour of the physicians. A patient-centred approach puts the patient in the centre of the process. Physicians need to know their role and have behaviour, which is conducive to providing patient-centred healthcare.

Due to the complete lack of accountability of the public sector to any stakeholder, the negative behaviour and role of the providers is affecting the satisfaction of the patients. Many patients found the providers to be “rude and uncaring”. This negatively influenced the satisfaction of the patients. In the private sector, the lack of accountability towards the patient affected the delivery of quality healthcare. Providers were found to only be accountable to third party funders rather than the patients. In order to provide patient-centred healthcare, providers need to be held accountable to the patient. The experts deemed that education was a means to ensure the provider is accountable to the patient. The patients need to be educated or have access to information
around their sickness and what treatment should be considered to resolve their ailments.

Continuous training and development was found to influence the physicians’ role and behaviour. The skills of the physicians were found to be inadequate due to the inability of the patient to receive quality healthcare. The need for constant training and development was found to be an effective way of providing quality healthcare. Medical Aid 1 and the Clinical Manager backed up this notion. This up skilling and training will ensure that the physician’s role will be effective in treating the patient, which will ultimately satisfy the patient.

Cultural competencies were found to be an important factor leading to the improvement of the physicians’ behaviour. The need to be cognisant of the patient and their circumstances was expressed by both clinical nurses interviewed. Once a provider is cognitive to the circumstances of the patient, they are able to treat the patient accordingly thus giving them the opportunity to treat the patient in a patient-centred approach. This approach will ensure that the patient is satisfied in the care they get helping improve the quality of care received.

5.4.4 Conclusion to Chapter 5

Uninsured patients are currently unsatisfied with the care they are receiving. The main variables associated with their dissatisfaction were the lack of access and the poor behaviour and attitude of the providers. Expert interviews were then conducted to establish the restraints affecting the delivery of quality healthcare and it was found that there were four factors affecting technical quality. These four factors were 1) Legislation and Litigation, 2) Accountability and Education, 3) Skills Competencies and 4) Cultural Competencies.

Through stakeholder analysis, a framework was formed which answered the main research question. The main variables leading to patient dissatisfaction were considered and measures as to how to improve their satisfaction were suggested. These suggestions were in line with the opinions of the experts in what they thought was holding back the delivery of quality care. Thus, a holistic
framework was formed in order to ensure the delivery of patient-centred healthcare shown in Figure 4 below. The link between functional quality and technical quality has yet to be established. The link will be established in Chapter 6 using the literature provided, as shown in Appendix 6, to refine the framework.

Figure 4: The current framework for the delivery of healthcare to the uninsured.
6 Chapter 6: Discussion of Results

6.1 Introduction
The previous chapter presented the results that answered the research questions stated in Chapter 3. The main research question was answered through the findings of research questions 1 and 2. Question 1 was answered by conducting in depth interviews with 28 uninsured patients who seek medical treatment. Question 2 was answered by conducting in depth interviews with 15 experts, who are involved in the delivery of healthcare.

The findings of research question 1 concur with the literature in terms of the variables that are currently affecting patient satisfaction. However, it was found that certain variables have more of an impact on the satisfaction of patients than others. The findings from research question 2 concur with the literature with regards to competencies, however, new findings emerged that were not evident in the literature as factors affecting the delivery of quality care.

Each of the research questions will be discussed separately below and the current framework developed in Chapter 5 will be further refined, using the literature, to answer the main research question. With the framework refined, a comprehensive patient-centred framework to deliver primary care will be formed. This framework will offer the user the ability to provide patient-centred primary healthcare in South Africa.

6.2 Discussion of Research Question 1: Which variables affect the delivery of functional quality patient-centred primary healthcare for the uninsured?
Research question 1 was concerned with determining the variables that are currently affecting patient satisfaction. Table 4 from Chapter 5 identifies the variables that are most affecting patient satisfaction. The data confirmed that the five variables, as identified in the literature, affect patient satisfaction, however, the data suggested that certain variables affect patient satisfaction more than other variables.
The data identified access as the variable that majority of patients thought was affecting their satisfaction the most. This was followed by the physicians’ role and behaviour; following on this was the level of care quality. Only two interviewee’s identified cost and one interviewee identified tangibles as the variable most affecting their satisfaction. These findings determine that the variables affecting patient satisfaction are identical to the literature; however, each variable has a different importance to the patient. Therefore, a lack of access and the poor behaviour and roles of the physicians was found to be the variables most affecting service quality.

In order to provide patient-centred primary healthcare, the care needs to be designed around the interests and needs of the patients and their families and thus quality should be measured to the extent to which those interest and needs are meet (DuPree et al., 2011). Therefore, in accordance to the needs and interest of the patients not being meet, accessibility, the physicians’ role and behaviour, the level of care, the cost and the tangibles need to be improved.

6.2.1 Accessibility
The majority of patients found that the inaccessibility of healthcare was a due to the long waiting times. These long waiting times were associated with the public health system where patients expressed that they would have to wait for “hours on end”. Majority of these patients would arrive early in the morning to get a position in the queue, enabling them to be attended to quickly. However, majority of the time, the patients would only be attended to in the late morning or early afternoon. The inability of the providers to provide timely care would affect their workday and force them to either take a day off work or call in sick.

The effect of the patient being forced to miss a workday was a major factor contributing to the dissatisfaction of the service. The dissatisfaction would affect the patients to such an extent that they would refuse to either seek treatment outright or became willing to pay for the treatment at a private facility as opposed to receiving the treatment for free.
There was little discussion around the accessibility of primary care clinics by the interviewees. The majority of patients would go straight to a hospital when they fell ill rather than seek treatment at a primary care clinic or general practitioner in their area. This behaviour would put added strain on the hospitals, as the number of patients would overwhelm the number of providers available at the hospital. This patient behaviour resulted in long waiting times and as a result, the providers who are under pressure would rush through the screening and treatment process of the patient. This, therefore, would affect the physician’s role and behaviour, which further affected the satisfaction of the patient and in turn would affect the level of care.

The literature surrounding patient satisfaction supported the notion that access was a vital component of quality care. Naidu (2009) identified access as a dimension that affects patient satisfaction. Further to Naidu (2009), Faezipour and Ferreira’s (2013) definition of patient satisfaction included the notion of the patient’s accessibility to resources and services.

The data therefore supported the notion of accessibility as a variable affecting patient satisfaction as was evident in the literature. It is therefore necessary to improve the accessibility of healthcare in an attempt to deliver quality healthcare. Accessibility can be improved by providing primary healthcare clinics and ensuring that patients use the clinics and only go to a hospital when they are referred to by the provider at the clinic. This will ensure that providers at hospitals are not under strain by the number of patients seeking primary care. This will therefore in turn improve the physicians’ role and behaviour, which ultimately will improve the satisfaction of patients. The physicians, in turn, will have greater time to spend on treating the patient, which will result in the improved level of care. Figure 5, below, details how an improvement in access will improve the physicians’ role and behaviour and care quality, which are both variables of patient satisfaction.
6.2.2 Physicians’ Role and Behaviour

The findings pointed to the physicians’ role and behaviour as a contributing variable to the patients’ dissatisfaction. Particular emphasis was placed on the physician’s behaviour towards the patient. They were found to be uncaring or unsympathetic towards the patients. This, as in the case of inaccessibility, forced patients to move from a public facility to a private facility where they were forced to pay for the consultation. The poor behaviour of the staff was so widespread that the patients started associating all public facilities with bad staff attitudes. This bad reputation was found to be wide spread, with patients from all around Gauteng expressing similar feelings. This bad attitude resulted in a number of interviewees becoming “frightened and afraid of the staff.” This was in no way a patient-centred approach to healthcare.

The findings from the interviews supported the literature, concerning the physicians’ role and behaviour having an effect on patient satisfaction. Adams (2001) determined that empathy, reliability and responsiveness are factors that lead to patient satisfaction. Naidu (2009) supported the findings by identifying the physicians’ role and behaviour as a dimension that affects patient satisfaction.
The data and the literature both supported the importance of the physicians’ role and behaviour in delivering quality healthcare. It is therefore necessary to include the importance of the variable as well as ways to improve it in order to build a framework for delivering healthcare in a patient-centred approach.

6.2.3 Care
The level of care was found to be a variable affecting patient satisfaction. Although the level of care was found to be not as important as access as well as the physicians’ role and behaviour, it was still found to be a variable contributing to patient dissatisfaction.

The data was supported by (Naidu, 2009) who identified care as a variable of patient satisfaction. This was further supported by (Faezipour and Ferreira, 2013) who used patient wellbeing as a construct of patient satisfaction. Adams (2001) included care as a factor leading to patient satisfaction.

The findings therefore supported the literature that care was a variable of patient satisfaction and in order to ensure a patient-centric approach to delivering healthcare, care needs to be considered as a variable.

6.2.4 Cost
The data found that cost was a variable that was affecting patient satisfaction. There was however evidence to support that patients are willing to pay for care as opposed to receiving it for free if it meant that they had improved access and the physicians role and behaviour was improved. It was however found that cost does affect patient satisfaction as a number of interviewees still considered the cost when determining what care they would access. A number of interviewees would rather wait until they had saved enough money to pay for a treatment at a private facility rather than seeking care from a public facility due to the dissatisfaction of the public facility.

The findings were supported by the literature, (Faezipour and Ferreira, 2013) indicating that patient satisfaction represents patient fulfilment concerning costs. Naidu (2009) used costs as a variable that leads to the satisfaction of the patient.
The findings support the literature that cost, as a variable of patient satisfaction, needs to be considered to ensure that a patient centric approach is adopted when delivering healthcare.

6.2.5 Tangibles

The findings supported the notion that tangibles are a factor of patient satisfaction even though the results were not overwhelming. The findings suggested that patients preferred gaining access and having physicians with a positive attitude than the physical look of the clinic or hospital. This was evident in a number of interviews as patients were not concerned about how the clinic looked but rather that they were seen speedily and had a physician who was caring and sympathetic to their condition and circumstance.

This finding supported the literature that tangibles were a variable of patient satisfaction as in the findings of Naidu (2009). Although the importance of tangibles was found to be less than the other variables of patient satisfaction, it was still considered important to some interviewees.

The variables identified, shown in figure 6 below, in the literature were supported by the findings of the interviews although they were found to not be equally important to the patients. This is possibly due to the nature of service quality being of a subjective nature as services are intangible, heterogeneous and inseparable. Therefore, because of the nature of services, patients will receive completely different service qualities at different times. Furthermore, the level of service quality is the result of an interactive process between the service provider and the service receiver (Owusu-Frimpong et al., 2010). In order to develop a patient centric delivery model, this interaction needs to be better understood, ensuring that the patient has a positive interactive process with the service provider.
6.3 Discussion of Research Question 2: Which factors affect the delivery of technical quality patient-centred primary healthcare?

Research question 2 addressed the factors that are inhibiting the delivery of high quality healthcare from a technical perspective. These factors were determined by interviewing experts involved in the delivery of healthcare in South Africa. The data concurred broadly with the literature, identifying the lack of skills and cultural competencies as factors affecting the delivery of quality care. However, what was interesting to find, was that the themes of accountability and education, as well as the current South African legislation and litigation were factors inhibiting delivery. Although there were some findings in the literature with regards to accountability, no real emphasis was placed on it.

6.3.1 Cultural Competencies

It was evident, that the lack of cultural competence of the providers was a contributing factor, thus the role and behaviour of the provider was affected by this lack of cultural competence. This would ultimately affect the satisfaction of the patient. Due to the complex and diversified nature of South African citizens, it is important that the providers of healthcare are culturally competent. South Africa is home to many different cultures, ethnicities and languages and as such, the cultural environment is very complex. Providers need to be cognisant
of the patients whom they are treating with particular emphasis on their cultural or ethical background and treat them in accordance to these customs.

The development of cultural competencies was in response to the recognition by Truong et al. (2014), that cultural and linguistic barriers between healthcare providers and patients could affect the quality of healthcare delivery. The experts interviewed supported this notion of the importance of cultural competencies in delivering quality healthcare.

In ensuring that the providers are cognisant of the patients’ cultural background, they will be able to delivery quality healthcare, and so improve the satisfaction of the patient. The notion of the importance of delivering quality healthcare, as a means of increasing patient satisfaction, was supported by Isaac et al (2010) and is shown in figure 7 below:

Figure 7: The importance of cultural competencies is ensuring patient satisfaction.

6.3.2 Skills Competencies
The experts interviewed identified the importance of constant training and development of providers to ensure the delivery of quality care. There was a consensus that providers of healthcare do not constantly up skill themselves once they are qualified. It was evident to the importance of constantly training and developing the providers so they stay “current” with the latest treatments and procedures. It was suggested that the providers embrace a team-based learning approach where they are able to learn and develop from one another’s experience and skills.

Further to this, it was found that providers would become demotivated should they not have the necessary skills, which would enable them to perform the required tasks. If they felt that, they were inadequate to perform their job, they
would feel demotivated, which would affect their self-esteem and confidence. This would influence the delivery of healthcare and affect patient satisfaction as the physicians’ role and behaviour would be affected.

Rowe et al. (2012) supported the findings that providers need to possess the necessary technical skills and further added that they must be able to educate others effectively, critically evaluate their own professional practise, and have good communication skills. This supports the notion of team based learning and development of providers, as suggested by the experts. The findings were supported by Khan & Ramachandran (2012), who suggested that in a clinical setting, a provider should be able to perform a skill in a specific setting or situation.

In ensuring that providers are able to delivery quality healthcare, they need to possess the technical skills necessary to provide the required care. These skills need to be continuously developed through training and development of the providers in a team based learning environment. The training will not only provide the skills necessary to perform the latest procedures and treatments to the patient but will ensure that the provider stays motivated and enthusiastic. This will in turn affect the care quality as well as the physicians’ role and behaviour further affecting patient satisfaction. This relationship is depicted in figure 8 below. The constant training and development of the physicians, in a team based approach, will ensure that the delivery of healthcare is done through a patient centric approach, putting the patient first by delivering them quality care with a positive behaviour and attitude.
6.3.3 Accountability and Education

The experts interviewed identified the lack of accountability towards the patient as a factor affecting the delivery of quality care. There was consensus that the providers were not held accountable to the patients. In order to provide patient-centred care, providers need to place the patient in the centre of the delivery of healthcare, and be held accountable as such.

The experts explained that in the public healthcare system there was no accountability at all. The providers were found to not be accountable to anyone, not the patient nor their managers. In the private sector, the providers were found to only be accountable to third party payers, rather than the patients. This accountability to third party payers was a result of the payers trying to control the costs of the providers. The private healthcare providers were found to be providing care through “codes” rather than offering what is best for the patient. The lack of accountability towards the patients was found to result in the inability to deliver quality care from both a technical and functional quality.

Rowe & Moodley (2013) supported the findings that providers need to be held accountable to the patients in providing quality healthcare at an affordable rate. To the researchers knowledge there was however, no literature supporting the
finding that accountability towards the patient is a means of providing technical quality healthcare. The findings found that the lack of accountability to the patients is currently resulting in poor health outcomes as well as affecting the functional quality variable of the physician’s role and behaviour, thus affecting patient satisfaction. In order to deliver patient-centred care, providers need to be held accountable to the patient.

The experts identified the patients’ lack of healthcare knowledge as a factor affecting the delivery of technical quality care. The experts determined that the patients need to be educated around their healthcare issues and that an informed patient will be able to ensure that their provider is delivering the correct care for their condition.

These findings supported the notion of Rashid & Jusoff (2009) and Naidu (2009) that patients do not have the technical knowhow to determine care quality. Although care quality is found to be a variable affecting functional quality, the lack of knowledge by the patient in determining the quality of care will ensure that little emphasis is placed on the level of care by the patients. This was in line with the findings, that a small number of patients found that the level of care quality was a variable most affecting their satisfaction. It was only apparent where the patient was in pain or discomfort and the provider was unable to alleviate that pain in a timely manner that the patient would be dissatisfied.

The finding ensures that in order to increase patient satisfaction, patient education as well as accountability will influence the care quality received as well as the physician’s role and behaviour. This relationship is shown below, in figure 9.
6.3.4 Legislation and Litigation

According to the experts interviewed, the current South African legislation around the inability of a doctor to be salaried in the private sector is having an impact on the delivery of quality care. Doctors therefore earn their income through consulting, testing and procedures they perform on patients. The inability of doctors to be salaried causes them to increase the number of tests or procedures performed on a patient, although these are often not necessary or do not impact on the quality of care of the patient. This misaligns the goals of the patient and provider. The patient wants to get healthy at an affordable cost; however, the provider wants to increase the test and procedure numbers in order to increase the income.

The current legislation is therefore causing the physicians’ roles and behaviours to change. The physicians are looking out for their own interest, first, rather than placing the patient at the centre of the treatment process, as is necessary when providing patient centric care. In this instance, the providers’ behaviour is causing negative impacts on the costs that the patient will incur. Thus, higher costs will affect patient satisfaction. This is supported by Rowe & Moodley (2013), whom stated that patients would be satisfied when they are provided the right care at an affordable cost.

The experts identified the current trend of increasing litigation against providers for malpractice. The increase in litigation was not found to be a means of
ensuring the providers are more accountable, but rather a means of making the lawyers, who represent the patients, more money. The increase in litigation is causing the providers to test for all possible conditions in response to the symptoms so that they are able to prove that they are covering their tracks. This practise, as with the legislation, is driving up costs for the patients as providers charge for each test conducted. The providers have to take out insurance on them due to the risk of litigation being bought against them. The providers will then roll this expense into the cost for the patient, and so increasing the cost to the patient. This will affect patient satisfaction in two ways as it alters the physicians’ role and behaviour as well as driving up costs.

The effect on the patient satisfaction by the legislation and litigation is shown below, in figure 10. The current legislation and litigation is leading to a change in how the providers behave and the role in which they play. This is causing the costs to increase and both these variables impact on patient satisfaction.

Figure 10: The current legislation and litigation affecting patient satisfaction.

6.4 Discussion of Main Research Question
The “current framework” from Chapter 5, which was built from the data collected through stakeholder engagement to answer research questions 1 and 2 will be further refined through the literature surrounding patient-centred healthcare from Chapter 2. The framework, shown in figure 11, will be further explained.
Patient satisfaction is placed at the top of the framework due to the importance of placing the patient at the centre of care, ensuring that the healthcare system is designed around the interest and needs of the patient (DuPree et al., 2011). Access was highlighted as the variable currently most affecting the level of patient satisfaction. Thus, the inaccessibility of healthcare needs to be addressed in order to satisfy the patient.

Currently, access and the lack of it is affected in part due to the large demand being placed on the public hospital and the high costs associated with private facilities. The large numbers of patients seeking treatment at public hospitals is having an affect on the level of care received as well as the physicians’ role and behaviour. Primary healthcare clinics are seen as a solution to improve the country’s healthcare sector, by making the system more effective, efficient and able to generate better patient outcomes (Starfield et al., 2005). By introducing patient-centred primary healthcare clinics, which are able to treat patients effectively, the demand for treatment at secondary or tertiary public hospitals will be diminished thus relieving the strain that is currently being experienced.

Once an increase in access to primary healthcare clinics have been established a patient centric approach, dealing with the current variables affecting patient satisfaction, need to be addressed. These variables, as determined by the findings and literature include; care quality, the physicians’ role and behaviour, costs and tangibles (Naidu, 2009). Therefore, the factors that providers have control over are placed at the bottom of the figure as by using these as levers, an improvement in patient satisfaction can be attained through the improvement of the variables affecting patient satisfaction.

Improving care quality would be made possible through the improvement of the providers’ skills or their skills competency (Leggat et al., 2010 & Rashid & Jusoff, 2009). The experts interviewed identified that providers competency can be improved by conducting team based learning and development. Further, educating the patient would allow the patient to take a participatory role in their and their families care. The notion of patient education, introduced by the experts is supported by O'Shea & Palmer (2014). O'Shea & Palmer (2014) state
that primary healthcare would incorporate primary medical treatment services, education of preventative healthcare and health. Patient education would ensure that the patient takes an active role in his or her own healthcare, both in treatment and preventative measures. The ability of the patient to conduct preventative healthcare on himself or herself would ensure that they are healthy, which would lead to improved healthcare outcomes. An educated patient would ensure that the provider is accountable to himself or herself, rather than any other stakeholder group involved in healthcare delivery. In ensuring that the provider is accountable to the patient, the patient will receive adequate treatments for their condition, which will result in improved care quality due to the improved behaviour and role of the physician. Improving care quality will in turn decrease the costs of care for the patient, due to the active role they take in the prevention process.

The physicians’ role and behaviour can be improved through the four factors identified by the experts. Equipping the providers with the right skills, through constant training and development (Leggat et al., 2010 and Rashid & Jusoff, 2009), in a team based learning environment, will ensure that they are fulfilling their roles in treating the patient, as well as ensuring they stay motivated and driven to provide the best possible care for the patient. The current lack of accountability leads to negative behaviour and thus, when the providers become accountable to the patients, they will improve their behaviour and role played, in delivering quality healthcare. It is thus important to ensure that the providers are accountable to the patients, as was described by DuPree et al. (2011) in their explanation of patient-centeredness, where providers need to meet the needs and expectations of the patients. In meeting the needs and expectations of the patients, the physicians’ role and behaviour would have improved, leading to an increase in patient satisfaction.

The importance of the providers to be cognisant of the cultures of the patients was highlighted as a factor leading to the satisfaction of the patients (Hammerich, 2014). Ensuring that the providers are cognisant of the cultural differences will alter the physician’s behaviour towards the patient leading to an increase in patient satisfaction. This is very important due to the cultural and
language diversity in South Africa. This competency can be developed through team based learning, where providers are able to learn how to deal with certain cultures through the experiences of their peers. The team based learning approach, supported by Rowe et al. (2012) whom stated that providers must be able to educate others effectively.

The current legislation is not conducive to providing patient centric care and, therefore, a reform is required which would ensure that the patient is placed in the centre of the caring process. The current legislation is altering the behaviour of the providers, which is driving up costs in the private sector, leading to a decrease in access, thus affecting patient satisfaction. The ability to salary a doctor, as identified by the experts, will ensure that their behaviour is not negatively altered. They will not be motivated to drive up costs by increasing the number of unnecessary tests conducted. This will make private healthcare facilities more accessible to the patient who currently cannot afford the high out of pocket expenses.

The trend of increasing litigation being brought upon providers is having a negative impact on the patients, as was identified by the experts. Even though this can be argued as a means of holding the provider accountable to the patient, patient satisfaction is affected. The litigation is seen to rather support the lawyers of the patients, who are charging the providers with malpractice. These litigation malpractices affect the private doctors the most as they can be sued directly whereas in the public sector, the government it sued rather than the individual provider. These pay outs need to be financed somehow and so the providers take out insurance against any litigation. As the one interviewee stated, “once burnt, twice shy.” Therefore, they conduct all test associated with the conditions even though they could rule some out. This is done in an attempt to cover all bases, but this leads to an increase in costs, which are passed onto the patient.

This holistic, patient centric approach to delivering primary healthcare is a working model that would need to be modified and adjusted in accordance to the change in variables that affect patient satisfaction as well as the factors that
can be used as levers to improve patient satisfaction. The levers allow the providers to make necessary changes to their delivery model, thus ensuring that they are able to deliver patient-centred care that satisfies the patient. The feedback loop allows the levers to be adjusted or altered as to the changing variables affecting satisfaction levels of the patient. Thus, a constant process of patient feedback is required to ensure the delivery of healthcare remains patient-centred care.
Figure 11: The holistic service quality framework for the delivery of patient-centred primary healthcare.
Chapter 7: Conclusion

7.1 Introduction
The previous chapter discussed and exhibited the holistic service quality framework for the delivery of patient-centred primary healthcare. This chapter will discuss the background to this research, as well as the objectives of the research. A summary of the main findings will follow with recommendations to all stakeholders involved in the delivery of healthcare, as well as recommendations to academics. The limitations of the research will be identified, and therefore, acknowledgment of implications for future research will be highlighted. Finally, a conclusion of the research will be presented.

7.2 Research Background and Objectives
Africa is yet to meet the Millennium Development Goals, set out by the United Nations General Assembly, to provide all people with access to affordable and quality healthcare (Ki-Moon, 2013). South Africa is no exception to this, as government expenditure on healthcare is seen to be increasing as the country prepares for the implementation of the National Health Insurance (NHI). The role-out of the NHI is South Africa’s answer to provide access to quality healthcare at an affordable price to all.

The current global trend of increasing non-communicable diseases, as well as South Africa’s high instance of communicable diseases is putting a double burden on the country’s healthcare infrastructure. This double burden of diseases is seen to be a major factor leading to increasing costs of care, and, as a result, government and providers are pushing for a more intense focus on disease education and prevention, ultimately primary healthcare (Deloitte, 2014).

Primary, or preventative, care is seen as a means to transform a healthcare system by providing disease education and prevention leading to improved quality and access to care whilst containing costs (O'Shea & Palmer, 2014). However, in order to ensure that the quality of care a patient receives is...
adequate, a patient-centred approach is needed, as it takes into consideration the complex environment shaping the delivery of care.

In order to develop a patient-centred approach to delivering quality healthcare, one needs to understand the complexities, both in terms of historical context, as well as in terms of the patient’s cultural and medical history. The complexities can be understood by utilising stakeholder engagement. This will allow the historical and current context to be better understood, as well as determine the variables that are affecting patient satisfaction. Therefore, the objective of this research was to build a holistic framework to deliver quality patient-centred primary healthcare.

The objective was answered through the main research question, which was answered through the results of the two sub questions. The first question sought to answer the question in determining which variables currently affect uninsured patients in South Africa. The second question sought to seek which factors are currently affecting the delivery of quality healthcare from an expert’s opinion. The information gathered from the interviews answering the two sub questions, as well as consolidation of previous research and literature enabled a framework to be formed. The framework can be used in ensuring the delivery of quality patient-centred primary care.

7.3 Main Findings
There were 28 in-depth interviews with patients conducted and 15 in-depth interviews with medical experts conducted in order to answer the main research question and sub questions.

The results showed that patient satisfaction of the uninsured in South Africa has the same variables as those identified in the literature. However, the impact that each variable had on the satisfaction was not equal. The data showed that access, followed by the physicians’ role and behaviour, were currently the variables most affecting patient satisfaction. What was particularly interesting is the finding that patients were willing to pay to ensure that they had increased access and improved behaviour by the physicians as opposed to receiving the
care free of charge from a public facility. Cost, which is a variable to patient satisfaction, was therefore not as important as access and the role and behaviour of the physician. However, certain individuals still found that cost did affect their satisfaction levels.

The results of the interviews with the 15 experts showed that competency, both in skills and culturally, were important factors in ensuring the delivery of quality care. There was a consensus that there was no constant training and development in a team-based environment and as a result, the delivery of quality healthcare was affected. In addition to this, there seemed to be a lack of cultural competencies by the provider to the patients they were serving. This is perhaps due to the cultural diversities that are present in South Africa and the inability of the providers to relate to everyone on a cultural basis. The experts, however, identified two more factors that were affecting the delivery of quality care that was not identified in the literature. Accountability and education, as well as the legislation and litigation in South Africa were identified as factors affecting the delivery of quality care. This was aligned with the literature that suggested that the context of a country should be considered when developing patient-centred healthcare. This finding would only be evident in South Africa although similar findings could be evident in other countries; the finding was unique to the South African context.

The main research question was then answered using the findings from the sub research questions, as well as the literature to refine the framework developed. It was found that the current variables most affecting patient satisfaction were a direct result of the factors identified by the experts. These factors could therefore be linked and aided in building the framework. Access, which currently affects patient satisfaction the most, could be improved by ensuring that a patient-centred approach to delivering healthcare is utilised.

The factors identified by the experts as skill and cultural competencies, accountability and education, and legislation and litigation could be linked to the variables most affecting patient satisfaction and thus they need to be improved in order to bring about a positive change in patient satisfaction. They
could therefore be used as levers to improve the delivery of patient-centred care. The framework to deliver patient-centred care was developed on themes rather than conclusive findings and may merit further research.

7.4 Recommendations to Providers

The findings from the sub questions and main research question provide useful insight to the providers of healthcare. The framework developed from the data, as well as the literature can be used when a provider strives to improve the quality and access of primary healthcare clinics. The framework illustrates the variables that are currently affecting patient satisfaction as well as identify the factors that can be used as levers to improve on those variables.

If providers are able to use these levers effectively, they will improve the delivery of quality care by ensuring that the patient is satisfied as well as improving the healthcare outcomes. Thus the ability to improve the satisfaction of the patient can be done through these levers that are available to the providers.

7.5 Recommendations to Government

The findings from the main research question can be used to ensure that the implementation of the NHI is a success in providing access to quality and affordable healthcare to all citizens.

The framework can be used by the government as a mechanism to improve the current delivery of healthcare as well as ensuring all new facilities abide by the patient-centred approach to delivering healthcare. The finding suggests the need for new legislation to be passed. The current legislation is resulting in the inability to provide quality healthcare, which is satisfying the patient, due to the inability of a doctor to be salaried in the private sector. Legislation should be passed that can bring about a decrease in the current trend of increasing litigation being bought upon providers. These factors are adversely affecting patient satisfaction and as a result, steps should be taken to remedy their impact.
7.6 Limitations

As the research was examined through qualitative research, the holistic patient-centred framework formed cannot be generalised across the population. The research was aimed at building theory, not testing a theory. The framework is based only on the perspective and information given by the interviewees. Therefore, this research developed a framework for patient-centred care and did not pursue the testing of the themes that emerged, nor provided a “solution for all.”

The limitation is that this patient-centred framework can only apply to a specific urban area in Gauteng based on the interviews and data gathered. Therefore, this framework cannot be generalised to rural areas or other urban areas in South Africa, until it is tested therein. Although this research assumes one patient-centred framework, there are probably several different frameworks depending on the location and patient demographics. In addition, the framework only applies to primary healthcare and not to secondary or tertiary facilities, as the satisfaction of the patients will most likely be different for those facilities as opposed to primary healthcare.

The framework was based on interviewees who were selected as uninsured patients in South Africa who seek medical care at least once a year. The use of uninsured patients was due to the inequality currently being experienced in South Africa where the rich have access to quality care. The uninsured patients could either not afford medical insurance or found it unnecessary. These patients were obliging to be interviewed and reveal the factors that are currently most affecting their satisfaction. Hence, the researcher used judgement sampling when selecting the patients. This, however, was in line with the research determining the satisfaction of uninsured patient in South Africa.

The framework was also based on expert interviewees who were obliging to be interviewed and reveal the factors that they felt were influencing the delivery of quality healthcare, hence purposive and snowball sampling was used. Therefore, to make the research more robust, quota sampling for example can be used when conducting the expert interviews.
7.7 Implications for Future Research

The patient-centred framework has its limitations as mentioned above. To reduce these limitations and make the patient-centred framework more robust, further research needs to be conducted. As this model only applies to primary healthcare facilities in one particular urban area in South Africa, the framework can be further tested through an explanatory study, hence a quantitative study. The future study can test the factors and the impact to which they can individually alter the variables affecting patient satisfaction in a particular setting. In addition, the weighting of the significant variables and factors can be identified as well as the causal links between the different variables and factors can be researched and then offered as suggestions to provide patient-centred healthcare.

Other areas of research to be conducted are to test the framework in other urban or rural areas. The patient-centred framework can form a framework to be tested in other locations and be adjusted accordingly as per the findings. This will allow different patient-centred models to be formed in accordance to the location and patient demographics.

7.8 Conclusion

The healthcare system in South Africa is set to undergo a reform through the implementation of the NHI. The implementation of the NHI alone will not bring about quality healthcare. Therefore a patient-centred approach, delivering quality primary healthcare is a possible solution to the factors that are currently affecting healthcare in South Africa. By ensuring that the patients are placed in the centre of the delivery process, will result in an increase in the quality care outcomes as well as the satisfaction of patients.

To ensure that patients are placed in the centre of healthcare delivery, all stakeholders need to be engaged to support the notion of patient-centred primary healthcare. This will result in the South African population becoming healthier and more productive in the ever-increasing competitive global economy.
REFERENCES


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APPENDICES

Appendix 1: Interview Guide for Users of Primary Care Facilities

Section 1: Socio-Demographic Factors

1. What is your age?
2. What is your gender?
3. Do you currently have medical insurance or medical aid?
4. What is the frequency of treatments per month or per annum? - Doctors, clinics, traditional healers etc.

Section 2: Patient Satisfaction

1. Tell me the story of your last visit to a primary healthcare facility. What type of facility was it and were you satisfied with the quality of healthcare delivered?

Prompts:

6. Reliability: the ability to perform the required service reliably and accurately.
7. Responsiveness: the willingness to help customers and provide prompt service.
8. Empathy: caring, individualised attention provided to customers.
9. Assurance: the knowledge and courtesy of employees and their ability to inspire trust and confidence.
10. Tangibility: the appearance of personnel, equipment and the physical facilities.
11. Access- Service available when required
12. Care Quality- effective treatment
13. Cost
14. Physician/traditional healer/nurse role and behaviour- If they fulfil their role as anticipated
15. Tangibles- Physical Facilities
16. Others
Appendix 2: Interview Guide for Providers of Primary Care

Section 1: General:
1. Is this a private or a public facility?
2. What is your current title?
3. Do you administer the healthcare you do you have play an administrative role?

Section 2: Variables affecting the delivery of quality healthcare:
1. Is it possible to provide high quality healthcare to all patients that seek treatment at your facility?
   Prompts: Access- Service available when required
             Care Quality
             Cost
             Physician role and behaviour
             Tangibles- Physical Facilities
             Others

Section 3: Factors that need to be considered to improve healthcare delivery:
What, in your opinion, needs to be done to improve the delivery of healthcare, allowing for greater access and equitable care?
Appendix 3: Interview Guide for Third Party Funders

Section 1: General:
1. Do you fund private or public healthcare?

Section 2: Variables affecting the delivery of quality healthcare:
1. Is it possible to provide high quality healthcare to all patients that you fund through a third party payment system?
   Prompts: Access- Service available when required
            Care Quality
            Cost
            Physician role and behaviour
            Tangibles- Physical Facilities
            Others

Section 3: Factors that need to be considered to improve healthcare delivery:
1. What, in your opinion, needs to be done to improve the delivery of healthcare, allowing for greater access and equitable care?
Appendix 4: Interview Guide for South African Healthcare Regulators

Section 1: General

1. What role do you play in the healthcare regulatory environment in South Africa?

Section 2: Variables affecting the delivery of quality healthcare:

1. Does the current legislative framework allow for the delivery of quality care within South Africa?

Prompts: Access - Service available when required
          Care Quality
          Cost
          Physician role and behaviour
          Tangibles - Physical Facilities
          Others

Section 3: Factors that need to be considered to improve healthcare delivery:

2. What, in your opinion, needs to be done to improve the delivery of healthcare, allowing for greater access and equitable care?
Appendix 5: Interview Guide for South African Medical Associations

Section 1: General
1. What role do you currently play within the South African Professional Medical Associations?

Section 2: Variables affecting the delivery of quality healthcare:
2. In your opinion, is it possible to provide high quality healthcare to all patients in South Africa?
   Prompts: 
   - Access- Service available when required
   - Care Quality
   - Cost
   - Physician role and behaviour
   - Tangibles- Physical Facilities
   - Others

Section 3: Factors that need to be considered to improve healthcare delivery:
3. What, in your opinion, needs to be done to improve the delivery of healthcare, allowing for greater access and equitable care?
Appendix 6: List of Variables with Literature References

Functional Quality: Patient Satisfaction

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<td>Physicians Role and Behaviour</td>
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Technical Quality

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<td>Skills Competencies</td>
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<td>Education and Accountability</td>
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<tr>
<td>Legislation and Litigation</td>
<td>Rowe &amp; Moodley (2013)</td>
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