

# MEASURING SATISFACTION OF HEALTH SERVICE PROVISION AMONG PRIMARY HEALTH CARE SEEKERS IN THE CITY OF JOHANNESBURG, SOUTH AFRICA

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## ABSTRACT

### *BACKGROUND:*

Customer satisfaction is an important element for assessing the quality of patient care services. There is a need to assess the health care systems to assess customer satisfaction as often as possible.

### *OBJECTIVES:*

To assess customer satisfaction on services provided in City of Johannesburg healthcare facilities, the study will:

Assess patient satisfaction levels on Patient rights, comprising of values and attitudes, waiting times and cleanliness.

Assess patient satisfaction levels on Patient safety, infection prevention and control.

Assess patient satisfaction levels on Clinical support services, comprising of availability of medicines and supplies.

### *METHODOLOGY:*

The survey was a descriptive cross-sectional study. A structured close-ended questionnaire will be used to collect data from 9 965 respondents in 80 COJ health facilities over a period of two weeks.

## **KEYWORDS**

Health service, Satisfaction, Patients, Johannesburg, Clinicians, Population.

## **INTRODUCTION**

Sub-Saharan Africa is undergoing health transition with a double disease burden as a result of globalization and urbanization [1]. South Africa faces an enormous challenge in transforming its health care delivery system - not only to meet citizens' expectations of good quality care, but also to improve critical health care outcomes linked to the Millennium Development Goals [2]. At a health facility level, patient satisfaction still remain as a proxy indicator to quality of care, and healthcare staff are interested in maintaining high levels of satisfaction in order to stay competitive in the healthcare market [3]. Striving to reach optimum quality of care and knowing the patients' service perspective is one core service quality indicator. Patient satisfaction has been recognized as a multi-dimensional healthcare construct affected by many variables that are stipulated in the South African National Core Standards.

South Africa's national drive by the National Department of Health to improve the quality of health care through the National Core Standards calls on leadership in the health sector to facilitate the initiative and change in practice [2]. The legal context of the National Core Standards for the health sector is the National Health Act, 61 of 2003, which promotes good quality health services, healthcare standards, and ratifies the Office of Standards Compliance. Therefore, the purpose is to set a benchmark for quality of care [4]. The government of the Republic of South Africa has committed itself to the philosophy that it is only through primary health care that an affordable health service can be rendered to all inhabitants of South Africa. Currently this is taking place through a partnership between the state, the community and the private sector [5].

## **SETTING**

The administration of the City of Johannesburg (COJ) Metropolitan Municipality is composed of 7 regions. The study was conducted in all the regions with a total of 80 PHCs (Primary health care) facilities. The City of Johannesburg has a population of approximately 4 million made up primarily of a young population aged between 30 and 39 years. This total population translates into roughly 1.3 million households. The city's population is projected to increase to about 4.1 million in 2015 implying an annual rate of growth of the population of about 1.3% per annum by 2015. Household projections further indicate that the number of households in the City is likely to increase from about 1.3 million in 2010 to about 1.5 million in 2015 with an average household size of about 3 persons [6].

## **PROBLEM STATEMENT**

The challenge for health care service provision is how to incorporate service user (customers) feedback in primary health care facility improvement plans. To improve the quality of service, user input is crucial. The South African national department of health developed an instrument to measure the satisfaction levels of clients utilising hospitals in South Africa [7]. This study will use the instrument to measure customer satisfaction in PHC facilities in the City of Johannesburg.

## **MAIN AIM**

Assess patient satisfaction of healthcare services using the national core standards' key priorities areas in City of Johannesburg primary health care facilities.

## **RESEARCH OBJECTIVES**

The study sought to:

Assess patient satisfaction levels on Patient rights, comprising of values and attitudes, waiting times and cleanliness.

Assess patient satisfaction levels on Patient safety, infection prevention and control.

Assess patient satisfaction levels on Clinical support services, comprising of availability of medicines and supplies.

## **RESEARCH SCOPE**

Donebedian, one of the renowned authorities on customer satisfaction spells out three approaches to study the quality of healthcare at the organisational level; namely:

a) Studying the outcome of medical care, in terms of recovery, restoration of function and of survival. For examples studying pre-natal mortality, surgical fatality rates and social restoration of patients discharged from psychiatric hospitals. This approach has limitations in that many factors other than medical care may influence the outcome and furthermore, some outcomes are not clearly defined and / or are difficult to measure.

b) Studying the process of care itself, rather than its outcomes. This approach includes the assessment of technical competence in the performance of diagnostic and therapeutic procedures. The limitation with this approach is that patients have difficulty in assessing technical aspects of medicine (Rao, Clarke, Sanderson and Hammersley, 2006).

c) Studying the settings in which the quality of health care takes place, and the instrumentalities of which it is the product but not the process of care itself. This approach is concerned with things such as adequacy of facilities and equipment, administrative structure, operation of programs and quality medical and non-medical staff. This approach offers the advantage of dealing with fairly concrete and accessible information. According to Donebedian, there were two classical studies that set the groundwork for research using this approach: The one that evaluated structural characteristics was done by Goldmann and Graham (1954) and the one that evaluated the characteristics of physicians done by Peterson (1956). Since then, many researchers have followed this approach in determining healthcare quality [8].

This study will follow the third approach because it provides the advantage of being able to obtain assessments from patients that can ultimately be used to improve the quality of healthcare at the organisational level.

## **LITERATURE REVIEW**

Few clinicians would debate that clients are the central focus of both service delivery and quality measurement. Yet, the client's perspective on quality care largely has been considered external to the service delivery process [9]. In recent years, client satisfaction with clinical services has gained recognition as an outcome of quality care. A noted authority in quality measurement, states:

Patient satisfaction may be considered to be one of the desired outcomes of care, even an element in health status itself. It is futile to argue about the validity of patient satisfaction as a measure of quality. Whatever its strengths and limitations as an indicator of quality, information about patient satisfaction should be as indispensable to assessments of quality as to the design and management of health care systems [10]. Furthermore, research has shown that client satisfaction (or dissatisfaction) is an indicator of other client behaviors, such as choice of practitioners or programs, disenrollment, use of services, complaints, and malpractice suits [11]. Tools designed to elicit client feedback often are the only channel through which clients can alert providers to their concerns, needs, and perceptions of treatment. "Patient feedback is especially important to the QA [quality assurance] process because it helps health care providers identify potential areas for improvement, such as patient education and follow-up, specific quality of care issues, and hospital procedures (e.g., reimbursement policies, the admissions process). It is also useful in program planning and evaluation [9].

Healthcare quality affects patient satisfaction, which in turn influences positive patient behaviours. Patient satisfaction and healthcare service quality, though difficult to measure, can be operationalized using a multi-disciplinary approach that combines patient inputs as well as expert judgment [12]. Patient satisfaction is now deemed an important outcome measure for health services; however, this professed utility rests on a number of implicit assumptions about the nature and meaning of expressions of 'satisfaction [13] Patients are

becoming increasingly involved in making healthcare choices as their burden of healthcare costs continues to escalate. At the same time, healthcare has entered a tightened market economy [14].

#### *DECLARATIONS, POLICIES AND GUIDELINES: SOUTH AFRICAN NATIONAL CORE STANDARDS*

The National Health Act, 61 of 2003 emphasises the need to foster good quality health services by developing structures to monitor the compliance of health establishments and agencies with health care standards. It provides for the creation of an Office of Standards Compliance as well as an Inspectorate of Health Establishments within each province. The Act further envisages a broad role for the Office of Standards Compliance in advising on health standards, revising or setting standards, monitoring compliance, reporting non-compliance, and advising on strategies to improve quality [2].

Access to quality basic health services was affirmed as a fundamental human right in the Declaration of Alma-Ata in 1978. The model formally adopted for providing healthcare services was "primary health care" (PHC), which involved universal, community-based preventive and curative services, with substantial community involvement [15]. Various studies have been conducted to reflect on the factors hindering achievement of the Declaration of Alma-Ata have included insufficient political prioritisation of health, structural adjustment policies, poor governance, population growth, inadequate health systems, and scarce research and assessment on primary health care [16][16]–[22][23]–[26]

#### *IMPORTANCE OF CUSTOMER SATISFACTION*

The roots of a dysfunctional health system and the collision of the epidemics of communicable and non-communicable diseases in South Africa can be found in policies from periods of the country's history, from colonial subjugation, apartheid dispossession, to the post-apartheid period. Racial and gender discrimination, the migrant labour system, the destruction of family life, vast income inequalities, and extreme violence have all formed part of South Africa's troubled past, and all have inexorably affected health and health services. In 1994, when apartheid ended, the health system faced massive challenges, many of which still persist [27]. It is from this paradigm that the City of Johannesburg has envisaged to undertake initiatives targeted at improving the quality of services as prescribed in the National Core Standards. The importance of consumer involvement in health care is widely recognised. Consumers can be involved in developing healthcare policy and research, clinical practice guidelines and patient information material, through consultations to elicit their views or through collaborative processes [28]. Patients' views are being given more and more importance in policy-making. Understanding populations' perceptions of quality of care is critical to developing measures to increase the utilization of primary health care services [29]. According to the Department of Health managers are therefore expected to ensure that they are compliant with these six fast-track areas in as short a time as possible. These fast-track areas are a subset of the most critical

standards and are largely reflected in the first 3 domains namely: Values and attitudes of staff, Cleanliness, Waiting times, Patient safety and security, Infection prevention and control and Availability of basic medicines and supplies [2].

There is increasing evidence that suggests that addressing consumerism in health care facilities leads to improved health care outcomes (Wadhwa, 2002). The influence of a patient's perceptions is an important health care aspect that is being increasingly recognized for its importance. Even though the patient's perception of quality relies more on the service aspects of health care, it correlates well with objective measures of health care quality [31]. The quality of service in health means an inexpensive type of service with minimum side effects that can cure or relieve the health problems of the patients [32]. It is easier to evaluate the patient's satisfaction towards the service than evaluate the quality of medical services that they receive. Therefore, research on patient satisfaction can be an important tool to improve the quality of services [33].

Patient perception regarding quality of healthcare determines the extent of utilization of available healthcare services, but this fact is often ignored by healthcare providers [34]. An estimated 84% of South Africa's population heavily relies on the public sector for health services [35]. This has left the country's public sector stretched and under resourced in various places including a shortage of health personnel, infrastructure and medical resources. High levels of poverty and unemployment means that healthcare is largely the burden of the South African Government [36].

Based on a patient's previous experiences, patients are often reluctant in seeking care from public healthcare facilities frequently, resulting in late presentations and complications regarding their health [37]. The scenario is often further demoralizing in rural healthcare centers due to lack of proper infrastructure [38]. It was opined in various reviewed articles that patients' satisfaction and their feedback are important for improving the quality of healthcare services and can be operationalized involving patient inputs and expert opinion [33], [39]–[41]. Similar issues have received much attention in a cross-sectional study by Kumari et al., (2009) among patients attending government hospital where faith on physician and waiting time for consultancy were identified to be the important determinants predicting patients' health-seeking behavior.

### *BENEFITS OF SATISFIED PATIENT LEVELS*

A patients' satisfaction levels regarding the healthcare facilities that they utilize are of great importance as satisfied patients are more likely to complete treatment regimens and to be compliant and cooperative [31] thus positively contributing to the patient's health [33]. Satisfaction can be defined as the extent of an individual's experience compared with his or her expectations[42]. Patients' satisfaction is related to the extent to which general health care needs and condition-specific needs are met. Customer satisfaction levels towards a health care system are considered as an important and useful indicator for the quality of healthcare functioning. Not only has research on health system and customer satisfaction managed to reduce health care

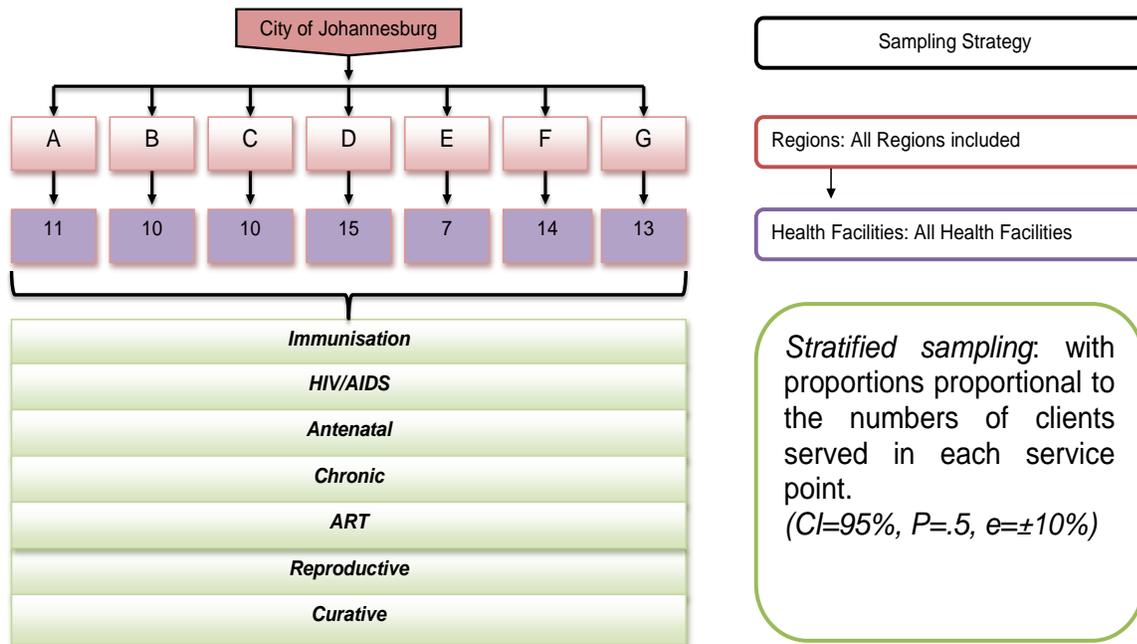
management and general health care costs but also suggest that customer satisfaction surveys have identified ways to improve health systems and increase their efficiency. In addition, health professionals may benefit from satisfaction surveys that identify potential areas for service improvement and health expenditure may be optimized through patient-guided planning and evaluation [42]. Evaluating and understanding patients' satisfaction with the public sector's health facilities is important for developing strategies to ensure that health system goals are attained [43]. However customer satisfaction studies remain challenged as there is a lack of a universally accepted definition of measure [39]. Due to a lack of standardized measurement for customer satisfactions levels, for the last 10 years researchers exclusively focus on the on patient experience such as aspects of the care experience such as waiting times, the quality of basic amenities, and communication with health-care providers, all of which help identify tangible priorities for quality improvement [44] This study was therefore undertaken with the aim to find out the level of patient satisfaction related to different parameters of quality health care.

Due to the importance and uniqueness of the characteristics of the health sector, one of the most important priorities of the City of Johannesburg Health Department is measuring the levels of satisfaction in the services that are provided to patients. The study will have direct implications for all primary health care service providers in Gauteng province.

## **METHODOLOGY**

### *STUDY DESIGN AND SAMPLE SIZE*

The customer satisfaction survey was a descriptive cross-sectional study. A structured close-ended questionnaire was used to collect data from 9 965 patients in 80 COJ health facilities, calculated at  $\pm 1\%$  precision level from a population of 2 876 130 visiting the health facilities over the period of July 2012 to March 2013. The questionnaire used a Likert scale to assess the varied satisfaction levels aligned to the National core standard priority areas. A sample design using multi-stage proportionate, stratified, systematic approaches were applied.



### STUDY METHODS AND DATA COLLECTION

The respondents answered a closed ended questionnaire that was loaded into the TouchPoll electronic data collection system. Data collection was conducted over a period of one week in the month of July 2014.

Stratified sampling was used with proportions proportional to the number of client reached in the District Health Information System (DHIS) for the period of July 2012 to March 2013. The parameters for the sample size were at a confidence interval of 95%, and a precision level of  $\pm 1\%$ . Data was used to calculate weekly population estimates at each health facility per service point and then the sample sizes were calculated at sub district level per service point. Using health facilities as stratas within sub districts proportions proportional to population sizes was calculated as the sample size. The service points served as stratas for the selection of clients with sample proportions also proportional to the numbers of people served per service point. Since participation was voluntary, in a case where a respondent declined to participate in the study a successive client was selected from the client register.

### DATA ANALYSIS

Data was analysed with Stata version 12.0 (Stata Corporation, College Station, USA). The study used confirmatory factor analysis to group Likert scale data into common themes and called them Priorities numbers one to six and the overall priority had all the Likert scale variables.

These scales were based on patients' perceptions on the services received. The study used reliability values to confirm if the generated priorities were reliable in summarizing the perception variables. The generated priorities variables were then summarized using means and medians and standard deviation and interquartile ranges as appropriate. Descriptive analyses included variable descriptions, cross tabulations and inferential analyses including tests of association by chi-square test.

Factor analysis was intended to take thousands and potentially millions of measurements and qualitative observations and resolve them into distinct patterns of occurrence. It was to make explicit and more precise, the building of fact-linkages going on continuously in the human mind. The factor analysis was applied in order to explore a content area, structure a domain, map unknown concepts, classify or reduce data, illuminate causal nexuses, screen or transform data, define relationships, test hypotheses, formulate theories, control variables, or make inferences. The consideration of these various overlapping usages was related to several aspects of the scientific method: induction and deduction; description and inference; causation, explanation, and classification and theory.

## **ETHICAL CONSIDERATIONS**

Project team members adhered to strict ethical standards during the site data collection visits. During data collection, processing and storage, strict ethical standards were followed. All participants were briefed on their participation in the study. Confidentiality of responses was assured. Participants had the right to choose if they wanted to participate and were not discriminated against if they refused to participate. All participants were asked for questions or concerns about the study. Efforts were made to ensure that the following principles are taken into consideration:

### *INFORMED CONSENT AND VOLUNTARY PARTICIPATION*

Informed consent was obtained from participants before commencement of the study. Either written or verbal consent was obtained from each of the participants. Verbal consent (where the participant is illiterate) was obtained in the presence of a literate witness who verified in writing and duly signed when an informed verbal consent was obtained.

Participants were free at any time to withdraw their participation from the study without having to face any negative consequences or disadvantages. Efforts were in place to ensure informed consent and privacy for all respondents. This was particularly necessary to protect the interest of minors and in addition, to prevent respondents from being coerced to participate. Furthermore, concerted efforts were made to ensure that no unrealistic expectations resulting from participation in the study were created. Respective participants had the right to change their decision or withdraw their prior informed consent at any stage of the study without incurring any

penalty whatsoever. To ensure respect for each participant, the process of securing consent was a gradual and emerging process where the respondent was capable of making an informed decision based on experience and information provided.

#### *COERCION AND PERVERSE INCENTIVES*

Any kind of coercion or issuing of perverse incentives was seen as a breach of ethical conduct and was deemed to be unethical. For this reason, the study team ensured that no undue incentives were provided to those who consented to take part in the study. Prospective participants were neither intimidated nor compelled to take part in the study.

#### *PRIVACY AND CONFIDENTIALITY*

The team kept personal information gathered from participants private and confidential by keeping the names of participants anonymous in reports. The study teams adhered to confidentiality and ensured anonymity of the data and reports, but were not able to guarantee that other participants regarded the information as confidential, although they were urged to do so.

#### *AVOIDANCE OF HARM OR NON-MALEFICENCE*

In this study, the study team carried the onus of ensuring that the dignity and the physical and emotional safety of all participants during the process were protected. The study did not evoke any emotional distress requiring counselling.

#### *INCLUSION AND EXCLUSION CRITERIA*

No person was inappropriately or unjustly excluded on the basis of race, age, sex, sexual orientation, disability, education, religious beliefs, marital status, ethnic or social origin, conscience, belief or language.

### **LIMITATIONS OF THE STUDY**

The limitation of this study was that the larger the customer base, the more expensive and time-consuming it could be to survey. Because of time and the expense required, a survey of this nature could only be conducted once at that particular time and as such it does not reflect current attitudes. Additionally, surveys by nature cannot include all customers — and results can be biased when customers either are excluded or don't bother to respond. Most important, surveys like this one measure opinion and are not reliable predictors of future behavior. Even surveys that ask customers about their intentions do not necessarily shed light on the future because

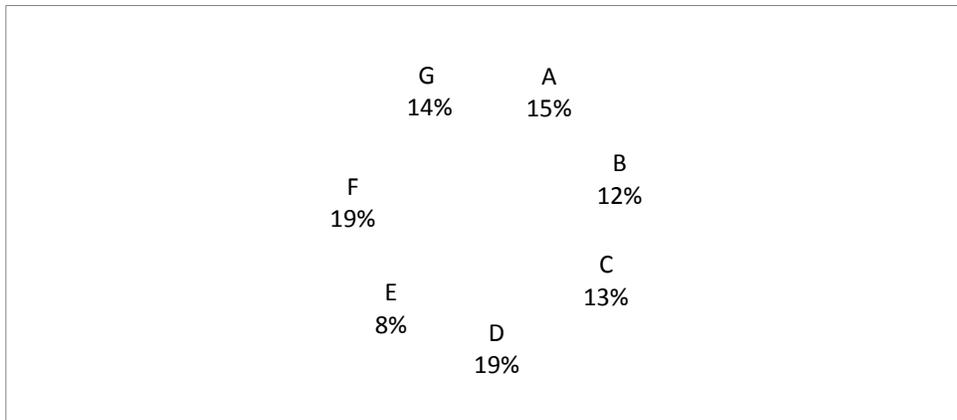
customers don't always do what they say they will do. All these issues need to be taken into account in this study.

## RESULTS

Given the number of clinics surveyed (80 Clinics) and the length required for this report, it was decided that although the analysis was done per health facility and per region and per core standard priority area, only the regional level perspective is presented in this report. Therefore, the results section of this survey will provide a regional overview of the respondent distribution by region, respondent distribution by region by gender. In addition, the results section will provide information on the overall composite satisfaction level for all clinics surveyed classified by region by core standard priority areas numbers one to six, The overall average satisfaction level for all clinics by region and the overall Satisfaction level per priority area by region.

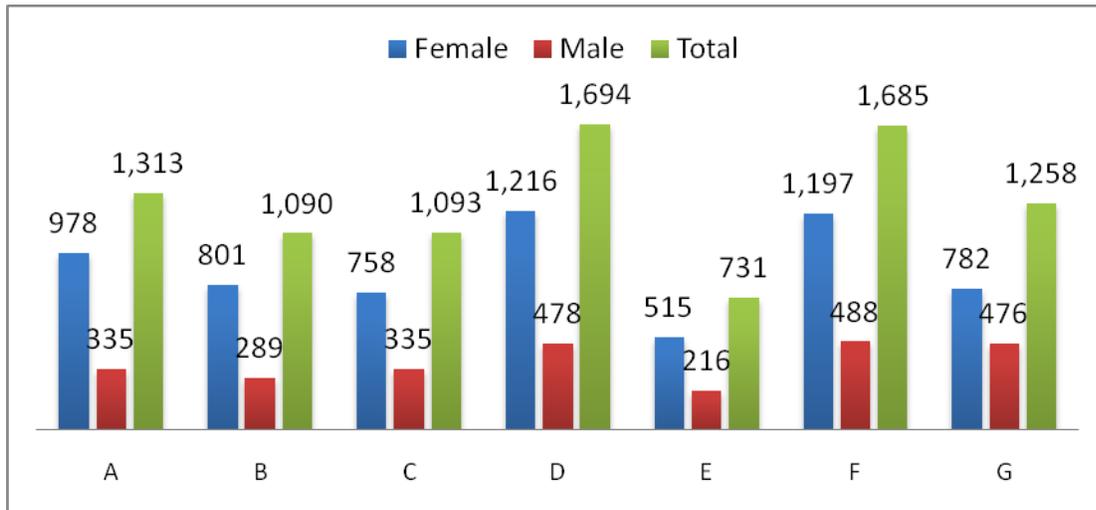
### DISTRIBUTION OF RESPONDENTS

Figure 1: Distribution of respondents by region



There were a total of 8 864 respondents from 80 clinics distributed as shown above. The chart above illustrates the overall response percentages per region. In total seven regions were surveyed with a total of 80 clinics distributed as follows: region A = 11 Clinics, region B = 10 Clinics, region C = 10 Clinics, region D = 15 Clinics, region E = 7 Clinics, region F = 14 Clinics and region G = 13 Clinics.

Table 1: Distribution of respondents per region by gender



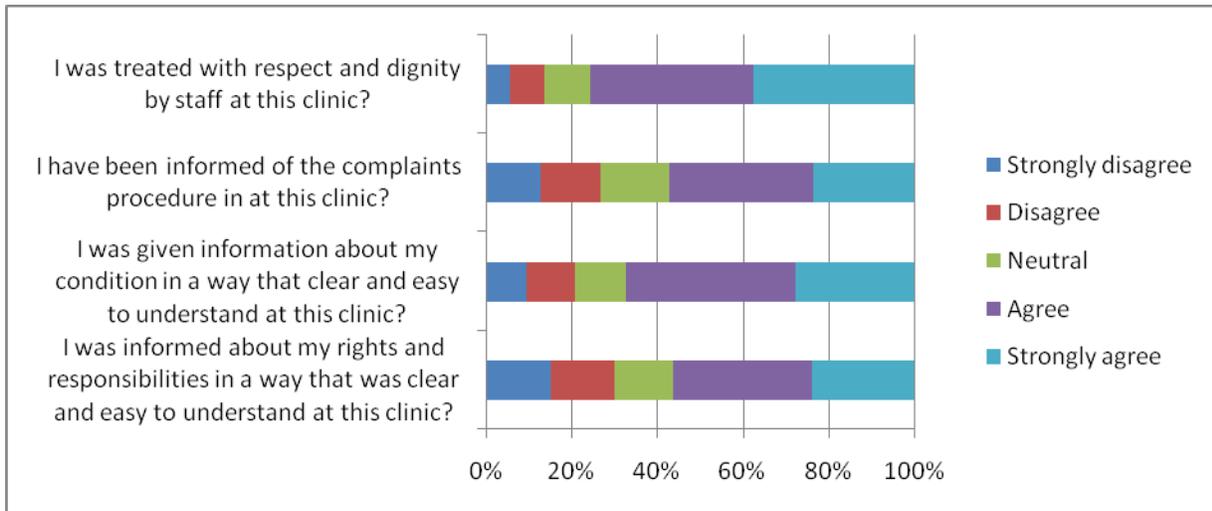
**OVERALL MEAN SATISFACTION**

To calculate overall satisfaction Cronbach's alpha, which is common measure of internal consistency ("reliability") was used. This measure is most commonly used when there are multiple Likert questions in a survey/questionnaire that form a scale and there is a need to determine if the scale is reliable. The survey indicated a high reliability with a Cronbach's Alpha of 0.917 and an Overall Mean Satisfaction level of 3.8.

**OVERALL SATISFACTION LEVELS PER PRIORITY AREA**

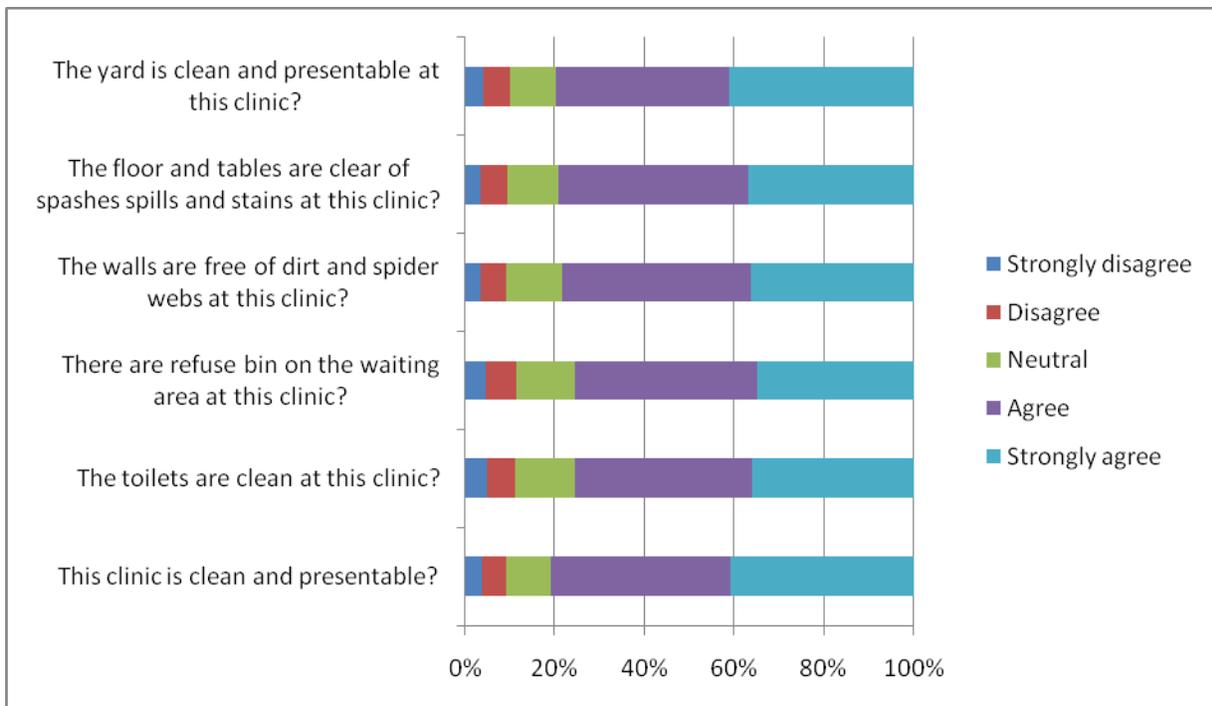
The following section looked at satisfaction levels per priority area in order to assess how satisfied respondents were with each element of the priority area. Responses were grouped by clinic and by region by priority area.

*Priority 1: Improving values and attitudes*



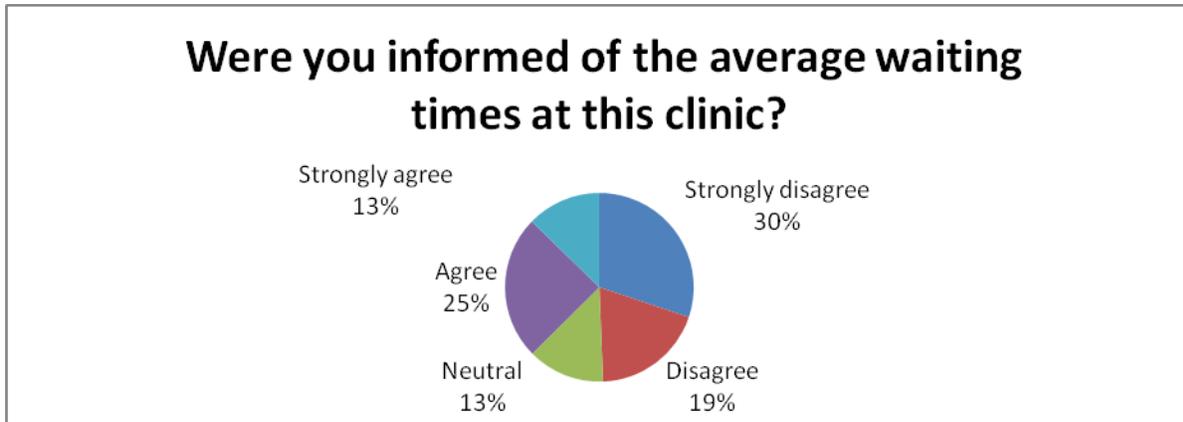
On overall, most individuals (70%) surveyed for priority 1 were in agreement that the clinics were improving values and attitudes. The score for each question in the priority area can be clearly seen in the table above. There were some who were neutral, disagreed or strongly disagreed. However, even when these are put together, they do not exceed 30%.

*Priority 2: Cleanliness of clinic*



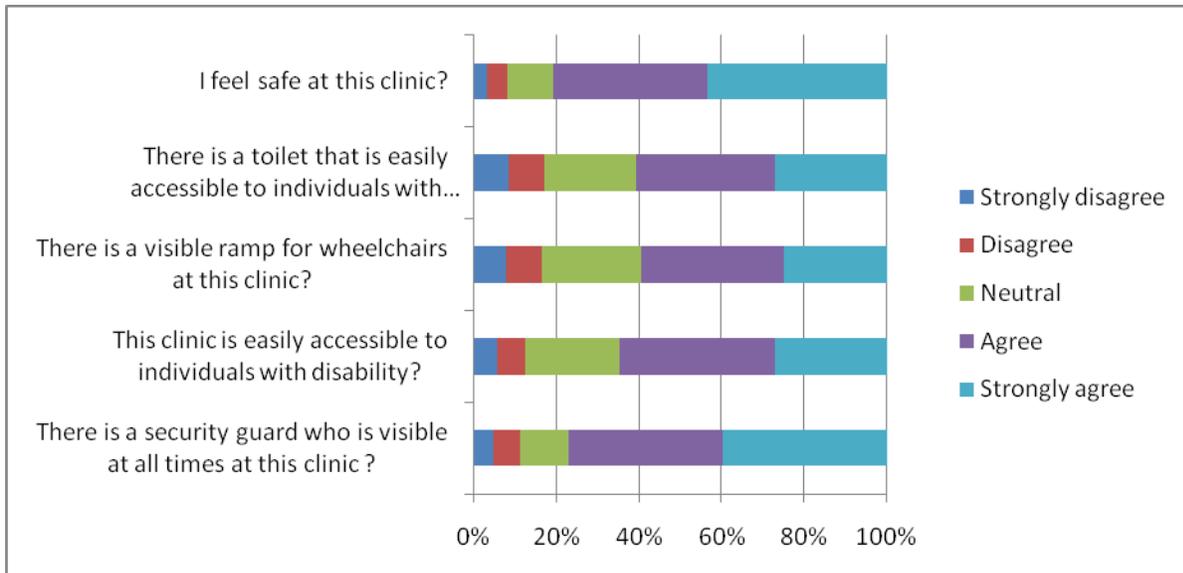
In priority 2, majority, almost 80% of respondents were in agreement that the clinics surveyed were clean. Only about 20% were neutral, disagreed or strongly disagreed.

*Priority 3: Waiting times*



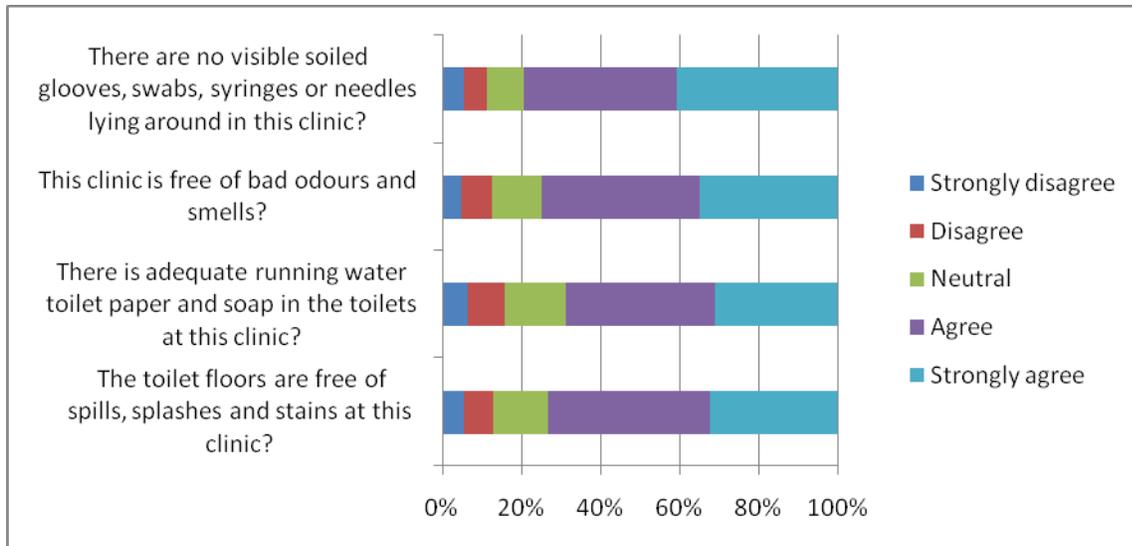
When it came to being informed of how long each patient was expected to wait in the queue before being attended to, most (49%) respondents either disagreed or strongly disagreed that they had been informed versus 38% who agreed or strongly agreed that they had been informed. It should be noted that 13% were neutral to this question.

*Priority 4: Safe and effective care.*



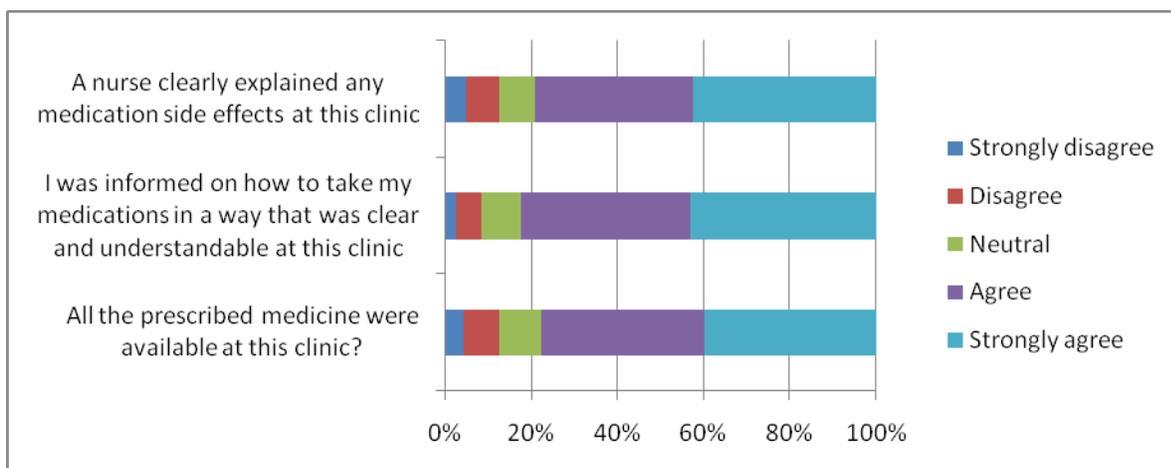
On the safety and effective care priority (Priority 4), almost 75% of respondents were satisfied. 25% were either neutral, disagreed or strongly disagreed. Elements of the categories are as presented in the table above.

*Priority 5: Infection Control*



About 87% of respondents surveyed were of the opinion that the clinics as a whole were implementing effective infection control measures appropriately. About 13% were in the neutral, disagree or strongly disagree range. Individual questions asked in line with this core standard priority area can be viewed from the table above.

*Priority 6: Availability of medicines*

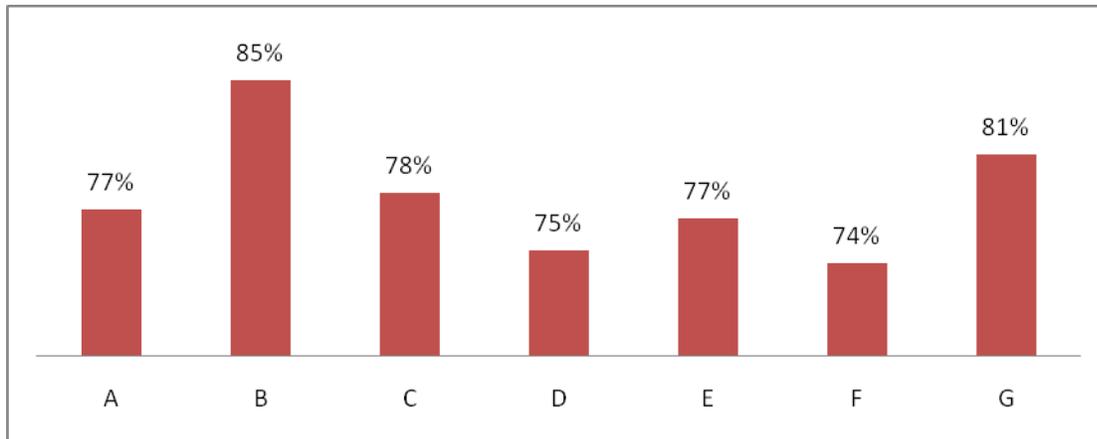


Availability of medicines priority had about 81% of respondents surveyed agreeing or strongly agreeing that this was adequate. Individual questions and responses for this category can be viewed in the table above.

*OVERALL AVERAGE SATISFACTION LEVEL BY REGION*

The following section looked at overall average satisfaction levels per region in order to assess how satisfied respondents were in each of the seven regions. Responses for all clinics in each region grouped together.

*Figure 2: All Clinics Overall Average Satisfaction Level per Region*



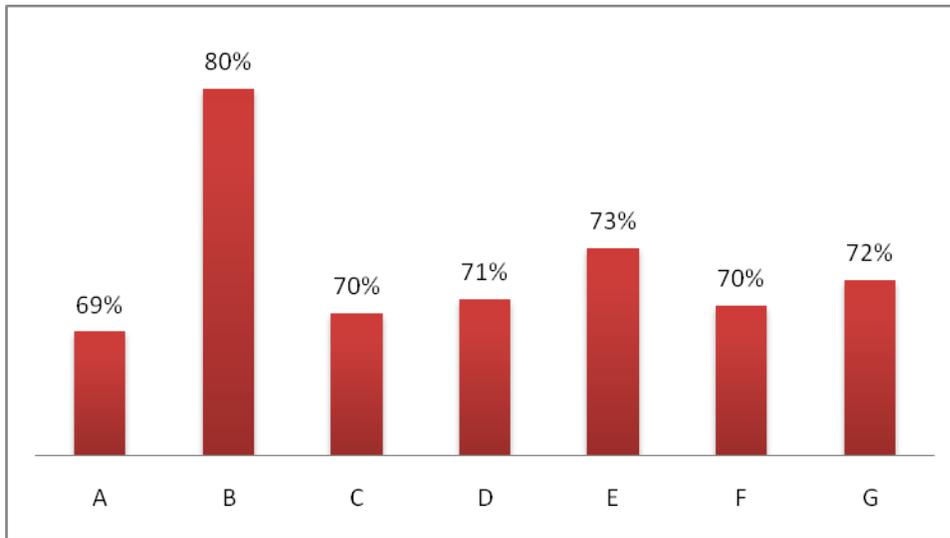
Region B had the highest overall satisfaction level of 85% among all regions surveyed, followed by region G and C with satisfaction levels of 81% and 78% respectively. Both region A and region E had a similar satisfaction level of 77% while region D (75%) and region F (74%) had a lower satisfaction level.

*OVERALL SATISFACTION LEVEL PER PRIORITY AREA BY REGION*

To assess patients’ satisfaction levels, the questionnaire was sub-divided into seven priority areas in order to measure how satisfied patients were with the quality of services that they were receiving from their local clinics. For reporting purposes, each region’s mean satisfaction level was discussed as per priority area where the minimum is 1 and the maximum is 5. Results of this are presented below.

*PRIORITY 1: IMPROVING VALUES AND ATTITUDES*

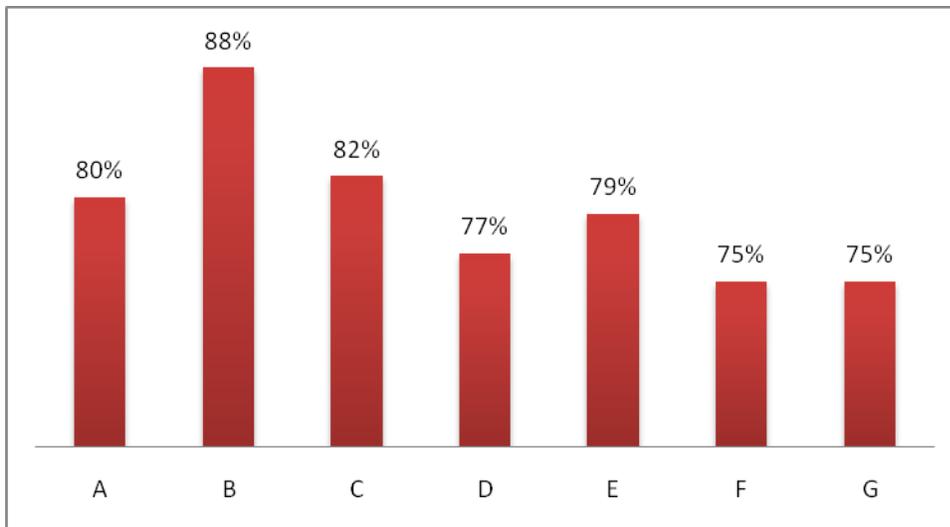
*TABLE 2: IMPROVING VALUES AND ATTITUDE*



Under priority number 1: values and attitude, region B patients gave the highest satisfaction level score of 80% followed by region E and G with 73% and 72% respectively.

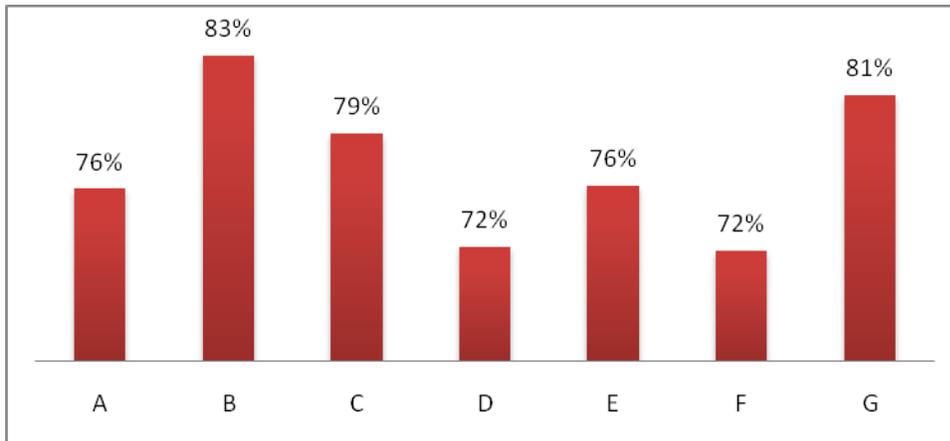
*PRIORITY 2: CLEANLINESS OF CLINIC*

*TABLE 3: PRIORITY 2: CLEANLINESS OF CLINIC*



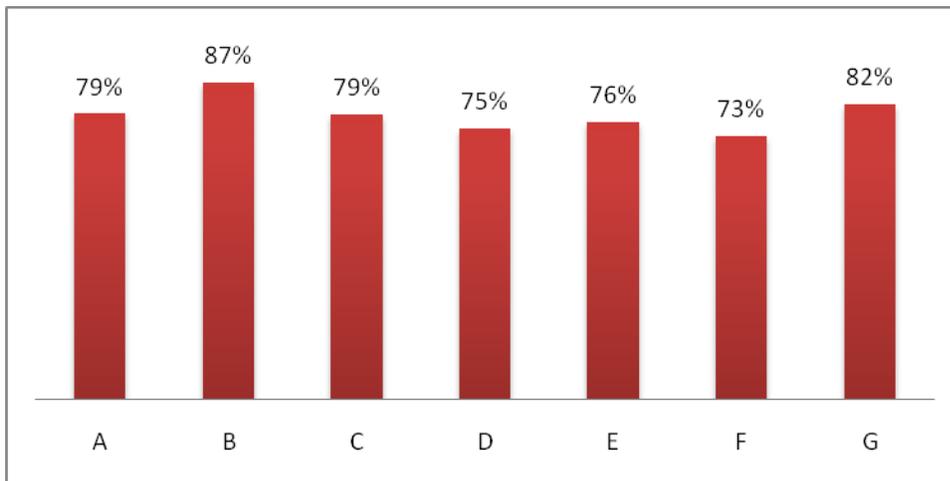
*PRIORITY 4: SAFE AND EFFECTIVE CARE*

*TABLE 4: PRIORITY 4: SAFE AND EFFECTIVE CARE*



Under priority number 4: safe and effective care, region b patients once again gave the highest satisfaction level score of 83% followed by region g and c with 81% and 79% respectively.

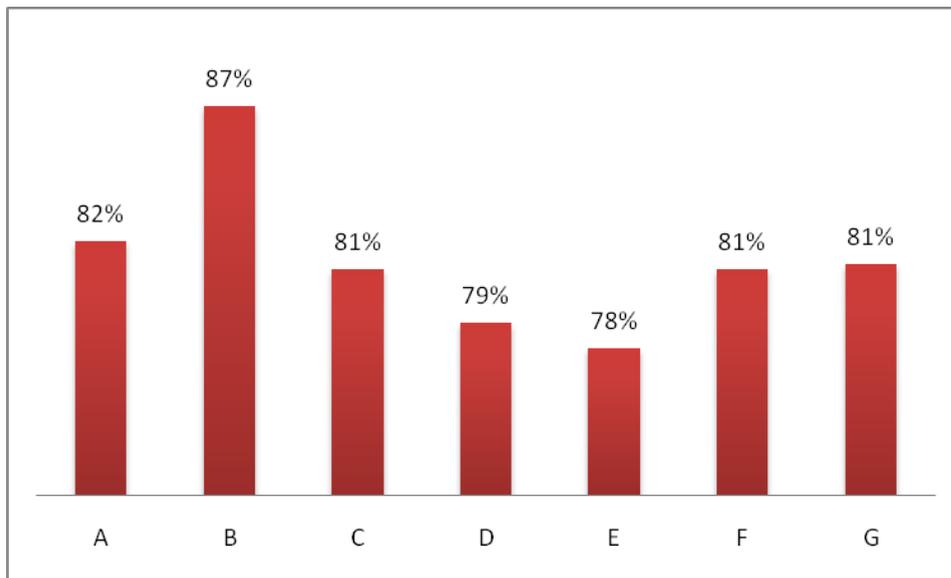
*PRIORITY 5: INFECTION CONTROL TABLE 5: PRIORITY 5: INFECTION CONTROL*



Inpriority number 5: Infection Control, region B patients once again gave the highest satisfaction level score of 87% followed by region G with 82% and region A and C both with 79% each.

*PRIORITY 6: AVAILABILITY OF MEDICINE*

*TABLE 6: PRIORITY 6: AVAILABILITY OF MEDICINE*



Under priority number 6: Availability of medicine, region B patients once again gave the highest satisfaction level score of 87% followed by region A with 82% and region C, F and G all with 81%.

## DISCUSSIONS

This study showed that across all national core standard priority areas patients scored satisfaction levels of 70% and above. This is very is a good indication to Clinics that they are on course in their quest to maintain or improve the quality of health care in all regions of the City of Johannesburg. Meeting citizens' expectations for good quality care is crucial to improving critical health care outcomes for all citizens as envisaged in the national core standards as adopted by the department of health (DoH). In addition, this clinic performance level also goes a long way in assisting clinics maintain their competitiveness in the healthcare market. Evidently, this study yielded a Cronbach's Alpha of 0.917 and an overall mean satisfaction level of 3.8.

In addition the overall average satisfaction levels per region intended to assess how satisfied respondents were in each of the seven regions yielded high average satisfaction levels. Of particular notice is that region B had the highest scores across all areas. This region outperformed all other regions by scoring not less than 80% in all areas. This clinic would serve as a center of excellence for all other clinics to emulate and to go to for training and observation purposes.

In spite of the above successes, the City of Johannesburg has a great work before them and that is to spend some time looking into those aspects where patients were neutral, disagreed or strongly disagreed with certain assertions in various priority areas of the national core standards health provision. Notably, the area dealing with waiting times that patients had to endure before being attended to was the sorest point as revealed in the study. Clinic management will need to

get to the root of this problem to ensure that patients are given information of how long they could be expected to queue before receiving medical attention. In all other priority areas particularly priorities 1, 3 and 5, the elements under each priority need to be attended to and patients educated on what the clinics are doing to meet patient expectations. This could persuade patients to score the clinics better next time perhaps.

## **CONCLUSIONS**

The study has provided information for the first time on how the clinics are doing against patient expectations. Going forward, the clinics should use the results from this study as a benchmark for planning future improvements per facility, per region and for the entire City of Johannesburg. The pegging achieved should be the base line for incremental improvements going forward.

Workshops should be held to inform all staff and clinic managers and facility based improvements plans need to be made for tracking what needs to be done to improve health service quality and patient relationships. The results could also be used as an indicator of what patients need to be educated on to help improve their understanding of what the clinics are doing to meet their expectations.

Clinics could look into investing in electronic queue management systems linked to large screen displays of what numbers are being attended to and who is next and so forth. This system could alleviate the lack of information on waiting times prevailing at the moment. It could also alleviate tensions and anxieties in patients. If this proves to be too expensive for clinics, perhaps they could consider using queue marshals to do the same job. Queue marshals could engage patients in queues and conduct health education, information giving and the like to improve not only the patient expectations but also patient clinic relationships.

Finally clinic management could use the results of regular patient satisfaction surveys not only to rate clinic performance but to also rate manager performance. This is crucial going forward. Keeping in mind that what is not measured is never going to matter, this is one way to get the message across that not only are the priority areas important but that the patient is king in quality clinic service provision. All should be measured and rewarded by how well they do on this.

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