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Patient experiences in a public primary health care clinic: A South African case study

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ABSTRACT

The South African Ministry of Health has recognized experiences of care as key to strengthen patient-centred care. This case study aims to measure patient-reported experiences of care at a clinic in South Africa, and its associations with the respondents' sociodemographic characteristics. A survey was conducted in 2019 on a convenience sample of 179 respondents. Questions on experiences of care were based on a standardised set of questions by the Organization for Economic Co-operation and Development (OECD). Logistic regression was used to examine the effects of respondents' characteristics on their experiences. The proportion of respondents who reported that a nurse spent adequate time with them during consultation was significantly higher among literate respondents (92.3 vs. 79.5%). Those who reported past negative experiences were significantly more likely to report a positive experience in regard to perceiving adequate consulting time (odds ratio = 3.865, with a 95% confidence interval between 1.555 and 9.607), receiving easy-to-understand explanations (4.308; 1.665–11.145), being given the opportunity to ask questions (2.156; 1.013–4.589) and shared decision–making (3.822; 1.728–8.457). The results can spur comparisons with other clinics in a similar setting and inform key stakeholders on aspects of the care experience that need greater improvement within the national framework for quality and safety assurance and patient experience measurement.

KEYWORDS

primary health care, patient experiences, patient-centred care, South Africa, Sibasa Clinic

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1. INTRODUCTION

1.1. Patient experiences of care

For more than three decades, increased attention has been placed on developing health systems that are more patient-centric, to allow greater responsiveness to patients' needs, expectations and preferences. Moving health care organizations towards patient-centric and value-based care trajectories is aligned with evidence that links the use and dissemination of patient data across health care organizations to steer patient-driven changes (De Rosis et al. 2020). Consequently, there is an ever-growing use of instruments to capture the voice of patients, typified by patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) (Coulter 2017; Price et al. 2014).

Greater attention is given to ways of capturing citizens' voices within a value-based care framework. Value-based care encompasses: i) the promotion of value-based pricing, purchasing and use of treatments and health care services in general; ii) enabling communication about treatment options and costs and; iii) minimising the impacts of costs with medicines and other related costs to financial toxicity (also known as catastrophic health expenditure), to which patients with several and severe morbidities are more at risk relative to those without severe diseases (President's Cancer Panel 2018; WHO 2018; Xu et al. 2005). The underlying assumption is that patent-centric and value-based care provide efficiency gains to health care systems in terms of increasing quality life years; greater cost-effectiveness, given patients' adherence to treatment choice where their voice was accounted for; decreased productivity loss and informal care burden and; contribution to employment sustainability. Given these effects, many countries strive for health care reforms, which aim at improving the performance of the health care system. A key component of performance is efficiency, and achieving efficiency gain means getting more value for money, i.e. investments are rewarded by increasing overall health care productivity (Gulácsi – Péntek 2014). Success requires multiple factors, including patient-centric and value-based care, where capturing the perspective of patients (via patient-reported outcome and experience measures) has the potential to inform decision-makers on where efficiency may be gained (Barbazza et al. 2019; Gilmore et al. 2019; Péntek 2019).

Patient experience encompasses all processes across the continuum of care observable by patients and which influence a patient's perception of the care delivered (Price et al. 2014; Wolfe et al. 2014). For example, the Agency for Healthcare Research and Quality (AHRQ) describes patient experience as "several aspects of health care delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health care provider" (AHRQ 2019). The interaction of many actors and settings makes patient experience a complex multidimensional concept (Sandager et al. 2016), which partly explains why it is difficult to define its core components, and thus, measuring them (LaVela –Gallan 2014).

Notwithstanding, patient experience is an intrinsically relevant dimension of quality of care (Duschinsky – Paddison 2018). There is strong evidence on the association of patient experience with health care quality indicators (Ahmed et al. 2014; Bleich et al. 2009; Doyle et al. 2013; Kingsley – Patel 2017; Llanwarne et al. 2013; Price et al. 2014). For example, two systematic reviews have highlighted that positive experiences of care were associated with a decrease in primary and secondary care use (e.g. number of hospital admissions, readmissions and primary care consultations), and greater adherence to prevention and treatment processes (Doyle et al. 2013; Price et al. 2014). On the other hand, poorer experiences of care are often associated with inadequate patient-doctor communication and poorer involvement of patients in decision making, with implications for clinical effectiveness and safety (Bao et al. 2017; Kelly et al. 2019). Given robust evidence on these associations, patient experience has been widely used as a proxy measure for care quality with many different purposes.

The use of PREMs varies across health systems and their purposes at the micro, meso and macro level may be complementary. For example, PREMs data can inform health care teams on the effectiveness of processes of care and provide insights into redesigning care pathways that better address the needs, expectations and preferences of patients (Kingsley – Patel 2017). Also, PREMs have been used for quality accreditation and certification (Fujisawa – Klazinga 2017), payment programs (LaVela – Gallan 2014), and to develop health policies that spur patient-centred care delivery (OECD 2017). Albeit interest in measuring performance data such as patient-reported outcomes and experiences is increasing, these are still underused in decision-making processes (Ivankovic et al. 2020).

Data collection on PREMs is maturing differently across Organization for Economic Co-operation and Development (OECD) countries. Contextual factors may partly explain these variations, but also the extent to which some aspects act as barrier for the use of PREMs: sampling, data collection, timeliness of data collection and reporting, type of data, level of data aggregation and data reporting (De Rosis et al. 2020). Thus, instruments that are set forth to collect PREMs data in different health care settings are of utmost importance to assure fit for purpose, streamline data collection, strengthen data quality and comparability, and enhance the actionability of PREMs data. Examples can be drawn from the work of the Picker Institute, the AHRQ's Consumer Assessment of Healthcare Providers and Systems program, the Commonwealth Fund and also the OECD. These organizations have been frontline pioneers in patient experience measurement with standardised tools, which allow for international comparisons and dissemination of good practices (OECD – EU 2019). Their work has positioned PREMs at the fore of patient-centred care and quality improvement initiatives across many countries (Fujisawa – Klazinga 2017). For example, in Hungary, researchers have recently investigated patient experiences with outpatient care on a national representative sample of 1,000 respondents using a set of standardised PREMs questions. A first study focused on forgone medical visits as an important factor of patient-centric care (Lucevic et al. 2019), examining questions regarding the existence of unmet medical needs if patients: (1) reported forgone medical visits due to costs; (2) forgone medical tests and treatment due to costs; (3) unfilled prescriptions for medicine, or skipped doses due to costs; (4) forgone medical visits due to difficulties in travelling. In addition, another study focused on the care experiences of the last outpatient consultation: (1) did the doctor spend enough time with the patient in consultation; (2) did the doctor provide easy to understand explanations; (3) did the doctor give the opportunity to ask questions or raise concerns about care or treatment; (4) did the doctor involve the patient in decisions about care and treatment (Brito Fernandes et al. 2019). Both studies were important in emphasizing the need to collect, analyse and report on these patient-reported data in Hungary, in a consistent manner over time, and to allow cross-national comparisons with other OECD countries, where the same standardised questions have been used. Conversely, measuring PREMS in South Africa is still in its infancy (Manga et al. 2018).

1.2. Patient experiences in South Africa

In South Africa, the Free Health Care policy of 1996 (Monson 2006) has ensured public primary health care (PHC) coverage to all citizens. In that regard, many improvements have been made, for example in access to care (e.g. 90% of the population now live within 7 km of a public primary care facility) and in health outcomes (e.g. increased life expectancy and reduction in child and maternal mortality) (McLaren et al. 2014). Despite the backdrop of these milestones, citizens still face a series of challenges, such as low life expectancy at birth, high infant mortality rates, health care professional and medicine shortages, and health professionals' overall limited knowledge about the needs and preferences of patients (OECD 2014, 2019a, 2019b, 2019c).

According to the 2017 General Household Survey, 71.2% of the population use public providers as a first choice of consultation when in ill-health (Statistics South Africa 2017), with PHC serving as the first point of entry into the health system. The quality of care in PHC facilities is a reoccurring topic that attracts public attention and scrutiny, following strong evidence throughout the years that the health system should be more responsive (e.g. Bresick et al. 2019a, 2019b; Kelly et al. 2019; Peltzer 2009; Peltzer – Phaswana-Mafuya 2012).

We conducted a brief literature review on quality of care in PHC in South Africa. The retrieved articles suggest a growing interest among researchers and government officials about improving quality of care. For example, the growing number of validated versions of the primary care assessment tool (PCAT), which focus on dimensions such as access, continuity, comprehensiveness, coordination and person-centredness (Bresick et al. 2015, 2016; Dullie et al. 2018). Baseline PCAT results in South Africa's Western Cape Province highlighted that a gap exists between the experiences of care reported by patients that used PHC services and the perception of PHC staff regarding the care they provided (Bresick et al. 2016; Mukiapini et al. 2018). These results underpin an increasing interest about patient care experiences, which are key to the implementation of a National Health Insurance scheme, which seeks to reform the current inequitable health system and place an emphasis on patient-centred care (Department of Health 2019a).

In 2017, the South African Ministry of Health published the "National Guideline on conducting Patient Experience of Care Survey in Public Health Establishments," introducing the first national survey on patient experiences in the inpatient and outpatient settings, and in mental health establishments (Department of Health 2017). This very important document showed the Government's commitment to improving quality of care and providing methodological guidance on how to set up a questionnaire survey fit to collect nation-wide data about experiences of care. This initiative followed those of previous ad-hoc evaluations of patient experience such as that of the Chronic Care Assessment of Patient Experience (CCAPE), which was developed as an approach to gauge the care experiences of chronic patients. The survey was designed to measure patient experiences against a set of norms and standards developed by the Health Ministry and the Office of Health Standards and Compliance. The survey focused on the following dimensions: i) dignity; ii) autonomy; iii) confidentiality; iv) prompt attention; v) access to social support networks during care; vi) quality of basic amenities; vii) choice of care provider and; viii) the responsiveness of the health system. The results of this survey aim to inform PHC facilities on how to achieve a standard of care that is equipped to serve the population once the proposed Universal Health Coverage policy is set into law. International comparisons are deemed as essential, but limited because of the design of the instruments used.

In addition, parallel to the introduction of the patient experience survey, the South African Health Ministry has set forth a programme: “The Ideal Clinic Realisation and Maintenance plan” (Hunter et al. 2017). This initiative seeks to encourage improvements in PHC facilities (e.g. good infrastructure and adequate staff) and foster greater cooperation among PHC facilities, the private sector and non-governmental organisations to address social determinants of health. In this regard, the Ideal Clinic initiative measures PHC facilities against a set of promulgated norms and standards (e.g. an Ideal Clinic should score an overall average of 70% in the patient experience of care survey). One of the PHC clinics in South Africa that has been assessed by this initiative is Sibasa Clinic, which is a nurse-led public clinic in the Vhembe District, Limpopo (South Africa). We provide further information about this PHC facility and its context in Box 1.

This study aims to measure patient experiences of care at Sibasa Clinic more in depth and in an internationally comparative manner, regarding patient–nurse communication and patient involvement in decision–making using a standardised set of PREMs, disseminated by the OECD. Furthermore, we aim to assess associations of experiences of care with sociodemographic characteristics of the respondents.

Box 1. Brief description of Sibasa Clinic and its context

Makwarela, home to Sibasa Clinic, is a small township in Thulamela municipality, which is the second largest municipality in Vhembe District, Limpopo Province. Vhembe district is one of the poorest in South Africa and the education and employment statistics reflect the poor state of affairs: 21.9% (48.6% in Makwarela) of the population have a completed Matric (High School Diploma) and 29.9% (35.8% in Makwarela) have a paid job (Statistics South Africa 2011).

Thulamela municipality has the highest concentration of health care facilities: 3 district hospitals, 1 referral hospital and 52 PHC facilities that include 49 clinics (one of them being Sibasa Clinic) and 3 community health care centres. In Vhembe, only 39% of clinics have an Ideal Clinic status, for which Sibasa Clinic applied in 2015 and was denied after failing to meet standards and norms of quality of care.

Sibasa Clinic is a small primary care clinic that serves the population living in the villages of Makwarela, Sibasa, Dzingahe and Miluwani. Based on the 2011 Census data, these villages represent an area of 7.4 km^2, with more than 4,200 households and a total population of 15.578, of which 53% are women. Monthly, on average, 4,000 people use the services provided at the Sibasa clinic. The clinic provides services during business hours (7am to 6pm) from Monday to Friday. Those who have emergencies after hours or on weekends have to seek care elsewhere (24-h clinics or hospitals). The clinic is meant to offer comprehensive services that are promotional, preventative, curative, rehabilitative and palliative. Services offered range from acute and chronic care, to family planning, antenatal and postnatal care, which includes vaccinations for children. The clinic has a staff of 22, which includes 17 female nurses of varying qualifications, 1 dietician and 1 pharmacy assistant. The other 3 staff member are non-health professionals. The clinic does not have a resident medical doctor, i.e. the clinic is nurse-led. This is not uncommon in South Africa as nurses are trained to be the face of PHC facilities.

2. METHODS

2.1. Study design, setting, study population and sampling strategy

In early 2019, a cross-sectional survey was conducted at Sibasa Clinic, South Africa. Given time and cost restraints, a convenience sample was built with adult patients (18 years old and over) who had received health care at Sibasa Clinic before. A total of 179 fully completed questionnaires were retrieved for further analysis. We used two modes of survey administration: self- and interviewer-administered. The latter was used to include those respondents who could not read, as Limpopo's proportion of illiterates is 7% among young people (age between 15 and 35 years) and 28.7% among adults (age between 35 and 64 years) (McLaren 2014). In the interviewer-administered survey, the interviewer did not discuss the questions or their meanings with the respondents. Ethical clearance was obtained from the Limpopo Province Research and Ethics Committee of the Premier's office (REC-111513-038). Consent was obtained from all respondents involved.

2.2. Data collection

The survey was composed of a set of standardised questions to measure patient-reported experiences with ambulatory care, as suggested by the OECD (Fujisawa – Klazinga 2017). These questions focused on the patient experience with patient-nurse communication and patient involvement in decision–making. These questions were originally in English; hence, we conducted a forward-backward translation to develop a Tshivenda version of the PREMs questions, with the support of a professional translator. This was necessary because almost 90% of the population is Tshivenda native-speaking. Both the English and the Tshivenda surveys were given to a sample of 10 Tshivenda and English-speaking individuals to complete as a pilot. Issues raised by respondents were reported and discussed with the interviewer, who was the same at all stages of data collection. The Tshivenda survey was found to correspond in content and meaning to the English version, with no culturally sensitive wording.

2.3. Variables

Respondents answered the following questions which serve as dependent variables: 1) did the nurse spend enough time with the patient in consultation; 2) did the nurse provide easy-to-understand explanations; 3) did the nurse give an opportunity to ask questions or raise concerns; 4) did the nurse involve the patient in decisions about care and treatment.

All questions had two possible answers: yes/no. These were presented in Tshivenda as Ee/Hai. The original questions in English language had a multiple point Likert scale as the answer option. In our survey, we decided to simplify the answer options, taking into consideration previous expectations towards respondents' characteristics (e.g. great proportion of illiterate respondents), but also to mimic the binary answer option of the current national survey on patient experiences in PHC facilities.

To assess associations between positive experiences with ambulatory care and respondents' sociodemographic characteristics, we considered the following independent variables: sex (women/men), age group (18–34, 35–64, 65 and over), job status (having a paid job/not having a paid job) and the existence of a past negative experience of care at the clinic (1: had a previous negative experience).

2.4. Data analysis

We used descriptive statistics to describe respondents' characteristics. The chi-square test was used to assess differences in the proportion of participants who had a positive experience by sociodemographic characteristics and existence of a past negative experience at the clinic. Multivariate logistic regression was used to assess associations between respondents' positive experience of care (dependent variable) and sociodemographic characteristics and past negative experience at the clinic. All analyses were conducted in Stata version 16. The level of significance was set at $P < 0.05$.

3. RESULTS

Our survey resulted in 179 fully completed questionnaires for further analysis (Table 1). The majority of the respondents were women (73.2%). The average age of the respondents was 36 years old (standard-deviation: 16). Most respondents were aged between 18 and 34 years old (58.1%), while respondents above 65 years of age accounted for 8.4% of the sample. The majority of the respondents (78.8%) did not have a paid job. Most respondents reported to have had a past negative experience while seeking care at the clinic (77.1%). The share of interview-administered questionnaires with illiterate respondents was of 29.1%. The proportion of illiteracy between women and men, and those with and without a paid job did not differ significantly (29.8 vs. 35.4% and 24.5 vs. 31.1%).

3.1. Patient experiences at Sibasa Clinic

The total proportion of respondents who reported that their nurse spent enough time with them was of 83.2% (Table 1). Overall, 86.6% of the respondents reported that the nurse gave easy-to-understand explanations. The proportion of respondents who reported being given the opportunity to ask questions or raise concerns was of 69.8%. Lastly, 78.8% of respondents stated being involved in decision-making about their care and treatment.

Our data suggested that the proportion of positive experiences with the time a nurse spent in consultation with a respondent differed significantly by literacy status: those who were literate reported better experience of care (92.3 vs. 79.5%). Moreover, those who reported previous negative experiences of care at the clinic had significantly better experiences of care regarding a nurse spending enough time in consultation (88.4 vs. 65.9%), providing easy-to-understand explanations (91.3 vs. 70.7%) and involving the patient in decision–making (84.8 vs. 58.5%).

3.2. Associations of the respondents' sociodemographic characteristics with positive experiences of care

Women were less likely than men to report positive experiences of care regarding a nurse spending enough time in consultation, giving opportunity to ask questions or raise concerns and in being involved in decision–making (Table 2). Conversely, women were twice as likely than men to report a positive experience regarding a nurse giving easy-to-understand explanations.

In contrast to young people (between 18 and 34 years of age), respondents aged between 35 and 64 years had a greater likelihood of positive experience of care with the duration of the consultation [Odds Ratio (OR) = 1.216; 95% Confidence Interval (CI): 0.462–3.198] and being given easy-to-understand explanations (OR = 2.139; 95% CI: 0.706–6.482), although the

Table 1. Proportion of positive experiences of care in Sibasa Clinic by respondents' characteristics

	Sample Size N (%)	Nurse spending enough time with patient during consultation		Nurse giving easy-to-understand explanations		Nurse giving opportunity to ask questions or raise concerns		Nurse involving patient in decisions about care and treatment	
		Yes (%)	χ^2 (*P* value)	Yes (%)	χ^2 (*P* value)	Yes (%)	χ^2 (*P* value)	Yes (%)	χ^2 (*P* value)
Sex									
Men	48 (26.8)	89.6	1.892	79.2	3.115	70.8	0.031	83.3	0.816
Women	131 (73.2)	80.9	(0.169)	89.3	(0.078)	69.5	(0.860)	77.1	(0.366)
Age groups (in years)									
18–34	104 (58.1)	81.7	0.788	83.7	2.104	72.1	1.010	78.9	0.021
35–64	60 (33.5)	86.7	(0.674)	91.7	(0.349)	68.3	(0.604)	78.3	(0.990)
65 and over	15 (8.4)	80.0		86.7		60.0		80.0	
Employment status									
No paid job	141 (78.8)	80.9	2.718	85.8	0.345	69.5	0.034	80.1	0.746
Has a paid job	38 (21.2)	92.1	(0.099)	89.5	(0.557)	71.1	(0.854)	73.7	(0.388)
Literacy									
Literate	127 (70.9)	92.3	4.319*	92.3	2.062	63.5	1.412	84.6	1.497
Illiterate	52 (29.1)	79.5	(0.038)	84.3	(0.151)	72.4	(0.235)	76.4	(0.221)
Previous negative experience									
No	41 (22.9)	65.9	11.524*	70.7	11.523*	58.5	3.221	58.5	13.021**
Yes	138 (77.1)	88.4	(0.010)	91.3	(0.001)	73.2	(0.073)	84.8	(<0.001)
Overall positive experiences (Yes, %)									
		83.2		86.6		69.8		78.8	

Source: Authors.
Note: **P-value* < 0.05; ***P-value* < 0.001.

Table 2. Multivariate logistic regression results to assess associations of respondents' characteristics with positive experiences of care in Sibasa Clinic

	Nurse spending enough time with patient during consultation		Nurse giving easy-to-understand explanations		Nurse giving opportunity to ask questions or raise concerns		Nurse involving patient in decisions about care and treatment	
	OR	**(95% CI)**	**OR**	**(95% CI)**	**OR**	**(95% CI)**	**OR**	**(95% CI)**
Sex								
Men (Reference)	–	–	–	–	–	–	–	–
Women	0.406	(0.142–1.155)	2.232	(0.883–5.642)	0.920	(0.436–1.939)	0.624	(0.252–1.543)
Age groups (in years)								
18–34 (Reference)	–	–	–	–	–	–	–	–
35–64	1.216	(0.462–3.198)	2.139	(0.706–6.482)	0.914	(0.441–1.898)	0.841	(0.365–1.935)
65 and over	0.551	(0.132–2.298)	0.978	(0.158–6.045)	0.709	(0.223–2.251)	0.840	(0.199–3.556)
Employment status								
No paid job (Reference)	–	–	–	–	–	–	–	–
Has a paid job	2.839	(0.770–10.472)	1.374	(0.490–3.850)	1.209	(0.518–2.825)	0.689	(0.281–1.687)
Literacy								
Literate (Reference)	–	–	–	–	–	–	–	–
Illiterate	2.591	(0.866–7.748)	1.506	(0.453–5.006)	0.615	(0.290–1.307)	1.618	(0.652–4.016)
Previous negative experience								
No (Reference)	–	–	–	–	–	–	–	–
Yes	3.865*	(1.555–9.607)	4.308*	(1.665–11.145)	2.156*	(1.013–4.589)	3.822*	(1.728–8.457)

Source: Authors.
Note: * *P-value* < 0.05; OR: Odds ratio; CI: Confidence interval.

differences were not statistically significant. Older respondents (65 years old and over) were less likely to report positive experience across all aspects of the care experience. Those who had a paid job were more likely to have a positive experience of care across all attributes of the care experience except that of being involved in decision–making about care and treatment (OR = 0.689; 95% CI: 0.281–1.687). In comparison with more educated respondents, those that were illiterate were more likely to have positive experiences of care across all attributes of the care experience except that of being given the opportunity to ask questions or raise concerns (OR: 0.615; 95% CI: 0.290–1.307). In addition, those who have had a past negative experience at the clinic were significantly more likely to report a positive experience of care across all attributes.

4. DISCUSSION

To our knowledge, this is the first study to assess patient experiences of care in South Africa using a set of standardised questions about PREMs endorsed by the OECD, commonly used for cross-national comparisons. We assessed the determinants of positive experiences of care in a public PHC facility (Sibasa Clinic) in Thulamela municipality, South Africa, by means of a cross-sectional study, using a self- or interviewer-administered survey.

Our findings show that a greater proportion of respondents reported positive experiences of care with a nurse providing easy-to-understand explanations (86.6%); conversely, the least proportion of positive experiences was related to being given an opportunity to ask questions or raise concerns (69.8%). These shares are aligned with those reported in the 2017 Patient Experience of Care (PEC) survey conducted in 168 randomly selected PHC facilities, where 76.5% of those respondents reported positive experiences of care (Department of Health 2019b). The comparability of these results is limited because of the differences between surveys (e.g. for reporting results on the PEC survey, it was decided that an average score of 80% across all items in the survey should be considered a positive patient experience).

Furthermore, our study revealed differences in positive care experiences across socio-demographic groups. In general, women reported lower proportions of positive experiences across all aspects of the care experience, except for that of a nurse giving easy-to-understand explanations. This result might be partly explained by the fact that Sibasa Clinic is a female nurse-led PHC facility. A different study in another nurse-led PHC facility highlighted the importance of nurse communication to a patient's satisfaction (and experience) (Nunu – Munyewende 2017). It could be that nurse training on communicational skills in South Africa is lacking and failing to address the expectations and specific needs of female patients.

Although differences in sociodemographic groups were observed, these were not significant except when literacy status was considered. The proportion of literate respondents that reported positive experiences of care regarding a nurse spending enough time with a patient during consultation was significantly greater than that of illiterate respondents. However, after adjusting for other characteristics of the respondents, our results show that illiterate respondents were 2.6 times more likely to report a positive experience compared with a literate respondent. Studies have shown that more educated people (assuming literacy as a proxy for education) place a higher degree of importance on their interaction with the clinician and are less likely to report positive experiences than less educated patients (Rademakers et al. 2012). Our findings also suggest that illiterate populations may require special attention from the health care system.

The adult literacy rate of South Africa is of 94.3%; however, Limpopo's literacy rate (where Thulamela Municipality is located) shows one of the lowest adult literacy rates: 89.9% (Myburgh et al. 2005). This may require a diverse skill-set from health professionals, including nurses, at these PHC facilities to adapt their communication style to the characteristics of a patient.

Our results show that a previous negative experience at the clinic is a determinant of future positive experiences of care. Those who have had a previous negative experience at the clinic were more likely to report a current positive experience compared with those who have never had a negative experience at the clinic before. This could signal that one's expectations adjust after a previous negative consultation at the same provider. In addition, such negative encounters have been shown to affect patients' behaviour outside the clinical setting (Bayuo 2017; Schwei et al. 2016). For example, patients in Ghana have reported opting-out of care in their nearby and designated facilities due to negative experiences (Bayuo 2017). Other studies have identified other determinants of negative patient experience such as age, with younger patients being more likely to perceive a negative experience (Brito Fernandes et al. 2019; Xie et al. 2019). There were no significant results regarding this in our study.

The systematic measurement of patient experiences in South Africa is somewhat a novelty. The national survey on patient experiences covers many domains and results are reported as an average score (on a scale from 0 to 100%). However, there are many methodological aspects of that survey that make results difficult to compare with those of other countries; hence, the importance of the use of a standardized set of questions on patient experiences, as those suggested by the OECD. To a limited extent, our results could be compared with those of the OECD's average of 11–19 countries. Our data show that the experiences of patients at the Sibasa Clinic regarding a nurse spending enough time in consultation (83.2 vs. 80.6%) or providing easy-to-understand explanations (85.5 vs. 88.5%) were similar to those of the OECD average (Statistics South Africa 2017). Greater differences were noticed on a nurse giving opportunity to ask questions or raise concerns (69.8 vs. 89.3%) and involving the patient in decision–making (77.1 vs. 83.6%) (Statistics South Africa 2017), signalling where improvement is needed the most.

4.1. Strengths and limitations

Our study was strengthened by the use of OECD's standardised PREMs with ambulatory care. Therefore, our results could be compared, to a limited extent, to those of other countries that used the same set of questions. Notwithstanding, our results should be considered in light of some limitations. The sample size and convenience sampling limited the ability to generalise findings to the Thulamela municipality, the country at large and our ability to contrast our results with those of other OECD countries with national representative samples. Also, the questions in our survey were presented as a binary response option, in contrast to the multi-point Likert answers suggested in OECD's survey. This was done to mimic the South African Department of Health's Patient Experience of Care standardised questionnaire and allow future comparisons. Finally, recollection of past negative experiences may have created a recall bias and affected respondents' responses on their current experiences of care.

4.2. Policy implications and recommendations

This study highlights the complexities of the patient-nurse relationship and the challenges posed by the sparse availability of data on patient experiences. These data can inform and support the decisions of clinic managers to strengthen patient-centred care. Our study identified that previous negative experiences of care and literacy status are focal points that require further attention. Notwithstanding, further studies are needed in South Africa, including more regions and larger sample sizes to generate more accurate data about patient experiences with ambulatory care.

5. CONCLUSION

Our results suggested that respondents expect to be given the opportunity to ask questions or raise concerns and be involved in decision–making about care and treatment. In general, respondents that were women, older (65 and over), with no paid job, educated and without a previous negative experience of care at the clinic were less likely to report a positive experience of care. These results at this PHC facility can inform the decisions of key stakeholders on aspects of the care experience that need greater improvement within the national framework for quality and safety assurance and patient experience measurement.

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