

# Patient Experience of Primary Health Care Users in KwaZulu-Natal

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## Abstract

This study was conducted to evaluate Patient Experience in primary health clinics in the province of KwaZulu-Natal (KZN). A quantitative study approach included 280 participants. The descriptive cross sectional study utilised a self-administered questionnaire as the research instrument, which was distributed to the target population of primary health care (PHC) users. The overall Patient Experience-Satisfaction showed that more than half of the respondents were not satisfied with the current Patient Experience in the primary health clinic. There was a significant association with age and the overall Patient Experience-Satisfaction ( $p < 0.05$ ). Older patients indicate a favourable Patient Experience when compared to younger patients, who are more critical of the Patient Experience elicited in primary health clinics. The results showed that gender did not significantly affect the overall Patient Experience-Satisfaction ( $p = 0.957$ ). Race significantly affected Patient Experience ( $p$  value = 0.011) with black respondents having a significantly lower mean rank of Patient Experience when compared to Indian respondents. There was an overall negative perception toward the Patient Experience elicited in users. There is an urgent need to review the service delivery of clinics. The need for a Patient Experience Model is highlighted for the health sector in South Africa.

**Keywords:** Patient Experience-Satisfaction; Primary Health Clinics; KwaZulu-Natal



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## Introduction

Primary Health Care (PHC) has been adopted as a vehicle of care in most African countries, including South Africa (SA). PHC Clinics (PHCCs) are the first point of entry for “patients” using the public system. Recent reports, according to the World Economic Forum, indicate that SA’s public health system is of poor quality, being ranked 132nd out of 144 member countries (Jackman n.d., 4). Bearing in mind that there are varying socio-economic profiles of the different member countries, the global rankings may be judged as being biased toward low and middle income countries. This highlights the need for research to be conducted within African countries in order to present an objective evaluation of the quality of health care. Research evaluating Patient Experience within PHCCs, can benefit SA in light of the impending National Health Insurance (NHI) implementation.

Traditional marketing methods focus on the customer as their primary source of product or service feedback, yet this trend has not gained momentum within the health care sector (Browne et al. 2010, 923). Emerging data now reveal that patient feedback has gained popularity in the evaluation of health quality and services via the Picker Principles and the Institute of Medicine Framework within high income countries (Browne et al. 2010, 925). The World Health Organisation (WHO) has similarly advocated the use of the patients’ perspective and further supports patient feedback as an important source of information when developing action plans for Quality Improvement (QI) in health care organisations (Amatya et al. 2017, 270). Patients are, therefore, well recognised for their role in ensuring that health care is delivered at acceptable standards. Despite the applicability of investigating health care from the patient’s perspective, studies that pertain to the Patient Experience of care have been scarce in SA, thus highlighting the need for further research (Browne et al. 2010, 925; Jobson 2015, 33).

Quality health care is key to the development of any nation, as a healthy nation can support economic productivity (Mgijima 2010, 28). Therefore, the health of SA citizens should be prioritised. The government of SA adopted the Batho Pele Principles within the various public service departments in order to provide a framework that could assist public servants on how to deliver quality service. It is apparent that public health care in SA faces significant challenges, with a specific concern noted in the human resources for health (Jackman n.d., 5). Statistical findings suggest a growing trend of PHCC users in an already over-burdened public system

(South African Department of Health 2015a, 22). This has placed a considerable burden on the public health sector. The move towards the NHI model of health care and the increase in public health users prompted a national audit of all public health care facilities in an effort to answer the following question: “Are the public health facilities capable of providing quality health care for the public?” (South African Department of Health 2015a, 37). The audit findings clearly indicated that PHCC systems, in particular, are lacking in many of the key areas deemed important in the provision of quality health care. These findings gave rise to the Ideal Clinic Initiative (spearheaded by former President, Jacob Zuma) which was developed to provide a baseline reference for the provision of services that support quality health care (South African Department of Health 2015a, 39; South African Department of Health 2015b, 28). The present study thus incorporates the Ideal Clinic Initiative, Picker Principles, Batho Pele Principles and the Institute of Medicine Framework as points of reference for the conceptual framework of the study.

## **Aim of the Study**

The aim of the study is to describe the Patient Experience of PHC users in the eThekweni Municipality of KZN, South Africa.

## **Research Methods and Design**

### **Study Design**

A quantitative research approach was adopted using a descriptive research design. The survey research strategy was applied.

### **Setting**

The study was set within three communities of Waterloo, Grove-End and Stonebridge, located in the eThekweni Municipality of KZN.

### **Study Population and Sampling Strategy**

There were 1 500 houses in total within the 2km radius of the three communities (Waterloo, Grove-End and Stonebridge) located within the eThekweni Municipality of KZN. This data were drawn from the eThekweni Housing Department based in Unit 20, Phoenix. The total number of houses was determined through a map of the region and a sample of 300 was obtained, based on the sample size table with a confidence

interval of 95% and a 5% margin of error. The sample population of 300 was obtained (Waterloo [100]; Grove-End [100] and Stonebridge [100]) using a cluster sampling strategy where the number of houses was similar in the 2km radius of the three communities. PHCC users were included in the study.

### **Data Collection**

The author developed a data collection tool based on the Consumer Assessment of Health Care Providers and Systems Tool, Primary Care Assessment Tool and Patient Experience Survey Tool (Wang et al. 2013, 517) and pre-tested the tool with 30 respondents from the Waterloo, Grove-End and Stonebridge communities. The 30 respondents were not included in the final 280 respondents. Field surveyors completed the Patient Experience survey over a period of four weeks from Monday to Friday (8am–6pm). The survey team consisted of 10 individuals, comprising one field co-ordinator (researcher), one data entry person, one driver and seven interviewers (English and isiZulu) who served to ensure an efficient data collection process for both English-speaking and non-English-speaking respondents. Field interviewers provided explanations for the questionnaire line items to ensure that the responses were valuable. A total of 300 questionnaires were collected, yielding a 100% response rate, but 20 questionnaires were excluded as these questionnaires were incomplete. Therefore, a total of 280 questionnaires were included for the data analysis.

### **Data Analysis**

The quantitative data were analysed through the use of the Statistical Package for Social Sciences (SPSS) Version 25.0. The use of descriptive and inferential statistics was included. A frequency analysis was conducted to outline the demographic profile and the reported Patient Experience of the participants. A principal component analysis was used to develop a summary variable (Overall Patient Experience-Satisfaction) based on the frequency distribution of the reported Patient Experience. The Kruskal-Wallis test was completed to determine the effects of age, gender and race on the summary variable.

### **Ethical Consideration**

Approval was obtained from the Humanities and Social Sciences Research Ethics Committee with protocol reference: HSS/0126/017D.

## Results

**Table 1:** Demographic Summary of the Respondents

Variable	Category	Frequency	%
Age	<20 years	17	6.1%
	21–25 years	41	14.6%
	26–30 years	44	15.7%
	31–35 years	61	21.8%
	36–40 years	49	17.5%
	41–45 years	23	8.2%
	46–50 years	22	7.9%
	50+ years	23	8.2%
Gender	Male	90	32.6%
	Female	186	67.4%
Race	Black	109	38.9%
	Indian	171	61.1%

Table 1 demonstrates the demographic profile of the sample population. The summary reveals that the majority of respondents belong to the age group 31–35, with two thirds being female. The age categories also show similar percentages, ranging from 14–18% among the younger age groups (21–25: 14.6%; 26–30:15.7% and 36–40:17.5%). As the age categories progress beyond 40 years, there is a subsequent decline of respondents. The majority of respondents are of Indian ethnicity.

**Table 2:** Reported Patient Experience in the Primary Health Clinics

Current Patient Experience in the Public Health Sector	Frequency Distribution						
	% Strongly Disagree + Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	% Agree + Strongly Agree
1.The clinic is easily accessible	75.3%	69.6%	5.7%	10.7%	2.9%	11.1%	13.9%
2. The clinic has a good infrastructure to provide quality health care	69.3%	64.3%	5.0%	16.4%	2.5%	11.8%	14.3%
3. I observe protocols for cleanliness in the clinic	70.0%	65.0%	5.0%	13.2%	4.3%	12.5%	16.8%
4.The management of the clinic is effective in providing positive outcomes	69.3%	63.9%	5.4%	16.1%	2.9%	11.8%	14.6%
5. The doctors provide quality care	69.3%	62.9%	6.4%	15.0%	2.5%	13.2%	15.7%
6. The nurses provide quality care	68.6%	61.1%	7.5%	16.4%	2.5%	12.5%	15.0%
7. There is good communication in the clinic	71.1%	62.9%	8.2%	15.7%	1.4%	11.8%	13.2%
8. I am educated about my health management	71.8%	63.9%	7.9%	15.0%	2.1%	11.1%	13.2%
9. I am informed about my health management	73.2%	66.1%	7.1%	12.9%	1.1%	12.9%	13.9%
10. The clinic gives my family and friends an opportunity to be involved in my care	75.3%	68.9%	6.4%	12.1%	2.5%	10.0%	12.5%
11. The medication I receive is properly dispensed	70.4%	64.3%	6.1%	13.9%	3.6%	12.1%	15.7%
12. There is co-ordination and continuity of care	68.5%	62.1%	6.4%	16.8%	2.1%	12.5%	14.6%
13. I receive a good quality of care	68.9%	62.4%	6.5%	15.1%	2.5%	13.6%	16.1%

14. I receive patient centred care	68.2%	62.5%	5.7%	15.4%	1.8%	14.6%	16.4%
15. The waiting time is appropriate to deliver quality health care	72.1%	66.4%	5.7%	16.1%	2.9%	8.9%	11.8%
Overall Patient Experience-Satisfaction	70.75%						14.51%
Cronbach's Alpha 0.989							

The results in Table 2 outline the reported Patient Experience in the PHC within the eThekweni Municipality. The percentages of the strongly disagree and disagree columns and columns representing agree and strongly agree responses were aggregated. The Cronbach Alpha value of 0.989 reflects a high internal consistency. Two important factors assessing Patient Experience elicited a strong disagreement above 75%. These were Factor 1 (The clinic is easily accessible) and Factor 10 (The clinic gives my family and friends an opportunity to be involved). Factor 15, which enquired about the appropriateness of waiting time, reflected a strong disagreement where 72% of the respondents were negative. The issue of cleanliness in the clinic (70%) and Factor 11, which is concerned with the dispensing of medication (70.4%), elicited strong disagreement. With reference to the quality of the care received, the co-ordination and continuity of care, more than two thirds of the respondents disagreed. A variable (Overall Patient Experience-Satisfaction) was developed to determine the overall satisfaction with Patient Experience in the PHC. The results show that more than half of the respondents are not satisfied with the current Patient Experience in the PHC.

In order to decide on the appropriate statistical test to use for assessing the effects of the demographic variables on the Patient Experience, a test of normality was carried out. The results presented in Table 3 show that there is a significant departure from normality in the measure for Overall Patient Experience-Satisfaction (Kolmogorov-Smirnov statistic=0.304, df=280, p-value<0.001, Shapiro-Wilk statistic=0.721, df=280, p-value<0.001). Because there is a significant departure from normality, non-parametric tests are more appropriate in testing for the effects of demographic variables on Patient Experience-Satisfaction.

**Table 3:** Tests of Normality

Tests of Normality						
	Kolmogorov-Smirnov <sup>a</sup>			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Overall Patient Experience-Satisfaction	0.304	280	<0.001	0.721	280	<0.001
a. Lilliefors Significance Correction						

The Kruskal-Wallis test was used to test if age, gender or race were significant factors affecting Patient Experience. The results show that age significantly affects Patient Experience (H=18.525, df=7, p-value =0.010). The age group with the lowest level of Patient Experience-Satisfaction is the 36–40 age group (mean rank =119.98) with the 46–50 age group having the highest level of Patient Experience-Satisfaction (mean rank =170.89).

**Table 4:** Age and Overall Patient Experience-Satisfaction

	Ranks				Kruskal-Wallis Test		
	Age	N	Mean Rank	Order of satisfaction	Statistic (H)	df	p-value
Overall Patient Experience-Satisfaction	< 20 years	17	137.35	3	18.525	7	0.010
	21–25 years	41	164.11	6			
	26–30 years	44	140.33	5			
	31–35 years	61	121.99	2			
	36–40 years	49	119.98	1			
	41–45 years	23	137.96	4			
	46–50 years	22	170.89	8			
	50+ years	23	167.35	7	<b>Age is a significant factor affecting Overall Patient Experience-Satisfaction</b>		



The results show that gender does not significantly affect the Overall Patient Experience-Satisfaction.

**Table 5:** Gender and Overall Patient Experience-Satisfaction

	Ranks				Kruskal-Wallis Test		
	Gender	N	Mean Rank	Order of satisfaction	Statistic	Df	p-value
<b>Overall Patient Experience-Satisfaction</b>	Male	91	140.16	1	0.003	1	0.957
	Female	189	140.66	2	<b>Gender is not a significant factor affecting Overall Patient Experience-Satisfaction</b>		

The results show that race significantly affects Patient Experience-Satisfaction ( $H=6.467$ ,  $df=1$ ,  $p$  value = 0.011) with black respondents having a significantly lower mean rank of Patient Experience-Satisfaction.

**Table 6:** Race and Overall Patient Experience-Satisfaction

	Ranks				Kruskal-Wallis Test		
	Race	N	Mean Rank	Order of satisfaction	Statistic	df	p-value
<b>Overall Patient Experience-Satisfaction</b>	Black	109	126.40	1	6.467	1	0.011
	Indian	171	149.49	2	<b>Race is a significant factor affecting Overall Patient Experience-Satisfaction</b>		

## Discussion

The higher female response rate was supported by Abdurraheem, Oladipo, and Amodu (2011, 18), who assumed that more females than males present for treatment in PHC since it has been shown that women have a significantly higher mean number of morbidities than men. While the study was conducted external to the clinic environment, the criteria stipulated that the respondents were currently receiving care at a PHCC. The findings of the study, therefore, dovetail with the findings offered by Abdurraheem et al. (2011, 18). The age demographic of the 31–35 grouping in the study showed higher frequencies in comparison to the other age groupings, and this is in keeping with the age demographics of patient populations in KZN (KwaZulu-Natal Department of Health n.d.). Bearing in mind that the three suburbs that are included in the survey are predominantly Indian and black based, the findings of the study are in keeping with the racial demographics of the areas.

## Access

More than three quarters of the respondents disagreed that the clinic is easily accessible. This could be explained by three possible scenarios. Firstly, while the sample was drawn from communities within a 2km radius surrounding the PHCC, a cohort of patients verbally communicated to field researchers that they travelled from other communities to receive care. This verbal representation, offered by the respondents, was noted but not included in the analysis of data. Secondly, literary sources have pointed out that challenges to health care service provision in SA included transport challenges and increased transport costs as being specific barriers to access (Cooke, Couper, and Versteeg 2011, 107; Gaede and Versteeg 2011, 99). There is agreement between these literary findings and the findings of the study, despite the fact that access has been constitutionally mandated as a basic human right, and the government aims to provide universal and equitable access to high quality health care services throughout the nine provinces (Levesque, Harris, and Russell 2013, 18). Thirdly, respondents' perceptions of accessibility may differ, where one respondent perceives a 2km radius to be accessible, whereas another respondent may disagree. Access within the context of health care can further be defined as the opportunity or ease with which consumers or communities are able to use appropriate health services in proportion to their needs (Levesque et al. 2013, 18). This definition of access extends beyond the proximity dimension and incorporates the ability of the patient to gain access for services within the clinic as deemed appropriate to their health needs. There is a perennial complaint offered by patients that health care staff restrict patient

access to services that could improve the management of their health (Cooke et al. 2011, 107; Gaede and Versteeg 2011, 99). Understanding the experiences of the patient in relation to the domain of access can, therefore, assist in changing the provision of health care to enhance the health outcomes of patients (Scheffler, Visagie, and Schneider 2015, 820). The findings of the study are aligned with literary sources that support the need to improve access in terms of the proximity dimension and use of available services within the clinic towards supporting a positive Patient Experience.

### **Physical State of the Infrastructure**

A report by the National Department of Health (NDoH) and the Health Systems Trust (South African Department of Health 2015b, 30) indicates that the physical state of the infrastructure in PHC in SA is poor, due to unequal development and the general lack of maintenance. The findings of this study are in agreement with the findings of the NDoH and the Health Systems Trust. The physical environment can also impact patients' valuation of the received care, which implies that if the physical environment is poor, then the valuation of the services may also be poor (Johnson 2014,16). Honda et al. (2015, 600) contend that the healthy work environment is essential for health care workers' well-being, in addition to ensuring safe and effective patient care. These authors bring to point an important note, that the dissatisfaction of health care workers towards their working environment had a negative impact on patients' safety and the quality of care (Odhayani and Khawaja 2014, 24; Schubert et al. 2012, 230). It is well known that health professionals in SA have been experiencing low levels of job satisfaction, which in turn has influenced the quality and effectiveness of service delivery (Odhayani and Khawaja 2014, 25). The findings of this study are, therefore, aligned with literary sources that support the need to improve the physical infrastructure of the PHC towards supporting a positive Patient Experience (Johnson 2014, 16; Odhayani and Khawaja 2014, 24; Schubert et al. 2012, 230).

### **Cleanliness of the Primary Health Clinics**

Only 16.8% of patients agreed that they observed protocols for cleanliness. This finding is supported by an earlier report that evaluated the state of clinic cleanliness in SA and reported that SA was failing in this regard (National Audit for Health Care Facilities 2012, 15). Less than 50% of PHC is compliant with infection control and cleanliness standards, with only 83% of PHC compliant in waste management processes (National Audit for Health Care Facilities 2012, 16). Patients should be able

to receive quality health care in a clean environment that supports good infection control.

## **Management**

More than two thirds of the respondents (69.3%) disagree that the management of the clinic is effective in providing quality care. Kaufman and McCaughan (2013, 50) contend that leaders cannot be seen to turn a blind eye to poor practice, as this sets the pattern of behaviour for the whole team and managers are essential participants in improving health care quality, who need to participate in ensuring that patients receive safe, efficient and equal care. While the finding of this study presents a dismal picture of management effectiveness, literary findings bring to light the benefits of management effectiveness towards ensuring quality care (Frojd et al. 2011, 266; Kaufman and Mccaughan 2013, 50). There is an evident management problem that exists in PHC which necessitates strategic intervention. One of the major roles that a health care leader performs is that of a change agent (Van Gorder 2015, 5) and creating a culture that supports change requires leaders who are dedicated and accountable to creating a new health care environment. Dynamic change in health care is necessary to create a positive atmosphere, promote sustainability and implement innovations (Parsons et al. 2010, 15). Bleich (2015, 297) reiterates that the single most important factor leading to improved Patient Experience-Satisfaction is the commitment and engagement of senior leadership, which can create a shared vision, unite the staff and transform the organisation.

## **Role of the Doctors and Nurses**

Respondents (69.3%) further disagreed that doctors provide quality care. Similarly, 68.6% of respondents disagreed that nurses provide quality care. It is clear from the findings of this study that patients are not accepting of the level of care offered by health care workers in the PHC. Patients expect the health care worker to be empathetic, friendly, attentive and sympathetic (Devanny 2015, 1; Kumar et al. 2013, 5; Papp, Markkanen, and Von Bonsdorff 2014, 362). Communication plays a huge role in nurturing the transparency and trust that is required between patients, physicians and nurses to build a strong connection (Kupperschmidt et al. 2010, 1; Manary et al. 2013, 201). Robinson et al. (2008, 600) note that effective communication between health care professionals and patients are related to better Patient Experiences. Nurses, who mostly manage the clinics vital to the Primary Health Care Strategy, are leaving the public sector citing an unpleasant work

environment and poor wages as the primary push factors (SA DoH 2015a, 14; 2015b, 40). Nurses and doctors are overwhelmed by patient numbers, according to the findings of Kumar et al. (2013, 4). Pelzang, Wood, and Black (2010, 186) found that the shortage of staff and overworked employees were the main barriers to eliciting a positive Patient Experience observed in the practical setting.

### **Communication**

Respondents disagree (71.1%) that there is effective communication in the clinic. According to the National Audit for Health Care Facilities (2012, 25) mechanisms to communicate consistently and systematically with patients and to share with communities the results and the progress of quality improvement initiatives are lacking. The findings of this study show that there is ineffective communication in the clinic. Epstein and Street (2009, 806) show that patient-centred communication has a positive impact on important outcomes, including patient satisfaction, adherence to recommended treatment, and the self-management of chronic diseases.

### **Patient Education and Information**

With regard to respondents being educated about their health management, 71.8% disagreed. There was a minor group of respondents (13.9%) who reported that they were informed about their health management. The Batho Pele principles of Access and Information require information to be readily available to citizens in order to empower them and to address their needs (Dookie and Singh 2012, 67). Unless information is made readily available to citizens on the services provided, they may not be educated and empowered to know the level and quality of services to expect, and the promptness with which these should be delivered. This disempowerment of the patient is not conducive to ensuring that service delivery of the highest quality is provided in the clinic and does not support a positive Patient Experience.

### **Involvement of Family/Friends**

Respondents (75.3%) disagreed that there was a welcomed involvement of family/friends. One of the components of patient engagement comprises the involvement of patients, their families or representatives, to improve health or health services (Carman et al. 2013, 233). Effective engagement also entails giving patients' family members or friends the opportunity to participate in care giving and express choices. This creates a respectful, empathetic environment where individuals feel valued and cared for (Luthra 2015, 5). A recent study suggests that family members

play an active role in supporting safe care delivery when they are involved in care giving and treatment planning through trustworthy communication (Boyle 2015, 2). The involvement of family and friends has proven to reduce the adverse events in hospital by the identification of barriers to quality health care (Manafa et al. 2018, 5). Therefore, involving the family member or friend can elicit a positive Patient Experience.

### **Dispensing of Medication**

The results reveal that respondents (15.7%) perceived that the medication they received was properly dispensed to them. In SA, officials found that in 2010 there was a shortage of medicines, with only 36% of the clinics that were inspected holding sufficient medication (Department of Health 2010, 23). This in turn had a negative influence on the dispensing of medication, since patients were unable to receive their medication as and when needed. Patients were requested to return to the clinic for repeat visits and this increased the cost burden placed on the patient.

### **Co-ordination and Continuity of Care**

Most respondents (68.5%) disagreed that there are co-ordination and continuity of care. Schang, Waibel, and Thomson (2013, 18) state that care coordination can be seen as part of a broader strategy to improve quality in health care delivery and, ultimately, to strengthen the performance of the health system. According to Shaw, Rosen, and Rumbold (2011, 12) co-ordinated and continuous care reflects a concern to improve Patient Experience and achieve greater efficiency and value from health delivery systems.

### **Quality of Care**

According to the results of Table 2, 68.9% of patients disagreed that the care they received translated to good quality care. Lupo (2016, 468) defined the quality of care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. According to the WHO, “quality health care is defined as care that consists of the proper performance according to standards” (WHO 2018, 27). PHC users in SA are dissatisfied with the quality of care that they receive and this has the potential to elicit a negative Patient Experience.

## **Patient-Centred Care**

Care that amounted to patient-centred care received a disagreeable response among most respondents (68.2%). The use of a patient-centred approach can significantly influence quality in health care (Australian Institute of Health and Welfare 2014, 4). Therefore, providing patient-centred care can contribute towards a positive Patient Experience.

## **Waiting Time**

The waiting time in PHC is considered to be inappropriate to deliver quality health care, as indicated by 72.1% of respondents. In SA, 75% of patients wait more than two hours in the clinic, and for 7% of them the waiting time could be more than seven hours. This means that an average patient will lose at least half a day of work when going to a public health facility (National Audit for Health Care Facilities 2012, 35). According to this Audit Report, patients are only provided with dates and no appointment time and this often results in most patients arriving early in the morning, causing over-crowding of the facilities (National Audit for Health Care Facilities 2012, 36). In a study that investigated patients' satisfaction, Vadhana (2012, 78) reported that waiting time was a significant factor that caused the majority of the respondents to feel uncomfortable with the services provided. According to the National Audit the following objectives were set out, together with targets to be met by March 2018:

- Patients will wait for less time, both before and between receiving services. The target is two hours maximum waiting time.
- Patients will spend less time in total at the clinic. The target is three hours maximum spent at the clinic.
- Patients will be satisfied with waiting times. The target is that 90% will be satisfied with their waiting time at the clinic.
- Patients will report a positive experience of care. The target is that 80% will report a positive experience when evaluating the waiting time spent at the clinic.

Waiting times impact negatively on patient costs when seeking care, as revealed in an explorative study investigating non-adherence to treatment in a Human Immuno-Deficiency Virus (HIV) study. The lost wages and transport costs that were related to longer waiting times had a negative impact on the patients' adherence to treatment

(Umar, Oche, and Umar 2011, 78). Therefore, it can be implied that long waiting times contribute to a negative Patient Experience.

There is a significant departure from normality in the measure for the overall Patient Experience-Satisfaction. Because there is a significant departure from normality, non-parametric tests are more appropriate in testing for the effects of the demographic variables on Patient Experience.

An earlier study (Campbell, Ramsay, and Green 2001, 90) conducted in 2001 has shown significant differences between people of varying age and ethnicity with respect to their assessments of primary care. Patients' perceptions of the quality of care have been found to be significantly different in the age category, where older patients consider the quality of care to be higher than younger patients (Kvist et al. 2014, 466). The earlier study conducted by Campbell et al. (2001, 90) against the recent study of Kvist et al. (2014, 466) shows a growing trend over the past decade where the older patients rate their experience of care more favourably. The findings of the present study show agreement with this trend.

Gender does not significantly affect the Overall Patient Experience-Satisfaction. A study conducted by Campbell et al. (2001, 90) expresses that gender was not significant in influencing patients' perceptions of the care received (Campbell et al. 2001, 92). Janicic et al. (2011,1701) found no significant difference in gender groups for satisfaction of health care, whereas Afzal et al. (2014,154), Gajovic et al. (2012, 4185) and Dulgerler, Ertem, and Ozer (2012, 2729) reported that gender showed no effect at all on the patient satisfaction score in their research. Overall, these studies show that gender is not a demographic predictor of patient perception.

Race significantly affects the Overall Patient Experience-Satisfaction, with black respondents showing a significantly lower mean rank of Patient Experience-Satisfaction. Non-white ethnic minority respondents reported less favourable assessments of care than white ethnic majority respondents in the study conducted by Campbell et al. (2001, 95). According to these authors, more research is needed to determine whether these differences reflect variation in the provision of care, greater expectations of services, or merely differences in reporting behaviour.



## Strengths and Limitations

The field researchers collected data in a flexible time frame to cater for both the employed and unemployed groups that were clinic patrons. This also ensured that males or females who were at work during the day were still afforded an opportunity to participate in the study. The study is limited in its generalisation as it has only been applied in small communities within the eThekweni Municipality. However the study design is adaptable and can be replicated in other provinces throughout SA. As a consequence of this limitation, the findings may not be fully representative of the Patient Experience in other provinces, and this should be taken into consideration when the results are interpreted.

## Implications or Recommendations

The study implies that the majority of patients perceive a negative Patient Experience. This brings to light a more accurate representation of how patients evaluate the care that they receive in PHC and impresses the urgency for a radical change effort. A comprehensive investigation of Patient Experience clearly indicates areas of care and service delivery that need to be addressed. This study further recommends that a Patient Experience Model be developed in SA.

## Conclusion

The findings of the study highlight a negative Patient Experience elicited in the receipt of health care at PHCCs in SA. In light of these findings, there is a need for the government of SA to address the challenges, as a means to strive for a positive Patient Experience in PHC.

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## Disclaimer

The views expressed in the submitted article represent those of the authors.

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