There is evidence that it is common practice amongst the poorer groups in the country to use private primary health care. Data are discussed to provide some perspective on the magnitude of this utilisation pattern. The chapter explores why low income groups pay out of pocket for the services of private providers, even where the care is often worse than in the public sector.

Themes from ten focus groups in Eastern and Western Cape are discussed. The essence of the themes is the perception that public sector treatment is not effective, that clinics cannot treat all illnesses and that the way that patients are treated in the public sector is unacceptable. People believe that they receive better quality care from private providers.

The chapter concludes that most patients are keen to use the private sector and that private practitioners play an important role in PHC delivery in many small towns. It is clear that the relationship between public and private services is intricate. There is a need to educate the public about the range of services that is available at public sector clinics, to overcome the incentives for private doctors to convince patients that private services are better, to ensure that politeness and respect are shown to patients in public sector clinics, and to establish acceptable working relationships between the public and private sectors (through contractual mechanisms, regulation, elimination of perverse incentives and perhaps accreditation of private providers).

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The Health Economics and Financing Programme is supported by a grant from the UK Government’s Department for International Development
Introduction

The inter-relationship between public and private sectors appears intricate yet firmly bound. The resources of the private sector are currently an important part of the health care delivery system in many towns. People often use both the public and private sector for the same health problem whilst doctors are often employed as district surgeons or medical officers as well as having their own private practices. The same private GP visited by patients on a cash basis may also be employed in the town’s hospital/health centre, may also be the district surgeon, responsible for medico-legal work and ultimately emergency cover. In return, payments from the state for the rendering of these services form an important part of his or her income. Without these payments, the viability of their remaining in practice may be questionable, and in turn this has ramifications for the whole population of the town, whether they use private or public services. Yet state payment is currently riddled with problems of inadequate monitoring and the perverse incentives inherent in any fee-for-service system.

This section explores to what degree and why low income groups pay out of pocket for the services of private providers. Results of an analysis of two household surveys are drawn upon, and qualitative information from focus groups is summarised. The complex inter-relationship between the public and private sectors at primary care level is then discussed.

Evidence is drawn primarily from two sources: an analysis of household survey data on illness/injury and health care expenditure and qualitative data generated by an ongoing study examining the desirability of contracting out primary care to private providers. McIntyre et al. analysed the Project for Living Standards and Development (LSDS) and the 1995 October Household Survey (OHS) and their analysis is heavily drawn upon here.

Use of private providers by low income groups

LSDS data (Table 1) suggest that 58% of all South Africans who seek care for an illness do so in the private sector. In the lowest income quintiles (1 and 2) this is 37% and 42% respectively, implying that this is also a common practice amongst poorer groups. These figures appear quite high, and McIntyre et al. point out that this may be an overestimate due to some poorly worded answer choices in the LSDS survey, which resulted in all respondents who had seen a part-time district surgeon (PDS) being likely to answer as if they had seen a private doctor. Whilst most PDS are private GPs, they deliver services to patients under contract to the state and patients do not pay. The LSDS data can perhaps be taken as a reflection of the role played by the private sector in the delivery of primary care (particularly in rural areas), but an overestimate of the amount of patients who are paying cash for these services.

An alternative source of estimates for the degree to which the private sector is used is the October Household Survey (OHS). Table 2 shows estimates of the percentage of ill or injured seeking care who use private services according to the OHS data. These figures are considerably lower than their LSDS equivalents, especially in the rural areas. The OHS reports an overall private sector utilisation figure of 31.2%. Note that both these estimates are percentages of those seeking care; in income quintiles 1 and 2 it is estimated that only 73% and 79% respectively of those ill or injured seek care.

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b New Purchaser/Provider relationships in primary care is a three year research project funded by the UK government’s Department for International Development. The project is being jointly undertaken by the London School of Hygiene and Tropical Medicine, the Centre for Health Policy of the University of the Witwatersrand and the Health Economics Unit of the University of Cape Town.

c covering 8 848 households and conducted in 1993

d covering 29 700 households
8: Patient choice of primary care provider

Table 1: Percentage of those who sought care who used private services (LSDS data)

<table>
<thead>
<tr>
<th>Income quintile</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>38.8</td>
<td>30.6</td>
<td>37.1</td>
</tr>
<tr>
<td>2</td>
<td>44.7</td>
<td>36.7</td>
<td>42.6</td>
</tr>
<tr>
<td>3</td>
<td>46.3</td>
<td>42.7</td>
<td>44.9</td>
</tr>
<tr>
<td>4</td>
<td>56.0</td>
<td>55.0</td>
<td>55.4</td>
</tr>
<tr>
<td>5</td>
<td>74.6</td>
<td>84.8</td>
<td>83.3</td>
</tr>
<tr>
<td>Total</td>
<td>48.9</td>
<td>64.9</td>
<td>57.5</td>
</tr>
</tbody>
</table>

Note: Income quintiles are shown in reverse order e.g. quintile 1 is lowest.

Table 2: Percentage of those ill or injured who used private services (OHS data)

<table>
<thead>
<tr>
<th>Income quintile</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13.1</td>
<td>24.8</td>
<td>16.5</td>
</tr>
<tr>
<td>2</td>
<td>18.5</td>
<td>24.0</td>
<td>20.7</td>
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<tr>
<td>3</td>
<td>17.5</td>
<td>29.9</td>
<td>24.2</td>
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<td>20.8</td>
<td>37.3</td>
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<tr>
<td>5</td>
<td>35.9</td>
<td>55.4</td>
<td>53.0</td>
</tr>
<tr>
<td>Total</td>
<td>18.4</td>
<td>40.1</td>
<td>31.2</td>
</tr>
</tbody>
</table>

Note: Income quintiles are shown in reverse order e.g. quintile 1 is lowest.

According to LSDS data, use of the private sector is higher in rural areas for all income quintiles except the fifth (highest income quintile). This pattern is contradicted by the OHS data, where urban use of the private sector is consistently higher for all income quintiles. A key explanation for this difference in the lowest income quintiles may be the classification of a visit to the district surgeon as use of the private sector. However even the lower figure from the OHS data means that a considerable proportion of poorer groups are paying for health care.

For those without medical insurance, primary care in rural towns in the Eastern and Western Cape is available from the clinic or the district surgeon at no charge, or a private GP. Anecdotal evidence suggests that private GPs charge a flat rate varying from R40 to R80 including drugs. In metropolitan areas the popularity of groups of clinics such as Carewell and Primecure is increasing as another private sector alternative. These clinics charge approximately R50-R60 for a consultation with a nurse/referral to a doctor, drugs, laboratory tests and x-rays. In either case, this payment represents a substantial sum, especially when services at a public sector clinic could be obtained for free.

d District surgeons are private GPs employed on a part time basis by the Province to render a range of curative PHC and medico-legal services on their behalf.
**Private doctor versus the clinic: views from the Eastern and Western Cape**

As one component of a larger study, ten focus group discussions (FGDs) were run between November 1998 and May 1999 in five rural towns in the Eastern and Western Cape. The purpose of the discussions was to determine possible reasons for the decision to pay for health care rather than use public sector clinics. Two FGDs were conducted in each town, one with women aged 20 to 30 years and one with women over 35 years. Recruitment took place within the community rather than at a particular facility, to try to capture the views of users and non-users of a variety of services. Women were invited to participate in the FGDs if they were not in full-time employment and did not have medical aid scheme coverage. Participants were asked to describe the facilities and services available to them for medical treatment if they or their children got ill, what their perceptions of the quality of service at each was and other benefits and disadvantages of using that service.

All of the five towns had recently had district surgeon/GP practices operating; but in two of these the district surgeon contract has recently ended. One of these towns was now without a doctor, with only a private GP visiting one morning a week. On other days the nearest doctor was 50km away in the next town. In the second town in which the district surgeon contract had ended, two private doctors remained and now did sessions at the community health centre.

Dissatisfaction with all public sector funded services, be they publicly run clinics or district surgeons, is a clear theme emerging from all the FGDs. Perceptions of the quality of treatment available from private doctors was on the other hand constantly favourable. In the hierarchy of preferences revealed by the FGDs a private GP was always seen as infinitely preferable to any other option. District surgeon services were commonly thought of as superior to the clinic, and in some cases considerably so; the clinic was sometimes dismissed entirely either for its poor quality of service or due to misconceptions as to the nature of services that it offers.

One participant summed up the decision process that seems common to many as follows: **“I would never go to the state doctor (district surgeon)... I will rather sit at home with my sick body and wait till I can lend money than go there”**. In many comments like this, the clinic was not even mentioned as a third option. Another client, recognising the clinic’s existence, summed up her decision process as **“If we have money, then we can go to the doctor. If I feel seriously sick on a Thursday (the day of week when private GP visits town), then I’d go to the doctor if I have the money. Otherwise during the week I’d have to go to the clinic”**. Themes emerging from the FGDs are described below to attempt to identify the factors shaping such attitudes to public sector care.

**Theme 1: Quality and choice come from paying for a service**

**“It’s that paying story versus that free of charge story”/“We get it for free so we have no choice”**.

The services of a private doctor are vastly preferred to any public services available. This was even true if it were the same doctor e.g. if you go and pay Dr X you will get better treatment than if you see him as a state patient. Comments demonstrate a clearly perceived link between the payment for the service and its improved quality; **“You pay and therefore you get better service”/“You have to go to a private doctor if you want to know how far your illness is”**. Participants in a town with a private doctor working on sessions were adamant that if you paid to go and see him in his rooms, you received better treatment than if you saw him at the public sector facility. **“At the private doctor, you feel good when you walk out of there”**. In all towns, perceptions of private service were that you received better medicines (“the best medicines”), a more thorough examination, privacy, respect and that all patients were treated equally. One participant said **“I believe that you can rather spend your money and then at least you know you are getting proper treatment”**.
In contrast, participants expressed frustration with the poor treatment that they received in public sector facilities alongside reluctance/fear to complain. In one town this frustration was expressed as follows: “It is not as if we have a choice, no matter how poor the service is we have to accept it because we are treated free of charge”. Most people seemed to know where and how they would complain, but had no faith that it would change anything. “You go through all that and nothing comes of the matter”. They felt that to complain would be pointless and may lead to worse treatment in the future.

**Theme 2: The treatment that you receive in the public sector isn’t effective**

“Our people feel that they are not getting well and so they go back again and again and again”.

Participants doubted the effectiveness of the treatment that they receive from publicly funded services. Common complaints were a lack of a proper examination and the poor quality or ineffectiveness of the drugs prescribed. “I go twice or thrice to the district surgeon/clinic and come back with lots of tablets that don't help” was a prevalent theme. When patients are not satisfied with the care that they have received or unsure of the explanation that they have received, they shop around for other opinions, often ending up with a private practitioner.

Participants said of district surgeons and public sector facilities, “They just pump you full of tablets. They never bother to tell you what is really wrong with you. It's only tablets and more tablets” / “Most of the time you get only tablets and you aren’t even examined” / “They just give you the same tablets month after month, they don't know if the circumstances have changed” / “I am not even sure some nurses know how to read BP” / “If the clinic’s medicine doesn’t seem to help you, you then go to the doctor out of your own accord”. A participant in the Eastern Cape said “We don’t have the money to pay the doctor, so our children often have to make do with the medicines we receive from the clinic, and that’s the reason the children become seriously ill”.

**Theme 3: The clinic can’t treat what is wrong with me**

“The clinic is for babies, pregnant women and TB” / “There is no clinic here”.

Misconceptions about whether there was a clinic in the vicinity, the nature of services that it offered, whether there was a charge and who should go there were common. In addition there was a general perception that the clinic wasn’t very useful as a health service. “You can’t really go if you are sick because there are no doctors” / “I don’t think that the clinic is equipped to deal with chronic illness” / “It’s just for children and TB and diabetics”. In an emergency one participant felt “I don’t think the clinic is much help, because in an emergency you will probably die first”.

On the other hand, some participants were quite positive about the clinic’s services, but still dismissed their usefulness for their own complaints. “There is no problem with the service, it is just that they cannot treat all illnesses there because they do not have the doctor or the best of medicines” / “There is only so much they can do, but they do their best because they are not doctors”.
**Theme 4: The way patients are treated in the public sector is unacceptable**

“Ugly” attitude of public sector health workers…“If you visit the clinic, you feel repressed and oppressed”.

People complained equally of the rudeness of district surgeons and nurses in clinics or day hospitals. For instance, one participant described how the district surgeon came out of his room and said to the people waiting “Look at you, you look like a bunch of sheep”. People commented “We are treated as if we are nothing” and about nurses in public sector facilities it was said “They have no way of speaking to people, that is why we stay away at times because it is so off putting when they are rude to you”.

A common theme is how the poor attitude of public sector staff discourages patients from attending. “I just stay away from that place because I get too angry”/ “I don’t feel like going because of the way that they treat the people”/ “…these nurses, some of whom come to work drunk”. In one town it was said, “Young girls do not want to come for birth control as they are too scared because they know the nurses will talk”. At another “I haven’t had my sugar tested for a long time because the surgery is always full and the atmosphere isn’t pleasant”. Nurses were criticised for having “no respect for privacy”. A non-user of public services explained, “I can’t take these bullying tactics, that’s why I don’t go there no matter how bad I feel”. Generally, nurses are regarded with the least favour; of a facility with both doctors and nurses, it was said, “The doctors aren’t so bad, its mainly the nurses that don’t treat us properly”, and “Nurses don’t care, only in front of the doctors”.

Bad attitudes of nurses, poor drug supplies and unhygienic conditions were all highlighted as weaknesses of the clinic’s services. Nurses were criticised for showing favouritism, being “bitchy”, “liking to criticise people and to insult them”, and “playing doctor”. Suggestions for improvement of clinic services included that attitudes of staff must change, there must be more respect, and that everyone should be treated the same.

It is important to note that attitudes to clinic services were not entirely hostile. In one town the clinic was praised for its accessibility. “I will go there for blood and sugar tests; if I feel my head spinning I go there”. It was commented that it was good to be able to talk to the sisters because they were women and “You don’t sit for hours”, and that “You can be on your way in an hour”. In another town it was said, “The relationship between the sisters and community is good. She’s part of the community. She lives here and she knows what most of the people’s situations are like”/ “If there could only be more sisters like that…” Another participant said of the same clinic sister, “She has very nice ways. I like her a lot. But the medicine they give you there is purely water…really”.

Comments about the services provided by private doctors were always highly favourable. Much emphasis was understandably placed on being treated with politeness. “He’s very good…very friendly as well”/ “Very good…he’s always got a smile on his face and he’ll always greet you politely”/ “The facilities aren’t that wonderful, they’re very basic but his medicines are very good and he loves sending you to hospital”. (This is in contrast to referral practice in the public sector: “It’s almost like they wait for you to be half dead or they are so fed up of seeing you and then they refer you to hospital”). Spending time talking to patients and examining them thoroughly was also frequently mentioned as a big difference from public sector services.

Other themes arising from the FGDs include excessive waiting times at some district surgeons and clinics. Some district surgeons operate a policy of using the same waiting area for their cash patients and their district surgery patients, with those paying cash being treated first. In effect people will pay cash to jump the queue. “If you want to go home early, you have to pay”. The view that white people are treated first and more favourably both in clinics and district surgeon practices, but particularly in district surgeon practices, was common, especially amongst the over 35 age group. Difficulties and expense in arranging emergency transport was also criticised, particularly in the Eastern Cape. The inaccessibility of public sector services at night and at the weekend is also a frequent reason why patients may turn to the private
sector. In the case of one public sector facility, it was commented that the security guard must call a nurse who must then decide whether to call a doctor and “By then, everybody is dead”. It was also noted that neither doctors nor nurses like coming out at night and are frequently rude.

Some differences between the two provinces and the two age groups were also noticeable. In particular, the younger age group in the Eastern Cape were the most positive about the services offered by the clinic. Also the most positive comments about the clinic services were made in the town where there was no longer a GP/district surgeon and some investment had been made recently in upgrading the clinic service. “It’s very neat” / “It’s always full” / “The people sit in a nice queue” / “If there is a serious problem with your baby, then they’ll let you go first” / “It’s not like before, then they just took people randomly and white people went first”.

Conclusions

Use of the private sector by low income groups appears widespread from the quantitative and qualitative data presented here. Two aspects of the role of the private sector in rural town primary care delivery should be recognised: first, that many patients are keen to use it in preference to the public sector and second, that private sector practitioners play a pivotal role in public health care delivery in many towns.

Overall, strong lessons for policy emerge from the data presented here and some difficult challenges for the public sector are raised. Lessons for policy include the need to educate the public about the range of services available at public sector primary care clinics and the quality of drugs available. Patients are not well placed to judge the quality of the services which they receive in the private sector, often appearing to make superficial judgements based on issues such as the likelihood of receiving an injection. A better informed public may be less easily persuaded to part with their money to the private sector for services which they could receive for free. However, the incentive for private doctors to convince patients that private services are better is a formidable obstacle, and one not easily addressed in a situation where the state must depend on doctors having private and state practices running concurrently.

It is equally pressing for clinics to start delivering services in a way that is acceptable to all patients. Underlying the continued strength and vitality of the private sector is the fact that people want to use it whenever they can afford to do so. Disturbingly, much of the evidence cited here points to the fact that they may often be doing so simply to be treated with politeness and respect, something which the public sector should be capable of. The views reported here are only from rural towns in two areas of South Africa, but dissatisfaction with the way in which public sector services are delivered is frequently echoed elsewhere. Carr-Hill expresses how fundamental a problem this is. “When health care is a public service, clinical effectiveness and economic efficiency cannot be the sole criteria. Health care also has to be socially acceptable”. In other words, precisely because people don’t have to pay, because this is a service for the benefit of all citizens, its acceptability is a vital factor in its overall quality. It seems that at present people are voting with their feet that this is not yet the case in South Africa.

How to forge an appropriate workable relationship between the public and private sectors at primary care level deserves greater attention. The present policy appears to be one of “muddle through”, often relying on individuals in a particular town to make things work in the absence of a proper policy framework. Whilst the right to choose a service which is socially acceptable is vital, the choice between public and private sector presently appears problematic in other ways. At present district surgeons, clinics and private GPs are all delivering roughly the same set of services with little co-ordination and some financial incentive for the district surgeon to undermine the role of the clinic. Evidence suggests that people pay high fees for care which may be no better than that of the public sector; often it may be worse. People shop around between the public and private sectors, wasting their own and the health sector’s resources.
In terms of the supply side, policy needs to be clarified on what role, if any, the private sector should play in public sector health care delivery at primary level. If the private sector is to be invited to participate more in the delivery of state services, contractual mechanisms should be revisited and the nature of the partnership reviewed. Equally important is to address the many problems of effectively regulating the quality of services delivered by the private sector. Perverse incentives inherent in any fee-for-service system where the doctor acts as the gate-keeper as well as the service provider could be further eliminated, for instance by access being only through the clinic, as is done in the Eastern Cape, or by changing the nature of the doctor’s terms of employment. Both the Free State and the Northern Province have eliminated the district surgeon contract in favour of part time medical officer appointments. However, it is a fine balance that each province or even region must strike, for if doctors’ incomes are threatened too severely they too will vote with their feet. The important role which many rural GPs play in providing comprehensive medical cover to a town deserves some creative approaches to partnership, perhaps revisiting some of the ideas around the accredited private provider system in cases where provinces have the capacity to negotiate and monitor new contracts adequately.

On the demand side, misconceptions about services available at the clinic should be addressed as well as those concerning the quality of drugs available. In the longer term, the perception that a free service must be a poor service needs to be tackled, although this can only be achieved in conjunction with an improvement in the quality of services on offer. At present, evidence would suggest that in many cases this perception is still all too valid.