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Private Health Facilities Participation in Comprehensive Health Service

Abstract

Primary care, as the first point of entry to the health system is reliant on access to healthcare services required by populations. This paper reflects on health service delivery by private healthcare practitioners and their contribution to district-based primary health care. Private health facilities were mainly doctors private consulting rooms. The health care providers included general practitioners (medical doctors), nurse specialists, and allied health professionals who provided primary and continued care to diverse populations in rural areas. Private health providers were mainly engaged in consultative and curative services while their participation in primary care included promotive and preventive services such as emergency care, family planning, antenatal care, HIV testing, general assessment, chronic care, Tuberculosis and malaria prevention and control amongst others. It is noteworthy that the practitioners provided services for extended hours out of normal working time such as doing evening home visits, weekends, and holidays. Private healthcare service consumers were urban and rural residents, who visited private health facilities for primary health care using medical aid services or out-of-pocket payments. Due to the high demand of healthcare services in public primary healthcare centers, clients opted to attend primary care at private healthcare facilities. The contribution of the private health sector in health service delivery complements the efforts undertaken to attain health goals through primary healthcare in the province.

Abbreviations

Comprehensive health service • Delivery primary care • Primary health care • Private health facilities

Review Article

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Introduction

The primary healthcare approach was developed and recognized as key to effective healthcare services by the World Health Organization (WHO) in its Alma Ata Declaration in 1978 [1]. Primary healthcare is the vehicle of public health service delivery and the first point of access to health services [2]. Moreover, it aims to provide universal health coverage and comprehensive basic care [3]. Accordingly, primary health care is meant to ensure accessible, acceptable, appropriate, available and affordable health care to healthcare consumers [4]. postulate that primary healthcare in Africa has suffered due to a lack of government commitment and investment, low-level healthcare workers with limited training, and a lack of supervision. Related to this, the private health sector has a meaningful and growing role in closing Africa's healthcare gap as it accounts for as much as 50% of healthcare provision [5]. In Ethiopia, Kenya, Nigeria and Uganda, an

estimated 40% of people in the lowest economic quintile receive healthcare from private, for-profit providers [5].

South Africa has a mixed delivery health system in which both the public and the private health sector offer diverse healthcare services, while they exist in parallel. Primary care services include public clinics, mobile clinics and district hospitals. In March 2021, the Minister of Health of South Africa reported that 84% of South Africans make use of public healthcare services, while the remaining 16% utilize private healthcare services (Turner 2021). However, the public sector alone is strained to fulfill the health needs of people due to the economic growth, and increased population [2]. As a result, private healthcare facilities have become the main sources of primary healthcare services in some rural areas in South Africa, while private healthcare is growing in both urban and rural settings. [2] Indicates that 17.2% of the South African population has private medical aid coverage, which affords them access to private medical care. The government together with the private health sector strives to improve delivery of comprehensive quality healthcare services to address the ever-changing disease landscape, increasing prevalence of non-communicable diseases, and pandemics.

Services at public primary healthcare centers begin at community health centers, as the first point of entry for healthcare consumers. The observation is that most of the primary health centers are nurse-led [6]. Procedurally, primary care consumers should begin at primary healthcare centers for care of non-emergency conditions, where they will be consulted and referred to an appropriate hospital or next level of care for definitive care. However, this sometimes proves to be a challenge as some primary health care facilities such as clinics have limited staff and specialists to conduct initial assessments, limited emergency and laboratory services to conduct tests before referral, and experience overcrowding while the facilities do not offer after-hours service. Additionally, once the clients have been referred, they still must be on waiting for assessment and management at the referred facilities, like any first-time client.

The primary healthcare centers mainly close at 4-5pm, and those that work for 24 hours, mainly offer services for maternal care, especially deliveries of booked pregnant clients. The implications are that clients who require after hours services should then go to the local or district hospitals for emergency and non-emergency services. On the other hand, for patients visiting the hospitals, if during initial assessment or triage [7] they are found to be “cold cases” or suffering non-emergency conditions, they are kept waiting while priority is given to emergencies. Further challenges in primary health services in public settings are long waiting hours, non-availability of care services after hours, and delayed referral to district hospitals [8]. South Africa’s constitution guarantees every citizen access to health services through the public and private health sectors [9].

However, there is a considerable variation in services provided among private and public or government facilities. Primary care facilities are meant to be the first point of contact for patients and should provide an initial assessment of the patient. In private health facilities, patients or clients are consulted immediately and referral is prompt after assessment. This paper contextualized the challenges such as the shortage of staff [10] which leads to long waiting times [11], inadequate access to public health facilities due to distance and non-availability of care services after hours, low patient satisfaction [12] as well as delayed referral to district hospitals from primary healthcare. During the Covid-19 pandemic [13], private health practices saw many clients consulting with them due to some challenges experienced in primary healthcare facilities such as lack of staff and personal protective equipment. This paper aims to reflect health service delivery by private health facilities and their contribution to the country’s district-based primary health care.

Purpose of the study

The study examined the characteristics of healthcare providers and consumers and the nature of health services delivered by private health facilities in a specific rural area in, Mpumalanga province, South Africa; to underscore the private health facilities ‘s contribution to the country’s primary healthcare system.

Research methods

A descriptive approach was followed.

Setting and population of the study

The study was conducted in a rural area in Ehlanzeni district, Mpumalanga which is one of the nine provinces

in South Africa. According to Statistics South Africa (SSA) Mpumalanga had an estimated population of 4. 4million people in 2017 which accounted to 7.9% of a share of the South African population (SSA 2017). Ehlanzeni district had a population of 1,950,000 in 2023 [14]. Its health profile indicates that the two leading causes of death in the district are non-communicable diseases (NCD) (39%) and communicable diseases such as HIV and TB (30%) [15]. These are the common healthcare problems that require attention at the level of primary healthcare. Ehlanzeni District itself is said to have 141 health care facilities which include 110 clinics, 15 Community Health Facilities, 11 District, Regional and Tertiary hospitals and 5 “other” hospitals distributed [15]. The region or rural area for the study has no privately owned hospital. There is one TB hospital and public clinics around. The largest number of facilities are concentrated in the City of Mbombela which is approximately 45 km from this rural area. There are approximately five (5) private practices owned and run by general practitioners (GPs) in the area. Private health facilities are mainly doctors private consulting rooms in their own buildings that were constructed for medical and surgical care. The regional health bureau list of facilities in the province indicates that most of higher levels private health facilities, especially hospitals and specialists’ units are in bigger metropolitan towns like Nelspruit, while primary clinics are found in smaller towns, mainly in the rural part of the region. The population in this study were healthcare consumers who sought and used healthcare services in the GPs’ private practices, healthcare providers working in these private practices and owners or managers of the respective private health facilities.

Data collection

Data were collected from healthcare providers in the specific rural area, to support the observations of the involvement of private practices in primary care in the rural area. A pretested structured self-designed instrument was used for data collection. The instrument was prepared and organized in three sections for healthcare consumers who were mainly patients and their escorts or companions, healthcare providers in the private health sector and health facility managers or owners. Data were collected from patients or their escorts during their wait before the doctor’s consultation, as they were usually in a hurry to return to their home after consultation. The researchers strived to make the purpose of the study well understood and for the participants to wait comfortably until the interview ended. With the GPs and other allied healthcare professionals, repeated visits were made as well as arranged appointments to ensure that there was no disturbance of the normal daily functions. All the participants opted to do the interviews over the weekend and after work. Permission was obtained from each recruited facility’s owner or manager and clients to proceed with interviews. Anonymity and confidentiality were maintained by conducting the interviews in the special waiting area away from the other clients for those waiting for consultation. There were no patients records or information related to their conditions asked. Numbers were allocated to the clients to avoid use of their names, and none of them was asked to provide name.

Observations

We designed an observation template. At each private practice, the researchers observed the inflow of patients for a period of 3 days, one of which was a Saturday or Sunday. The researchers asked the owner or manager of the private health facility for permission before carrying out the observations of the client flow. There were no reported refusals to participate in the observations as they did not disturb the activities in the private practice. The observation was of the characteristics of healthcare providers and consumers; and the nature of health services delivered by private health facilities.

InterviewsWe conducted semi-structured interviews with facility managers, healthcare practitioners and clients. These participants were conveniently selected based on their availability and experience of the private healthcare services provided at the sites. We asked them about their experience of services, type of services they offered or received, the importance of having doctors’ rooms in the area, and their reasons for choice of private facilities rather than public primary healthcare facilities, the role the private doctors rooms played in the community. Each interview lasted approximately 20mins and field notes were recorded with participants’ consent.

Data analysis

Data were analysed manually using a statistical calculator due to the size of the sample (N=30). Descriptive analysis

for selected variables were calculated appropriately for addressing the study purpose. Units of analysis were private health facilities, service consumers, healthcare providers and managers or owners representing their respective facilities.

Results

Primary data were gathered from 30 participants (3 health facility owners or managers who were the GPs, 6 healthcare workers, who were other allied health practitioners and 21 service consumers who were clients or their escorts.

Characteristics of included health facilities

Private health facilities were mainly doctors private consulting rooms, situated in rural areas. The GPs were providing healthcare services in their own buildings that were constructed for that purpose. Among the three (3) included private health facilities in the rural area, two (2) were private doctors' rooms with facilities led by owners. The facilities included other allied health workers such as dentists, radiographers, and optometrists. One private facility was established in partnership and consisted of allied health workers. These private healthcare facilities were in the same rural area; within approximately 15 km from the district hospital or public primary healthcare facilities. The private practices were within walking distance for some of the service consumers in the rural area.

It is noteworthy that accessibility of primary healthcare services includes the proximity of health facilities to patients' homes; and therefore the ease with which patients were able to utilize healthcare services within a reasonable distance [16]. The average number of patients per day in each private facility was between 20 and 30 on weekdays and 10 on weekends. The observation data showed that the private health facilities in the rural area provided services out of normal working time such as weekends and holidays. Some doctors also provided home visits after work, to assess emergencies. The private health facilities were found to support the provision of primary healthcare by community health clinics which did not have doctors as they were mainly nurse-led, level 1 (district) hospitals where there are limited specialist services; and Level 3 (academic) hospitals which have most specialist services; but were approximately 42 km from the rural area where the study was done.

Characteristics of healthcare workers

The healthcare workers were general practitioners, and allied health professionals who provided both primary and continued care to diverse populations. Private GPs were the important point of first contact and ongoing care for healthcare consumers. Cross referrals were also made to allied health professionals such as optometrists, radiographers, dentists, dieticians, etc. This is in line with PHC provision which aims to address the broader determinants of health and focuses on the comprehensive and interrelated aspects of health and wellbeing. Service years at the facilities ranged from 10-20 years, meaning that the private facilities were in existence for a long.

Characteristics of service consumers

The observation was that patients and clients at the private practices were urban dwellers and rural residents, who visited the private health facilities for current medical conditions, for continued care or for follow-up visits. Some healthcare consumers used medical aid services while others did out-of-pocket payments. Sixteen (16) female (%) and five (5) male clients participated in the study. The ages of patients ranged from toddlers to the elderly. The majority, 15 (71.5%) were from the surrounding rural areas and the rest 6 (28.5%) were urban dwellers. More than half of clients (12/21) travelled approximately 5km or walked to reach their preferred private healthcare facility. Some patients from the urban areas needed to travel up to 30km to arrive at their favorite private health facilities, which took them close to 30 minutes to travel with public transport. Three-fourths of participants (15) (75%) had a history of multiple visits to the same private health facility.

The reason was that they received consultation, as well as treatment at the same time, and it was easy to get referrals for specialist care. The waiting time at the same facility was acceptable as it took 1 hour 30 minutes maximum when the practice was busy, and the follow-up appointment date was provided by the doctor. This is in line with the submission that patients' choice to use services from private or public healthcare providers is determined by several factors such as socio-demographic characteristics, and economic, social and physical access. The type of health services delivered, and outcomes were influenced by the characteristics of patients [17].

Nature of healthcare services provided at private facilities

It is common knowledge that there is currently no free healthcare offered in South Africa. Clients using primary care at the private healthcare services paid through their medical aid schemes or out of pocket. The observation was that a range of medical services were provided. Private health facilities were mainly engaged in curative services while their participation in primary care included emergency services such as for first aid, respiratory distress, primitive and preventive services such as family planning, antenatal care, HIV testing, general assessment, chronic care, Tuberculosis and malaria prevention and control. The clients indicated their preference of private practice because professionals in the private health facilities commonly told the diagnosis and treatments were prescribed with tailored counseling. Although the private practices did not have laboratory services within, they worked closely with the privately owned laboratory services. The medical doctors were responsible for the collection of specimens; tests were efficient, and the clients were able to receive their test results on time. Additionally, some private health facilities were organized by imaging services like X-ray, ultrasound, and endoscopy. The referral linkage to either public or private and to higher or lower health facilities was found to be efficient as clients did not have to wait for a long time before the referral to the next level.

One of the five private practices was found to provide HIV services exclusively. This is in line with this common communicable disease affecting people in the area. HIV and other diagnostic tests were said not to be readily available in public primary clinics, as they have no laboratory setup in house. The private health facilities in the region have been allowed to run specific health programs that were primarily practiced in public healthcare facilities including the provision of preventive health services. Provision of HIV testing and care, tuberculosis, malaria, and family planning services were among these healthcare services. The private health facilities reported providing HIV counseling and testing services, although none were providing TB DOTS services as there is a TB hospital 20km distance away. Even though it is resource intensive and with different capacities, the private health sector strived to make state-of-the-art medical services by using specialized equipment and installing advanced diagnostic technology such as ultrasound scans.

This enabled the GPs to serve patients directly without having to refer them to public facilities. Moreover, as part of quality service, private health facilities' laboratories where they referred their clients had regular external quality assessment (EQA) and demonstrated good performance. For instance, the GPs indicated that an estimated 71.5% of patients requested multiple laboratory tests. Commonly requested samples for diagnosis were blood, urine and sputum followed by stool. In addition to this, patients were also sent for other diagnostic techniques and interventions such as to psychologists, cardiologists, obstetricians, pediatricians and pulmonologists.

Discussion of the results

The researchers acknowledge the growing role of private health facilities especially in rural areas, because generally, private health facilities are found densely in towns where there is better infrastructure and easier access to medical supplies [2,10]. Indicate that high quality public health-care services are dependent on several factors such as accessibility, affordability, acceptability, adequacy, and availability. Accessibility is an important factor for all primary healthcare consumers [17]. Patients at private health facilities in the rural area for this study were mainly attracted by positive perception about diagnostic equipment and treatment, expectations of better skilled assessment by the GPs and allied health workers, low waiting time and better supportive customer strategies related to immediate referral to the next level of care. [18] posit that primary healthcare facilities are the gatekeepers to secondary healthcare. A study conducted in Ghana stated that perceived health system responsiveness was better in private than in public [19].

The fifth household health services utilization and expenditure survey in Ethiopia stated that there was higher rate of dissatisfaction with waiting time and availability of pharmaceuticals in public facilities [20]. Additionally, a study conducted in India showed that private providers often offered a diagnosis and immediate referral for definitive care [21]. Comfortably, the private primary health care consumers in this study indicated to be satisfied with the expedited primary care from private GPs. Private health facilities worked for extra time out of normal working

hours in the evening, weekends and holidays. This finding of opening for extended hours per day supports those who stated that private facilities are opened for longer time. This helped to catch clients, who may not have access to public health facilities as only emergency cases served out of normal working hours.

In addition to this, weekends were suitable for some patients (cold cases) or their escorts as they may not be occupied by other businesses. Additionally, private health facilities worked more time to satisfy clients. Private health facilities have mainly engaged in providing outpatient services for all adult and pediatric patients. Family planning and antenatal care (ANC) services were also delivered by private health facilities while antiretroviral therapy (ART) and immunization services were seen practiced. A systematic review on the role of private health sector in providing quality health services showed that private health sector contributes much in creating access to health service delivery like family planning and control of communicable diseases [22]. Even though private health facilities were mainly targeted on diagnosis and curative services, their engagement to the preventive activities were profound. For example, participation in the provision of other services were found greater. Managing of emergency cases, at least providing first aid and referral services were provided in the private health facilities included in this study.

However, patients in private health facilities were requested to pay immediately for services. In contrast, WHO indicated the need to access emergency health care regardless of sociocultural factors and the ability to pay before receiving services. Private health facilities were not fully involved in provision of intensive care for seriously ill patients due to different reasons. As a result, seriously ill patients were commonly referred to public healthcare facilities. Referral was practiced as a two-way process could be among public and other private, medical practitioners; and ensured that a continuum of care is maintained to patients or clients. In general, patient referral to either side, public or private, up level or down was very important to exhaust all the benefit to patients. In this study, patient satisfaction to prices of services delivered was associated with availability of private services and history of visit to other primary health facilities. There is no established system of serving patients who cannot afford service cost in private health settings.

According to [23] the advantages of private healthcare are short wait times, quality care, better facilities, adequate resources available, appointments are not rushed, and proper disease control and prevention practices are utilized. The disadvantages of private healthcare are that it is expensive, there are fewer facilities, and patients are responsible for paying for healthcare visits, pharmaceuticals, and additional resources such as wheelchairs. On the other hand, a study by [24] highlighted doctors' extended shifts as a risk to practitioner and patient. It was indicated in this study that getting access to more specialized levels of service depended on referrals. The participants preferred to pay to see a private general practitioner (GP) who may refer them on for hospital services if necessary.

Conclusion

To get the perceived high-quality health services within a short waiting time from a reputable provider, patients prefer private health facilities even though higher service charges required. The issue of equity of access to offered health services by the private sector is noted. Significant health workers are practicing healthcare provision in private health facilities on a full-time basis. The GPs in the private sector are available for every patient/client who can pay for services. Private health providers have worked in their buildings and provided user-friendly services [25]. A few medical services in agreement to their level were provided by private health facilities. The referral network is open and functional to either public or private and from lower or higher facilities. Private health facilities mainly provide curative services to patients of different ages and socio-economic groups.

They are also providing preventive and primitive services related to some selected health programs. Effective healthcare service delivery is a result of a well-organized and well-functioning health system that clearly understands the health priorities of the prospective community. Private healthcare facilities in this rural area make available services tailored to the local health needs of the community by properly scanning and focusing on health problems with the highest concern. Comprehensive and integrated health services are designed to maximize benefits to the intended population. Private health facilities have established associations in the region as well as the

province with other similar entities in the public sector. The private practice sector's contribution to the health goals of the people in the region as well as the delivery of comprehensive healthcare services is highly significant. A further study is recommended to evaluate the successes and challenges of private healthcare practices.

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