Community preferences for improving public sector health services in South Africa

What aspects of public sector health service quality improvements should be prioritised?

Key points

→ Communities view the routine availability of effective medicines as the greatest priority for improved public sector health services; the least important priority is treatment by doctors.

→ Routine availability of medicines is ten times more important than treatment by doctors.

→ A thorough examination and clear explanation of a patient’s diagnosis and treatment by health professionals are also highly valued community priorities.

→ Communities tolerate poor quality public sector service characteristics such as long waiting times, poor staff attitudes and the lack of direct access to doctors if they receive the medicine they need and a thorough examination and if a clear explanation of their diagnosis and treatment is provided.

Introduction

For some time, there has been criticism of the quality of public sector health services. Various aspects of public services have been raised as areas of concern, but these have largely been based on anecdotal evidence. There has been limited research to identify what communities regard as the greatest problems with public sector health services.

This research explored communities’ views on the elements of public health services that they find particularly problematic. It aimed to quantify the priority placed on each of these aspects of public service delivery that requires attention.

Methods

This research used an approach called a ‘Discrete Choice Experiment’ (DCE) (see Box 1 for an explanation of DCE methods). The first step was to identify the aspects of existing public health
services that most concern communities. Several focus group discussions were undertaken at workshops with civil society groups in Mpumalanga, North-West and Western Cape, as well as community-based focus group discussions in the Eastern and Western Cape. The main themes raised in these discussions were:

◊ Staff attitudes.
◊ The clinical service experience (particularly whether or not there was a thorough examination and expert advice provided).
◊ Availability of medicines.
◊ Whether treatment was provided by a doctor or nurse.
◊ Waiting times.

These discussions also identified concerns about confidentiality, particularly the use of different coloured folders for patients who are HIV-positive.

These elements of service provision were used as the basis for the DCE questionnaire. Two ‘levels’ of each attribute was identified, being expressed in positive or negative terms (see Table 1, 0=negative, 1=positive). It is necessary to have a continuous variable to calculate the strength of preference given to each attribute (i.e. the extent to which respondents’ see that aspect of service delivery as important). As geographic access to health facilities is a major concern in South Africa, transport costs were included as a continuous variable attribute in this study.

Experimental design methods were used to identify the 16 ‘choice sets’ presented to respondents (see Figure 1 for an example of a choice set). As the questionnaire

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff attitude</td>
<td>0</td>
<td>The staff at the health facility do not treat me with respect</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>The staff at the health facility treat me with respect</td>
</tr>
<tr>
<td>Examination</td>
<td>0</td>
<td>The staff at the health facility do not examine me</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>The staff at the health facility examine me thoroughly</td>
</tr>
<tr>
<td>Expert advice</td>
<td>0</td>
<td>The staff at the health facility do not explain what is wrong with me or what I need to do to get better</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>The staff at the health facility explain what is wrong with me and give me advice about what I need to do to get better</td>
</tr>
<tr>
<td>Availability of medicine</td>
<td>0</td>
<td>When I go to the health facility, they don’t have the medicine I need and I go away without any medicine</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>When I go to the health facility, I get the medicine I need</td>
</tr>
<tr>
<td>Treatment by doctors or nurses</td>
<td>0</td>
<td>When I go to the health facility, I first see a nurse who is trained to treat most illnesses and only see a doctor if the nurse cannot treat my illness</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>When I go to the facility, I always see a doctor</td>
</tr>
<tr>
<td>Waiting time</td>
<td>0</td>
<td>I spend a whole day in the health facility before I go home</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I spend about half a day in the health facility before I go home</td>
</tr>
<tr>
<td>Transport costs</td>
<td>40</td>
<td>Transport to and from the health facility costs about R40</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Transport to and from the health facility costs about R20</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Transport to and from the health facility costs about R10</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Transport to and from the health facility costs about R5</td>
</tr>
</tbody>
</table>

Table 1: Overview of attributes & levels

Figure 1: Example of a choice set
was used in a household survey, which would include respondents with low literacy levels, a pictorial depiction of each attribute level was provided to accompany the textual description (which was translated into the language of respondents: English, Afrikaans and isiXhosa).

Household surveys were undertaken in the Eastern and Western Cape provinces; as we had insufficient resources to undertake a national survey, we selected two provinces that are very different in terms of urban-rural mix and socio-economic status. In the Western Cape, Cape Town, Overberg and Central Karoo districts were sampled, while in the Eastern Cape, the districts of Amathole, Cacadu, Nelson Mandela Bay and Ukhahlamba were sampled in the survey. Approximately 500 households were included in the survey in each province.

Findings

Overall health service preferences

◊ The respondents had an overall preference to not use public sector health facilities.
◊ If they were to use public sector health services, by far the most important preference for such use would be the regular availability of medicines (see Figure 2).

◊ The availability of medicines was seen as ten times more important than direct access to a doctor.
◊ The next two most important preferences were clinicians providing information on the diagnosis and treatment and undertaking a thorough examination (3.9 and 3.6 times more important respectively than direct access to a doctor).
◊ These were followed by waiting time and staff attitudes (2.4 and 1.7 times more important respectively than direct access to a doctor).

Provincial health service preferences

◊ There were slightly different preferences in the two provinces included in the survey (see Figure 3). However, in both provinces, the greatest preference was availability of medicines.

◊ For direct access to a doctor, this was the least important preference in the Western Cape, and the second lowest preference in the Eastern Cape.
◊ For staff attitudes, this was the least important preference in the Eastern Cape, and the second lowest preference in the Western Cape.

◊ The least important preference was direct access to a doctor (as indicated by the weight of one in Figure 2). Thus, respondents were not strongly opposed to seeing a nurse first and only seeing a doctor if the nurse was not able to deal with their health problem.
◊ The availability of medicines was seen as ten times more important than direct access to a doctor.
Clinicians undertaking a thorough examination was also valued quite highly in both provinces, while expert advice was even more highly valued than a thorough examination in the Western Cape and less highly valued in the Eastern Cape.

What do these findings mean?
These findings suggest that communities are prepared to tolerate poor quality public sector service characteristics such as a long waiting time, poor staff attitudes and the lack of direct access to doctors if they are guaranteed that they will receive the medicines they need, a thorough examination and a clear explanation of the diagnosis and prescribed treatment from health professionals.

Limitations of the study
Unfortunately, due to resource constraints, we were only able to undertake the household survey in two provinces. Nevertheless, the fact that similar concerns about elements of service quality in public sector facilities were raised in other provinces during the focus group discussions lends some credibility to the findings in the Eastern and Western Cape.

It is also important to recognise that respondents’ stated preferences are influenced by their personal experience of services. For example, if respondents only have experience of consulting a nurse, they are unlikely to place great weight on consulting a doctor in preference to a nurse.

While the findings indicate a very strong preference for the availability of medicines at public sector facilities, it is unclear whether this relates to addressing an absolute absence of medicines in facilities or the absence of medicines that patients regard as effective (e.g., a patient being given Panado when s/he expected to receive something ‘stronger’). The focus group discussions and feedback sessions with fieldworkers indicated that households are most concerned about the availability of medicines that will resolve their health problems.

Policy recommendations
Given the overall preference not to use public service facilities, there is an urgent need to introduce demonstrable improvements in the quality of public sector health services. Failure to do this will mean communities do not attend public health services when care is needed.

The study identified the aspects of health services that are regarded as the greatest priorities by communities. Based on the expressed preferences of households surveyed, this brief makes the following policy recommendations:

◊ Government can achieve ‘quick wins’ by addressing medicine procurement and particularly distribution (potentially through the use of private distributors) so that all public facilities have constant availability of all essential medicines. This will increase the uptake of public health services.

◊ There should also be efforts to ensure that clinicians undertake adequate patient examinations and explain the nature of a patient’s illness and what is required for successful treatment. This is likely to require improved staffing levels to ensure adequate consultation times and should also reduce waiting times.

◊ As the priority community preferences for improving public sector health services are addressed, service improvements that take longer to implement, such as changing staff attitudes, will become increasingly important.

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