Exploring public perceptions of South African private and public hospitals and preferences for health care providers

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Public Health.

Johannesburg

May 2013

DECLARATION

I, Lebogang Komape, declare that this research report is my own work. It is being submitted for the degree of Master of Public Health in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.

Signature:_____

Date:_____

Student number: 9703746R

Ethical Clearance Number: M081156

DEDICATION

This research report is dedicated to my daughter, husband, parents and siblings. Thank you for all your love and support. Thank you for believing in me!

A special dedication is made in memory of my sister Lesego Komape (1983-2009). Love and miss you always. You are forever in my heart!

ABSTRACT

Introduction

The intention of this study is to explore how members of the South African public perceive private and public hospitals in the country. A better understanding of both positive and negative perceptions can guide improvements in public sector services and strengthen public confidence in the health system.

Methodology

Eight focus groups, delineated in terms of race and experience with the public/private sectors were run. Thematic content analysis was used in analyses.

Results

There was an almost-automatic perception that private hospitals are “better than” public hospitals. However with further exploration, a much more nuanced set of perceptions, acknowledging positive and negative components of each sector, emerged.

Discussion

The key concepts arising from this study focussed around issues of trust and the acceptability of health services, which includes discipline, responsiveness, assurance, respect and dignity, choice of health care provider, confidentiality and communication .Currently within the introduction of a National Health Insurance

(NHI) system in South Africa, trust and acceptability of health services are crucial determinants of the extent of the buy-in that the public will demonstrate towards the planned changes.

ACKNOWLEDGEMENTS

I am most appreciative of the time, support, and guidance given to me by so many. The following people need special mention.

To the people who contributed most to this study, the participants, thank you for your involvement and willingness to share your experiences with me. I have learnt so much from listening and trust that the time and effort you put into this study will result in benefits to all health service users.

A special thank you goes to my current research supervisor, Bronwyn Harris as well as my previous research supervisor, Ermin Erasmus, thank you for your consistent support, assistance and dedication to this study.

TABLE OF CONTENTS

DECLARATION ii
DEDICATION iii
ABSTRACT iv
ACKNOWLEDGEMENTS vi
TABLE OF CONTENTS vii
LIST OF TABLES x
ABBREVIATIONS xi
CHAPTER 1: INTRODUCTION 1
INTRODUCTION TO THE STUDY 1
LITERATURE REVIEW 3
THE HISTORICAL CONTEXT OF THE SOUTH AFRICAN HEALTH SYSTEM 3
Development of the Private Health Sector 3
Fragmentation of the Public Health Sector 4
The time for change: Democracy and the South African Health System 6
The current South African health system 7
The Inception of the National Health Insurance system (NHI) 11
UNDERSTANDING PERCEPTIONS OF THE SOUTH AFRICAN HEALTH SYSTEM 13
Quality of care 14
Trust 16
Value for money 19
Respect and dignity 20
RATIONALE 22
AIM OF THE STUDY 22
STATEMENT OF THE PROBLEM 22
Complement existing evidence 22
PURPOSE OF THE STUDY 23

Health system responsiveness 23
OBJECTIVES OF THE STUDY 24
CHAPTER 2: MATERIALS AND METHODS 25
STUDY DESIGN 25
PARTICIPANT SELECTION 26
STUDY SAMPLE 27
PROCEDURE 29
DEVELOPMENT OF A TOPIC GUIDE 30
DATA COLLECTION 31
DATA ANALYSIS 32
TRUSTWORTHINESS 34
DEPENDABILITY 34
CONFIRMABILITY 34
REFLEXIVITY 34
ETHICAL CONSIDERATIONS 36
CHAPTER 3: FINDINGS 37
THEME 1- BEAUTY AND THE BEAST: THE PRIVATE-PUBLIC SPLIT 41
Hospital hospitality and the cared-for patient 41
'You take what you get and play by their rules': the disempowered public patient vs. the empowered private patient 46
THEME 2- BEAUTY BECOMES THE BEAST AND THE BEAST BECOMES THE BEAUTY: THIN LINE BETWEEN GOOD AND BAD 47
Is the private health sector all that good and the public sector all that bad? 48
THEME 3-The unconvinced service user: trust and confidence in the public health sector 52
The lesser of the two evils 52
CHAPTER 4: DISCUSSION 54
DISCIPLINE 56
RESPONSIVENESS AND ASSURANCE 57
COMMUNICATION AND MANAGEMENT 58

Convincing the public 59
Origin of perceptions 60
LIMITATIONS TO THE STUDY 61
CHAPTER 5: CONCLUSION AND RECOMMENDATIONS 63
APPENDIX A: FOCUS GROUP TOPIC GUIDE 73
APPENDIX B: PARTICIPANT DEMOGRAPHIC INFORMATION 75
APPENDIX C: PARTICIPANT INFORMATION SHEET 77
APPENDIX D: CONSENT FORMS 80
Declaration By Participant 80
Declaration By Researcher 82
APPENDIX E: ETHICAL CLEARANCE CERTIFICATE 83
APPENDIX F: VIEWS ABOUT PRIVATE AND PUBLIC HOSPITALS 84

LIST OF TABLES

Table 1: Constitution of focus groups 38

Table 2: Demographics of focus group participants 39

Table 3: Themes and sub-themes 40

Table 4: Views about private and public hospitals 84

Table 5: Views about private and public hospitals, based on expectations 87

Table 6: Staff knowledge, attitudes and skills 88

Table 7: Efficiency, system preparedness and organization 90

Table 8: Accountability in the private and public hospitals 91

Table 9: Accountability and profit in the private hospitals 93

Table 10: The power to complain in private and public hospitals 94

Table 11: Disempowerment in the public hospitals 95

Table 12: Money/Cost and expectations in private and public hospitals 96

Table 13: Quality of medication in private and public hospitals 97

Table 14: Personification of private and public hospitals 98

Table 15: Affordability of private and public hospitals 99

Table 16: Over-servicing in private hospitals 101

Table 17: Working conditions and impact on productivity in private and public hospitals 102

Table 18: Trust in the public hospitals 104

Table 19: Recommendations and possible considerations for the future in order to improve the condition of the public hospitals 105

ABBREVIATIONS

CIET - Centro de Investigacion de Enfermedades Tropicales (Tropical Disease Research Centre)

DOH- Department of Health

NHI - National Health Insurance

PHC - Primary Health Care

SACBIA -South African Costs and Benefit Incidence Analysis

WHO -World Health Organization

CHAPTER 1: INTRODUCTION

The purpose of this chapter is to provide an overview of the key issues pertaining to perceptions that people have about public and private hospitals in South Africa and how those perceptions may have been formed over time. Understanding these perceptions is important both in achieving health system responsiveness and in the South African context of contemporary health system reform. In addition to reviewing the literature about existing perceptions and the importance of understanding them, this chapter will also present a brief account of the evolution of the public and private health sectors in South Africa, looking at historical as well as current issues in an effort to contextualise the perceptions documented and discussed.

INTRODUCTION TO THE STUDY

Recently, the South African health system has begun introducing policies and programmes to facilitate moving towards mandatory health insurance in the form of a National Health Insurance (NHI) (Ministry of Health, 2011). Together with a strengthened primary health care service, *public* hospitals will be a key component of the proposed NHI system, providing, for most citizens, the only available hospital care (given the unaffordability of private hospital services) (McIntyre, 2007a; McIntyre, 2009b). At the same time, private sector reform is visualised to take place alongside changes in the public sector in order to transform, the health system as a whole (Ministry of Health, 2011). Perceptions of poor quality of health care may

dissuade patients from using the available services because health concerns are among the most significant of human concerns (Lafond, 1995). Ensuring good quality of care is not only important because of the NHI; rather, it should be a goal of any well-functioning health system. However, in the present South African context of NHI, it is important to understand perceptions that people have about both public and private hospitals in South Africa not only to build quality services but also, because ultimately it is the public – as beneficiaries and contributors to the healthcare system – who will be affected by the NHI and who will affect its implementation. The extent to which the NHI will be acceptable to society is critical to its success. For the planned NHI to be feasible, the general public has to feel confident about using the public sector (McIntyre, 2009a; Goudge, 2012). Confidence can be demonstrated by, among other things, public willingness to access public hospitals (as well as primary services) as their provider of choice. Choice of health service providers is influenced not only by cost and affordability, but also by perceptions and experiences of public and private sector health care available (Broomberg, 2006).

To provide insight into how certain perceptions of private and public hospitals have developed, it is important that the historical context of the South African health system be reviewed as a backdrop to this research report, in that it has played a major role in shaping both the current health system and access to health care.

LITERATURE REVIEW

THE HISTORICAL CONTEXT OF THE SOUTH AFRICAN HEALTH SYSTEM

Historically, South Africa's health system has been characterised by two parallel sectors, the private and the public sectors. This division has largely mirrored a socio-economic fragmentation in the health system, in which a minority of the relatively wealthy have access the private health sector for all of their care requirements and are usually covered by private health insurance (medical schemes). At the same time, the majority of the population is mostly-dependent on under-resourced, tax-funded public sector health facilities, especially for hospital-based, inpatient care (McIntyre and Gilson, 2002; Coovadia et al., 2009; Ataguba and Akizili 2010; Ataguba and McIntyre 2012). The public health system has been, and remains, overburdened by the volume of users (Ataguba and McIntyre, 2012) and there is an inequitable distribution of resources between the public and private sectors relative to the population served by each (Schneider et al., 2007; McIntyre et al., 2007a; Ataguba and Akazili, 2010; Ataguba and McIntyre, 2012).

Development of the Private Health Sector

Historically, private hospitals were initially limited to non-profit mission hospitals, which were located in rural areas, and industry facilities such as on-site hospitals at large mines (McIntyre et al., 2007a; Coovadia et al., 2009). General private for-profit hospitals are a more recent development, with particularly rapid growth since the 1980's. The number of for-profit general hospital beds increased by 87% between 1988 and 1993 between the three large private hospital groups in South

Africa (Schneider et al., 2007; McIntyre, 2007b; Coovadia et al., 2009; Mills et al., 2012).

Private practice by medical doctors and most other health professionals has always been permitted in South Africa and many private specialists now locate their consulting rooms within private hospitals and admit their patients to these hospitals, creating a beneficial relationship between the two, further fuelling the growth of the private sector. Most for-profit private providers are now heavily concentrated in the metropolitan and other large urban areas (McIntyre et al., 2007a; Coovadia et al., 2009)

This trend of rapid growth in the private sector which has continued since 1994 and the private-public split it has created remains one of the biggest challenges to achieving health equity; a central concern of the new NHI policy reform (McIntyre et al., 2007b; Coovadia et al., 2009).

Fragmentation of the Public Health Sector

The public health system was racially and structurally fragmented until the first democratic elections in South Africa in 1994. The fragmentation was evidenced in the structure of the public sector, which had a range of public sector health authorities, including health departments, at national level and associated regional offices within each of the four former provinces (Cape, Orange Free State, Natal and Transvaal) as well as the ten former ‘homelands’. These authorities were in keeping with the ethnic and population divisions of the apartheid state (Schneider et. al., 2007; McIntyre et al., 2007a, Coovadia et al., 2009).

Massive inequalities in public sector health services also existed, with health service provision biased towards historically 'white' areas while 'black' geographic areas were systematically under-funded as a result of apartheid policies (McIntyre et al., 2007b). The usage of private and public services was also skewed racially, where the majority of the 'white' population was using the private sector and the majority of the 'black' population using the public sector (McIntyre et al., 2007a; Coovadia et al., 2009).[1]

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[1] The choice of terminology in referring to populations as 'black' or 'white' is rooted in the country's history and indicates a statutory stratification of the South African population in terms of the former Population Registration Act. The use of these terms does not imply the legitimacy of this racist terminology, but is necessary for emphasising the impact of former apartheid policies on the South African health system. The Population Registration Act of 1950 was introduced by the National Party in an attempt to produce a more orderly and rigid system of racial classification (Posel, 2001).This act allowed for people to be classified as white, native or coloured. According to the act, the definitions were as follows:

> "A 'white person' is one who in appearance is, or who is generally accepted as, a white person, but does not include a person who, although in appearance obviously a white person, is generally accepted as a coloured person. (Section 1 [xv],
>
> "A 'native' is a person who is in fact or is generally accepted as a member of any aboriginal race or tribe of Africa. (Section 1 [x]).
>
> A 'coloured person' is a person who is not a white person or a native. (Section 1 [iii])" (Population Registration Act, 1950 as cited in Posel, 2001, p 102).

The time for change: Democracy and the South African Health System

With the newly elected democratic government in 1994 came policy frameworks and priority issues which were spelt out in the White Paper for the Transformation of the Health System in South Africa and later legislated via the National Health Act, which was finally promulgated in 2004. The White Paper emphasized the need to promote equity, particularly in relation to redressing the historical inequities which arose as a result of apartheid policies. It also noted that there was a need to "establish health care financing policies to promote greater equity between people living in rural and urban areas and between people served by the public and private sectors" (Department of Health, 1997).

The new Constitution, which was formally adopted in 1996, resulted in the creation of nine provinces, which integrated the former provinces and 'homelands'. The public health system was streamlined into a single Department of Health at the national level and one in each of the nine provinces. Responsibilities were distributed between three tiers of government, namely national, provincial and local (district and sub-district) in relation to health services (National Health Act, 2004). In addition to health department restructuring, the public sector embarked on a range of efforts to redress some of the equity and efficiency challenges inherited in 1994, by, for example, removing user fees for children younger than 6 years and pregnant

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Later, natives were referred to as 'blacks' or 'africans' and an additional classification for 'indians' was included. This classification is still used on official documents and, given that inequality remains racialised, is used in this study.

women, and instituting a primary health care (PHC) facilities' "building and upgrading" programme (Schneider et al., 2007; McIntyre et al., 2007a; Coovadia et al., 2009).

In 2006, a "Charter of the Public and Private Health Sectors" was finalized, the purpose of which was to outline how both sectors would contribute to transforming the health system. While the process of developing the Charter strengthened interaction between government and the private health sector and resulted in some concrete strategies, there is still considerable uncertainty about how the intention of this White Paper (carried over more recently into the planned NHI reforms) to unite the public and private sectors will be achieved (McIntyre et al., 2007a, Coovadia et al., 2009).

The current South African health system

Eighteen years since the inception of democracy, there are still inequities in the health system. The distinct split between the private and public sectors remains, with vast discrepancies in the resources consumed by each. Private hospitals, for example, consume a large proportion of health resources, while serving only a small percentage of the population (McIntyre et al., 2007 b, Coovadia et al., 2009; Ataguba and McIntyre, 2012). Less than 15% of the population belongs to private sector medical schemes, yet 46% of all health care expenditure is attributed to these schemes (Macha et al., 2012). In 2005, annual expenditure on medical schemes and out-of-pocket payments was approximately R9500 per beneficiary. A further 21% of the population use the private sector on an out-of-pocket basis mainly for primary level care, but are generally dependent on the public sector for

hospital care (expenditure per head R1500 per person in 2005) (Coovadia et al., 2009).The remaining 64% of the population are entirely dependent on the public sector for all their health care services (less than R1300 was spent per person for government primary care and hospital services in 2005) (McIntyre et al., 2007a; Coovadia et al., 2009).

The socio-economic status of an individual in South Africa can be seen as one of the primary determinants of whether they will use the public or private health sectors (McIntyre et al., 2007 a, McIntyre et al., 2007 b). This is because private hospital services generally cost much more than services at public hospitals and are therefore only accessible to relatively wealthy households and those with private health insurance (Matsebula and Willie, 2007; Ataguba and Akazili, 2010; Ataguba and McIntyre, 2012). Indeed, medical scheme membership may be an even more important determinant of private sector utilisation than socio-economic status (McIntyre et al., 2007 a). This is because medical scheme membership is usually offered as part of an employment package, thus someone in a minimum wage job can have basic medical scheme coverage and be able to access a private hospital. Such membership is almost exclusively restricted to formal sector workers, and sometimes their dependants too (Ataguba and Akazili, 2010; Ataguba and McIntyre, 2012). This therefore means that the under-resourced public hospitals are left to cater for the majority of the population, who are unable to afford private health care. Additionally, a vast majority of out-patient visits by the poorest 60% of the population are within the public sector while the reverse is true for the richest 20% of the population, that uses the private sector substantially more than the public sector (McIntyre et al., 2007 a; Ataguba and McIntyre, 2012).

There is marked variation in the general condition of public and private hospitals in South Africa. Generally, private hospitals have been found to be better equipped in terms of resources, staffing and infrastructure (Zwi et al., 2001; McIntyre et al., 2007a). In contrast, a government- commissioned “facilities’ audit” conducted soon after 1994 found that many state facilities were in poor condition, with one-third requiring complete replacement or major repair (Schneider et al., 2001).

There have however been programmes since 1994 to renovate and revitalise public hospitals and clinics, particularly in the rural areas. Over this time 1,345 new clinics have been built and 263 upgraded, improving the availability of health care services (Schneider et al., 2007; McIntyre et al., 2007a; Coovadia et al., 2009).

Human resources are similarly maldistributed between the private and public sectors. It has been reported that 79% of doctors work in the private sector, with one specialist doctor serving less than 500 people on average in the private sector but nearly 11,000 people in the public sector (McIntyre et al., 2007a; McIntyre et al., 2009b). There has also been a substantial decrease in the nurse-to-population ratio in the public sector, from 149 professional nurses per 100,000 population in 1998 (Day, 1998) to 110 per 100,000 population in 2007 (Coovadia et al., 2009). The ratio between patients and health workers does not only reflect shortages, but has led to reduced quality of care, demotivation among health workers and has had a negative impact on health worker attitudes (McIntyre et al., 2007a).

Ongoing and worsening staff shortages, particularly of skilled health workers have placed additional strain on the health system, especially the public hospitals. “Demoralised and demotivated are common descriptors of health care providers

and many are making use of opportunities to leave the public health system" (Schneider et al, 2007, p.296).

The literature also shows that in less developed countries health care providers in the public sector tend to earn far less than those in the private sector (Stillwell et al., 2004). Combined with the range of other factors influencing health worker morale in the public sector, this may affect the quality of care received by public sector patients.

A number of policies aimed at improving the relations between health care workers and patients have been instituted because rudeness, random acts of unkindness, physical assault, and neglect by nurses have been widely reported (McIntyre et al., 2007a, Coovadia et al., 2009). These policies include the *Batho Pele Strategy*, a *Patients' Rights Charter*, and other interventions such as client satisfaction surveys and complaints boxes; however the evidence demonstrates that very little has changed over this time (Schneider et al., 2007; McIntyre et al., 2007a; Coovadia et al., 2009). The ethos where patients are treated as subjects to be disciplined, rather than citizens with rights, still seems prevalent amongst some service providers (Modiba et al, 2001, Schneider et al., 2007; McIntyre et al., 2009a; Coovadia et al., 2009). Public sector health workers in South Arica are frequently described as cruel and uncaring with no regard for patient confidentiality (Modiba et al, 2001). This has fuelled perceptions that the public health system is strained, under-resourced and has 'worsened' over time (Schneider et. al., 2007).

The Inception of the National Health Insurance system (NHI)

Health system reform and the idea of mandatory health insurance have been on the table since the 1930's in South Africa, as noted by the Collie Committee of Enquiry (1936) (McIntyre et al., 2009a). The possibility of introducing mandatory health insurance was re-raised by progressive academics in the early 1990s and was formally incorporated into the African National Congress's National Health Plan (African National Congress, 1994; McIntyre and Gilson 2002; McIntyre et al., 2007a). The Taylor Committee of Inquiry into a Comprehensive System of Social Security for South Africa (2002) proposed that a comprehensive package of services be covered and that South Africa move ultimately toward a NHI system that integrates the public sector and private medical schemes within the context of a universal contributory system (Taylor, 2002; McIntyre et al., 2007 a; Van den Heever and McIntyre, 2007).

After various efforts to introduce mandatory health insurance post-1994, a resolution to implement a National Health Insurance system was finally taken at the ANC Conference in Polokwane in December 2007 (McIntyre et al., 2009a). The Ministerial Advisory Committee on National Health Insurance was established in August 2009 to carry forward this resolution. It was tasked with providing the Minister of Health and the Department of Health with recommendations regarding relevant health system reforms and matters relating to the design and roll-out of National Health Insurance (Ministry of Health, 2011).

The health policy landscape was fundamentally changed in August 2011 with the release of the much-anticipated Green Paper on NHI. The Green paper stipulates:

> “South Africa is in the process of introducing an innovative system of health care financing with far reaching consequences on the health of South Africans. The National Health Insurance commonly referred to as NHI will ensure that everyone has access to appropriate, efficient and quality health services. It will be phased-in over a period of 14 years. This will entail major changes in the service delivery structures, administrative and management systems” (Ministry of Health, 2011, p4).

The Green Paper further stipulates that:

> To successfully implement a health care financing mechanism that covers the whole population such as NHI, four key interventions need to happen simultaneously:

- a complete transformation of health care service provision and delivery
- the total overhaul of the entire health care system
- the radical change of administration and management
- the provision of a comprehensive package of care underpinned by a re-engineered Primary Health Care (Ministry of Health, 2011).

Transitioning from the divided public and private health care systems to a single national system based on universal coverage – access to care based on need rather than ability to pay- would, as the Green Paper intimates, require a “well articulated implementation plan” (Gray et al, 2011, p5). While not providing a

detailed plan, the draft policy document outlines some of the elements which will be executed in a three-phased approach:

- phase 1 (2011-2015) –establishment of the Office of Standards Compliance(OHSC), piloting of the new system with an emphasis on improving quality care, development of NHI district management and governance structures, refining the costing model;
- phase 2 (2016-2010) – the key features of this phase are further real life demonstration and further contracting of independent providers which includes the accreditation and contracting of general practitioners and networks, public and private hospital accreditation; and
- phase 3 (2021-2025) – marked by 'maturing of the plans outlined in phase 2, including hospital reimbursement reforms, population registration as well as the production of NHI cards (Ministry of Health, 2011, Gray et al., 2011).

UNDERSTANDING PERCEPTIONS OF THE SOUTH AFRICAN HEALTH SYSTEM

Co-existing with the inequitable health system in South Africa and the concentration of resources in the private sector are strong public perceptions about public and private hospitals (Broomberg, 2006; McIntyre, 2007b, McIntyre et al., 2009a). There is often an almost automatic perception that private hospitals are better than public hospitals. It is not uncommon for people to think and feel negatively about public hospitals as can be seen, for example, in the many media reports regarding poor

quality of services in public hospitals, resource shortages, staff attitudes and poor cleanliness (*The Star*, Jan 30, 2012; *The Star* July 27, 2012).

Perceptions about health care delivery can be examined along various dimensions, including service quality, responsiveness, patient satisfaction, staffing, and cleanliness of facilities (Holthof, 1991; Kalda et al., 2003; Sandoval et al., 2007). Understanding how these dimensions are perceived can make a valuable contribution to health care strategic planning and to health authorities' decision-making processes (Kalda et al., 2003; Sandoval et al., 2007). Additionally, this understanding can assist in targeting the needs of specific patient groups, for example, those at risk of having worse experiences in a hospital (Nguyen Thi et al., 2002).

Considering patient perceptions can assist in focusing care quality programmes, (Nguyen Thi et al., 2002). Understanding of public perceptions can also help inform the work of health care policy and decision-makers, particularly in relation to resource allocation decisions (Sandoval et al., 2007). Perceptions may also inform the choice of service provider (Sandoval et al., 2007), and this is important in the South African context of policy reform, which seeks to overcome the public-private split.

Quality of care

Perceptions of poor quality of health care may dissuade patients from using available services. In Nepal in the 1990s, for example, it was found that despite the government having made substantial investments in health care to increase access, utilization of facilities remained low because of clients' negative perceptions of

quality (Lafond, 1995). This may be because health concerns are among the most salient of human concerns and people actively ‘seek out’ quality care, while avoiding care perceived to compromise or undermine their health (Lafond, 1995).

Studies conducted in other developing countries such as Bangladesh similarly reveal that, while increasing access and reducing costs are important, perceived quality of health care services has a relatively greater influence on service user satisfaction (Andaleeb, 2001). Andaleeb (2001) also found that in Bangladesh private hospitals were perceived to offer better quality of care than public hospitals because of the high concentration of resources in the former. Private hospitals are often felt or assumed to be more desirable destinations for care, while public hospitals are often associated with negative images.

In South Africa, the 2nd Kaiser Family Foundation National Household Survey on health care (Community Agency for Social Enquiry - CASE, 1999) documented public perceptions regarding health policy, health status, health care utilisation, access and barriers to access as well as the quality of health care. Results pointed to significant differences between the experiences of respondents using public facilities and those using private facilities. Those visiting a private facility were more likely than those attending a public facility to rate that facility as ‘excellent’: - 45% versus 19% at a primary-level and 59% versus 14% at a secondary-level. Fifty two percent of those who visited a private rehab/chronic facility gave the facility a rating of excellent, compared to 18% of those who visited a public facility (Kaiser Foundation, 1999). A social audit commissioned by the Gauteng Provincial Government in 2003 and designed to evaluate the performance of health services

in the eyes of the public found that slightly more than half of respondents were satisfied with health services (Gauteng DOH and CIET, 2003)

A more recent study – the South African Costs and Benefit Incidence Analysis (SACBIA) study by McIntyre et al., (2009b) - revealed that there is dissatisfaction among South Africans with *both* the private and the public sectors of the health system. Concerns about public sector services were primarily related to patient-provider engagements, cleanliness of facilities and drug availability, while the affordability of medical schemes and how the profit motive affects private providers' behaviour, were raised as issues regarding private sector care (McIntyre, 2009; McIntyre et al., 2009b).

Trust

Studies have also shown that if a health system cannot be trusted to guarantee a threshold level of quality, it will remain underutilized. A 1987 World Bank assessment of the health sector in Bangladesh found that real constraints in the form of an absence of critical staff, unavailable essential supplies, inadequate facilities and poor quality of staffing fed public distrust in the system and affected utilisation rates. It remains imperative for health care providers to focus on, and deliver, quality services in order to maintain or regain patient confidence and trust, as well as for the system to increase resources and address other barriers to care (Andaleeb, 2001).

In Sub-Saharan Africa, public views on health care have been investigated on a large scale through the Afro barometer, which, in 2005, carried out a survey in 18 African countries, including South Africa, Zimbabwe, Mali and Zambia. It explored

the determinants of public satisfaction and dissatisfaction with health and education services across the countries surveyed, finding that public satisfaction was affected by accessibility of services, “user-friendliness”, the position of the user in the social structure, service experiences, and encounters with providers as well as corruption or dishonesty of service workers (Bratton, 2007).

Specific problems encountered with public hospitals or clinics included long waiting times due to overcrowding reported by 73% of public hospitals and clinic users. Sixty six percent experienced shortages of medicines and 54% encountered problems with absent doctors. Fifty three percent of respondents encountered problems with staff who behaved disrespectfully towards them, while 52% of respondents reported that the fees for consultations or medicines were too expensive. A third of the respondents said they encountered substandard (“dirty”) health facilities and a quarter had received demands from health care workers for illegal payments (“bribes”) (Bratton, 2007).

Given the history of enforced racial segregation in South Africa, perceptions may still be influenced by race. A study by Myburgh et al., (2005) examining patient satisfaction, access and barriers to health care, and attitudes towards health policy revealed that white South Africans – the racial group most advantaged in the pre-democracy era in South Africa - were 1.55 times more likely to report excellent service in health care than their black African counterparts (most systematically disadvantaged during apartheid). Possible explanations for this difference may include differences in client values, including how they expect to be attended to by the health care provider. It could also be that the actual treatment provided might

have been different because of the race or class influence on the patient-provider dynamic or because white and wealthy people, are more likely to access private hospitals, which as previously stated, are better resourced than public hospitals (Myburgh et al., 2005).

Among all private sector visitors, whites were somewhat more likely to rate the facility they visited as excellent: - 53% of whites compared to 42% of Africans and 39% of coloureds using a private facility gave a rating of excellent (Kaiser Foundation, 1999). The Kaiser Foundation study also revealed that across all race groups, utilisation of public hospital facilities was significantly more common than private hospitals when seeking primary care. It was found that 94% of Africans, 82% of coloureds and 77% of Indians relied almost exclusively on public hospitals when visiting hospitals in the past year, while 75% of their white counterparts went to private hospitals.

Another aspect of quality of care that the Kaiser Foundation survey (1999), the Gauteng Department of Health and Centro de Investigacion de Enfermedades Tropicales (Tropical Disease Research Centre) (DoH and CIET) survey, as well as the SACBIA study by McIntyre et al., (2009), sought to assess was perceptions amongst those who had actually *used* a health service recently, especially in light of media reports and stereotypical portrayals of public sector health services as poor in quality. Overall, users of private hospital inpatient care more frequently reported being satisfied or very satisfied than public hospital users. Even so for public services, between 75% and 90% of inpatient users reported being satisfied or very satisfied, depending on the aspect of quality care and the hospital type. There was

greater satisfaction with district hospitals on most issues compared to regional, tertiary and central hospitals. Waiting time was the source of the greatest dissatisfaction, but there were also concerns about lack of confidentiality, poor privacy in consultations and disrespectful treatment by staff, particularly in public hospitals (Kaiser Foundation, 1999; Gauteng DOH and CIET, 2003; McIntyre et al., 2009b).

Value for money

General views on the public and private health sectors as sought by the Kaiser Foundation study demonstrated that only 57% of respondents felt that private providers provide care that is really needed, with 43% concerned about how the profit motive affects private providers' behaviour resulting in over servicing. Yet, those who reported they had been admitted to a private hospital within the previous year were most likely to feel that private providers only provided needed treatment.

In the SACBIA study, (McIntyre et al., 2009b) approximately half of respondents felt that private health care was too expensive relative to what was received, indicating that there are concerns regarding value for money. Both surveys, however found a relationship between how people responded and their socio-economic status, with the majority of the richest quintile feeling that although private care is expensive, it is worth paying for. This was also the case for medical scheme members relative to non-members. Additionally, respondents who had been inpatients in a private hospital in the previous year were more likely to view private care as being worth the extra cost (62% and 64% in the Kaiser Foundation and SACBIA study respectively). Those without personal experience were more likely to view private

care as being too expensive relative to the quality of care received (Kaiser Foundation, 1999; McIntyre et al., 2009b).

Respect and dignity

Perceptions of whether patients are treated respectfully and with dignity are also important for understanding the acceptability of health care and its representation (Gilson, 2007). In relation to general views on the public sector, just over half of respondents in both the Kaiser Foundation and SACBIA surveys expressed the view that patients at public hospitals are rarely treated with respect and dignity (Kaiser Foundation, 1999; McIntyre, 2009; McIntyre et al., 2009b). A higher percentage (63% and 66% In the Kaiser Foundation and SACBIA study respectively) of respondents in the highest income quintile, and medical scheme members, also held this opinion.

Users of private hospitals had a more negative view of public hospitals. This may highlight the importance of distinguishing between views based on perceptions and those based on actual experience (Kaiser Foundation, 1999, McIntyre 2009a, McIntyre et al., 2009b). Indeed, more than half of those who had been admitted to a public hospital within the past year were of the view that patients were usually treated with respect and dignity in these hospitals. However, more than half of those using outpatient services at a public hospital in the past year indicated that respectful treatment was rare (Kaiser Foundation, 1999; McIntyre, 2009a; McIntyre et al., 2009b). The Gauteng DoH and CIET survey reported a higher percentage (90%) of participants who raised a concern with the attitudes of health workers and regarded this as ‘bad service’ (Gauteng DoH and CIET, 2003).

Differences may also emerge in the relative emphasis placed on different aspects of care according to how recently respondents actually used a public sector hospital. Those who had recently used a public sector hospital ranked the following aspects more highly than respondents who had never used a public hospital or had used one more than a year ago -: good communication between provider and patient, availability of drugs and provision of patient transport (Kaiser Foundation, 1999). Similar findings emerged in the SACBIA study where the nature of staff-patient engagements and communication, as well as cleanliness of the facility and the availability of drugs, was regarded by respondents as being of particular importance (McIntyre et al., 2009b). Users of public hospital inpatient care reported waiting time as the source of greatest dissatisfaction, but there were also concerns about a lack of confidentiality, privacy in consultations and respectful treatment by staff (McIntyre et al., 2009b).

It is important to recognise the various perceptions that people hold of public and private hospitals and to understand these in light of contemporary health system reforms in South Africa. The success of the NHI will rest, in part, on improving integration between the public and private sectors as well as on improved quality of care delivered in the public sector.

RATIONALE

AIM OF THE STUDY

The aim of the study is to understand perceptions that the public have about private and public hospitals in South Africa as well as their preferences for health care providers.

STATEMENT OF THE PROBLEM

Complement existing evidence

There is limited evidence and few studies on perceptions regarding public and private hospitals in South Africa. Most studies to date, including the Kaiser Foundation (1999), SACBIA study (2009), and Gauteng DoH and CIET surveys (2003), have been largely quantitative in nature, structured according to categories such as satisfaction, cleanliness, access, service quality, views of corruption, and information about health services.

Existing studies have also mainly centred on perceptions of particular health programmes and not necessarily on general perceptions. A differentiating feature of this study is that it generates insights about perceptions of public and private hospitals in a very open-ended, qualitative way. In this more open-ended exploration participants were given an opportunity to express their perceptions and the mental images they have of these hospitals. Through its explorative nature, the study aimed to get richer more fully fleshed out and contextualised experiences than is possible through the use of a structured questionnaire (Ulin, 2004). Focus

groups were used to explore these perceptions and elicit valuable contextual information to assist in explaining particular findings (Gaskell, 2000).

PURPOSE OF THE STUDY

Health system responsiveness

This study is important because it provides useful information about how people perceive private and public hospitals and their choice of health care providers. It also provides insights into what the public believe should be done in order to improve the condition of public hospitals. Globally, service responsiveness has been highlighted by the World Health Organisation (WHO) as one of the important objectives that countries should strive towards in order to improve health system performance (WHO, 2000). Exploring the perceptions, feelings and images that people have around public and private hospitals can provide insight into what the public expect from the health system, especially in light of current policy reform and the introduction of a NHI system in South Africa.

As recipients of health care services, as well as funders thereof (through, for example the tax system, contributions to medical schemes, and out-of-pocket payments) peoples' perceptions and evaluations must be explored and understood in order to facilitate strategic decision making and design effective service delivery systems that meet people's needs (Andaleeb, 2001). Information from this research could also be used towards addressing negative perceptions and strengthen positive impressions.

OBJECTIVES OF THE STUDY

- To explore the range of perceptions and images that the public have about private and public hospitals
- To explore differences in perceptions based on race, and recent or non-recent direct experience of the private and/or the public sector
- To explore, in light of these perceptions, people's thoughts regarding their choice/preference of health service provider
- To explore the origins of the perceptions that the public have about private and public hospitals
- To make recommendations on what might be done to improve/change perceptions around public and private hospitals

CHAPTER 2: MATERIALS AND METHODS

The purpose of this chapter is to describe the qualitative research methodology used in order to answer the objectives set out for this study

STUDY DESIGN

Because of the exploratory nature of the study, a qualitative approach was used. Qualitative studies are designed to investigate the broader psychological, social, political or economic contexts in which research questions are situated (Ulin, 2004). This type of research typically begins with general open-ended questions, moving towards greater precision as detailed information emerges (Ulin, 2004). Qualitative research can direct researchers to underlying behaviours, attitudes and perceptions that influence health outcomes and can help to explain social and programmatic obstacles to informed choice or the use of services (Ulin, 2004). In using this approach, researchers can be provided a more in-depth understanding of perceptions that people have and more valuable contextual information to assist in explaining particular findings (Gaskell, 2000). A basic premise of qualitative logic is that ‘who’ a person is- their identity and social position- influences how they interpret and respond to things, events and interactions. Therefore people with different life contexts may respond differently to the same experience (Ulin, 2004).

The data were collected through the use of focus group discussions, which elicit subjective understandings in a collective process (Ulin, 2004). Focus groups

encourage open conversation and facilitate the expression of ideas and experiences as well as draw upon participants' attitudes, feelings, beliefs, experiences and reactions that might have been left underdeveloped in one-to-one interviews, questionnaires, observations or surveys (Kitzinger, 1996; Gibbs 1997). Not only are knowledge and experiences explored but also what people think, how they think and why they think that way (Kitzinger, 1996), important for the purposes of this research, which is interested in the social context of public perceptions.

Focus groups, in their nature, are group discussions designed to explore a specific set of issues and the group is 'focused' in the sense that it involves some kind of collective activity, facilitated around a specific set of issues (.Kitzinger, 1996; Gibbs 1997). Additionally, group participants provide an audience for each other and thereby encourage a greater variety of communication and interaction. While opinions are not always initially available or easy for people to articulate, these may emerge in such an interactive setting as others talk (Robinson, 1999).

These focus groups were constituted using the following criteria:

- Race, with a focus on black and white participants, and a person's past experience/s with public and private hospitals.

PARTICIPANT SELECTION

The study population was members of the black and white public with recent direct experience of either a private or public hospital, as well as those without recent direct experience of either type of hospital. The participants were required to have

basic communication skills in English or Sotho, languages spoken by the researcher.

STUDY SAMPLE

Perceptions about private and public hospitals cannot be understood outside of context. Context refers not only to the physical setting in which a behaviour, attitude, or process takes place, but also the historical, social, political climates and the organisational or individual characteristics that influence it (Ulin, 2004). While sensitive to the issues around transformation in South Africa, the researcher opted to have separate focus groups for black and white research participants. Firstly, because of the injustices of the past and continuing inequities in South Africa, it was likely that black and white people would generally have different experiences of accessing hospitals. In order to encourage free discussion and idea sharing in the focus groups, it made sense to put people together if they were, on balance, likely to share similar racial identity. Secondly, the topic is sensitive and political because it is linked to inequities in society (which remain racialised, albeit in a complex way) and it was anticipated that participants may have wanted to reflect on negative experiences. Thus a situation where, for example, black and white respondents engaged in political arguments was avoided. Such dynamics would have been negative for those involved, and would have also made the groups very difficult to manage and would have been detrimental to the research.

Furthermore, participants were also divided up according to their experiences with public and private hospitals. This was done to see whether recent experience with a private or public hospital would have any influence on the perceptions that the

participants held about the hospitals. Some focus groups were made up of participants with recent, direct experience of a hospital (defined as their own direct experience of being admitted in the previous year, or that of a friend or relative close to them). Other groups contained participants with no such recent, direct experience. Again, the idea was a homogenous group in terms of their type of experience.

There was no further grouping of respondents through other variables such as gender or socio-economic status. This would have necessitated an increase in the number of focus groups, which would not have been feasible in the context of a Master of Public Health (MPH) project.

Using the above guidelines, the following focus groups were constituted:

- Private Hospital Users:

Group 1: Black participants with recent direct experience of a private hospital

Group 2: Black participants with no recent direct experience but would choose to go to a private hospital if they were to require health care now

Group 3: White participants with recent direct experience of a private hospital

Group 4: White participants with no recent direct experience, but would choose to go to a private hospital if they were to require health care now

- Public Hospital Users:

Group 5: Black participants with recent direct experience of a public hospital

Group 6: Black participants with no recent direct experience of a public hospital, but would choose to go to a public hospital if they were to require health care now

Group 7: White participants with recent direct experience of a public hospital

Group 8: White participants with no recent direct experience of a public hospital, but would choose to go to a public hospital if they were to require health care now

Because of the need to find people who had both recent and no experience of the private and public sectors (a complex configuration), 'word of mouth' and recommendations from potential participants - snowball sampling (Pope, 2005) - was used to recruit eight participants per group. The researcher first approached potential participants in social and work settings, for example, church / work. If these individuals were not eligible, they were asked to pass on the researcher's contact details to others who might be. These potential participants were asked to contact the researcher if they were interested in being part of the study. Once contact was made and suitability established, an appropriate time and venue that suited the participants, was established.

PROCEDURE

According to Greenbaum (2000), focus groups should be implemented using a discussion/topic guide that has been prepared in advance to ensure that the appropriate topics are covered in the session. A topic guide enables the facilitator to guide the discussion in order to fulfil the research aims, by directing and

encouraging the flow of discussion over important areas as well as ensuring that the discussion remains relevant to the topic (Robinson, 1999). Although this may seem like a semi-structured way of doing things, the open-ended nature in which the questions are posed and the nature of focus group discussions in themselves allows for more interactive dialogue and open expression of ideas as the participants hear other peoples' responses and are allowed to make additional comments as they go along (Robinson, 1999; Greenbaum, 2000).

DEVELOPMENT OF A TOPIC GUIDE

A topic guide was therefore developed and used to structure the anticipated themes (Appendix A). The topics included in the guide were derived on the basis of literature regarding public perceptions of private and public institutions generally. In this study it was directed at hospitals in particular.

The overarching question in the topic guide focused on perceptions about public and private hospitals and whether participants would use these same services in the future. The key points of discussion included quality of care, cleanliness, patient satisfaction, staff attitudes, the extent to which views were shared and commonly held within the group, origins of their perceptions, as well as what could be done to improve the state of the public hospitals. It was, however, the intention of the researcher to start with a very open-ended exploration and to allow for the emergence of any drivers of perceptions, regardless of these anticipated discussion points. Group members were encouraged to engage with one another, formulate ideas and draw out thoughts that had not been articulated previously.

Two pilot focus groups were held to test the focus group topic guide and to provide the opportunity for a practice run for the researcher.

DATA COLLECTION

Following the pilot groups, final adjustments were made to the topic guide and, between March 2009 and November 2011, eight focus groups were held, moderated by the researcher. The groups consisted of between four and eight participants and took place either in the evening during the week or on the weekends to accommodate working participants, at venues accessible by public transport, including homes of certain participants, a lecture theatre at the University of the Witwatersrand, the board room of a rehabilitation facility and at the researchers' parents' home. Participants were reimbursed for their travelling costs up to an amount of R50.

All participants completed a demographic information sheet (Appendix B), which captured demographic details such as gender, age and level of education. This enabled the researcher to provide a thorough description of the focus group participants. The discussions were carried out by the researcher, in English with the white participants and in Sotho and English with the black participants. All were audio recorded and each session was immediately translated and transcribed verbatim by the researcher. Translation from Sotho to English was confirmed with trusted Sotho-speakers to get consensus on the choice of terminology. This was important, as during the data analysis, meaning was derived from the participants' actual words.

DATA ANALYSIS

Thematic content analysis was used to explore the themes that both emerged from the data (inductive analysis) and through the preconceived categories based on the literature and research questions (deductive analysis). 'Atypical', as well as 'typical', themes were examined because an atypical case may yield insight into a problem or provide new leads for further enquiry, even if (or indeed because) it seems at odds with the 'norm' (Ulin, 2004).). An atypical or unique point of view may also represent a much larger group of study participants who were unwilling to express themselves fully in the group or were simply not represented in a particular focus group (Ulin, 2004).

Based on the literature about perceptions and public-private hospitals- both in South Africa and internationally- certain themes (such as quality of care) were anticipated and the data were analysed deductively. There is, for example, a supposed perception that public hospitals are inferior as compared to private hospitals (Andaleeb, 2001), and the indirect aim here was to explore whether this was a perception held, thus a deductive approach was incorporated. This approach according to Elo is suitable for use when testing known concepts (Elo, 2007); in this case the perceived inferiority of public hospitals to private hospitals. Also with the use of a topic guide some key points of discussion had been identified and were anticipated.

However, because knowledge regarding public perceptions of private and public hospitals in South Africa is relatively limited, theory grounded in the data (an inductive approach) was also used to derive categories and examine emergent

concepts (Starks, 2007). An inductive approach allows a move from the specific to the general, where immersion in text is carried out and particular phrases and comments made by the participants are observed, noted and meaning is derived from them and then combined into codes, labels, a larger category and a general theme (Ulin, 2004; Elo, 2007; Starks, 2007).

Inductive and deductive codes were identified and developed until saturation was achieved. Saturation occurs when themes and categories are well developed and further exploration of codes yields minimal or no new information to further challenge or elaborate on them (Giacomini and Cook, 2008). Links were drawn and analysed between different racial groups, direct past experience of private and public sector and future choice to utilise either service. Content areas and concepts were derived from the data. Data displaying was carried out, where data was laid out and an inventory constructed of what emerged from the focus groups as related to each theme, visually capturing the variation or richness of each theme (Ulin, 2004).

Primary coding - grounded in the text by using the words of the respondents – was initially carried out, followed by higher order coding to consolidate these primary codes. Thematic development then followed where the higher order codes were converted into themes and sub-themes.

TRUSTWORTHINESS

DEPENDABILITY

The methodological parallel to empirical ’reliability’ in a quantitative study is whether the results are dependable, whether the research process is consistent and carried out with careful attention to the rules and conventions of qualitative methodology. If the data are dependable, logically consistent patterns of response will be found (Ulin, 2004). In this study, the data were coded and analysed by both the researcher and supervisor in an attempt to establish consensus around the emerging themes.

CONFIRMABILITY

As a co-participant in the research process, the researcher needs to maintain a distinction between personal values and those of the study participants in order to minimise any possible influence of these values on the group discussions (Ulin, 2004). Applying reflexivity contributes to the confirmability of the results and is elaborated upon below.

REFLEXIVITY

Reflexivity refers to the ‘researcher’s critical self-awareness’ and is a vital process in which the researcher questions and observes themselves at the same time as they listen to, and observe, the participants (Ulin, 2004; Starks, 2007). This is important because firstly, in qualitative research the researcher is in partnership with the participants – working together to explore ideas and find answers - and secondly, because as the researcher listens to all participants, interprets and

responds to what they are saying, they – the researcher- are a key research instrument too, in other words, a researcher is not only absorbing information but also influencing how it is elicited and expressed (Ulin, 2004).

As a clinician who has worked in both the public and the private sectors, I often found myself agreeing with the views expressed by the participants during the focus group discussions and afterwards, in their analysis. Many of the negative representations of the public sector were the same complaints that my patients used to come to me with. Additionally, a close family member of mine was admitted to a public hospital during the data collection process of this study and I witnessed and experienced the neglect, poor staff attitudes and lack of information that some of the participants referred to.

I also found that the white participants seemed somewhat reluctant to express their views concerning public hospitals and their apparent negative association towards them – perhaps, I wondered, because I am a black South African and such criticism might be viewed as a negative reflection on South Africa's democracy or even racism? In contrast, the black participants seemed more comfortable expressing negative views but also their perceived racial discrimination experienced in the hospitals based on race.

To minimise the risk of me leading or overly influencing the participants, I made an effort to be conscious of my facial expressions and tone of voice when exploring views. And, during analysis, I constantly examined the issues that I found myself agreeing, or disagreeing, with, constantly questioning my interpretation along the way.

ETHICAL CONSIDERATIONS

Each participant was provided with an information sheet detailing the objectives of the study, which was also verbally explained (Appendix C). Written informed consent was obtained from each study participant; including permission to audio record the focus group discussions (Appendix D). These audio tapes were coded by numbers, followed by a description of how the groups were constituted, e.g. ‘white, choose private’. The audio tapes were stored on a secure server available only to the researcher and supervisor and will be kept for a period of up to six years as per University of the Witwatersrand policy, where after they will be destroyed.

Participants were informed that they may opt out of the study at any time and that, while complete confidentiality could not be guaranteed as the researcher was unable to control what participants discussed outside of the groups, confidentiality of the study participants would be ensured by not documenting individual participants’ names. Ethical clearance was obtained from the University of the Witwatersrand Committee for Research on Human Subjects (Medical). Ethical standards were maintained in the focus group discussions by ensuring that participants were not forced to share their views if they chose not to (see Appendix E).

CHAPTER 3: FINDINGS

The purpose of this chapter is to present the results derived from the eight focus group discussions. These groups were constituted as demonstrated in Tables 1 and 2. Three key themes emerged out of these discussions, namely ‘Beauty and the beast: the private-public split, ‘Beauty becomes the beast and beast becomes the beauty: the thin line between good and bad’ and ‘the unconvinced service user: trust and confidence in the public health sector’. Additionally, participants contributed a set of recommendations for improving the image and quality of care delivered at public sector hospitals.

Participants were purposively chosen for each focus group according to the criteria presented in Table 1.

Table 1: Constitution of focus groups

	Black	White
Private hospitals	Recent direct experience of private hospital (Group 1)	Recent direct experience of private hospital (Group 3)
	No recent direct experience, but would choose to go to private hospital should they require health care now (Group 2)	No recent direct experience, but would choose to go to private hospital should they require health care now (Group 4)
Public Hospitals	Recent direct experience of public hospital (Group 5)	Recent direct experience of public hospital (Group 7)
	No recent direct experience, but would choose to go to public hospital should they require health care now (Group 6)	No recent direct experience, but would choose to go to public hospital should they require health care now (Group 8)

Although two of the groups were classified as “would choose to go to public hospital should they require health care now” it should be noted from the outset that that “choice” emerged as largely a “necessity” for members of these groups, who expressed that they would prefer private health care but would have to use public services due to the costs of seeking private care.

> *You know the only reason I would go to the government hospital is because I don’t have the money to go to the private, but if I had the money I would go to the private hospital (G6: Black, no recent experience, would choose public).*

Table 2: Demographics of focus group participants

	Group 1 (n=8)	Group 2 (n=8)	Group 3 (n=8)	Group 4 (n=8)	Group 5 (n=8)	Group 6 (n=8)	Group 7 (n=5)	Group 8 (n=4)	Total
Age (in years):									
21-30	1	0	0	2	1	0	0	0	4
31-40	4	3	1	1	2	1	0	0	12
41-50	2	2	3	2	2	1	1	0	13
51-60	1	2	2	1	1	2	2	2	13
61-65	0	1	2	2	2	4	2	2	15
Level of education:									
Grade 9 and below	1	0	0	0	3	4	2	1	11
Grade 10	0	3	2	5	5	4	2	3	24
Tertiary qualification	5	4	4	3	0	0	1	0	17
Postgraduate qualification	2	1	2	0	0	0	0	0	5
Gender:									
Female (F)	6	7	6	5	7	5	4	4	44
Male (M)	2	1	2	3	1	3	1	0	13

There were more female than male participants in the study. Participants' ages ranged between 21 and 65. Most had at least secondary education (matric/grade 12) or tertiary qualifications (see Table 2). Both age and level of education were found to not have any impact on the participants' perceptions of private and public hospitals and preferences for service providers.

In general, there were more similarities than differences across the eight groups. Contrary to what was anticipated, 'recent direct experience' and 'race' did not bring

about key differences in the views that were expressed by the participants. This is seen in the main themes and sub-themes which emerged from the data collected (summarized in Table 3).

Table 3: Themes and sub-themes

THEME	SUBTHEME
Beauty and the beast: the private-public split	*Hospital hospitality and the cared-for patient*
	You take what you get and play by their rules: the disempowered vs. the empowered patient
Beauty becomes the beast and beast becomes the beauty: the thin line between good and bad	*Is the private health sector all that good and the public sector all that bad?*
The unconvinced service user: trust and confidence in the public health sector	*The lesser of the two evils*

The first theme - "Beauty and the beast: the private-public split" - emerged during the initial part of each focus group as, across all groups, participants started off with strong views that private was "good" and public was "bad". In this theme, negative statements were initially and almost-automatically expressed about public hospitals and positive ones about private hospitals. As the discussions progressed however, different views emerged and "Beauty became the beast and beast became the beauty: Participants questioned whether the private sector was really as good as it seemed. At the same time, they showed feelings of empathy towards the 'condition' that the public hospitals are in. Reasons to justify why the public

hospitals are in this ‘bad’ state were then offered as the discussions proceeded. The final theme- “The unconvinced service user: trust and confidence in the public health sector “ -emerged as some participants voiced that even if changes were to be made to the public sector it would take a lot for them to have trust and confidence in the public health sector. These themes and sub-themes are discussed below with selected illustrations from participants. More detailed quotes are presented in tables 4-19 in Appendix F.

THEME 1- BEAUTY AND THE BEAST: THE PRIVATE-PUBLIC SPLIT

Across all eight focus groups, there was, at least initially, a strong association of public hospitals with “bad” (the beast) and private hospitals with “good” (beauty). Positive comments regarding private hospitals related to respectful, caring staff attitudes, their good knowledge and skills, as well as their productive work ethic. By contrast, public hospitals were immediately associated with feelings of disempowerment, abuse from hospital staff, neglect, poor maintenance of the facilities, feeling unsafe and uncared for, as well as shortages of equipment and supplies.

Hospital hospitality and the cared-for patient

Hospitality within the private hospital environment was associated with feelings of being cared for, being respected, the look and feel of the environment, neatness,

privacy, a sense of peacefulness and tranquillity, as well as having access to “the doctor” (see Table 4).

> *They were marvellous, incredible. The care I got from the nurses and my doctor; they took good care of me. My doctor did a wonderful job* (G3: White, recent experience private)

In contrast, views expressed regarding public hospitals related to overcrowding, poor maintenance of the facilities, poor treatment received, lack of personal safety and that of their personal belongings as well as lack of privacy and dignity.

> *Things are bad* (G5: Black, recent experience public)

Similar perceptions and expectations were reflected by those who had had no direct experience (see Table 5).

> *It [public hospital] just isn’t well maintained, things get stolen or break and never get fixed, [and] it has a bad reputation* (G2: Black, no recent experience, would choose private)

> [You] *Expect resources- fully equipped, current necessary equipment, up to date bedding, machinery, modern technology* (G2: Black, no recent experience, would choose private)

Scepticism regarding the quality of medication and treatment received at public hospitals was also expressed. A recent user of a public hospital commented that she felt there were ‘money-saving strategies’ that resulted in patients receiving medicine of ‘poorer quality’ than in a private hospital.

You get proper medication in the private hospital (G8: White, no recent experience, would choose public)

The good thing is that it is free, but the bad thing is that it might not be of good quality (G2: Black, no recent experience, would choose private).

This was reaffirmed by other participants who felt poor quality medicine delayed or compromised pain relief for patients in public hospitals.

Staff attitudes, knowledge and skills were also described as good or bad in relation to the private-public split, with participants expressing higher and more positive expectations regarding the knowledge and skills of staff working in private hospitals, compared to those in public hospitals. It was felt that private hospital staff members had a “sense of pride” in their work, were well-trained, and more knowledgeable about current trends and developments in the medical field due to their having access to the latest technology (see Table 6).

Participants also expressed what they felt was a marked difference in the work ethic of the nurses in these two sectors; private sector staff were viewed to be more passionate and have a more positive attitude towards their work and public sector nurses were viewed as rude, “arrogant” and “disgruntled”.

*Everybody knows their job, they know what they’re supposed to do (*G2: Black, no recent experience, would choose private)

*They have poor attitudes, very poor, attitude towards their job, towards you as a patient (*G2: Black, no recent experience, would choose private)

When the groups consisting of black participants with recent direct experience of a public hospital and white participants with recent direct experience of a private hospital were asked to personify private and public hospitals, the following views emerged:

> Private Hospital: *"Rich, white person, good life, healthy looking nice"* (G5: Black, recent experience public)
>
> Public Hospital: *"Poor, sick person"* (G7: White, recent experience public)

Within the discussion about private hospitals and in keeping with the sub-theme of hospitality, sentiments of a well-functioning system that provides users with a sense of welcome were expressed. This included efficiency, well organized systems, preparedness and individualised care, as well as being treated by a familiar doctor as an individual rather than just another body in a hospital bed, while the contrary was expressed about public hospitals (see Table 10).

> *[in the public hospitals] There is less efficiency, I would be sceptical if I was to go there* (G2: Black, no recent experience, would choose private)
>
> *[in the private hospitals] You get individualised treatment, like an individual with my own needs. They look at me as me and not another woman who has had a baby, not just another number* (G6: Black, no recent experience, would choose public).

The participants were also of the initial view that there seems to be more accountability in private hospitals than public hospitals. This was associated with the

perceived level of efficiency in the private sector and a lack thereof in the public hospitals (see table 8).

> *There is less accountability in the government hospitals (*G2: Black, no recent experience, would choose private)

This sense of accountability in the private hospitals was linked to the 'for-profit' nature of such care in South Africa. In particular, participants felt that the income-generating potential of patients can dictate the nature of the treatment and care received. They felt that the private hospitals treated them well because they were paying customers, whereas in the public hospitals, the nurses

> *"tell themselves that people are not paying so they [patients] don't have a say"* (G1: Black, recent experience private).

> *Private hospitals, the model is very business-like; if you have no money you are out, so they will smile with you until your medical scheme is exhausted* (G2: Black, no recent experience, would choose private).

> *The one in private is compelled because I'm paying his salary. He is making a lot of money from me lying in that bed so he has to come and speak to me otherwise I won't be back to see him again* (G4: White, no recent experience, would choose private).

‘You take what you get and play by their rules’: the disempowered public patient vs. the empowered private patient

In private hospitals, participants suggested that it was within the rights of patients to complain if they experienced less than ideal treatment, while in the public sector, patients were presented as disempowered and at the mercy of the hospital staff, in particular the nurses (see table 10).

> *I have the power to complain in a private hospital, I don’t have to tolerate all the nonsense* (G2: Black, no recent experience, would choose private).

> *You just take what you get, you have no choice but to grin and bear it, what can I do […]We have less power, have to play by their rules, you take what you get* (G5: Black, recent experience public).

For public-hospital users, this perception of being disempowered in the nurse-patient relationship was so strong that some resigned themselves to silently ‘putting up with’ abuse and ill-treatment without complaining so as to avoid further victimisation. Participants felt that standing up to one nurse would not only result in worse treatment from that particular nurse, but from the entire staff. This left them feeling even more powerless and vulnerable. Furthermore, it was felt across the groups that this increased abuse and victimisation would take place in front of the other patients; evoking feelings of humiliation and belittlement (see Table 11).

> *If I complain I get treated worse than before, all the nurses will know that I complained and they'll spite me* (G6: Black, no recent experience, would choose public)

They'll tell you that you think you're better or special and they'll tell you in front of everybody (G6: Black, no recent experience, would choose public).

These feelings of empowerment and disempowerment were also linked with money, thus forging the clichéd connection between money and power. Participants felt that they had the right to complain in private hospitals because they are paying for the service, whereas in public hospitals that right is taken away by virtue of the service being free (see Table 12).

In the government hospital because we're not paying we can't say anything (G7: White, recent public)

Your expectation, your expense, you pay a lot of money so you expect a certain standard (G2: Black, no recent experience, would choose private)

THEME 2- BEAUTY BECOMES THE BEAST AND THE BEAST BECOMES THE BEAUTY: THIN LINE BETWEEN GOOD AND BAD

As the discussions progressed in each group, there was a shift away from splitting private and public hospitals into an "all good" vs. "all bad" dichotomy to a more complex understanding of both. This is an interesting feature of the transcripts and shows the importance of group dynamics and the ways that people subtly challenged and introduced new ideas to the discussion. They started to raise questions about whether private hospitals are really as good as they are perceived to be while displaying empathy towards public hospitals and voicing opinions that sought to justify reasons for their "poor condition".

> *There are private hospitals and even public ones that have different reputations, they are not all good, even in the private hospitals certain wards or sections may not be all that great; it's not always the hospital as a whole; busy areas or sections of the hospitals may be more affected* (G1: Black, recent experience private).

When asked about whether expressed negative views about public hospitals could be generalized to all public hospitals some of the participants felt that it was not possible to do so. They felt that private hospitals had some negative aspects too, which did not necessarily make them as good as they might seem to be. These negative aspects, such as picking up infections, were felt to be more acceptable or tolerated in private hospitals than they are in public hospitals.

> *She got an infection in a private hospital; it's more acceptable when it happens in a private hospital which is a dangerous way of looking at things* (G3: White, recent experience private).

Is the private health sector all that good and the public sector all that bad?

As the focus group discussions progressed, doubts about the goodness of private hospitals emerged, especially concerning affordability and expense. The participants felt that private hospitals were expensive and were only accessible to those who have medical insurance. At the same time, public hospitals were positively appraised regarding their affordability.

> *Money, it costs a lot of money to go to a private hospital* (G6: Black, no recent experience, would choose public)

You can go [to a public hospital] without paying, if you have treatment that you always have to keep on attending, you have to pay at a private clinic, yet there (public hospital) if they told you keep on going then you don't have to pay (G2: Black, no recent experience, would choose private).

Even if you would have to pay, but you would never pay as much as you do in the private (G2: Black, no recent experience, would choose private)

And the prescription medication, that is also expensive. In the government hospitals it's all free (G4: White, no recent experience, would choose private)

Over-servicing in order to achieve profit gains was another negative concept expressed about private hospitals.

Those tests can be very expensive. And sometimes you get the feeling they don't actually need to do it but they do it anyway because they can (G4: White, no recent experience, would choose private).

Or sometimes there is a cheaper way of doing the investigation, but they'll do the more expensive one to make money out of you (G4: White, no recent experience, would choose private).

Some participants felt that there was less overcrowding in the private hospitals because private hospitals are accessed by fewer people as not everyone can afford to go there. The participants felt that private hospitals are perceived to be good because they have all the required resources to provide health care services, whereas government hospitals are expected to deliver the same quality of service with fewer resources.

If I'm working in a government hospital that does not have even basic injections then it's going to be harder for me to do my job and I won't be able to do it properly (G4: White, no recent experience, would choose private)

It's easy to say that the nurses in the private hospitals do their jobs and it's true they do, but they have no reason not to. They have all the equipment they need at their fingertips so they actually have no excuse for not doing their jobs properly (G4: White, no recent experience, would choose private)

Related to this, participants raised the issue of large workloads in the under-resourced public sector and how it has a negative impact on productivity. More positively, though, they suggested that public hospital personnel have the adequate skills they require to do their jobs but are constrained by limited resources. Additionally, the availability of good specialists, as well good treatment and care in public hospitals, were expressed.

You get very good nurses, but they are burnt out because of the understaffing (G1: Black, recent experience private)

I agree that private hospitals are good and I would go there in a heartbeat, but we also need to look at what circumstances the government is making these people work under (G4: White, no recent experience, would choose private)

Participants acknowledged that often it was the same nurse working in both public and private sectors, complicating the division of all good vs. all bad practices

amongst staff. More generally, there was a sense that rudeness and kindness could be found in both sectors.

> *The attitudes of the nurses, those same nurses who work in public hospitals also work in private hospitals* (G1: Black, recent experience private).

> *They can still be rude and horrible in the private sector; I'd like to believe that you can still find rude nurses in the private hospitals, it's not just limited to public hospitals only, they may be more obvious in the public hospitals* (G1: Black, recent experience private)

When asked about the origins of negative perceptions of the public sector, participants pointed to the role of media reports portraying public hospitals in a negative light.

> *We get to hear about all these things in the media because the media reports on it; they don't report about infections at private hospitals. The media feeds us what they want us to swallow; don't be so quick to swallow* (G3: White, recent experience private)

> *Maybe we think they (the problems) are so high in the government hospitals because we get to hear so much about it* (G3: White, recent experience private).

THEME 3-THE UNCONVINCED SERVICE USER: TRUST AND CONFIDENCE IN THE PUBLIC HEALTH SECTOR

After exploring perceptions of private and public hospitals, participants were asked to suggest specific improvements they felt could be made to public hospitals: important recommendations and possible considerations for the future in order to improve the condition of the public hospitals. Emergent recommendations included benchmarking public hospitals against private hospitals, the government making financial investment into public hospitals, improvements in security, buildings and equipment, proper staffing and improvements in staff attitudes. See Table 16 in the appendices for detailed quotes supporting these ideas.

The lesser of the two evils

Participants were asked about what they thought it would take to get those who do not use public hospitals to use them. Some, especially those who had access to private hospitals, were sceptical and expressed that it would take a lot of effort to convince them to use the public hospitals, even if they were sympathetic to the causes of “bad conditions” in the public sector. Public hospital users felt that they had no choice in the matter but were not necessarily happy about this or trusting thereof.

> *It’s like flying an airline that you know has been crashing a lot of planes, you wouldn’t trust them completely ever again* (G1: Black, recent experience public).

These users felt that they have to access public hospitals and although an improvement in the condition of the facilities, such as building refurbishments, purchasing of new equipment as well as improving on cleanliness and availability of resources, would be a very welcome change, it would not necessarily have any bearing on their accessing of the facilities, given they had no financial choice but to access them. It would merely make them more comfortable and user-friendly.

However, most of the participants across all eight groups were of the opinion that public hospitals would be accessed by a greater proportion of the South African public provided improvements were made.

> *If everything else was in place people would go there because they don't want to spend the amount of money that they are spending in the private sector* (G8: White, no recent experience, choose public).

These were supported by feelings that the public sector needs to reinvent itself and embark on an aggressive marketing and rebranding campaign in order to attract people to public hospitals. Additionally, they suggested that public hospitals will have to visibly 'prove' to people that things have changed.

> *I would probably go, but will have to be 100% sure that they have improved* (G1: Black, recent experience public).

> *For a lot of people it will be difficult to believe that it (change) has happened unless they can prove it* (G2: Black, no recent experience, choose private).

CHAPTER 4: DISCUSSION

In discussing the findings presented in the previous chapter, the key principles of health system responsiveness as an indicator of health system performance will be drawn upon, along with the suggested recommendations from the participants on how to change their perceptions around public and private hospitals in order to improve health services. The implications of these on acceptability and trust in the South African health system and health system reforms will also be discussed.

It emerged from this study that the public appears to hold both positive and negative perceptions about private and public hospitals

Differences in perception based on race and recent or non-recent direct experience of the private or public hospital were insignificant, however those with recent direct experience of a public hospital held a more positive view of the public sector as compared to those without. Further exploration of the origins of these perceptions revealed that those without recent direct experience of either sector derived their perceptions from hearsay, word of mouth and media reports. Although two of the groups were classified as “would choose to go to public hospital should they require health care now” it should be noted that “choice” emerged as largely a “necessity” for members of these groups, who expressed that they would prefer private health care but would have to use public services due to the costs of seeking private care.

These perceptions were found not to be influenced much by race and recent or non-recent direct experience of the private or the public sector, however those with recent direct experience of the public hospitals were found to have a more favourable view towards them as compared to those without.

Negative views relating to the public sector were centred on poor staff attitudes, shortages of medicine, staff and resources, poor management, overcrowding (including long waiting times) and poor maintenance of facilities, while the positive included the fact that the services are free and the presence of specialists. Those relating to the private sector on the negative scale were the high cost of health care and possible over-servicing, while positive views related to clean facilities, feelings of being cared for, having access to the doctor and being given a 'personal touch'.

The distinct split in opinions among the participants, where the public hospitals were seen as beastly or 'all bad' and the private hospitals were seen as beauty or 'all good' has been noted in other studies and contexts (Broomberg, 2006; McIntyre et al., 2007b; Kaiser Foundation, 1999; McIntyre et al., 2009b) and is perhaps unsurprising. Additionally, it emerged that those who were classified as 'would choose to go to public hospital should they require healthcare now', was not really a matter of 'choice' but rather of 'necessity' as they could not afford to go to a private hospital due to the high cost of accessing private healthcare (Schneider et al., 2007; McIntyre et al., 2009a; Coovadia et al., 2009). However, the 'beauty and beast' split changed across the course of each focus group as the group participants provided an audience for each other (Robinson, 1999) and the conversation became more nuanced, questioning the merits and demerits of both

sectors and evolving into the second theme of beauty becoming the beast and vice versa. This more nuanced 'take' on the public and private sectors not only implies that there is perhaps a general dissatisfaction with the entire health care system- public *and* private- but also, that there are members of the public who have a sympathetic, positive outlook about the public sector.

These perceptions resonate closely with what has been termed the 'acceptability' of health services, which refers to 'the nature of service provision and how this is perceived by individuals and communities' (Thiede et al., 2007, p110). The manner in which health services are delivered and in which patients are attended to may confirm patients' beliefs and sensitivities and depending on whether these are positive or negative, could be a potential deterrent to using and interpreting the system (Thiede et al., 2007). Acceptability of health care links closely to trust between health service providers and users, and incorporates concepts such as discipline, responsiveness, assurance, respect and dignity, choice of health care provider, confidentiality and communication (Gilson, 2007).

DISCIPLINE

Andaleeb (2000) introduces the notion of discipline to describe 'the sense of order that one perceives in a given service environment […] reflected in both the behaviours of the staff and the appearance of the overall hospital environment' (p.30). Cleanliness, for example, is a manifestation of the extent of order and discipline in an organization. Therefore, in a hospital environment, the extent of discipline can influence perceptions of service quality (Andaleeb, 2000). The

discipline described by the participants regarding private hospitals included positive staff behaviour (respectful treatment of patients, efficient, caring service) as well as a clean physical environment. Such forms of discipline would seem to play a role in attracting patients to particular facilities and providers, especially - for those who can afford it - to the private sector (McIntyre et al., 2009). In contrast, the public sector was largely perceived to lack discipline. How the public perceives the level of discipline in hospitals is very important to acceptability and trust in those services.

RESPONSIVENESS AND ASSURANCE

Responsiveness, or the willingness of staff to be helpful and to provide prompt services, is an important component of service quality (Andaleeb, 2000) and was raised as a concern by participants about staff in public hospitals. Assurance is defined as the knowledge and behaviours of employees that convey a sense of confidence that service outcomes will match expectations (Andaleeb, 2000). Responsiveness and assurance are important aspects of the acceptability, or fit between lay and professional health beliefs and patient-provider engagement (Gilson, 2007). Health beliefs include perceptions about the effectiveness of treatment provided, the possibility of cure and the perceived importance of drugs to effective care, and in this study can be seen in the expressed scepticism regarding the quality of medication and treatment received at public hospitals. Patient-provider engagement includes the patient's ability to exercise voice in medical care encounters, as well as provider behaviours and attitudes towards patients-particularly communication practices and the maintenance of confidentiality (Gilson,

2007). Patient-provider engagement in public hospitals was perceived in a negative light by participants who felt disempowered because of an inability to complain about services that they felt were not up to standard. They also spoke of not having a say in their care and felt at the mercy of the nursing staff. Anxieties were raised by the participants about the perceived lack of technical competence of public sector personnel, their poor attitudes and work ethic. Such concerns have been shown to have a negative influence on patient trust in providers and provider choice or preference (Gilson, 2007). Participants felt that nursing staff in the public sector were disgruntled and not willing to do their jobs and care for patients.

COMMUNICATION AND MANAGEMENT

In order to strengthen acceptability and trust, emphasis must be placed on health worker training, particularly in their communication skills. This was raised as a concern with patients feeling belittled by providers, especially in the public sector. Improving the communication skills of health personnel as recommended by the participants will help to develop a more client-centred approach to service provision (Gilson, 2007). Improved communication should also incorporate patients being informed in a language they can understand, which also involves listening to them and their concerns. Communication with patients is vital to delivering service satisfaction because when hospital staff take the time to answer questions that concern patients, it can alleviate their feelings of uncertainty (Andaleeb, 2000) as well as maintain their right to dignity, which is a basic human right that can be

undermined through bad treatment from health providers and the health care system (Gilson, 2007).

Participants also recommended that management and leadership be strengthened to ensure that managers should not only shape acceptability through their influence over staff education, personnel decisions and resource management and allocation, but also through their own responsibility towards patients (Gilson, 2007).

CONVINCING THE PUBLIC

Participants offered explanations for the negative stereotypes surrounding ill-discipline, lack of responsiveness, poor communication and poor management in public hospitals. For example, it was felt that public health sector workers work under less favourable conditions as compared to private sector workers, where private sector personnel were deemed as being ‘privileged’ in that they are paid better, work in more resourced environments in terms of equipment and availability of medical equipment and drugs and that they do not necessarily encounter staff shortages or overcrowding in the private hospitals. The high costs of seeking health care in private hospitals as well as possible over-servicing were also raised as concerns. While more sympathetic, it is important to note that the very aspects that evoke this sympathy are the very reasons why such negative stereotypes are painted about public hospitals in the first place.

With any reform, there is always a possibility that even if the problems in the public sector were to be substantially alleviated; full utilisation would still not be

guaranteed if the quality of services is perceived to remain compromised. Measures to address some of the mentioned acceptability issues have been and continue to be taken in various policies and programmes such as the hospital revitalisation plan and the patients' rights charter. Many such measures have also been planned for in the proposed NHI reforms (Schneider et al., 2007; McIntyre et al., 2007a; Coovadia et al., 2009; Ministry of Health, 2011). Yet, in implementation, as this research confirms, the effect of these policy measures appears to be unnoticeable and continue to be cited by service users as requirements for improvement (Schneider et al., 2007). The possible implications for policy that emerge from this are that strategies to ensure successful implementation as well as monitoring and evaluation measures need to be improved. The state would thus have to undertake more public discussion about the NHI itself- informing and anticipating future perceptions as well as a rebranding and marketing PR campaign to convince service users that the changes that have been implemented indeed are valid and sustainable.

ORIGIN OF PERCEPTIONS

In this study as in the Kaiser Foundation (1999) and SACBIA (McIntyre et al, 2009b) surveys, participants who had recent direct experience of public hospitals were more favourable in their outlook than those without. This is an important point of contrast to solely negative portrayals of public hospitals, which are often perceived to be of an inferior standard to private hospitals (Broomberg, 2000). Most of the negative perceptions held by those participants without recent direct

experience of hospitals came from friends, relatives and in some cases the media; similar to findings by McIntyre et al. (2009a). Sources of perceptions are generated directly from experience but also indirectly and this finding brings to the fore the role of the media, hearsay and word of mouth in fuelling perceptions. While not overlooking or minimizing the negative perceptions that the public has expressed, positive perceptions can be utilized to create better channels and strategies of communication for both the public and private health sectors. With the introduction of the NHI system, communication and public involvement in the NHI dialogue has potential in itself to alter perceptions.

LIMITATIONS TO THE STUDY

A methodological shortcoming of focus group discussions is that passive or shy participants may not always express their views, while opinionated participants may dominate (Robinson, 1999). Within this study, some participants were quieter than others. However, a conscious effort was made to involve them – through for example making eye contact, addressing them individually, etc. Further one-on-one interviews to compliment the findings of the focus group discussions could enrich the findings by giving space to all.

Language can be a barrier in focus group discussions in terms of group participants using different terminology, however the nature of a discussion in itself allows for clarification of any unfamiliar terminology (Robinson, 1999). Additionally in this study some English words do not exist in Sotho, however, in the translation, consensus was sought with other Sotho-speaking experts.

What is often deemed as a common limitation with qualitative research is that the results are not always generalizable. Given that perceptions are a subjective understanding of a situation, these findings cannot be generalized. Rather than aspiring to statistical generalizability or representativeness as is the case with quantitative research, qualitative research usually aims to reflect the diversity within a given population.

The participants who were classified as those who would “choose to go to a public hospital should they require health care now” were found to not necessarily choose to go there but rather go there because they cannot go to the private sector, thus choose the public hospital seemingly by default.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

The aim of this study was to understand perceptions that the public have about private and public hospitals in South Africa, the origins of these perceptions as well as their preferences for service providers. The historical background of the health system in South Africa is plagued by gross inequities in the distribution and availability of health services among the different racial groups as well as between the private and public sectors. These inequities remain a key problem for the health system today (McIntyre, 2007a).Within the current context of health system reform through the introduction of a NHI system in South Africa, trust and acceptability of health services is a crucial determinant of the extent of the buy-in that the public will demonstrate towards the planned changes. It is therefore important, now more than ever, to understand the perceptions and experiences that the public has of the health services – both private and public- in South Africa. These perceptions will influence their preference of service (for those who have a choice), their experience of care, and future expectations of the health system (Sandoval et al., 2007), encourage confidence in the contemporary health system reforms (Gilson, 2007; McIntyre, 2009a; Goudge, 2012), assist policy and decision-makers in determining the correct allocation of resources, as well as designing of appropriate health programmes (Nguyen Thi et al., 2002; Sandoval et al., 2007).

Ultimately, it is through acceptability and trust of the health system that the proposed NHI system reforms will gain approval and buy-in from the public. This can be achieved, for example, with the state better adopting more improved communication strategies such as engaging the public in discussions regarding expectations and experiences of health services by conducting follow-up surveys such as the SACBIA study and more qualitative work.

The department of health also needs to find ways to respond to negative media reports in an un-defensive manner as well as proactively presenting and highlighting cases of best practice. There is a positive, sympathetic voice towards the public sector and health policy should be targeted towards it as well as change the existing negative stereotypes. Better communication and public involvement in the proposed health system reforms would in itself alter these negative perceptions.

At a facility level, improved responsiveness with more overt measures that indicate that complaints are being addressed needs to be implemented. Ongoing public education about patients' rights is important, but as participants noted many are aware of their rights, but do not act on them for fear of victimisation or nothing being done about it. Therefore accountability measures in which individual providers can be held responsible for disrespectful or unacceptable actions should be explored, , as well as broader accountability measures, which might include strengthening the management and leadership structures within facilities and districts, an opportunity that the planned NHI system presently recognises.

REFERENCES

African National Congress (1994). A National Health Plan for South Africa. Johannesburg: African National Congress. Available online at URL: http://www.anc.org.za/show.php?id=257. Accessed November 2012.

Andaleeb S. (2000). Service quality in public and private hospitals in urban Bangladesh: a comparative study. Health Policy 53: 25-37.

Andaleeb S. (2001). Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. Social Science and Medicine 52:1359-1370.

Ataguba JE, Akazili J. (2010). Health care financing in South Africa: moving towards universal coverage. Continuing Medical Education 28: 74–8.

Ataguba JE and McIntyre D. (2012). Paying for and receiving benefits from health services in South Africa: is the health system equitable? Health Policy and Planning 27:i35–i45.

Bratton M. (2007). Are you being served? Popular Satisfaction with Health and education Services in Africa. Afro barometer Working Paper no.65.

Broomberg, J. (2006) Consultative investigation into low income medical schemes. Johannesburg: LIMS.

Coovadia H, Jewkes R, baron P, sanders D, McIntyre D. (2009). The health and health system of South Africa: historical roots of current public health challenges. The Lancet 374:817-34.

Day C, Gray A. Health and related indicators. In: Ntuli A, ed. South African health review 1998. Durban: Health Systems Trust, 1998:203–16. Available online at URL: http://www.hst.org.za/publications. Accessed October 2012

Elo S, Kyngas H. (2007). The qualitative content analysis process. Journal of Advanced Nursing 62(1).

Gaskell G, Bauer M. (2000). Qualitative Researching with text, image and Sound. A practical handbook. SAGE Publications, London.

Gauteng DoH, CIET Africa. (2003). Social Audit on Health Service Performance. Available online at: http://www.gov.za. Accessed June 2008.

Giacomini M, Cook D, (2008). Users' guides to the medical literature. Qualitative research in health care. Are the results of the study valid? (Reprinted) JAMA July 19, 2000:284:3. Available online at URL: http://www,jama.com.

Gilson L. (2007). Acceptability, trust and equity. In: McIntyre D and Mooney G, ed. The economics of health equity. Ch. 7 (p124-147). Cambridge University Press.

Goudge J, Akazili J, Ataguba J, Kuwawenaruwa A, Borghi J, Harris B, Mills A. (2012). Social solidarity and willingness to tolerate risk- and income-related cross subsidies within health insurance: experiences from Ghana, Tanzania and South Africa. Health Policy and Planning 27: i55-i63.

Gray, et al. Health Policy and Legislation. In Padarath A, English R, editors. South African Health Review 2011. Durban: Health Systems Trust; 2011.

http://www.hst.org.za/sites/default/files/sahr_2011.pdf. Accessed September 2012.

Greenbaum TL. (2000). Moderating Focus Groups. A guide for group facilitation. Library of Congress Cataloging-in-Publication Data.

Holthof B. (1991). Total quality in acute care hospitals: guidelines for hospital managers. Health Policy, 18: 243-250.

Hsieh Hsiu-Fang, Shannon SE. (2005). Three Approaches to Qualitative Content Analysis. Qualitative Health Research 15:1277. Available online at URL: http://qhr.sagepub.com/content/15/9/1277. Accessed July 2012.

Kalda R, Polluste K, Lember M. (2003). Patient satisfaction with care is associated with personal choice of physician. Health Policy 64: 55-62.

Kaiser Foundation. (1998). Kaiser National Household Survey. Available online at www.kff.org. Accessed October 2008.

Kitzinger J. (1996). Introducing focus groups in qualitative research. In: Mays N, Pope C, editors. Health care. BMT Publishing Group. London, pp36-45.

Lafond K. (1995). Improving the quality of investments in health: Lessons on sustainability. Health Policy and Planning. 10:63-76.

Macha J, Harris B, Garshong B, Ataguba JE, Akazili J, Kuwawenaruwa A, Borgi J. (2012). Factors influencing the burden of health care financing and the distribution of health care benefits in Ghana, Tanzania and South Africa. Health Policy and Planning 27: i46-i54.

Matsebula T, Willie M. (2007). Private Hospitals. In: Harrison S, Bhana R. Ntuli A, editors. South African Health Review 2007. Durban: Health systems trust. 2007. Available online at: http://www.hst.org.za/publications/711. Accessed June 2008.

McIntyre D, Gilson L. 2002. Putting equity in health back onto the social policy agenda: experience from South Africa. Social Science and Medicine 54: 1637–56.

McIntyre D , Thiede M, Nkosi M , Mutyambizi V , Castillo-Riquelme M, Gilson L, Erasmus E, Goudge J. (2007 a). Shield Work Package 1 Report: A Critical Analysis of the current South African Health System. Health Economics Unit, University of Cape Town and Centre for Health Policy, University of the Witwatersrand.

McIntyre D, Thiede M. (2007 b). Health care Financing and Expenditure. In: Harrison S, Bhana R, Ntuli A, editors. South African Health Review 2007. Durban. Health Systems Trust. Available online at: http://www.hst.org.za/publications/711. Accessed June 2008

McIntyre D, Goudge J, Harris B, Nxumalo N, Nkosi M. (2009a). Prerequisites for National Health Insurance in South Africa: Results of a national household survey. South African Medical Journal 99: 725-729.

McIntyre D and Mills A. (2012). Research to support universal coverage reforms in Africa: the SHIELD project. Health Policy and Planning 27: i1-i3. Available online at URL: http://heapol.oxfordjournals.org. Accessed October 2012.

McIntyre D, Okorafor O, Ataguba J, Govender V, Goudge J, Harris B, Nxumalo N, Moeti R, Maja A, Palmer N and Mills A. (2009b) Health care access and

utilisation, the burden of out-of-pocket payments and perceptions of the health system: Findings of a national household survey. SACBIA Report 2009.

Mills A, Ally M, Goudge J, Gyapong J, Mtei G. (2012). Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania. Health Policy and Planning 27:i4-i12. Available online at URL: http://heapol.oxfordjournals.org. Accessed October 2012.

Minister of Health. National Health Insurance in South Africa. Policy Paper. Government Notice 657. Government Gazette No. 34523, 12 August 2011.

Modiba P, Gilson L and Schneider H (2001) Voices of service users. In A Ntuli (Ed). South African Health Review 2001. Durban: Health Systems Trust.

Myburgh N, Solanki G, Smith M, Lalloo R. (2005). Patient satisfaction with health care providers in South Africa: the influence of race and Socio economic status. International Journal for Quality Health care. 17(6):473-477.

Nguyen Thi P L, Briancon S, Empereur F, Guillemin F. (2002). Factors determining inpatient satisfaction with care. Social Science and Medicine 54:493-504.

Pick W. Human resources development. In: Harrison D, editors. The South African health review 1995. Durban: Health Systems Trust, 1995. Available online at URL: http://www.hst.org.za/publications. Accessed October 2012

Pope C, Mays N. (2005). Qualitative Research in Health care. 2nd Edition. Chapters 1-3. Oxford University Press. England.

Posel D. (2001). Race as Common Sense: Racial classification in Twentieth-Century South Africa. African Studies Review 44(2):87-113. Available online at URL: http://www.jstor.org/stable/525576. Accessed August 2012.

Republic of South Africa. (2004). National Health Act No. 61 of 2003: National Health Act, 2004. Vol. 469 Cape Town 23 July 2004 No. 26595. Available online at URL: http://www.info.gov.za. Accessed January 2013.

Robinson N. (1999). The use of focus group methodology- with selected examples from sexual health research. Journal of Advanced Nursing 29(4):905-913.

Sandoval A, Barnsley J, Berta W, Murray M, Brown A. (2007). Sustained public preference on hospital performance across Canadian provinces. Health Policy 83: 246-256.

Schneider H, Barron P, Fonn S. (2007). The promise and the practice of transformation in South Africa's health system. In: State of the nation South Africa. Available online at URL: http://www.hsrcpress.ac.za. Accessed June 2011.

Skade T. (2012). Ill-equipped hospitals losing nurses. The Star, January 30, 2012. Available online at URL: http://www.iol.co.za. Accessed December 2012.

Smith J. (2012). Protector to probe hospital baby shambles. The Star, July 27, 2012. Available online at URL: http://www.iol.co.za. Accessed December 2012.

Starks H, Trinidad SB. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. Qualitative Health

Research 17(10): 1372-1380. Available online at URL: http://www.qhr.sagepub.com.

Stillwell B, Diallo K, Zurn P, Vujicic M, Adams O, Dal Poz M. (2004). Migration of health care workers from developing countries: strategic approaches to its management. WHO Bulletin 82:8. Geneva, August 2004. Available online at URL: http://scielosp.org. Accessed December 2012.

Taylor V. (2002) Report of the Committee of Inquiry into a comprehensive system of social security for South Africa. Available online at URL: http://www.cdhaarman.com/Publications/Taylor%20report.pdf. Accessed November 2012.

Thiede M, Akweongo P, McIntyre D. (2007). Exploring the dimensions of access. In: McIntyre D and Mooney G, ed. The economics of health equity. Ch. 6 (p103-123). Cambridge University Press.

Ulin P, Robinson ET, Tolley EE. (2004). Qualitative methods in Public health- A field guide for applied research. Chapter 6. Jossey-Bass. United States of America.

Van den Heever, McIntyre D. (2007). Social or National Health Insurance. In: Harrison S, Bhana R, Ntuli A, editors. South African Health Review 2007. Durban: Health Systems Trust. Available online at URL: http://www.hst.org.za/publications/711. Accessed June 2008.

WHO. (2000). World Health Report. Health Systems: Improving performance. Geneva.

Zwi AB, Bruhga R, Smith E. (2001). Private health care in developing countries (Editorial). BMJ 323:463–4. Available online at http://www.bmj.com. Accessed March 2012.

APPENDIX A: FOCUS GROUP TOPIC GUIDE

1) General Exploration: " Tell me about public / private hospitals"

[Open ended list of factors/perceptions that will be documented on a flip chart in the form of a mind-map. The intention is to use mind-mapping to generate a list of perceptions, ideas and images that are foremost in people's minds]

2) Further unpacking / exploration of the above points raised by participants

[This next step is to unpack the topics raised in the first point so as to ensure clarity of intended meanings. The intention here is to be driven by what the respondents say and especially to explore themes and concepts that seem interesting or are unusual. A particular point to explore here would be whether the respondents see all private and public hospitals in the same light or whether they have different perceptions about for example public hospitals with private wards or public hospitals without private wards. Should the discussion not flow spontaneously, familiar concepts such as waiting times, staff attitudes will be used as prompts]

3) Explore origins of perceptions: "What makes you feel or have that view about private / public hospitals"

[Open ended list of where the participants' perceptions are generated from, for example, from their own personal experience, friends, family, media reports, etc]

4) Explore choices in health service providers: "What in your view are the care options available to you"

[The intention here is to explore for example in a group of participants that have recent, direct experience of a private hospital whether they would access the same provider again, access a public hospital and/or what it would take to get them to go to one]

5) Possible factors to improve / change perceptions: “What in our opinion can be done to improve/ and or change the perceptions you have expressed about private / public hospitals”

[Open ended list of factors that will improve/change the participants’ perceptions will be documented on a flip chart in the form of a mind-map. The intention once again is to use mind-mapping to generate a list of ideas and images that are foremost in people’s minds]

APPENDIX B: PARTICIPANT DEMOGRAPHIC INFORMATION

SOCIO-DEMOGRAPHIC DETAILS

Participant Number	Date of focus group

Race of participant (Please tick (√) :

African	
White	

Gender (Please tick√):

Male	
Female	

Age (in complete years):_____

Home language (Please tick (√) :

English	
Afrikaans	
Sotho	
Zulu	
Tswana	
Pedi	
SiSwati	
Venda	
Shangaan	
Xhosa	
Ndebele	

Education level: (Tick (√) one of the options, as applicable)

Never went to school: □

Out of School: □

Last Grade attended; Grade ____

University / College: □

Highest qualification obtained _____

Consent form signed and received: Please tick (√): □

APPENDIX C: PARTICIPANT INFORMATION SHEET

TITLE OF THE RESEARCH PROJECT: Perceptions of South African private and public hospitals and preferences for health care providers.

PRINCIPAL INVESTIGATOR: Lebogang Komape

CONTACT DETAILS: Tel: (011) 614 7125

Cell: 073 526 6884

E-mail: lkomape@hotmail.com

Good day,

My name is Lebogang Komape and I am a Masters student at The University of the Witwatersrand School of Public Health. I am conducting this research as part of the requirements to qualify for a Master of Public Health degree. I would like to provide you with some information about a research project that I am undertaking and to invite you to participate. Let me begin by telling you a bit about the research so please take some time to read the information presented here, which will explain the details of this project.

Please feel free to ask me any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study will be conducted in Johannesburg, South Africa according to the ethical guidelines and principles of the University of the Witwatersrand Ethics Committee. It seeks to gather information on people's perceptions of private and public hospitals and their choices in service providers. It will consist of focus group discussions, with 6-8 people per group. It is expected that the study will be completed at the end of 2009.

I invite you to participate in this research by granting me permission to include you as a participant in one of the focus groups. These will take approximately 60-90 minutes of your time and will be carried out at The University of the Witwatersrand.

The focus group discussions will be audio-recorded to provide the research team an accurate record of the discussion. These tapes will be transcribed and kept for 2 years if no publications are made or 6 years after publication.

As a participant in the research you can expect that all the information you provide will be treated in confidence. To this end, the following procedures will be adhered to in this project:

(i) No one outside the research team will have access to the information you provide

(ii) Your name and other identifiable information will not be published in our report

(iii) Recordings, notes and transcripts of the group discussions will be stored using codes, so no one outside the research team will be able to link the information provided to the names of the respondents.

Neither the researcher nor any member of the research team can however fully guarantee the confidentiality of the focus group discussions as the researcher has no control over what is discussed outside of the groups.

You will not be paid for participation in the study, but reimbursement for transportation costs up to R50 will be given and light refreshments will be served. There will be no costs involved for you, if you do take part and we don't anticipate that any harm will come to you through your participation in the research.

APPENDIX D: CONSENT FORMS

Declaration By Participant

By signing below, I ……..……. agree to take part in a research study entitled Perceptions of South African private and public hospitals and preferences for health care providers.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I understand that confidentiality from the other focus group members cannot be guaranteed.
- I understand that the focus group discussions will be audio recorded.

Signed at (*place*) .....…..…… on (*date*) ……...…… 2009.

..... ……..

Signature of participant **Signature of witness**

Declaration By Researcher

I *(name)* ……..…….. declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

Signed at (*place*) .....…..……. on (*date*) ……...…… 2009.

....

Signature of researcher **Signature of witness**

APPENDIX E: ETHICAL CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Komape

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M081156**
PROJECT	Perceptions of South African Private and Public Hospitals and Preferences for Health Care Providers
INVESTIGATORS	Miss L Komape
DEPARTMENT	School of Puiblic Health
DATE CONSIDERED	08.11.28
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 09.02.16 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : E Erasmus

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX F: VIEWS ABOUT PRIVATE AND PUBLIC HOSPITALS

Table 4: Views about private and public hospitals

Private hospitals	Public hospitals
"They were marvelous, incredible. The care I got from the nurses and my doctor; they took good care of me. My doctor did a wonderful job" (G3: White, recent experience private)	"*It just isn't well maintained, things get stolen or break and never get fixed, it has a bad reputation*" (G2: Black, no recent experience, choose private)
"I think that private hospitals are great" (G1: Black, recent experience private)	*"Things are bad"* (G5: Black, recent experience public)
"Respect, everybody teats you with respect" (G1: Black, recent experience private)	*"It's very full there. Sometimes there is no place to sit so you have to wait outside"* (G6: Black, no recent experience, would choose public)
"It feels like you are in a place where you are going to be looked after, like the way a hospital is meant to be" (G4: White, no recent experience, would choose private)	*"Dilapidated, the hospital itself is just dilapidated. Nothing gets maintained there, it's terrible"* (G3: White, recent experience private)
"Comfort, prompt service, good food" (G2: Black, no recent experience, choose private)	*"You know the only reason I would go to the government hospital is because I don't have the money to go to the private, but if I had the money I would go to the private hospital" (G6: Black, no recent experience, would choose public)*

Private hospitals	Public hospitals
"You feel so safe; your car is safe, there is a guard at the gate to monitor the entry and exit" (G1: Black, recent experience private)	*"I think security is a problem because things get stolen there and people get attacked"* (G4: White, no recent experience, would choose private)
"The doctor comes to see you, everybody fussed over you and you really feel cared for" (G1: Black, recent experience private)	"*But the stealing also happens in the ward you know with the patients' things. If you bring your own blanket and your cup and all that, it gets stolen. I don't know who steals it; maybe it's the nurses, the other patients or even the visitors who come to the hospital. I don't know who steals it, but it gets stolen*"; "*I think the patients' things like the cell phones, watches are not safe in the wards because anyone can steal them. So I can say if I was there I would worry about my things*". "*Everybody steals your things; it's not safe in those wards*" (G6: Black, no recent experience, would choose public).
"It was incredible how whatever I asked for was not too much trouble" (G3: White recent experience private)	*"They sometimes don't have the curtains around the beds. You must take off your clothes in front of everybody"* (G6: Black, no recent experience, would choose public)
"*It was a pleasant experience*" (G1: Black, recent experience private)	*"In some of the public hospitals they don't even have the basic things like utensils, the patient has to bring their*

	own" (G2: Black, no recent experience, choose private)
"It just looked so neat, I had my own room" (G1: Black, recent experience private)	*"When you get to emergency there is no saying that your urgent situation will be attended to urgently"* (G2: Black, no recent experience, choose private)
"*I felt at peace, the place looked so nice*" (G1: Black, recent experience private hospital)	*"The service, to access the service you have to queue"* (G2: Black, no recent experience, choose private)

Table 5: Views about private and public hospitals, based on expectations

Private Hospital	Public Hospital
"You expect a certain level of efficiencies" (G2: Black, no recent experience, choose private)	"*You don't expect to be treated well there*" (G2: Black, no recent experience, choose private)
"Expect resources- fully equipped, current necessary equipment, up to date bedding, machinery, modern technology" (G2: Black, no recent experience, choose private)	"*When you go to a public hospital, there is a possibility you land up on the floor, you will sleep on the floor, which is not an option in a private hospital; it's non-negotiable*" (G2: Black, no recent experience, choose private)

Table 6: Staff knowledge, attitudes and skills

Private Hospitals	Public Hospitals
*"Everybody knows their job, they know what they're supposed to do" (*G2: Black, no recent experience, choose private)	*"They have poor attitudes, very poor, attitude towards their job, towards you as a patient"; (*G2: Black, no recent experience, choose private)
*"Private hospitals train their people well, making sure they know their stuff" (*G2: Black, no recent experience, choose private)	*"There is a certain amount of arrogance from the service providers, the nurses and other staff".* (G3: White recent experience private)
*"They care what happens to you, they really take good care of you" and "The staff has a sense of pride and belonging" (*G2: Black, no recent experience, choose private)	*"Everybody is disgruntled". (*G2: Black, no recent experience, choose private)
"It's nice to be looked after by kind people, kindness is a rare quality in nurses these days" (G3: White, recent experience private)	*"Nurses are not like they used to be, the standard of nurses has dropped over the years generally, but it's worse in the government hospitals"* (G3: White, recent experience private)
"*Sufficient information; what you get from the service providers; very patient; explain things to you; I don't think you get that in the public hospitals*" (G1: Black, recent experience private)	*"Even the way the nurses speak to you, they speak to you like you are stupid"* (G6: Black, no recent experience, would choose public)
"I think the ones in the private hospital	*"The nurses say they are busy but*

probably know more too. They have access to all these things so they get to know more about what is available for modern medicine and all the new treatments that come out" (G4: White, no recent experience, would choose private)	*sometimes they are not. They are busy talking and laughing there"* G5: Black, recent experience public)
"They have a different work ethic 'I'm a nurse, this is what I do'" (G1: Black, recent experience private)	*They know we need them so they don't care"* (G5: Black, recent experience public)
"They behave in a certain way, the way a nurse is supposed to; carry themselves in a certain way, self-respecting and to the point, like they did in the olden days. None of the funny attitude and rude behaviour" (G1: Black, recent experience private)	*"They told me 'wait for me I'm coming you're not the only person who is sick' 'Are you my boss, then fire me if you are my boss' "* (G5: Black, recent experience public)

Table 7: Efficiency, system preparedness and organization

Private Hospitals	Public Hospitals
"Efficiency; things happen the way they're supposed to happen, at the time they're supposed to happen" (G1: Black, recent experience private)	*"There is less efficiency, I would be skeptical if I was to go there"* (G2: Black, no recent experience, choose private)
"It's like they are expecting you, they are well prepared for you" (G1: Black, recent experience private)	*"In the public hospital you just go and then you are seen by any other doctor".* (G2: Black, no recent experience, choose private)
"You get individualised treatment, like an individual with my own needs. They look at me as me and not another woman who has had a baby, not just another number" (G6: Black, no recent experience, would choose public)	*"Accessibility to the doctor, sometimes you won't even see a doctor for the day, so unlike you know, in private"* (G2: Black, no recent experience, choose private)

Table 8: Accountability in the private and public hospitals

Private Hospital	Public Hospital
"They can be rude in the private hospitals too, but less likely; chances of getting into trouble are greater in private" (G1: Black, recent experience private)	*"There is less accountability in the government hospitals" (*G2: Black, no recent experience, choose private)
"In the private sector if you are found to be doing something wrong to me you are out" (G1: Black, recent experience private)	*"Nurses are different in each sector because of the accountability thing"* (G1: Black, recent experience private).
"They have to because now the power is with me as a patient; now I can get her into trouble if she does anything unsatisfactory towards me; my doctor will know about it and will also be unhappy" (G1: Black, recent experience private)	*"You can't complain, nothing will happen. Even if you complain they won't do anything"* (G5: Black, recent experience public)
"When they work in the public hospital they know that the repercussions are not that bad; in private they know that it will be a very serious issue if a particular nurse was seeing to a patient and something went wrong, they might end up in the matron's office or in the	*"In the state hospital there is also some sheltered employment, if somebody is doing something wrong they would be protected rather than be reprimanded; people know they would not be expelled"* (G2: Black, no recent experience, choose private)

authority's offices so they tend to be more careful when they are in private than when they are in the state hospitals" (G2: Black, no recent experience, choose private).	*"There is just no accountability; no one wants to stand up and say 'he, this is wrong' "*(G4: White, no recent experience, would choose private)

Table 9: Accountability and profit in the private hospitals

Private Hospitals	
*"In private people are working for themselves; they want the business from us; it brings money for them so they treat us well because they know if they don't we're out" (*G1: Black, recent experience private).	*"Private hospitals, the model is very business-like; if you have no money you are out, so they will smile with you until your medical scheme is exhausted"* (G2: Black, no recent experience, choose private).
*"My doctor was very strict with the nurses; they know that he doesn't want anything bad with his patients; we bring him money at the end of the day; the doctor knows that" (*G1: Black, recent experience private).	*"The one in private is compelled because I'm paying his salary. He is making a lot of money from me lying in that bed so he has to come and speak to me otherwise I won't be back to see him again"* (G4: White, no recent experience, would choose private)

Table 10: The power to complain in private and public hospitals

Private Hospitals	Public Hospitals
"I have the power to complain in a private hospital, I don't have to tolerate all the nonsense" (G2: Black, no recent experience, choose private).	*"You have less sense of entitlement and demands on your side as the patient is less";* (G2: Black, no recent experience, choose private)
"They treat you really special; the senior nurse comes and checks on you every morning. She opens up the dialogue for you to voice any complaints". (G2: Black, no recent experience, choose private)	*"Those people can be very spiteful, rather keep quiet and pray you come out alright" (*G2: Black, no recent experience, choose private)
"As a patient I have the right to complain about anything I'm unhappy about" (G3: White, recent experience private)	*"I as the patient am not allowed to become irritated because then they will treat me even worse" (*G1: Black, recent experience private)
"When you have a complaint, you expect to get prompt feedback" (G2: Black, no recent experience, choose private)	*"You just take what you get, you have no choice but to grin and bear it, what can I do" and "We have less power, have to play by their rules, you take what you get"* (G5: Black, recent experience public)
"They know that we know we can complain and they don't want a bad name" (G1: black, recent experience private).	*"They know we need them so they don't care"* (G5: Black, recent experience public).

Table 11: Disempowerment in the public hospitals

Public Hospitals	
"If I complain I get treated worse than before, all the nurses will know that I complained and they'll spite me". (G6: Black, no recent experience, would choose public)	*"Especially if you are very sick. At least if you can walk and do some things for yourself it's better even if they treat you bad you don't care. But if you are very sick, they will leave you there and they won't even feed you. They leave your food next to you until it gets cold then they come and take it away and say you don't want food"* (G6: Black, no recent experience, would choose public)
"They'll tell you that you think you're better or special and they'll tell you in front of everybody" (G6: Black, no recent experience, would choose public)	*"They are in charge of you when you are there, they know you need them"* (G5: Black, recent experience public)

Table 12: Money/Cost and expectations in private and public hospitals

Private Hospitals	Public Hospitals
"You expect a certain level of service, I'm allowed to throw a fit; it's my right as a paying customer" (G1: Black, recent experience private)	*"In the government hospital because we're not paying we can't say anything".* (G7: White, recent public)
"Your expectation, your expense, you pay a lot of money so you expect a certain standard" (G2: Black, no recent experience, choose private)	*"I think it's because the government hospital is free so they do what they want but because the private hospital is not free they can't do what they want".* (G5: Black, recent experience public)
My expectations are high because I'm paying so much of my precious money. I'm paying for it so I have the right to speak if I'm unhappy. I spend a lot of money so I also expect a certain standard" (G1: Black, recent experience private)	*"That's why if I had the money I would go to the private hospital rather than the government because in the government it's like you don't have any rights but in the private you have rights. Because the nurses will tell you that you are not paying me so you can't tell me"*(G8: White, no recent experience, choose public)
"I pay so much money to be there so it's natural to want to get the best" (G1: Black, recent experience private)	*"They can't give you panado when you're paying on your medical scheme in the private hospital. So here because we're not paying we can't say anything"* (G6: Black, no recent experience, would choose public)

Table 13: Quality of medication in private and public hospitals

Private Hospitals	Public Hospitals
"*Those free medication may not necessarily be what would be prescribed in a private hospital*" (G2: Black, no recent experience, choose private)	"*The good thing is that it is free, but the bad thing is that it might not be of good quality*" (G2: Black, no recent experience, choose private)
"You get proper medication in the private hospital" (G8: White, no recent experience, choose public)	"*I think they are trying to save money so they give us the cheap pills like panado. In the private hospital they will give you proper pills*". (G6: Black, no recent experience, would choose public).
	"*Which means it is going to take longer to deal with the pain*" (G2: Black, no recent experience, choose private)

Table 14: Personification of private and public hospitals

Private Hospitals	Public Hospitals
"Rich, white person, good life, healthy looking nice" (G5: Black, recent experience public)	*"Poor, old lady who is very poor"* (G5: Black, recent experience public)
"Healthy, rich person" (G7: White, recent experience public)	*"Poor, sick person"* (G7: White, recent experience public)

Table 15: Affordability of private and public hospitals

Private Hospitals	Public Hospitals
"Expense" (G2: Black, no recent experience, choose private),	*"Even if you would have to pay, but you would never pay as much as you do in the private"* (G2: Black, no recent experience, choose private).
"We pay a lot of money, thank God for medical scheme, I don't think I would be able to afford it otherwise, all these tests being done on me are expensive. I wouldn't have managed it without my medical scheme" (G1: Black, recent experience private)	*"You can go without paying, if you have treatment that you always have to keep on attending, you have to pay at a private clinic, yet there (public hospital) if they told you keep on going then you don't have to pay"* (G2: Black, no recent experience, choose private).
"And the prescription medication, that is also expensive. In the government hospitals it's all free" (G4: White, no recent experience, would choose private)	*"Some people may want to save their medical scheme and go to a public hospital and get them for free"* (G1: Black, recent experience private)
Money, it costs a lot of money to go to a private hospital" (G6: Black, no recent experience, would choose public)	*"All public hospitals have problems; and not all private hospitals are rich and have nice things; everybody has problems; the problems are not all the same"* (G5: Black, recent experience public)
"She got an infection in a private hospital; it's more acceptable when it	*"There are private hospitals and even public ones that have different*

happens in a private hospital which is a dangerous way of looking at things" (G3: White, recent experience private)	*reputations, they are not all good, even in the private hospitals certain wards or sections may not be all that great; it's not always the hospital as a whole; busy areas or sections of the hospitals may be more affected"* (G1: Black, recent experience private)

Table 16: Over-servicing in private hospitals

Private Hospitals	
"Those tests can be very expensive. And sometimes you get the feeling they don't actually need to do it but they do it anyway because they can" (G4: White, no recent experience, would choose private)	*"Or sometimes there is a cheaper way of doing the investigation, but they'll do the more expensive one to make money out of you"* (G4: White, no recent experience, would choose private)
"You know that whatever is wrong with you will be investigated; sometimes over-investigated" (G4: White, no recent experience, would choose private)	*"In a good way in that whatever is wrong with you they will dig until they find it, but also in a bad way because sometimes they dig and dig and R500 000 later, they still don't know what is wrong with you" (G4: White, no recent experience, would choose private)*
"And the private hospitals only have a few people that go there because not everybody can afford it" (G6: Black, no recent experience, would choose public)	*"In the private there's few people so less mistakes and problems happen"* (G5: Black, recent experience public)

Table 17: Working conditions and impact on productivity in private and public hospitals

Public Hospitals	
"In the government hospitals there are excellent doctors, not coping with the workload" (G1: Black, recent experience private)	*"I agree that private hospitals are good and I would go there in a heartbeat, but we also need to look at what circumstances the government is making these people work under"* (G4: White, no recent experience, would choose private)
"It's easy to say that the nurses in the private hospitals do their jobs and it's true they do, but they have no reason not to. They have all the equipment they need at their fingertips so they actually have no excuse for not doing their jobs properly" (G4: White, no recent experience, would choose private)	*"But you know it's the people that make the place dirty. Sometimes you find that the place has been cleaned, but the people come and make it dirty. Where there is too many people it will always be dirty. The private hospitals don't have so many people so that's why it stays clean"* (G6: Black, no recent experience, would choose public)
"You get very good nurses, but they are burnt out because of the understaffing" (G1: Black, recent experience private)	*"If I'm working in a government hospital that does not have even basic injections then it's going to be harder for me to do my job and I won't be able to do it properly"* (G4: White, no recent experience, would choose private)
"People are not coping because of overload, the nurses are overworked"	*"If you don't have the equipment you need then it's impossible to do your job properly"* (G4: White, no recent

(G1: Black, recent experience private)	experience, would choose private)
"They can still be rude and horrible in the private sector; I'd like to believe that you can still find rude nurses in the private hospitals, it's not just limited to public hospitals only, they may be more obvious in the public hospitals" (G1: Black, recent experience private)	*"The attitudes of the nurses, those same nurses who work in public hospitals also work in private hospitals"* (G1: Black, recent experience private).
"The positive point is that you do get good specialists" (G2: Black, no recent experience, choose private),	*"You get a holistic approach"* (G2: Black, no recent experience, choose private),
"I was treated fine" (G5: Black, recent experience public),	*"They are trying, they do their best with whatever they've got"* (G5: Black, recent experience public),
"They really tried for me, they did a good job" (G1: Black, recent experience public).	

Table 18: Trust in the public hospitals

Public Hospitals
"*I would probably go, but will have to be 100% sure that they have improved"* (G1: Black, recent experience public).
"It's like flying an airline that you know has been crashing a lot of planes, you wouldn't trust them completely ever again"; (G1: Black, recent experience public).
"They are going to have to win society's trust" " (G2: Black, no recent experience, choose private)
"I don't think I trust it; I've lost so much faith in the system; trust is earned, I would still have fears, what if something goes wrong" (G1: Black, recent experience public).
"For a lot of people it will be difficult to believe that it (change) has happened unless they can prove it" " (G2: Black, no recent experience, choose private)
"I have to be 100% sure that they've changed or improved things before I decide to go there" (G4: White, no recent experience, would choose private)
"They would need to do aggressive marketing to get me in there" (G2: Black, no recent experience, choose private)

Table 19: Recommendations and possible considerations for the future in order to improve the condition of the public hospitals

Benchmarking public hospitals against private hospitals	**Government making financial investment into public hospitals**	**Improvements in security, buildings and equipment**	**Proper staffing and improvements in staff attitudes**
"*Look at the private hospitals and see what could be done to make the public hospitals like that, approach those that are doing it right"* ". (G3: White, recent experience public)	"*The government needs to first start by putting money into these hospitals so that things can be fixed*" (G4: White, no recent experience, would choose private	"*I think they need to first start by fixing the buildings, equipment and everything else that is broken in the hospital or buy new ones if the old ones can't be fixed*". (G3: White, recent experience public)	"*Improve staffing numbers in the hospitals*"; (G3: White, recent experience public)
"*They must look at what happens in the private*	*"Renovate the hospitals, add a coat of paint here and*	"*I think also to improve the security, you know. Get a*	"*Increase the numbers of doctors and nurses and*

hospitals and try to improve it like that" (G8: White, no recent experience, choose public)	*there, fix all the broken stuff"* (G1: Black, recent experience private)	*proper security company to do the job*" (G6: Black, no recent experience, would choose public)	*provide them with adequate training*" (G8: White, no recent experience, choose public)
"I think it will help because they do the same thing, help sick people, so why can't they learn from them" (G6: Black, no recent experience, would choose public)	*"I think that the government needs to go back to the drawing board and look at where things have gone wrong. You know the public hospitals have gradually deteriorated over time and they need to find out why"* (G4: White, no recent experience, would choose private)	"*And also make sure there are enough tablets and medicines*"; (G6: Black, no recent experience, would choose public)	*"People right at the top are not qualified for the job. "Getting the right people in the right places, people that are qualified for the job, not because it's my cousin or whatever"* (G2: Black, no recent experience, choose private)
"Give the hospitals more money; see what the private hospitals do and make it the	*"The government needs to stop all this corruption and abuse of money and use the*	*"More people to clean the hospital; fix the grass; make it nice; make it look nice;*	*"Get more people to do the work; pay them good money so that they are not always*

same; like it is in the private hospitals" (G5: Black, recent experience public)	*money for what it's meant for, fixing the hospitals"* (G7: White, recent experience public)	*windows are so dirty here; paint the walls* (G5: Black, recent experience public)	*striking"* (G5: Black, recent experience public)
They should have a standard that they can compare themselves to. Pair a government hospital to a private hospital and work towards getting the government hospital to that same standard" (G4: White, no recent experience, would choose private)	*"It's going to need a lot of money"* (G4: White, no recent experience, would choose private) *"The government has money to put into these hospitals and they must just do it"* (G3: White, recent experience private)	*"Make the hospitals bigger; extend the hospitals; bigger space for the patients"* (G5: Black, recent experience public) *"They need to just pump a lot of money into those hospitals and buy medicines, machines, improve the security"* (G4: White, no recent experience, would choose private)	*"The nurses and the doctors and in fact everyone that comes into contact with patients or their families has to be trained on people skills and how to treat people right"* (G4: White, no recent experience, would choose private)