

# **Analysing patient satisfaction in a medium-sized private healthcare provider**

**Mmanone Caroline Mokoena**

**23870338**

Mini-Dissertation submitted in partial fulfilment of the  
requirements for the degree on *Master of Business  
Administration* at North-West University  
Potchefstroom campus

**Supervisor:** Prof Ronnie Lotriet

**November 2015**



## ABSTRACT

The purpose of this study was to analyse patient satisfaction in private healthcare in South Africa. The healthcare structure in South Africa consists of public and private healthcare. Public health care is made available by the government and is therefore available to 80% of the South African population. The governance and challenges that the public healthcare sector is facing were also reviewed just get a broad understanding of the healthcare sector. Private healthcare sector was also reviewed in general and the challenges that the private healthcare is facing were also reviewed to get a broad understanding. An empirical investigation was carried out in a medium sized private healthcare provider. The investigation was based on the private healthcare service that the healthcare provider renders. The investigation was aimed at identifying the gaps between the healthcare service provided and what the patients expect as satisfactory service.

The investigation was aimed at identifying the gaps between the healthcare service provided and what the patients expect as satisfactory service. The objectives were divided into primary and secondary objectives.

The gaps/findings were identified between the healthcare service provided and what the patients expect. The identified findings were grouped by the empirical investigation constructs, namely: admissions, nursing care, doctor communication, theatre procedure and overall impression about the facilities and the service.

The study will help the management of the hospital to focus resources on the identified gaps. Working on the identified gaps will be noted through positive returns on hospital investments, reduction in a number of patient complaints, increased occupancies in the hospital. Continuous improvement on hospital service and securing the hospital market share. Patient satisfaction must be continuously reviewed to keep hospital patients content with the healthcare service.

**Key words:** Patient, satisfaction, private, health care, South Africa.

## ACKNOWLEDGEMENTS

- First of all I would like to thank God for giving me the strength to get this far. I would like to thank everyone who contributed to the success of my study.
- I would like to express my sincere gratitude to my study leader Prof Ronnie Lotriet, for the guidance he gave me in the process of completing my dissertation. May God bless you with good health and all the desires of your heart Professor Ronnie Lotriet.
- I would like to say thank you to Wilma Breytenbach from the statistical consultation services at North West University (NWU) Potchefstroom campus for guidance on statistical analysis of my empirical investigation.
- I would like to thank Antoinette Bischoff for editing my dissertation. You have been a great help just when I needed it more.
- I would like to give special thanks to the hospital management that helped me with my pilot study, the patients who completed my questionnaires and the members of the COVIJ group who allowed me the opportunity to be the group chairperson.
- I would like to thank Nico Mashigo (May his soul rest in peace) member of the COVIJ group who died in his final year of studies for the contribution he made to the group.
- I would like to thank my kids Naledi and Rorisang for their patience and support: I am sorry for not always being there when you needed me.
- Lastly, I would like to thank my husband and my siblings for the continuous support through my studies. May the good lord bless you all.

## TABLE OF CONTENTS

ABSTRACT	ii
ACKNOWLEDGEMENTS	iii
LIST OF FIGURES	vii
LIST OF TABLES	viii
LIST OF ABBREVIATIONS	ix

### CHAPTER 1: THE NATURE AND SCOPE OF THE STUDY

1.1	INTRODUCTION	11
1.2	PROBLEM STATEMENT	11
1.3	OBJECTIVES OF THE STUDY	11
1.3.1	Primary objective	11
1.3.2	Secondary objectives	12
1.4	RESEARCH METHODOLOGY	12
1.4.1	Literature review	12
1.4.2	Empirical study	12
1.4.3	Research design	13
1.4.4	Measuring instrument	13
1.4.5	Report back on the findings	13
1.5	SCOPE OF THE STUDY	13
1.6	LIMITATIONS OF THE STUDY	13
1.7	CONTRIBUTION OF THE STUDY	14
1.8	LAYOUT OF THE STUDY	14
1.9	CHAPTER SUMMARY	14

### CHAPTER 2: LITERATURE REVIEW

2.1	INTRODUCTION	16
2.2	OVERVIEW OF PUBLIC HEALTHCARE IN SOUTH AFRICA	17
2.3	PRIMARY HEALTHCARE IN SOUTH AFRICA	18
2.4	THE BATHO-PELE PRINCIPLE IN PUBLIC HEALTHCARE	19
2.4.1.1	Consultation	19
2.4.1.2	Setting service standards	20

2.4.1.3	Increasing standards	20
2.4.1.4	Ensuring courtesy	20
2.4.1.5	Providing information	20
2.4.1.6	Openness and transparency	20
2.4.1.7	Redress	21
2.4.1.8	Value for money	21
2.4.1.9	Encouraging innovation and rewarding excellence	21
2.4.1.10	Customer impact	21
2.4.1.11	Leadership and strategic direction	21
2.5	GOVERNANCE STRUCTURE IN PUBLIC HEALTHCARE	22
2.5.1	National Health Amendment Bill	22
2.5.2	Medicines and Related Substances Amendment Act, 59 of 2002	22
2.5.3	Medical Schemes Act, 31 of 1998	22
2.5.4	Choice of Termination of Pregnancy Act, 92 of 1996	22
2.5.5	Tobacco Products Control Act, 23 of 2007	22
2.5.6	Nursing Act, 33 of 2005	22
2.5.7	Mental Healthcare Act, 17 of 2002	22
2.5.8	Pharmacy Amendment Act, 1 of 2000	23
2.5.9	STATUTORY BODIES FOR HEALTH SERVICE PROFESSION <sup>23</sup>	
2.5.10	CHALLENGES FACED BY PUBLIC HEALTH SECTOR	23
2.7.1.1	Prevention and treatment of HIV/AIDS	24
2.7.1.2	Prevention of new epidemics (MDR-TB)	24
2.7.1.3	Pandemic influenza a H1N1 virus	25
2.7.2	Prevention of alcohol abuse	25
2.7.3	Distribution of financing and spending on healthcare	26
2.7.4	Availability of health personnel in public sector	26
2.7.5	Operational efficiency in public health sector	27
2.7.6	Quality of care in public health sector	28
2.7.7	Devolution of management in public health	28
2.7.9.1	District health system	28
2.7.9.2	Devolution of staffing, budgeting expenditure control	29
2.7.8	Health worker morale	29
2.7.11	Leadership and innovation in public health	30
2.8	OVERVIEW OF PRIVATE HEALTH IN SOUTH AFRICA	30

2.9	CHALLENGES FACED BY PRIVATE HEALTH SECTOR	32
2.9.1	Increased costs and more responsibility for patients	32
2.9.2	Increased consolidations amongst schemes and providers	32
2.9.3	Policy direction that is needed from the government	32
2.9.4	Technology as provision for competitive edge	32
2.9.5	Skills shortage	33
2.10	REVIEW OF HLONOLOFATSO HOSPITAL	33
2.11	DIMENSIONS OF PATIENT SATISFACTION	33
2.11.1	Primary dimensions of patient satisfaction	34
2.11.2	Secondary dimensions of patient satisfaction	34
2.12	SUMMARY	36

### **CHAPTER 3: EMPIRICAL INVESTIGATION**

3.1	INTRODUCTION	37
3.2	RESEARCH METHODOLOGY	37
3.2.1	Research questions	37
3.2.2	Pilot study performed	38
3.2.3	Critical success factors	39
3.2.4	Target population	40
3.2.5	Scope of the study	40
3.2.6	Research instrument and design	42
3.3	STATISTICAL ANALYSIS	43
3.3.1	Demographic information about respondents	43
3.3.1.1	Gender of respondents	43
3.3.1.2	Age profile of respondents	44
3.3.1.3	Education profile of respondents	46
3.3.1.4	Race of respondents	46.
3.3.1.5	Citizenship of respondents	47
3.3.1.6	Employment status of patients	48
3.3.1.7	Type of respondents employment	50
3.3.1.8	Payment method	50
3.3.1.9	Hospitalisation	51
3.3.1.10	Duration of hospital stay	51
3.4	DATA ANALYSIS	52

3.4.1	Validity and reliability	53
3.4.2	Results of confirmatory factor analysis	54
3.4.3	Means of constructs	55
3.5	DESCRIPTIVE STATISTICS	56
3.5.1	Descriptive statistics by education	56
3.5.2	Descriptive statistics by gender	57
3.5.3	Descriptive statistics by age	58
3.6	SUMMARY	59

## **CHAPTER 4: INTERPRETATION OF THE EMPIRICAL STUDY RESULTS**

4.1	INTRODUCTION	61
4.2	DETAILED HOSPITAL PROCESS	61
4.2.1	Admission through emergency unit	63
4.2.2	Admission through pre-admission desk	63
4.2.3	Admission brought in by ambulance	63
4.2.4	Nursing care provided to patients	64
4.2.5	Administering patient account	65
4.2.6	Doctor communication to patient	65
4.2.7	Theatre procedure	67
4.2.8	General impression about service	67
4.2.8.1	Post discharge process	67
4.3	MAIN FINDINGS OF THE STUDY	67
4.3.1	Findings from literature review	67
4.3.2	Findings from empirical study	67
4.3.2.1	Processes that were rated best	67
4.3.2.2	Processes that were not rated good	68
4.4	ADMISSION PROCESS PROVIDED TO RESPONDENTS	68
4.5	NURSING CARE PROVIDED TO RESPONDENTS	70
4.6	DOCTOR COMMUNICATION	71
4.7	THEATRE PROCEDURE	71
4.8	GENERAL IMPRESSION ABOUT OVERALL SERVICE	72
4.9	SUMMARY	73

## **CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS**

5.1	INTRODUCTION	74
5.2	MAIN FINDINGS OF THE STUDY	74
5.2.1	Processes that require attention	75
5.2.2	Admission service provided to respondents	75
5.2.3	Nursing care provided to respondents	75
5.2.4	Doctor communication to respondents	75
5.2.5	Theatre procedure	76
5.2.6	General impression about the overall service	76
5.2.7	Comparing results by education, gender and age	76
5.3	EVALUATION OF THE STUDY	76
5.4	RECOMMENDATIONS	77
5.5	CONCLUSION	78
	REFERENCES	82
	APPENDIX A: QUESTIONNAIRE	85
	APPENDIX B: EDITOR'S DECLARATION	92

### **LIST OF FIGURES**

Figure 2.1:	Illustration of detailed hospital process	31
Figure 2.2:	Presentation of hospital statistics	33
Figure 3.1:	Presentation of study population by gender	42
Figure 3.2:	Presentation of study population by age	43
Figure 3.3:	Presentation of study population by education level	44
Figure 3.4:	Presentation of study population by race	45
Figure 3.5:	Presentation of study population by citizenship	46
Figure 3.6:	Presentation of study population by employment status	47
Figure 3.7:	Presentation of study population by employment type	48
Figure 3.8:	Presentation of study population by method of payment	49
Figure 3.9:	Presentation of study population by history of hospitalisation	50

Figure 3.10: Presentation of study population by length of stay	51
Figure 4.2: Illustration of admission process	61
Figure 4.3: Illustration of nursing care service	64
Figure 4.4: Doctor communication	65
Figure 4.5: Theatre procedure	66
Figure 4.6 Evaluating the service	67

## LIST OF TABLES

Table 2.1:	Illustration of hospital performance	33
Table 3.1:	Managerial Critical Success Factors	37
Table 3.2:	Presentation of patients by payment method	39
Table 3.3:	Major surrounding towns that feed the hospital admissions	40
Table3.4:	Presentation of Cronbach alpha values	52
Table 3.5:	Confirmation factor analysis	53
Table 3.6:	Presentation of means and standard deviations for respondents	55
Table 3.7:	Presentation of p and d-values based on education	56
Table 3.8:	Presenting study population based on gender	57
Table 3.9:	Presenting study population based on age	58

## LIST OF ABBREVIATIONS

HH	Hlononofatso Hospital
SA	South Africa
NHI	National Health Insurance
DoH	Department of Health
HR	Human Resources
PHC	Primary Health Care
HIV	Highly Immunodeficiency Virus
TB	Tuberculosis
MDR-TB	Multi Drug Resistant TB
XDR-TB	Extensively Drug Resistant TB
HPCSA	Health Professions Council of South Africa
PPD	Paid Patient Day
ANOVA	Analysis of Variances
STD	Standard
MSA	Measure of Sample Adequacy
CSF	Critical Success Factors
PERSAL	Personnel and Salary Management System
MTEF	Medium Term Expenditure Framework
HR	Human Resources
ART	Antiretroviral Therapy
LoS	Length of Stay
AIDS	Acquired Immunodeficiency Syndrome

# CHAPTER 1

## NATURE AND SCOPE OF THE STUDY

### 1.1 INTRODUCTION

The healthcare group in subject is one of the top three healthcare providers in South Africa. The group provides healthcare to medical aid patients and private patients on a varying scale depending on the patient's needs and what they can afford. The research will be carried out in Hlonolofatso hospital, a division of the healthcare group that is situated in central Johannesburg.

The aim of this study is to analyse the challenges and problems that create dissatisfaction to hospital patients and lead the patients to a negative perception about private healthcare service providers. Analysis of these challenges will help with the establishment of the severity of the impact that these challenges have on the overall hospital performance. The healthcare group has got its hospitals scattered across the provinces and Hlonolofatso hospital specifically, is situated quite close to its competitors. The hospitals are shaped by the type of market that it serves based on its location. A hospital that is based in an upmarket area will eventually specialise on high value surgeries and the medical aid patients will be high in volumes because the market is well-off based on affordability. A hospital within the healthcare group that is based in a lower market area will have a lot of private patients and medical aid patient with a lower plan based on affordability as well.

To ensure that each hospital will focus more on customer service, the healthcare group has centralised some functions into a shared service office to enhance consistency in dealing with the suppliers and taking advantage of supplier discounts on a bulky scale. The centralised functions include but not limited to: Finance, Procurement, Credit control/Debtors, Information Technology and Human Resources.

Centralisation of these functions is aimed at giving hospitals enough time to focus on the operational factors to enhance customer service and maintain satisfied patients that will be prepared to refer their loved ones to the healthcare group hospitals. The

referrals will help the hospital group to conquer new markets, whilst the shared service is supporting the hospitals from a central point. This in a way creates synergy between the hospitals and the support functions at centre.

## **1.2 PROBLEM STATEMENT**

Centralisation of some of the functions between the hospitals and head office seem to have created confusion to patients about services they will get from the hospital without delay and which services they will have to wait for due to centralisation. The services referred to are admissions through the casualty/emergency unit and reception. Emergency patients will come to the hospital without a medical aid authorisation number and the hospital will have to make a request on their behalf before admission. This sometimes delays the admission process depending on the medical aid response. Normal admissions through hospital reception will obtain an authorisation number before admission (pre admission) and the admission process is therefore quicker.

The patients' and doctors' confusion have led to a negative perception that the patients and doctors have about the hospital service provision. This can be depicted from major indicators year on year such as, number of admissions, surgical cases, level of occupancy and average length of stay in the hospital. It is important that the broken confidence about customer service expectations be restored in order to take the hospital to greater heights.

## **1.3. OBJECTIVES OF THE STUDY**

The objective of this study is to identify and analyse these issues and the operational impact that it could have had to the business through a questionnaire survey. Striking out a balance between what the patients require from the hospital as service provision and the actual service provided by the hospital is important in order to maintain a well-balanced relationship between the relevant stakeholders.

### **1.3.1 Primary objective**

The primary objective of this study is to analyse those factors that are causing dissatisfaction to patients and doctors in a private healthcare provider. The drive behind the objective is the declining trends in hospital major indicators year on year like, number of admissions, surgical cases, level of occupancy and length of stay.

### **1.3.2 Secondary objectives**

The secondary objectives is to:

- Identify patients' expectations as far as admissions services, nursing care, theatre procedure, doctor communication and general impression about the overall hospital experience and the hospital facilities as a whole.
- Analyse the overall service that the hospital is currently offering to the patients.
- Identify the gap between the patients' expectations in as far as the healthcare service is concerned in the hospital and the current healthcare service provided to the patients and make recommendations on what remedial actions can be done to continuously improve service delivery and bridge the dissatisfaction gap, restore patients' trust and confidence about the hospital service delivery.

## **1.4 RESEARCH METHODOLOGY**

### **1.4.1 Literature review**

The literature review will give the researcher more insight on the researched topic and help to form an informed opinion. The hospital is facing a unique challenge in terms of how it is internally structured, the geographical environment where it is situated and the market that it serves. However great insight was drawn from currently available literature on customer service, supply chain, change management and internal management reports in order to learn more and understand the researched topic.

### **1.4.2 Empirical study**

The empirical study is the strategy that the researcher used to gather information, analyse and interpret it in order to formulate an opinion. The empirical study identifies the research design, research participants, and the statistical analysis that was used to analyse the collected data.

### **1.4.3 Research design**

The aim of this research study was to use a qualitative method to collect data that was researched by setting up a pilot study and interviews with the hospital management team. The Management committee (MANCO) and Heads of departments (HODs) have helped to identify the areas of concern and critical success factors that must be continuously focused on, and designing and disseminating questionnaires to the study population. A convenience sampling method was used as discharged patients were requested by the HOD to complete the questionnaire. In convenience sampling the patients selected for sampling are easy, inexpensive or convenient to sample (Levine *et al.*, 2011:252). Literature was also reviewed in light of the primary and secondary objectives of the research topic. The patients' response rate was good as all the patients that were requested to complete the questionnaire on discharge in the wards during the research had completed the questionnaire.

The qualitative study was limited to the healthcare Hlonolofatso Clinic.

### **1.4.4 Measuring instrument**

Interviews were scheduled with the relevant stakeholders such as management and doctors, questionnaires were distributed to all the patients that were coming in and out of the hospital at the time of the empirical investigation. The literature review and the information gathered on interviews and questionnaires aided the researcher to gather valid and reliable data, interpret it and conclude on it in order to form an opinion.

#### **1.4.5 Report back on the findings**

All the findings gathered through interviews with management, doctors and empirical investigation questionnaires with the patients were put together in a report and recommendations on areas of improvement and methods of improvements were suggested by the researcher.

#### **1.5 SCOPE OF THE STUDY**

- The research reviewed hospital trends on the major indicators from the past five years to the current year.
- Reviewed trends were only done at Hlonolofatso Clinic that is situated in central Johannesburg.

#### **1.6 LIMITATIONS OF THE STUDY**

- Research was limited to Hlonolofatso Clinic – a division of the larger healthcare group.
- The researcher has limited knowledge on the subject matter.
- The reluctance of the patients to complete the questionnaires.
- Refusal of doctors to give the researcher the time for interview.
- Management and key staff resistance to the researcher's meetings.
- Availability of old literature reviews that may be irrelevant to the study.

## **1.7 CONTRIBUTION OF THE STUDY**

The study will contribute towards continuously improving hospital service to the evolving patient base and better management of the target market changes from the active working class through to senior citizens in the patient base. The contribution will be more towards giving more insight on factors that are causing negative perceptions about healthcare service delivery and overall patient dissatisfaction to management's attention and making recommendations regarding areas and methods of improvement.

## **1.8 LAYOUT OF THE STUDY**

The research study is laid out in chapters as follows:

Chapter 1- Nature and scope of study

Chapter 2 – Literature review

Chapter 3 – The empirical investigation

Chapter 4 – Interpretation of results

Chapter 5 – Conclusions and recommendations

### **1.8.1 Chapter 1 – Nature and scope of study**

This chapter provides background of the researched topic and the general information about the hospital that is being researched. It also provides the detail of the research methodology that will be used, the period that will be reviewed, challenges that the researcher will come across and the value add that the study is going to bring to the business that is being researched.

### **1.8.2 Chapter 2 – Literature review**

This chapter provides theoretical framework of the hospital customer service management, supply chain management literature and trend analysis of internally and externally generated management reports. The chapter will also elaborate on reviewed healthcare models and challenges that have been previously analysed and the outcomes about the study findings.

### **1.8.3 Chapter 3 – The empirical investigation**

This chapter contains the methodology that was followed during the study and provides full details of processes that were used to collect research data, through reviewing internal procedures, interviews with the relevant stakeholders, and survey questionnaires to the patients.

### **1.8.4 Chapter 4 – Interpretation of study results**

This is the critical chapter in the sense that it interprets the findings of the empirical study, and reflects the main purpose of the study. This chapter will bring about a comparison and service gap between the actual service provision at the hospital based on the gathered information and what should be based on the hospital internal set standards.

### **1.8.5 Chapter 5 – Conclusions and recommendations**

This chapter is the contribution of the whole research study, conclusions and recommendations of the study.

## **1.9 SUMMARY**

In this chapter the nature of the study was analysed and the scope of the study was laid out. The participants that were needed to complete the study were identified and the method of collecting all the needed data was also identified. The next chapter is the literature review of the study.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

Healthcare in South Africa (SA) varies from the most basic primary healthcare to highly specialised care facilities that are available in both the private and public health sectors. The healthcare delivery system therefore comprises public and private healthcare, with most of the population accessing public healthcare. The public health sector is stretched and under-resourced in most places. This is due to the fact that the public sector provides health services to about 80% of the population. The challenges of the public health sector emanates from servicing a large population when the resources are scarce, from personnel to funds and the burdening by breaking diseases. Healthcare spending however does not reflect with this approximately half of healthcare expenditure attributed to spending by private medical schemes and private out of pocket expenditure (Media Club SA, 2012).

As a young democracy SA faces the challenge of finding a balance between a developed and lesser developed health system to provide quality healthcare to all citizens (Coetzee, *et al.*, 2012).

Significant progress has been made over the last 10 years towards ensuring a long and healthy life for all South Africans, which is outcome 2 of government's 2014-2019 medium term expenditure framework (MTEF). Over the medium term the department of health will continue to contribute to increased life expectancy and improved quality of life for South Africans through sustaining the expansion of the HIV and Acquired Immunodeficiency Syndrome (AIDS) treatment and prevention programme, revitalising healthcare facilities and ensuring the provision of specialised tertiary hospital services. Spending on these three areas takes up 85.2% of the department's total budget over the MTEF. In line with the national development plan and government's 2014-2019 MTEF, national health insurance is also a major priority for the department (Department of National Treasury, 2015:266).

The SA private healthcare industry faces significant changes in national health policy, which most notably include the likely introduction of National Health Insurance (NHI). The NHI is intended to bring about reform that will improve service provision and healthcare delivery. It will promote equity and efficiency to ensure that all South Africans have access to affordable, quality healthcare services regardless of their employment status and ability to make a direct monetary contribution to the NHI fund (Media Club SA, 2012).

## **2.2 OVERVIEW OF PUBLIC HEALTHCARE IN SOUTH AFRICA**

Before South Africa's first democratic elections, hospitals were assigned to particular racial groups and most were concentrated in white areas. There were 14 health departments characterised by fragmentation and duplication. After the 1994 elections the dismantling began and transformation is now fully under way. The high levels of poverty and unemployment mean healthcare remains largely the burden of the state. The department of health holds overall responsibility for healthcare, with a specific responsibility for the public sector.

Provincial health departments provide and manage comprehensive health services through a district based public healthcare model. Local hospital management has delegated authority over operational issues such as the budget and human resources to facilitate quicker responses to local needs.

Public healthcare consumes around 11% of the government's total budget, which is allocated and spent over the nine provinces in the country. Allocation of these resources and the standard of healthcare provided across the provinces varies from one province to another (Media Club SA, 2012).

The Department of Health (DoH) is focused on implementing an improved health system. The improvement of the health system will be based on the 10-point plan strategic programme. This programme puts emphasis on improving the functionality and management of the system through stringent budget and expenditure monitoring.

The programme aims at improving the hospital infrastructure and Human Resources (HR) management as well as procurement of the relevant skills and equipment. Under this programme the health facilities such as nursing colleges and tertiary hospitals are being upgraded and rebuilt to lay the way for the implementation of the National Health Insurance (NHI) scheme. This scheme is intended to bring about reform that will improve the service provision and health care delivery. It will promote equity and efficiency to ensure all South Africans have access to affordable quality healthcare services regardless of their employment status and ability to make a direct monetary contribution to the NHI fund. This raises the question of relative pricing between the two sectors (Ramjee, 2013). This scheme will be phased in over a period of 14 years and the government invested R1 billion to its pilot projects. Government will ensure the success of this scheme through strict regulation of the health sector to make health services affordable to all citizens (Media Club SA, 2012).

### **2.3 PRIMARY HEALTHCARE IN SOUTH AFRICA**

Immediately after the election of Nelson Mandela as the country's first democratically elected president, primary healthcare that was available at the clinics throughout SA was declared free at the point of delivery. Primary healthcare facilities are the only available or easily accessible health service for local communities (Peltzer, 2009:1). Primary healthcare advocates an approach to healthcare based on principles that allow people to receive the care that enable them to lead socially and economically productive lives (Denill & Rendal-Mkosi, 2009:4). Reinforcing such a far reaching health policy was the complementary educational policy to provide each school-going child with a nutritious food ration during the school day. Primary healthcare in its focus on the health of families and community rather than individual health alone, it sought to identify and address the social conditions and factors that influence population health broadly.

Primary healthcare targets are mainly hygiene, sanitation, nutrition, water, housing conditions and occupational threats. Primary healthcare involves specialised programmes and interventions to address the health needs of vulnerable and high risk groups, particularly women and children. The primary healthcare programme focused

on a localised package of health services including mandatory immunisations, school-feeding and baby food supplementation, communal childcare and family planning. Through regular extension of the enumerated population and continual updating of individual and household records, the primary healthcare model also allowed for the measurement of changes over time and provided a longitudinal understanding of health and disease changes in the population. A key contribution to the primary healthcare was its unique emphasis on community empowerment and participation in the delivery of healthcare (Keegan, *et al.*, 2010).

The national health plan envisioned the fundamental restructuring of the national health system premised on the Primary Health Care (PHC) approach. Specifically PHC sought to:

- Eliminate the fragmentation and duplication of services by integrating all health services under a single ministry of health.
- Decentralising the health organisation and management of health services through a well-coordinated district health system.
- Make comprehensive, community based healthcare accessible to all South Africans by establishing PHC centres as a foundation of the national health system.

The primary healthcare played a symbolic and inspirational role; the direct influence on district and sub district health development is at best. The transformation of health systems and implementation of PHC has posed an extreme challenge to every government attempting health system reform. SA's experience is different due to diverse amalgamation of factors like (Keegan, *et al.*, 2010):

- High rates of medical migration.
- Severe health worker shortages.
- Imbalance of resources and inequities in personnel distribution.
- Complex and evolving burden of disease with emerging infectious and non-communicable epidemics.
- Curative-orientated health service, and

- Deficiencies in managerial capacity and health system leadership at all levels.

## **2.4 BATHO-PELE PRINCIPLE IN PUBLIC HEALTHCARE**

The eight Batho-pele principles were developed to serve as acceptable policy and legislative framework regarding service delivery in the public service. The government requires certain standards from practitioners who deliver a service to the public. Batho-pele is the name given to the government's initiative to improve service delivery to the public (Meyer *et al.*, 2009:140). These principles are aligned with the constitutional ideals of Department of Community Safety and Liaison (2011):

- Promoting and maintaining high standards of professional ethics.
- Providing service impartially, fairly, equitably, and without bias.
- Utilising resources efficiently and effectively.
- Responding to people's needs, the citizens are encouraged to participate in policy-making
- Rendering an accountable, transparent and development oriented public administration

### **2.4.1 The Batho-pele principles**

The Batho-pele principles are listed below (Department of Community Safety and Liaison, 2011).

#### **2.4.1.1 Consultation**

Based on this principle, service users should be consulted about the service that they are receiving and be allowed to comment on areas of improvement. The identified areas of improvement should be conveyed to senior management to ensure that they will be given attention.

#### **2.4.1.2 Setting service standards**

This principle reinforces the need for benchmarks to constantly measure citizen satisfaction based on the services received. Service provision requires standards that are precise and measurable so that users can judge for themselves whether they are receiving the promised service or not.

#### **2.4.1.3 Increasing access**

One of the prime aims of Batho-pele principle is to provide a framework for making decisions about delivering public services to the many South Africans who do not have access to them. Access to information and services empowers citizens and creates value for money, quality service and reduces unnecessary expenditure for the citizens.

#### **2.4.1.4 Ensuring courtesy**

This kind of courtesy goes beyond a polite smile, please and a thank you. This principle requires service providers to empathise with the citizens and treat them with as much consideration and respect as they would like for themselves. Public service is committed to continuous, honest and transparent communication with citizens. This involves communication of services, products, information and problems that may delay the efficient delivery of services to promised standards. If applied properly, the principle will help demystify the negative perceptions that the citizens in general have about the attitude of public servants.

#### **2.4.1.5 Providing information**

This principle requires that available information about service delivery be made available at the point of delivery. An alternate arrangement has to be made for users who are far from the point of service delivery.

#### **2.4.1.6 Openness and transparency**

This principle emphasises that the public should know more about the way national, provincial and local government institutions operate. The public should know how well these institutions utilise resources that the public consumes and who is in charge of the office. However it is anticipated the public will take advantage of this principle and make suggestions for improvement of service delivery mechanisms and to even make government employees accountable and responsible by raising queries with them.

#### **2.4.1.7 Redress**

This principle emphasises the need to identify quickly and accurately when services are falling below the promised standard and to have procedures in place to remedy the situation. This should be done at the individual transactional level within the public as well as organisation level in relation to the entire service delivery programme. Public servants are encouraged to welcome complaints as an opportunity to improve service, and to deal with them so that weaknesses can be remedied quickly for the good of the citizens.

#### **2.4.1.8 Value for money**

Many of the improvements that the public would like to see often require no additional resources and can sometimes even reduce costs. Failure to give the public a simple and satisfactory explanation to an enquiry may result in an incorrectly completed form which will cost time and money to rectify.

#### **2.4.1.9 Encouraging innovation and rewarding excellence**

Public servants should be allowed to come up with new ways of doing things. They should encourage partnerships with different sectors in order to improve service delivery. Excellence should be rewarded for staff who go the extra mile to deliver excellent service.

#### **2.4.1.10 Customer impact**

If all the Batho-pele principles are put into practise then the chances of service delivery improvement are greatly improved. This great improvement will in turn have a positive impact on citizens/patients. This principle looks at the benefits that have been given to public office customers internally and externally.

#### **2.4.1.11 Leadership and strategic direction**

Leaders in the public sector must create an atmosphere that allows creativity amongst public servants. Management in the public sector must ensure that goals are clearly and properly set and that intensive planning is done.

### **2.5 GOVERNANCE IN PUBLIC HEALTH SECTOR**

The National Health Care Act, 61 of 2003 (SA, 2003) provides a framework for a single health system for SA. The act provides for a number of basic healthcare rights including the right to emergency treatment and right to participate in decisions regarding one's health. The implementation of the act was initiated in 2006 and some provinces are engaged in aligning their provincial legislation with the national act. Other legislation relating to healthcare includes laws such as:

### **2.5.1 National Health Amendment Bill, 2010**

The bill ensures that all health establishments comply with minimum standards through an independent entity (SA, 2010).

### **2.5.2 Medicines and Related Substances Amendment Act, 59 of 2002**

This act makes drugs more affordable and provide for transparency in the pricing of medicines (SA, 2002a).

### **2.5.3 Medical Schemes Act, 31 of 1998**

This act regulates the medical schemes industry to prevent it from discriminating against “high risk” individuals like the aged and sick (SA, 1998).

### **2.5.4 Choice of Termination of Pregnancy Act, 92 of 1996**

This act legalises abortion and allows for safe access to it in both public and private health facilities (SA, 1996).

### **2.5.5 Tobacco Products Control Act, 23 of 2007**

This act limits smoking in public places and creates awareness of the health risks of tobacco by requiring certain information on packaging and prohibiting the sale of tobacco products to anyone younger than 18 years (SA, 2007).

### **2.5.6 Nursing Act, 33 of 2005**

This act provides the introduction of mandatory community service for nurses (SA, 2005).

### **2.5.7 Mental Healthcare Act, 17 of 2002**

This act introduces a process to develop and redesign mental health services so as to grant basic rights to people with mental illnesses (SA, 2002b).

### **2.5.8 Pharmacy Amendment Act, 1 of 2000**

This act allows non-pharmacists to own pharmacies with the aim of improving access to medicines. This act came into effect during May 2003 (SA, 2000).

## **2.6 STATUTORY BODIES FOR HEALTH-SERVICE PROFESSION INCLUDE:**

- Allied Health Professions Council of SA;
- Council for Medical Schemes;
- Health Professions Council of SA;
- Medicines Control Council;
- The National Health Laboratory Services;
- South African Dental Technicians Council;
- South African Medical Research Council;
- South African Nursing Council; and
- South African Pharmacy Council

The abovementioned list of legislations, acts, bills and other legal documents is not exhaustive. The full copies of health related legal documents can be found on the Department of Health's website.

## **2.7 CHALLENGES FACED BY THE PUBLIC HEALTH SECTOR**

Although restructuring of the public health sector post 1994 achieved substantial improvements in terms of access, rationalisation of health management and more

equitable health expenditure, fifteen years later these early gains have been eroded by a greatly increased burden of disease related to HIV/AIDS. However despite the enormity of the challenges in the public health sector there are opportunities for significant systems improvements and progress on the major policy priorities. The challenge for policy makers is to demonstrate rapid improvements in the quality of care and service delivery indicators such as waiting time and patient satisfaction. At the same time the policy makers must address the intractable health management issues that destruct efficiency and drive up costs. The establishment of a district based system was one of the biggest post-1994 innovations By Making health management more responsive to local conditions and distributing resources more equitably. In retrospect its success has been hamstrung by the failure to devolve authority fully, and by the erosion of efficiency through lack of leadership and low staff morale. Ten of the biggest challenges facing the health sector relate to the prevention and control of epidemics are as follows (Harrison, 2009:18):

- Prevention and treatment of HIV/AIDS.
- Prevention of new epidemics.
- Prevention of alcohol abuse.
- Distribution of financing and spending.
- Availability of health personnel in the public health sector.
- Quality of care.
- Operational efficiency.
- Devolution of authority.
- Health worker morale, and
- Leadership and innovation.

### **2.7.1 Prevention and treatment of HIV/AIDS**

The priority that is mostly felt by the national and provincial health ministries is the need to cope with the growing demand for antiretroviral therapy (ART). This requirement creates a challenge to health service management, in that other health services that are equally cost effective may be compromised. Therefore a clear and rational approach to the prevention and treatment of HIV/AIDS is critical to the

sustainability of the South African health system. Failure to create a concerted and comprehensive prevention programme at sufficient scale has undoubtedly contributed to the high levels of morbidity and mortality. Early implementation of this plan would have alleviated the massive burden of orphan-hood on the socio-economy (Harrison, 2009:2).

### **2.7.2 Prevention of new epidemics (MDR-TB)**

With regards to multi drug resistant tuberculosis (MDR-TB), it is not certain whether HIV infection predisposes to drug resistant TB. The increased detection of MDR-TB simply reflects the higher incidence of TB together with inadequate case management (Lawn & Churchyard, 2009). The MDR and extensively drug resistant XDR TB present a major public health threat in SA. This threat could significantly increase mortality over the next years unless it is properly contained by effective HIV and TB prevention and case management. The prevention of MDR and XDR-TB requires a heightened response to TB that is focused on (Harrison, 2009:23):

- Earlier detection of patients with TB, particularly those who are HIV positive.
- Increasing patient adherence and treatment completion rates.
- Instituting adequate drug susceptibility testing and drug resistance surveillance.
- Preventing hospital outbreaks by proper ventilation and infection control measures.

### **2.7.3 Pandemic influenza – a H1N1 virus**

In addition to MDR-TB a vigilant eye should be kept on the evolution of H1N1 viral influenza. A total of 12 619 cases of H1N1 viral infection was confirmed in South Africa for the year up to November 2009 and the confirmed mortality rate was 0.72% then. Most fatalities were associated with co-existent disease (especially HIV) or pregnancy. Until an affordable vaccine is available in South Africa, the mainstay of the response should be active case management by identifying serious cases and treating complications aggressively (Harrison, 2009:23).

#### **2.7.4 Prevention of alcohol abuse**

Alcohol harm and interpersonal violence constitute the most significant health risk factors in South Africa after unsafe sex. With notable exception, lowering the blood alcohol limit for drivers from 0.08 to 0.05 mg/dl in 2004 the government response to preventing alcohol abuse has been rather mild. The National Liquor Act 59 of 2003 (SA, 2003) is intended to regulate the alcohol industry and prescribe advertising and sales to minors. The department of health promulgated regulations to require health warnings on alcohol advertising sales. Taxes on alcohol have been raised and there have been modest attempts to reduce drunk driving. The absence of clear policy statement from government and a comprehensive programme of action have had little effect in the eradication of alcohol abuse. Such a programme would need to include (Harrison, 2009:24):

- A concerned national programme to shift prevailing norms about alcohol misuse.
- Active enforcement of current legislation and a clampdown on advertising that to which children and teenagers are exposed to.
- Community level programmes for alcohol prevention, starting at schools and involving a broad range of community stakeholders.
- Community engagement in action against illegal liquor outlets.
- Great enforcement of laws against drunk driving (Seedat, 2009).

Although it could be argued that the priority is to ensure effective enforcement of current alcohol levels, the effect of lowering the limit even further may be to reduce aggregate blood alcohol levels of drunk driving. Preventing alcohol abuse requires a concerted, multi-faceted response, and measures should be combined with law enforcement related to seatbelt use, speeding and other traffic law violations.

### **2.7.5 Distribution of financing and spending on healthcare**

South Africa has a very progressive system of healthcare financing, with the richest 20% of the population contributing about three times the proportion of personal income than the poorest 60% of the population needs. A common observation is the disproportionate financing of the private sector, relative to the number of beneficiaries. Almost five times as much is spent on each person on medical aid than an uninsured person using the public sector. It must also be noted that there is no financial cross subsidization of the wealthier by the poor and the fact that wealthier people are prepared to spend more on private health care does not distort public health sector financing (Harrison, 2009:24).

### **2.7.6 Availability of health personnel in public sector**

The absence of a uniform national health system will always bring the difference in provision of human resources in the public and private sector. This difference is driven by the willingness of the wealthiest to pay for more healthcare. The disparities are not known with any degree of accuracy. Provision in the public sector is calculated with the number of posts in the personnel and salary (PERSAL) system. The private sector provision is often calculated from registrations with the Health Professions Council of South Africa (HPCSA), which fails to take into account the large number of professionals who left the country or are no longer practicing. SA has a largely nurse-based health system and interpersonal benchmarks should be used with caution. A full assessment of the success of implementation is beyond the scope of this research paper but the experience of the past 20 years has illuminated some of the most important strategies going forward such as (Harrison, 2009:27):

- Adequate remuneration for the health professionals is probably the most important incentive to keep them in the health sector.
- The effects of the rural and scarce skills allowances and the occupation-specific dispensation will need to be closely monitored over the years.
- Provision for study leave, preferential admission for specialisation and a work environment respectful of professional autonomy and conducive to personal

growth. These are moral boosting incentives that could reduce the differentials between public and private sector.

- The success of the community service programme suggests that supply could be further strengthened by incentives such as study bursaries in return for years of work.
- The clinical associate can significantly strengthen the health system at primary health care level.
- Community health workers could play a critical part in the community-based component of patient adherence for TB and HIV in the prevention and management of other chronic diseases.
- Procurement of health services from professionals in the private sector could improve public sector supply and reduce the incentive to over service the insured population.

While many of these strategies are long term, there are possibilities for more immediate gains as well. A common problem is insufficient administrative and auxiliary support, even for unskilled categories such as hospital porters. An assessment of staffing at Chris Hani Baragwaneth Hospital in 2010 found a 30% shortage in staff and 46% shortage of managers and administrators. These shortages distract health professionals from patient care and often prolong hospital administration and admission. A proactive strategy to fast track appointments and replacement of support staff could rapidly improve the working environment and improve the quality of patient care (Harrison, 2009:27).

### **2.7.7 Operational efficiency in public health**

The importance of sourcing new resources for public health sector is as important as improving the efficiency of health service provision in the sector. Improving operational efficiency requires a deliberate and multi-faceted approach involving the following factors (Harrison, 2009:28):

- Greater separation of political and management responsibilities to enable senior health managers to focus on service management.

- Devolution to clear management responsibilities, linked to accountability for performance.
- Proper use of management information in decision-making.
- Better financial management like tracking expenditure and relating it to service performance.
- Effective planning for, and use of time in meetings.
- Better use of time of health professionals and reduction in paperwork and data collection.
- A commitment to punctuality.
- Systematic processes for improving the quality of care.

### **2.7.8 Quality of care in public health**

There are still significant inefficiencies in the health system stemming from poor quality of care. These weaknesses are endemic and require an intense approach which includes facility-based accreditation and monitoring – a programme based monitoring and quality system. Improving the quality of care requires both the carrot and stick. Incentivised processes of training and technical support need to be backed up by systems of accountability for quality and performance. The first requires a strong degree of horizontal support facilitated by none or governmental agencies that are mandated to achieve quality improvement. The second requires implementation of the provisions of the National Health Act 61 of 2003 and the quality policy (Harrison, 2009:29).

### **2.7.9 Devolution of management authority in public healthcare**

There are two urgent priorities with respect to devolution of authority, namely the institutionalisation of the district health system and devolution of staffing, budgeting and expenditure control of hospital management. Some of the key challenges with regard to management authority are discussed below (Harrison, 2009:31).

### **2.7.9.1 District health system**

Since 1994 the district health system has been recognised as the main mechanism for implementation of primary health care. Yet it has failed to be properly institutionalised. District management teams have been appointed and are responsible for day-to-day management of primary health facilities and community outreach. A number of initiatives have strengthened their capacity including management training and tools for budgeting and experience analysis. However they have acted as units of de-concentrated provincial system rather than as management entities with delegated authority. The effect has been accountability to provincial government, often largely driven by the imperatives of the Public Finance Management Act, no. 1 of 1999, and insufficient accountability to the people of the district for health service provision.

### **2.7.9.2 Devolution of staffing, budgeting and expenditure control to hospitals**

The high degree of management centralisation at provincial level sets up a vicious cycle. The competent managers are frustrated by the lack of autonomy and leave the sector. Provinces are reluctant to devolve management authority to junior or less competent managers. The sense of exclusion from decision-making experienced by many senior clinicians in central and provincial hospitals will have to be addressed.

### **2.7.10 Health worker morale**

Field studies concluded that although nurses ascribed their morale to overwork, this was not the main factor. A sense of neglect and lack of support was actually at the heart of problems of low morale. The following strategies can be implemented to improve staff morale amongst health sector workers (Harrison, 2009:32):

- A national campaign to affirm the value of health workers and link it to rewards and recognition.

- Re-asserting the primary role of district management team in supporting personnel within the district instead of interacting with provincial and national processes.
- The simplification of paperwork, including a brutal trimming of the national health information minimum dataset and condensing annual business plans and programme reports.
- Facilitated processes of in-service support to health workers that go beyond occasional trainings.
- Incentivising further study and personal development through a dedicated programme that is linked to study aids.

There are places of excellence and dedicated health workers in clinics and hospitals across the country that renders high quality services even in the face of constrained resources. A common factor in all these situations is strong and motivated leadership within the health facility. It is imperative that the type of leadership training that has been provided to senior and middle-level health managers should now be extended to clinic managers. The morale of health workers will only improve if they have a real sense of mission and personal fulfilment, which to a large extent depends on the ability of national and provincial managers to articulate a clear vision and plan of action.

### **2.7.11 Leadership and innovation in public health**

A number of factors that are critical to the success of the implementation of the 2004-9 strategic plan includes (Harrison, 2009:32):

- Leadership: political leaders as well as managers in the health system must clearly articulate and communicate a vision and a mission that will resonate with front line health workers.
- A programme of action that is developed and captures the imagination of those charged with its implementation. This would require greater empowerment of leaders at the local level to drive the change agenda.

The abovementioned critical success factors remain relevant even today. However the third mechanism that can be added is a mechanism for leadership development and public innovation in the health sector.

## **2.8 OVERVIEW OF PRIVATE HEALTHCARE SECTOR IN SOUTH AFRICA**

The private sector largely evolved in a policy vacuum, with government focused on general tax-funded health services for the non-paying population. Medical schemes pre-dated the development of the public health system. Medical aid evolution has a coherent system of funding care emerged as a response to the need for insurance in the absence of access to free public services for income earners and their dependants.

Private health system serves over 8 million people (17% of the population), it plays a substantial social protection role for income earners. The private health system in South Africa has raised competition concerns for much of the past decade with hospital and specialist costs showing dramatic increases which cannot be justified on economic grounds (Van den Heever, 2012).

Hospitals are increasingly competing for limited health care resources, making customer satisfaction with the experience of care an increasingly important goal for hospitals (Zimmerman & Dabelko, 2013). Patients' satisfaction with healthcare services is a measure of the quality of care received and of the responsiveness of healthcare systems to patients' expectations (Lumadi & Buch, 2011).

## **2.9 CHALLENGES FACED BY PRIVATE HEALTHCARE SECTOR**

Medical aid schemes in the private health sector are facing increasing costs and competition and so are the healthcare providers. Everyone in the private health sector will need continuous innovation in order to service the patients/members better and stay ahead of the game. The private health sector is faced with the following challenges (Agility Global Health Solutions, 2012):

### **2.9.1 Increased costs and more responsibility for patients**

Most of the medical schemes have moved towards the system of savings accounts in order to shift more day-to-day care responsibility to the member. Most of the time patients do not want to use up all their benefits or the benefits are not adequate, which leads to a sicker population.

### **2.9.2 Increased consolidations amongst schemes and providers**

It is anticipated that in the few years to come there will not be so many schemes to choose from as cost pressures and economies of scale drive consolidation in the industry.

### **2.9.3 Policy direction that is needed from the government**

Medical aid schemes will be looking for guidance on how the government plan to roll out the National Health Insurance (NHI) plan. Clarity on the NHI keeps coming out year on year. The Prescribed Minimum Benefits (PMB) will continue to be under review as PMB is the major cost driver for medical aid schemes. PMB is the cheapest package a medical scheme can cover ranging R400-570 per month. This puts private healthcare out of reach for most South Africans.

### **2.9.4 Technology as provision for competitive edge.**

Medical schemes that have invested in the latest technology will reap the benefits in the long run. Treatment protocols not only ensure less costs but also provide best evidence treatment plans and health outcomes for patients leading to short and long-term savings for medical schemes.

### **2.9.5 Skills shortage**

Shortage of supply of healthcare professionals from nurses to doctors and specialists will continue to impact the cost of quality of healthcare in both the public and private healthcare sector.

Most of the medical schemes have moved towards the system of savings accounts in order to shift more responsibility to the member (Agility Global Health Solutions, 2012).

### **2.10 Overview of Hlonolofatso Healthcare Group**

Patient satisfaction is a multi-dimensional healthcare subject that is affected by many variables in and out of healthcare facilities. The quality of healthcare that patients receive in a healthcare facility will hugely and directly influence their satisfaction on service delivered. Patient satisfaction will in turn influence positive behaviour like loyalty and word of mouth referrals to the facility (Naidu, 2008). Healthcare providers should regularly monitor healthcare quality and accordingly initiate service delivery improvements to achieve and maintain high levels of patient satisfaction. A reward system is an important part of an organisation's design and must be aligned with the strategy, structure, employee involvement and hard work (Cummings & Worley, 2009:434). A reward system will help to keep staff motivated to become the best in their work. Successful leaders build confidence by encouraging innovation and calculated risk taking rather than by punishing and criticizing what is less than perfect (Adams & Spinelli , 2012:506).

Healthcare quality is difficult to measure owing to inherent intangibility and inseparability features. Quality healthcare is dynamic considering customer changes that have taken place and the increasing competition in the health industry. Quality healthcare is difficult to measure and define because it is the customer themselves and the quality of their lives being evaluated.

Patient satisfaction is a complex, multi-dimensional issue that needs to be approached from several angles. It is very hard to determine one aspect of patient satisfaction like satisfaction with doctor or staff demeanour without knowledge on the level of

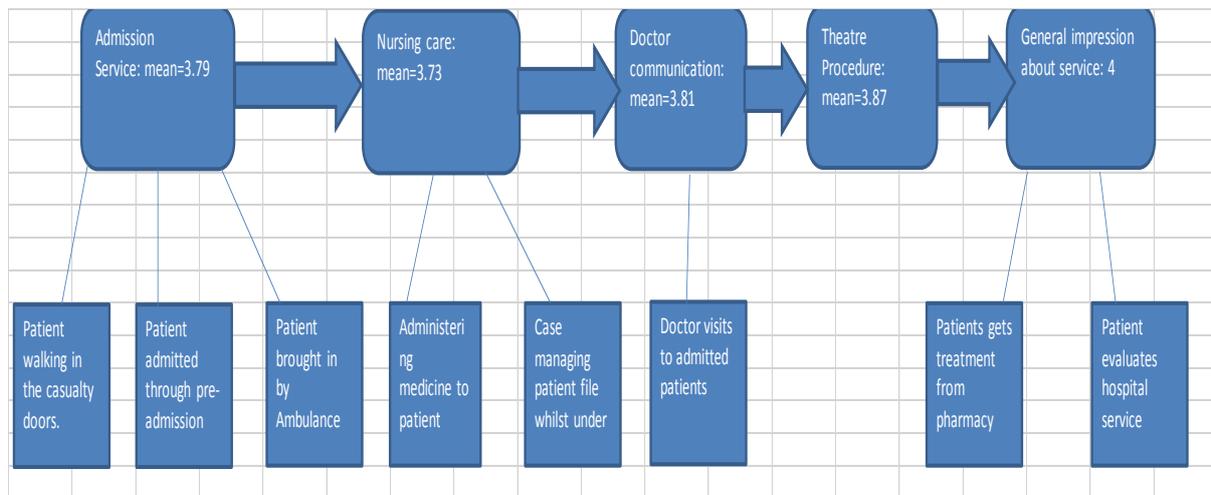
satisfaction with the quality of time spent with the doctor or in the hospital (Khattak, *et al.*, 2012). Nowhere is this more evident than in the hospital, where operational excellence is central to the clinical treatment of patients, the equality of their experience and of course, cost (Chase & Jacobs, 2011:306). Patient expectation with regard to the quality of service in a healthcare facility has been directly linked with the level of satisfaction. Patient satisfaction tools are further classified as general because they mostly measure the overall or general patient satisfaction (Naidu, 2008).

Hospitals do not have a simple line of command, but are characterised by a delicate balance of power between different interest groups (management, medical specialists, nursing staff and referring doctors), each of them having ideas about what should be targets for operation performance.

In hospitals product specifications are often subjective and vague. Hospital care is not a commodity that can be stocked, the hospital is a resource-oriented service organisation (Chase & Jacobs, 2011:306-307).

Hlonolofatso hospital is a 233-bed hospital and therefore classified as medium-sized by the department of health. The hospital is situated in Parktown, Hillbrow and competing with a number of private hospitals. Hlonolofatso hospital (HH) is a division of a big Healthcare Group and has its protocols and control environment aligned to that of the group. The primary objective of this research is to analyse factors that impact on patient satisfaction in a hospital. The research focused on general patient satisfaction in HH on the basis of primary and secondary satisfaction dimensions.

**Figure 2.1: Illustration of the hospital admission process from admission through to discharge**



(Source: Own compilation)

## 2.11 PATIENT SATISFACTION DIMENSIONS

Patient satisfaction is a multi-dimensional healthcare construct affected by many variables. Healthcare quality affects patient satisfaction, which in turn influences positive patient behaviour like loyalty. Patient satisfaction and healthcare service quality, though difficult to measure can be operationalized using a multi-disciplinary approach that combines patient input as well as expert judgement (Naidu, 2008). Patient satisfaction will therefore be measured on primary and secondary dimensions as mentioned below.

### 12.11.1 The primary dimensions

On the other hand patient satisfaction is defined as an evaluation of distinct healthcare dimensions. It may be considered as one of the desired outcomes of care and so patient satisfaction information should be indispensable to quality assessments for designing and managing healthcare. Patient satisfaction enhances hospital image, which in turn translates into increased service use and market share. Satisfied customers are likely to exhibit favourable behavioural intentions which are beneficial to the healthcare provider's long-term success. Patients turn to express intentions and

experiences in positive ways such as praising and preferring the healthcare provider over competitors or increasing their purchase/consultation volumes (Naidu, 2008). Patient satisfaction is mainly influenced by the following primary factors (Wan *et al.*, 2008):

- Caring;
- Empathy;
- Reliability; and
- Responsiveness.

These primary dimensions on patient satisfaction are also part of the HH value chain. The hospital group's values are deeply rooted into these primary patient satisfaction dimensions.

#### **2.11.2 The secondary satisfaction dimensions are (Naidu, 2008):**

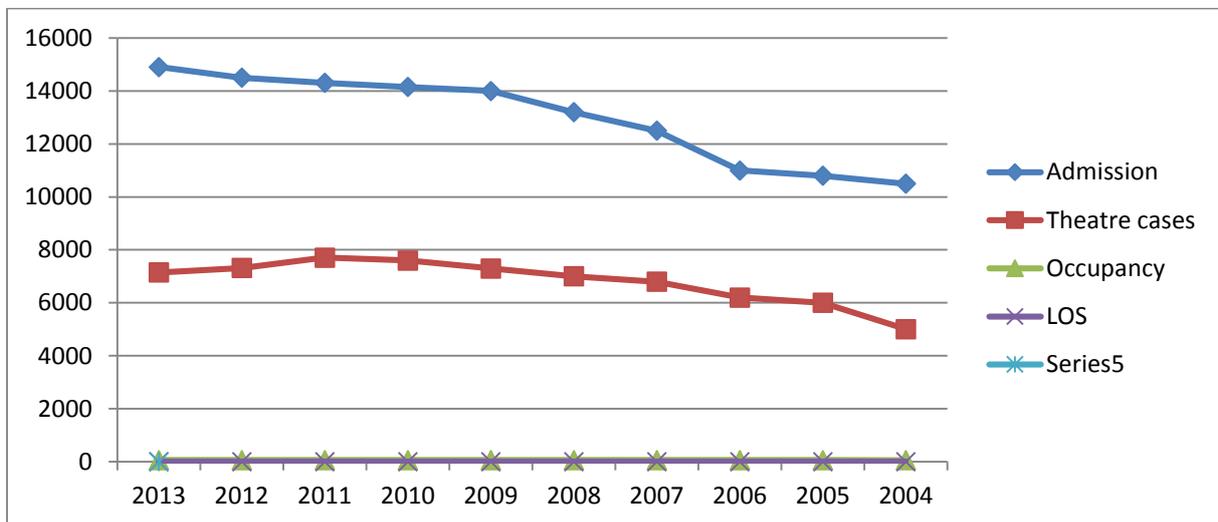
- **Admissions** – speedy admission of patient into beds, efficiency in dealing with external and internal issues around patient admission and responsiveness in patient request is vital when admitting the patient.
- **Discharge** – Patients receiving information about their condition, where to go get medication for taking home, procedures and treatment plan post-discharge.
- **Nursing care** – The responsiveness of the nursing staff, their understanding, the adequacy and individualism of attention and warm caring attitude towards the patients.
- **Food** – The food should be tasty, nutritious, attractively presented and at correct temperatures.
- **Housekeeping** – Patients' perception about the cleanliness of the hospital in general and the wards, the neatness and decoration of the hospital in general and appearance of nursing and admin staff.
- **Technical services** – The hospital physicians attending to the needs of the patients timeously and punctual in doing their ward rounds.

Hospital performance for the past ten years is illustrated on the graph below. **Table 2.1: Illustration of hospital performance**

Activity	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004
Admission	14900	14500	14308	14150	14001	13200	12500	11000	10800	10500
Theatre case	7145	7317	7706	7600	7300	7000	6800	6200	6000	5005
Occupancy	68	65	66	65	63	65	64	63	63	62
LOS	3.4	3.3	3.4	3.3	3.4	3.4	3.5	3.4	3.4	3

(Source: Own compilation)

**Figure 2.2: Graphical presentation of hospital performance**



(Source: Own compilation)

The data depicted above is the hospital statistics based on activities; that data is used to measure growth in the hospital. Patient admissions statistics is reviewed month on month during the year but also month-to-month comparison is performed. Admissions are the main drivers and indicators of growth in a hospital. This is so because all things start with admissions. When admission numbers are growing from one month to another it is a good sign because all the other activities like theatre cases, length of stay and bed occupancies will start to show a positive upward trend. Theatre cases are vital to a hospital because that is the biggest source of revenue. It is therefore important that a hospital should have nimble theatres that will attract doctors to do their cases. The good condition of the theatres goes along with modern theatre equipment, the hospital should keep up with advanced theatre equipment that will

make doctors works easy when in theatre. This all in all will form part of the secondary factors of satisfaction under facility outlook.

Based on the data above it can be noted that admissions have been quite flat in the last years and have started to slightly improve in 2013. This in actual fact means that HH market share has not grown in the past five years. The theatre cases have rather declined in the previous five years, a slight improvement is observed in 2011 but it starts to decline again in 2012 and 2013. The average annual occupancy and length of stay has not really grown but remained flat. This is true on the reflection of admission because occupancy and length of stay will have a direct relationship with the number of admissions.

## **2.12 SUMMARY**

Patients who receive their medical care in a private hospital usually have expectations due to the fact that they pay lots of money for the service to be provided to them. Therefore they do not want to receive compromised quality of care when it comes to health service in private healthcare provider. It is therefore important that the healthcare provider lives up to the expectation of the patients in order to keep the patients satisfied, maintain the market share and even penetrate new emerging markets.

## **CHAPTER 3**

### **EMPIRICAL INVESTIGATION**

#### **3.1 INTRODUCTION**

In the previous chapter a literature review was conducted on the concept of satisfaction with regard to patients in private and public health care. This chapter covers the empirical investigation on the study at hand in order to determine the satisfaction that patients have in private healthcare facility. The investigation will give more insight on the biographical information of the sample, the age, gender and education level of the patients, and more biographical information about the selected sample.

The goal of the empirical investigation was to analyse the data collected from the questionnaires and formulate a conclusion on each section/function of the hospital contributing to patient service. The empirical investigation is based on functions that were identified in the literature review as separate functions that complete the patient's satisfaction. The completed questionnaires were then captured and analysed for patient satisfaction, on a Statistical Analysis System (SAS) in order to read the full results of the questionnaires and to draw conclusion.

The data is presented in a tabular and graphical formats using bar and pie charts to present a visual interpretation of the results.

#### **3.2 RESEARCH METHODOLOGY**

##### **3.2.1 Research questions**

The primary purpose of the study was to obtain information with regard to the negative perception that patients have about service delivery in the hospital therefore resulting in low admissions and occupancies and reduced theatre cases. The questions were deduced from the primary and secondary dimensions of patient satisfaction. The

dimensions were empirically researched by making use of a self-administered questionnaire. The structured questionnaire consisted of the following five constructs that are based on the primary and secondary dimensions of patient satisfaction: admissions service, nursing care, doctor communication, theatre procedure and general impression about the hospital facility and biographic section about the patients/respondents.

### **3.2.2 Pilot study performed**

A pilot study consisting of 15 participants (management committee and heads of departments) was performed ahead of designing the study questionnaires. The purpose of the pilot study was to get an understanding of the areas of concern from hospital management and to ensure that the study will add value to hospital processes. Various meetings were set up with hospital management to identify the hospital critical success factors and areas of concern. Management have identified the following areas of concern:

- Patient communication through interaction with the patient.
- Time delays during any process that a patient must undergo.
- The comfortability created for the patient to have a good experience despite their ill-health.
- The level of care, respect and privacy offered to the patients throughout the hospital process.

### **3.2.3 Managerial critical success factors (CSFs)**

Hospitals have to identify and ensure that critical success factors are well in place to ensure sustainability of the business. During the pilot phase of the research several meetings with the hospital management team through the research process were held in order for management to give insight on the hospitals critical success factors. These critical success factors are directly linked to the construct that were analysed in the

empirical investigation. The following were mentioned by the management committee (MANCO) and heads of departments (HOD):

**Table 3.1: Critical success factor identified by management**

<b>Critical success factor</b>	<b>Most critical</b>	<b>Least critical</b>
Patient care	Yes	
Empathy for patients	Yes	
Respect for patients and colleagues	Yes	
Competence	Yes	
Sympathy for patients	Yes	
Passion for work	Yes	
Good communication skills	Yes	
Confidentiality	Yes	
Embrace change	Yes	
Advanced technology	Yes	
Availability of specialists	Yes	
Responsibility	Yes	
Accountability	Yes	
Professionalism	Yes	

(Source: Own compilation)

Management was asked to categorise the identified and above listed critical success factors as most or least critical. The research has identified 15 critical success factors and management categorised 10 as the most critical factors in the success of a hospital. Patient care, professionalism, respect, confidentiality and communication were identified as the most critical ones by the managers due to the number of complaints received in a given month. All these identified CSFs if well implemented in the hospital will yield an efficient quality management and ensure continuous improvement. Ever since the times of Florence Nightingale, hospitals have been seeking ways to achieve quality and process improvement.

Hospital personnel are well suited to analytics of total quality management (TQM) because so much of healthcare involves precise measuring of patients' responses to drugs and clinical procedures (Chase & Jacobs, 2011:310). In a service business the customer (patient) and the front-line service employee (admission clerk) interact to create a service. Effective interaction depends on the skills of the front-line service employees and the support processes backing these employees. Successful service companies focus their attention on both their customers and their employees. They understand the service profit chain which links service firm profits with employee and customer satisfaction (Kotler & Armstrong, 2012:262).

The study questionnaire was designed based on the identified areas of concern by management and the questionnaire was approved by the management team.

#### **3.2.4 Target population**

The sampled patients were selected from the hospital. Therefore convenient sampling was used. In convenience sampling the respondents selected are easy, inexpensive or convenient to sample (Levine *et al.*, 2011:252). Meetings were arranged with the hospital management to request access into the hospital in order to distribute the research questionnaire. Thorough explanations were made to management about the research questionnaire in order to assure them that patients' rights were not violated at all. Each questionnaire was clearly explained to the patient before completion and they all completed it on free will. Hospital management then informed all unit managers in various wards about the questionnaires that the patients had to complete for research purposes and allowed placement of the questionnaires in the wards. A period of three months (October to December 2014) was used to collect the information requested in the questionnaire. More acute patients who were able to read and write were requested to complete the questionnaire and drop it in a sealed box that was placed in the ward.

The respondents (patients) were geographically widely distributed as they are from all around Parktown because the hospital is situated in Hillbrow, Parktown. A total of 120 questionnaires were placed in wards and a total of 109 questionnaires were fully completed and returned. Eleven of the questionnaires were not fully completed and

therefore did not help at all for the sake of the research. The respondents represent 30% of the hospital patient base over the three month period. An 80% response rate was achieved due to only 109 of the 120 distributed questionnaires being used.

### 3.2.5 Scope of the research

A sample of patients that were admitted (in-patients) in the hospital during the months of October to December 2014 was conveniently used. The main reason for using in-patients at that point in time is because they have just had the hospital experience and willing to share the experience on their discharge. Also it is a readily available sample that had just been admitted at the selected hospital for testing. Ad hoc selection of the patients from out of the hospital would require further assurance to first ensure that the sample was indeed a patient in the hospital and that their experience is surely recent based on the changes that could have taken place in the hospital between the last period of discharge and recently. A representation of patients by method of payment is presented in a tabular form below in table 3.1.

**Table 3.2 Representation of patients by payment method**

Payment method	Percentage (%)	Cumulative frequency (%)	Number of patients
Medical aid	70	70	76
Private	15	85	17
Foreign	10	95	11
Contract	5	100	5
<b>Total</b>	<b>100</b>		<b>109</b>

(Source: Own compilation)

As presented in the table above, the significant number (70%) of admissions is medical aid patients. These patients' bills are submitted to the medical aid on discharge and the medical aid settles their bill. A good percentage of patients is also made up of private patients. These are the patients who settle their accounts on discharge or even pay in advance whilst in hospital. Then there are foreign patients whose accounts are settled by the various foreign governments as per contracts that they have with the

hospital. There are also contract patients whose accounts are paid on contractual arrangement made between the patient and the hospital.

A geographic presentation of the major base towns for the hospital is presented in a tabular form below in table 3.2.

**Table 3.3: Major surrounding towns that feed the hospital admissions**

<b>Town</b>	<b>Percentage (%)</b>	<b>Cumulative Frequency (%)</b>	<b>Number of patients.</b>
Soweto	20	20	22
Alexandra	20	40	22
Central Johannesburg	30	70	33
Mozambique	20	90	22
Botswana	5	95	5
Swaziland	5	100	5
Total	100		109

(Source: Own compilation)

As presented in the table above, the largest percentage of patient referral base is from Johannesburg due to the hospital being in central Johannesburg. A significant referral also comes from Soweto due to the convenience of being 10 kilometres away from the hospital. There is a good percentage of referrals seen as well from Alexandra at 20 kilometres radius from the hospital. There is quite a good number of foreign patients that come through to the hospital due to a contract the hospital has with foreign (Mozambican) national government. The hospital has a contract to service government officials in Mozambique and their families. The other referral base is just pure word of mouth based on previous experience by patients.

### **3.2.6 Research instrument and design**

A qualitative research approach was adopted. Qualitative research methods use historical data; the goal of this method is to use past data in order to predict the future

(Levine *et al.*, 2011:634). Data was collected from a sample of patients that were admitted in the hospital between October and December 2014 by means of a structured self-administered questionnaire. An example of the research questionnaire is attached to this study as annexure A.

The structure of the questionnaire was as follows:

- SECTION A: Biographic information about the patients.
- SECTION BA: The admission service that patients get from hospital.
- SECTION BB: The nursing care that the patients received when admitted.
- SECTION BC: Doctor and patient communication.
- SECTION BD: Theatre procedure if patients went to theatre.
- SECTION BE: Patients' general impression about the hospital.

This structure was guided by a pilot study that was done with the hospital management in order to identify areas of concern regarding hospital service to the patients.

### 3.3 STATISTICAL ANALYSIS

The descriptive data analysis method was followed using the analysis of variances (ANOVA) method. In using ANOVA the following assumptions are made about the study population:

- **Randomness and independence:** a random sample is selected to ensure independence of their responses.
- **Normality:** the sample is selected from a normal study population.
- **Homogeneity of variance:** this assumption states that variance amongst the study groups is equal.

Therefore variances were analysed amongst population means. The validity and reliability tests were performed using the Cronbach alpha values and confirmatory

factor analysis was used to measure the appropriateness of study constructs. Means and standard deviations of constructs were calculated and analysed for all constructs. The p-values and effect sizes were analysed for the respondents based on education, age and gender.

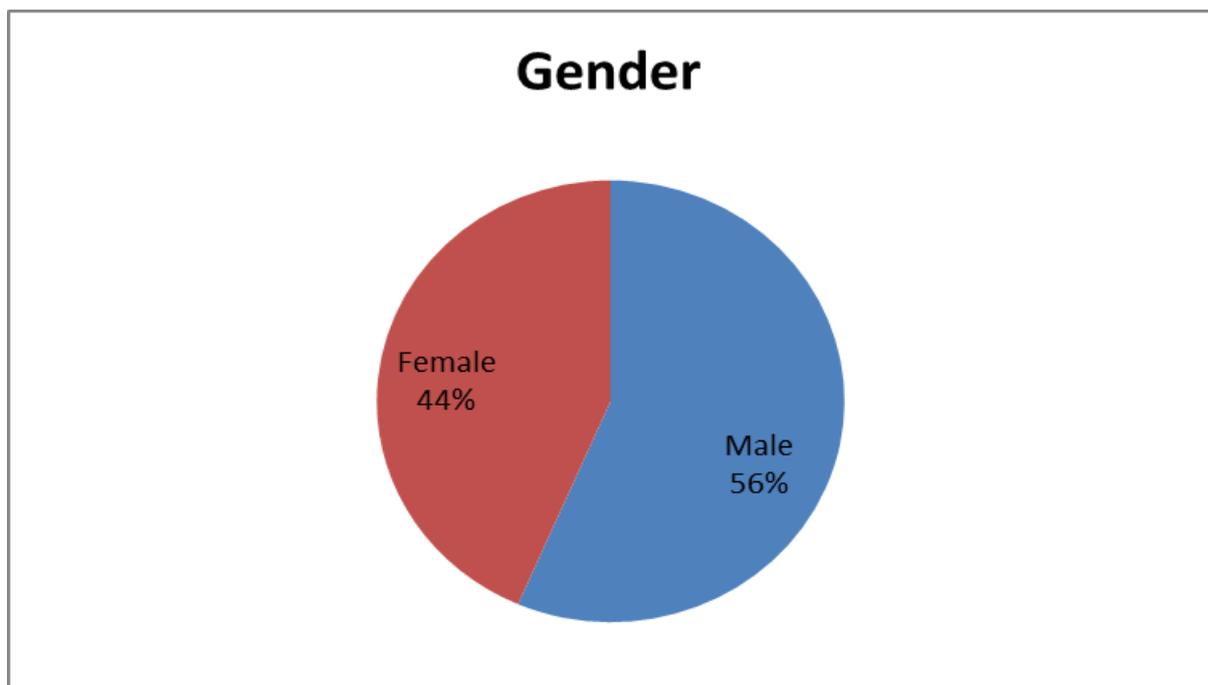
### 3.3.1 DEMOGRAPHIC INFORMATION ABOUT THE RESPONDENTS

In section A of the questionnaire a biographic background of the patients was researched. The following aspects were covered in the section: gender, age, education, race, citizenship, state of employment, type of employment, payment of hospital account, regularity of hospitalisation and length of hospital stay.

#### 3.3.1.1 Gender of respondent respondents

The majority of the respondents were male (56%) and 44% were females as presented in the graph below.

**Figure 3.1 Presentation of respondents by gender**

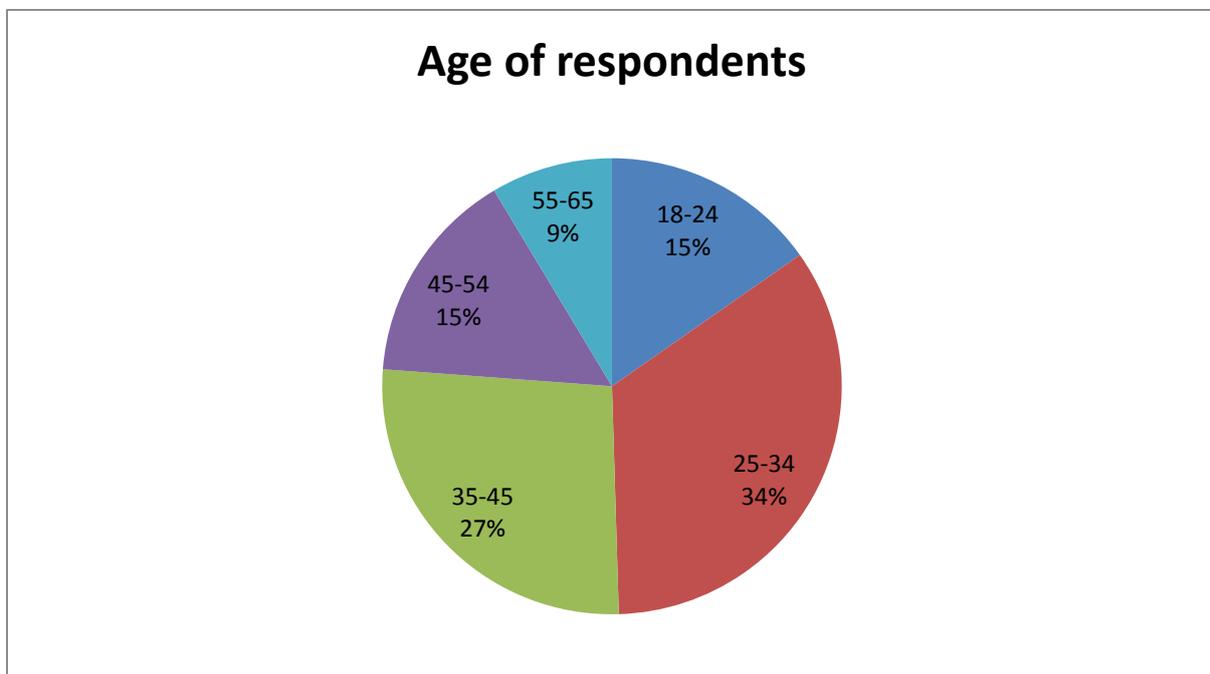


(Source: Own compilation)

### 3.3.1.2 Age profile of the respondents

The age of the patients were categorised to determine the concentration of the respondents for the sake of the research. As can be noted on the graph below that the patients that were above the age of 65 did not want to complete the questionnaire due to fatigue from being ill, some were blind and others were not strong enough to hold the pen due to nature of their illness.

**Figure 3.2: Presentation of respondents by age**



(Source: Own compilation)

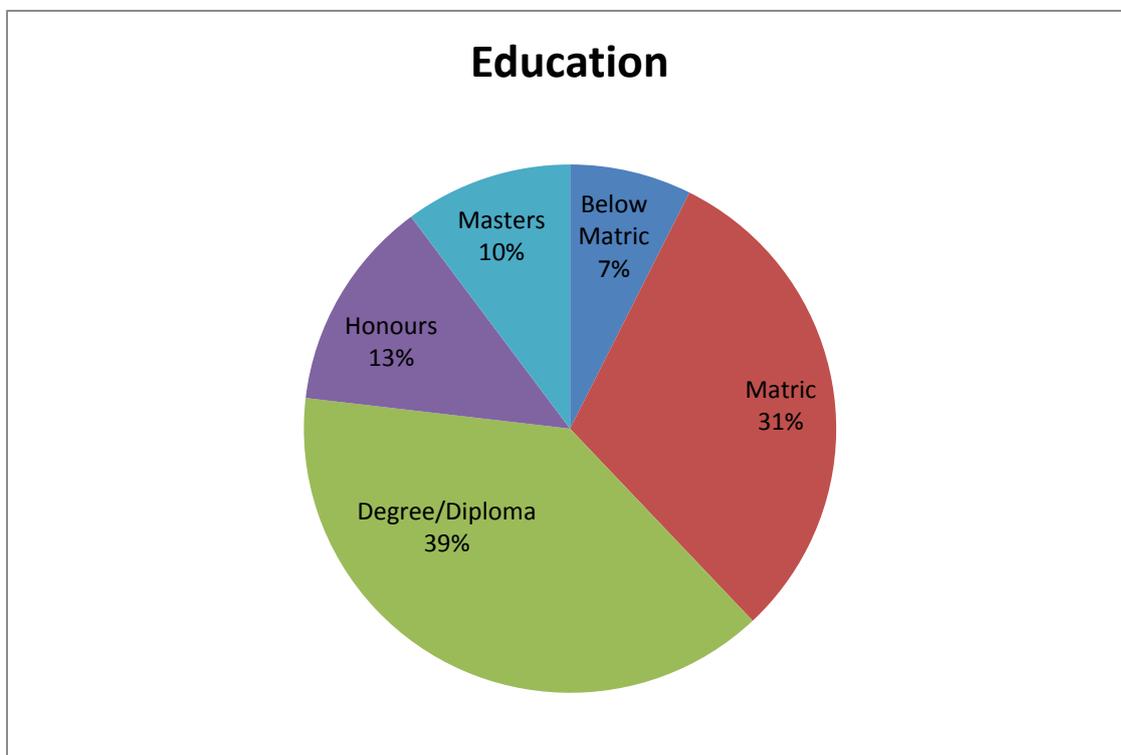
The majority of the respondents were between the ages of 25 and 34 and made 34% of the research sample, 27% of the sample was between the ages of 35 to 35, 15% of the population was between the ages of 18 to 24 and 45 to 54. The minority of the sample was between the ages of 55 to 65 and represented 9%. Based on the presented graph above it is evident that the younger generation between the ages of 18 to 24 are indifferent about their experience based on experience and the fact they usually have not been hospitalised often. The middle generation between the ages of 25 and 45 are more vocal about their experience of service provided and this is aligned with the fact that they are working and paying for their own healthcare and can easily

compare the service rendered versus the amount of money paid for it. The patients above the age of 45 are also indifferent about their experience and service provided due to change in behaviour based on maturity expected with their age. Beyond the age of 65 they did not even seem interested to comment about their experience in hospital.

### 3.3.1.3 Education profile of the respondents

Education of the respondents was categorised to determine their level of judgement based on the service provided to them.

**Figure 3.3: Presentation of respondents by level of education**



(Source: Own compilation)

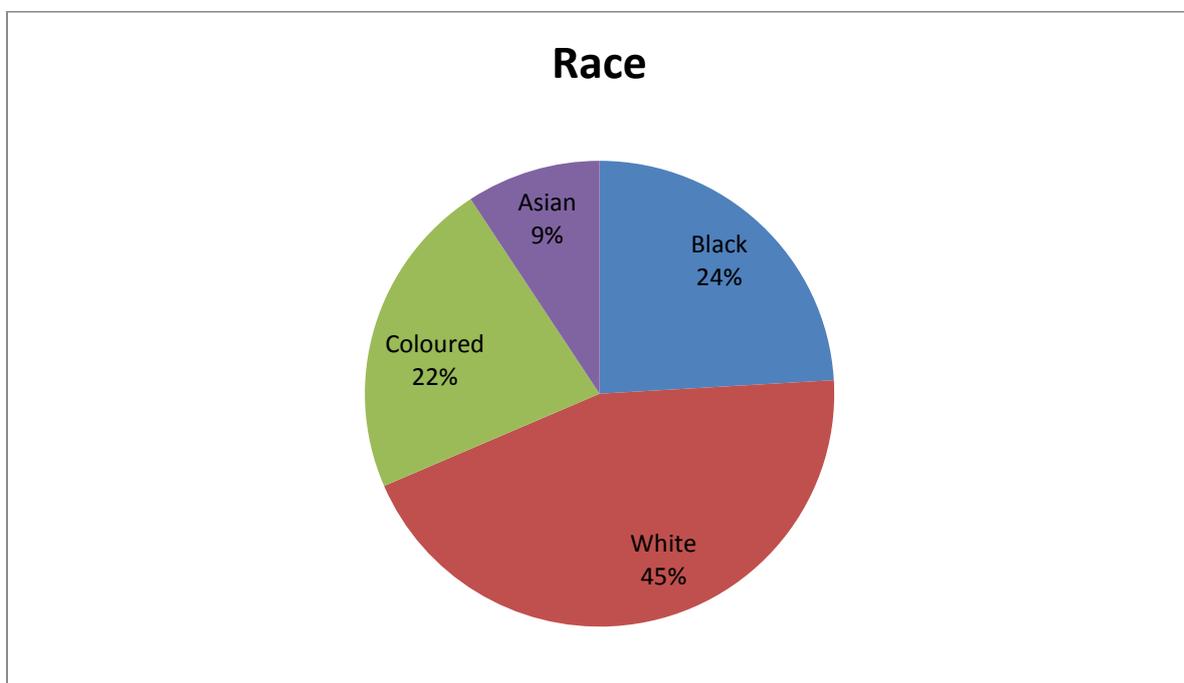
The majority of the respondents (39%) had a degree or diploma certificate. In this case the level of the respondents is aligned with the majority of the respondents at the ages between 35 and 45 and at that age they make up a significant number of the economic active population. These respondents are therefore educated, working and paying for their own healthcare services. A significant percentage is also observed on the

respondents who only have matric at 31 percent, 13% had honours degrees, 10% has master's degrees and none of the samples had a doctoral degree.

### 3.3.1.4 Race of the respondents

Race of the respondents was categorised to determine how opinionated patients are across ethnic groups.

**Figure 3.4: Presentation of respondents by race**



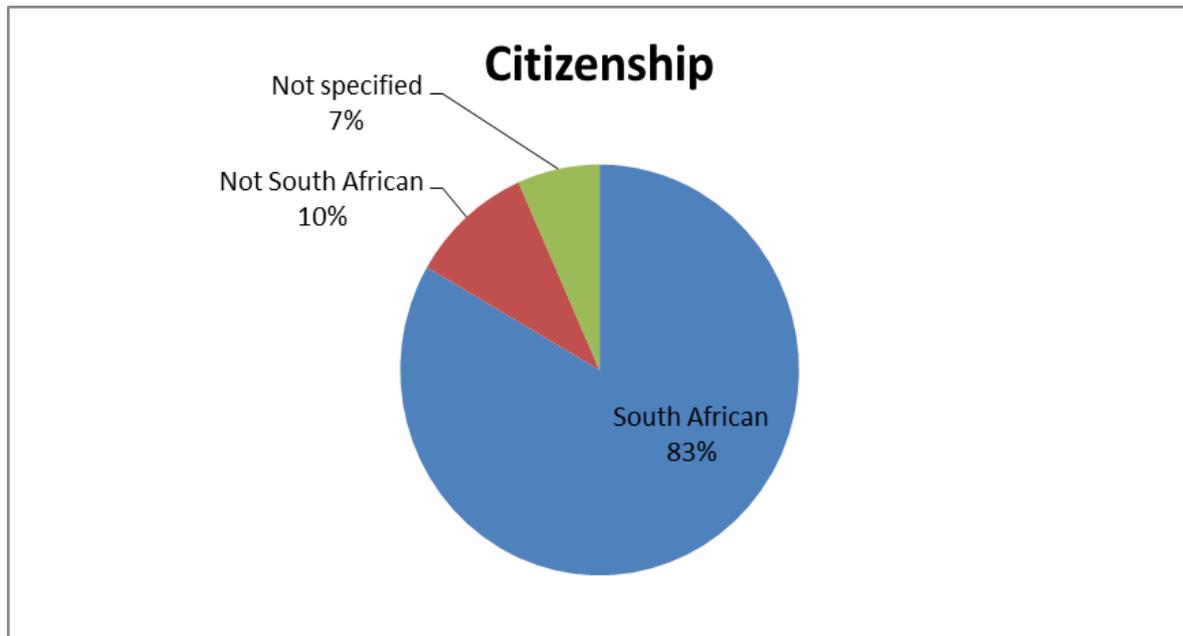
(Source: Own compilation)

The majority of the sampled target market was the white ethnic group making up 45% of the sample, 24% of the sample was black people, followed by 22% of the coloured ethnic group and lastly the minority was the Asian ethnic group making up 9% of the sampled population.

### 3.3.1.5 Citizenship of the respondents

Citizenship of the respondents was categorised to determine the service opinions of foreign patients in the hospital.

**Figure 3.5: Presentation of the respondents by citizenship**



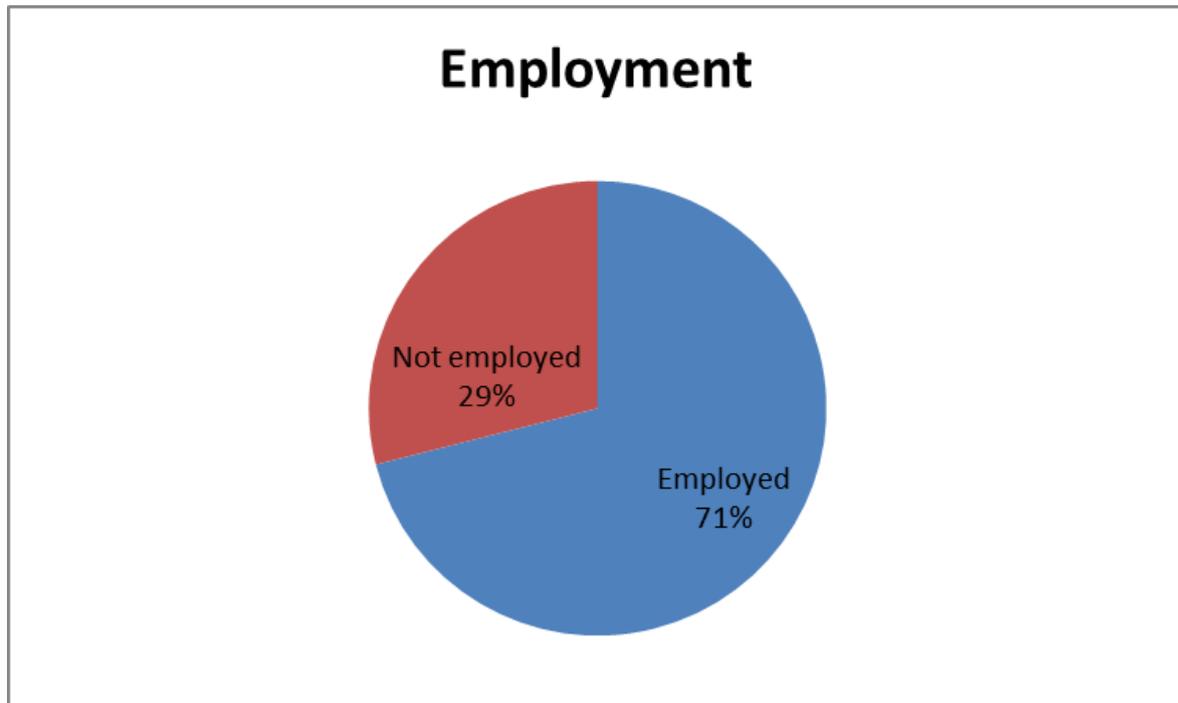
(Source: Own compilation)

The majority of the sampled respondents were South Africans making up 83%, 10% were not South Africans and 7% did not specify their citizenship in the questionnaire.

### 3.3.1.6 Employment status of the respondents

Employments of the respondents was categorised to determine if patients are paying for the service themselves or not.

**Figure 3.6: Presentation of the respondents by employment status**



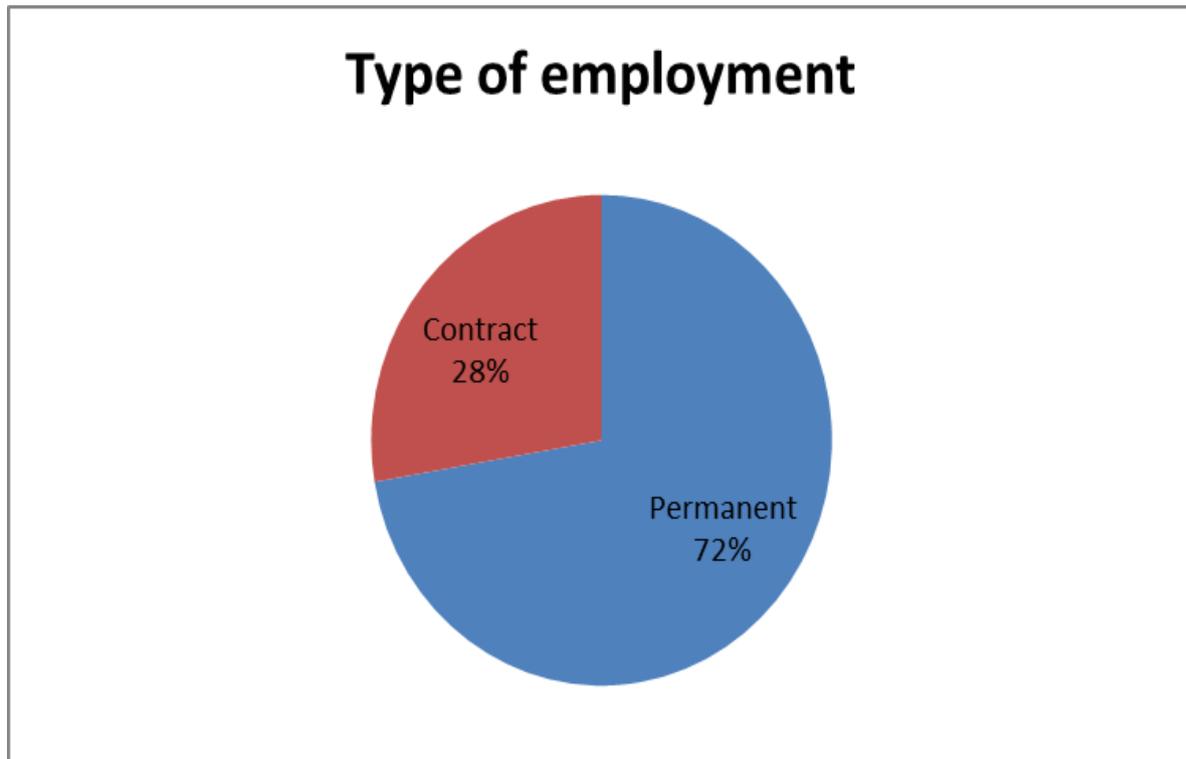
(Source: Own compilation)

The majority of the respondents were employed and had medical aids to pay for their healthcare services. The employed respondents made up 71% of the sample, 29% were not employed and would therefore be using other methods to pay for their healthcare services.

### **3.3.1.7 Type of employment**

The type of employment of the respondents was categorised to determine if they are permanently employed or not because permanent employment will give a good indication of whether the patient has a medical aid or not.

**Figure 3.7: Presentation of the respondents by type of employment**



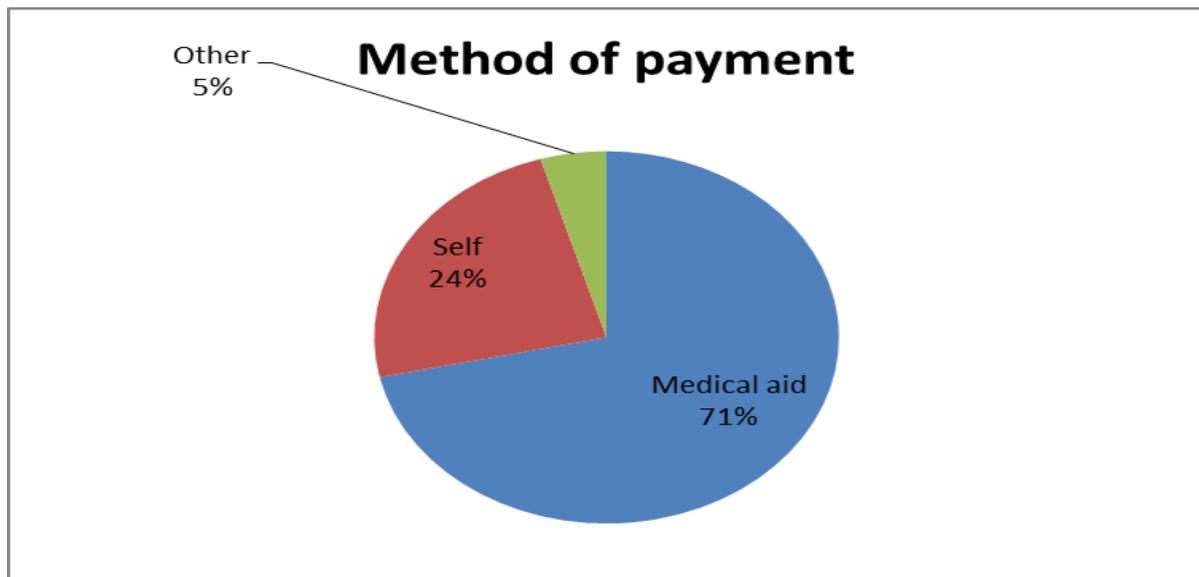
(Source: Own compilation)

The majority of the sampled respondents were permanently employed and made up 72% of the sample; 28% were not permanently employed. This will mean 28% of the respondents are employed on a temporary basis.

### **3.3.1.8 Hospitalisation payment method**

The method of payment that the patients used was categorised to determine the number of patients who have medical aids to pay for their health services.

**Figure 3.8: Presentation of respondents by method of payment**



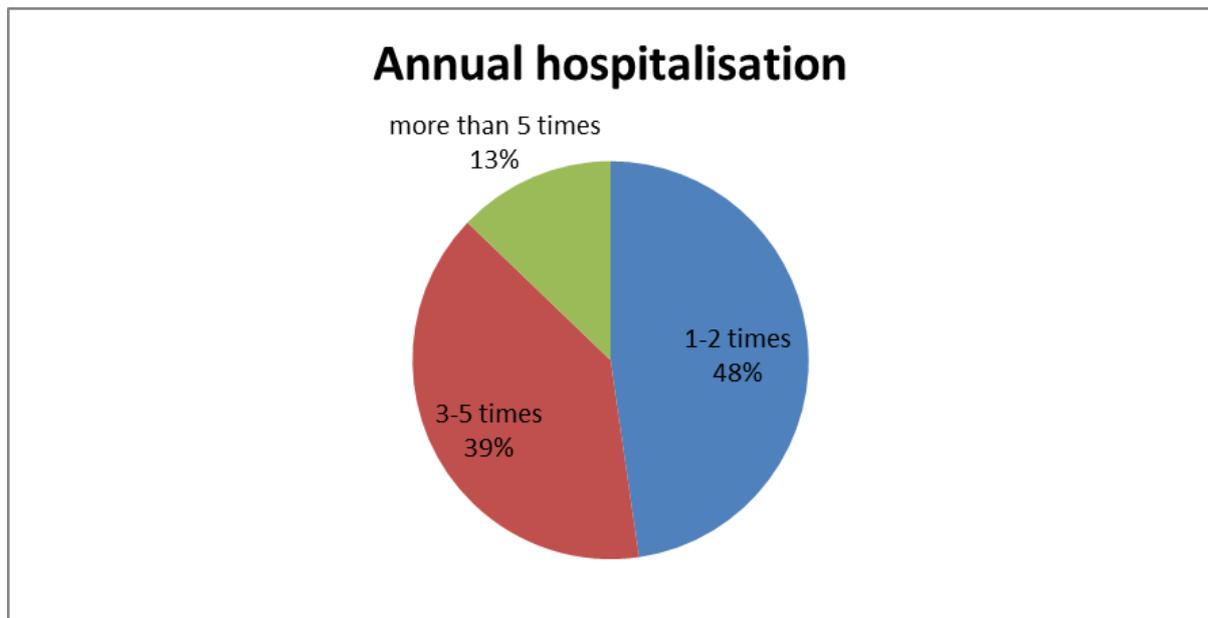
(Source: Own compilation)

The majority of the respondents paid for their health services through medical aid and made up 71%; 24% paid out of their own pockets and 7% used other methods of payment. This can be directly linked with 72% of the respondents that are permanently employed as per the two previous graphs.

### **3.3.1.9 Hospitalisation**

A pattern of how often are the respondents hospitalised was categorised to determine if that can have an effect on their satisfaction about healthcare service provided to them.

**Figure 3.9: Presentation of respondents by history of hospitalisation**



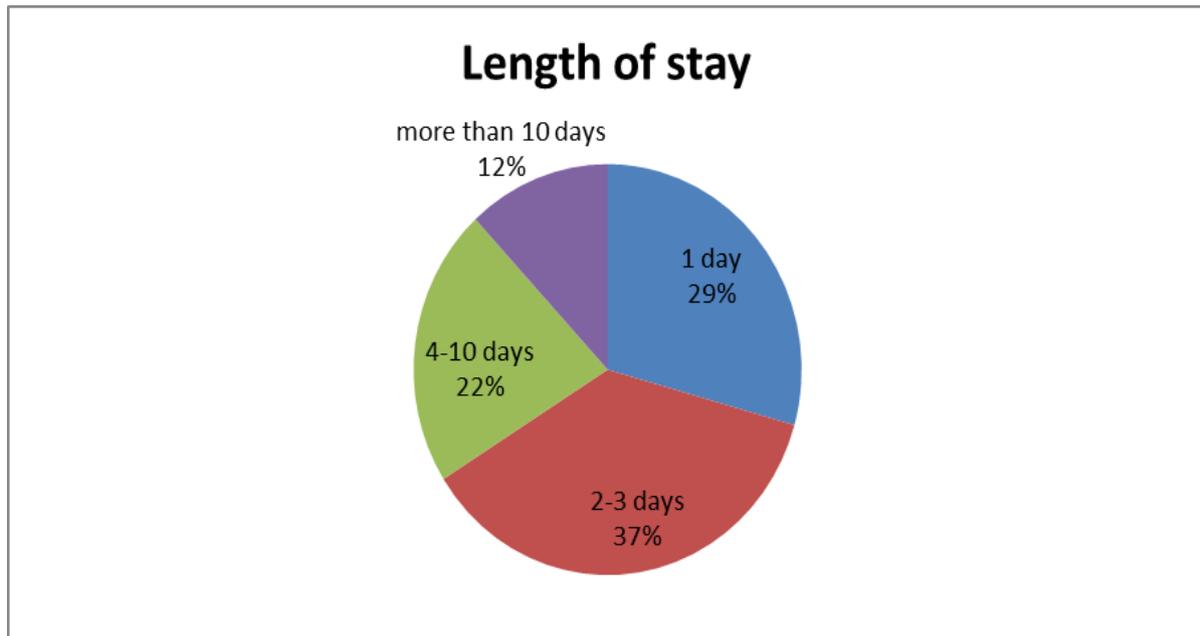
(Source: Own compilation)

The majority of the respondents were hospitalised between 1 to 2 times in a year, making up 48% of the respondents. A significant number of the respondents were hospitalised 3 to 5 times in a year and they made up 39% of the sample and a minority of 13% were hospitalised more than five times in a year.

#### **3.3.1.10 Duration of hospital stay**

The duration of respondents' stay in the hospital was also analysed to determine if they are sick from dire illnesses or not.

**Figure 3.10: Presentation of respondents by hospital stay**



(Source: Own compilation)

The majority of the respondents have stayed in the hospital for 2 to 3 days and they make up 37% of the sample. A significant number of the respondents have stayed in the hospital for only a day and make up 29% of the sample. A significant number of the respondents also stayed in the hospital for 4 to 10 days due to the intensity of their illness and they make up 22% of the sample. Lastly the minority (12%) of the respondents have stayed in the hospital for more than 10 days due to the intensity of their illness and they made up 12% of the sample. The short length of stay has got a negative effect on hospital occupancy.

### **3.4 STATISTICAL ANALYSIS OF DATA**

Data was captured and analysed by the North-West University's Statistical Consultation Services at the Potchefstroom campus using SAS. Frequency tables were drawn to describe the demographic variables of the study population. Cronbach alpha reliability coefficients were computed for each measuring construct to determine the reliability of constructs. The Cronbach alpha has become the most popular form of reliability assessment for multiple item scales (Warner, 2008:854). To determine

whether factor analysis may be appropriate, Kaiser-Meyer-Olkin's measure of sample adequacy (MSA) was used. The Kaisers measure of adequacy gives an indication of inter-correlations amongst constructs and was done for all constructs (Tabachnick & Fidell, 2011; 54). Effect sizes were used to indicate the practical significance of a construct, the extent to which a difference is large enough to have a significant impact in practice. If the entire population from where the sample was randomly selected is measured, the size of the correlation or regression coefficient found is known as the effect size (Miles & Shevlin, 2010:120). The following guidelines were used for d-values regarding differences between means:

- $d=|0.2|$  is small effect
- $d=|0.5|$  medium effect (noticeable with a naked eye) and
- $d=|0.8|$  (practically significant).

### 3.4.1 Validity and reliability

**Table3.4: Presentation of the Cronbach Alpha values**

<b>Construct</b>	<b>N</b>	<b>Cronbach Alpha</b>
Admission service	81	0.93
Nursing care	100	0.96
Doctor communication	103	0.95
Theatre procedure	92	0.89
General impression – Service	105	0.96
General impression – Facility	87	0.65

Note: N=Study population

(Source: Own compilation)

The Cronbach alpha coefficients for all the sample constructs was calculated and yielded values that are between 0.65 and 0.96. This means that the collected data from the selected sample of patients is therefore valid and reliable. The study population varies when noted on the table above. This is due to open-ended questions that some of the patients did not respond to.

### 3.4.2 Results of confirmatory factor analysis

To determine the appropriateness of constructs, Kaiser's measure of sample adequacy (MSA) was computed for each construct. The MSA gives an indication of the inter-correlations amongst the constructs. The construct validity for the constructs was assured by means of factor analyses. The communality is an estimate of the proportion of variance in each of the original p variables that is produced by a set of retained components (for example, 0.52-0.87) of factors (Warner, 2008:1000).

The N of factors is the number of factors that were analysed and the percentage (%) variance is measured between the construct items.

**Table 3.5: Confirmatory factor analysis**

Items	Construct	MSA	N of factors	% Variance	Communalities
BA1 BA2 BA3 BA4 BA6	Admission service	0.85	1	79%	0.52 - 0.87
BB1 BB2 BB3 BB4 BB5 BB7	Nursing service	0.93	1	87%	0.79 - 0.94
BC1 BC2 BC3 BC4 BC5 BC6	Doctor communication	0.81	1	83%	0.71 – 0.94
BD1 BD2 BD3	Theatre procedure	0.79	1	77%	0.43 – 0.88

BD4					
BE1 BE2 BE3 BE4 BE5 BE6	General impression – service	0.83	1	84%	0.73 – 0.93
BE8 BE10	General impression – facility	0.83	1	84%	0.73 – 0.76

(MSA=measure of sample adequacy, N=number, Items – refer appendix1) (Source: Own compilation)

The MSA for the constructs was between 77% to 87%, which means that there are strong correlations amongst constructs.

### 3.4.3 Means of constructs for respondents

The arithmetic mean is the most common measure of central tendency. The mean is the only common measure in which all the values play an equal role. The mean serves as a balance point in a set of data (Levine *et al.*, 2011:114).

The standard deviation on the other hand serves as a measure of variation. The standard deviation helps to see how a set of data clusters or distributes around the mean (Levine *et al.*, 2011:121).

**Table 3.6: Presentation of the means and STD deviations for the respondents**

<b>Construct</b>	<b>N</b>	<b>Mean</b>	<b>STD deviation</b>
Admission service	108	3.79	0.59
Nursing care	108	3.73	0.79
Doctor communication	108	3.81	0.54
Theatre procedure	95	3.87	0.64
General impression- Service	108	4.04	0.95
General impression- Facility	90	3.62	0.92

(Note: N= Study population, STD= Standard deviation) (Source: Own compilation)

The mean values for all the constructs on a scale of 1 to 5 (1=strongly disagree, 5=strongly agree) were all above 3, leaning very close to a 4. This means the selected sample positively agrees that hospital services are good across the departments as per the constructs. The sampled patients' general impression about the service is rated a 4, which means the overall service is experienced to be good by the sampled patients.

### **3.5 DESCRIPTIVE STATISTICS**

These are cross-tabulations/contingency tables.

#### **3.5.1 P-values and effect sizes on the constructs for differences between education levels**

Descriptive statistics is a method that helps to collect, summarise, present and analyse a set of data (Levine *et al.*, 2011:32). In this case information has been collected, summarised, presented and analysed based on the respondent's level of education. The p-values as stated in the table below is the probability of getting a test statistic equal to or more extreme than the sample result. The p-value is also known as the observed level of significance (5%;  $p < 0.05$ ) (Levine *et al.*, 2011:333). The d-value,

also known as Cohen's  $d$  describes the difference between two means in terms of the number of standard deviations. A larger value of  $d$  corresponds to a larger and therefore more easily detectable difference between two distributions of scores (Warner, 2008:104-105).

**Table 3.7: Presenting study population  $p$  and  $d$ -values based on level of education**

Construct	Group	N	Mean	Std dev	$p$ -value*	$d$ -value
Admission service	1	41	3.66	0.74	0.10	0.29
	2	67	3.87	0.47		
Nursing care	1	41	3.53	0.72	0.03*	0.40
	2	67	3.85	0.81		
Doctor communication	1	41	3.60	0.69	<0.05*	0.50
	2	67	3.95	0.34		
Theatre procedure	1	36	3.66	0.73	<0.05*	0.50
	2	59	4.00	0.56		
General impression-Service	1	41	3.83	0.95	0.08	0.35
	2	67	4.16	0.95		
General impression-Facility	1	41	3.62	1.13	0.97	0.01
	2	67	3.63	0.81		

Note: 1=matric and below, 2=above matric, STD dev= standard deviation

(Source: Own compilation)

\* Random sampling assumed

The means were further calculated across education groups within the sample and they remained positively above 3, leaning very close to a 4. This means that the sampled patients were positively feeling good about the hospital service across the constructs. Looking at the  $d$ -values on the table above it is noticeable that doctor communication matters across education levels. The  $d$ -value for doctor communication has a medium effect as per the table above, which means there was a noticeable difference between the education groups' perception on this construct. When looking at the mean for education group 2 (mean=3.95) was thus higher with a medium effect in practice than those in education group 1 (mean=3.6). Thus the

perception of patients with higher education regarding doctor communication was practically higher than those with lower education (group 1).

### 3.5.2 P-values and effect sizes on the constructs for differences across gender

**Table 3.8: Presenting study population based on gender**

Construct	Group	N	Mean	Std dev	p-value *	d-value
Admission service	1	60	3.77	0.56	0.75	0.06
	2	47	3.80	0.61		
Nursing service	1	60	3.70	0.81	0.80	0.05
	2	47	3.74	0.77		
Doctor communication	1	60	3.76	0.58	0.32	0.17
	2	47	3.86	0.45		
Theatre procedure	1	56	3.88	0.62	0.36	0.05
	2	38	3.81	0.68		
General impression-Service	1	60	3.97	0.92	0.49	0.13
	2	47	4.10	0.99		
General impression-Facility	1	52	3.62	0.91	0.42	0.05
	2	37	3.59	0.93		

N= Sampled population, STD dev. = Standard deviation, 1=Males, 2=Females (Source: Own compilation)

\* random sampling assumed

The means across gender were all above 3, leaning very close to a 4. This means that the sampled patients were happy about the hospital service across all constructs. The overall experience on hospital service was above 4 for female patients with insignificant difference to male patients, followed by theatre procedure and doctor communication respectively. The d-value for the constructs was below 0.5 as can be noted on the table above. This means there was no difference in perceptions for all constructs between male and female patients.

### 3.5.3 P-values and effect sizes on the constructs for differences across age

**Table 3.9: Presenting study population based on age**

Construct	Group	N	Mean	Std dev	p-value *	d-value
Admission service	1	55	3.71	0.59	0.12	0.30
	2	53	3.88	0.59		
Nursing service	1	55	3.68	0.63	0.20	0.11
	2	53	3.78	0.94		
Doctor communication	1	55	3.78	0.58	0.40	0.15
	2	53	3.86	0.49		
Theatre procedure	1	49	3.85	0.55	0.72	0.06
	2	46	3.90	0.74		
General impression-Service	1	55	3.92	0.89	0.18	0.25
	2	53	4.16	1.01		
General impression-Facility	1	43	3.62	0.93	0.95	0.01
	2	47	3.63	0.92		

N= Study population, STD dev=Standard deviation, 1= between 18-34years, 2= between 35-over 65 years.

\* Random sampling assumed

(Source: Own compilation)

The calculated means across the age groups were well above 3, which means the sampled population was positively happy about the hospital service across age groups. The general impression about hospital overall experience was the highest, meaning that the sampled population is having a good experience about the service. The d-values for all constructs were all below 0.5. This means there was not a noticeable difference of perception amongst patient age groups on all the constructs.

### 3.6 SUMMARY

The empirical study in this chapter was informed by the literature review that was done in the previous chapter (chapter 2). The literature review was based on factors that affect or influence patient satisfaction in private healthcare. Therefore most of the

respondents/patients are from the central Johannesburg suburbs as the hospital is based in central Johannesburg. Biographical information of the patients was analysed in 10 categories as follows: gender, age, education, race, citizenship, employment, type of employment, payment of account, regular patient or not and frequency of admission.

The selected sample therefore (62%) has more than matric in qualifications and working permanent employment and has a medical insurance. This then makes private healthcare affordable to them. The hospital uses the critical success factors as a guideline to measure patient satisfaction through satisfaction questionnaires that patients had to complete on discharge. These questionnaires were analysed and presented in report form in the management monthly meeting where process improvement was also discussed.

In the following chapter the main findings in the empirical study will be interpreted.

## **CHAPTER 4**

### **INTERPRETATION OF THE EMPIRICAL RESULTS**

#### **4.1 INTRODUCTION**

In the previous chapter an empirical investigation of the study was conducted on the concept of satisfaction with regard to patients in private health care. In this chapter, interpretation of the results will be done per investigated constructs. The interpretations will be based on the results of the empirical research of the study. The interpretations will give more insight on the biographical information of the study population, the age, gender and education level of the patients.

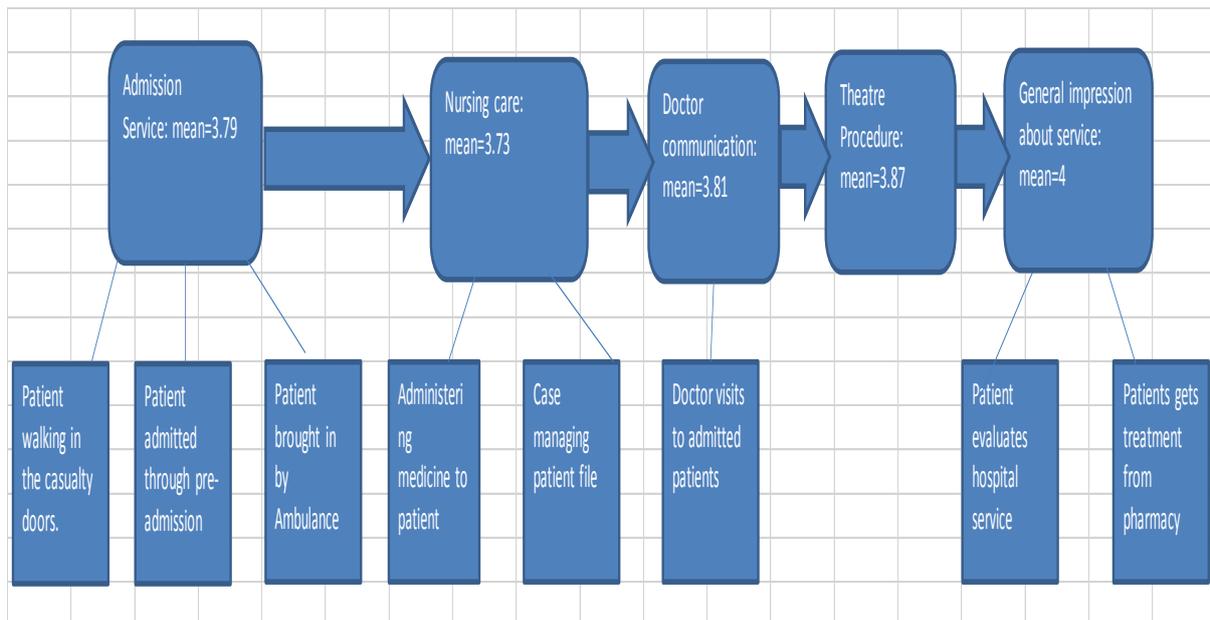
The interpretation will further be done by each construct that was investigated in order to get more insight on patient perceptions based on the individual constructs. The empirical study constructs were as follows:

- Admission service;
- Nursing care;
- Doctor communication;
- Theatre procedure;
- General impression – service; and
- General impression – facility.

#### **4.2 DETAILED HOSPITAL PROCESS OUTLINE FROM ADMISSION TO DISCHARGE**

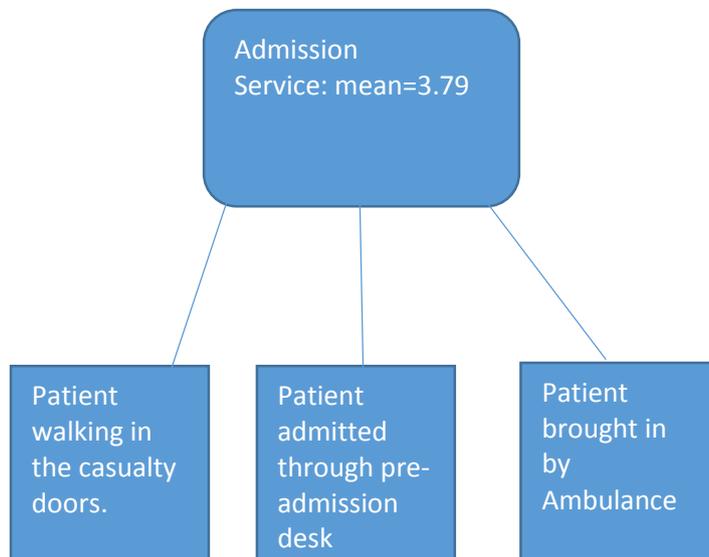
The hospital process is illustrated in a flow diagram that will be followed by a narrated walk through notes for ease of reference.

**Figure 4.1: Detailed hospital process outline**



(Source: Own compilation)

**Figure: 4.2: Illustration of the admission process:**



(Source: Own compilation)

#### **4.2.1 Admission process through the emergency unit for walk in patients**

Patient will walk through the emergency unit get welcomed by a porter and sit in the queue to open a file. The porter will then explain the admission process to the patient whilst sitting in the queue and ask if they have the necessary documentation that will be needed to open a file. When the patient has the needed documentation they will continue to wait in the queue; if not they will call someone to bring the documentation or send someone home to fetch it. Then the patient will be issued with the necessary form to complete whilst waiting in the queue. After completing the forms the patient's vital signs will be taken and they will also get triaged. To be triaged is a process where nurses are assessing the severity of patient illnesses to ensure that they get medical attention based on the severity of their illnesses and avoid patient health deteriorating in a queue to see a doctor. The patient file will then be loaded on the system and the admission clerk will call the medical aid to ensure that there are funds available in the medical aid card for the patient to consult or if it is a cash patient then they will immediately pay for consultation. The patient will be issued with a reference number (visit number) and wait to see a doctor.

The patient will go through to emergency doctors rooms and be seen by a doctor and the doctor will decide if the patient will be admitted or should just get medicine and go home. If the patient is getting medicine and go home the process ends. If the patient is admitted then, they will be informed accordingly and the porter will call the ward and inform the nurses in the ward that there is a patient that needs to be admitted into the ward. Then the admission clerk will admit the patient to the ward and the ward or emergency porter will wheel the patient to the ward for admission. During the admission process the patient has expectations with regard to the service that is rendered to them. They expect to be treated with care, dignity and respect. They expect the admission staff to constantly communicate to them the reasons why they are not progressing to the next level (delays). They expect to be heard when they have concerns and fears and the staff to respond with empathy. They expect confidentiality with regard to their sickness. On the hospital side the staff has to ensure that they possess the required character traits to take care of the patients and to deliver quality service as far as they can in compliance with the prevailing protocols and terms of reference in the hospital.

#### **4.2.2 Admission through the pre-admission desk**

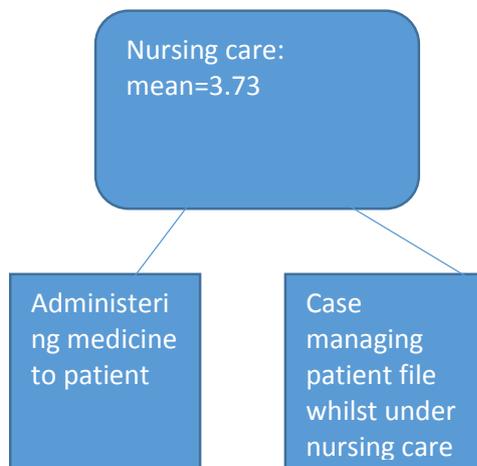
The patient will walk through the hospital with a doctor's note and get directed to the pre-admission desk. The pre-admission clerk will review the note from the doctor and book the patient in the hospital for that particular date. On the specified doctors date the patient will walk in the hospital and get sent to the ward for admission into a bed. Then the ward process starts.

#### **4.2.3 Admission process for patients brought in by an ambulance**

Patients that are brought in by an ambulance are always prioritised and therefore get attended to by the emergency doctor immediately. The admission process for these patients starts in the ambulance where the paramedic will complete the necessary forms, take vital signs of the patient and administer medication as allowed by the medical profession council. When the patient gets to the hospital they are wheeled straight into the emergency doctors consulting rooms for inspection. Then the emergency doctor will inform the admission clerk to admit the patient into the hospital and the porter will inform the ward about the patient that must be admitted to the ward. When the patient needs emergency surgery the admitting doctor will call the specialist on call to attend to the patient accordingly.

#### 4.2.4 Nursing care

Figure 4.3. Illustration of nursing care service



(Source: Own compilation)

When the patient gets to the ward, there will be a senior nurse (unit manager) to welcome the patient to the ward. The nurse will introduce her/himself to the patient and explain the ward process to the patient. The patient will be admitted on the system into the ward and be put to bed. The nurses will administer medication to the patient as per the admission doctor's instructions until the referenced doctor comes to see the patient of which afterwards the patient treatment plan may be altered based on the specialist's instructions. If there are tests to be done on the patient, the nurses will carry them out as instructed by the doctor and record the results and maintain any sort of proof that the doctors must review.

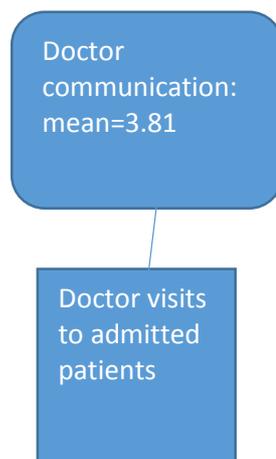
#### 4.2.5 Administration of patient account by case managers

When the patient is admitted in the hospital, the case managers will review the patient file on a daily basis with regard to the daily costs for the patient's hospital stay and communicate the costs with the medical aid and the patient on daily basis. In case of any possibility that the medical aid will not cover some of the hospital costs, the case managers must inform the patient accordingly and explain to the patient that they the

patient remains personally accountable for the hospital account. When the patient agrees they will inform the nurses to continue with the treatment and if the patient refuses the nurses will not administer the medication. When the medical aid cannot pay anymore, they will suggest to the hospital that the patient must be discharged. Then the patient will get discharged on depletion of funds or choose to pay from their pocket. Any surprises with regard to extra costs may cause patient dissatisfaction, therefore it is important to manage their expectation and keep them constantly informed.

#### 4.2.6 Doctor communication to patients in hospital

Figure 4.4: Doctor communication to patient

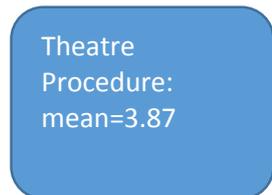


When the patient is admitted the doctor will make visits once or twice a day to check on the patient and make sure that the prescribed medication is working as it is supposed to. During the doctor's visits a nurse will always accompany the doctor to make notes on the doctor's observations and administer medication as the doctor may alter. As the doctor is visiting the patient, the patient remains with a level of expectation with regard to the quality of service that the doctor is rendering to them. The time that

the doctor is taking to check the patient, the manner in which the doctor communicates feedback back to patients. Sometimes patients may even complain to the doctor about any bad treatment that they are getting from the nursing staff.

#### 4.2.7 Theatre procedure

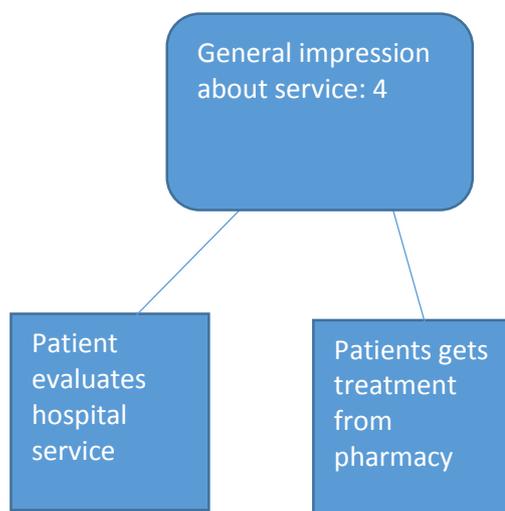
Figure 4.5: Theatre procedure



When the patient has to go to theatre for an operation, then the nursing staff will inform the patient accordingly and tell the patient the time and date of their operation. The nurses will inform the patient of any do's or don'ts before the operation as instructed by the specialist that will be performing the operation or procedure. On the day of the procedure the patient will get prepared for theatre by the nurses and the ward porter will wheel the patient to theatre and hand the patient over to theatre staff for any further preparation before the operation. Theatre staff will wheel the patient into theatre where they will meet their doctor and the doctor will first introduce himself again and explain the procedure to the patient and start working on the patient as soon the patient consents and signs the forms. Through all these procedures the patient has an expectation with regard to the quality of service to be received, the level of care, empathy and responsiveness. When the patients' expectations are not met through all these processes, the patient will start to have complaints.

#### 4.2.8 General impression about the service

Figure 4.6: Evaluating the service



(Source: Own compilation)

When the patient is discharged from hospital, they are usually discharged by the doctor. Then the nurses will inform the patient of their discharge and prepare the patient to go home. The nurses will get medication that the patient must take home and explain to the patient as to how they should take their medication at home. The nurses will inform the patient of any post discharge follow up visits that the patient must make to their doctor. Failure to thoroughly communicate the discharge process up to the patient's expectation may lead to the patient not being satisfied.

#### **4.2.8.1 Post-discharge process**

When the patient is discharged they wait in the waiting room for their loved ones to collect them. Whilst waiting for their loved one they are requested to evaluate their experience in the hospital from when they were admitted to the point when they are discharged out of the hospital. Most of the time that is when the patient will voice their unhappiness about everything that did not make them happy. The evaluation is usually done right at the end because patients do not want to complain whilst in hospital, they fear to be victimised or ill-treated by the nurses. However when they are discharged they find it easy to voice their concerns. The process would have been immediate if the patients were willing to evaluate the process continuously so that their complaints are attended to quicker and even before they are discharged to ensure that their hospital stay is comfortable and satisfying to their expectations and needs.

### **4.3 MAIN FINDINGS OF THE STUDY**

The primary purpose of the study was to obtain information regarding the perceptions that the patients have about the service that the hospital delivers to them. The empirical investigation will give further insight as to whether the respondents' perceptions are negative or positive. These perceptions will further be interpreted in line with the satisfaction that respondents derive from the healthcare service delivered by the hospital.

#### **4.3.1 Findings from the literature review**

- Private healthcare is expensive therefore more responsibility is pushed to the patients.
- Policy direction is still needed from the government with regard to the NHI.
- Continuous technology advancement is needed to keep up with times and disease break-outs.
- Shortage of healthcare professionals in the healthcare sector in general.

### **4.3.2 Findings from the empirical study**

Findings from the empirical study are grouped into ones that were rated good by the respondents and the ones that were not rated good and therefore requires management attention going forward to ensure improvement.

#### **4.3.2.1 Processes that were rated best by the respondents**

##### **Admission process**

- Administration staff explained the admission process in a way that the patients understood.
- Respondents were comfortable to divulge personal information about their sickness.

Refer to section 4.4 below for discussion of empirical results.

##### **Nursing Service**

- Respondents received a warm welcome into the wards.
- The nursing staff treated respondents with required respect through their hospital stay.
- Nursing staff appeared skilled when carrying out administering procedures and they always made notes.

Refer to section 4.5 below for discussion of empirical results.

##### **Doctor communication**

- Doctors were caring towards the patients.
- Doctors informed the patients that what had to be done and the result thereof.

Refer to section 4.6 below for discussion of empirical results.

##### **Theatre procedure**

- Nursing staff efficiently prepared the respondents for surgery.
- Doctors explained the theatre procedure in a way that the respondents understood.

Refer to section 4.7 for discussion of empirical results.

## **General impression about facility**

- Respondents would come back to the facility whenever in need of healthcare service.

### **4.3.2.2 Processes that were not rated as good by respondents and therefore require management attention**

#### **Admission service**

- Patients are waiting long in queues.
- Communication is not prompt to inform patients about delays when in queues.
- Admission staff conduct is not always friendly and considerate towards patients. Refer to section 4.4 below for discussion of empirical results.

#### **Nursing service**

- There is inconsistency with the nursing care provided by day and night nursing staff.
- Nursing staff is not responding promptly towards the needs of the patients. Refer to section 4.5 below for discussion of empirical results.

#### **Doctor communication**

- Doctors do not keep the patients informed about their health progress whilst in hospital.
- Doctors do not listen to patients concerns and respond in a way that they understand.
- Doctors do not make ward rounds at reasonable time of the day. Refer to section 4.6 below for discussion of empirical results.

#### **Theatre procedure**

- Nursing care after patients have been for surgery is not good.

Refer to section 4.7 below for discussion of empirical results.

### **General impression about the facility**

- The overall appearance of the facility was not good.
- It was not easy for the loved ones to find the facility and visit with ease.

Refer to section 4.8 below for discussion of empirical results.

### **4.4 Admission service provided to the respondents**

All patients that come in to hospital start at the casualty or reception in order to be admitted into the hospital. The admission service is therefore the first experience of service that the patients are exposed to. The research questionnaire was therefore designed in such a way that the patients would be able to assess the admission process on its own and give feedback on their satisfaction with that service. The questions that the respondents were asked about the admission service were as follows:

- Was everything explained to them in a language that they understand. (BA1)
- That the admission process was carried out promptly without a long wait. (BA2)
- Admission staff has kept the respondents informed of the delays during the admission process. (BA3)
- Whether respondents were comfortable divulging personal information to the admission clerks about their sickness and what actually was not comfortable about divulging. (BA4)
- Whether the admission staff member was friendly and considerate through the admission process. (BA6)

The Cronbach alpha coefficient for admissions was 0.93 which means that the collected data with regard to admissions is valid and reliable. The Measure of Sample adequacy (MSA) was 0.85 for the admission service which means there is a strong inter-correlation between admission service and other services of the hospital. The overall mean for all admissions questions were very close to one another, however

BA2 had the highest mean at 3.85 which means the respondents are happy about the way the admission process was explained to them. However the lowest mean was observed on BA2 with a mean of 3.79 followed by BA6 with a 3.80 mean and BA3 with 3.81 mean. This means that there is room for improvement with regard to the long waiting to be admitted, staff conduct (friendly and considerate) and continuously communicating to keep respondents informed about any experienced delays in the process.

#### **4.5 NURSING CARE PROVIDED TO THE RESPONDENTS**

When patients have been admitted in the hospital then they get exposed to nursing care by the nurses based on the doctor's diagnosis. Nursing care is therefore the next level of experience after the admission process. The questionnaires were designed in such a way that the patients could assess nursing care separate from all the other processes. The questions were numbered from BB1 to BB7. The questions that the patients were asked about nursing care were as follows:

- Were the patients warmly welcomed into the ward. (BB1)
- Were the patients treated with the required care and respect during their ward stay. (BB2)
- Nursing staff friendliness and prompt response to patient needs. (BB3)
- Nursing staff competence towards the patient when administering medication or even carrying out doctor's orders. (BB4)
- Any noted variance in care between day and night shift nurses. (BB5)
- Patient is satisfied with the overall medical care that they received in the ward. (BB7)

Question BB6 was a motivation for BB5 which the respondents did not want to elaborate on.

The statistical analysis for the nursing service yielded the following with regard to nursing care: The Cronbach alpha coefficient for nursing care is 0.96 which means the data that was collected on nursing care is valid and reliable. The MSA is 0.93 which means there is a strong inter-correlation between nursing care and other functions in

the hospital. The highest mean in the nursing care questions was on question BB7 at 3.84 and the lowest mean was on BB5 with a mean of 3.72 and BB3 with a mean of 3.73. This means the respondents were satisfied with the medical care received in the ward however there is room for improvement with regard to variation of service delivery between day and night staff, staff friendliness and their prompt response to hospital needs.

#### **4.6 DOCTOR COMMUNICATION WITH THE RESPONDENTS**

When patients are admitted and nursed in the wards, the doctor constantly communicates with the patient and the nurses then administer medication and patient care to the patients. The self-administered questionnaire was designed in a way that enabled the patient to assess doctor communication on its own. The questions under doctor communication were numbered from BC1 to BC6. The questions that were asked the patients regarding doctor communication were as follows:

- Was the doctor always caring towards the patient. (BC1)
- Was the doctor taking time to listen to the patient concerns and responded in a way that the patient understood. (BC2)
- Did the doctor keep the patient informed about their health progress throughout their hospital stay. (BC3)
- Did the doctor make ward rounds at reasonable times for the patient. (BC4)
- Was the patient always kept informed about any tests that were done on them and the results of the tests. (BC5)
- Doctor communicated the results in a way that the patient understood. (BC6)

The Cronbach alpha coefficient for doctor communication was 0.95 which means the data collected on doctor communication was valid and reliable. The MSA was 0.81 which means there is strong inter-correlation between doctor communication and other functions of the hospital. The means on the questions were close to one another, however the highest mean was for BC1 with a mean of 3.88 and the lowest means were on BC3, 2 and 4 with the mean of 3.77, 3.78 and 3.79 respectively. This means that the doctors in the hospital are caring towards the respondents however there is

room for improvement with regard to keeping the patient informed about their health progress throughout their hospital stay, taking the time to listen to patient concerns and respond in a way the respondents understand and making rounds at a reasonable time for the respondents.

#### **4.7 THEATRE PROCEDURE IF RESPONDENTS WENT TO THEATRE**

The questionnaire was designed in such a way that patients that had theatre experience could also share their theatre experience. However not all of the sampled patients had gone to theatre. The questions were designed in a way that made it easy for patients to assess theatre experiences on its own. The questions were numbered from BD1 to BD4. The questions that were asked to the patients were as follows:

- Did the doctor explain the procedure to be performed in a way that the patient understands. (BD1)
- Was the theatre nurses and staff in general considerate about the patient's fears regarding the surgery. (BD2)
- Nursing efficiency with regard to theatre preparation. (BD3)
- Nursing care towards the patient on their return from theatre. (BD4)

The Cronbach alpha coefficient for theatre procedure was 0.89 which means the data collected on theatre procedure is valid and reliable. The MSA is 0.79 which means there is a significant inter-correlation between theatre procedure and other functions of the hospital. The means of the questions were quite close to one another however BD1 had the highest mean at 3.95 and BD4 and BD2 had the lowest mean at 3.83 and 3.88 respectively. This means that doctors are well informing the respondents about the theatre procedures to be performed, however the nurses need to improve on how they treat the patients from theatre and be more considerate with regards to respondents' fears about the surgery.

#### **4.8 GENERAL IMPRESSION ABOUT THE OVERALL SERVICE**

Patients were asked through the questionnaire to give their general impression about the facility. Some of the questions on the questionnaire were open to allow them the opportunity to give specific answers with regard to their hospital experience. The questions were numbered between BE1 to BE10. The questions that the patients were asked to assess from strongly agree to strongly disagree were as follows:

- Linen was changed daily on my bed. (BE1)
- The availability of hot and cold water in the hospital bathrooms. (BE2)
- Cleanliness of the facility through their stay and the frequency of cleaners' rounds in the wards. (BE3)
- Food temperature when served and presentation of the food thereof. (BE4)
- Would they refer loved ones to the healthcare giver in the future. (BE5)
- Would they come back to the facility whenever in need of healthcare. (BE6)
- How easy was it for the loved ones to come visit the patient at the facility as far as public transport is concerned. (BE8)
- The patients' overall satisfaction about the appearance of the hospital. (BE10)
- Two open questions where they had to state the best and worst aspect about the hospital with regard to their hospital stay. (BE11 and 12)

The Cronbach alpha coefficient for the general impression about the service was 0.96 which means that the data collected about the service is valid and reliable. The MSA is 0.83 which means that there is a strong inter-correlation between the overall impression about the service and other functions in the hospital. The means of the questions were in such a way that BE6 had the highest mean of 4.28 and BE10 and 8 with the lowest means of 3.58 and 3.84 respectively. This means that the respondents will choose the hospital whenever in need of healthcare service; however there is room for improvement with regard to the hospital maintenance (facility appearance) and the means to reach the hospital.

## **4.9 SUMMARY**

The interpretation of the results was informed by the empirical study in the previous chapter (chapter 3). The empirical investigation was based on factors that are affecting or influencing patient satisfaction in private healthcare. Therefore most of the respondents/patients are from the central Johannesburg suburbs as the hospital is based in central Johannesburg. The hospital processes that were rated as good by the respondents were identified as well as the ones that were not rated as good and therefore require management attention.

In the following chapter the conclusions and recommendations will be made on the study.

## **CHAPTER 5**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

In the previous chapter an empirical investigation of the study was interpreted on the concept of satisfaction with regard to patients in private health care. In this chapter, conclusions and recommendations will be given. The conclusions and recommendations are based on the literature review of the study, empirical investigation of the study and interpretations that were derived from the empirical investigation. The conclusions and recommendations will give more insight on the biographical information of the study population, the age, gender and education level of the patients.

The hospital process flow was illustrated in the previous chapter from the admission service through to the discharge process. The process is also narrated in order to further explain sub-processes under each main process.

The content of this chapter is also evaluated to determine if the study objectives, as set in the first chapter, were met. Conclusions about the study are based on the analysis made on the empirical investigation of the respondents. Recommendations will also be made based on the conclusions reached on the study.

#### **5.2 MAIN FINDINGS OF THE STUDY**

The primary purpose of the study was to obtain information to analyse factors that are causing patient dissatisfaction in private healthcare. The secondary objective was to identify patients' expectations as far as admissions services, nursing care, theatre procedure, doctor communication and the general impression about the overall hospital experience and the hospital facilities as a whole. The study objectives were empirically researched by making use of a self-administered questionnaire. The questionnaire consisted of the following constructs: biographical information of the

respondents, admissions service, nursing care, doctor communication, theatre procedure and general impression about the hospital facility. The main findings of the study are based on the primary and secondary objectives of the study and are discussed in the sections that follow.

### **5.2.1 Processes that requires management attention**

Through the empirical investigation that was done in chapter three, the study has identified areas that require management attention in order to improve the service provided to the respondents. The areas of concern are grouped in line with the empirical study constructs that were used in the questionnaire.

### **5.2.2 Admission service provided to the respondents**

The analysis of the mean of the questions under the admission service revealed that there was room for improvement in the following areas:

- Administering the admission process promptly without long delays.
- Admission staff not being friendly and considerate to the respondent with ill health.
- Keeping respondents informed about any delays during the admission process.

### **5.2.3 Nursing care provided to the respondents**

The analysis of the mean of the questions under nursing care revealed that:

- Nursing care between day and night staff was not consistent.
- Nursing staff was not always friendly and responded to respondents needs promptly through their hospital stay.

#### **5.2.4 Doctor communication to the respondents**

The analysis of the mean of the questions under doctor communication revealed that there was room for improvement in the following areas:

- Doctors did not keep the respondents informed about their health progress throughout their hospital stay.
- Doctor did not take the time to listen to the respondents' concerns and respond in a way that the respondent understands.
- Doctors did not make rounds daily and at reasonable times throughout the respondents' hospital stay.

#### **5.2.5 Theatre procedure if respondents went to theatre**

The analysis of the mean of the questions under the theatre procedure revealed that there was room for improvement in the following areas:

- Nursing staff must improve the level of care when the patient comes back to the ward from theatre.
- Nursing staff should be considerate towards the patient regarding their fears about the surgery.

#### **5.2.6 General impression about the overall service**

The respondents felt that it was not easy for their loved ones to come and visit them in the hospital due to means of transport.

The respondents were also not happy about the appearance of the facility as far as maintenance is concerned.

### **5.2.7 Comparison of results by education, gender and age**

The empirical results were also analysed across education, gender and age and it was noted that there is a noticeable difference in education levels with regard to doctor communication. There was not a noticeable difference of opinion amongst gender and age. The means of constructs under gender and age were very close to another at a rating of 3 and leaning very close to a 4.

## **5.3 EVALUATION OF THE STUDY**

Evaluation is a process of ascertaining the decision areas of concern, selecting appropriate information, collecting and analysing information in order to report summary data that is useful to decision-makers in selecting amongst alternatives (Kumar, 2011:324). The primary objective of the study was to identify factors that are creating a negative perception about the healthcare service delivery and create a dissatisfaction in patients. This objective is driven by the declining trends in hospital major indicators year on year such as, number of admissions, surgical cases, level of occupancy and length of stay. Consumer satisfaction depends on whether the product or service perceived performance matches a buyer's expectation (Kotler & Armstrong, 2012:37). The secondary objective was to identify patients' expectations as far as admissions services, nursing care, theatre procedure, doctor communication and general impression about the overall hospital experience and the hospital facilities as a whole. Hospitals like other businesses have been raising the level of their customer service to improve patient experience (Chase & Jacobs, 2011:312).

The primary and secondary objectives of the study were achieved as factors that are affecting the declining performance in the hospital were identified in section 4.3.2.2 above. Recommendations will therefore be made in order to suggest areas where resources should be allocated to improve service.

## 5.4 RECOMMENDATIONS

The following recommendations were identified in line with the observed areas of improvement that the respondents voiced in terms of the questionnaire responses:

Respondents perceived the admission service to have areas of improvement with regard to being prompt and done without long delays for the patients. Admission staff is not continuously communicating delays in the process and their conduct not friendly and considerate considering their state of ill-health. It is therefore recommended that continuous customer care workshops be given to admission staff about the hospital value system in alignment with critical success factors. Staff conduct must be continuously assessed in line with the number of complaints raised by the patients. Good conduct must be well acknowledged and bad conduct be accordingly reprimanded with the intention to correct it. Management must continue to encourage nurses towards good behaviour. Staff conduct can also be continuously communicated through staff meetings and staff rewards and recognition functions where good conduct can be recognised and rewarded. Respondents perceived the nursing care delivered by the day and night staff not to be consistent in terms of being good. They also perceived the nursing staff not to be friendly and responding promptly to their needs. The perception about the night and day nursing care not being the same is directly linked to the internal reports that shows that most of the complaints are about the night nursing staff, where the patients feel that they do not check them regularly as supposed to and sometimes they talk loud and disturb their sleep. Patients often complain that when they ring the service bell at night they do not get a prompt response. It is therefore recommended that the night supervisor make regular rounds to the various wards to ensure that the nurses are attending to the patients as regular as supposed to by reviewing the observation notes in the patient files. Nursing staff conduct will be continuously communicated through departmental meetings and customer care workshops.

The respondents identified the following areas of improvement under doctor communication; doctors do not keep them informed about their health progress through their stay in hospital, doctors do not listen to their concerns and respond in a way that they understand and doctors do not make daily rounds in the reasonable time of the day. It is therefore recommended that regular service meetings be held between

hospital management and the doctors to bring patients' concerns to the doctor's attention and have the doctors committing to an improved service. Also good conduct by doctors should be applauded to encourage the good conduct to grow and continue. Communication with the patients is key because it informs the patients about their ill-health. An informed patient is always better off because they can lead a better life if they know better about their health. Doctors must also try and respond to patient complains in simplest terms to ensure that they will understand.

Respondents felt that the nurses are not always considerate about their fears about the surgery and they did not treat them well when they return to the ward after a theatre procedure. It is therefore recommended that the unit manager should make rounds to all patients that have been to theatre and back to the ward and just to assure them that their health is in good nursing care. Unit managers should also assign the more qualified nurses to care for patient that are coming from theatre. It should also be continuously communicated and encouraged that the nurses should be patient with patients that have concerns about theatre procedures that they are facing and treat them with caution when they come back from theatre.

Respondents stated that it was not easy for their loved ones to come and visit them in the hospital. They were also not fully satisfied about the overall appearance of the hospital facility. It is therefore recommended that flexibility be applied around visiting hours especially for family members that come from far. It is further recommended that facility maintenance be constantly kept up to keep the hospital appearance in good order.

## **5.5 CONCLUSION**

This study reports valuable facts with regards to patients' perceptions about the service that the hospital renders. As patients are the target market of the hospital it is critical that the hospital maintains a positive perception of the target market. Healthcare is the most intensive of service industries in the range of service activities and the impact these activities have on the customer. The hospital should also keep up with evolving market trends in order to capture its target market and even penetrate new markets.

The study has identified critical areas (prompt response to patient needs, staff conduct and continuous communication across functions) of improvement for the hospital which remains the cornerstone of any successful business. Based on this study it is evident that continuous communication is critical in both ways, from patient to service provider and from service provider to the patient.

Healthcare as a service is characterised by extensive customer contact, a wide variety of providers and literally life or death as potential outcomes. Here are some of the important factors that set hospitals operations apart from other organisations:

The key operators in the core processes are highly trained professionals (medical specialists) who generate requests for service (orders) but are also involved in delivering the service.

The relationship between prices that can be charged and actual performance is not as direct as in most other production environments. Quality and service measures are largely based on opinion rather than hard evidence.

## REFERENCES

Adams, R. & Spinelli, S.J. 2012. *New venture creation: Entrepreneurship for the 21<sup>st</sup> century*. 9<sup>th</sup> ed. Singapore: McGraw Hill Irwin.

Agility Health Solutions. 2012. Private healthcare set to face tough challenges in 2013. <http://www.moneyweb.co.za/archive/private-healthcare-set-to-face-tough-challenges-in.pdf> Date of access: 18 November 2015.

Chase, B.R. & Jacobs, F.R. 2011. *Operations and supply chain management*. New York, NY: McGraw-Hill.

Coetzee, K.S., Klopper, C.H., Ellis, M.S. & Aiken, H.L. 2012. A tale of two systems – Nursing practice environment, wellbeing, perceived quality of care and patient safety in private and public hospitals in South Africa: A questionnaire survey. *International Journal of Nursing Studies*, 50:162-173. <http://www.elsevier.com/ijns>. Date of access: 26 August 2014.

Cummings, T.G & Worley, C.G. 2009. *Organisational development and change*. 9<sup>th</sup> ed. Mason, OH: South-Western Cengage Learning.

Dason, B., Nkwankwo.S. & Owusu-Frimpong, N. 2010. Measuring service quality and patient satisfaction with access to public and private healthcare delivery. *International journal of public sector management*, 23(3):n.p. <http://www.emeraldinsight.com/0951-3558.htm> Date of access: 26 August 2014

Dennill, K. & Rendall-Mkosi, K. 2012. *Primary healthcare in Southern Africa. A comprehensive approach*. 3<sup>rd</sup> ed. Cape Town: Oxford University.

Department of Community Safety and Liaison. 2011. *Batho-pele menu KwaZulu-Natal*. Durban: Department of Health.

Department of National Treasury. 2015. *Estimates of National Expenditure 2015*. Cape Town: Government Printers

Harrison, D. 2009. An overview of health and healthcare in South Africa 1994 – 2010: Priorities, Progress and Prospects for new gains.  
<ftp.bhfglobal.com/files/bhf/overview1994-2010.pdf> Date of access: 26 August 2014.

Keegan, K. & Tollman, S.M. 2010. A perspective on primary health care in South Africa. School of public health. Johannesburg: University of Witwatersrand.

Khattak, A. Alvi, M.I. Muhammad, Yousaf, M.A, Shah, S.Z & Akhter, S. 2012. Patient Satisfaction – A comparison between Public & Private Hospitals of Peshawar. *International Journal of Collaborative Research on Internal Medicine & Public Health*, 4(5):713-722.

Kotler, P. & Armstrong, G. 2012. Principles of marketing. 14<sup>th</sup> ed. London: Pearson education.

Kumar, R. 2011. Research methodology. A step by step guide for beginners. 3<sup>rd</sup> ed. London. Sage.

Lawn, S. & Churchyard, G. 2009. Epidemiology of HIV – associated tuberculosis. *Current Opinion in HIV and AIDS*, 4:325-333.

Levine, D.M., Stephan, D.F., Krehbiel, T.C. & Berenson, M.L. 2011. Statistics for Managers. Using Microsoft Excel. 6<sup>th</sup> ed. London: Pearson.

Lumadi, T.G. & Buch, E. 2011. Patients' satisfaction with midwifery services at a regional hospital and its referring clinics in the Limpopo province of South Africa. *Africa Journal of Midwifery*, 13(2):14-28.

Media Club South Africa. 2012. Healthcare in South Africa.  
<http://www.southafrica.info/about/health.htm#.VkxRJXYrJD8> 18 November 2015.

Meyer, S.M., Naude, M., Shangase, N.C. & Van Niekerk, S.E. 2009. The Nursing Unit Manager. A comprehensive guide. 3<sup>rd</sup> ed. Johannesburg: Heinemann.

Miles, J. & Shevlin, M. 2010. Applying regression & correlation. London: Sage.

- Naidu, A. 2008. Factors affecting patient satisfaction and healthcare quality. *International journal of healthcare quality assurance*, 2(4):n.p.  
<http://www.emeraldinsight.com/0952-6862.htm>. Date of access: 26 August 2014.
- Peltzer, K. 2009. Patient experiences and health system responsiveness in South Africa. *BMC Health Services Research*, 9(117):n.p.  
<http://www.biomedcentral.com/1472-6963/9/117> Date of access: 26 August 2014.
- Ramjee, S. 2013. Comparing the cost of delivering hospital services across the public and private sectors in South Africa. Research report commissioned by the Hospital Association of South Africa. Cape Town: University of Cape Town.
- SA. 1996. Choice of Termination of Pregnancy Act (No. 92 of 1996)
- SA. 1998. Medical Schemes Act (No. 131 of 1998)
- SA. 1999. Public Finance Management Act (No. 1 of 1999)
- SA. 2000. Pharmacy Amendment Act (No. 1 of 2000)
- SA. 2002. Medicines and Related Substances Amendment Act (No. 59 of 2002)
- SA. 2002. Mental Health Care Act (No. 17 of 2002)
- SA. 2003. National Health Act (No. 61 of 2003)
- SA. 2003. National Liquor Act (No. 59 of 2003)
- SA. 2005. Nursing Act (No.33 of 2005)
- SA.2011. National Health Amendment Bill, 2011
- Schaay, N., Sanders, D. & Kruger, V. 2011. Overview of health sector reforms in South Africa. Human Development Resource Centre. Department for International Development in London 2011.
- Van den Heever, A. 2012. Review of competition in the South African health system. Graduate school of public and development management. Johannesburg: University of the Witwatersrand. (Dissertation: MBA)

Wan, E., Wan, R. & Kamaruzaman, J. 2008. Service quality in health care setting. *International Journal of Health Care*, 22(5):n.p. <http://www.emeraldinsight.com/0952-6862.htm> Date of access: 26 August 2014.

Warner, R.M. 2008. *Applied Statistics: from Bivariate through multivariate techniques*. London: Sage.

Zimmerman, J. & Dabelko, I.H. 2013. *Collaborative models of patient care: New opportunities for hospital social workers*. Potchefstroom: North-West University. (Dissertation – Masters).

## **APPENDIX A: QUESTIONNAIRE**

Dear Patient/Respondent

The hospital hereby request 10 minutes of your time to please complete the attached questionnaire for a researcher who is an employee at hospital. The questionnaire is required to the researcher to complete her studies. The responses will also be presented to the hospital management to help them identify areas of improvement. It is anonymous and confidential therefore requires your honest opinion.

Your co-operation in this regard is highly appreciated.

The researcher

## Biographical Information

Please mark with an "X" next to the appropriate answer

### Section A

<b>1. Gender</b>	a. Male	b. Female				
<b>2. Age</b>	a. 18-24	b. 25-34	c. 35-45	d. 45-54	e. 55-65	f. Over 65
<b>3. Education</b>	a. Below matric	b. Matric	c. Degree/Diploma	d. Honours	e. Masters	f. Doctoral
<b>4. Race</b>	a. Black	b. White	c. Coloured	d. Asian		
<b>5. Citizenship</b>	a. South African	b. Not South African	c. If not, please specify			
<b>6. Employment</b>	a. Yes	b. No				
<b>7. Type of employment</b>	a. Permanent	b. Contractual				
<b>8. Payment of hospital account</b>	a. Medical Aid	b. Private or Self	c. Other, please specify			
<b>9. How regular are you hospitalised</b>	a. Once or twice a year	b. 3-5 times a year	c. More than five times			
<b>10. How many days were you currently hospitalised</b>	a. One day	b. 2-3 days	c. 4-10 days	d. More than 10 days		

## Section B

Please mark with an "X" the appropriate answer next to each statement or scale provided

From 1= Strongly disagree to 5= Strongly agree

<b>A. Admission Service</b>	<b>1. Strongly disagree</b>	<b>2. Disagree</b>	<b>3. Neutral</b>	<b>4. Agree</b>	<b>5. Strongly agree</b>
1. I understand what was explained to me in my preferred language.					
2. The admission process was carried out promptly and I am satisfied that I did not wait long to be admitted					
3. Admission staff kept me informed during delays in the admission process to keep me from suspense.					
4. I was comfortable during the admission process to divulge					
5. If you disagree with the statement in (Q4) please motivate.					
6. The admission staff was friendly and considerate throughout the admission process.					
<b>B. Nursing care</b>	<b>1. Strongly disagree</b>	<b>2. Disagree</b>	<b>3. Neutral</b>	<b>4. Agree</b>	<b>5. Strongly agree</b>

1. I was warmly welcomed by the nursing staff into the ward that I was admitted into					
2. Nursing staff treated me with the required care and respect through my hospital stay.					
3. Nursing staff was friendly and responded promptly to my needs through my hospital stay.					
4. Nursing staff appeared skilled to administering procedures to me and they always made notes on my file.					
5. Both night and day nursing care was good.					
6. Motivate your answer in Q5 briefly:					
7. I am satisfied with the overall medical care that I received in the ward.					
<b>C. Doctor Communication</b>	<b>1. Strongly disagree</b>	<b>2. Dis-agree</b>	<b>3. Neutral</b>	<b>4. Agree</b>	<b>5. Strongly disagree</b>
1. Doctor was always caring towards me as a patient.					
2. Doctor took his time to listen to					

my health concerns and responded in the way that I understood.					
3. Doctor kept me informed of my health progress through my hospital stay.					
4. Doctor made his ward rounds daily throughout my hospital stay and at a reasonable time of the day.					
5. Doctor kept me informed of the necessary test that needed to be done on me.					
6. Doctor informed me of all the test results in a way that I understood.					
<b>D. Theatre procedure</b>	<b>1. Strongly disagree</b>	<b>2. Disagree</b>	<b>3. Neutral</b>	<b>4. Agree</b>	<b>5. Strongly agree</b>
1. Doctor explained the procedure to me in a way that I understood.					
2. Nursing staff was considerate about my fears with the surgery.					
3. Nursing staff efficiently prepared me for surgery.					

4. Nursing staff treated me well immediately on my return to the ward.					
<b>E. General impression about hospital facility</b>	<b>1. Strongly disagree</b>	<b>2. Disagree</b>	<b>3. Neutral</b>	<b>4. Agree</b>	<b>5. Strongly agree</b>
1. Linen was changed daily on my bed.					
2. There was always hot and cold water in the bathrooms.					
3. The facility was kept clean the whole time, the cleaners came daily.					
4. Food was always served at the right temperature and was well presented.					
5. I would refer loved ones to this healthcare provider anytime.					
6. I would come back to this hospital the next time I need healthcare					
7. If strongly disagree/ agree with Q6 above, please briefly motivate:					
8. It was easy for my loved ones to come visit me in the hospital.					

9. If strongly agree/disagree with Q8 above, please briefly motivate.					
10. I am satisfied with the overall appearance of facility.					
11. According to you, what was the best aspect in terms of your hospital stay:					
12. According to you what was the worst aspect with regard to your hospital stay (requires immediate attention)					

## APPENDIX B: EDITOR'S DECLARATION



27 November 2015

### TO WHOM IT MAY CONCERN

**Re: Letter of confirmation of language editing**

The dissertation **Analysing patient satisfaction in a medium sized private healthcare provider by Mmanone Caroline Mokoena (23870338)** was language, technically and typographically edited. The citations, sources and referencing technique applied were also checked to comply with university Harvard guidelines. Final corrections as suggested remain the responsibility of the student.

**Antoinette Bisschoff**

Officially approved language editor of the NWU since 1998  
Member of SA Translators Institute (no. 100181)