

MEDIA RELEASE NO. 6

USE AND QUALITY OF HEALTH CARE SERVICES

The **South African National Health And Nutrition Examination Survey (SANHANES-1)** was established by the Human Sciences Research Council (HSRC) as a population health survey that will be repeated regularly to address the changing health needs in the country and to provide a broader and more comprehensive platform to study the health and nutritional status of the nation on a regular basis.

The study, compiled by a research consortium comprising the HSRC and the Medical Research Council (MRC), was financed by the national Department of Health and the UK Department for International Development (DFID) and the HSRC.

SANHANES-1 provides critical information to map the emerging epidemic of non-infectious, or non-communicable diseases (NCDs) in South Africa, and to analyse the underlying social, economic, behavioural and environmental factors that contribute to the population's state of health. Data on the magnitude of and trends in NCDs, as well as other existing or emerging health priorities, will be essential in developing national prevention and control programmes, assessing the impact of interventions, and evaluating the health status of the country.

Methodology

SANHANES-1 included individuals of all ages living in South Africa, except those staying in educational institutions, old-age homes, hospitals, homeless people, and uniformed-service barracks. The study was conducted during 2012; 25 532 individuals (92.6% interview response rate) completed a questionnaire-based interview; 12 025 participants had a physical examination completed by a medical doctor, and 8 078 participants provided a blood specimen for biomarker testing. A biomarker is a measurable characteristic that reflects the severity or presence of the state of some disease. This first round of SANHANES will provide baseline data of a representative sample of the population for future analysis over long periods of time (longitudinal surveys).

Key findings

The overwhelming majority of participants (96.8%) received care when they needed it, ranging from 96.0% of black African to 99.4% of white participants.

Just over one third (36.1%) of participants ever needed care from the private health sector with a mean duration of 1.8 years since such health care was received; corresponding demand from the public health sector was 45.8% and a mean duration of 2 years.

Over a third of respondents reported that their reasons for needing care from a doctor or hospital the last time was due to acute conditions (38.4%) and other conditions (40.3%); a lower proportion of respondents (18.0%) reported chronic conditions as their reasons for needing care.

Almost three-quarters (71.0%) of the population who received care in in-patient facilities received it in public hospitals as opposed to private hospitals (27.7%). Among the respondents who received in-patient care, such care was for acute conditions (17.1%), chronic conditions (20.1%) and a very small percentage for communicable diseases (3.6%), and the rest (59.2%) indicated other reasons.

Payments for the last in-patient health care for participants over the last 12 months were through medical aid contributions (25.3%), followed by out-of-pocket payments (17.9% total, that is 11.4% self-paying and 6.5% paid by a family member) and other sources (11.3%), while the rest were free of charge (47.5%).

Slightly more than 38% of participants aged 15 years and older received out-patient care, which may have been received at a hospital out-patient department, health centre, clinic, private offices or at home, with 40.0% of them having had care once in the preceding 12 months.

Among out-patient users of health care, most used public health facilities (62.7%), with fewer seeking care in private health facilities (35.4%).

Nearly four in ten (38.4%) of respondents sought out-patient care for acute conditions, slightly less than a fifth (18.0%) for chronic conditions and a very small percentage for communicable diseases (3.3%).

Payments for the last out-patient health care visit were contributions from the medical aid (20.2%), followed by out of pocket (18.7%, that is, 15.2% self-paying and 3.5% paid by family), other (4.3%) and the rest were free of charge at the point of care (57.7%).

The overwhelming majority of participants were satisfied with in-patient (85.4%) and out-patient (86.0%) health care services they received but less satisfied with health services (71.3%) and health provision (69.3%) in their area.

Although public sector users were less satisfied (83.1%) than private sector users (92.1%), the differences were not statistically significant. Overall, the dissatisfaction levels for in-patient (6.0%) and out-patient (6.9%) health-care services were low. The satisfaction level with out-patient public care received was 80.1% compared with 96.5% for participants seen in the private health sector. The rate of very satisfied was much higher in the private sector than in the public sector (57.1% compared to 24.5%).

The overall level of dissatisfaction was 5.6%, while 1.2% of participants were very dissatisfied. A similar pattern was seen for in-patient care.

In relation to waiting times before patients received care (i.e. whether patients were seen promptly), the majority of those seen as outpatients in the private sector (87.7%) had a good or very good experience when compared with the public sector users (59.5%). The corresponding figures for in-patients in the private and public sectors were 93% and 72.4%, respectively.

In total, 95.5% of private sector patients compared with 80.4% in the public sector experienced respectful treatment (good or very good) in health-care out-patient facilities and for in-patient facilities, 97.6% and 84.9% respectively.

Concerning communication between health-care providers and patients, 95.1% of private sector out-patients, compared with 80.1% in the public sector, had their conditions clearly explained (good or very good) by health-care providers. For in-patients these figures were 96.8% and 84.9%, respectively.

Comparing experiences of participants in making treatment decisions (good or very good) between in-patients in the private sector with those in the public sector, a total of 94.4% and 81.5%, respectively, said they were involved in the decision by health-care providers, and for out-patients, respectively, 92.6% and 77.6%.

In total, 95.4% of private sector out-patients compared with 83.7% in the public sector could speak privately (good or very good) to health-care providers, and for in-patients, respectively, 97.4% and 81.6%.

Comparing the experiences of private sector out-patients with that of the public sector, 92.4% and 79.5%, respectively could see the care provider of their choice, while in the case of in-patients, 96.9% of private sector compared with 82.9% in the public sector could see the care provider of their choice.

The majority of both public and private out-patients found the cleanliness of facilities to be very good or good (88.6%). A larger proportion of private out-patients thought the cleanliness was very good compared to public out-patients (50.4% compared to 22%), whereas a larger proportion of public out-patients (63.2%) thought cleanliness was good compared to private care out-patients (44.8%); the same pattern was recorded for in-patients.

The majority of in-patients, both public and private sector users, found the availability of medicines to be very good or good (88.6%). Private in-patients were more likely than public in-patients to find medicine availability to be very good (66.2% compared to 29.1%), and the inverse was true for medicine availability being good (55.8% public and 31.3% private); a similar pattern was seen for out-patients.

The majority of both private and public-sector users found out-patient facilities to have very good or good availability of tests (83.0%). Private out-patients were more likely to believe the availability of tests was very good compared to public out-patients (47.7% compared to 17%), and public sector out-patients were more likely to think the availability of tests was good compared to private out-patients (59.2% compared to 48.2%); the pattern was similar for in-patients.

Notes

Firstly, the findings confirm the continued existence of health inequalities especially between whites and black Africans due to the legacy of apartheid. Secondly, and more importantly, the findings mainly show that South Africans held positive perceptions towards the quality of services available in both public and private services. This was true for both in- and out-patients services on such parameters, being treated respectfully, clarity of explanations, involvement of patients in decision-making, experience of privacy, cleanliness of facilities and the availability of medicines and tests. However, the finding that waiting times were much longer in the public health sector when compared to the private sector, although expected, is of some great concern as it implies there is a shortage of health professionals in the public sector, which may lead to overcrowding.

There is consistency between the findings from the present study and previous ones in as far as the continued existence of health inequalities especially between whites and black Africans. In particular, whites have more access to private health insurance through medical schemes and that medical scheme membership increases access to health care.

According to the current study, it appears that the South African population is overwhelmingly satisfied with health services (similar findings were observed in other studies). These results contradict accounts of the dismal state of health care in the country.

The often-repeated myth that the quality of the health care system is bad is not supported by evidence. While there are pockets of unacceptable health care services provided in facilities, these should not be used to generalise the state of the entire health-care system. Although some may argue that those who are satisfied with the public health care system have low expectations, this still remains to be investigated; at present, there is no data to substantiate such an assertion.

Recommendations

On the basis of the present findings, the SANHANES-1 Study recommends the following:

- The government and the media should be encouraged to introduce a major communication campaign to support health-care providers in the public sector by communicating a clear and unambiguous message that:
 - Most participants who used public health facilities consider health facilities to be clean, to have medicines and to have testing equipment for diagnosis, and
 - Most participants perceived health care providers to treat them with respect, ensuring privacy, giving them a clear explanation of their presenting conditions and available treatment options, involving them in decision-making regarding the treatment options to encourage adherence, and are satisfied with the ease with which they could see a health care provider they were happy with.
- A combination of home-based care, managed by community health workers and the use of point-of-care technology should be introduced by the health sector. This will reduce patient load at primary care facilities, reduce waiting times and reduce the cost of health care in the long run.

The HSRC remains available to support the Department of Health in the implementation of these recommendations.

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