THE ROLE OF THE CONSUMER PROTECTION ACT 68 OF 2008 IN ADDRESSING THE CHALLENGES OF HEALTHCARE PATIENTS AS CONSUMERS

by

NOLWANDLE WITNESS NGCOBO

(STUDENT NO. 21627113)

Submitted in fulfilment of the requirements for the degree

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Department of Applied Law

Faculty of Management Sciences

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Supervisor: Dr R E Von Staden

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APPROVED FOR FINAL SUBMISSION

Supervisor: ___ _____ Date: 1/09/2023

DECLARATION

I declare that the work and findings in this dissertation titled “The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers” is entirely a result of my own original work, except where otherwise stated. No part of this dissertation has been previously presented for academic examination towards any qualification or tertiary institution. I have duly acknowledged all sources used for the purpose of this work, by means of complete references.
I further declare that all data presented is authentic to the best of my knowledge.

27/10/222

Nolwandle Witness Ngcobo Date

Approved for final submission

Supervisor: 1/09/2023

Dr R E Von Staden (PhD) Date

DEDICATION

I dedicate this thesis to God, who gave me the stamina and ability to successfully complete this research.

This project is dedicated to my lovely family who have encouraged and supported me throughout and respecting the opportunity to concentrate on completing my study.

I dedicate to my son Nhlanzeko Ngcobo, you have made me more fulfilled than I could ever imagined. I love you. You are my inspiration for achieving greatness.

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First and foremost, to God is the glory for granting me the strength and capacity of fulfilling this difficult journey. God has blessed me with perseverance and fortitude necessary to accomplish my objectives. (Proverb 16: 3).

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To my mom, Nontokozo Rosemary Ngcobo, thank you for the love and support you have given me. You deserve praise for the moral and material support. I am grateful that you are proud of everything I do.

My sister Tira, my brother Latrell, My son Nhlanzeko and relatives, may this thesis inspire and motivate you to empower yourselves and dream big.

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ABSTRACT

The Consumer Protection Act 68 of 2008 applies to the healthcare consumer market in South Africa and it is widely accepted that patients accessing healthcare services in both the public and private sectors qualify as consumers (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33). The National health Act 61 of 2003 was introduced with the aim of transforming the healthcare system by providing South Africa's population, including vulnerable groups, with the "best possible" healthcare services available resources allow, in an equitable manner. Despite progress in transforming the healthcare sector in South Africa, the healthcare system continues to face several challenges, particularly in respect of the quality of healthcare services delivered. There are numerous complaints from patients about the poor-quality of service they receive.

The CPA aims to promote and advance the social and economic welfare of consumers, particularly vulnerable consumers, by establishing a legal framework to achieve and maintain a consumer market that is fair, accessible, efficient, sustainable, and responsible and to improve consumer awareness and information. One of the ways in which the CPA wants to achieve these aims is through the fundamental consumer rights.

The aim of this study is to investigate the challenges of patients as consumers of public healthcare services in the INanda district of eThekwini and the role of the Consumer Protection Act 68 of 2008 in addressing these challenges. The research design used in this study is quantitative. The target population of this study included adult patients as consumers of public healthcare services who reside in Shembes Village, in the Inanda district of eThekwini municipality, in the province of Kwa-Zulu Natal (KZN), SA and the sample size was 375 respondents. Purposive, convenience non-probability sampling was used in this study for selecting participants. The research instrument used as data collection instrument in the survey employed for this study was a questionnaire comprising closed and open ended questions. Inferential and descriptive statistical analysis of the data was undertaken using SPSS version 27.0.

The results from the study found that, in relation to awareness, understanding and infringement of patient rights contained in both the CPA and the NHA, respondents had higher levels of awareness and understanding and lower levels of infringement. The study found no significant difference in awareness and understanding of patient rights in terms of the NHA, when compared to fundamental consumer rights contained in the CPA. Furthermore, patients are confronted with a wide and varied range of challenges.

The study concluded that the CPA has a role to play in addressing some of these patient challenges. However, there is a degree of duplication in protection provided to patients in terms of the NHA and the CPA.

Keywords: Consumer, patients, health, healthcare

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LIST OF ACRONYMS AND ABBREVIATIONS

CESCR	Committee on Economic, Social and Cultural Rights
CESCR GC 14	CESCR General Comment 14
CSDH	Commission on the Social Determinants of Health
HEU	Health Economics Unit
ICESCR	International Covenant on Economic, Social and Cultural Rights
KZN	KwaZulu-Natal
NDP	National Development Plan
NPRC	National Patients' Rights Charter
NHI	National Health Insurance South Africa
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organisation

Legislation

Constitution	Constitution of South Africa (South Africa, Department of Justice and Constitutional Development. 1996)
CPA	Consumer Protection Act 68 of 2008 (South Africa, Department of Trade and Industry 2008)
NHA	National Health Act 61 of 2003 (South Africa, Department of Health. 2003)

CHAPTER ONE

INTRODUCTION AND STUDY OVERVIEW

1.1 Introduction

The World Health Organisation (WHO) (2017: 01) states health is important to both individuals and societies, noting the right to health is a structural feature of basic human rights, vital to every human being, irrespective of religious belief, political conviction, and economic or social status. This right to health is contained as legal obligation in the International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN General Assembly 1966) and many other international agreements, Constitutions and legal systems in countries around the world (Magnusson 2017: 01). O'Mathúna *et al.* (2005: 07) note although rights will not resolve all problems, they are helpful in assisting to evaluate issues and provide guidance for improvement.

The right to health was first recognized in 1948, in the WHO Constitution (WHO 1948), wherein it is stated the enjoyment of a first-rate health standard is one of the basic rights of all human beings (Mamad 2013: 28; Dhai and Mahomed 2018: 08-09). The Constitution of South Africa (Constitution) (SA Department of Justice and Constitutional Development 1996), provides the people of South Africa (SA) with the right of access to healthcare services (Section 27(1)). The Constitution directs the state to take reasonable legislative measures, within available resources, to achieve the progressive realisation of this right (Section 27(3)). The National Health Act 61 of 2003 (NHA) (SA Department of Health 2003), aims to provide the people of SA with the "best possible" healthcare services available resources allow, in a fair and equitable manner (Section 2).

Although some progress has been made in transforming the healthcare sector in SA, the health system remains a two-tiered system with separate public and private sectors (van Rensburg and Engelbrecht 2012: 179). According to Motsoaledi (2011), each of these two tiers face different challenges. He warned of poor quality of care in the public sector and increasing costs in the private healthcare sector. Studies, such as the one undertaken

by the Health Economics Unit (HEU) (2012: 4), have revealed that patients who access healthcare in the public sector continue to encounter poor quality service.

The World Health Organization (WHO) (2018: 60), in a joint report released with, amongst others, the OECD and World Bank, describes the public healthcare sector as responsible for providing healthcare service to 84 percent of the population of SA; this makes it imperative to address poor-quality service delivery. The final findings of the Health Market Inquiry into the Private Healthcare Sector (Competition Commission 2019: 210) describe the private healthcare market as challenged by “high and rising” costs. According to Maseko and Harris (2018: 22), most citizens can only access healthcare services in the public healthcare sector because of the high costs of private healthcare. Aikman (2019: 53) concurs and notes private healthcare services are only available to those who can afford medical aid. The author states the majority of the population depend on the public sector for these services. The WHO (2007: 3) highlights that effective healthcare services deliver safe, effective and quality health interventions “to those who need them, when and where needed, with minimum waste of resources”.

The Consumer Protection Act 68 of 2008 (CPA) (SA Department of Trade and Industry 2008) applies to the healthcare sector in SA (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33). The CPA aims to deliver better protection for consumers (Ally 2017: 01), promoting and advancing the “social and economic welfare of consumers”, particularly vulnerable consumers by: establishing a legal framework to achieve and maintain a transformed consumer market, described in the Act as “fair, accessible, efficient, sustainable and responsible”; and to improve “consumer awareness and information” in order to encourage consumer responsiblity and informed decision-making and behaviour (SA Department of Trade and Industry 2008: Section 3(1)(a); (e)).

In terms of Section 1 of the CPA, a consumer is defined as a person to whom both goods and services are marketed during the ordinary course of business (SA Department of Trade and Industry 2008: Section 1). It is widely accepted that patients who access

healthcare services in both the public and private sectors qualify as consumers (Van Den Heever 2012: 02; Govender 2017: 01).

The healthcare system in SA is regulated in terms of the NHA, introduced with the aim of transforming the healthcare system of the apartheid era. The previous system was characterised by inequality and fragmentation, thus the NHA aims to provide the country's population, including vulnerable groups, with the "best possible" healthcare services available resources permit, in an equitable manner (Section 2(a)(ii)).

1.2 Background to the study

Despite progress in transforming the healthcare sector in SA, the healthcare system remains a two-tiered structure, with separate public and private sectors each facing different challenges (van Rensburg and Engelbrecht 2012: 179). According to Aikman (2019: 53), the current crisis in the South African healthcare system is complex and multifaceted, with each aspect that needs to be understood and addressed in order to improve the quality of healthcare service delivery in SA. It is widely accepted that the country's public healthcare sector is under-resourced and overburdened, resulting in the delivery of poor-quality services (SA Department of Health 2017: 12). Complaints from patients regarding the poor-quality of service are numerous (Aikman 2019: 52). Gumede, Green and Dlamini (2015: 32) explain quality service, in the context of healthcare, as an act or action by staff members, characterised by capability, activeness, distribution of information, and polite manners by staff, as well as helpfulness.

Public sector healthcare facilities have been assessed using core quality standards, which uncovered problems with quality in staff attitude, long waiting times, poor cleanliness and infection control, as well as drug shortages and safety and security problems experienced by both patients and staff (SA, Department of Health 2017: 12). Research has revealed some of the greatest difficulties experienced in healthcare service delivery in the public sector to include lengthy waiting periods, bad staff attitudes, an inability to gain access to doctors, and drug shortages (HEU 2012: 04).

Aikman (2019: 54) notes many patient complaints relate to poor attitudes of staff at hospitals. This echoes findings concerning public healthcare facilities by Young (2016: 04), who adds the sector is plagued with faults, weaknesses and inadequacies, including long waiting times for healthcare services, poor disease control and poor-quality healthcare delivery (Young 2016: 04). Patients waste time in long queues, crowded into small spaces, leading to an increased risk for the spread of infections; both have an economic impact on patients, who often have to return on concurrent days when they do not receive the healthcare services they need (Aikman 2019: 53). Failure in the delivery of quality healthcare has resulted in the public distrusting the South African healthcare system (Maphumulo and Bhengu 2019: 01).

The CPA aims to promote and advance the “social and economic welfare of consumers”, particularly vulnerable consumers, by establishing a legal framework to achieve and maintain a consumer market that is fair, accessible, efficient, and sustainable, as well as responsible, and to improve “consumer awareness and information” (SA Department of Trade and Industry 2008: Section 3(1)(a); (e)). One of the ways the CPA wants to achieve these aims is through the fundamental consumer rights, as set out in chapter 2 of the Act.

Steps have been taken to advance the quality of healthcare services delivered in SA (Maphumulo and Bhengu 2019: 02). However, patients continue to complain of the poor-quality healthcare services they receive (Aikman 2019: 52). The CPA applies to the healthcare sector in SA and patients are now characterised as consumers (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33).

1.3 Rationale for the study

Despite the aim of the NHA (SA Department of Health 2003) to transform the healthcare system in the country, as shown in a study by Maphumulo and Bhengu (2019: 03), patients in the public healthcare sector still experience a number of challenges in the received healthcare service quality. However, since this evidence is largely anecdotal and the research conducted limited, identifying what communities perceive to be the most significant challenges with public sector healthcare service delivery (HEU 2012: 1;

Aikman 2019: 52). The CPA applies to the public healthcare sector in SA and aims to provide patients, as consumers, with a healthcare consumer market that is a “fair, accessible, efficient, sustainable and responsible” consumer market (Section 3 (1)(a)).

This study will make a contribution by investigating patient challenges as healthcare service consumers and examining the role of the CPA in addressing these challenges. This study will benefit patients as consumers of healthcare services in identifying some of the challenges faced in healthcare service delivery in the public sector and raising awareness of the CPA role in addressing these challenges.

1.4 Problem statement

There is a large amount of evidence that the delivery of healthcare in SA is inundated with numerous challenges that negatively impact the quality of public sector healthcare service delivery (Maphumulo and Bhengu 2019: 01). However, much of this evidence is anecdotal and limited research has been conducted to identify what communities consider as the biggest healthcare service delivery challenges in the public sector (HEU 2012: 1; Aikman 2019: 52).

Gumede *et al.* (2015: 33) state the evaluation of patient satisfaction has been given more attention in recent years and is a useful tool for improving the quality of healthcare services. Aikman (2019: 55), believes the lack of research into the challenges of patients creates difficulties in addressing a problem that is under-researched. She asserts data regarding patient complaints are, to a large extent, anecdotal and believes a study of the challenges in the healthcare system could provide insight into the nature of the problem, assisting to address the challenges.

Studies investigating the challenges experienced by patients in the public sector in SA have revealed that these include: long waiting times, insufficient staff, adverse events, and inadequate hygiene and infection control, along with an uptake in litigation as a result of avoidable mistakes, shortages of resources including medicine and equipment, and poor attitude of hospital staff, as well as poor record-keeping (HEU 2012: 1; SA

Department of Health 2017: 03; Aikman 2019: 52; Maphumulo and Bhengu 2019: 02). Healthcare workers in SA's public healthcare sector have been described as indifferent and uncaring with no respect for patient confidentiality (Komape 2013: 10). The WHO (2018: 60), in conjunction with other associated institutions and bodies, including the OECD and World Bank, reports the public healthcare sector is responsible for providing healthcare service to 84 percent of the population of SA and it is therefore imperative that issues resulting in poor-quality service delivery are identified and addressed.

In order to address patient challenges, it is also important patients are aware of their rights and the level and quality of healthcare services they can expect (Hassim, Heywood and Berger 2007: 247). The National Patients' Rights Charter (NPRC) (SA, Department of Health 1999) acknowledges the importance of information for patients in understanding and enforcing their rights and therefore, requires all users of the healthcare system must be informed of their rights. Public healthcare facilities are required to display the NPRC (SA, Department of Health 1999) in local languages (Hassim, Heywood and Berger. 2007: 247). Van den Heever (2012: 07) notes without awareness of their rights, consumers are unable to take advantage of the protection provided by the CPA.

The CPA applies to the healthcare sector in SA and aims to transform this sector into a "fair, accessible, efficient, sustainable and responsible" consumer market (SA Department of Trade and Industry 2008: Section 3(1)(a)) through, *inter alia,* introduction of the fundamental consumer rights contained in Chapter 2 of the CPA. Adopting the characteristics of the transformed consumer market the CPA aims to achieve, can provide a framework with the potential to contribute to overcoming some challenges experienced by patients as consumers. Furthermore, the CPA aims to promote and advance the "social and economic welfare of consumers" by "improving consumer awareness and information and encouraging responsible and informed consumer choice and behaviour" (SA Department of Trade and Industry 2008: Section 3(1)(e)).

1.5 Aim, objectives and research questions of the study

The aim, objectives and research questions of the study are set out below.

1.5.1 Aim

The aim of this study is to investigate the challenges of patients as consumers of public healthcare services in the Inanda district of eThekwini and the role of the CPA in addressing these challenges.

1.5.2 Objectives

The objectives of this study are:

- To examine the extent to which patients as consumers are aware of their rights in terms of the NHA;
- To examine the extent to which patients as consumers are aware of their fundamental consumer rights in terms of the CPA;
- To investigate the challenges of patients as consumers of public healthcare services delivered in the public healthcare sector in the Inanda district of eThekwini; and
- To explore the role of the CPA in addressing the challenges of patients as consumers.

1.5.3 Research Questions

The research questions arising from the objectives of the study are:

1. To what extent are patients as consumers aware of their rights in terms of the NHA?
2. To what extent are patients as consumers of healthcare services aware of their consumer rights in terms of the CPA?
3. What are the challenges of patients as consumers of public healthcare services delivered in the public healthcare sector in the Inanda district of eThekwini?
4. Does the CPA have a role in addressing the challenges of patients as consumers?

1.6 Research methodology

Research methodology examines the research design and method; population and sample size; data collection and analysis; validity and reliability, and ethical concerns considered in this study.

1.6.1 Research design and method

Research design provides the framework within which research is conducted; it connects the fundamental components in a research project (Akhtar 2016: 24). A research design guides the collection and analyses of data (Mabitsela 2012: 24). The research design used in this study is descriptive. According to Kabir (2016: 124), descriptive research designs assist in providing answers to the questions of who, what, where, and when, in addition to how, with these connected to a research problem that, generally, cannot provide answers to why. This study adopted a descriptive research design, as it is concerned with investigating what challenges patients encounter in accessing healthcare services in the public sector, rather than the underlying causes of these challenges.

1.6.2 Research methods

According to Daniel (2016: 92), research can be conducted using quantitative, qualitative or mixed methods. The author states both quantitative and qualitative research can realise the same goal, by adopting different techniques and procedures, each with different strengths and logic. The research design used in this study is quantitative.

1.6.3 Target population, sample size, sampling method and recruitment process

A target population is the group of people a researcher wants to research and analyse (Mack 2020: 1-2). The target population of this study includes adult patients as consumers of public healthcare services who reside in Shembes Village, in the Inanda district of eThekwini municipality, in the province of Kwa-Zulu Natal (KZN), SA.

Inclusion and exclusion criteria describe who can be included or excluded from a study sample (Garg 2016: 642). The participants included in this study are adult female and male consumers of any race who use healthcare services in the public sector and reside in Shembes Village in Inanda Township, located in the eThekwini municipality, SA. Minors and those consumers who do not access healthcare services in the public sector will be excluded from the study.

A sample is a subsection of the population that participates in a study and should represent an entire group or universe and sampling is the procedure of selecting a sample from a population (Pandey and Pandey 2015: 40-41). The statistics of Census 2011 provided by Statistics SA (StatsSA) (2011); the population of Shembes Village in Inanda Township is 10 017 people. The sample size used in this study was based on the guidance of Sekaran and Bougie (2013: 268), who propose a sample of 375 is sufficient to draw inferences from, for a population of between 10 000 and 15 000. Hence, for this study, the sample size was 375 respondents from Shembes Village in Inanda Township.

Non-probability sampling was used to identify participants for this study, which according to Moletsane (2012: 64), is appropriate for a survey when selecting participants. Purposive, convenience sampling was used for this study.

DeCarlo, Cummings and Agnelli (2020: 101) explain recruitment as the process used by the researcher to advise prospective participants about the study and request them to participate. This study used snowball recruitment to recruit consumers who access healthcare services in the public healthcare sector. According to Cawthra *et al.* (2017: 88), snowball recruitment involves identifying primary participants and then requesting them to nominate other willing participants with similar experience. Snowball recruitment aligns with the sampling method used in the study, which is purposive, convenience sampling.

1.6.4 Research tools/instruments and data collection

This study used both primary and secondary sources of data. Kumar (2011: 24) describes a research tool or instrument as a method of collecting information for a study, which includes a questionnaire. As Wagner, Kawulich and Garner (2012: 22) explain, a survey can be used to collect information from large groups of people in a short amount of time by using questionnaires or interviews. The research instrument or tool used as data collection instrument in the survey employed for this study was a questionnaire.

1.6.5 Data analysis

The questionnaire gathered data that were analysed and interpreted to describe consumer challenges and awareness. The quantitative data collected in this study was analysed using the Statistical Package for Social Sciences (SPSS) version 27.0. Data from the open-ended questions were analysed by the researcher using content analysis to examine and identify recorded communication patterns (Parveen and Showkat 2017: 03), in an effort to gain insight into the challenges patients experience as consumers of healthcare services.

1.6.6 Validity and reliability

Bryman (2012: 45) notes the quality of research is tested using the concepts of validity and reliability.

Validity

The concept of validity, as Leedy and Ormrod (2005: 210) state, is the extent to which a research instrument measures what it set out to measure, and the extent to which the clarification of the results of an examination are warranted. In this study, factor analysis is used to assess validity.

Reliability

The measure of reliability is explained by Sekaran and Bougie (2013: 228) to show the degree to which the instrument is without bias and error free. Consequently, reliability deals with whether the study results are repeatable or replicable. In this study, reliability was measured by conducting a pre-test and Cronbach's Alpha test to measure internal consistency, as suggested by Bryman (2012: 120) and Maree (2019: 261). The reliability scores for all sections considered exceeded the recommended Cronbach's alpha value, demonstrating a degree of acceptable, consistent scoring for these sections of the research.

1.6.7 Ethical considerations

Ethical issues that need to be considered in research include ensuring respondent participation is voluntary (Edmonds and Kennedy 2017: 171), and their information will be kept confidential (Wiles *et al.* 2008: 417), in addition to understanding they are free to withdraw from the study should they wish to do so (Gordon and Prohaska 2006: 286). Furthermore, participants need to be protected from any personal harm while participating in a study (Sim and Waterfield 2019: 3011).

Participation in this study was voluntary and free from coercion. Participants were able to withdraw from the study whenever they wished to do so and not at risk of any personal harm.

According to Kumar (2011: 246), confidentiality will be maintained by ensuring the information provided by respondents is kept anonymous. Confidentiality will be maintained by ensuring all information, answers and opinions provided in this study are treated as private and in strict confidence to ensure respondent anonymity.

1.6.8 Informed Consent

To ensure all participating consumers clearly understood the objectives of the study and provided informed consent to participate in the study, all who participated were provided with a copy of the letter of information (Attached in Appendix C and D). The information letter and consent form were provided in both English and isiZulu, as isiZulu is the primary home language of the research population. Participants were afforded the opportunity to accept or decline participating in the study.

1.7 Contribution of the study

The aim of this study is to investigate the challenges of patients as consumers of public healthcare services in the Inanda district of eThekwini, as well as the role of the CPA in addressing these challenges. The results from this study will assist in identifying and highlighting some of the challenges patients experienced in accessing healthcare in the public system, while ascertaining the extent to which patients as consumers of healthcare

services are aware of their rights in terms of the CPA. The results will further equip patients with information regarding the role of the CPA in addressing their challenges.

1.8 Outline of the study

Chapter One

This chapter consists of the general introduction and overview of the study. It set out the problem statement, the rationale, and the aim and objectives of the study. A brief introduction of the methodology adopted was discussed, along with an introduction to the study contribution on the role of the CPA in addressing patient challenges in the public healthcare sector.

Chapter Two

Literature reviewed in this chapter will focus on patient challenges, the fundamental role of health in society and the legal framework that aims to advance the right to health, in existing literature. It also examines the important role of health in society by exploring both the international and South African regulatory frameworks. Social justice is introduced as the theoretical framework and discussed. The challenges of patients will be explored and selected patient rights in terms of the NHA discussed. Finally, the importance of patient awareness of rights and the role of the NPRC (SA, Department of Health 1999) in increasing awareness of patient rights are examined.

Chapter Three

The rights of patients as consumers of healthcare services in terms of the CPA are detailed in this chapter through a review of relevant literature, along with an examination of the application of the CPA to the healthcare consumer market in SA. The focus is on selected fundamental consumer rights with a role to play in addressing the challenges patients experience as consumers in the healthcare consumer market. The importance of ensuring consumers are aware of these fundamental consumer rights will also be discussed, while the importance of measuring the quality of services delivered will be explored.

Chapter Four

The research methodology adopted in this study is outlined. Key aspects are explored including the research design and method; population and sample size; data collection and analysis; validity and reliability and ethical considerations.

Chapter Five

This chapter presents the results and discusses the findings based on the primary data collected using the questionnaire.

Chapter Six

The significant findings of the study will be discussed in this chapter, in relation to the aim and objectives. Thereafter, conclusions and recommendations will be provided, followed by possible further research and limitations to this study.

1.9 Conclusion

This chapter provided a background to the study and set out its aim and objectives. It presented the research problem, introduced the methodology used and outlined the chapter structure. Chapter Two uses literature to review patient challenges, the fundamental role of health in society and the legal framework that aims to advance the right to health.

CHAPTER TWO
LITERATURE REVIEW

PATIENT CHALLENGES, THE FUNDAMENTAL ROLE OF HEALTH IN SOCIETY AND THE LEGAL FRAMEWORK THAT AIMS TO ADVANCE THE RIGHT TO HEALTH

2.1 Introduction

On 1 April 2011, the CPA came into operation, with the aim to improve protection for consumers (Ally 2017: 01); it applies to the healthcare sector in SA (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33).

According to Von Staden (2021: 2-3), it is challenging to introduce the CPA into the healthcare market, since before its introduction to this unique and specialised consumer market, a legal framework with a strong ethical foundation already regulated many aspects of this market. She notes the patient is, therefore, not an “unprotected consumer”, because this unique consumer is protected in terms of both health law and the CPA.

The healthcare sector is a complex service industry that provides services involving a significant degree of intangibility, inseparability of production and consumption, and significant interaction and communication between the service provider and the consumer (Mohamed, Mohamed and Azizan 2017: 02). It is essential that the application of CPA into the consumer healthcare market be accomplished in a way that both recognises the complexity of this specialised market and serves to advance its primary aim; the promotion of health and health equity (Von Staden 2021: 3).

Despite the international and South African legal frameworks that recognise and protect the right to health as a fundamental human right, patients that access healthcare in the public sector in SA face numerous challenges that need to be addressed in order to improve health outcomes and equity in health.

This chapter will examine the important and fundamental role of health in society by exploring both the international and South African regulatory frameworks that seek to explain, recognise and protect the right to health as a fundamental human right. Social justice will be introduced and discussed as the theoretical framework. This chapter will then explore the challenges of patients from three perspectives, an historical perspective, current challenges and concern for the future as SA continues with the implementation of National Health Insurance (NHI). Selected rights accorded patients in terms of the NHA will be discussed. This will be followed by an examination of the NPRC (SA, Department of Health 1999) which has as an aim increasing awareness of patient rights.

2.2 The fundamental role of health in society

Dhai and Mahomed (2018: 09) note the right to health is protected in the Universal Declaration of Human Rights (UDHR) (UN General Assembly 1948), the Constitution of the WHO (1948: Preamble) and a number of international treatises.

The WHO (1948: Preamble) identifies health as a foundational right and describes it as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". It explains the value and significant role good health plays in society and highlights the duty of the state in promoting and protecting health. The Preamble (WHO 1948) provides that:

> "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all".

The Preamble (WHO 1948) further draws attention to the responsibility of government in ensuring the right to health and adds that "[g]overnments have a responsibility for the

health of their peoples which can be fulfilled only by the provision of adequate health and social measures".

Good health is viewed as an important foundation for human development, because of its effect on productivity, education, social and political stability, economic return and equity (Wesso 2014: 01). The WHO (2017: 01) asserts health is essential not only for individuals, but for society as a whole and provides that in the absence of good health, individuals are unable to enjoy other basic human rights. It recognises that: "[t]he right to health is a fundamental human right that is indispensable for human well-being, for well-functioning societies and economies, and for the ability to exercise all other human rights".

The importance and significance of health is acknowledged internationally, with the right to health defined as a human right and well-established in international law (WHO 2017: 7). Health as a human right is progressively accepted at both international and national levels around the world (Flood and Gross 2014a: 4).

The importance of the right to health is acknowledged in the UDHR (UN General Assembly 1948: Art 25(1)), which provides that every person has the right to a living standard that is "adequate" for "health and well-being", including medical care. The ICESCR (UN General Assembly 1966: Art 12(1)) recognises everyone has the right to enjoy the "highest attainable standard of physical and mental health" and includes a set of minimum core duties states need to comply with, which comprises creating conditions to ensure medical service provision to everyone in the event of illness (Article 12(2)(d)). The ICESCR (UN General Assembly 1966) is generally recognised as the foundation of international human rights law, as regards the protection of the right to health (Dhai and Mahomed 2018: 09).

The ICESCR (UN General Assembly 1966: Art 12(2)) places a legal duty on member states to ensure the progressive realisation of the right to health, including execution of a national plan, founded on human rights principles that aim to ensure this right is realised for every person. SA ratified the ICESCR (UN General Assembly 1966) in 2015 and is

under a legal obligation to ensure the right to health is progressively realised in the country. Von Staden (2021: 137) asserts the introduction of the CPA to the healthcare sector can be seen as forming part of SA's national plan to ensure the right to health is realised for every person. She believes the CPA needs to use the authoritative explanation and interpretation of the right to health, used by the Committee on Economic, Social and Cultural Rights (CESCR) in General Comment 14 (CESCR 2000) to conceptualise health and regulate this market in a manner that promotes health and health equity.

The United Nations (UN) CESCR ensures compliance of member states with the provisions of the ICESCR (UN General Assembly 1966), while providing authoritative interpretation of the right to health, as contained in Article 12 of the ICESCR (UN General Assembly 1966). According to the CESCR (2000: GC14: para 11), the right to health is an inclusive right that comprises appropriate and suitable delivery of healthcare services, while simultaneously addressing the social determinants of health. The focus of this study is to determine the challenges of patients as consumers of healthcare services; therefore, an in-depth examination of the social determinants of health is beyond the study scope. Nevertheless, a brief explanation will be provided of this important right to health element in order to provide an inclusive perspective.

The WHO Commission on the Social Determinants of Health (CSDH) (2008: 34) believes that: "water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social, and economic forces that fail to make clean water available to all".

There is broad acknowledgment of the influence the political, economic and social circumstances in which people live has on both health outcomes and equality in health (Pelser 2012: 226). The WHO (2018: 59) asserts income inequality and socio-economic status generally predict and reflect health outcomes. Umuhoza and Ataguba (2018: 53; 63) state that in SA and other Southern African countries, poor health outcomes are disproportionately concentrated amongst the poor members of society. The authors add this is due to a number of different reasons, including an unequal distribution of social

health determinants. They further assert many social health determinants that exert influence over both health status and inequality in health, are located outside the healthcare market. Horn (2015: 28) agrees and argues that the burden of disease is linked to poverty and discrimination.

The significance of a social determinants approach to health has been recognised in SA. The National Development Plan (NDP) 2030, outlined by the National Planning Commission (NPC) (2012: 335) states that addressing the social determinants that affect health need to be addressed and references the recommendations of the CSDH (2008). The Revised White Paper (SA Department of Health 2017: 1) also highlights the important role played by social determinants of health in SA. This perspective is reinforced by some challenges patients experience that do not arise in the healthcare sector, but nevertheless impact healthcare service delivery, as discussed in paragraph 2.6.2.

The CESCR (2000: GC14: para 8-9) states the right to health consists of rights or entitlements and freedoms. These rights are based upon a system that not only protects health but also ensures equal opportunity to every person to enjoy the highest attainable level of health, subject to resource availability. Dhai (2020: 437) explains rights ensure equal opportunity for every person to enjoy the highest attainable standard of health, while freedoms include the ability to make informed choices.

The CESCR (2000) recognises the right to health as encompassing the right to healthcare and the social determinants of health, while acknowledging the right to health is not an unlimited right, however, it is necessarily dependant on the availability of state resources. Von Staden (2021: 137) believes this broad definition of the right to health can provide guidance to the manner in which a transformed consumer market, as envisioned by the CPA in Section 3(1)(a)), is implemented in the healthcare sector.

2.2.1 The obligation to respect, protect, promote and fulfil the right to health

As discussed above, SA is a member of the ICESCR (UN General Assembly 1966); therefore, the country is bound by an obligation to respect, protect and fulfil the right to

health, as contained in the CESCR (2000: GC 14: para 33). Similar obligations are found in Section 7(2) of the South African Constitution, which provides the state must “respect, protect, promote and fulfil” the rights contained in the Bill of Rights, which include the right of access to healthcare services, as set out in Section 27(1). Section 2(1)(c) of the NHA also provides the state must protect, respect, promote and fulfil the right of South African citizens to the Constitutional right of access to healthcare services.

Member states have an obligation to fulfil the right to health by recognising the right in the national legal framework by way of legislation where possible (CESCR 2000: GC 14: para 33). SA recognises the right to health in the Constitution (Sections 27; 28 (1)(c); 24(a)) and the NHA (Section 2). Von Staden (2021: 138) believes the application of the CPA to the healthcare sector can be seen as part of the duty of the state to realise the right to health by implementing legislation, however, she warns that such legislation must be applied in a manner that respects, protects, promotes and fulfils the Constitutional right to health.

A joint report by the WHO, OECD and, International Bank for Reconstruction and Development/The World Bank (WHO 2018: 64), indicates that in order to achieve national health objectives, governments should use both legislation and regulation to achieve national health objectives. They note regulation is required to address a variety of factors outside clinical practice or the management of healthcare that influences behaviour in delivering or using healthcare services. The report adds that various regulatory interventions often fail to meet the intended objectives, partly because responsible agencies do not have sufficient enforcement capacity.

2.2.2 Availability, accessibility, acceptability and quality as essential elements in advancing the right to health

The CESCR (2000: GC 14: para 12) sets out four important elements or guiding principles that need to be considered in ensuring the recognition of the right to health; these principles are “availability, accessibility, acceptability and quality”. According to the WHO (2017: 13), these guiding elements assist in clarifying the extent of government obligation

in advancing the right to health. They guide governments in making decisions regarding objectives, resources, focus and the extent of reform activities within public health law (WHO 2017: 06). Von Staden (2021: 138) asserts these essential elements can assist in adding substantive content to the “fair, accessible, efficient, sustainable and responsible” healthcare consumer market, as intended in Section 3(1)(a) of the CPA.

These principles will be briefly examined in order to provide a broader understanding of the issues that need to be considered in respecting, protecting, promoting and fulfilling the right to healthcare services access, as set out in the Constitution (Section 27(1)) and the NHA (Section 2(1)(c)).

Availability

The availability component of access investigates whether the appropriate health services are provided at the most suitable place and time to fulfil the needs of the population (McIntyre and Ataguba 2017: 01). Availability, as mandated by the CESCR (2000: GC 14: para 12(b)), obligates the state to provide sufficient functioning healthcare facilities, goods and services. This goal may be achieved by allowing the private sector to provide healthcare facilities and services under the directive of the state (CESCR 2000: GC 14: para 35). The exact mix of the healthcare facilities, goods, and services provided, will differ due to local conditions including a country’s level of development, its unique health challenges and available resources, together with the current balance of healthcare service providers between the public and private sectors (WHO 2017: 15). It should encompass the social determinants of health including safe, clean drinking water, sufficient hospitals, clinics, and essential medication (Muller 2017: 04).

Accessibility

The second element is accessibility, which provides that healthcare services must be accessible to every person (CESCR 2000: GC 14: para 12(b)). The Committee interprets accessibility as consisting of four elements; each of which will be briefly examined below. Von Staden (2021: 140-1) notes that Section 3(1) (a) of the CPA aims to make the consumer market more accessible, aligning with the principle of accessibility as explained

by the CESCR (2000: GC 14: para 33). She adds this can provide guidance to interpreting the meaning of an accessible healthcare consumer market, as required by the CPA.

The first element of accessibility is non-discrimination, which essentially requires that healthcare services must be accessible to everyone, particularly vulnerable or marginalised population groups, without discrimination on any of the prohibited grounds (CESCR 2000: GC 14: para 18). The CPA provides protection to vulnerable consumers and identifies the right of the consumer to equality and non-discrimination (Sections 8-10) as a fundamental consumer right in the consumer market.

The second element of accessibility is physical accessibility which requires healthcare services to be within a safe physical distance for everyone, especially vulnerable and marginalised groups that include ethnic minorities, indigenous populations, women, and children, as well as teenagers, the elderly, the disabled, and people living with HIV/AIDS (CESCR 2000: GC 14: para 12(b)). The introduction of primary healthcare clinics, as the foundation of public healthcare service delivery in SA, aims to address problems associated with physical accessibility by providing a "point of entry" into healthcare services closer to where patients live (Nesengani *et al*. 2021: 2071).

Both O'Donnell (2007: 2821) and Moyo (2016: 09) identify accessing healthcare services in SA as a challenge for patients. According to Gazana (2015: 01-02), progress has been made to improve access to healthcare facilities and economic equity. Despite this progress, access barriers for patients remain, including a lack of transport to access healthcare, which is problematic for individuals living in poverty (SA Department of Health 2017: 02). Access barriers include: long travel distances and expensive costs of travel, particularly in remote and rural areas; excessive out-of-pocket payments; lengthy queues; and discouraged patients (Harris *et al*. 2011: 103).

Economic accessibility is the third element of accessibility and the CESCR (2000: GC 14: para 18) states it is focused on ensuring provision of affordable and equitable healthcare services. The principle of equity requires emphasis on ensuring poorer households are

not disproportionately weighed down with healthcare expenses. The WHO (2017) agrees governments need to ensure action is taken to protect poor and vulnerable individuals, by ensuring they are not burdened with healthcare expenses in a disproportionate manner.

Economic accessibility is addressed in the public healthcare sector, which is funded by the taxpayer (NPC 2012: 339; Competition Commission 2019: 44). Access to public healthcare services is based upon a means-test (Competition Commission 2019: 44) and the fees payable by patients are determined by the Uniform Patient Fee Schedule (SA Department of Health 2017: 17). Some patients have to pay a facility-based fee at hospital level, with the amount payable determined according to patient economic classification, based on income, while some patients do qualify for free public healthcare (Competition Commission 2019: 44). Despite advances in respect of reducing costs to patients, high out-of-pocket payments have been identified as an access barrier (Harris *et al.* 2011: 103).

The final element of accessibility is information accessibility, which deals with the right of individuals to receive information about health issues and to ensure such information is treated confidentially (CESCR 2000: GC 14: para 12(b)). This element is addressed in both the NHA and the CPA. Chapter 2 of the NHA sets out the rights users of healthcare services have in terms of the Act, including the right to informed consent (Section 7) and the right to participate in decision-making (Section 6; 8). These patient rights are discussed in paragraph 2.7.2. The aim of the CPA, as set out in Section 3(1)(e) to improve "consumer awareness and information" and encourage "responsible and informed consumer choice and behaviour", aligns with this element. Furthermore, the right to disclosure and information is recognised as a fundamental consumer right (Part D) and is discussed in paragraph 3.4.2.

Acceptability

The third guiding principle is acceptability, which states that those involved in healthcare service provision must ensure services are provided in a manner that acknowledges and

complies with medical ethics, is culturally appropriate, and respectful of patient confidentiality (CESCR 2000: GC 14: para 12(b)). Patients should be treated with respect and have their views considered when it comes to decision-making related to their health (World Bank 2018: 43). The right to confidentiality (Section 14) is a patient right in terms of the NHA and is discussed in paragraph 2.7.2, while the CPA also recognises the right to privacy (Part B). However, this right does not address patient challenges, as it focuses on the right to restrict unwanted direct marketing (Section 11), the regulation of time for contacting consumers (Section 12), and is therefore not canvassed in this study.

Both staff attitudes and breaches of confidentiality have been identified as challenges of patients **(**SA Department of Health 2017: 03-04; Burger *et al.* 2016: 193; Maseko and Harris 2018: 24; Harris *et al.* 2011: 116). These challenges are discussed in paragraph 2.6.2.

Quality

The final guiding principle is quality and requires healthcare services must be both scientifically and medically correct and of good quality (CESCR 2000: GC 14: para 12(b)). Good health is exceptionally important, with healthcare service delivery that must be of the highest quality, while healthcare professionals have a legal and ethical responsibility to deliver the best possible care to patients (Muller 1996: 67). The highest attainable standard of health cannot be achieved in the absence of effective and high-quality healthcare services (WHO 2017: 20). Policy in the healthcare sector must ensure everyone access to quality healthcare services, regardless of their ability to pay (CSDH 2008: 139). The knowledge, skills and attitudes of healthcare professionals should be of good quality, according to accepted norms, and as perceived by users (World Bank 2018: 43).

According to Wesso (2014: 03), the National Core Standards was developed by the Office of Health Standards Compliance to provide a framework to benchmark the quality of healthcare provided. The author adds that using policy and legislative directives, the

Department of Health is committed to a vision of a healthcare system that provides quality healthcare services (Wesso 2014: 03).

A fundamental consumer right of the CPA is the right to fair value, good quality and safety (Part H) that includes the consumer's right to demand quality service (Section 54). This right is discussed in paragraph 3.4.5.

Mthanti (2015: 17) asserts, despite increased access in the public healthcare sector in SA, the quality of the services provided has remained poor and is a significant barrier to advancing health. According to Dhai (2020: 436), the quality of healthcare services delivered in SA is the result of a number of critical factors. Many of the challenges experienced by patients accessing healthcare services in the public sector are related to quality and are discussed in paragraph 2.6.

The CESCR (2000: GC 14: para 12) thus recognises "availability, accessibility, acceptability and quality" as guiding principles or essential elements crucial in ensuring the right to health is realised for everyone. These essential elements are incorporated in both the NHA patient rights and the fundamental consumer rights of the CPA and can be used to guide and add substantive content to a "fair, accessible, efficient, sustainable and responsible" healthcare consumer market, as envisioned by Section 3(1)(a) of the CPA (Von Staden 2021: 141).

The next section will examine the internationally recognised right to health from a South African perspective, as a right contained in the Constitution and the NHA.

2.3 Recognition of the right to health in South Africa

The right to health is a constitutionally protected right also recognised in the NHA.

2.3.1 The Constitutional right to health in South Africa

The Constitution is the supreme law of the country and obligations imposed by it have to be fulfilled (Section 2), including the right to health (Section 27). The foundational values

of the Constitution are human dignity, equality and human rights (Section 1(a)) and it requires the state to respect, protect, promote and enforce all rights in the Bill of Rights (Section 7(2)). According to Barit (2017: 13), the Constitution guides how law should be implemented and how it should be applied in our society. Okeng Ebi (2016: 15) believes the Constitution instructs the government to provide conditions that will ensure adequate and quality healthcare services for all South Africans.

The right to health is recognised in the Constitution of SA, Act 108 of 1996 (SA Department of Justice and Constitutional Development 1996) as a right of access to healthcare services, including reproductive healthcare for all (Section 27(1)(a)). This right is, however, not an unlimited right and Section 27(2) of the Constitution provides the state has a duty to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to healthcare services. Section 27(3) states emergency medical treatment may not be refused to anyone and Section 28 (1)(c) provides the right to basic healthcare services to all children. Section 24 (a) states everyone has the right to an "environment that is not harmful to their health or wellbeing".

According to Carstens and Pearmain (2007: 25), the Constitution does not contain one single right to health as recognised in international law, but comprises individual rights that, when read together, may be interpreted as the right to health. According to Liebenberg (2010: 76), the health rights in the Constitution form part of the group of socio-economic rights that aim to provide everyone in SA with access to both the economic and social means that provide the foundation to afford equal participation in an unequal South African society. Moyo (2016: 02-03) notes the Constitution clearly provides for the Constitutional imperative to advance quality of life for all and to release the potential of every person. Langford (2014: 5) believes the socio-economic rights in the Bill of Rights are founded upon the "language and jurisprudence" used in the ICESCR (UN General Assembly 1966).

The Constitution recognises the right to health (Section 27) but does not provide guidelines that assist in determining the obligation of the state to ensure the right of access to healthcare services (Competition Commission 2018: 22). Both international law and the jurisprudence of the South African courts, as concerns socio-economic rights contained in the Bill of Rights, need to be referred to in order to appreciate what constitutes this right and its limitations (Okeng Ebi (2016: 39-40). The Constitution (Section 39(1)) and the CPA (Section 2(2)) contain provisions that direct the courts in South African to consider international law in interpreting the Bill of Rights and in applying the CPA. According to Okeng Ebi (2016: 39-40, 51), the courts of SA have generally referred to the ICESCR and general comments of the CESCR when applying the socio-economic rights contained in the Constitution. The author adds that the right to access healthcare needs to be viewed in the context of international and regional human rights instruments, as well as the Constitution and national legislation. Forman and Singh (2014: 317) state a justiciable Constitutional right to healthcare has played an important role in advancing the right to health and health equity, beyond merely enforcing this right through litigation. The authors assert the Constitutional right to health has given rise to legislation and policy that aim to increase equity in health.

In the case of Soobramoney v Minister of Health, KwaZulu Natal (1998: para 11; 20; 22), the Constitutional Court distinguished between the right not to be refused emergency medical treatment (Section 27(3)) and the right of access to healthcare services (Section 27(1)). The court noted that Section 27(3) is expressed in the negative and is therefore not a positive right but is not limited by the availability of resources as compared with the positive duty imposed on the state by Section 27(2) in terms of which the right of access to healthcare services is limited by available resources.

The following section will examine the role of the NHA in implementing the right of access to healthcare, as contained in Section 27 of the Constitution.

2.3.2 The National Health Act 61 of 2003 (NHA)

The NHA is founded upon the health rights contained in the Constitution and aims to regulate national health, by establishing a unified national health system that consists of the public and private sectors that both ensure the people of SA are provided with the "best possible" healthcare services available resources can provide, in an equitable manner (Section 2(a)(i); (ii)).

The Act sets out the rights and duties of both those involved in providing healthcare services and users of these services (Section 2(b)). Furthermore, the Act aims to protect, respect, promote and fulfil the Constitutional rights to the progressive realisation of the right of access to healthcare services, including reproductive healthcare, the right to an environment not detrimental to health or well-being, the right of children to basic healthcare services, and the protection of vulnerable groups (Section 2(c)(i-iv).

Despite recognition of the right of access to healthcare contained in the Constitution (Section 27(1)(a)) and the NHA (Section 2(a)(ii)), SA is currently struggling with an increasing, quadruple burden of disease comprised of high infectious disease rates, particularly HIV/AIDS and TB, non-communicable diseases, high maternal and child mortality, as well as increasing levels of violence and trauma (World Bank 2018: 58; de Villiers 2021: 3). This burden of disease represents a significant challenge to an already overwhelmed and overburdened public healthcare system that cannot service this increasing demand (de Villiers 2021: 3). The NDP 2030 (NPC 2012: 332) opines that this quadruple burden of disease facing SA has uncovered weaknesses in the health system. According to Motsoaledi (SA Department of Health 2011), the former Minister of Health in SA, the result of these coinciding epidemics is increasing rates of mortality and morbidity.

Despite some progress in addressing the quadruple burden of disease in SA, the public healthcare sector continues to face several challenges primarily related to poor quality and unequal access to healthcare services (South African Government 2019: 29). Von Staden (2021: 132) believes it is important to understand the state of health of the South

African population, in order to understand the challenges faced in healthcare service delivery and the role of the CPA in addressing these challenges.

The right to health in SA is, therefore, recognised in both the Constitution and the NHA, as ensuring the health of everyone, by progressively achieving the right of access to quality healthcare services, within affordable resources. The aim of the CPA needs to support this goal of progressive realisation of the right to health, for it to be effective in the healthcare consumer market (Von Staden 2021: 5). The following section will examine the role of the law in advancing the right to health in the healthcare market.

2.4 Role of the law in advancing the right to health

Both globally and nationally, the capacity of law to enhance the right to health is increasingly recognised (WHO 2017: 1). Legal frameworks have a significant role in ensuring the structure of any health system is effective (WHO 2017: 107). However, law is not always an "unmitigated social good" and can, sometimes, be a barrier to improving health as a human right (WHO 2017: 69). In other words, it is essential that the way the CPA is introduced into the healthcare consumer market must seek to further the aims of this specialised consumer market and not act as a barrier to health (Von Staden 2021: 5).

Despite recognition at international and national level of the important and critical role of the right to health, patients continue to face challenges in accessing quality healthcare services in SA. Due to the critical role health plays in enabling individuals to exercise all other human rights, it is imperative the health challenges of patients are addressed as a matter of achieving social justice. The following section will explore social justice as the theoretical framework underpinning this study.

2.5 Social justice as theoretical framework

According to Maree (2019: 35), a theoretical framework positions a research study. Hutchinson and Duncan (2012: 107) state the theoretical framework used by a researcher generally frames the research question and aims of a study. The theoretical framework

serves to justify the relevance of a research question (Van Hoecke 2011: 14). Taekema (2018: 1, 5) explains the theoretical perspective or framework provides the context for conducting research, by establishing the conceptual foundation that ensures a coherent and structured collection of knowledge built on prior research.

As Bauling and Nagtegaal (2015: 151) explain, the CPA as social justice legislation develops the transformative goal of the Constitution to stimulate and encourage socio-economic change in a South African society characterised by poverty and inequality. This study uses social justice as a theoretical framework due to the important role of health in enabling individuals to exercise all other human rights (WHO 2017: 01) and the fundamental role it occupies in the South African transformation agenda. The law in SA has been used to promote social justice, as evidenced in the preambles of the Constitution, the CPA and the NHA.

These preambles all draw attention to the necessity of addressing socio-economic inequality and poverty, and aim to establish a society based on social justice in order to improve the quality of life of all citizens. The Constitution created a legal framework for the establishment of a transformed society (Liebenberg 2010: 1-2). According to Davis and Klare (2010: 404), the Constitution is distinctive because it is a transformative Constitution, committed to social justice and transformation in both the public and private sectors. Liebenberg (2010: 206) asserts the introduction of justiciable socio-economic rights by the Constitution, including the right of access to healthcare services, plays an important role in advancing social justice in South African society. The legal framework in SA, based on the Constitution, orders social and economic life and together with social justice legislation, including the CPA, directs the economic sector of the country by establishing norms and standards that regulate interactions between consumers and suppliers in the consumer market (van Eeden and Barnard 2017: 89).

De Villiers (2021: 2) states SA remains a country impacted by ongoing “social inequality, poverty, unemployment, a heavy burden of disease” and an inequitable distribution of quality healthcare services. Burger and Christian (2018: 01) note, since the end of

apartheid, reforming the healthcare system has been high on the country's transformation agenda. Van Eeden and Barnard (2017: 60) assert the CPA forms part of the ongoing cycle of the transformation of South African law. Consumer protection policies aim to empower vulnerable consumers with the same benefits other economic groups in society enjoy, by addressing the power imbalances in the consumer market (McGregor 2017: 10). The underlying rationale for legal reform within the consumer market is based on the acknowledgment that consumers lack bargaining power and are, as such, vulnerable to exploitation (van Eeden and Barnard 2017: 26).

Liebenberg (2010: 27) emphasises the importance of a commitment in terms of the Constitution, to establish a society in SA based on social justice. The author notes the consequences of past injustices need to be dealt with and institutions need to be restructured to address social injustice. According to Burger and Christian (2018: 1), despite a commitment to transform the healthcare sector, access to quality healthcare services remains largely dependent upon the ability to pay for such services, rather than need, reinforcing the notion of health being a commodity instead of a social investment. The authors state that transforming the healthcare market is crucial to achieving social justice in SA.

2.5.1 Social justice as a concept

The fact that the Constitution does not explicitly reference social justice, except in the preamble, does not mean it is not a core value of the Constitution (Moseneke 2002 cited in Bauling and Nagtegaal 2015: 158). The term social justice is widely used and broadly defined (Almgren 2013: 01). It is a multidimensional concept that impacts the lives of individuals and communities in many ways and is based on the ideal of respect for human dignity (Bauling and Nagtegaal 2015: 158).

Peñaranda (2015: 993-988) describes social justice as an historical process related to ensuring social, cultural, and individual conditions that empower individuals to live a dignified life, in which opportunities are provided that support the development of skills and potential. This, in turn, allows individuals to fulfil their own needs and pursue interests

and aspirations. The author adds that social justice refers to the way social institutions balance fundamental rights and obligations and determine the distribution of benefits in a manner that promotes social cohesion. According to McGregor (2017: 06-07), social justice prevails when people have equal access to freedom, rights and opportunities, and the neediest members of less-developed society are cared for.

Almgren (2013: 01) believes social justice may be described as a philosophical framework, political philosophy or belief system used to determine how the flow of collective rights and obligations takes place between individuals and society. As McGregor (2017: 06-07) explains, it relates to taking right actions to create circumstances that promote the common good and therefore, benefit everyone. The author adds social justice is achieved when there is equitable distribution within society with regard to food, housing, healthcare, and education, along with job opportunities, safe working conditions, and access to the marketplace.

2.5.2 Promoting social justice in the healthcare sector

Nemetchek (2019: 244, 245) describes social justice as a widely debated, yet critical term in healthcare that ensures basic human rights are protected and ethical standards maintained. The author adds that healthcare codes of conduct and professional literature confirm the responsibility of healthcare professionals to promote social justice. Peñaranda (2015: 988) adds it is a standard that healthcare professionals generally acknowledge in the public health system. Striving for social justice has the potential to effect change that improves and supports the health of both individuals and communities, by recognising and addressing injustice, oppression, and inequality, while encouraging participation, opportunity, fairness, and equality, as well as cohesive relationships (Nemetchek 2019: 244). Horn (2015: 26) argues that eastablishing a link between public health and social justice is essential, particularly in low income communities, as the health of the population is often significantly impacted by social injustice and poverty.

Theories of social justice, according to Ruger (2004: 1075), tend to focus on justifying healthcare as a special social benefit. Nemetchek (2019: 245) agrees and notes

healthcare literature often describes social justice as highlighting the fair distribution of benefits and burdens in society, advancing conditions that promote equitable living and health, and incorporating elements of social reform. Habibzadeh, Jasemi and Hosseinzadegan (2021: 01-02) note, in the health system, social justice reflects the provision of equitable healthcare services to all people, despite the personal circumstances of individuals. They remark on an increasing number of social and health inequalities around the world that have, in recent decades, focused attention on the importance of social justice in the provision of healthcare services. To achieve this goal, the authors assert it is vital to train skilled and qualified healthcare specialists to provide the much-needed care for diverse populations in a constantly changing human environment. Habibzadeh *et al.* (2021) add that a focus on social justice will ensure social transformation is pursued on behalf of the burdened and vulnerable population, with efforts aimed at addressing social inequalities such as poverty, unemployment, and lack of healthcare.

Stronks *et al.* (2016: 06) argue the ability of an individual to be healthy should be a major concern in social justice, which asserts that pursuing this ideal requires government action, because it is the government's responsibility to create the conditions that enable people to be as healthy as possible. Nemetchek (2019: 246) concurs social justice needs to focus on social responsibility and not individual responsibility; it involves meeting the needs of the people as a function of justice and not charity; and places a responsibility on the government to redistribute resources in order to reduce poverty, need, and inequality. Stronks *et al.* (2016: 28) emphasise that many human rights have implications for health and the social determinants of health, asserting that by addressing social justice issues across a broad spectrum of human rights, may positively address the right to health. Social justice can provide a solid foundation for urgently needed interventions in the delivery of public healthcare (Horn 2015: 29).

According to the WHO (2017: 01), the role of the law as a means of advancing the right to health is increasingly recognised, both globally and nationally, with legal frameworks a critical element in ensuring the effectiveness and efficiency of healthcare systems. The

CPA cannot, fundamentally, alter the structure of the healthcare sector in SA but can assist patients, as consumers of healthcare services, in addressing some of the challenges they experience through increased awareness of their rights and introduction of a legal framework for a transformed consumer market in the healthcare sector that provides patients with fundamental consumer rights (Rowe and Moodley 2013: 06).

2.5.3 Promoting social justice in a healthcare consumer market

Consumer access to justice is a concept noted by McGregor (2017: 10) that is critical in developing consumer protection legislation. The author believes consumers are more likely to find market justice when consumer protection addresses inequality in the marketplace. The transformation agenda of the CPA is set out in its aims, contained in Section 3 of the Act that focuses on the welfare of the consumer and the type of transformed consumer market the Act aims to establish.

The purpose of the CPA is to promote and advance the “social and economic welfare of consumers” in SA (Section 3). One of the ways this aim is achieved, is through the fundamental consumer rights that impose positive obligations on service providers (Chapter 2). In order to realise this purpose, the CPA aims to establish a legal framework to achieve and maintain a consumer market that is “fair, accessible, efficient, sustainable and responsible”, in other words, a transformed consumer market (Section 3(1)(a)). McGregor (2017: 06-07) is of the opinion that a lack of social justice in the market has a negative impact on consumer justice, because when individual rights are violated, they are left powerless. The author states a lack of justice in the market has contributed to the global consumerism movement, which has resulted in the unjust consequences of corporate domination, globalisation, and capitalism.

The aim of the CPA is to protect consumers within the framework of a free market economy (SA Department of Trade and Industry 2011: 6; van Eeden and Barnard 2017: 24), whereas the Revised White Paper (SA Department of Health 2017: 9) characterises healthcare as a social investment and not as an ordinary trade commodity. Von Staden (2021: 39) opines these different approaches expose an underlying concern that adopting

the consumer market focus of the CPA, is fundamentally incompatible with the healthcare market aims, while introducing a market focus into the healthcare sector will increase the likelihood of health being considered an ordinary commodity, instead of a social investment (SA Department of Health 2017: 9).

Concern has been expressed that a consumerist, market-orientated approach is not an ideal system within which to deliver healthcare services, because the healthcare consumer market differs from other consumer markets in many fundamental ways (Goldstein and Bowers 2015: 163). The commodification of the healthcare sector is, to a large extent, viewed from a negative viewpoint as it results in uncertainty and numerous real-world challenges (Slabbert and Pepper 2011: 800). The CSDH (2008: 95) asserts health should be characterised as a common good and not a market commodity. Le Roux-Kemp (2010: 244) agrees and cautions a consumerist model to healthcare does not take the significant social component of healthcare into account. According to Pearmain (2004: 9), the relationship between a free-market and human rights in the healthcare sector is controversial, adding that an effort to integrate these approaches must be managed with caution. Flood and Gross (2014b: 453) state there is support for characterising healthcare as a human right from a social justice perspective, and not a commodity.

Von Staden (2021: 99; 55), discusses concerns that a market-focused approach to the delivery of healthcare services will fail to ensure equitable distribution of services and improve health outcomes for all. The author adds there is concern the commodification of health fails to allow for the strong human rights framework that protects health, recognises health as a scarce resource and promotes social justice. She states the legislature in SA has, despite these concerns, included the healthcare market within the ambit of the CPA.

The regulatory framework of the healthcare sector, including the Constitution, the NHA and the CPA, refers to the need to address socio-economic inequality and poverty and aims to establish a society based on democratic values, social justice, and fundamental human rights, in order to improve the quality of life of the population and free the potential

of individuals (Preamble: Constitution; NHA; CPA). Therefore, this study adopts social justice as a theoretical framework, due to the important role of health in enabling individuals exercise all other human rights (WHO 2017: 01) and the fundamental role it occupies in the transformation agenda in SA. The following section will investigate the challenges patients experience as consumers of public healthcare services in the South African healthcare market.

2.6 Patient challenges as consumers of South African public healthcare services

This section investigates the challenges of patients as consumers of healthcare services delivered in the public healthcare sector, from three perspectives. An historical perspective, current challenges, and a concern for the future as SA aims to introduce NHI. This broad approach will be adopted in an effort to provide a holistic overview of the challenges patients' experience.

Aikman (2019: 55) believes there is a lack of research into patient challenges and notes the difficulties in addressing an under-researched problem. She asserts data on patient complaints are, to a large extent, anecdotal and believes a study of healthcare system challenges could provide insight into the nature of the problem, assisting in addressing the challenges.

An important reason to address the challenges patients experience in accessing public sector healthcare services is the introduction of NHI in SA (SA Department of Health 2017). Concern has been raised that should these challenges not be addressed, the introduction of NHI in SA will prove disastrous for patients (Dhai 2020: 433). Transformation in the healthcare sector in SA is an ongoing process that is part of the broader goal of transforming South African society (van Rensburg and Engelbrecht 2012: 121) and is currently driven by the expansion of Universal Health Coverage (UHC) in the form of NHI (SA Department of Health 2017). According to de Villiers (2021: 3), the healthcare sector in SA is presently involved in the challenging and complex task of implementing the NHI, while at the same time recognising the system is struggling under significant pressures at this time.

The implementation of NHI aims to transform the health system by addressing structural imbalances and reducing the quadruple burden of disease (SA Department of Health 2017: 08). It also aims to deliver healthcare services using a people-centred approach, considering social, cultural and economic factors and prioritising vulnerable communities (SA Department of Health 2017: 03). This is achieved by addressing the social determinants of health and through increased access by delivering affordable healthcare services based on need, instead of the ability to pay (SA Department of Health 2017: 01).

Dhai (2020: 435) notes despite the promise of “comprehensive quality” healthcare services as a Constitutional right of every South African, the reality is different as the country progresses towards UHC. The author states the reality of SA is currently one of limited resources, which necessitates the quality of healthcare services delivered will be limited to “sufficient or adequate”. She warns the manner in which quality is interpreted is crucial, as terms such as “sufficient” and “adequate” are uncertain, vague and unclear. Dhai (2020: 435) adds that as SA implements NHI, it is important to focus on the “minimum standard of quality that is truly effective” in improving health outcomes and which is “ethically acceptable” to everyone in ensuring the realisation of the right to health as a human right.

The following section will explore the challenges patients face from an historical perspective.

2.6.1 Historical perspective of patient challenges

In order to understand the challenges patients currently encounter as consumers in SA’s healthcare consumer market and the role of the CPA in addressing these challenges, it is helpful to examine the historical dimensions of these challenges. Existing healthcare system challenges in SA are a product of healthcare history in the country (Delobelle 2013: 163). According to Brauns and Stanton (2016: 23-26), the journey from apartheid to democracy has been characterised by unjust and inequitable laws and a wide range of human rights violations. The author’s state good quality healthcare was historically only

available to those who could afford it. They add although apartheid ended decades ago, the country is still dealing with inequality in the way healthcare services are delivered.

Okeng Ebi (2016: 15) and Maphumulo and Bhengu (2019: 01) agree many challenges in the healthcare system in SA are rooted in apartheid, when the healthcare system was highly fragmented and discriminatory. Seedat (1984, cited in Brauns and Stanton 2016: 27) states that in the apartheid period, patients in the public healthcare sector often had to spend an entire day and evening waiting to access healthcare services at busy major hospitals. According to Coovadia *et al.* (2009: 817), in 1994 when apartheid ended, the healthcare system faced huge challenges, many of which still characterise the structure of the healthcare system today. Aikman (2019: 52) notes current challenges in the healthcare sector are extremely complex and complicated, because healthcare in SA is multifaceted and complicated as a result of its complex history.

Countries are products of their history and, in SA, exclusion based on race has been a feature that significantly influenced all aspects of South African society (World Bank 2018: 6). Despite the introduction of democracy to the country close to 30 years ago, poverty and discrimination continue to affect South African society (World Bank 2018: 7) and impact the nature of the healthcare market (Coovadia *et al.* 2009: 817).

Although some progress has been made in transforming the healthcare sector in SA, the health system remains a two-tiered system with separate public and private sectors (van Rensburg and Engelbrecht 2012: 179), providing better health services for the rich than the poor in SA (World Bank 2018: 21). According to Motsoaledi (SA Department of Health 2011), each of these two tiers face different challenges. He warned of poor care quality in the public sector and increasing costs in the private healthcare sector.

In order to overcome the legacy of apartheid and transform the manner in which healthcare services are provided, justiciable socio-economic rights, including access to healthcare, were included in the Constitution (World Bank 2018: 22). The NDP 2030 (NPC 2012: 332; 68-69) holds that both health and healthcare service delivery in SA have been

affected by historical social forces and the provision of quality healthcare is identified as a priority in the plan. The NDP 2030 (NPC 2012: 350), further noted the National Consumer Council needs to consider the health goals of the NDP in carrying out its mandate, reinforcing the role of the CPA to the healthcare market.

According to Malakoane *et al.* (2020: 01), since achieving democracy, the SA government has focused on enacting legislation, charters, policies and strategic plans to strengthen public healthcare system performance and enhance service delivery. The authors further state that despite these efforts, both performance and outcomes in the public healthcare system remain poor. Gazana (2015: 18) states this is due to a shortage of resources in the public healthcare sector to operate effectively; leaving it extremely far behind in terms of delivering as promised.

Burger and Christian (2018: 01) highlight that the government aimed to advance access to healthcare for the underprivileged and most marginalised in society by growing the healthcare facility network and bringing an end to consumer fees for primary healthcare. Mthanti (2015: 02) notes a goal of the post-apartheid government is to ensure equal access to basic healthcare services for all South Africans. The author added the goal was to remedy the unequal and ineffective healthcare system rooted in apartheid. Madlabana (2019: 05) agrees but warns many municipalities are not providing effective service delivery despite attempts at improving service delivery; this has resulted in citizens complaining and protesting for improved services.

Through the use of policy and legislation, the Department of Health has indicated its commitment to a vision of an accessible, caring and high-quality healthcare system (Wesso 2014: 03). However, health problems and social inequalities entrenched in poverty still exist (Delobelle 2013: 160). In order for the economy of SA to advance, the healthcare system must be improved (Wesso 2014: 01).

Notwithstanding legislative attempts (Constitution Section 27; NHA Section 2) to transform the healthcare sector in SA and address the challenges of patients, many

patients still encounter numerous problems in the public healthcare sector services they receive. The following section will explore some of these challenges.

2.6.2 Challenges patients experience in the public healthcare consumer market

This section will examine the challenges of patients, firstly by investigating structural challenges and then by focusing on research that documents the challenges from a personal and individual perspective.

According to the WHO (2007: 3), effective healthcare services should aim to deliver safe, effective and quality health interventions “to those who need them, when and where needed, with minimum waste of resources”. However, studies have revealed that patients who access healthcare in the public sector continue to encounter poor quality service (HEU 2012: 4).

Begg *et al*. (2018: 78) explain the government apportions a substantial annual budget to realise the Constitutional mandate to deliver access to quality healthcare services. The authors warn a variety of limitations, flaws and faults in the healthcare system endanger the health of South African citizens, resulting in an overall loss of confidence among patients and an alarming increase in medico-legal claims. Dhai (2015: 02; 2020: 436) agrees problems related to the service quality delivered to patients in both the public and private sectors, but more so in the public sector, have contributed to an increase in medico-legal claims, which impacts both healthcare providers and the finances available to deliver healthcare services.

Significant evidence exists that healthcare delivery in SA is plagued by a number of challenges that negatively impact the quality of public sector healthcare services delivered (Maphumulo and Bhengu 2019: 01). Dhai (2020: 436) warns the quality of healthcare services delivered in SA is currently impacted by several critical challenges, resulting in dissatisfaction amongst patients regarding the quality and acceptability of the healthcare services delivered.

The following section will examine some of the structural challenges as background to challenges experienced by patients in an effort to provide context to these challenges.

Structural challenges

According to Okeng Ebi (2016: 15), regardless of efforts to address disparities and to unify the fragmented healthcare system, the country's problems of inequality remain. The biggest equity challenge faced by the South African healthcare system is due to the division between public and private healthcare services (McIntyre *et al.* 2007: ii; van Rensburg 2021: 01). Inequality in expenditure has been acknowledged as a reason for different health outcomes between the healthcare sectors and differences in resources available in each sector, in relation to the population each sector serves, which continues to reinforce inequity in health outcomes (McIntyre *et al.* 2007: ii).

The WHO (2018: 60) in a joint report, stated, even though the public healthcare sector is responsible for providing healthcare services to 84 percent of the population of SA, only 48.2 percent of the country's total health expenditure is spent in this sector. By comparison, the private sector provides healthcare services to 16 percent of the population, spending 51.8 percent of the total health expenditure. It was reported SA's public healthcare sector is under-resourced and overloaded, resulting in delivery of poor-quality services (Competition Commission 2018: 270; Revised White Paper SA Department of Health 2017: 12). The reports distinguish quality-related challenges are exaggerated by the inequitable distribution of financial and other healthcare resources, in relation to the populations served by the public and private sectors.

The public healthcare sector offers free healthcare services to certain categories of patients, by comparison, the private sector is well equipped, highly specialised but only accessible to people who can afford the services, generally through medical aid (Gazana 2015: 18; Aikman 2019: 53). The final findings of the Market Inquiry into the Private Healthcare Sector (Competition Commission 2019: 210) describe the private healthcare market as challenged by "high and rising" costs. According to Maseko and Harris (2018:

22) most citizens access healthcare services in the public healthcare sector because of the high costs of private healthcare.

Dhai and Mahomed (2018: 08) describe patients that access healthcare services in the public sector in SA as the country's "most vulnerable poor". They note these patients are the victims of poor leadership and inadequate management and governance and it is essential to address their challenges. Khademi, Mohammadi and Vanaki (2019: 576) add protecting the rights of hospitalised patients is critical, as they are the most vulnerable of those who access healthcare services. De Villiers (2021: 3) agrees and notes SA faces significant challenges in the provision of healthcare services, including an increasing quadruple burden of disease, "systemic and structural" challenges in the delivery of healthcare services that are exacerbated by societal problems related to poverty and unemployment.

Ranchod *et al.* (2017: 107) note inequality in resource distribution between the public and private healthcare sectors in SA has also resulted in higher quality care in the private sector and poor-quality care in the public sector. Maphumulo and Bhengu (2019: 01) agree inequity in expenditure in healthcare between the public and private sectors, relative to the populations they are responsible for, has resulted in an "under-resourced and overburdened" public healthcare sector that further aggravates the quality of healthcare services provided. Van Rensburg (2021: 07) argues before increasing access to those who currently have access to quality healthcare services, priority needs to be given to those with limited access to quality healthcare services.

Dhai (2020: 436) opines poor conditions that underpin the delivery of quality healthcare services are also the result of an information management system that is incoherent, fragmented, and poor, with inadequate leadership. The author adds the high burden of disease has resulted in an upsurge in the use of healthcare services, causing increased patient loads for healthcare providers, which has also impacted the quality of care delivered. Amukugo and Nangombe (2017: 14) agree and add public healthcare facilities are often perceived as not functioning and unresponsive to the needs of patients. The

following section will examine challenges of patients from a personal, individual perspective.

Individual patient challenges

It is difficult to categorise patient challenges, therefore, the approach adopted in this section is to focus on the work of various authors in this field who have documented the challenges of patients from an individual perspective.

Countries around the world experience many challenges that negatively impact the health of their populations (WHO 2017: 01). Studies investigating the challenges experienced by patients in the public sector in SA have revealed patient challenges are varied, complex and may have serious consequences (Ha, Mirzoev and Morgan 2015: 01; Aikman 2019: 56).

The National Department of Health (2017: 03-04) reports many quality challenges in healthcare service delivery have been identified, including poor delivery systems, poor information, lack of recourse and disregard for human dignity; these inadequacies endanger the health and lives of all patients. The report lists the attitude of staff, extended waiting times, lack of cleanliness and infection control, as well as drug shortages and the safety of both patients and staff, as cause for concern in the public sector.

Burger *et al.* (2016: 193) noted long waiting times and rude nursing staff as challenges highlighted by patients, while a study by Maseko and Harris (2018: 24) found patients complained about the attitude of staff and the lack of cleanliness within facilities. The HEU (2012: 3) study investigated staff attitudes, the clinical service experience, availability of medicines and waiting times. It found patients experienced challenges across each of these dimensions. Young (2016: 4-9) found long waiting times, poor hygiene and a lack of basic resources including gloves and bed linen resulted in poor quality services delivered in the public healthcare sector. According to Mokgoko (2013: 104-105; 63), patients expect to be attended to from 08h00 and are frustrated when healthcare

professionals arrive late. The author adds patients experience difficulty in finding transport to take them home should they finish late due to long waiting times at healthcare facilities.

Maphumulo and Bhengu (2019: 02) found patients face a number of challenges including long waiting times, because of insufficient staff, adverse events, inadequate hygiene and infection control, as well as increases in litigation due to avoidable mistakes, shortage of resources including medicine and equipment, and poor attitude of hospital staff, along with poor record-keeping. The South African Demographic and Health Survey (SADHS 2003) highlights the main cause for dissatisfaction and discontent in public sector hospitals and the community healthcare sector were long waiting periods. Amukugo and Nangombe (2017: 14) found long queues and long waiting times result in poor quality patient care.

According to Moyo (2016: 27), common challenges experienced by the public include a lack of cleanliness, safety and security of staff and patients, lengthy wait times, as well as poor staff attitudes and productivity, in addition to corruption, particularly at a senior managerial level, inadequate infection control and medication shortages. The author further states healthcare facilities often do not have sufficient staff or drugs to provide adequate healthcare services and these service delivery challenges must be addressed as they pose a serious barrier to the ability of patients to access quality healthcare services.

A study by Harris *et al*. (2011: 116) found patients were extremely dissatisfied with the length of time taken to receive service at healthcare facilities. The authors add other factors that lead patients to dissatisfaction included the lack of cleanness, privacy, and confidentiality. The Rural Health Advocacy Project (n.d: 06), found common issues within the healthcare system that frustrate patient access to quality care include drug shortages, lack of resources, fraud, and vacancy freezes, along with understaffing, lack of ambulances, and disregard of the Remuneration for Work Outside the Public Service policy.

The absence of basic services is often reported as barriers in providing or improving quality healthcare, such as reliable water and electricity, telephone access and long patient waiting times (Mthanti 2015: 01).

As explained by Khademi, Mohammadi and Vanaki (2019: 576; 577), healthcare providers are generally known as advocates for the rights of patients. However, the authors note several findings regarding the violation of patient's rights, including a lack of information provided, disrespect of patients' basic humanity, privacy and dignity, and the violation of the right to choose. Komape (2013: 10) agrees healthcare providers in the public healthcare sector in SA are often described as indifferent and uncaring, with no respect for patient confidentiality, displaying bad attitudes, and prone to neglecting patients. The underlying reasons for these attitudes must be addressed to improve quality of care and to ensure the successful implementation of policies aimed at improving the quality of services in general (Mthanti 2015: 25). The recognition of what is perceived as the violation of patient rights can assist healthcare providers to understand more about patients' main concerns (Khademi, Mohammadi and Vanaki 2019: 576).

In a study conducted by Mokgoko (2013: 104-105) it was found that when patient expectations are not met, it leads to frustration and anger. The challenges patients experienced may even result in serious consequences such as increased pain and suffering (Rogers, Karlsen and Addington-Hall 2000: 31), physiological and psychological consequences (Brennan, Carr and Cousins 2007: 206), even death (Ha *et al.* 2015: 01). A joint report by the WHO, OECD and World Bank (WHO 2018: 35) found delays in receiving appropriate treatment in emergency situations may result in preventable deaths.

Therefore, patients who access healthcare services in SA are faced with many different challenges, with some rooted in the history of the country. There is concern that as SA looks to fully implement UHC in the form of NHI, a failure to address challenges patients experienced will undermine the aim to provide affordable, quality healthcare services to all.

The next section will examine the patient rights contained in the NHA that aim to empower and protect patients as they access healthcare services.

2.7 The National health Act 61 of 2003

The NHA came into force in 2005 and gives effect to the right of access to healthcare services, as set out in Section 27 of the Constitution, and provides strategic implementation of health rights in SA (Okeng Ebi 2016: 95).

The NHA (Preamble) acknowledges the socio-economic injustices and inequities of past healthcare services, the need to establish a society based on social justice and fundamental human rights, and the need to improve the quality of life for all in the country. Okeng Ebi (2016: 96) states access to healthcare services is a fundamental human right, essential to the accomplishment of other fundamental human rights; thus, the underlying principle of the NHA is to fulfil the transformative goal of the Constitution by addressing healthcare challenges. According to Hassim, Heywood and Berger (2007: 230-233), the NHA establishes a structured framework for the national health system, considering the duties enforced by the Constitution on the national, provincial and local tiers of government with regards to the regulation and provision of healthcare services. The authors add that apart from the Constitution itself, the most significant source of health service rights is the NHA.

2.7.1 Patient rights in terms of the NHA

The NHA refers to patients as users of healthcare services (Section 1). Chapter 2 of the Act sets out the rights that users of healthcare services have in terms of the Act. These rights include *inter alia*, the right to informed consent (Section 7), the right to participate in decision making (Section 6; 8) and the right to confidentiality (Section 14). According to Moult and Müller (2016: 02), the Act addresses a wide variety of health-related issues and provides both patients and healthcare providers with rights and obligations.

The following section will discuss three core patient rights, the right to informed consent, to participate in medical decision-making and the right to confidentiality that are crucial in

addressing the challenges of patients and providing protection as they access healthcare services.

The right to informed consent

Informed consent is a fundamental patient right that establishes the foundation for the right of a patient to participate in the medical decision-making process and is based on the principle of respect for patient autonomy and the right to self-determination (Dhai 2008: 27; Chima 2013: 1). The NHA requires that healthcare services may not be provided to a patient without the patient's informed consent (Aderibigbe and Chima 2019: 01). Section 7(1) of the NHA provides that subject to the consent provisions contained in Section 8, a "health service may not be provided to a user without the user's informed consent". If a patient is unable to give informed consent, then consent can be given by a person nominated by the patient (Section 7 (1)(a)(i)), or a person authorized by law (Section 7 (1)(a)(ii)). It is the responsibility of the healthcare providers to take "all reasonable steps" to ensure that the patient gives informed consent (Section 7(2)).

Section 6 specifies that a user should have full knowledge before providing informed consent (Barit 2017: 14). The Act establishes the right of patient to self-determination and informed consent is required every time a patient receives medical treatment (Britz and Roux-Kemp 2012: 746). Aderibigbe and Chima (2019: 02) stress that patient competence, understanding, appreciation of shared information, and voluntary decision-making are necessary preconditions before informed consent can be considered valid.

The right of a patient to participate in the medical decision-making process

The right of a patient to participate in the medical decision-making process is contained in both Sections 6 and 8 of the Act. In terms of the NHA, a patient must participate in the medical decision-making process, by providing informed consent after being supplied with a wide range of information, in a language the patient understands. Section 6 of the NHA sets out the information that must be provided by a healthcare provider to a patient in order to empower and assist the patient to participate in the medical decision-making process. Section 6 (1) of the NHA provides that:

“Every health care provider must inform a user of the

a) user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;

(b) range of diagnostic procedures and treatment options generally available to the user;

(c) benefits, risks, costs and consequences generally associated with each option; and

(d) user's right to refuse health services and explain the implications, risks, obligations of such refusal.”

Section 6(2) provides that a healthcare provider must provide this information to a patient in a language that he or she understands and in a manner that takes the level of literacy of the patient into account.

In terms of Section 8 (1) of the NHA, a patient has the right to participate in the medical decision-making process. This section deals with ensuring patient participation in circumstances in which a patient lacks capacity or is unable to provide informed consent. This section empowers patients to make decisions and highlights the importance of patient autonomy, by ensuring the patient is involved and engaged in the decision-making process (Carstens and Pearmain 2007: 883; Slabbert and Labuschaigne 2022: 32).

The right to confidentiality

The right to confidentiality is fundamental patient right and without an assurance of confidentiality a patient may not want to disclose significant information about his or her medical condition and this lack of disclosure may affect the accuracy of the diagnosis and the treatment provided (Singh 2017: 151). Moodley (2017c: 61-62) highlights the importance of privacy in the provision of healthcare services. She adds that information about a person’s health is sensitive and privacy is essential in protecting the sensitivity of this information.

The NHA recognises the right of the patient to confidentiality as a fundamental patient right and contains provisions that aim to ensure that the right of the patient to confidentiality is protected in the manner in which medical records are looked after (Section 14; 15). According to Moult and Müller (2016: 02), the Act has elevated the ethical principle of patient confidentiality to a legislative requirement in the delivery of healthcare services.

Section 14(1) of the NHA provides that all information about a patient is confidential, including information about the health status of the patient and the treatment they receive. Singh (2017: 151) note that the right to confidentiality is not absolute and confidential information may be disclosed, in strictly regulated circumstances. Section 14(2) states that any information about a patient cannot be disclosed by anyone, unless the patient provides written consent to the disclosure, the disclosure is required in terms of a court order or law, or if a failure to disclose the information would constitute a serious threat to public health.

However, Grobler and Dhai (2016: 23) and Njotini (2018: 14) note that breaches of confidentiality do happen and ensuring confidentiality is maintained in the healthcare sector is challenging because of the complex nature of the healthcare market. They add that breaches in confidentiality occur due to the use of electronic records, third-party payment for healthcare services, and the sharing of patient information between different healthcare providers.

Section 15 (1) provides that any person who has access to the health records of patients, may only disclose this personal information when it is needed for a legitimate purpose and such disclosure is within the ordinary course and scope of the person's duties, and in the interest of the patient. Section 15(2) uses the definition of personal information as contained in the Promotion of Access to Information Act 2 of 2000 (Section 1) in which it is defined as information about the medical history of a person as well as any information about the physical or mental health, well-being and disability of a person that is identifiable.

The NHA recognises the right of the patient to confidentiality and protects this confidentiality by ensuring that medical records are kept in a manner that protects the confidential information of the patient. Even though the right to confidentiality is a fundamental patient right and is essential in the provision of healthcare services, the right to privacy as contained in (Part B) of the CPA does not address the health challenges of the patient as it focuses on the right to restrict unwanted direct marketing (Section 11) and the regulation of time for contacting consumers (Section 12) and is therefore not canvassed in this study as stated in paragraph 2.2.2.

Therefore, the NHA recognises the core patient rights of informed consent, the right to participate in decision making and the right to confidentiality. However, there is recognition that it is important for patients to be informed of their rights in order to be in a position to enforce these rights (National Patients' Rights Charter, SA, Department of Health 1999). The following section will discuss the importance of awareness of rights and the manner in which an attempt has been made to increase awareness of patients' rights recognised in terms of the NHA.

2.8 Importance of awareness of rights and National Patients' Rights Charter as instrument to create awareness of NHA patient rights

The NPRC (SA, Department of Health 1999) was developed in SA by the Department of Health, together with several other organisations, such as the HPCSA. The Charter was developed to aid in improving the quality of healthcare services by raising public awareness of the main health rights for those who use public healthcare facilities (Moyo 2016: 13).

Pieterse (2010: 11) asserts the NPRC (SA, Department of Health 1999) has been successful in raising awareness of patient rights. Moyo (2016: 13) agrees the Charter has been successful in ensuring the provision of appropriate, good quality and human-rights based healthcare services, adding its success is largely dependent on the extent to which patients are aware of it and willing to assert their rights. Okeng Ebi (2016: 101) warns a lack of awareness of its provisions by the public has been identified as a challenge

The NPRC (SA Department of Health 1999) acknowledges the importance of information for patients in understanding and enforcing their rights and therefore, requires all users of the healthcare system must be informed of their rights. According to Hassim, Heywood and Berger. (2007: 247), public healthcare facilities are required to display the NPRC (SA, Department of Health 1999) in local languages. The authors note this assists to create awareness of both patient rights and the level and quality of healthcare services patients can expect at public healthcare facilities.

2.9 Conclusion

The CPA aims to improve protection for consumers (Ally 2017: 01) and applies to the healthcare sector in SA (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33). It is essential the application of CPA into the consumer healthcare market be accomplished in a way that both recognises the complexity of this specialised market and serves to advance its primary aim, the promotion of health and health equity (Von Staden 2021: 03). This chapter examined the important and fundamental role of health in society and found without good health, it is impossible to exercise other functions in society (Wesso 2014: 01; WHO 2017: 01). The significant legal framework both internationally and nationally in SA that aims to protect the right to health as a fundamental human right was explored.

Social justice as a theoretical framework underpins this study because the law in SA has been used to promote social justice. The preambles of the Constitution, the NHA and the CPA all draw attention to the need to address socio-economic inequality and poverty, and aim to establish a society based on social justice, in order to improve the quality of life of all citizens. The Constitution created a legal framework for the introduction of democracy in SA and the establishment of a transformed society (Liebenberg 2010: 1-2).

The importance of rights awareness was discussed, because it is important to ensure patients as consumers are aware of their rights and the quality of healthcare services they can expect (Hassim, Heywood and Berger 2007: 247). Therefore, both rights and

awareness of rights are important in addressing patient challenges within the healthcare consumer market.

Despite the international and South African legal framework that recognises and protects the right to health as a fundamental human right, patients who access healthcare in the public sector in SA face numerous challenges that need to be addressed to improve health outcomes and equity in health. The following chapter will explore the CPA in the healthcare sector and examine the role of this legislation in addressing the health challenges of patients.

CHAPTER THREE

LITERATURE REVIEW

PATIENTS RIGHTS AS CONSUMERS OF HEALTHCARE SERVICES IN TERMS OF THE CONSUMER PROTECTION ACT 68 OF 2008

3.1 Introduction

Health is recognised as a human right (Flood and Gross 2014a: 4; WHO 2017: 7). The ICESCR (UN General Assembly: 1966: Art 12(2)) places an obligation on member states to ensure the progressive realisation of the right to health, which includes implementing a national plan to ensure this right is realised for all. The South African Constitution recognises the right to health as including the right of access to healthcare services (Section 27(1)). According to Von Staden (2021: 137; 142), the introduction of the CPA to the healthcare consumer market can be regarded as forming part of SA's national plan to ensure the right to health is realised for all. The author believes this perspective is helpful in how the CPA is applied to the healthcare consumer market in SA. She adds this multi-sectoral approach provides an important foundation for recognising health not just a commodity but as a human right and the CPA has a role to play in advancing this right.

This chapter will examine the application of the CPA to the healthcare consumer market in SA, with a focus on selected fundamental consumer rights that possibly have a role to play in addressing the challenges of patients as consumers in the healthcare consumer market. Some of the patient challenges discussed in Chapter Two will be linked to certain fundamental consumer rights. Further, where applicable, patient rights contained in the NHA will be analysed and compared to consumer rights. The importance of ensuring consumers are aware of these fundamental consumer rights will be discussed. Finally, the possibility and value of measuring the quality of services delivered will be briefly explored. This study characterises a supplier as a healthcare provider in terms of the CPA and a consumer as a patient.

3.2 Application of CPA to the healthcare consumer market

According to van Eeden and Barnard (2017: 1), the consumer movement arose out of an awareness that legal rules and economic systems, especially uncontrolled consumerism within society, was failing to serve the interests of consumers and businesses alike. The authors state that the failure to address fundamental power imbalances characterising the relationship between consumers and businesses lead to the exploitation of vulnerable consumers. As a result, governments have intervened in markets around the world to address this power inequality (Mupangavanhu 2015: 117).

According to Mugobo and Malunga (2015: 226), consumer protection refers to the laws and regulations that govern the relationship between service providers and consumers. It is important to interrogate the challenges consumers face before attempting to effectively implement the law (Naudé 2006: 363).

The CPA applies to all transactions in the country for the supply and promotion of goods and services, unless the transaction is exempted in terms of Sections 5(3) or 5(4) of the Act (Section 5(1)). Nonetheless, it appears that healthcare services have not been exempted from in terms of these sections (Slabbert and Labuschaigne 2022: 33). It is generally acknowledged that the CPA applies to healthcare transactions in SA (Howarth and Davidow 2010: 5; Slabbert and Pepper 2011: 800; Kirby 2012: 2; Rowe and Moodley 2013: 21; Slabbert and Labuschaigne 2022: 33).

According to the CSDH (2008: 35), improved health outcomes and equitable health can be attained by governments, implementing economic and social regulation and policy, based upon a multi-sectoral approach. The NDP 2030 (NPC 2012: 350) also supports such an approach and states the National Consumer Council, needs to review the NDP health goals in implementing its own plans.

3.2.1 A transaction in terms of the CPA

A transaction is defined in Section 1 of the CPA as an agreement between two or more individuals, for the supply of goods or services for consideration in the ordinary course of

business. Pertinent aspects of this definition will be briefly discussed below to show the CPA applies to the healthcare sector in SA.

An agreement

The CPA defines an agreement as an "arrangement or understanding" between or among two or more parties that intends to "establish a relationship in law" between them (Section 1). Von Staden (2021: 53) notes while consumer agreements are generally based in contract, the CPA does not limit the use of consumer rights to contractual agreements but allows for a wider application to relationships established in law. She adds this is important in the public healthcare consumer market, where it is sometimes hard to establish a contractual relationship between the healthcare service provider and the patient as a consumer.

The supply of goods or services

Both goods and services are supplied in the public healthcare sector and are thus subject to the Act. According to Section 1 of the CPA, goods are defined as including "anything marketed for human consumption" this would include medication and goods such as medical devices (Slabbert and Pepper 2011: 800; Slabbert and Labuschaigne 2022: 33). The CPA has a broad definition of a service, defined as including work performed by a person for the "direct or indirect benefit of another" (Section 1). Healthcare services are provided for the direct benefit of the patient, while the giving of advice and a consultation are also included in the definition (Slabbert and Pepper 2011: 800; Slabbert and Labuschaigne 2022: 33). According to the definition, a service also includes the provision of accommodation or sustenance (Section 1). Therefore, the provision of beds and food or so-called "hotel services" (Carstens and Pearmain 2007: 287) provided in public hospitals are subject to the CPA.

For consideration

"Consideration" in terms of Section 1 of the CPA is "anything of value given and accepted in exchange" for goods or services including money, "irrespective of its apparent or

intrinsic value, or whether it is transferred directly or indirectly, or involves only the supplier and consumer or other parties in addition to the supplier and consumer".

Von Staden (2021: 55) asserts the requirement of consideration needs to be investigated because of the specialised and complex manner in which payment is made for healthcare services in the healthcare consumer market. A significant number of patients access healthcare services in the public sector for free, based on the Uniform Patient Fee Schedule (SA, Department of Health 2017: 17) and subject to the means tests (Competition Commission 2019: 44). The public healthcare sector is funded by the taxpayer (NPC 2012: 339; Competition Commission 2019: 44) and according to Von Staden (2021:55), this falls within the ambit of the definition of consideration in the CPA.

The Competition Commission (2018: 32) states healthcare services are provided to about 84 percent of the population and about five million of the 44.9 million individuals, who accessed healthcare services in the public sector in 2015, received an income that was more than the means test, therefore, did not qualify for free public hospital care. Von Staden (2021: 57) asserts according to these figures, approximately 40 million people who used the public sector, were eligible for free public healthcare services and did not pay directly for these services. The author submits all patients who access healthcare services via the public sector, whether they pay directly or indirectly via taxation for these services, would still be protected in terms of the CPA.

In the ordinary course of business

According to Von Staden (2021: 60), based on the objective, holistic, circumstance-based approach used by the Supreme Court of Appeal in the Eskom Holdings Limited v Halstead-Cleak (2017: para 20) case, healthcare services delivered in the public healthcare consumer market, can be considered as "in the ordinary course of business".

Howarth and Davidow (2010: 5), Slabbert and Pepper (2011: 800), Kirby (2012: 2) and Rowe and Moodley (2013: 21) assert, based on the definition of a transaction, the CPA applies to healthcare related transactions in SA, in the public sector. However, the

introduction of the CPA into the healthcare market is challenging, because this specialised consumer market was regulated by a legal and ethical framework, that pre-dated the introduction of the CPA into this sector (Von Staden 2021: 63; Slabbert and Labuschaigne 2022: 33). The following section will discuss patients as consumers in the healthcare consumer market.

3.3 Patients as consumers in the healthcare consumer market

According to Jacobs, Stoop and Van Niekerk (2010: 313), Slabbert and Pepper (2011: 800) and Rowe and Moodley 2013: 01-02; Slabbert and Labuschaigne 2022: 33), the introduction of the CPA to the healthcare sector in SA means, from a legal perspective, patients are now described as consumers. Von Staden (2021: 160), however, notes a patient is not an “unprotected consumer” and the vulnerable position of patients is recognised in a well-established legal and ethical framework that aims to protect the welfare of patients accessing healthcare services. Patients as consumers of healthcare services are provided rights as patients in terms of the NHA (Dhai and Mahomed 2018: 09) and as consumers under the CPA (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33).

The rights of patients as set out in the NHA and in the NPRC (SA, Department of Health 1999) which assists in interpreting and raising awareness of these patient rights (Hassim, Heywood and Berger 2007: 247) and were discussed in Chapter 2 of this study. The NHA focuses on the right of the patient to informed consent and to participate in medical decision-making (Sections 6-8), as well as the right to confidentiality (Section 14). The NPRC (SA, Department of Health 1999) highlights the right to informed consent, confidentiality and the right to choose.

The rights of patients as consumers in the healthcare consumer market are described as fundamental consumer rights and are set out in Chapter 2 of the CPA. They include the right of equality (Sections 8-10); the right to privacy (Sections 11-12); the right to choose (Sections 13-21); and the right to disclosure of information (Sections 22-28); as well as the right to fair and responsible marketing (Sections 29-39); right to fair and honest

dealing (Sections 40-47); the right to fair and reasonable terms and conditions (Sections 48-52), along with conditions and the right to fair value, good quality and safety (Sections 53-61). Not all these rights play a role in addressing the challenges of patients and only selected consumer rights will be discussed in paragraph 3.4 below.

Rowe and Moodley (2013: 18) note, from a legal perspective, characterising patients as consumers of healthcare services may have both legal and ethical implications for the doctor and the patient. According to Callahan (2008: 302), both health and healthcare services cannot be treated as ordinary commodities, because the onset of illness and patient recovery from poor-health are generally unpredictable, making the demand for healthcare services irregular and inconsistent. Goldstein and Bowers (2015: 163) add that a patient's use of healthcare services is usually involuntary and based on necessity, because healthcare services are accessed when a patient is in poor-health and requires care, which results in a powerless consumer. The authors express concern that the commodification of the healthcare market will not result in empowered patients who demand better quality services.

Le Roux-Kemp (2010: 230-231), furthermore, argues that despite the numerous concerns regarding the negative impact of consumerism on the manner healthcare services are delivered, there is acknowledgement that characterising patients as consumers may result in positive change in the healthcare market, because patients may begin to play an active role in demanding improvement in the quality of the healthcare services they receive. Barapatre and Joglekar (2016: 155) agree extending consumer rights to patients accessing healthcare services will be beneficial in assisting patients to achieve the benefits of good health. Nevertheless, Churchill (2007: 411) disagrees and believes identifying patients as consumers and healthcare as a commodity will weaken the ethical foundation underpinning the delivery of healthcare services, with negative consequences for the healthcare provider, the patient, society as a whole, and the aim of improving health outcomes and equity in health.

There are significant implications in labelling patients as consumers of healthcare services, according to Rowe and Moodley (2013: 16), who believe the labels used to describe and classify individuals often shape their identity and influence their behaviour. The authors assert a person describing himself or herself as a patient, may behave differently and have different expectations from those individuals who identify as consumers. Herxheimer and Goodare (1999: 3) emphasise the language used to describe individuals who use healthcare services, is complicated. The authors add the labels used to describe individuals are not neutral and exert an influence over the manner in which they view themselves and interact with one another. Recent legislative interventions have impacted the traditional view of the doctor-patient relationship by introducting new labels to refer to patients including user, consumer and even data subject (Slabbert and Labuschaigne 2022: 31).

Deber *et al.* (2005: 350) believe patients dislike many of the terms or labels used to describe them, in place of the term “patient”. The authors add patients value the intimate relationship they share with healthcare providers and do not want their relationship to be characterised as that of a buyer and seller. Le Roux-Kemp (2010: 126-127) warns viewing patients as consumers may have the unintended consequences of their relationship with healthcare providers being regulated predominantly from a business perspective, thus adopting business ethics, in place of medical ethics. De Jager, Du Plooy and Femi Ayadi (2010: 133) suggest a more business-like approach may result in increased expectations from patients regarding the quality of healthcare services they receive. Potter and McKinlay (2005: 468) note adopting a business perspective to this relationship does not adequately recognise the vulnerability and dependency of the patient on the healthcare provider in healthcare service delivery.

Von Staden (2021: 162) notes, despite concerns that the application of the CPA to the healthcare consumer market in SA could play a role in the commodification of the delivery of healthcare service and have a negative effect on patients, the CPA applies to the healthcare sector. She believes the application of the CPA to the healthcare consumer market must be done in a manner that advances the social and economic welfare of

patients as consumers, and recognises patients as uniquely vulnerable consumers. She asserts this approach is supported by the aim of the CPA to promote and advance consumers' social and economic welfare, particularly that of vulnerable consumers (Section 3(1)(a); (b)).

The following section will examine selected, relevant, fundamental consumer rights that possibly have a role to play in addressing the challenges of patients and empowering patients as consumers in the healthcare consumer market.

3.4 Fundamental consumer rights as set out in the CPA

The aim of the CPA to promote and advance the "social and economic welfare of consumers" in SA within the context of a transformed consumer market, is achieved by, amongst others, providing consumers with fundamental consumer rights (Section 3(1)). This section will examine selected, pertinent, fundamental consumer rights that may feature in addressing the challenges of patients as consumers of public healthcare services in the healthcare consumer market. The next section will examine the fundamental right of the patient, as a consumer, to choose.

3.4.1 The right to choose

De Stadler (2013: 28) states a consumer must not be compelled to enter a transaction or remain in a transaction with a supplier. She adds the fundamental right of the consumer to choose is a comprehensive right that includes the right of consumers to choose a supplier and cancel agreements. According to De Jager *et al.* (2010: 133), managerial structures in the public healthcare system should facilitate the delivery of flexible healthcare that is people centred with the interests of the public, and consumers guiding decision- making at all levels.

Rowe and Moodley (2013: 19) note that despite the patient rights contained in the NHA that aim to uphold the right of the patient to exercise free choice in the healthcare market, the reality is the current structure of the healthcare consumer market in SA limits the patients' freedom of choice, as a consumer, to access healthcare services in the public

sector. They add that patients often have little or no choice in selecting the healthcare provider they would prefer in the public healthcare consumer market, because of a high turnover of healthcare providers in this sector. De Jager *et al.* (2010: 134) agree the choice of the consumer is limited in public healthcare facilities, since patients generally receive treatment at a clinic or hospital where they are designated. The authors add public healthcare facilities at different levels serve specific areas and according to needs. Slabbert and Labuschaigne (2022: 32) assert that freedom of choice and the right of patients to self determination is often limited in the public sector by a lack of funds or long waiting lists and free choice is in reality “a choice on paper only”.

Carstens and Pearmain (2007: 372) state the type of healthcare services delivered at public healthcare facilities are predetermined, in accordance with existing clinical protocols and guidelines, generally applied uniformly across the public healthcare sector. They state this practise restricts the patient’s ability to exercise free choice, as they are unable to ask for services that do not fall within the ambit of these pre-existing services, clinical guidelines and protocols. The authors believe the attitude towards healthcare service delivery in the public sector is “these are the services on offer - take them or leave them”. Du Toit and van Eeden (2014: 738-739) assert that patients, as users of healthcare, have limited rights of choice. Wolf (2018: 03) notes, despite limitations, people still consume healthcare by making use of the healthcare services available to them, therefore, to varying extents, do have some choice in making decisions regarding their health.

O’Mathúna *et al.* (2005: 17) assert every patient should have the right to freely choose the treatment and medical procedures they require, based on the provision of sufficient and adequate information by providers. Barapatre and Joglekar (2016: 05) believe the health information presented by healthcare providers is used by the patient to assist in making informed choices concerning proposed treatment. In a healthcare consumer market, a patient who does not trust his or her healthcare provider should have the right to choose another (O’Mathúna *et al.* 2005: 17).

The following sections will examine the manner in which the fundamental consumer right to choose is introduced into the healthcare consumer market by the consumer's right to select suppliers (Section 13) and the right of the consumer, with respect to the supply of services (Sections 19).

3.4.1.1 Right to select suppliers: Section 13

The consumers right to select suppliers, as set out in Section 13 of the CPA, regulates the business practice of bundling or conditional selling, according to van Eeden and Barnard (2017: 26, 158). The authors explain bundling is supplying particular goods or services, on condition a consumer also purchases other goods or services from the same or a different supplier. They believe the consumer's freedom of choice will be limited by a contractual term that makes the supply of goods or services conditional on the purchase of additional goods or services. Von Staden (2021: 517) is of the opinion that conditional selling or bundling in the healthcare consumer market occurs in circumstances where patients cannot choose service providers and are required to use specific service providers to access other services, such as blood tests or x-rays.

De Stadler (2013: 29) states conditional selling or bundling is permitted in terms of Section 13, in circumstances where bundled transactions may be beneficial for the consumer. She believes suppliers should be careful to inform consumers of the benefits and reasons for bundling goods and services, as this approach would empower consumers to make informed choices. Du Toit and van Eeden (2014: 738-739) agree there are limited circumstances where Section 13 permits bundling of goods and services.

In terms of Section 13(1)(i-iii), bundling of goods and services is allowed, should the supplier be able to show bundling the good or services:

- Is more convenient for the consumer and this convenience is more important than the limitation on the freedom of choice;
- Is economically beneficial to the consumer; or
- Are offered separately to the consumer at individual prices.

According to Slabbert and Labuschaigne (2022: 33), there is a significant degree of duplication between this fundamental consumer right and the right of the patient to informed consent, as set out in Section 6 of the NHA. Von Staden (2021: 521) asserts the disclosure of information, as required in terms of the NHA, would and should include the disclosure of bundling or conditional selling practices. The author believes Section 13 of the CPA does not provide the patient, as a consumer, with significant additional rights above the patient rights contained in the NHA.

Section 6 of the NHA states that healthcare providers must inform patients of the "range of diagnostic procedures and treatment options generally available to the patient", as well as "the benefits, risks, costs and consequences generally associated with each option". Compliance with the provisions in this section should make it difficult for healthcare service providers to bundle goods or services in contravention of Section 13 of the CPA (Von Staden 2021: 520).

The NPRC (SA Department of Health 1999) provides patients have the right to:

- Choose a healthcare service provider for treatment, provided the choice of the patient complies with the ethical rules and standards applicable to healthcare service provision (right 2.5);
- Know and be able to identify the person providing healthcare services as a healthcare service provider (right 2.6); and
- Request a referral for another opinion to a healthcare service provider of their choice (right 2.10).

Despite both the NHA and the CPA providing the patient as a consumer with rights that recognise the importance of the right to choose, the structure of the consumer healthcare market in SA restricts the patient's right to choose. This is done by placing limits on the patient's freedom of choice as a consumer, in the manner in which healthcare services are accessed in the public sector (Von Staden 2021: 516).

3.4.1.2 Consumer rights with respect to service delivery (Section 19)

As discussed in paragraph 2.6.2, extended waiting times to receive healthcare services have been identified in numerous studies as a significant challenge facing patients accessing public sector healthcare services. (HEU 2012: 4; SA Department of Health 2017: 12; Burger *et al.* 2016: 193; Young 2016: 4-9; Mokgoko 2013: 104-105; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Harris *et al.* 2011: 116).

According to Sections 19 (2) and (3) of the CPA, it is implicit in all transactions involving the supply of goods or services that service providers perform the services on the agreed date, and at the agreed time, or within a reasonable time. In the event of a healthcare provider failing to perform healthcare services at a location, on a date, or at a time, as agreed with the patient, Section 19(6) provides the patient, as a consumer may:

- Accept the performance of services as tendered; or
- Reject the performance of services and require the performance of services at the agreed location, date and time; or
- Cancel the agreement without penalty and treat the services performed as unsolicited services, in accordance with section 21.

Van den Berg (2011: 598) highlights the importance of healthcare providers communicating with patients to advise of delays in service delivery, especially when they have to wait for appointments for lengthy periods of time. Von Staden (2021: 528; 529) cautions the remedies in terms of Section 19 for patients, as consumers of healthcare services, are not particularly helpful for vulnerable patients in the public sector desperate to receive medical treatment. Rejecting the performance of services or cancelling the agreement in accordance with Section 21, does little to assist patients to receive the medical attention they may urgently need. The author adds, although Section 19 of the CPA appears to provide patients, as consumers, with extra rights, the remedies provided may be counter-productive to ensure patients receive timeous and appropriate medical treatment, while it is also uncertain whether this consumer right will be effective in addressing the health challenges of patients.

The following section will examine the manner in which the fundamental consumer right to disclosure and information is introduced into the healthcare consumer market.

3.4.2 The right to disclosure and information

The fundamental right of the consumer to disclosure and information is introduced into the healthcare consumer market in terms of the right to information in plain and understandable language (Section 22), as is the right to disclosure of the price of services (Section 23) of the CPA. The relevant provisions of each of these sections are examined below.

3.4.2.1 The right to information in plain and understandable language (Section 22)

The National Department of Health (2017: 03-04) has identified inadequate provision of information as a challenge for patients in the healthcare sector. According to Manyonga *et al.* (2014: 561), healthcare providers have a duty to ensure patients have received and understood the information provided to them. The authors note the difficulty of achieving this goal in SA, which has 11 official languages, with interpreters often used in the delivery of healthcare services due to language barriers. Van den Berg (2016: 229) states clear communication between a patient and a healthcare provider is an important foundation to ensure a patient participates in decisions concerning medical treatment. He warns effective communication is problematic in a multilingual society such as SA, because the reality is healthcare providers and patients often do not speak the same first language. Effective communication between a healthcare provider and a patient is fundamental in promoting patient autonomy, and ensuring patient participation in the healthcare decision-making process (Roodbeen *et al.* 2020: 02).

Section 6(2) of the NHA states the information that must be provided to the patient to assist in the process of medical decision-making, in terms of Section 6(1), must be given in a "language that the user understands and in a manner which takes into account the user's level of literacy". According O'Mathúna *et al*. (2005: 17), healthcare facilities are responsible for making information available to patients. The NPRC (SA Department of Health 1999) recognises the important role of providing information and states the right

to information with regard to health is an essential part of the right of access to healthcare services (right 2.3 (g)), should contain information regarding the availability of healthcare services, and the way a patient can best make use of the provided services. The Charter also highlights the importance of providing information to a patient in the language the patient understands.

The CPA requires notices, documents, visual representations and written agreements, required in terms of the CPA or any other law, to be produced, provided or displayed to consumers in plain language (Section 22 (1); Section 50(2)(b)(i)). Du Preez (2009: 75–76) and Stoop (2017: 6) believe the requirements of Section 22 apply to written agreements and do not include verbal agreements. Singh (2017: 136) states there is no legal requirement in the healthcare consumer market that agreements must be in writing and the requirement of informed consent is not based on a need for written documentation.

Jacobs, Stoop and Van Niekerk (2010: 329) and Stoop (2017: 4) highlight the need to use plain and understandable language in the consumer market, in terms of Section 22 of the CPA, is no longer simply a requirement, it is now a fundamental consumer right. The use of plain language aims to use clear and effective communication to ensure greater transparency and disclosure by suppliers (Stoop 2017: 16). De Stadler (2013: 105) opines plain language does not mean language must be “simple” or “dumbed down”, particularly in circumstances where the information provided is complex. She explains this approach to the plain language requirement is misleading and prefers that the focus of this section of the CPA should be on using understandable language, as opposed to plain language.

Von Staden (2021: 511-512; 494-5) explains Section 22 of the CPA uses a “consumer-centred subjective approach” to determine whether information has been provided in plain and understandable language or not. The author adds informed consent, as required in the NHA, also has a number of informational requirements and adopts a “patient-centred subjective approach” that focuses both on the requirement to provide information and

ensures the patient has understood the information provided. She questions whether the provisions of Section 22 of the CPA extend this patient right in a meaningful and context-appropriate manner, because of the significant informational requirements of the patients' right to informed consent as set out in the NHA.

3.4.2.2 The right to disclosure of the price of services (Section 23)

Patients are generally concerned with issues concerning access, quality and cost in the delivery of healthcare services (Kinney 2000: 339). According to Leach (2018: 53), service delivery must be effective and efficient, timeous and cost effective. As discussed in paragraph 2.2.2, the way in which patients pay for healthcare services in the healthcare consumer market is complicated and varied. As stipulated by the Competition Commission (2019: 44), value-based purchasing is not an important issue for patients, as consumers in the public healthcare consumer market, because payment for goods and services delivered is not in accordance with the value of the goods or services provided, but rather as determined by the UPFS, according to the economic classification of the patient.

Section 23 states consumers must be given the price of healthcare services before such services are supplied, except in circumstances where a supplier has given an estimate to the consumer regarding the transaction. Van den Berg (2011: 598) finds healthcare providers do not need to comply with the Section 23 requirements in circumstances where price estimates of proposed treatment have been provided to a patient. Von Staden (2021: 512) adds there is commonality between this section of the CPA and the requirements of Section 6(1)(c) of the NHA, which states the costs associated with different treatment options must be disclosed to the patient to enable him or her to make an informed decision regarding available types of treatment.

Von Staden (2021: 513) asserts this section of the CPA may assist patients in making "value-based purchasing decisions", nonetheless, due to the way in which patients "pay" for healthcare services in the public sector, disclosing the price of goods or services does

not empower them to any significant extent. The following section will examine the right to fair and honest dealing.

3.4.3 The right to fair and honest dealing

This section will focus on one aspect of the fundamental consumer right to fair and honest dealing, the regulation of over-selling and over-booking in terms of Section 47. As discussed in paragraph 2.6.2, patients experience significant challenges in receiving goods and services timeously. Extended waiting times to receive healthcare services have been identified in numerous studies as a challenge facing patients accessing public sector healthcare services (HEU 2012: 4; SA Department of Health 2017: 12; Burger *et al.* 2016: 193; Young 2016: 4-9; Mokgoko 2013: 104-105; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Harris *et al*. 2011: 116).

In hospitals, patients may not receive delivery of healthcare services as agreed, in situations where surgeon's lists may be postponed or cancelled (Rowe and Moodley 2013: 22). Furthermore, drug shortages and a lack of basic resources are also challenges identified by patients. The HEU (2012: 3) and National Department of Health (2017: 03-04) both found drug shortages were problematic for patients, while the Rural Health Advocacy Project (n.d: 06), Moyo (2016: 27) and Maphumulo and Bhengu (2019: 02) identified both shortages in medicine and equipment, as well as lack of resources. In addition, Young (2016: 4-9) found a lack of basic resources and Mthanti (2015: 01) identified the absence of basic services including water, telephone access and reliable electricity to be challenges of patients.

Section 47(2) of the CPA states a supplier, in this study a healthcare provider, is not allowed to accept payment for goods or services, in circumstances where there is no reasonable intention to supply such goods or services, or the intention is to supply goods or services materially different from those for which payment was accepted. Section 47 (3) states that should a supplier promise to deliver healthcare services at a specified date or time and does not do so, as a result of insufficient stock or capacity to supply the goods or services as agreed, or similar goods or services, the consumer in this study, the patient,

must be refunded with interest. The section adds a healthcare provider must also compensate the patient for costs that are "directly incidental" to the breach of contract by the healthcare provider. According to Rowe and Moodley (2013: 22), a healthcare provider may be unable to recover payment for services they cannot supply as initially agreed.

Von Staden (2021: 524) explains applying Section 47 in the public healthcare consumer market is problematic, because of the manner in which payment for healthcare services is made. She notes payment for goods and services in the public sector does not relate to the actual value of the goods and services received; this may result in patients experiencing difficulties in enforcing their rights in terms of this section.

Section 47(3) limits the right of the patient as a consumer two ways. First, Section 47(4) permits a healthcare provider to supply a patient with comparable goods or services which the patient may accept or reasonably refuse. Second, in terms of Section 47(5), a healthcare provider is not liable for the additional costs incurred by the patient as a consumer, in circumstances where the shortage of stock or capacity results from circumstances beyond healthcare provider control. This section does, however, place a duty on the healthcare provider to take reasonable steps to advise the patient of the stock or capacity shortage, as soon as possible. Section 47(6) adds a shortage of stock or capacity cannot be considered the result of circumstances beyond the control of the healthcare providers when the shortage is completely or partially, “directly or indirectly”, the result of a failure of the healthcare provider to perform ordinary or routine business activities “adequately and diligently”.

Paragraph 2.6.2 of this study identified poor leadership, along with inadequate management and governance, as challenges in the public healthcare sector (Dhai and Mahomed 2018: 08). Von Staden (2021: 525-6) asserts Section 47(6) may provide effective recourse for patients, because shortages of stock or capacity cannot be considered beyond the control of the supplier where such shortages are the result of supplier failure to perform ordinary business activities adequately and diligently. She adds

the patient has a right to be supplied with comparable goods or services, or a refund including interest and compensation for costs "directly incidental" to the breach of contract of the supplier (Section 47 (3)). The author believes compensation for costs that are "directly incidental" can provide patients, particularly in the public healthcare sector, with an effective mechanism to ensure timeous delivery of services, especially for those patients who have not paid for services, where a refund would not apply. She concludes that this fundamental consumer right may help patients in the public sector to obtain healthcare services timeously but enforcing this right may be problematic, because the way payment is made for healthcare services, is not related to the actual value of the services provided.

3.4.4 The right to fair, just and reasonable terms and conditions

Application of the fundamental consumer right to fair, just and reasonable terms and conditions in the healthcare consumer market are examined in terms of the following sections of the Act that regulate the use of:

- Unfair, unreasonable or unjust contract terms (Section 48);
- Written consumer agreements (Section 50);
- Notice for certain terms and conditions (Section 49); and
- Prohibited transactions, agreements, terms or conditions (Section 51).

The negative consequences of standard form contracts and exclusionary clauses in SA have been mitigated by enacting a number of provisions in the CPA which include Sections 48, 49 and 51 (Tait 2020: 948). McQuoid-Mason (2012: 67) notes that the CPA has significantly altered the common law position regarding the use of exclusionary clauses by healthcare providers.

In terms of Section 48(1) a supplier, which in this study is a healthcare provider, may not enter into an agreement to supply goods or services at an unfair, unreasonable or unjust price or terms. According to van Eeden and Barnard (2017: 232), this fundamental consumer right to fair, just, and reasonable terms and conditions, is the first instance of the notion of fairness in the law relating to consumer contracts in SA. They add that parties

in a consumer agreement are now protected in the event of an agreement being unreasonable, unfair, or with unjust conditions (Section 52).

Letzler (2012: 22) asserts the fundamental consumer right to fair, just and reasonable terms and conditions is relevant in the healthcare context, where the use of standard form contracts, often containing exclusionary clauses, have become standard practice, particularly in the private sector. An exclusionary clause has the effect of excluding, altering or limiting one of the parties' liability to the contract (Stoop 2008: 496). Exclusionary clauses in the healthcare market generally protect the healthcare provider or hospital from liability arising from negligent conduct that may cause harm to the patient and have been upheld in South African common law, on the basis of sanctity and freedom of contract (Letzler 2012: 22).

Mupangavanhu (2015: 120-121) warns exclusionary clauses in standard form contracts undermine the values of equality, dignity and freedom, since the patient, as a consumer, is generally in an unequal bargaining position and unable to effectively negotiate contract terms and has no choice but to agree to standard form contract terms. Van Deventer (2020: 260) asserts consumers often feel bombarded with information they cannot read and do not understand and frequently end up making poor decisions, or even avoiding decision-making altogether.

3.4.4.1 Unfair, unreasonable or unjust contract terms: Section 48

Section 48 limits the use of exclusionary clauses by requiring the courts and the legislature to examine consumer agreement contents using the standard of fairness, reasonableness and justice (Hawthorne 2012: 361-362). According to Kok (2010: 63), the CPA does not preclude the use of exclusionary clauses. The author asserts that in situations where neither party is at fault, exclusionary clauses will still be used in order to allocate risk between the parties in a consumer agreement. He notes, in terms of the CPA, the allocation of risk must be fair and the healthcare provider must ensure the patient as a consumer is aware of the risk they have agreed to accept.

3.4.4.2 Notice required for certain terms and conditions: Section 49

Archakova (2013: 28) finds contractual terms and conditions are, in many instances, not brought to the attention of consumers and consumers are not provided with proper assistance in understanding the content of a contract. Section 49(1) states the attention of the consumer must be drawn to agreements containing an exclusionary clause. In terms of Section 49(2), extra care must be taken in making consumers aware of exclusionary clauses that relate to risks of an unusual nature; of which the consumer could not reasonably be expected to be aware of, or in circumstances where there is a chance of serious injury or death.

Von Staden (2021: 422) asserts this includes the delivery of healthcare services and adds it is critical the patient as a consumer is made aware of any exclusionary clause. She states the healthcare provider must ensure the nature and potential effect of the risk of the healthcare services provided is drawn to the attention of the patient in a manner that complies with the plain language requirements of Section 22 of the CPA. The author adds the Act requires the consumer to indicate they are aware of and understand the contents of the exclusionary clause. She notes the requirements of informed consent contained in Section 6 of the NHA also require this information to be provided to the patient. Stoop (2015: 1103) warns consumers should not sign consumer agreements as a simple formality, because suppliers may rely on the consumers' signature as evidence the consumer has been made aware of the exclusionary clause and the contract or term may, therefore, be considered fair. Tait (2020: 954) advises that the requirement that exemption clauses be brought to the attention of the consumer are not limited to cases where risks may be considered unexpected.

3.4.4.3 Written consumer agreements: Section 50

No legal requirement exists for contracts entered into between a healthcare provider and a patient to be in writing, according to Singh (2017: 136), who emphasises agreements in the healthcare sector may be based on either verbal or written consent to treatment by the patient. However, written contracts used in the healthcare sector are usually standard form contracts (Letzler 2012: 22). These are contracts that are "drafted in advance by the

supplier of goods or services and presented to the consumer on a take-it-or-leave-it basis, thus eliminating opportunity for arm's length negotiation" (Barkhuizen v Napier 2007: para 135). Richards (2019: 18) cautions that standard-form contracts often contain unfair terms that are misused by suppliers to take advantage of consumers.

Section 50(2)(b)) does provide a degree of protection to patients, because when a consumer agreement is in writing, healthcare providers must provide the patient, as a consumer, a free copy, or free electronic access to a copy, containing the terms and conditions of the agreement, while written agreements must comply with the plain and understandable language requirements of Section 22 of the CPA. According to Stoop (2015: 1104), the plain and understandable language requirement is important in addressing problems associated with unfairness in standard form contracts. He asserts parties to a contract often fail to reach consensus, because these contracts are frequently not well-structured and generally written in an official language. Section 50(3) provides protection to a patient as a consumer when a consumer agreement is not in writing, because the healthcare provider must keep a record of the transaction.

3.4.4.4 Prohibited transactions, agreements, terms or conditions: Section 51

The CPA further limits the use of exclusionary clauses in terms of Section 51, by addressing terms, conditions or agreements generally referred to as a blacklist (Stoop 2015: 1098; van Eeden and Barnard 2017: 248). Section 51(3) provides that when a supplier fails to comply with these provisions, the agreement will be considered void, to the extent that it contravenes Section 51.

In terms of this section, an exclusionary clause that excludes liability for gross negligence in a healthcare contract is on the blacklist. Therefore, any contract between a patient and a healthcare provider will be void, should it limit or exempt a healthcare provider from liability for any loss, caused either directly or indirectly by the gross negligence of the service provider or any employee (Section 51(1)(c)(i)).

A comparative analysis between the fundamental consumer right to fair, just and reasonable terms and conditions, as contained in the CPA and existing patient rights in terms of the NHA, shows these sections of the CPA have added significant rights to the patient as a consumer in the healthcare consumer market, according to Von Staden (2021: 425), particularly regarding the use of standard form contracts and exclusionary clauses. The following section will discuss the fundamental right of the consumer to fair value, good quality and safety.

3.4.5 The right to fair value, good quality and safety

Several challenges facing patients as consumers of healthcare services in the South African public healthcare consumer market were discussed in Chapter 2 (paragraph 2.6.2), with many of these challenges related to the quality of the healthcare services delivered (Competition Commission 2018: 6; WHO 2018: 60). The CPA addresses the issue of quality in the consumer market, using the fundamental right of the consumer to fair value, good quality and safety. This section will discuss this fundamental consumer right by examining the right of the consumer to demand quality service in terms of Section 54 of the CPA.

Right of the consumer to demand quality service: Section 54

Section 54 of the CPA provides consumers have a right to demand quality service and addresses two quality issues, namely the quality of the goods or products provided and the quality of the services provided. This study will offer a cursory discussion of the complex and wide-reaching product liability sections, contained in the right of the consumer to fair value, good quality and safety, because the study focus is on patient challenges and does not extend to an in-depth examination of product liability in terms of the Act.

A healthcare service provider who, in the course of providing services, installs a device such as a prosthesis, implant, or pacemaker, may be considered a supplier of those goods and will, therefore, be subject to the strict product liability provisions of the CPA (Jacobs, Stoop and Van Niekerk 2010: 384; Van den Heever 2012: 13; Rowe and

Moodley 2013: 21-22). Section 54 applies to circumstances where healthcare service providers install goods during the performance of a service. In terms of Section 54(1)(c) and Section 61(2), a healthcare service provider who installs goods during the performance of services, must ensure the goods supplied are not defective and of a quality a patient is, generally, entitled to expect.

Slabbert and Pepper (2011: 801) and Slabbert and Labuschaigne (2022: 34) express concern that, in terms of the CPA, healthcare service providers such as doctors are now within the chain of liability introduced by the Act, which extends from the manufacturer to the consumer. The authors warn the strict CPA liability provisions in the healthcare market may be problematic and could result in increased litigation.

In terms of Section 54(1) (a) and (b), a patient has the right to healthcare services being performed and completed timeously and in a manner and quality patients are "generally entitled to expect". Jacobs, Stoop and Van Niekerk (2010: 365) assert this is a factual inquiry based on the facts of each case.

Moyakhe (2014: 80) emphasises that healthcare policy aims to deliver good quality healthcare to patients. Amukugo and Nangombe (2017: 13) state it is important to provide quality healthcare services to those in need. Kenya (2016: 01) affirms the quality of healthcare service delivery is reflected in aspects such as newer technology, efficient medication, competent staff and an adequate staff-patient ratio, as well as effectiveness, accessibility and efficiency.

Chahal and Kumari (2012: 183) contend several elements impact the quality of healthcare services delivered, including *inter alia* the physical quality of the healthcare facility, the nature and quality of the interaction between the healthcare provider and the patient, and the technical quality of the delivered goods and services. Each of these elements will be briefly discussed. First, according to Chahal and Kumari (2012: 187), the physical quality of the healthcare facility is a critical element that influences the healthcare service delivery quality and includes the state of repair of buildings such as waiting rooms, clinics, theatres

and consultation facilities. The authors add the state of equipment and appearance of healthcare providers and other staff are also important.

The second element is the nature and quality of the interaction between the healthcare provider and the patient. Chahal and Kumari (2012: 188; 631) state several studies found the attitude and behaviour of healthcare providers is important to patients. The authors add approachability, kindness, helpfulness, efficiency in responding to patient queries, and support directly influence the quality of the interaction.

Finally, the technical quality of the goods and services delivered is assessed using a wide range of facilities, from the types of products available, to the adequacy of parking spaces (Tlapana 2017: 74). Technical quality in healthcare also includes the technical competences of healthcare providers, such as the knowledge and skills required to provide professional care and services (Amukugo and Nangombe 2017: 13) and accurate diagnoses, as well as efficient and effective procedures (De Jager *et al.* 2010: 135). Everyone has the right of access to healthcare services that adhere to acceptable safety standards (O'Mathúna *et al.* 2005:18; Azizan and Mohamed 2013: 308).

Section 54(2) provides that when a healthcare provider fails to deliver healthcare services either timeously, or in terms of the expected standard, the patient as a consumer may require the healthcare provider to remedy the defective quality of the services delivered, or refund the patient a reasonable portion of the price paid for the services. Letzler (2012: 16-17) warns that those who deliver healthcare services in the public healthcare consumer market must pay attention to these provisions, to avoid paying the "hard-earned taxes" of the public on consumer claims, where healthcare providers have not complied with this provision in the CPA.

Section 54 provides consumers with the right to demand quality service, including the right to services being performed and completed timeously and in a manner and quality patients are "generally entitled to expect" (Section 54(1) (a);(b)). The quality patients are "generally entitled to expect" may be measured against a number of elements, including

the physical quality of the healthcare facility, the nature and quality of the interaction between the healthcare provider and the patient, and the technical quality of the delivered goods and services (Lehtinen and Lehtinen 1982; Camilleri and Callaghan 1998, cited in Chahal and Kumari 2012: 183). However, the remedy provided in terms of Section 54(2), requiring the healthcare provider to remedy the defective quality of the services delivered, or refund the patient a reasonable portion of the price paid for the services, may present difficulties for patients when trying to enforce the prescribed remedial action and result in consumer claims settled by the public healthcare with the "hard-earned taxes" of the public (Letzler 2012: 16-17).

The CPA, therefore, provides some fundamental consumer rights to patients as consumers, with these rights potentially able to address the challenges patients experience as consumers. However, in some instances, duplication exists between the protection provided in terms of the CPA and the protection for patients in the NHA. The following section will explore the importance of patient awareness, as consumers, of their rights in terms of the CPA.

3.5 Importance of patients as consumers being aware of their rights in terms of the CPA

Van den Heever (2012: 07) points out consumers might not, in many instances, even be aware of the protection provided by the CPA. The author notes consumers are unable to take advantage of the protection provided by the Act without awareness of their rights. One of the ways the CPA aims to promote and advance the "social and economic welfare of consumers" is by "improving consumer awareness and information and encouraging responsible and informed consumer choice and behaviour" (SA Department of Trade and Industry 2008: Section 3(1)(e)). Nevertheless, Rowe and Moodley (2013: 16) note empowering patients as consumers in SA, may prove beneficial to only some patients. They warn that "disempowered state patients" receiving free healthcare may find it difficult to consider themselves consumers and benefit from this approach to healthcare service delivery.

According to Woker (2010: 230), a lack of awareness regarding rights results in consumers accepting imperfect services. Both Modiba (2015: 2) and Govender (2017: 04) believe a lack of public education, particularly in respect of people from disadvantaged areas, means consumers are not aware of their rights.

Lazarus and Butler 2001(cited in Ndlovu 2012: 02) assert that as a result of education, patients have become increasingly mindful of health issues, and there has been an increase in awareness amongst patients who are demanding increased accessibility to healthcare facilities According to Hassim, Heywood and Berger. (2007: 247), The NPRC (SA Department of Health 1999) assists in creating awareness of both patient's rights and the level and quality of healthcare services patients can expect at public healthcare facilities.

The manner in which the NPRC (SA Department of Health 1999) has been used to assist in raising awareness of patient rights contained in the NHA, could be used as a guideline to raise awareness of the fundamental consumer rights patients have in terms of the CPA. The following section will examine the importance of measuring service quality as a mechanism to address quality issues.

3.6 Measuring service quality

Challenges experienced by patients may be measured using a mechanism for tracking challenges. According to Leach (2018: 62), customer satisfaction with a service is often determined by the quality of that service. In addition, consumer attitude toward service quality is determined by the gap between a consumer's actual experience and his or her expectations (Tlapana 2017: 79; Chahal and Kumari 2012: 182; Armstrong and Kotler 2013: 237). Gothan (2009: 39) agrees and states measuring service quality is a way to determine the extent to which service delivery matches customer expectations. De Jager *et al.* (2010: 133) assert patients need to have higher expectations regarding the quality of healthcare services they receive. Wesso (2014: 12) points out that a patient's perception of the delivered service quality will influence their choice of a healthcare

provider. The author suggests the quality of the service delivered is closely related to consumer satisfaction.

Isik, Tengilimoglu and Akbolat (2011: 1921) describe SERVQUAL as a useful measurement tool in measuring and monitoring service quality in healthcare facilities, at the same time enabling healthcare providers to determine in which areas the quality of services provided can be improved. SERVQUAL is a popular model of monitoring service quality by measuring how customers perceive the quality of services they receive (Kiumarsi, Isa and Jayaraman 2015: 349). According to Amukugo and Nangombe (2017: 13), many healthcare facilities have quality assurance (QA) standards, however, these standards are often not accurately complied with to respond to the needs of patients. Archakova (2013: 9) proposes a framework for measuring service quality against five elements, including, “tangibility, reliability, responsiveness, assurance and empathy”.

Measuring service quality is an important mechanism to address quality related issues in order to respond to the needs of patients. Using a mechanism such as SERVQUAL to measure and monitor service quality in healthcare facilities, may assist in ascertaining areas in which the service quality can be improved (Isik *et al.* 2011: 1921). Archakova’s (2013: 9) five elements could instead be adopted as a framework to measure public healthcare consumer market quality.

3.7 Conclusion

This chapter examined the application of the CPA to the healthcare consumer market in SA and established, based on the definition of a transaction, the CPA applies to healthcare related transactions in the public healthcare consumer market of the country (Howarth and Davidow 2010: 5; Slabbert and Pepper 2011: 800; Kirby 2012: 2; Rowe and Moodley 2013: 21; Slabbert and Labuschaigne 2022: 33).

The concept of the patient as a consumer was explored and there is agreement that, from a legal perspective, patients are considered consumers (Jacobs, Stoop and Van Niekerk 2010: 313; Rowe and Moodley 2013: 01-02; Slabbert and Labuschaigne 2022: 33) and

have rights as patients in terms of the NHA (Dhai and Mahomed 2018: 09) and as consumers under the CPA (Rowe and Moodley 2013: 02). There are concerns the application of the CPA to the healthcare sector in SA could increase the commodification of healthcare service delivery and negatively impact patients; in order to avoid this, application of the CPA to the healthcare consumer market must be done in a manner that advances the social and economic welfare of patients as consumers (Von Staden 2021: 162).

Selected fundamental consumer rights that possibly have a role to play in addressing the challenges of patients as consumers in the healthcare consumer market were examined. It appears the CPA provides patients as consumers with a number of fundamental consumer rights with the potential to address the challenges of patients as consumers. However, in some instances, there is duplication between the protection provided in terms of the CPA and the protection for patients in the NHA. The manner in which the NPRC (SA Department of Health 1999) has been used to assist in raising awareness of patient rights contained in the NHA was discussed and it was suggested the Charter may be used as a guideline to implement a similar method to raise awareness of the fundamental consumer rights patients have in terms of the CPA.

Finally, measuring service quality was discussed as an important mechanism for addressing quality related issues, in order to respond to the needs of patients. SERVQUAL may assist as a mechanism to measure and monitor service quality in healthcare facilities, to ascertain areas in which the service quality can be improved (Isik *et al.* 2011: 1921). Alternatively, the five elements identified by Archakova (2013: 9) could be adopted as a framework to measure quality in the public healthcare consumer market.

The next chapter will outline the research methodology adopted in this study

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

Choosing the most appropriate research method is important because it will determine the specific procedures and strategies to be followed in the design of a study (Creswell 2009: 11; Akhtar 2016: 68). This chapter will describe the research methodology adopted in this study. Key aspects will be examined such as the research design and method; population and sample size; data collection and analysis; validity and reliability and ethical considerations.

4.2 Research design and method

This section will discuss the research design and method used in this study.

4.2.1 Research design

Research design is the framework within which research is conducted, it connects the fundamental components in a research project (Akhtar 2016: 24). A research design guides the collection and analyses of data (Mabitsela 2012: 24). According to Majid (2018: 01), research design describes the overall strategy or technique used to integrate the different elements of the study in a manner that is able to effectively address the research problem. The research design adopted in this study takes the aims and objectives of this study into account.

The research design used in this study is descriptive, which Kabir (2016: 124) states helps to answer questions such as who, what, where, when, and how, related to a research problem and generally cannot provide answers to why. Akhtar (2016: 75) states descriptive research is used to identify and attain data on the characteristics of an issue such as a situation, issue of community, or a group of people. The author notes it is the study of people in society, describing social events, social structure or social situations.

According to Clow and James (2014, cited in Msosa 2015: 57), survey is a popular method of conducting descriptive research.

This study adopted a descriptive research design, as it is more concerned with answering the question “what” rather than “why”, because it aimed to investigate the challenges of patients as consumers of public healthcare services in the Inanda district of eThekwini and the role of the CPA in addressing these challenges.

4.2.2 Research method

Choosing an appropriate method for research is critical in any research project (Govender 2017: 90). Daniel (2016: 92) points out research can be conducted using quantitative, qualitative or mixed methods. The author states both quantitative and qualitative research can be used to achieve the same goal using different techniques and procedures, each with different strengths and logic. The research design adopted in this study is a quantitative approach.

Quantitative research is constructed on the measurement of quantity or amount (Gounder 2013: 09). It relates to establishing what people think or do and takes numerical measurement, through questioning or examining people and collecting data (Creswell 2009: 175). According to Mayoux (2006: 117), quantitative research relates to a large-scale survey based on individual questionnaires. The advantage of a quantitative approach is that using statistical data saves both time and resources (Daniel 2016: 94). Wagner *et al.* (2012: 100) assert the use of a questionnaires is a common approach to quantitative research.

4.3 Target population, sample size and sampling method

This section will describe the target population, inclusion and exclusion criteria, sample, sample size and sampling method used in this study. Planning field work is an important step in research and the population best suited to the research topic must be carefully selected (Bryman 2012: 184). Selecting the population and sample provides a foundation

for designing a questionnaire and deciding how best to administer it (Bryman and Bell 2011: 170).

4.3.1 Target population

A population is a cluster of individuals of the same class living within a given area (Tuff and Tuff 2012: 01) and includes all members from a specified group (Soetewey 2020: 03). A target population is the entire group of people a researcher is interested in researching and analysing (Mack 2020: 1-2). It is, furthermore, also described as the universal group, meaning all members of the hypothetical group of people from whom the researcher aims to generalise the results of a study (Pandey and Pandey 2015: 40). Cooper and Schindler (2008, cited in Tlapana 2017: 09) define the target population as those individuals in possession of relevant information able to answer the measurement questions.

The target population of this study comprises adult patients as consumers of public healthcare services who reside in Shembes Village, in the Inanda district of eThekwini municipality, KZN province, SA. This geographic area was chosen because it is a disadvantaged area where most patients access healthcare services in the public sector and largely depend on the closest facility. Furthermore, it is an area accessible to the researcher.

4.3.3 Inclusion and exclusion criteria

Inclusion and exclusion criteria describe who can be included or excluded from a study sample (Garg 2016: 642). Inclusion criteria are described as the basic characteristics of the target population the researcher will include in the study to answer the research questions (Patino and Ferreira 2018: 84).

The sample participants included in this study comprised adult female and male consumers of any race, who use healthcare services in the public sector, and reside in Shembes Village in Inanda Township, located in the eThekwini municipality, SA. Minors

and those consumers who do not access healthcare services in the public sector were excluded from the study.

4.3.3 Sample

In an ideal world, research would involve the collection of data from every individual within the population but this is impractical, inefficient, time-consuming and not economical (Welman, Kruger and Mitchell 2005: 55). Sampling is described as deciding on a portion of the population, in a research area, which will represent the entire population (Archakova 2013: 22). A sample is, therefore, the portion of the population selected for investigation (Bryman 2012: 187). A sample is a subsection of the population that participates in a study and should represent an entire group or universe and sampling is the procedure of selecting a sample from a population (Pandey and Pandey 2015: 40-41).

Sampling is the procedure adopted by the researcher to select the sample and draw conclusions from that sample in order to make generalisations for the population as a whole (Sekaran and Bougie 2013: 241). The sample of this study comprised members that have been chosen from the population residing in Shembes Village in Inanda Township for the investigation, in other words, a subset of the population.

4.3.4 Sample size

For research findings to be credible and in order to be able to generalize the findings to the entire population, a sample needs to be representative of the population (Bryman and Bell 2011: 168). Sample size is referred to as the number of selected individuals from whom data are collected (Lavrakas 2008: 781). According to Tuff and Tuff (2012: 01), the size of the sample is the number of individuals within a population the study will collect data from. Sekaran and Bougie (2016: 263) provide guidelines to determine a sufficient sample size.

As reported in the statistics of Census 2011 (StatsSA 2011), the population of Shembes Village in Inanda Township is 10 017 people. The sample size used in this study was

based on the guidelines of Sekaran and Bougie (2013: 268), who suggest for a population of between 10 000 and 15 000, a sample of 375 is sufficient to draw inferences from. For this study, the sample size thus consisted of 375 respondents from the Shembes Village in Inanda Township.

4.3.5 Sample selection method

According to Arizon (2010: 83), there are two types of sampling methods used in research, namely, probability and non-probability sampling. The author explains the population will be represented in the sample through probability sampling, meaning every member of the target population has an equal and independent chance of selection in the sample. He adds, by comparison, there is no guarantee in non-probability sampling that each element of the population will be represented. Mohsin (2016: 13) agrees not every unit of the population has an equal chance of participating in the investigation with non-probability sampling.

Non-probability sampling methods select samples using non-random methods (Pandey and Pandey 2015: 53). According to Moletsane (2012: 64), non-probability sampling is an appropriate method for choosing participants to participate in a survey. A non-probability sampling method is used for this study. There are different types of non-probability sampling, including purposive and convenience sampling (Mohsin 2016: 53). Purposive sampling, as Etikan, Musa and Alkassim (2016: 02) explain, is also called judgment sampling, and uses participants who are intentionally selected due to certain characteristics or qualities they possess in relation to the study purpose. This study used purposive sampling to select participants who are patients and access public sector healthcare services.

Convenience sampling is a sampling method that collects data from different groups or a population with readably accessible and available participants (Govender 2017: 94). Convenience sampling is an “expedient” method of sampling, because the researcher uses participants who are both available and accessible (Wagner *et al.* 2012: 92). This study used both purposive and convenience sampling to select participants who are

patients who access public sector healthcare services and who were readily available and easily accessible to the researcher, due to money and time constraints.

4.3.6 Recruitment process

Recruitment, according to DeCarlo *et al.* (2020: 101), is the process the researcher uses to advise prospective participants regarding the study and request their participation. The authors note recruitment may take several different forms; however, researchers must ensure the recruitment strategy adopted aligns with the sampling method used in the study. Cawthra *et al.* (2017: 86-87) note the recruitment of participants involves selecting individuals from the study population to take part in the research. The authors note participants with experience of a particular issue need to be recruited for critical cases.

This study investigated the challenges of patients as consumers of public healthcare services. Therefore, participants were recruited who were consumers who access healthcare services in the public healthcare sector. Snowball recruitment was used for this study. According to Cawthra *et al.* (2017: 88), snowball recruitment involves identifying primary participants and then requesting them to nominate other willing participants with similar characteristics. Snowball recruitment aligns with the sampling method used in the study, namely, purposive and convenience sampling.

4.4 Data collection

Typically, data collection covers two types of data, primary and secondary data (Hussain and Rehman 2012: 26). This study used both primary and secondary sources of data. Primary data refers to the information obtained from direct, first-hand experience, and includes data collected from observations, surveys, experiments, questionnaires and interviews (Ajayi 2017: 02-03). Secondary data is previously collected data concerning a certain topic or area of interest, accessed by reviewing secondary sources (Johnston 2014: 620).

The data for this study were collected through a review of literature and the administration of a questionnaire. Primary data were collected using a self-completion questionnaire,

with secondary data collected from research papers, books, journal articles, and reports, as well as websites, government publications, and legislation, along with government policies.

4.4.1 Research instrument

The means by which information is collected for a study, which includes questionnaires, is highlighted by Kumar (2011: 24) as the research tool or instrument. According to Wagner *et al.* (2012: 22), a survey can be used to collect information from large groups of people within a short space of time by using questionnaires or interviews. In addition, Ghauri and Grønhaug (2002: 94) describe a questionnaire as an operational tool aimed at collecting the opinions and attitudes of participants and is a popular method to collect data in a business environment. The purpose of a questionnaire in a study is to extract information from the sample (Anwana 2018: 126).

4.4.2 Questionnaire Design

Since a questionnaire is a list of questions, to which the respondents record their answers (Kumar 2011: 145), its development is a vital stage of the research process, because the quality of the data collected depends on the quality of the questionnaire (Msosa 2015: 58). Therefore, the questions need to be designed in a manner that provides answers to the study objectives (Meadows 2003: 563). A questionnaire is a popular way of collecting data; it is an effective tool to investigate participant views (Ghauri and Grønhaug 2002: 94). The questionnaire was drafted by the researcher, structured according to the study aim and objectives, and informed by the literature reviewed.

Structured questions are standardised with a fixed scheme and predetermined questions, whereas respondents select answers from a list of options and all participants are provided with identical questions (Foxcroft and Roodt 2006: 154; Kothari 2004: 101). The questionnaire consists of both open- and closed-ended questions. Closed-ended questions are questions whereby the possible answers are set out in the questionnaire or schedule and the respondent selects the category that best describes their answer (Kumar 2011: 151). The open-ended questions of the study are aimed at investigating

challenges faced by patients as consumers of the healthcare sector service delivery and their overall views relating to consumer protection as a way to address the challenges they encounter. An attempt was, nonetheless, made in drafting the questionnaire used in this study to categorise patient challenges, in order to facilitate completing the questionnaire and analyses of collected data.

The research instrument comprised of 23 items, each of which were measured on a nominal or ordinal scale. The questionnaire used to collect data for the study was divided into five sections that measured various themes as illustrated in Table 4.1 below. The style of questions consisted of eight tick-box questions, twelve Likert scale type questions and five open-ended questions.

Table 4.1: Themes in the questionnaire

A	Demographic profile
B	Characterisation as a user of healthcare services
C	Awareness and understanding of patient rights contained in the NHA
D	Awareness and understanding of the fundamental rights contained in the CPA
E	Challenges experienced by patients in accessing healthcare services

4.4.3 Questionnaire administration

According to Bryman (2012 232), the self-administered questionnaire requires respondents to answer questions by completing the questionnaire themselves. In this study, the questionnaire used was self-administered, using both hard and electronic copies. Questionnaires were distributed with a request to be returned after completion and contained basic instructions on how to be completed. The rationale for using both hard and electronic copies is twofold, first expediency, as the use of electronic copies can save time and is cost-effective (Nayak and Narayan 2019: 36). Second, hard copies were used to not exclude those members of the population who do not have internet access. The disadvantage of electronic copies is that some applicants without internet access may not be reached (Njanjobea 2016: 21). Participants without internet access were invited using a direct door-to-door approach.

Harlow (2010: 97) asserts it can be challenging to administer a paper-based survey to a large population. Even when using a small sample, paper surveys tend to be costly, such as costs incurred through printing and data entry (Wright 2005: 10). It is possible certain members of the population do not have access to the internet, making it problematic for them to respond (Howard 2021: para. 14 line 1-2). Therefore, participants without internet access were provided with a hard copy questionnaire. The electronic copies were set using Google forms, with links shared via emails and/or telephonic communication to participants. The advantage of online recruitment is to the ability to reach a wide variety of applicants and it is inexpensive, while also the quickest method to recruit (Njanjobea 2016: 21).

The questionnaire was not administered within any specific healthcare facility. As research was not conducted within a particular healthcare organisation, a gatekeeper's letter was not necessary. The focus of this study is on consumers of any public healthcare services, who reside in the Shembes Village of Inanda, district of eThekwini, and not limited to a particular facility. The response rate was 100 percent, with all 375 administered questionnaires returned upon completion.

4.4.4 Pre-test

According to Ornstein (2013: 100), the survey pre-test is a procedure that can be used to identify problematic questions in a survey and correct the defective questions before the questionnaire is distributed to respondents in a study. Christensen, Johnson and Turner (2014: 192) note a pre-test helps to ensure respondents understand the questions, identifies ambiguities that may exist in questions, and assists in ensuring instrument reliability. Pre-testing is explained by Patel (2019b: 08-09) as a preliminary test, used on a small sample of population, to expose any weaknesses respondents may encounter, while it also identifies inappropriate terms in the questions, as it may demonstrate some questions are unintelligible to respondents. As a method of checking questions work as intended and are well-understood, pre-testing has the capacity to reduce sampling error (Hilton 2015: 01).

Pre-testing the questionnaire on a few respondents allows any unsuspected anomalies and difficulties in the questions to be discovered and rectified (Igwenagu 2016: 44). In this regard, Patel (2019a: 03) recommends reviewing the research instrument to minimise survey validity and measurement errors. Furthermore, pre-testing is helpful, because no person writes perfectly (Chaudhary and Israel 2014: 01). A pre-test should be undertaken under similar field conditions on a group of people similar to the study population (Kumar 2011: 158).

A pre-test was administered to 10 consumers of public healthcare services in Shembes Village in Inanada Township. The purpose was to test the validity and reliability of the instrument and ensure all questions were easily understood and relevant to the study. The consumers of public healthcare services selected for the pre-test were not used for the main study and were recruited using the snowball recruitment method, as suggested by Cawthra *et al.* (2017: 88). Following the pre-test, the researcher re-examined the wording used in the questionnaire and reworded questions that appeared to have ambiguity.

4.5 Data analysis

The quantitative data collected in this study was analysed using computer software known as the Statistical Package for Social Sciences (SPSS), version 27.0. As Bryman and Bell (2011: 354) state, SPSS is a popular computer software package used in analysing quantitative data for social science studies. Data from the open-ended questions were analysed by the researcher by means of content analysis, which is used to identify or examine patterns of recorded communications; it provides an analysis of what is being said, written or recorded (Parveen and Showkat 2017: 03). Content analysis was used in this research in order to identify and gain insight into the challenges patients experience as consumers of healthcare services.

Both descriptive and inferential statistics were used to analyse the data. Descriptive research helps provide answers to research questions (Kabir 2016: 124). Hence, in descriptive statistics, the findings of the collected data are described (Govender 2017:

99). In this study, the form of percentages using tables and graphical presentation in descriptive statistics was used to present the analysis of data. The benefit of descriptive statistics is it rationalises and simplifies large amounts of information into an uncomplicated summary, using two basic approaches, namely numerical and graphical (Sharma 2019: 03; Tlapana 2017: 130).

Inferential statistics allow the researcher to make a general statement regarding the entire population, based on the sample, by applying various statistical tests Cawthra et al. (2017: 187). This study used statistical tests to provide credence to the study. SPSS computer software, version 27.0 was employed to analyse the data using factor analysis, correlation analysis and Pearson's Chi-square statistical test.

4.6 Validity and reliability

Bryman (2012: 45) notes the quality of research is tested using the concepts of validity and reliability.

4.6.1 Validity

According to Leedy and Ormrod (2005: 210), validity is the extent to which the instrument measures what it is supposed to measure, it is the extent to which the clarification of the results of an examination are warranted. In this study, factor analysis was used to assess validity.

Factor analysis, as stated by Mulaik (2009: 433), is used when the researcher formulates and tests a hypothesis regarding how a set of theoretical variables contains the cause of the observed variables. Gorsuch (2015: 4) explains factor analysis is used to search data for qualitative and quantitative purposes and is useful when the volume of data is large. In this study, factor analysis was used to measure construct validity. As discussed above, factor analysis is a statistical technique used to establish whether the different variables do, in fact, measure the same thing (Wagner *et al.* 2012: 268). Validity was measured by conducting a pre-test of the questionnaire to assess whether respondents understood the questions and to identify and amend any possible ambiguities in questions.

4.6.2 Reliability

Gounder (2013: 03) points out reliability refers to the quality of a measurement procedure that ensures repeatability and accuracy. Sekaran and Bougie (2013: 228) maintain the reliability measure shows the degree to which the instrument is without bias and error free, consequently, reliability deals with whether the study results are repeatable or replicable. Reliability is achieved when different attempts at measuring the same subjects achieve the same result (Govender 2017: 102). According to Arizon (2010: 29), the finding is reliable when anyone repeats or obtains the same, similar or identical outcomes.

Reliability is the degree to which a questionnaire, test, observation, or any measurement procedure delivers the same or matching results on repeated trials (Ruland, Bakken and Røislien 2007: 04). In this study, reliability was measured using the Cronbach's Alpha test to measure internal consistency, as suggested by Bryman (2012: 120). In quantitative research, internal reliability is ensured using the Cronbach's alpha test, which is a test used to determine how closely related a set of items are as a group (Sileyew 2019: 35). The Cronbach's alpha test was used to ensure reliability of this quantitative study, which was also measured by conducting a pre-test.

4.7 Ethical considerations

It is important to consider ethics during research, in order to ensure adherence to ethical standards and values (Hussain and Rehman 2012: 29). This means it is important to ensure ethical regulations and codes of conduct guide researchers in their dealings with participants (Daniel 2016: 98). Ethical considerations assist the researcher in avoiding potential harm or other problematic issues while conducting research (Hussain and Rehman 2012: 29). According to Daniel (2016: 98), ethical research deals with integrity, where in research, it depends how the researcher designs their research.

Ethical issues to be considered in research include ensuring respondent participation is voluntary (Edmonds and Kennedy 2017: 171), participant information is kept confidential (Wiles *et al.* 2008: 417), and they understand they are free to withdraw from the study should they wish to do so (Gordon and Prohaska 2006: 286). Furthermore, participants

need to be protected from any personal harm while participating in a study (Sim and Waterfield 2019: 3011).

To reduce risks for participants, researchers must ensure research is conducted in an environment that encourages participants to discuss sensitive issues and ensures protection from any personal harm (Sim and Waterfield 2019: 3011). Participation in this study was voluntary and free from coercion. Participants were reminded of their right to withdraw from the study should they wish to and participants were not at risk of any harm.

Since confidentiality is closely allied with anonymity, it means anonymity is a way wherein confidentiality is operationalised (Wiles *et al*. 2008: 417). Anonymity is referred to as keeping a secret, such as protecting respondents by refraining from referring to them by name (Akaranga and Makau 2016: 06). According to Kumar (2011: 246), confidentiality is maintained by ensuring information provided by respondents is kept anonymous.

Confidentiality was maintained throughout this study by ensuring the information provided by respondents was kept anonymous. Respondents were not identified, and any information shared was and will be kept confidential. The completed questionnaires were collected by the researcher and will be stored and ultimately disposed of in a manner that will ensure confidentiality. Maintaining confidentiality was and will be ensured with all information, answers and opinions provided in this study treated as private and in strict confidence to ensure respondent anonymity. All questionnaires answered will be stored as follows: Hard copies will be held in a secured and locked steel cabinet under control of the researcher and destroyed by shredding after five years. Soft copies will be saved with a secure password on a flash drive, with files deleted after five years. The information provided will be used for research purposes only, in addition to which. The collected data will be accessible only to the researcher, statistician and supervisor of this study.

Furthermore, all the processes involved in this study were accomplished in accordance with the research plan, as required by the Institutional Research Ethics Committee of the

Durban University of Technology. The researcher followed and adhered to all the ethics requirements of the academic institution.

4.7.1 Informed Consent

Informed Consent is a process that provides adequate details to the participant with regard to the study, in a language understood by the participant, in order for the participant to voluntarily confirm their willingness to take part in the research study (Spicker 2011: 133; Nijhawan *et al.* 2013: 134). Maree (2019: 48) suggests issues such as the research aim, anonymity, confidentiality and the right to withdraw from the study, should be explained to participants in a language they understand.

To ensure all participants understood the study objectives, a copy of the letter of information was provided to all participants. The information letter and consent form were provided in both English and isiZulu, since isiZulu is the primary spoken language of the majority of the research population. Participants were provided the opportunity to accept or decline participating in the study. The information provided through the consent form or consent letter will only be used for its intended purpose.

4.8 Conclusion

This chapter described the research methodology adopted in this study. Key aspects were examined such as the research design and method; population and sample size; data collection and analysis; as well as validity and reliability, and ethical considerations. The next chapter presents the results and discusses the findings based on the primary data collected using the questionnaire.

CHAPTER FIVE

ANALYSIS OF RESULTS AND DISCUSSION OF THE FINDINGS

5.1 Introduction

The research methodology and research tools used in this study were outlined in the previous chapter. This chapter presents the results and discusses the findings based on the primary data collected using the questionnaire. The questionnaire was the main data collection tool and was distributed to 375 respondents, characterised as patients who are consumers of public healthcare services, and who reside in Shembes Village in the Inanda district of eThekwini municipality, KZN, SA. The aim of the survey was to investigate the challenges faced by patients as consumers of healthcare services delivered in the public healthcare sector and the role of the CPA in addressing these challenges.

SPSS version 27.0 was used to analyse the data obtained from the responses. The analysis will result in the presentation of descriptive statistics in the form of graphs, cross tabulations, and other figures for the quantitative data gathered. Descriptive statistics refer to statistical methods used to “organise and summarise data in a meaningful way” (Maree 2019: 226).

Statistical inference is important according to Maree (2019: 242), as it uses the findings from the data collected from the sample to generalise or draw conclusions concerning the population. Inference techniques include the use of correlations and Chi-square test values interpreted based on p-values. The traditional strategy to reporting results involves declaring a statement of statistical significance, where a p-value is generated from a test statistic. A significant result is indicated by "$p < 0.05$".

5.2 The Sample

In total, 375 questionnaires were distributed to patients as consumers of public healthcare services in Shembes Village in the Inanda district of eThekwini. The sample size in this

study was based on the guidelines of Sekaran and Bougie (2013: 268), who propose a sample of 375 is sufficient for a population of between 10 000 and 15 000, to draw inferences from. All 375 responses were returned, thus achieving a response rate of 100 percent.

5.3 The Research Instrument

The research instrument comprised of 23 items, each of which were measured on a nominal or ordinal scale.The questionnaire used to collect data for the study was divided into five sections that measured various themes, as illustrated in Table 5.1 below.

Table 5.1: Themes in the questionnaire

A	Demographic profile
B	Characterisation as a user of healthcare services
C	Awareness and understanding of patient rights contained in the NHA
D	Awareness and understanding of the fundamental rights contained in the CPA
E	Challenges experienced by patients in accessing healthcare services

5.4 Section A: Analysis of demographic profile

This section summarises the demographic profile of the respondents. The profile or characteristics include age, the highest educational qualification obtained, type of public healthcare facility regularly accessed, and the reason for accessing healthcare services at that healthcare facility.

5.4.1 Age

Figure 5.1 below describes the overall age distribution of the respondents.

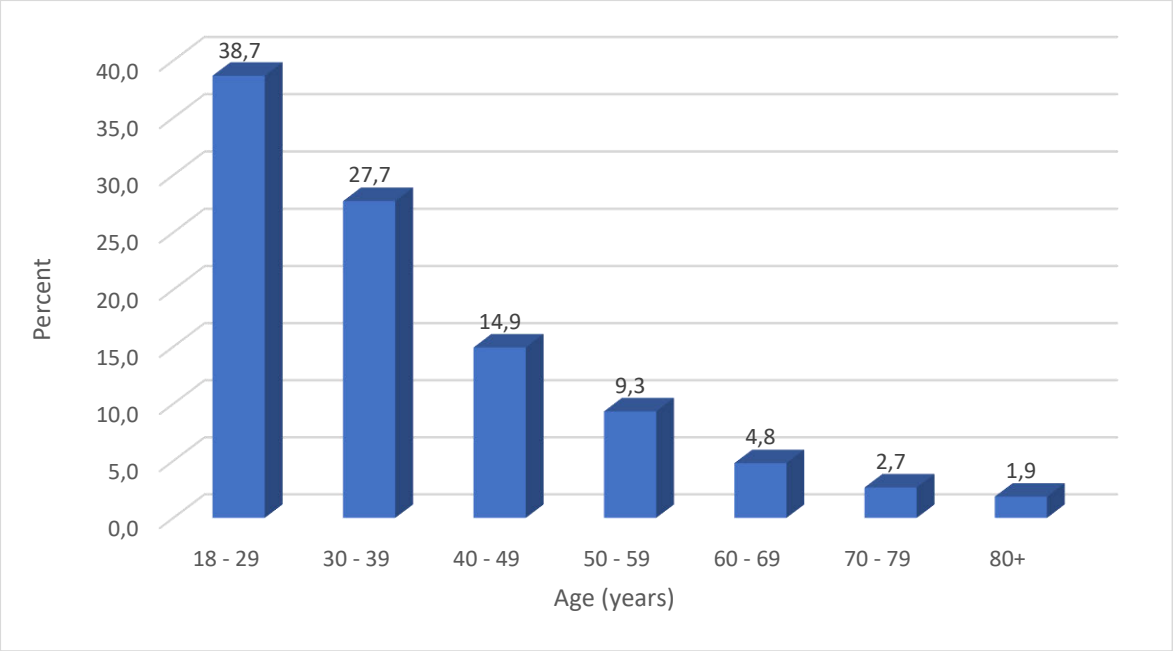

Figure 5.1: Age

As shown in Figure 5.1, the composition in respect of age was categorised into seven groups, namely 18-29 years, 30-39 years, 40-49 years, and 50-59 years, as well as 60-69 years, 70-79 years, and 80 years and over. Figure 5.1 reveals the majority of respondents (38,7 percent) were in the age category 18-29 years, followed by 27,7 percent of respondents in the 30-39 years age category. A mere 14,9 percent of respondents were in the 40–49 years age category, with the age group 50-59 years accounting for 9,3 percent of respondents, while 4,8 percent of the respondents were in the 60-69year category and only 2.7% of respondents were between the ages 70-79 years old. The remaining respondents (1.9 percent) were over the age of 80 years old.

Figure 5.1 revealed dissimilar the age distributions, as there are significantly more respondents younger than 40 years ($p < 0.001$). This analysis reveals 66,4 percent of respondents were under the age of 40 years. According to the results of the 2011 Census (StatsSA2011), 73,3 percent of the population that resides in Inanda are younger than 40 years of age. The study findings appear to mirror the age characteristics of the population of Inanda.

5.4.2 Educational Qualification

Figure 5.2 below indicates the education levels of the respondents.

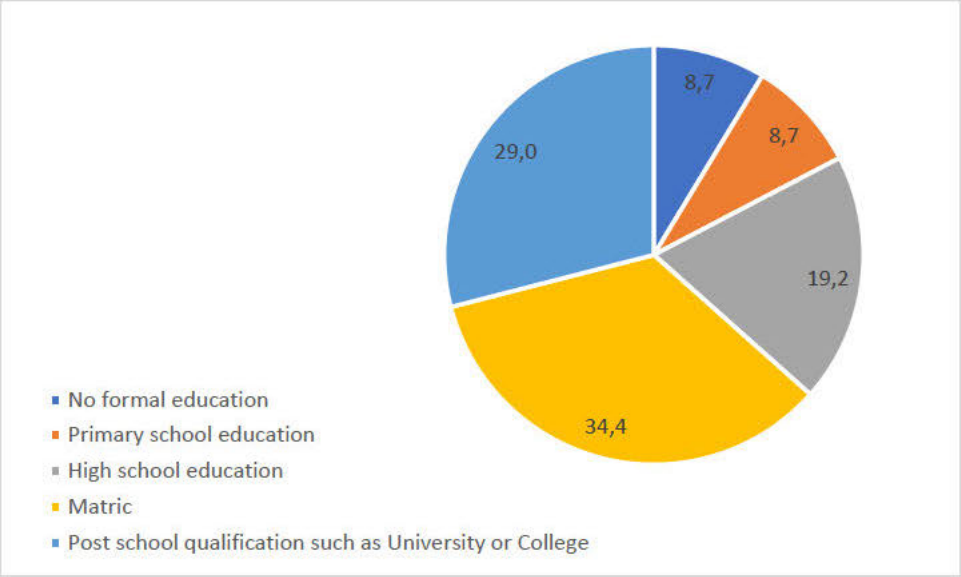

Figure 5.2: Educational qualification

As shown in Figure 5.2, respondents were categorised into five groups, in terms of their educational qualifications, namely: no formal education, primary school education, high school education, and matric, as well as post-school qualifications, such as University or College. Figure 5.2 indicates 8,7 percent of the respondents have no formal education and similarly, 8,7 percent of the respondents have a primary school education, while 19,2 percent of respondents were educated to high school level, 34,4 percent have a matric and 29 percent have a post-matric qualification.

The results in Figure 5.2 reveal 63,4 percent of respondents have a high educational qualification, such as a matric or post-matric qualification. These findings indicate the responses gathered would have been from an informed or learned source; as such, the respondents may have the capacity for increased awareness and understanding of both patient and consumer rights.

The importance of information accessibility was discussed in paragraph 2.2.2 of this study that reviewed the four guiding principles to be considered in ensuring the right to health, including the principle of accessibility (CESCR 2000: GC 14: para 12). Information accessibility is an important aspect of accessibility and focuses on the right of individuals to receive information with regard to health issues (CESCR 2000: GC 14: para 12(b)). The aim of the CPA, as set out in Section 3(1)(e), to improve "consumer awareness and information" and encourage "responsible and informed consumer choice and behaviour", aligns with this element. Furthermore, the right to disclosure and information is recognised as a fundamental consumer right (Part D) and was discussed in paragraph 3.4.2.

5.4.3 Types of public healthcare facilities regularly accessed

Figure 5.3 below indicates the types of public healthcare facility or facilities respondents visited regularly to access healthcare services.

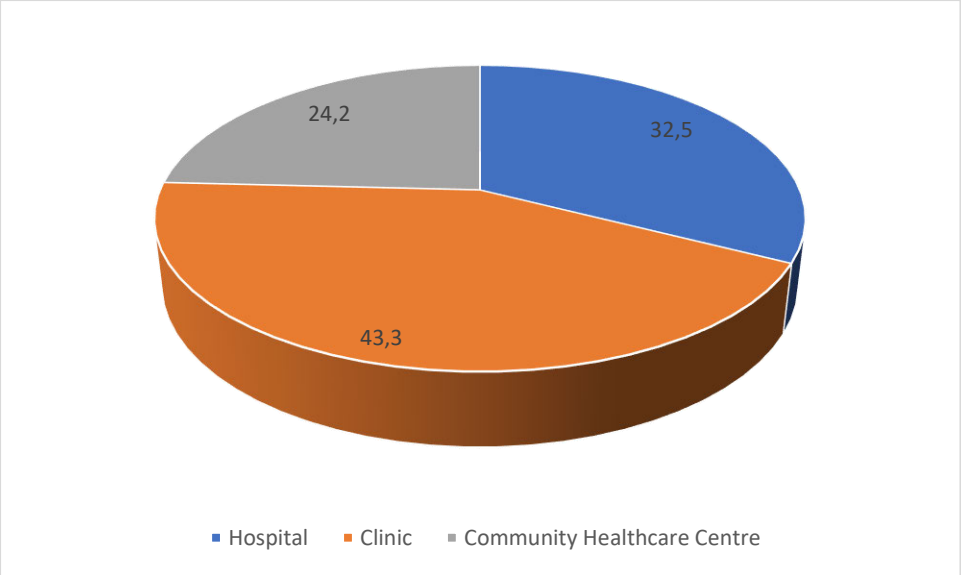

Figure 5.3: Types of public healthcare facilities regularly accessed

As shown in Figure 5.3, public healthcare facilities accessed by respondents were characterised as hospitals, clinics and community healthcare centres. Figure 5.3 reveals that 43,3 percent of respondents regularly accessed healthcare services in clinics,

followed by 32,5 percent of respondents that visited hospitals, and 24,2 percent of respondents accessed healthcare services in community healthcare centres.

This analysis reveals significantly more respondents used clinics and hospitals than community healthcare centres ($p < 0.001$). The reason for this result may be because the majority of respondents indicated they accessed the healthcare facility closest to their home, as illustrated in Figure 5.4 below, which may have been a hospital or clinic, rather than a community healthcare centre.

As discussed in paragraph 2.2.2, both O'Donnell (2007: 2821) and Moyo (2016: 09) identify accessing healthcare services in SA as a challenge for patients. Despite some progress, access barriers for patients remain, including a lack of transport to access healthcare, which is problematic for individuals living in poverty (SA National Department of health 2017: 02). Access barriers include vast travel distances and high travel costs (Harris *et al.* 2011: 103).

5.4.4 Reason for accessing healthcare services at this facility

Figure 5.4 below indicates the reasons respondents accessed healthcare services at the respective facilities.

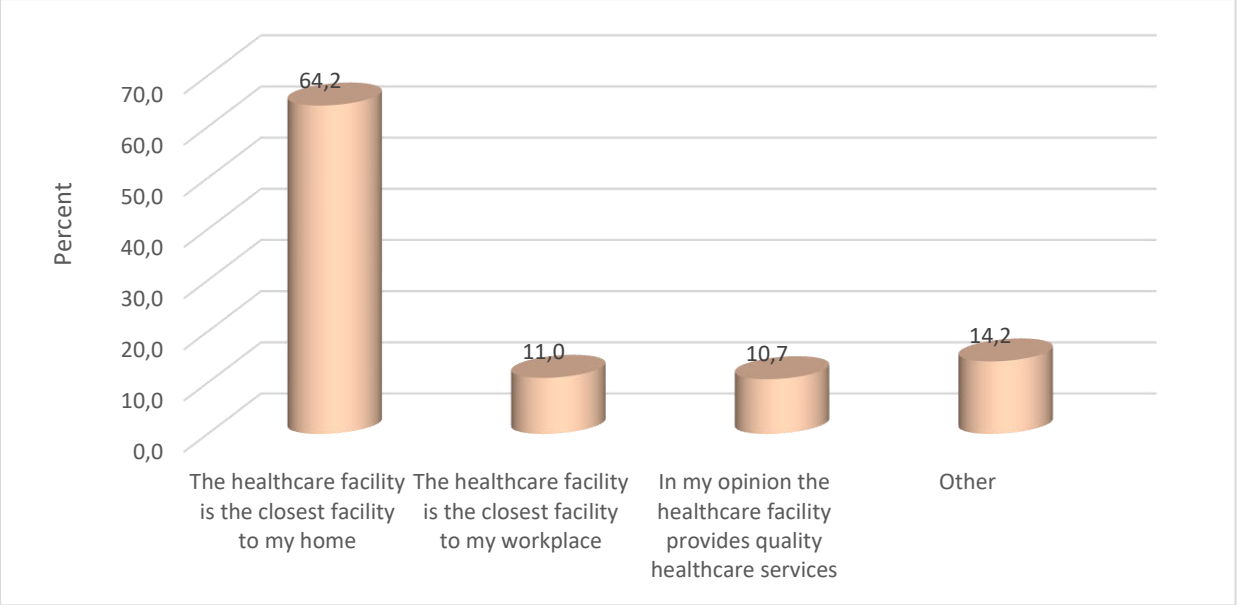

Figure 5.4: Reason for accessing healthcare services at this facility

As shown in Figure 5.4, the reasons respondents could choose for accessing a particular healthcare facility were, the healthcare facility is closest to my home or closest to my place of work, in my opinion, the healthcare facility provides quality healthcare services, and other reasons. Results indicate approximately two-thirds of the respondents (64,2 percent) chose the facility because it was closest to their homes ($p<0.001$). The other three options had similar levels of response with 11,9 percent of respondents indicating they attended the chosen facility because it was closer to their workplace, 10,7 percent of respondents accessed the facility because it provides quality service, and 14,2 percent of respondents had other, unspecified reasons.

This analysis reveals a higher percentage of respondents accessed healthcare services in the facility closest to their home. As stated in Chapter Four of this study, the geographic area where the researcher distributed the questionnaire was chosen for the study because it is in a disadvantaged area, where most patient's access healthcare services in the public sector and depend on the closest facility. As discussed in paragraph 2.2.2 of this study, the CESCR (2000: GC 14: para 12) states the second element of accessibility in ensuring the right to health is physical accessibility. This requires healthcare services to be within a safe physical distance for everyone, particularly vulnerable and marginalised groups (CESCR 2000: GC 14: para 12(b)).

5.5 Descriptive analysis

According to Cawthra *et al.* (2017: 187), descriptive statistics allow the researcher to describe the data by organising and summarising it. A descriptive analysis of the data allows the data to be presented using graphs and tables. This section explores the respondents' score patterns for each variable and each section. The responses are presented using summarized percentages for the variables that comprise each section, and followed by additional analysis based on the statements' significance.

5.5.1 Section B: How respondents characterise or describe themselves when accessing healthcare services

The CPA applies to the delivery of healthcare services and as a result, from a legal perspective, patients are now considered consumers (Jacobs, Stoop and Van Niekerk 2010: 313). This section was designed to establish how respondents characterise themselves when they access healthcare services and the reason behind such characterisation. Responses were elicited from two perspectives in the section, first, how respondents currently describe or characterise themselves and second, how they would prefer to be treated or characterised when accessing healthcare services. Two open-ended questions were included to provide respondents with an opportunity to provide an explanation for their responses, should they wish to do so.

5.5.1.1 The manner in which respondents currently characterise or describe themselves

Figure 5.5 below indicates how respondents currently describe or characterise themselves when accessing healthcare services.

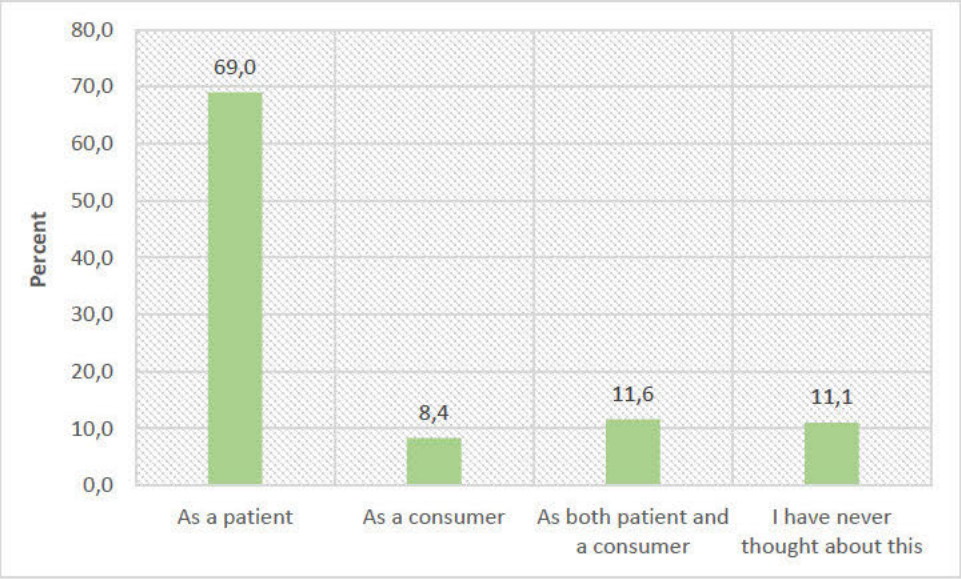

Figure 5.5: The manner in which respondents currently characterise or describe themselves

The options provided to respondents as to how they currently describe or characterise themselves (Figure 5.5) were, as a patient, consumer, both patient and consumer, or they had never considered how to describe or characterise themselves. The results indicate more than two-thirds of respondents (69 percent) currently describe or characterise themselves as patients ($p < 0.001$) when they access healthcare services. By comparison, only 8,4 percent of respondents characterised themselves as consumers. The remaining options had similar results, with 11,6 percent of respondents currently characterising themselves as both a patient and a consumer and 11,1 percent of respondents stated they have never thought about how to characterise themselves when accessing healthcare services.

This analysis reveals a significant number of respondents currently describe or characterise themselves as patients. Rowe and Moodley (2013: 16) assert there are significant implications in labelling patients as consumers of healthcare services. The authors believe the labels used to describe and classify individuals often shape their identity and influence their behaviour. They state a person describing himself or herself as a patient may behave differently and have different expectations from those individuals who identify as consumers. Herxheimer and Goodare (1999: 3) agree the labels used to describe individuals are not neutral and exert an influence over the manner in which they view themselves and interact with one another.

5.5.1.1.1 Analysis of open-ended Question 5.5

This open-ended question (5.5) was included in the questionnaire to provide respondents with an opportunity to offer an explanation for their responses, should they wish to do so. The data are presented and analysed according to the choices provided in the closed-ended questions, as a patient, as a consumer, as both a patient and consumer, and I have never thought about this. The sub- themes are presented and discussed below.

Reasons for the manner in which respondents currently characterise or describe themselves:

As a patient

The data analysis of respondents who characterised themselves as a patient resulted in the following sub-themes:

Payment for healthcare services

- Healthcare facilities are not a business sector;
- There is poor service in the public sector, and citizens who receive poor service cannot be consumers;
- Free service/no medical aid;
- I only attend for medical reasons not sales agreements; and
- Waiting for long periods of time before being attended to, as contrast to private facilities where service is paid for.

This is how they are labelled

- I consider myself as a patient; and
- That is how we are addressed and referred to by our medical practitioners.

The quality of healthcare services received

- At a public healthcare facility, there is a shortage of resources, poor treatment, and very little opportunity to raise questions; and
- Good Service.

Of the respondents, 44, 8 percent provided an explanation as to why they identified themselves as patients. The results indicate the majority of respondents describe themselves as patients because they do not pay for healthcare services and do not consider healthcare a business. The results also indicate respondents describe themselves as patients because this is how they label themselves or are labelled by healthcare practitioners. Finally, some respondents describe themselves as patients and link this characterisation to the quality of healthcare services they receive.

The results indicate a perception among respondents that when they do not pay for healthcare services, they are not consumers. These findings will be discussed further below.

As a consumer

The analysis of respondent data of those who characterised themselves as consumers resulted in the following sub-themes:

Payment made for the healthcare services received

- I pay for my healthcare service; and
- I use my medical aid.

The quality of healthcare services received

- Excellent service provided

An explanation was provided by 5,3 percent of respondents why they identified themselves as consumers. The results indicate the majority of respondents characterised themselves as consumers because they paid for the healthcare services they received. The results further indicate some respondents characterised themselves as consumers because they believe they received good quality services since they are consumers.

A similar trend appeared among these responses, where a perception exists among respondents that when they pay for healthcare services, they are consumers and as such, can expect better quality service. These findings will be discussed further below.

As both a patient and a consumer

The data analysis of respondents who characterised themselves as both a patient and a consumer resulted in the following sub-themes:

Payment made for the healthcare services received

- I pay for my healthcare service;

- I access healthcare as a patient to seek medical attention and also as a consumer because I pay for the service provided; and
- It is a consumer services industry.

The quality of healthcare services received

- Good service provided.

An explanation was provided by 8, 8 percent of respondents why they characterise themselves as both a patient and a consumer. The results indicate the majority of respondents characterised themselves as both a patient and consumer because they paid for the healthcare services they received. The results indicate some respondents describe themselves in this manner and link this characterisation to the quality of healthcare services they receive.

The results presented above suggest a link between the manner in which those who use healthcare services currently describe themselves and whether payment is made for healthcare services received.

The finding that payment for healthcare services is linked both to the manner in which respondents characterise themselves and the quality of services they receive is interesting, in light of the fact a large proportion of patients access healthcare services in the public sector for free, based on the Uniform Patient Fee Schedule (SA Department of Health 2017: 17) and subject to the means tests (Competition Commission 2019: 44). The findings suggest it is a misnomer that they are not consumers because they do not pay directly for healthcare services and as a result, receive poor quality service delivery. The public healthcare sector is funded by the taxpayer (NPC 2012: 339; Competition Commission 2019: 44) and falls within the ambit of the definition of consideration in the CPA.

5.5.1.2 The manner in which respondents would like to be treated by healthcare providers

Figure 5.6 indicates how respondents would like to be treated by healthcare providers at the healthcare facility.

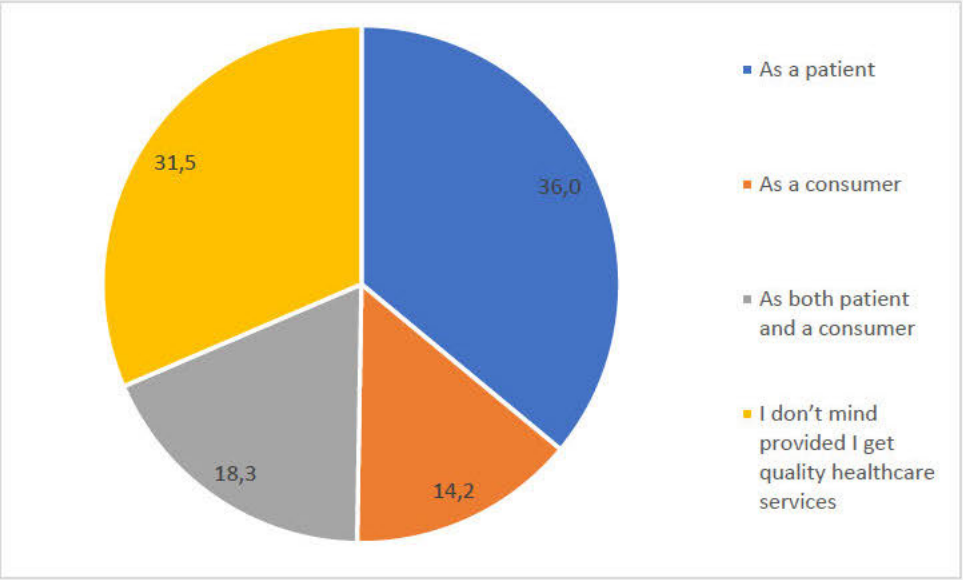

Figure 5.6: The manner in which respondents would like to be treated by healthcare providers

Figure 5.6 above used the same options as Figure 5.5, namely, as a patient, consumer, both a patient and a consumer, and I do not mind, provided I receive quality healthcare services. The results in Figure 5.6 revealed 36,5 percent of respondents indicated they would prefer to be treated or characterised as patients, while 14,2 percent of respondents indicated they would like to be treated as consumers. Further to this, 18,3 % percent of respondents indicated they would prefer to be treated as both a patient and a consumer, while 31,5 percent of respondents are not concerned with how they are characterised, provided they receive quality healthcare services.

The analysis indicates the majority of respondents, when asked how they would prefer to be described or characterised, still preferred to be described as a patient. These findings are substantiated by Deber *et al.* (2005: 350), who believe patients dislike many of the

descriptive terms or labels used in place of “patient”. The authors add patients value the intimate relationship they share with healthcare providers.

A significant number of respondents indicated they were more concerned with the quality of healthcare services delivered, than the labels used to describe them. This focus on quality is aligned with the idea that, without good health, individuals are unable to enjoy other basic human rights (WHO 2017: 01).

5.5.1.2.1 Analysis of open-ended Question 6.5

Questions 6.5 is an open-ended question included in the questionnaire to provide respondents with an opportunity to offer an explanation for their responses, should they wish to do so. This section presents the findings of the open-ended question in which respondents gave reasons for how they would like to be treated by healthcare providers when accessing healthcare services. The data are presented and analysed according to the choices provided in the closed-ended questions, namely as a patient, as a consumer, as both a patient and consumer, and I have never thought about this. The sub-themes are presented and discussed below.

Respondents who would like to be treated by healthcare providers:

As a patient

The analysis of respondent data of those who would like to be treated as a patient resulted in the following sub-themes:

- Attending for medical reasons;
- Cannot afford to be a consumer;
- For good quality service; and
- Payment for health care services can mislead patients for the sake of financial gain or profit.

An explanation was provided by 15,7 percent of respondents as to why they would like to be treated as a patient by healthcare providers. The results indicate the majority of these

respondents associated not paying for services or negative connotations of consumerism with preferring to be treated as a patient. The results also indicate respondents would prefer to be described as patients, because they are receiving medical care or treatment and some respondents link this characterisation to the quality of healthcare services they receive.

The analysis suggests the majority of respondents would prefer to be described as patients, because they are receiving medical care or treatment. As discussed above, these findings are substantiated by Deber *et al.* (2005: 350), who believe patients dislike many of the terms or labels used in place of “patient” to describe them.

These results also suggest a link exists between the manner those who use healthcare services currently describe themselves, and whether payment is made for healthcare services received.

As a consumer

The analysis of data for respondents who would like to be treated as a consumer resulted in the following sub-themes:

- Payment for my services;
- Timeous service; and
- Better quality service.

Of the respondents, 9,6 percent offered an explanation why they would like to be treated as a consumer. The results indicate the majority of respondents would like to be treated as consumers, because they believe they will receive better quality service. The results also indicate respondents would prefer to be treated as consumers, since they pay for the healthcare services they receive. The results further indicate respondents would like to be treated as consumers because they associated this characterisation with greater autonomy or choice in the healthcare treatment they receive.

These results also suggest there is a link between the manner in which those who use healthcare services currently describe themselves and whether payment is made for healthcare services received or not.

As both a patient and a consumer

The data analysis of respondents who would like to be treated as both a patient and a consumer resulted in the following sub-themes:

- Management is more efficient and effective;
- Patients who pay are given preferential treatment; and
- Regardless of whether the service is paid for or provided for free, quality and good service should be maintained.

An explanation was provided by 8,8 percent of respondents regarding why they would prefer to be treated as both a patient and a consumer. The results indicate respondents would like to be treated as both a patient and consumer because they link this characterisation to the delivery of better quality healthcare services.

I do not mind, provided I receive quality healthcare service

The analysis of respondent data, for those who indicated they do not mind how they are characterised provided they receive quality healthcare services, resulted in the following sub-themes:

- Quality is the most important factor; and
- Fair treatment is more important than the label.

Responses were provided by 12,5 percent of respondents concerning the choice that they did not mind how they were characterised, provided they receive quality healthcare services.

Comparative analysis of the findings regarding the manner in which respondents currently characterise or describe themselves and how they would like to be treated when accessing healthcare services

The findings of this section indicate:

- The majority of respondents currently describe themselves as patients and when given a choice, would still choose to be treated as patients;
- A significant number of respondents indicated they are more worried about the quality of healthcare services delivered, than the labels used to describe them;
- Whether respondents characterised themselves as patients or consumers, the reasons are linked to payment for services; and
- Payment for services is linked to better quality services.

These findings align with Le Roux-Kemp (2010: 230-231), who argues that, in spite of the numerous concerns with regard to the negative impact consumerism has on how healthcare services are delivered, there is acknowledgement that characterising patients as consumers may result in positive change in the healthcare market, since patients may begin to play an active role in demanding improvement in the quality of the received healthcare services. Barapatre and Joglekar (2016: 155) agree extending consumer rights to patients accessing healthcare services will be beneficial in assisting patients to achieve the benefits of good health.

Churchill (2007: 411) disagrees and believes identifying patients as consumers and healthcare as a commodity will weaken the ethical foundation underpinning healthcare service delivery, with negative consequences for the healthcare provider, the patient, society as a whole, and the aim of improving health outcomes and equity in health. Goldstein and Bowers (2015: 163) express concern that the commodification of the healthcare market will not result in empowered patients who demand better quality services.

The finding that payment for healthcare services is linked to both to the manner in which respondents characterise themselves and the quality of services they receive is challenging, as respondents appear to believe they are not consumers, because they do not pay for healthcare services directly. However, according to Von Staden (2021: 57), all patients who access healthcare services via the public sector, whether they pay directly or indirectly via taxation for these services, would still be protected in terms of the CPA.

5.5.2 Section C: Awareness and understanding of patient rights contained in the NHA

The NHA provides users with a number of rights, including the right to participate in decision-making, the right to informed consent, and the right to confidentiality. This section was designed to establish the level of respondent awareness and understanding of the patient rights contained in the NHA. The NPRC (SA Department of health 1999) acknowledges the importance of providing information for patients in understanding and enforcing their rights and therefore, requires all users of the healthcare system must be informed of their rights. According to Hassim, Heywood and Berger (2007: 247), public healthcare facilities are required to display the NPRC (SA Department of Heaalth 2009) in local language in order to assist in creating awareness of both patient rights and the level and quality of healthcare services patients can expect at public healthcare facilities.

The score patterns for each of the respective questions are summarised in the tables and graphs that follow. Table 5.2 summarises the scoring patterns.

Table 5.2: Awareness and understanding of patient rights contained in the NHA

		I am aware of and understand this right		I am aware of but do not understand this right		I have never heard of this right		I am aware of this right but it has been infringed		Chi-Square p-value
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	
According to Section 6, a user has the right to have his/her health status explained	C7.1	286	77.5%	31	8.4%	37	10.0%	15	4.1%	< 0.001
According to Section 6, a user has the right to have the range of available treatments explained	C7.2	252	68.3%	52	14.1%	38	10.3%	27	7.3%	< 0.001
According to Section 6, a user has the right to have the benefits, risks, costs and consequences of each suitable treatment explained	C7.3	202	54.9%	61	16.6%	56	15.2%	49	13.3%	< 0.001
According to Section 7, a user has the right to provide informed consent for the treatment they receive	C7.4	215	58.4%	65	17.7%	51	13.9%	37	10.1%	< 0.001
According to Section 8, a user has the right to participate in decisions about their health and treatment	C7.5	226	61.2%	60	16.3%	54	14.6%	29	7.9%	< 0.001
According to Section 14, a user has the right to have the information about his/her health status and treatment kept confidential	C7.6	266	73.1%	46	12.6%	34	9.3%	18	4.9%	< 0.001

A Chi-square goodness-of-fit test was conducted to determine whether the score patterns per statement were considerably different per option. The null hypothesis claims similar numbers of respondents scored across each option for each statement (one statement at a time). The alternate declares a significant difference amongst the levels of awareness and infringement. The results are shown in Table 5.2 above. When results (p-values) are less than 0.05, considered the level of significance, it indicates dissimilar distributions. This means the differences between the way respondents scored were significant, indicating a significant difference between levels of awareness and infringement of patient rights contained in the NHA.

Figure 5.7 below shows the scoring pattern for awareness and understanding of patient rights contained in the NHA.

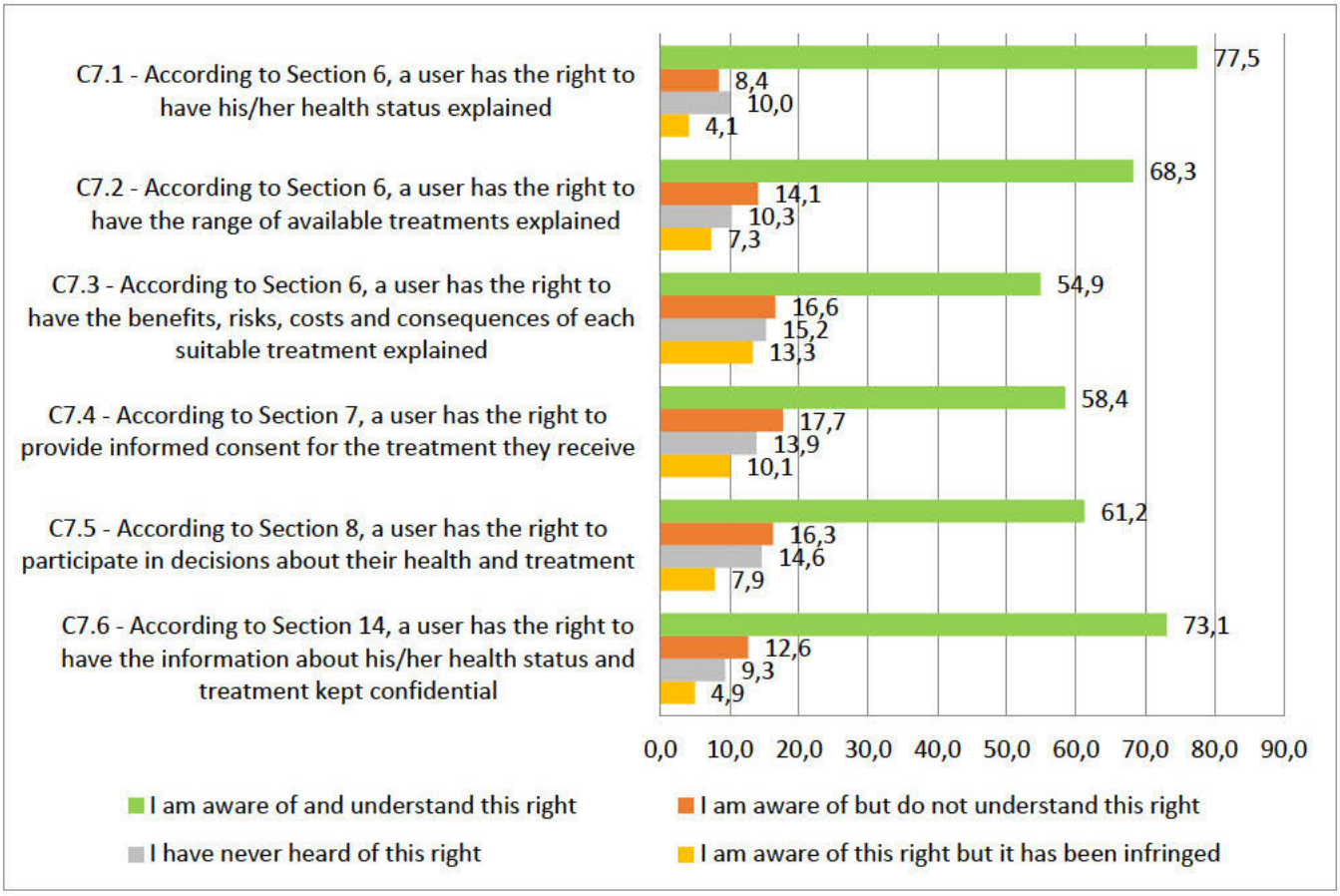

Figure 5.7: Rights of patients in terms of the NHA

The following patterns are observed from the results in Figure 5.7 above:

- All statements show (significantly) higher levels of awareness whilst other levels of awareness are lower. Statement C7.3, a user has the right to have the benefits, risks, costs and consequences of each suitable treatment explained has the lowest level of awareness and statement C7.1, a user has the right to have his/her health status explained has the highest level of awareness.
- There are no statements with a higher level of infringed rights.
- The significance of the differences is tested and shown in Table 5.2.

Statement C7.1 - According to Section 6, a user has the right to have his/her health status explained

According to Section 6(1)(a) of the NHA, a user has the right to have his/her health status explained, except in circumstances where such disclosure would not be in the best interests of the user. As indicated in Table 5.2 above, the majority of respondents (77,5 percent) are aware of and understand this right. A further 8,4 percent of respondents are aware of but do not understand the right and 10 percent of respondents indicated they have never head of the right. Only 4,1 percent of respondents indicated they are aware of the right and it has been infringed by healthcare providers.

Statement C7.2 - According to Section 6, a user has the right to have the range of available treatments explained

According to Section 6(1)(b), a user has the right to have the range of available treatments explained. As reflected in Table 5.2 above, a large number of respondents (68,3 percent) indicated their awareness and understanding of the right to have the range of available treatments explained. While 14,1 percent indicated they are aware of the right but do not understand what it means, 10,3 percent of respondents were unaware of the right. Although 7,3 percent of respondents are aware of the right but believe the right to have available treatment options explained has been infringed by the healthcare practitioners.

Statement C7.3 - According to Section 6, a user has the right to have the benefits, risks, costs and consequences of each suitable treatment explained

A user has the right to have the benefits, risks, costs and consequences of each suitable treatment explained, according to Section 6(1)(c). As illustrated in Table 5.2 above, a high proportion (54,9 percent) of respondents indicated they are aware of and understand this right. Lower percentages of respondents indicated their awareness of the right but did not understand what it means (16,6 percent), while 15,2 percent of respondents had not heard of the right, and 13, 3 % are aware of the right but believed it had been infringed

Statement C7.4 - According to Section 7, a user has the right to provide informed consent for the treatment they receive

Section 7(1) of the NHA provides healthcare services may not be provided to a user without their informed consent. As indicated in Table 5.2 above, responses showed 58,4 percent of respondents are aware of the right, 17,7 percent are aware of the right, however, do not understand its meaning and 13,9 percent of respondents are not aware of the right. In addition, 10,1 percent of respondents are aware of the right but believed it had been infringed.

Statement C7.5 - According to Section 8, a user has the right to participate in decisions about their health and treatment

Section 8(1) of the NHA states a user has the right to participate in any decision affecting his or her personal health and treatment. The results in Table 5.2 above, indicates 61,2 percent of respondents are aware of this right, 16,3 percent have heard of the right but do not understand its meaning and 14,6 percent have never heard of this right. A further 7,9 percent of respondents indicated they are aware of the right but believe it has been infringed by healthcare practitioners. `

Statement C7.6 - According to Section 14, a user has the right to have information about his/her health status and treatment kept confidential

In terms of Section 14 (1) of the NHA, a user has the right to have information regarding his/her health status and treatment kept confidential. Table 5.2 above reveals 73,1

percent of respondents indicated they are aware of and understand this right. Furthermore, 12,6 percent of respondent are aware but do not understand this right, while 9,3 percent of respondents have never heard of the right, and 4,9 percent understood the right but believe the right has been infringed.

The results indicate the right with the highest level of awareness and understanding was the right of the patient to have his/her health status explained, followed by the right to confidentiality. By comparison, the patient right to have the benefits, risks, costs and consequences of each suitable treatment explained had the lowest level of awareness and understanding, followed by the right to provide informed consent. The results further indicate there are no significant differences in the infringement of any of the rights.

The high levels of awareness and understanding of rights may be attributed to the NPRC (SA Department of Health 1999) having to be displayed at public healthcare facilities, in order to create awareness of both patient's rights and the level and quality of healthcare services patients can expect at public healthcare facilities (Hassim, Heywood and Berger 2007: 247). The low levels of infringement may be attributed to the relatively high levels of awareness and understanding of rights.

5.5.3 Section D: Awareness and understanding of the fundamental rights contained in the CPA

Patients as consumers of healthcare services are provided rights as consumers under the CPA (Rowe and Moodley 2013: 02; Slabbert and Labuschaigne 2022: 33). The purpose of this section was to ascertain whether respondents are aware of and understand pertinent, fundamental consumer rights contained in the CPA.

For each consumer right discussed below, a Chi-square goodness-of-fit test was conducted to determine whether the score patterns per statement were considerably different per option. The tables indicating the results for each individual consumer right are contained in Appendix H.

The null hypothesis claims similar numbers of respondents scored across each option for each statement (one statement at a time). The alternate asserts there is a substantial difference that exists amongst the levels of awareness and infringement.

When results (p-values) are less than 0.05, which is considered the level of significance, it indicates the distributions were dissimilar. This means the differences between the way respondents scored are significant. The results indicated a significant difference between levels of awareness and infringement for all fundamental consumer rights contained in the questionnaire. The results reveal a higher level of awareness regarding the consumer rights and a low level of infringement.

5.5.3.1 The right to choose

The fundamental right of a consumer to choose was examined in terms of the right to select suppliers (Section 13) and the right to services being provided on the agreed date and time or within a reasonable time (Section 19). The purpose of this section is to determine whether patients as consumers are aware of this right, understand this right, or have never heard of this right and finally, whether this right has been infringed.

Figure 5.8 below shows the scoring pattern for the right to choose.

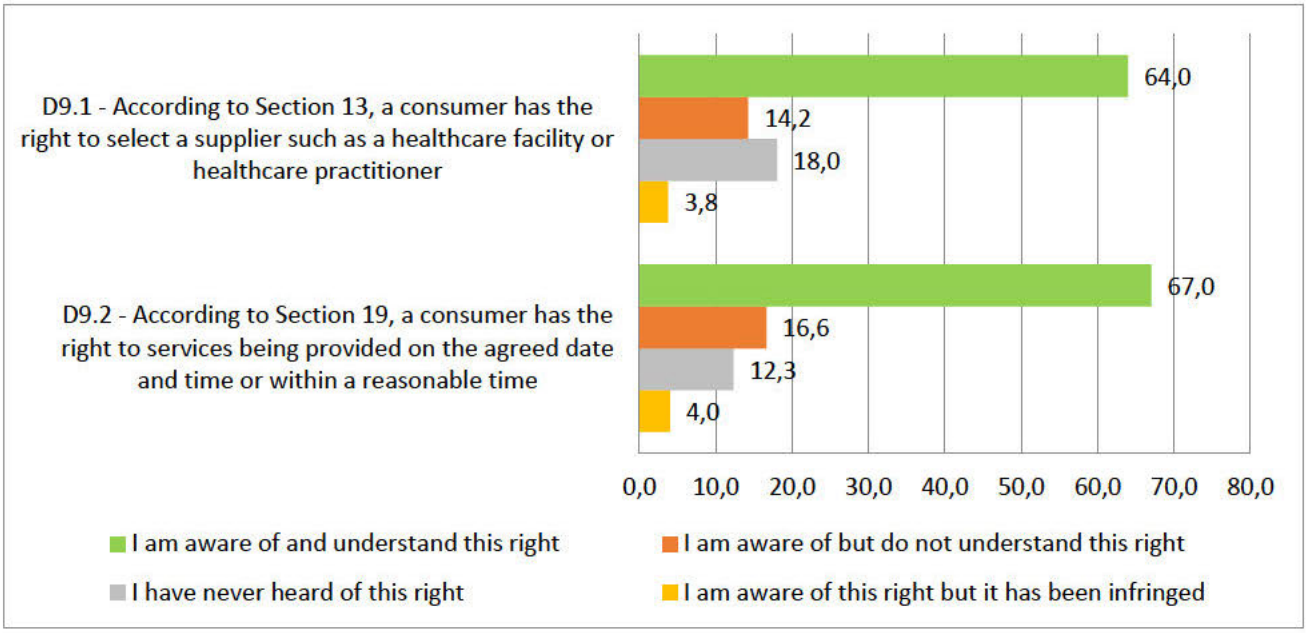

Figure 5.8: The right to choose

The following patterns are observed from the results in Figure 5.8 above:

- Scoring patterns are very similar, indicating a high level of awareness and lower level of infringed rights.

Section 13 of the CPA states that a consumer has the right to select a supplier. In the context of healthcare service delivery, this includes the right to select a healthcare facility or provider. Respondents were asked whether they are aware, as a consumer, of the right to choose a supplier such as a healthcare facility or practitioner. The majority of respondents (64,0 percent) indicated they are aware of the right. While 14,2 percent stated they are aware of, but do not understand this right, 18 percent had never heard of the right. Only four percent were aware of the right but believe it has been infringed.

According to Section 19 of the CPA, a consumer has the right to services being provided on the agreed date and time or within a reasonable time. As with Section 13 of the CPA, the majority of respondents (67,0 percent) are aware of this right. Furthermore, 16 percent of respondents are aware of the right, however, do not understand it, while 12,3 percent of the respondents have never heard of the right. Only four percent of respondents were aware of the right but believe it has been infringed.

The high level of awareness and lower level of infringed rights is an interesting result, as far as the right to select a supplier such as a healthcare facility or healthcare practitioner (Section 13) is concerned, in light of the literature reviewed. It was noted from the literature reviewed that the current structure of the healthcare consumer market in SA limits the patients' freedom of choice as a consumer, to access public sector healthcare services and patients often have little or no choice in the public healthcare consumer market to select the healthcare provider they would prefer, because of a high turnover of healthcare providers in this sector (Rowe and Moodley 2013: 19). De Jager *et al.* (2010: 134) agree the choice of the consumer is limited in public healthcare facilities, as patients generally receive treatment at the clinic or hospital where they are designated. Slabbert

and Labuschaigne (2022: 32) assert that freedom of choice in the public sector is constrained by a lack of funding or long waiting lists and free choice is in reality “a choice on paper only”.

Carstens and Pearmain (2007: 372) note the type of healthcare services delivered at public healthcare facilities are predetermined, in accordance with existing clinical protocols and guidelines, generally applied uniformly across the public healthcare sector. They state this practise restricts patient ability to exercise free choice, since they are unable to ask for services that do not fall within the ambit of these pre-existing services, clinical guidelines and protocols. Du Toit and van Eeden (2014: 738-739) assert patients, as users of healthcare, have limited rights of choice. Nevertheless, Wolf (2018: 03) find, people still consume healthcare, despite limitations, by making use of the healthcare services available to them and to varying extents, therefore, do have some choice in making decisions regarding their health.

The right to services being provided on the agreed date and time or within a reasonable time (Section 19) also yielded an interesting result, with a high level of awareness and a low level of infringement. The literature reviewed regarding the challenges patients experienced suggested long waiting times is a challenge commonly cited by patients (HEU 2012: 4; SA, Department of Health 2017: 12; Burger *et al.* 2016: 193; Young 2016: 4-9; Mokgoko 2013: 104-105; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Harris *et al.* 2011: 116).

5.5.3.2 The right to disclosure and information

The fundamental right of the consumer to disclosure and information is introduced into the healthcare consumer market in the CPA, in terms of the right to information in plain and understandable language (Section 22) and the right to disclosure of the price of services (Section 23). The purpose of this section is to determine whether patients as consumers, are aware of this right, understand this right, have never heard of this right and finally, whether this right has been infringed.

Figure 5.9 below shows the scoring pattern for the right to disclosure and information.

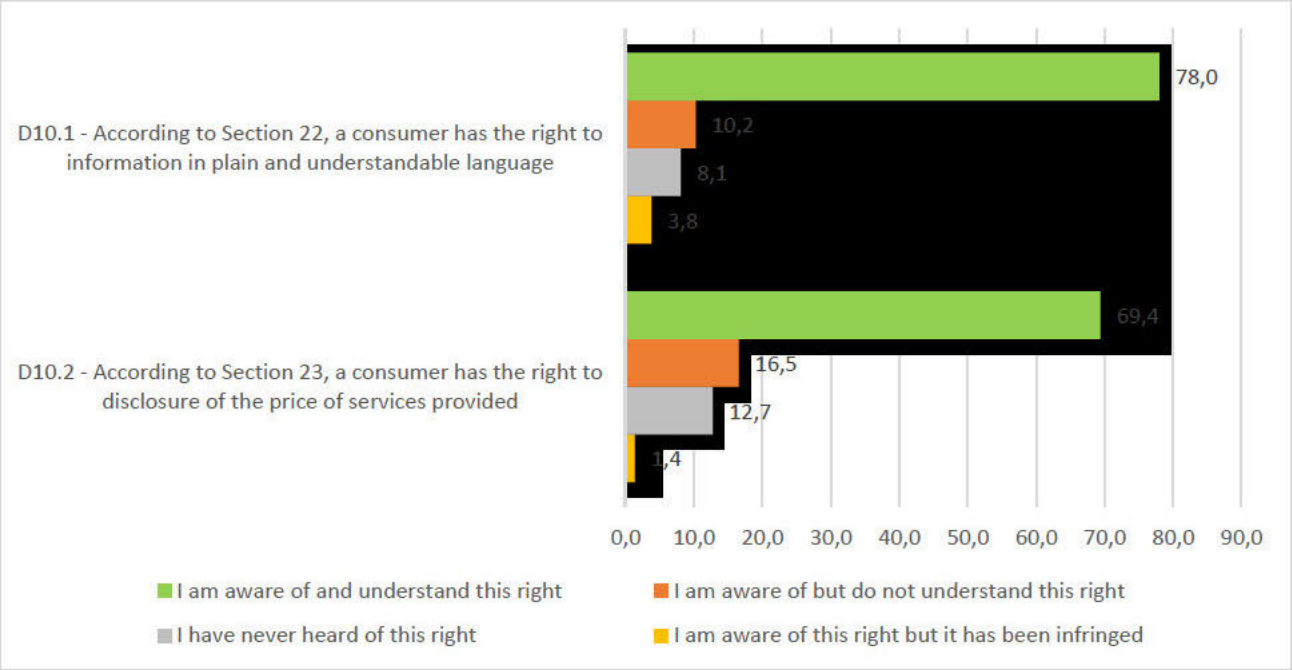

Figure 5.9: The right to disclosure and information

The following patterns are observed from the results shown in Figure 5.9:

- The scoring patterns are very similar.
- There is a high level of awareness regarding the right to disclosure and information.
- There is a low level of infringed rights.

In terms of Section 22, a consumer has the right to information in plain and understandable language. The majority of respondents (78,0 percent) indicated they are aware of and understand the right. In addition, 10,2 percent of respondents are aware of the right but do not understand it and 8,1 percent indicated that they had never head of the right. Only 3,8 percent of respondents are aware of the right but believed the right has been infringed

According to Section 23, a consumer has the right to disclosure of the price of services provided. The majority (69,4 percent) of respondents are aware of this right. 16,5 percent of respondents are aware of but do not understand the right and 12,7 percent of

respondents have never head of the right. Only 1,4 percent of respondents indicated the right has been infringed.

The consumer's right to information in plain and understandable language (Section 22) revealed a high level of awareness of the right but a low level of infringement (3,8 percent). This level of infringement was higher than the score for the right to disclosure of the price of services provided (Section 23), which indicated 1,4 percent but lower for the awareness of the right (69,4 percent) as compared to 78 percent. This lower level of infringement may be due to the manner in which payment is made for healthcare services in the healthcare consumer market.

A large proportion of the patient population access healthcare services in the public sector for free, based on the Uniform Patient Fee Schedule (SA, Department of Health 2017: 17) and subject to the means tests (Competition Commission 2019: 44). Patients may be less concerned with disclosure of the price of goods or services provided, as the amount payable is determined according to the economic classification of the patient, not the value of the provided goods or services.

5.5.3.3 The right to fair and honest dealing

The fundamental consumer right to fair and honest dealing was examined, in terms of the regulation of over-selling and over-booking, as set out in Section 47 of the CPA. The questions in this section of the questionnaire focused on the right of the consumer to receive goods, such as medication and services, for example treatment, at the specified date and time. The purpose of this section is to determine whether patients as consumers are aware of this right, understand this right, have never heard of this right and finally, whether this right has been infringed.

Figure 5.10 below shows the scoring pattern for the right to fair and honest dealing.

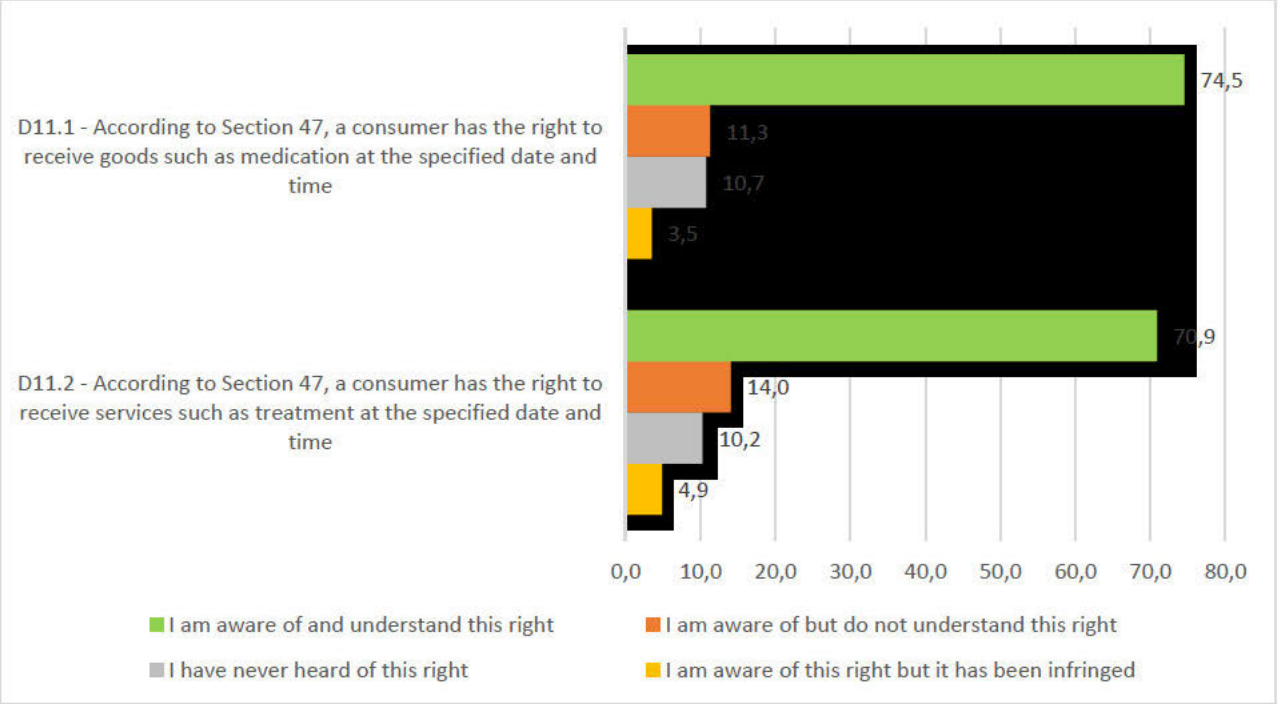

Figure 5.10: The right to fair and honest dealing

The following patterns are observed from the results illustrated in Figure 5.10:

- Scoring patterns are very similar
- Both statements show high level of awareness of the right to fair and honest dealing
- There is a low level of infringed rights.

The majority of the respondents are aware of and understand the right to receive goods such as medication (74,5 percent) and services such as treatment (70,9 percent) at the specified date and time. Similar scoring patterns were observed in respect of respondents who are aware of and do not understand this right as regards receiving goods such as medication (11,3 percent) and services such as treatment (14 percent). The same pattern occurred in respect of respondents who had not heard of this right, 10,7% in respect of medication and 10,2 percent in respect of services. Finally, the scoring pattern was similar regarding the infringement of the right to receive medication (3,5 percent) and treatment (4,9 percent) timeously.

The results that indicate higher levels of awareness and low levels of infringement are interesting, in light of the literature reviewed in paragraph 2.6.6, which noted both an absence of medication and extended waiting times to receive healthcare services were identified as significant challenges by patients (HEU 2012: 4; SA, Department of Health 2017: 12; Burger *et al.* 2016: 193; Young 2016: 4-9; Mokgoko 2013: 104-105; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Harris *et al*. 2011: 116). Furthermore, drug shortages and a lack of basic resources are also challenges identified by patients (HEU 2012: 3; SA National Department of Health 2017: 03-04; Moyo 2016: 27; Maphumulo and Bhengu 2019: 02).

5.5.3.4 The right to fair, just and reasonable terms and conditions

The fundamental consumer right to fair, just and reasonable terms and conditions in the healthcare consumer market was examined, in terms of sections 48 to 52 of the Act as discussed in paragraph 3.4.4.

According to Section 50, a consumer has the right to enter a contract based on fair, just and reasonable terms and conditions. Sections 49 and 51 provide a supplier is not entitled to limit his/her risk or liability, in terms of an exclusionary clause in a contract, without explaining the nature of the limitation to the consumer. The purpose of this section was to determine whether patients as consumers are aware of this right, understand this right, have never heard of this right and finally, whether this right has been infringed.

Figure 5.11 below illustrates the scoring pattern for the right to fair, just and reasonable terms and conditions

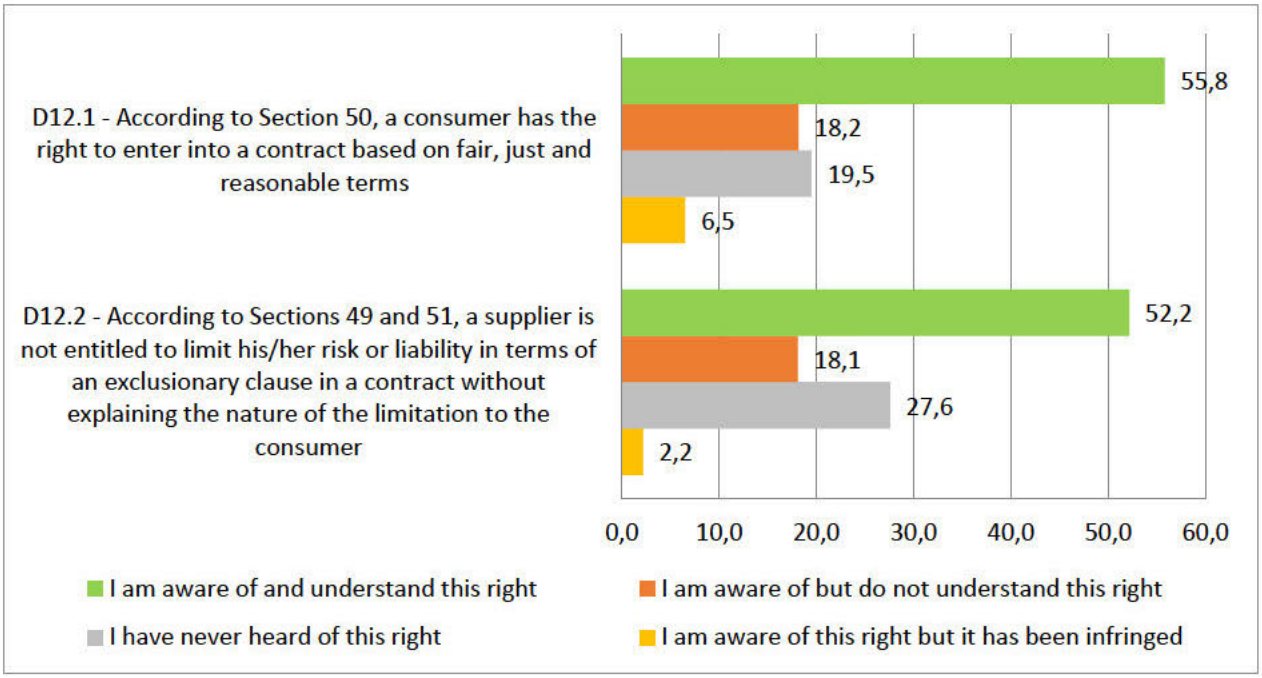

Figure 5.11: The right to fair, just and reasonable terms and conditions

The following pattern is observed from the results in Figure 5.11 above:

- Scoring patterns are very similar with higher levels of awareness and lower levels of infringement.

It was indicated by 55,8 percent of respondents that they were aware of and understood the right to enter a contract based on fair, just and reasonable terms (Section 50). Similarly, 52,2 percent are aware a supplier is not entitled to limit his/her risk or liability in terms of an exclusionary clause in a contract, without explaining the nature of the limitation to the consumer.

Regarding respondents who are aware of but do not understand the right, the results were similar in respect of the rights in Section 50 (18,2 percent) and Sections 49 and 51 (18,1 percent). In addition, 19,1 percent of respondents have never heard of the right to enter a contract based on fair, just and reasonable terms (Section 50) and 27,6 percent have never heard a supplier is not entitled to limit his/her risk or liability, in terms of an exclusionary clause in a contract, without explaining the nature of the limitation to the consumer. Finally, 6,5 percent of respondents believe their right to enter a contract based

on fair, just and reasonable terms has been infringed, while only 2,2 percent believe their rights regarding limitation of risk or liability, in terms of an exclusionary clause in a contract, have been infringed.

The results indicate awareness and understanding of this fundamental consumer right is lower than the other consumer rights discussed above. This lower level of awareness and understanding of the right to fair, just and reasonable terms and conditions, when compared to other rights, may be due to the majority of patients that currently describe or characterise themselves as patients, rather than consumers as set out in Figure 5.5 above.

This lack of awareness of this right may, furthermore, also be attributed to no legal requirement for contracts entered between a healthcare provider and a patient to be in writing, with agreements in the healthcare sector probably based on either verbal or written consent to treatment by the patient (Singh 2017: 136).

5.5.3.5 The right to fair value, good quality and safety

Section 54 of the CPA provides consumers have a right to demand quality service. According to this section, a consumer has a right to services being performed and completed in a timely manner and in a manner and quality the consumer is generally entitled to expect. The purpose of this section was to determine whether patients as consumers are aware of this right, understand this right, have never heard of this right and finally, whether this right has been infringed.

Figure 5.12 below shows a scoring pattern for the right to fair value, good quality and safety

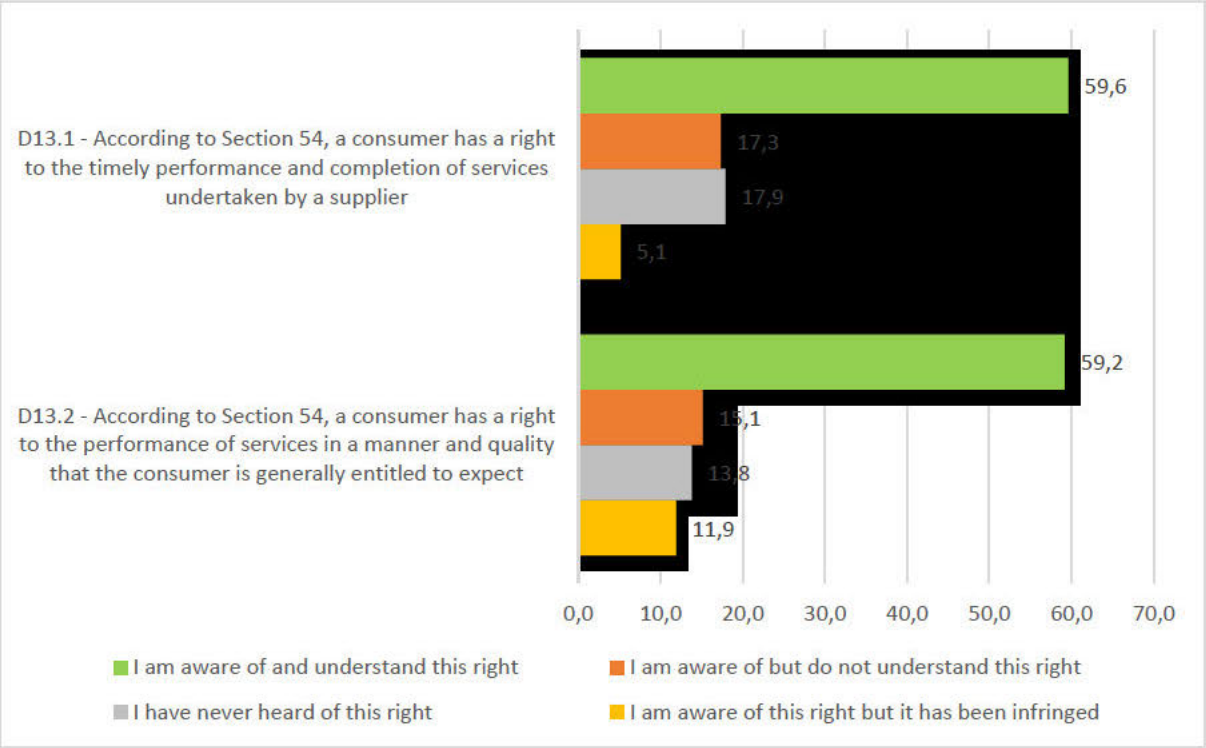

Figure 5.12: The right to fair value, good quality and safety

The following patterns are observed from the results in Figure 5.12 above:

- Scoring patterns are very similar with higher levels of awareness and lower levels of infringement.

As regards the right of the consumer to the timely performance and completion of services, 59,6 percent of respondents indicated that they are aware of and understand this right. 17,3 percent of respondents stated they are aware of but do not understand the right, and 17,9 percent had not heard of the right. 5,1 percent of respondents noted they believed this right has been infringed.

The results for the consumer right to the performance of services in a manner and quality the consumer is generally entitled to expect are similar to the results for the right to timely performance and completion of services. It was indicated by 59,2 percent of respondents that they are aware of and understand the right, while 15,1 percent of the respondents indicated they were aware of but did not understand the right, and 13,8 percent had not

heard of the right. Furthermore, 11,9 percent of respondents stated they believed the right has been infringed.

The results indicate both the right to timely completion of services and the quality of services delivered have similar levels of awareness and infringement. However, performance of services in a manner and quality the consumer is generally entitled to expect has a higher level of infringement.

These findings are interesting in respect of low levels of infringement, because both timeous service delivery and quality of services delivered are identified as challenges for patients in the reviewed literature. Extended waiting times to receive healthcare services were identified as a significant challenge for patients by several authors (HEU 2012: 4; SA Department of Health 2017: 12; Burger *et al.* 2016: 193; Young 2016: 4-9; Mokgoko 2013: 104-105; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Harris *et al*. 2011: 116). Poor quality service delivery in the public healthcare sector was additionally identified as a significant challenge for patients by a number of authors (Young 2016: 4-9; SA National Department of Health 2017: 03-04; Maphumulo and Bhengu 2019: 02).

5.5.3.6 Comparative analysis of the findings regarding awareness and understanding of patient rights and fundamental consumer rights

The analysis considered respondent awareness and understanding of their rights as patients, in the NHA, as discussed in Section C, along with awareness and understanding of the fundamental rights contained in the CPA, as discussed in Section D.

Figure 5.7 indicates levels of awareness of the rights of patients in terms of the NHA range from 54,9 percent to 77,5 percent. By comparison, the results indicated patients believed their rights had been infringed at significantly lower levels, ranging from 4,1 percent to 13,3 percent.

The results set out in Figures 5.8, 5.9, 5.10, 5.11 and 5.12, regarding levels of awareness of the fundamental consumer rights contained in the CPA, ranged from 52,2 percent to

78 percent. By comparison, the results indicated patients believed their rights had been infringed at significantly lower levels, ranging from 1,4 percent to 11,9 percent.

The results indicate no significant difference in awareness and understanding of patient rights in terms of the NHA, when compared to fundamental consumer rights contained in the CPA. This is an interesting result considering public healthcare facilities are required to display the NPRC (SA Department of Health 1999) in an effort to provide information for patients, so as to improve understanding and enforcement of their rights in terms of the NHA (Hassim, Heywood and Berger 2007: 247).

No such corresponding requirement exists requiring public healthcare facilities to display information regarding the fundamental consumer rights contained in the CPA. However, it must be noted one of the aims of the CPA is to improve “consumer awareness and information”, to encourage “responsible and informed consumer choices and behaviour” (SA Department of Trade and Industry 2008: Section 3(1)(e)). It is possible awareness and understanding of consumer rights originated external to public healthcare facilities as consumer rights, which unlike patient rights, are not limited to the provision of healthcare services but have a much wider application.

Moreover, high levels of awareness are supported by the results in Figure 5.2, indicating that collectively, 63.4 percent of respondents that participated in the survey are educated, with 34.4 percent having attained a matric and 29 percent with a post- matric qualification. This high level of awareness is in line with the statement of Lazarus and Butler 2001 (cited in Ndlovu 2012: 02), who states as a result of education, patients have become increasingly mindful of health issues, with a subsequent increase in awareness amongst patients, who are demanding increased accessibility to healthcare facilities (Lazarus and Butler 2001, cited in Ndlovu 2012: 02). Furthermore, according to Van den Heever (2012: 07), consumers are unable to take advantage of the protection provided by the CPA without awareness of their rights. It is important to ensure patients as consumers are aware of their rights and the quality of healthcare services they can expect (Hassim, Heywood and Berger 2007: 247).

The results indicate no significant difference in the infringement of patient rights in terms of the NHA and the infringement of fundamental consumer rights contained in the CPA. For both sets of rights, respondents indicate similarly low levels of infringement. The results indicate patients believed their rights in terms of the NHA were infringed more often than their fundamental consumer rights contained in the CPA. Patient rights infringement ranged from 4,1 to 13,3 percent, as compared to fundamental consumer rights infringement that ranged from 1,4 to 11,9 percent.

The analysis indicates patient rights are infringed up to 13,3 percent of the time and fundamental consumer rights are infringed up to 11,9 percent. According to Mthanti (2015: 25), the underlying reasons for these infringements must be addressed to improve quality of care and ensure successful implementation of policies aimed at improving service quality in general. The recognition of what is perceived as the violation of patients' rights can assist healthcare providers to understand more about patients' main concerns (Khademi, Mohammadi and Vanaki 2019: 576). It is important to identify and address the nature of the infringement of both these types of rights to establish a society based on social justice that contributes toward improving the quality of life of all citizens, as set out in the preambles of the Constitution, the NHA and the CPA.

5.5.4 Section E: Challenges experienced by patients in accessing healthcare services

This section was designed to explore the challenges experienced by respondents in accessing healthcare services. A Likert scale was used and respondents were requested to indicate their level of agreement or disagreement with each statement. The challenges identified and discussed in the literature review were grouped into the following headings in the questionnaire: adequate staffing, information management, safety and security, as well as cleanliness, maintenance of buildings and grounds, facilities, and medication, along with availability of beds. This was done in an attempt to streamline the challenges and make it easier for respondents to answer the questions.

Respondents were requested to express their views regarding the challenges they experienced in response to given statements, by indicating whether they strongly agree, agree, are uncertain, or disagree or strongly disagree with the statement.

At the end of this section of the questionnaire, Question 22 offered respondents an opportunity to provide any other challenges they may have experienced in the delivery of healthcare services; 66,4 percent of respondents provided additional comments in this section of the questionnaire. The responses are divided into sub-themes and analysed below. The responses provided correspond with the themes of the close-ended questions in this section and will, as such, be presented under the relevant theme. An additional sub-theme that did not correspond with the themes in the questionnaire emerged namely, breaches of confidentiality. This is not unexpected, as patient challenges discussed in the literature reviewed note breaches in confidentiality is a challenge for patients. However, in light of the study aim and inability of the CPA to address breaches of confidentiality, this theme was not included in the questionnaire. Nevertheless, these responses are included for added perspective.

5.5.4.1 E15 - Adequate staffing

Respondents were asked to express their views by indicating their level of agreement or disagreement with each of the statements regarding adequate staffing.

Figure 5.13 below shows the scoring pattern for adequate staffing.

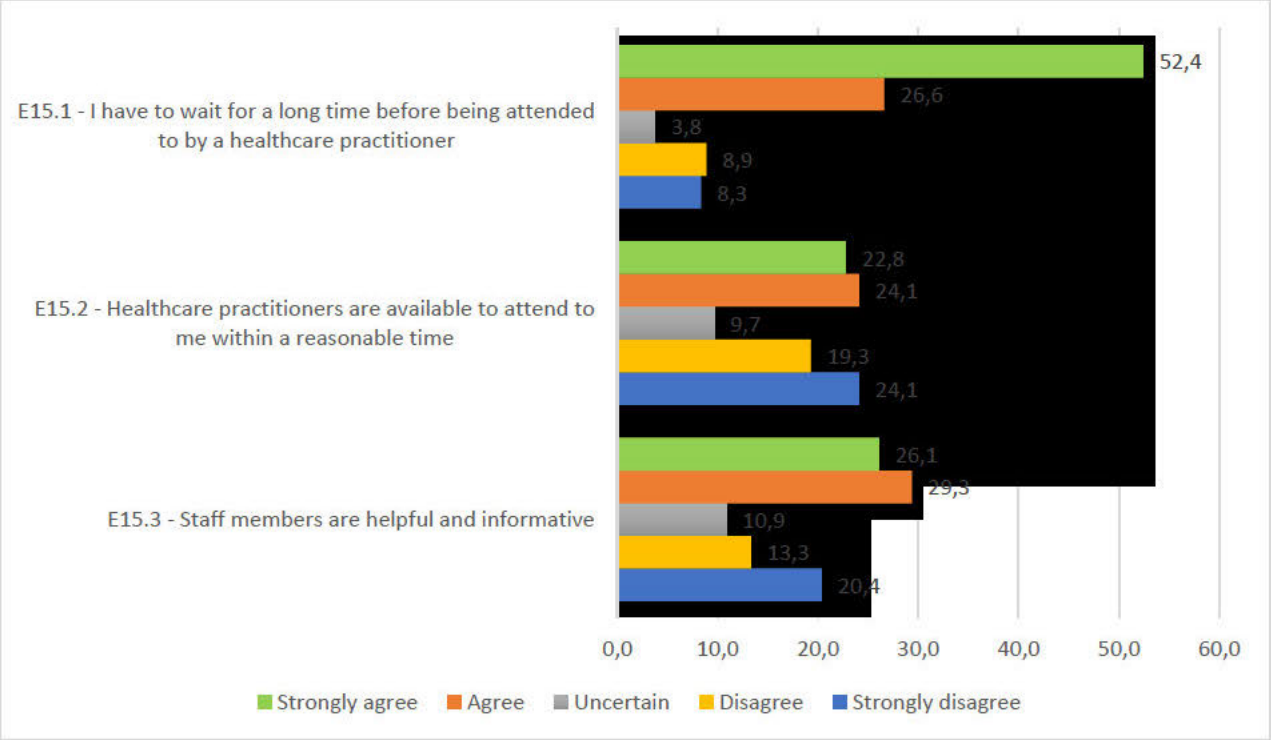

Figure 5.13: Adequate staffing

The following patterns are observed from the illustrated results in Figure 5.13:

- There are higher levels of agreement than disagreement in all instances.
- E15.1 shows a significantly higher level of agreement.
- The levels of agreement for statement E15.2 and E15.3 are lower than for E15.1.
-

The results show 79 percent of the respondents agreed they have to wait for a long time before being attended to by a healthcare practitioner. The results for statements E15.2 (46.9 percent) and E15.5 (55,4 percent) indicate significantly lower levels of agreement with the statements. However, these lower levels remain at the 50 percent level, indicating respondents believe adequate staffing is a challenge for patients.

The results shown in Figure 5.13 above for the individual sub-themes, concerning challenges associated with adequate staffing, reveal that:

Statement E15.1 - I have to wait for a long time before being attended to by a healthcare practitioner

A significant majority of respondents (79percent: (strongly agree 52,4 percent; agree 26,6 percent) agree with the statement that they had to wait for a long time before being attended to by a healthcare practitioner. By comparison, 17.2 percent of respondents disagreed with the statement (disagree = 8,9 percent; strongly disagree 8, 3 percent). Only 3.8 percent of respondents indicated that they were uncertain about this statement. The results indicate that extended waiting times is a challenge experienced by almost 80% of patients.

These findings are consistent with the literature reviewed in paragraph 2.6.6, which found extended waiting times to receive healthcare services were identified by patients as a significant challenge (HEU 2012: 4; SA Department of Health 2017: 12; Burger *et al.* 2016: 193; Young 2016: 4-9; Mokgoko 2013: 104-105; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Harris *et al*. 2011: 116). According to Aikman (2019: 53), patients waste time in long queues, crowded into small spaces, leading to an increased risk for the spread of infections; both impact patients economically, as they often have to return on concurrent days when they do not receive the healthcare services they need (Aikman 2019: 53). Results published in the South African Demographic and Health Survey (SADHS 2003) reported the main cause for dissatisfaction in public sector hospitals and the community healthcare sector was long waiting periods.

Statement E15.2 - Healthcare practitioners are available to attend to me within a reasonable time

Agreement was indicated by an aggregate of 46,9 percent of the respondents (strongly agree 22,8 percent; agree 24,1 percent) that healthcare practitioners are available to attend to patients timeously. The percentage of respondents that disagreed with this statement was a similar average of 43,4 percent (strongly disagree 24,1 percent; disagree 19,3 percent). The remaining 9,7 percent of respondents stated they were uncertain. The results indicate a similar percentage of patients stated healthcare practitioners are available and unavailable to attend to patients timeously.

These findings align with Mokgoko (2013: 104-105; 63), who noted patients expect to be attended to from 08h00 and are frustrated when healthcare professionals arrive late. Furthermore, Maphumulo and Bhengu (2019: 02) found patients face several challenges, including long waiting times, because of an absence of human resources. Moyo (2016: 27) found insufficient staff numbers pose a serious barrier to the ability of patients to access quality healthcare services.

Statement E15.3 - Staff members are helpful and informative

Just more than half the respondents (55,4 percent: strongly agree 26.1 percent; agree 29.3 percent) agreed with the statement that staff members are helpful and informative. By comparison, only one third of respondents (33,7 percent: (strongly disagree 20,4 percent; disagree 13,3 percent) disagreed with the statement and 10.9 percent of the respondents stated they were uncertain. Despite the results indicating more patients found staff members helpful and informative, slightly more than one third of patients experienced challenges with staff attitudes.

These findings are supported by the literature, from which it was found that rude and poor staff attitudes is an area of concern in the public sector (SA National Department of Health 2017: 03-04; Burger *et al.* 2016: 193; Maseko and Harris 2018: 24; HEU 2012: 3; Moyo 2016: 27). Komape (2013: 10) asserts healthcare providers are often described as indifferent and uncaring, with minimul respect for patient confidentiality and prone to neglecting patients for whom they are responsible. According to Khademi, Mohammadi and Vanaki (2019: 576; 577), healthcare providers are, nonetheless, generally known as advocates for the rights of patients. However, the authors note several findings regarding patient rights violations, including disrespect of patients' basic humanity.

Responses to the open-ended question

Question 22 gave respondents an opportunity to add any other challenges they may have experienced in the delivery of healthcare services. The following responses align with the following sub-theme, under the theme adequate staffing:

I have to wait for a long time before being attended to by a healthcare practitioner

- Staff shortages at healthcare facilities are to blame for the slow healthcare services provided.
- Sluggish service is provided by healthcare professionals and patients have to wait for a long time before being attended to.
- Long queues, we arrive very early but still go home late.
- Certain facilities would make you wait outside premises for hours and you would get sicker due to weather conditions as well.
- Waiting times and queues are longer since Covid-19 pandemic because of social distancing and we queue outside the buildings.
- We are dismissed/discharged at late hours when transport is no longer available to go home, you would sometimes have to wait at the cold waiting rooms until there is a means of transportation in the morning.
- Some clinics close early, while others only accept a certain number of patients each day.

Healthcare practitioners are available to attend to me within a reasonable time

- Healthcare practitioners use their phones while on duty.
- Staff members are ignorant, they do not attend to sick patient when they call for attention in beds. They do not pay attention to viral things or individuals who require medical attention and sometimes disturbed by using cell phone while on duty.
- Most of the time healthcare professionals arrive late to start work, and also take long breaks or lunch time.
- Sometimes they would stop working and attend long meetings without leaving staff on duty to continue attending to patients in line.

Staff members are helpful and informative

- Staff have a bad attitude, they don’t treat us with dignity, they are disrespectful and irresponsible, and often yell at patients.
- We had a difficult time giving birth because they had untrained interns or careless qualified healthcare providers helping us.

- Poor services and uncooperative nurses.
- Medical professionals lacked compassion.
- There is discrimination at the healthcare facility. No fair or equal treatment or service was provided to the individuals.

The results from the open-ended questions provide additional insight into the extent and nature of the challenges patients face. These findings are consistent with and supported by the literature discussed above.

5.5.4.2 E17 - Information management

Respondents were asked to indicate their level of agreement or disagreement with statements relating to the manner in which information is managed in the healthcare facility.

Figure 5.14 below shows the scoring pattern for information management.

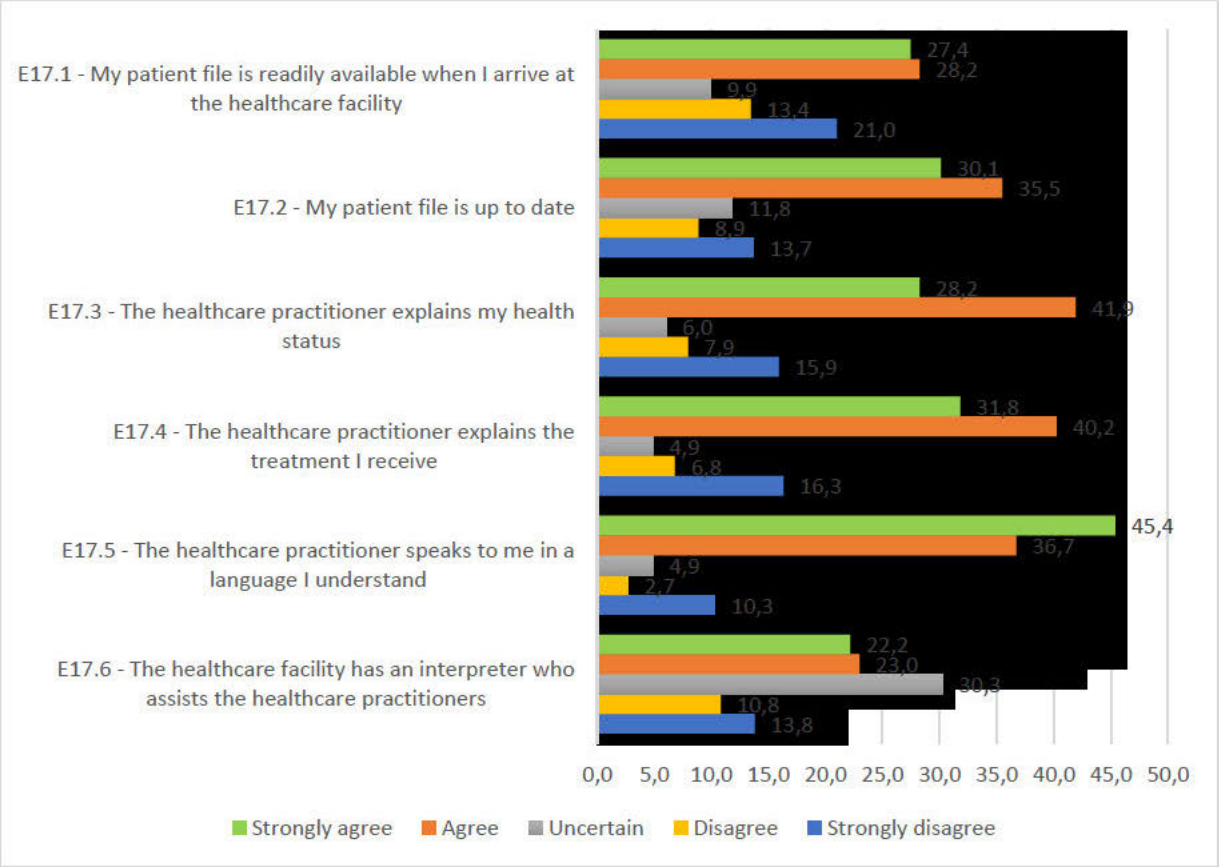

Figure 5.14: Information management

The following patterns are observed from the results shown in Figure 5.14:

- There are significantly higher levels of agreement for all statements.
- Note that E17.6 has a high level of uncertainty.

The results shown is Figure 5.14 above for the individual sub-themes, for challenges patients experience associated with information management, are discussed below.

Statement E17.1 - My patient file is readily available when I arrive at the healthcare facility

More than half the respondents (55,6 percent: strongly agree 27,4 percent; agree 28,2 percent) agreed their patient file is readily available when they arrive at the healthcare facility. By comparison, 34,4 percent (strongly disagree 21 percent; disagree 13,4 percent) of respondents disagreed on aggregate with the statement, with 9,9 percent of respondents that stated they were uncertain. The results indicate when patients arrive at the healthcare facility, slightly more than half of patients' files are available, while close to one third of patients find their patient file is not readily available.

Statement E17.2 - My patient file is up-to-date

Almost two thirds of respondents (65,6 percent: strongly agree 30,1 percent; agree 35,5 percent) agreed with the statement. By comparison, 22,6 percent (strongly disagree 13,7 percent; disagree 8,9 percent) of respondents disagreed with the statement. Furthermore, 11,8 percent of respondents stated they were uncertain. The results indicate when patients arrive at the healthcare facility 65,6 percent find their patient file is up-to-date.

Despite the majority of patients stating their patient file was readily available and/or up-to-date, record keeping appears to be a challenge experienced by patients, as 34,4 percent of patients indicated their patient file is not readily available and 22,6 percent indicated their patient file is not up-to-date when they arrive at the healthcare facility. These findings support the work of Maphumulo and Bhengu (2019: 02), who found patients face challenges where poor healthcare facility record-keeping is concerned. The

National Department of Health (2017: 03-04), also identified inadequate provision of information as a challenge for patients in the healthcare sector.

Statement E17.3 - The healthcare practitioner explains my health status

The majority of respondents (70,1 percent: strongly agree 28,2 percent; agree 41,9 percent) agreed healthcare practitioners do explain their health status. By comparison, 23,8 percent (strongly disagree 15,9 percent; disagree 7,9 percent) of respondents disagreed with the statement. Six percent of respondents stated they were uncertain. The results indicate healthcare practitioners generally do explain a patient's health status.

According to Manyonga *et al.* (2014: 561), healthcare providers have a duty to ensure patients have received and understood the information provided to them. These findings suggest there is compliance with the patient rights contained in Section 6(1) of the NHA, which states healthcare providers must inform a patient of his/her health status, except in circumstances where such disclosure is not in the best interests of the patient.

Statement E17.4 - The healthcare practitioner explains the treatment I receive

Agreement was indicated by the majority of respondents (72 percent: strongly agree 31,8 percent; agree 40,2 percent) that healthcare practitioners explain the treatment to the patient. Less than one quarter of respondents (23,1 percent: strongly disagree 16,3 percent; disagree 6,8 percent) disagreed with the statement. A further 4,9 percent of respondents stated they were uncertain. The results indicate healthcare practitioners explain the treatment the patient will receive.

These findings suggest the patient rights contained in Section 6(1)(b) of the NHA are supported and patients are advised of the treatment options generally available to them. Khademi, Mohammadi and Vanaki (2019: 576, 577) assert, despite healthcare providers generally known as advocates for the rights of patients, there are several findings regarding the violation of patient's rights, including a lack of information provided. This assertion is supported by the results that found 23,1 percent of respondents stated the treatment they received was not explained.

Statement E17.5 - The healthcare practitioner speaks to me in a language I understand

The majority of respondents (82,1 percent strongly agree 45,4 percent; agree 36,7 percent) agreed healthcare practitioners communicate in a language they understand. By comparison, only 13 percent (strongly disagree 10,3 percent; disagree 2,7 percent) of respondents disagreed with the statement and 4,9 percent of respondents stated they were uncertain. The results indicate more than 80 percent of respondents are spoken to in a language they understand.

These findings suggest the patient rights in Section 6(2) of the NHA are generally upheld and healthcare providers are providing information to patients in a language that he/she understands and in a manner that considers the literacy level of the patient into account. Furthermore, the fundamental consumer right to information being provided in plain and understandable language (CPA Section 22) appears to have been upheld.

Statement E17.6 - The healthcare facility has an interpreter who assists the healthcare practitioners

An aggregate of 45,2 percent (strongly agree 22,2 percent; agree 23 percent) of the respondents agreed the healthcare facility has an interpreter who assists healthcare practitioners, while 24 6 percent (strongly disagree 13,8 percent; disagree 10,8 percent) of respondents disagreed with the statement, and 30,3 percent of respondents stated they were uncertain. The results indicate almost one third of respondents are uncertain whether the healthcare facility has an interpreter to assist the healthcare practitioners. This result aligns with the result of the previous sub-theme, in which 82,1 percent of respondents stated healthcare practitioners spoke to them in a language they understood. They may not have required the services of an interpreter and uncertainty regarding this theme aligns with the previous results.

These findings are in alignment with results from Van den Berg (2016: 229), who states clear communication between a patient and a healthcare provider is an important foundation to ensure a patient participates in decisions regarding medical treatment.

Responses to the open-ended question

Question 22 gave respondents an opportunity to provide any additional challenges they may have experienced in the delivery of healthcare services. The following responses align with the following sub-theme under the theme Information management:

- Lack of information supplied by healthcare professionals regarding the treatment they are offering and their failure to reveal important details such as side effects.
- Missing files and inadequate file administration.
- Difficulty understanding the healthcare provider's language when receiving services.
- Patients are given less opportunity to ask questions.

The results from the open-ended questions provide additional insight into the extent and nature of the challenges patients face. These findings are consistent with and supported by the literature discussed above.

5.5.4.3 E18 - Safety and security

Respondents were asked to indicate their level of agreement or disagreement on different statement relating to their safety and security when accessing healthcare service.

Figure 5.15 below shows the scoring pattern for safety and security.

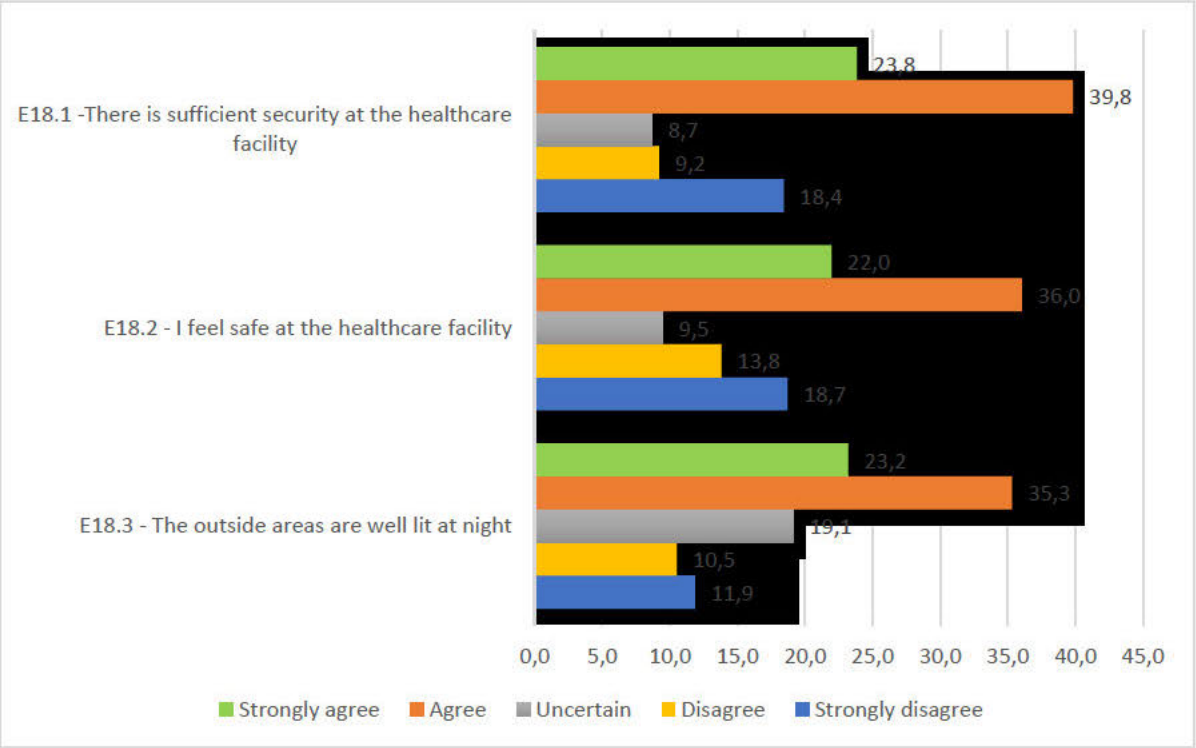

Figure 5.15: Safety and security

The following pattern is observed from the results depicted in Figure 5.15:

- Similar and significantly higher levels of agreement

Statement E18.1- There is sufficient security at the healthcare facility

Close to two thirds of the respondents (63,6 percent strongly agree 23,8 percent; agree 39,8 percent) agreed there is sufficient security at the healthcare facility. Less than one third (27,6 percent: strongly disagree 18,4 percent; disagree 9,2 percent) of respondents disagreed with the statement, and 8,7 percent of respondents stated they were uncertain. The results indicate almost two thirds of respondents believe there is sufficient security at the healthcare facility.

Statement E18.2- I feel safe at the healthcare facility

The majority of respondents (58 percent: strongly agree 22 percent; agree 36 percent) agreed they feel safe at the healthcare facility. By comparison, 32,5 percent (strongly

disagree 18,7 percent; disagree 13,8 percent) of respondents stated they felt unsafe, and 9,5 percent of respondents stated they were uncertain.

Statement E18.3 - The outside areas are well lit at night

Agreement was indicated by the majority of respondents (58,5 percent: strongly agree 23,2 percent; agree 35,3 percent) that outside areas are well lit at night. While 22,4 percent (strongly disagree 11,9 percent; disagree 10,5 percent) of respondents disagreed with the statement, 19,1 percent of respondents stated they were uncertain. The results indicate a high percentage of respondents indicated they were uncertain, which might be due to not having required healthcare services at night, therefore, have no knowledge of the lighting at the facility.

These results indicate that in each of the three sub-themes, more respondents responded positively toward safety and security. However, in each sub-theme a significant percentage of respondents expressed concerns about safety and security.

These findings support literature reviewed that described the safety and security of both patients and staff as an area of concern in the public sector (SA National Department of Health 2017: 03-04; Moyo 2016: 27).

Responses to the open-ended question

Question 22 gave respondents an opportunity to share any additional challenges they may have experienced in the delivery of healthcare services. The following responses align with the sub-theme that follows, under the theme safety and security:

- The facility does not have enough parking space. Parking spaces were only reserved for staff to use and not patients. Patients had to park outside the healthcare facilities, which was in an unsafe neighbourhood.
- We do not feel safe at the healthcare facility.
- There is a rate of theft.
- There is a shortage of security.

- Security do not search for harmful or dangerous items that are illegal to enter with at healthcare facilities such as knife and firearms.

The results from the open-ended questions provide additional insight into the extent and nature of the challenges patients face. These findings are consistent with and supported by the literature discussed above.

5.5.4.4 E19 - Cleanliness and maintenance of buildings and grounds

Respondents were asked to indicate their level of agreement or disagreement with statements relating to cleanliness and maintenance of buildings and grounds.

Figure 5.16 below shows the scoring pattern for cleanliness and maintenance of buildings and grounds.

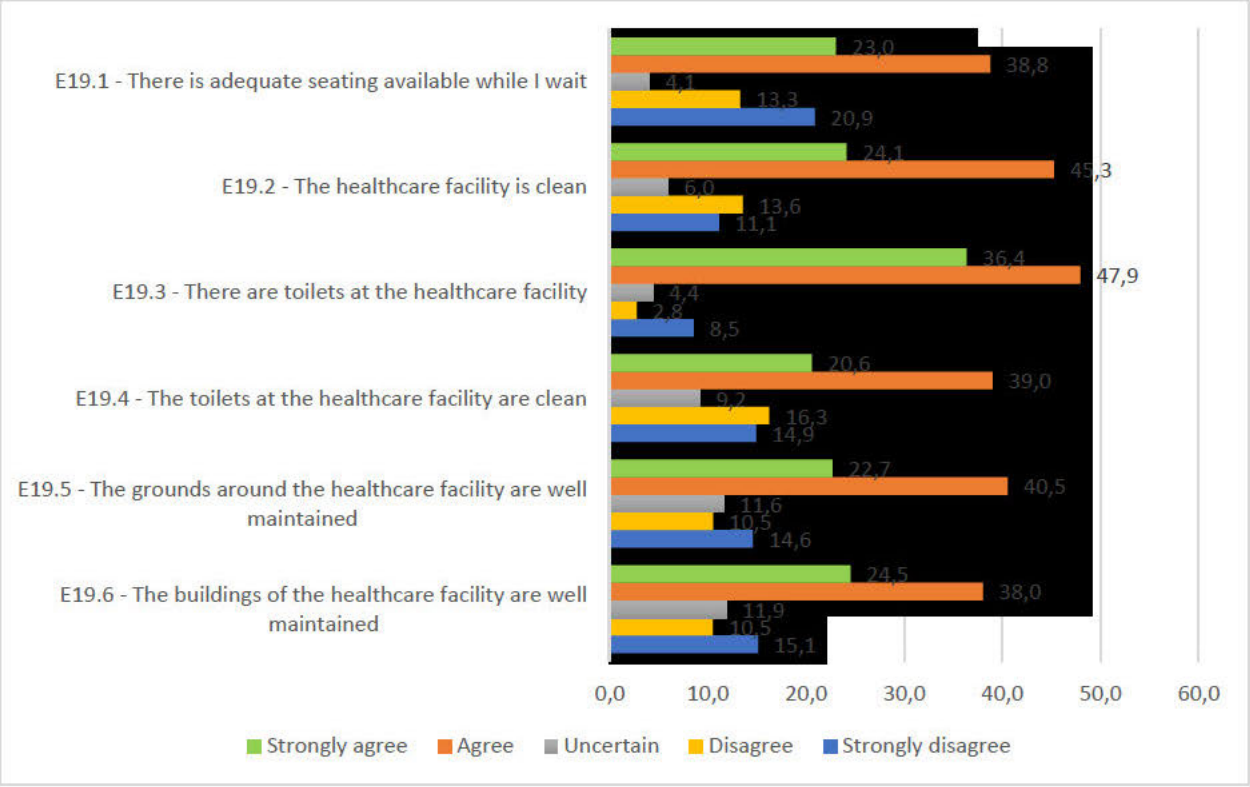

Figure 5.16: Cleanliness and maintenance of buildings and grounds

The following pattern from the results shown in Figure 5.16 is observed:

- Similar and higher levels of agreement.

The analysis for each of the sub-themes shown in Figure 5.16 above, are discussed below.

Statement E19.1 - The facility has adequate seating available while I wait

The majority of respondents (61,8 percent: strongly agree = 23 percent; agree = 38,8 percent) agreed the facility has adequate seating available. By comparison, 34,6 percent (strongly disagree = 20,9 percent; disagree = 13,7 percent) of respondents disagreed with the statement, while 4,1 percent of respondents stated they were uncertain. The results indicate, despite almost two thirds of respondents stating the facility had adequate seating, slightly more than one third noted the facility did not have adequate seating.

Statement E19.2 - The healthcare facility is clean

Agreement was indicated by the majority of respondents (69,4 percent: strongly agree 24,1 percent; agree 45,3 percent) with the statement. By comparison, 24,7 percent (strongly disagree 11,1 percent; disagree 13,6 percent) of respondents disagreed with the statement. Six percent of respondents stated they were uncertain. The results indicate the majority of respondents stated the healthcare facility is clean. However, almost a quarter of respondents noted the facility was not clean.

Statement E19.3 - There are toilets at the healthcare facility

A large percentage of the respondents (84,3 percent: strongly agree 36,4 percent; agree 47,9 percent) agreed with the statement. By comparison, 11,3 percent (strongly disagree 8,5 percent; disagree 2,8 percent) of the respondents disagreed with the statement, and 4,4 percent of respondents stated they were uncertain. The results indicate more than 80 percent of respondents agreed the healthcare facility has toilets.

Statement E19.4 - The toilets at the healthcare facility are clean

Agreement was indicated by the majority of respondents (59,6 percent: strongly agree 20,6 percent; agree 39 percent) agreed with the statement. By comparison, 31,2 percent (strongly disagree 14,9; disagree 16,3) of the respondents disagreed with the statement, while 9,2 percent of the respondents stated they were uncertain. The results indicate almost 60 percent of respondents stated the toilets at the healthcare facility are clean but close to one third of respondents noted they were not clean.

Statement E19.5 - The grounds around the healthcare facility are well-maintained

The statement drew agreement from the majority of respondents, with 63,2 percent (strongly agree 22,7 percent; agree 40,5 percent) that agreed on aggregate with the statement. By comparison, 25,1 percent (strongly disagree 14,6 percent; disagree 10,5 percent) of respondents disagreed with the statement. In addition, 11,6 percent of respondents stated they were uncertain. The results indicate almost two thirds of respondents believed the grounds around the healthcare facility are well-maintained.

Statement E19.6 - The buildings of the healthcare facility are well-maintained

The majority of respondents (62,5 percent: strongly agree 24,5 percent; agree 38 percent) agreed with the statement. By comparison, 25,6 percent (strongly disagree 15,1 percent; disagree 10,5 percent) of the respondents disagreed with the statement, and 11,9 percent of respondents stated they were uncertain. The results indicate almost two thirds of respondents believed the grounds around the healthcare facility are well-maintained.

In each of the sub-themes examined above, apart from the availability of toilets, the response rate was clustered around 60 percent for those respondents who agreed the healthcare facility was clean and well-maintained. Between 25 and 30 percent of respondents found the opposite to be true. These findings are consistent with the literature reviewed, in which patients identified a lack of cleanliness and infection control as challenges in the delivery of public sector healthcare services (SA National Department of Health 2017: 03-04; Maseko and Harris 2018: 24; Maphumulo and Bhengu 2019: 02; Moyo 2016: 27; Young 2016: 4-9).

Responses to the open-ended question

Question 22 gave respondents an opportunity to provide any additional challenges they may have experienced in the delivery of healthcare services. The following responses align with the sub-theme that follows, under the theme cleanliness and maintenance of buildings and grounds:

- The healthcare facility is not clean.
- The restrooms are filthy, and the bedding is filthy, old, and unchanged.
- The buildings are not well-maintained

The results from the open-ended questions provide additional insight into the nature and extent of the challenges faced by patients. These findings are consistent with and supported by the literature discussed above.

5.5.4.5 E20 - Facilities and medication

Respondents were asked to indicate their level of agreement or disagreement with statements relating to healthcare facilities and medication.

Figure 5.17 below shows the scoring pattern for facilities and medication.

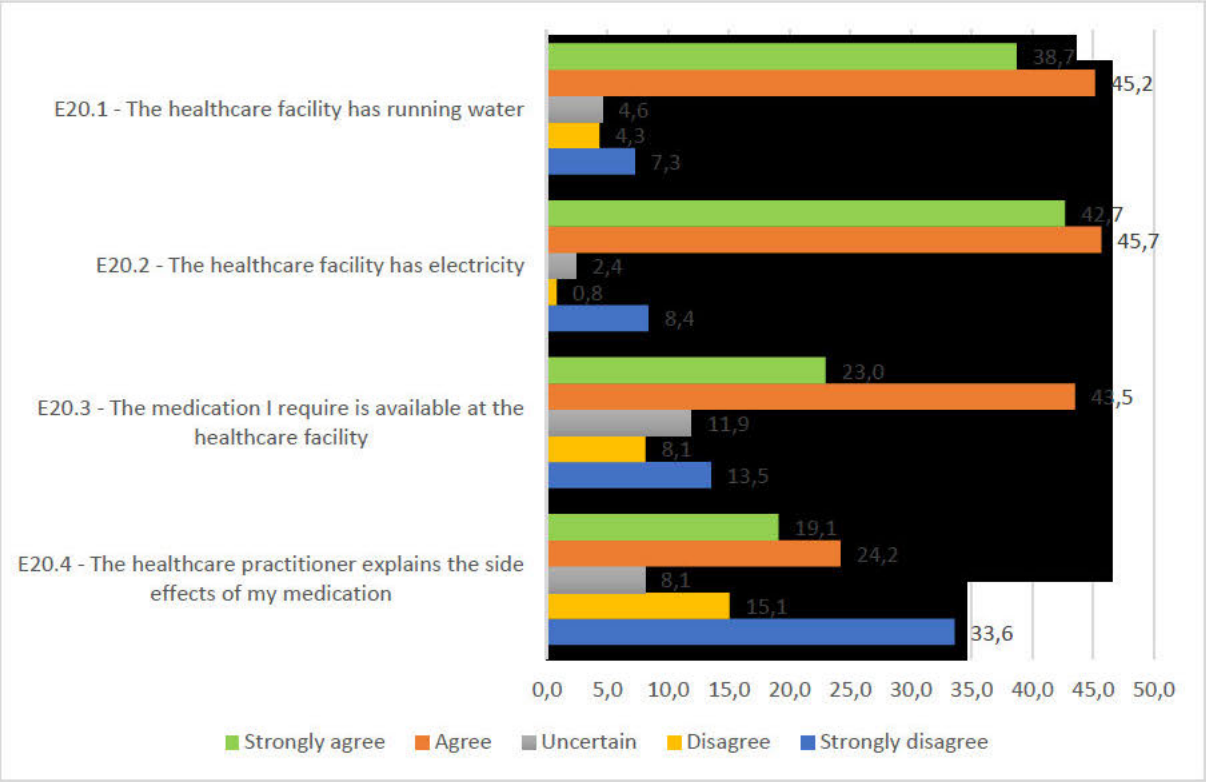

Figure 5.17: Facilities and medication

The following patterns from the illustrated results (Fig. 5.17) are observed:

- There is a significantly higher level of agreement for E20.1, E20.2 and E20.3
- A significantly higher level of disagreement is found for the statement on healthcare practitioner explaining the treatment's side-effects.

The analysis for each of the sub-themes shown in Figure 5.17 above, are discussed below.

Statement E20.1 - The healthcare facility has running water

The statement was agreed with by the majority of respondents (83,9 percent: strongly agree 38,7 percent; agree 45,2 percent). By comparison, 11,6 percent (strongly disagree 7,3 percent; disagree 4,3 percent) of the respondents disagreed with the statement. In addition, 4,6 percent of the respondents stated they were uncertain. The results indicate more than 80 of respondents indicated the healthcare facility has running water.

Statement E20.2 - The healthcare facility has electricity

The majority of respondents (88,4 percent: strongly agree 42,7 percent; agree 45,7 percent) agreed with the statement. By comparison, 9,2 percent (strongly disagree 8,4 percent; disagree 0,8 percent) of the respondents disagreed with the statement, and 2,4 percent of respondents stated they were uncertain. The results indicate more than 80 percent of the respondents indicated the healthcare facility has electricity.

These findings appear to be inconsistent with the literature reviewed, where a lack of basic resources was cited as the cause of poor quality public healthcare sector service delivery (Young 2016: 4-9; SA National Department of Health 2017: 03-04; Maphumulo and Bhengu 2019: 02). The absence of basic services is often reported as a barrier in providing or improving quality healthcare, these services include water, telephone access and reliable electricity, among others (Mthanti 2015: 01).

Statement E20.3 - The medication I require is available at the healthcare facility

Agreement was indicated by the majority of respondents (66,5 percent: strongly agree 23% percent; agree 43,5 percent) with the statement. By comparison, 21,6 percent (strongly disagree 13,5 percent; disagree 8,1 percent) of respondents on average disagreed with the statement, while 11,9 percent of respondents stated they were uncertain. The results show slightly more than two thirds of the respondents agreed the medication required by patients is available at the healthcare facility. However, more than 20 percent of the patients find the medication they require is not available at the healthcare facility.

These findings are consistent with the literature reviewed that cited drug shortages as a challenge for patients accessing public sector healthcare services (SA National Department of Health 2017: 03-04; Maphumulo and Bhengu 2019: 02; Rural Health Advocacy Project n.d: 06). According to Moyo (2016: 27), healthcare facilities often do not have sufficient drugs to provide adequate healthcare services and these service delivery challenges must be addressed, as they pose a serious barrier to the ability of patients to access quality healthcare services.

Statement E20.4 - The healthcare practitioner explains the side effects of my medication

Only an aggregate of 43,3 percent of respondents (strongly agree 19,1 percent; agree 24,2 percent) agreed with the statement. By comparison, most respondents (48,7 percent: strongly disagree 33,6 percent; disagree 15,1 percent) disagreed with the statement, with 8,1 percent of the respondents that stated they were uncertain. The results indicate close to half of the respondents were not provided with information regarding the side-effects of the medication they were prescribed.

These findings suggest the patient rights contained in Section 6(1)(b) of the NHA are supported by less than 50 percent of the time and patients are often not provided with information concerning the side-effects of the prescribed medication. Khademi, Mohammadi and Vanaki (2019: 576, 577) assert, despite healthcare providers generally known as advocates for patient rights, there are several findings regarding the violation of patient's rights, including a lack of information provided.

Responses to the open-ended question

Question 22 gave respondents an opportunity to add any other challenges they may have experienced in healthcare service delivery. The following responses align with the sub-theme that follows, under the theme facilities and medication:

- Shortage of treatments.
- They do not have enough chairs and benches to sit patient while on queues and waiting to be attended.
- There are not enough rest rooms for patients to use, so they have to wait in long lines to use the restrooms at medical facilities.

The results from the open-ended questions provide additional insight into the nature and extent of the challenges faced by patients. These findings are consistent with and supported by the literature discussed above.

5.5.4.6 E21 - Availability of beds

Respondents were asked to indicate their level of agreement or disagreement with the statement that the healthcare facility has beds available when they need them.

Figure 5.18 below shows the scoring pattern for availability of beds.

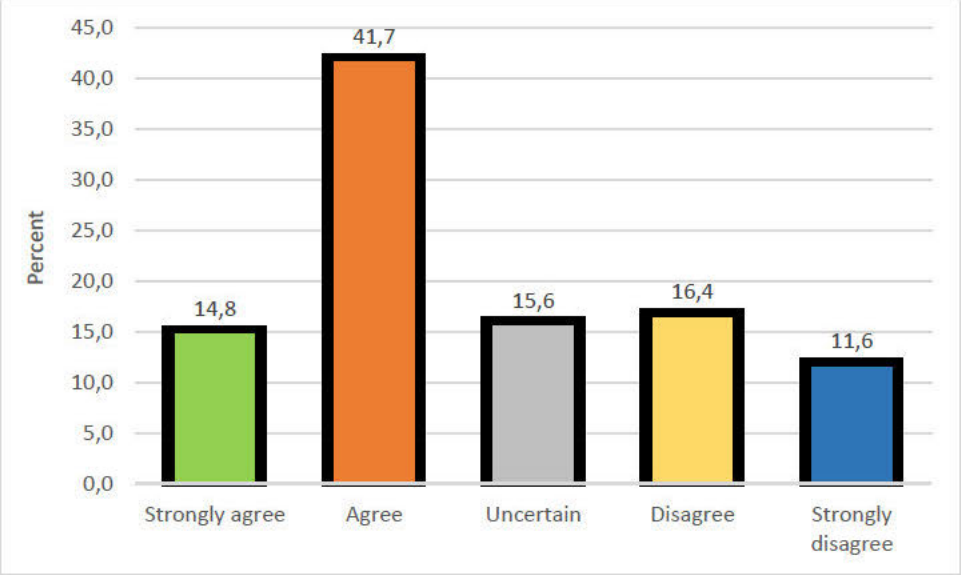

Figure 5.18: Availability of beds

The following pattern is observed from the results shown in Figure 5.18:

- There is a significantly higher level of agreement

The majority of respondents (56,5 percent: strongly agree 14,8 percent; agree 41,7 percent) agreed with the statement "The healthcare facility has beds available when I need one". By comparison, 28 percent (strongly disagree 11,6 percent; disagree 16,4 percent) of the respondents disagreed with the statement and 15,6 percent of the respondents stated they were uncertain. The results indicate slightly more than half of the respondents agreed with the statement that the healthcare facility has beds available when they need them. This indicates less than half the respondents indicated beds were unavailable.

These findings are consistent with the literature reviewed that cited a lack of basic resources resulted in poor quality services delivered in the public healthcare sector (Young 2016: 4-9; SA National Department of Health 2017: 03-04; Maphumulo and Bhengu 2019: 02; Mthanti 2015: 01).

Responses to the open-ended question

Question 22 gave respondents an opportunity to raise any additional challenges they may have experienced in the delivery of healthcare services. The following responses align with the sub-theme that follows, under the theme availability of beds:

- The healthcare facilities have a shortage of resources such as, available beds.
- We have to wait on the waiting rooms until admitted patients would be discharged so the next patient would get a new bed available.
- Date of admission to the hospital is postponed until there are available beds or doctors to attend to the patients.

The results from the open-ended questions provide additional insight into the nature and extent of the challenges faced by patients. These findings are consistent with and supported by the literature discussed above.

5.5.4.7 Lack of privacy and confidentiality

An analysis of the responses to Question 22 resulted in an additional theme being included, lack of privacy and confidentiality. The following responses align with this theme:

- The facility lacks privacy, it is brought to everyone’s attention what you are there for as healthcare professional would shout out loud for directing patients to rooms or departments to go to. For instance, a nurse would come to waiting room shout that all those who are there for HIV injection or please follow me, by the time you do follow instruction, everyone who is watching you will already be aware of what you are there for and won't be able to keep your status a secret.
- Male staff cleaners would frequently be on duty inside female restrooms and vice versa.

- There is a problem with confidentiality, healthcare practitioners unintentionally or without consent disclose personal information to patient's partners or parents.

The literature reviewed in this study identified breaches of confidentiality as a challenge for patients. Despite the right to confidentiality being a fundamental patient right, recognised in the NHA (Section 14), the right to privacy (Sections 11-12), as contained in (Part B) of the CPA, does not address the health challenges patients experience, instead, it focuses on the right to restrict unwanted direct marketing (Section 11) and the regulation of time for contacting consumers (Section 12); therefore, it is not canvassed in this study.

5.5.4.8 Opportunity for respondents to provide feedback about the quality of the services received after accessing healthcare services at the facility

Respondents were asked to indicate whether they were afforded an opportunity to provide feedback concerning the quality of healthcare facility services received.

Figure 5.19 below shows the scoring pattern for responses.

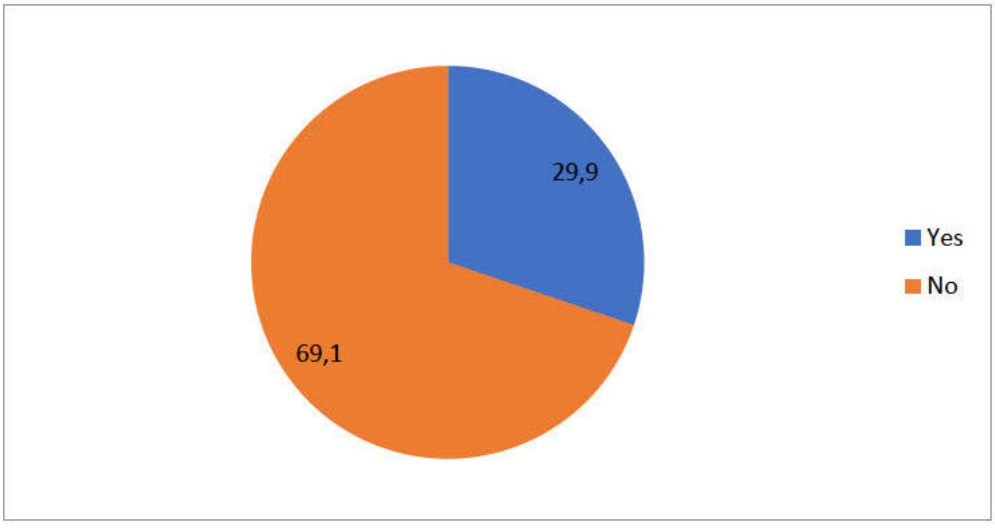

Figure 5.19: Opportunity for respondents to provide feedback about the quality of the services received

It was indicated by 29.9 percent of the respondents that they are given an opportunity to provide feedback with regard to the quality of services. However, the majority (69.1 percent) of the respondents stated they are not given an opportunity to provide feedback. The results indicate most respondents felt they are not offered an opportunity to provide feedback regarding the quality of services they received.

These findings appear to align with the assertion by Carstens and Pearmain (2007: 372) that the attitude towards public sector healthcare service delivery is: “these are the services on offer - take them or leave them”. According to Amukugo and Nangombe (2017: 13): 02), many healthcare facilities have quality assurance (QA) standards, however, these standards are often not accurately complied with to respond to the needs of patients. Isik *et al.* (2011: 1921) state measuring service quality is an important mechanism in addressing quality related issues in response to patient needs. The authors suggest a mechanism such as SERVQUAL may be used to measure and monitor service quality in healthcare facilities, while ascertaining areas in which the service quality can be improved.

5.6 Reliability Statistics

As stated by Ruland *et al.* (2007: 04), the two most important elements of precision are reliability and validity. The author’s state reliability is calculated by taking several measurements on the same subjects. Maree (2019: 260) describes reliability as the degree to which any measurement procedure produces the same or matching results on repeated trials, in other words, is “repeatable and consistent”.

In this study, reliability was measured by conducting a pre-test and the Cronbach’s Alpha test was used to measure the internal consistency, as suggested by Bryman (2012: 120) and Maree (2019: 261). For a newly developed construct, a reliability coefficient of 0.60 or above is regarded as "acceptable”.

Table 5.3 below presents the Cronbach's alpha score for each of the items that represented the questionnaire.

Table 5.3: Cronbach's alpha score and research instrument reliability

	Section Name	N of Items	Cronbach's Alpha
C7	Awareness and understanding of patient rights contained in the NHA	6	0.873
D9	The right to choose	2	0.703
D10	The right to disclosure and information	2	0.645
D11	The right to fair and honest dealing	2	0.879
D12	The right to fair, just and reasonable terms and conditions	2	0.828
D13	The right to fair value, good quality and safety	2	0.778
E15	Adequate staffing	2	0.841
E17	Information management	6	0.909
E18	Safety and security	3	0.853
E19	Cleanliness and maintenance of buildings and grounds	6	0.912
E20	Facilities and medication	4	0.808

Sections C7, D9, D10, D11, D12, D13, E15, E17, E18, E19, and E20 were considered in obtaining the Cronbach's Alpha scores. The reliability scores for all sections exceeded the recommended Cronbach's alpha value. This demonstrates a degree of acceptable, consistent scoring for these sections of the research.

5.7. Inferential statistics

Cawthra *et al.* (2017: 187) explain inferential statistics allows the researcher to make a general statement regarding the entire population, based on the sample, by applying various statistical tests. This section of the study used statistical tests to provide credence to the study. SPSS computer software, version 27.0 was employed to analyse the data using factor analysis, correlation analysis and Pearson's Chi-square statistical test. For the study, SPSS was used to determine the correlation between the independent and dependent variable, with tests conducted at a 95 percent level of confidence. Thus, p should be <0.05 or $p<0.001$, for statistically significant relationships.

5.7.1 Factor Analysis

Maree (2019: 264) explains that factor analysis is a statistical technique with data reduction its main objective, determining which items "belong together". A typical

application. In survey research, factor analysis is applied when a researcher needs to represent various questions with a few hypothetical components.

Regarding Table 5.4 below:

- Principal component analysis was applied as the extraction technique, while Varimax with Kaiser Normalization was applied as the rotation technique. The number of variables with high loadings on each component is minimized through this orthogonal rotation strategy (Uddin *et al.* 2021: 85). It simplifies the interpretation of the factors (Kothari 2004 cited in Rambaruth 2021: 68).
- As shown by Factor analysis as well as loading demonstrates that there are inter-correlations between variables.
- Items of questions with comparable loading imply measurement along a similar factor. An examination of the content of items loading at or beyond 0.5 (and using the higher or highest loading in instances where items cross-loaded at greater than this value) effectively measured along the several components.

A summarised table reflecting the results of the Kaiser-Meyer-Olkin (KMO) and Bartlett's Tests precedes the matrix tables. The table below citing KMO and Bartlett's Test demonstrates the two tests that indicate the suitability of data for structure dedection. The KMO Measure of Sampling Adequacy is a statistic that reveals the proportion of variance in the variables that might be caused by underlying factors. High values (close to 1.0) commonly indicate a factor analysis may be of use with the data. When the value is less than 0.50, the factor analysis results probably will not be particularly relevant. (Joshi and Pandya 2019: 108).

Bartlett's test of sphericity tests the theory that the correlation matrix is an identity matrix, which would indicate the variables are unrelated and therefore, inadequate for structure detection. Small values of the significance level (less than 0.05) indicate that a factor analysis may be useful with the data (Musoga, Ngugi and Wanjau 2021: 51; Devi *et al.* 2022: 8686). The requirement is that the KMO Measure of Sampling Adequacy should be greater than 0.50 and Bartlett's Test of Sphericity less than 0.05 (Wadood, Akbar, and

Ullah 2021: 2423). In all instances, the conditions are satisfied, which allows for the factor analysis procedure.

Table 5.4 shows the values of the KMO and Bartlett's tests meet all criteria.

5.7.2 KMO and Bartlett's Test

Table 5.4: KMO and Bartlett's Test

		Kaiser-Meyer-Olkin Measure of Sampling Adequacy	Bartlett's Test of Sphericity		
	Section Name		Approx. Chi-Square	df	Sig.
C7	Awareness and understanding of patient rights contained in the NHA	0.832	1064.141	15	0.000
D9 - D13	The right to choose The right to disclosure and information The right to fair and honest dealing The right to fair, just and reasonable terms and conditions The right to fair value, good quality and safety	0.877	1894.298	45	0.000
E15	Adequate staffing	0.505	278.375	3	0.000
E17	Information management	0.857	1466.607	15	0.000
E18	Safety and security	0.683	544.879	3	0.000
E19	Cleanliness and maintenance of buildings and grounds	0.872	1511.113	15	0.000
E20	Facilities and medication	0.706	624.735	6	0.000

As illustrated in Table 5.4, all the prerequisites for factor analysis are satisfied. In other words, the value of the KMO Measure of Sampling Adequacy should be greater than 0.500 and the value of Bartlett's Test of Sphericity sig. should be less than 0.05.

Factor analysis is only performed for the Likert scale items. According to Maree (2019: 264), a Likert scale is well-suited to this kind of analysis. Certain components were further divided into finer components, illustrated by the rotated component matrix below.

5.7.3 Rotated Component Matrices

This section contains the results for patient rights contained in the NHA, consumer rights contained in the CPA and patient challenges.

Patient rights contained in the NHA

Table 5.5 below indicates the results for patient rights contained in the NHA.

Table 5.5: Patient rights contained in the NHA

C7. Awareness and understanding of patient rights contained in the NHA	Component
	1
According to Section 6, a user has the right to have his/her health status explained	0.739
According to Section 6, a user has the right to have the range of available treatments explained	0.780
According to Section 6, a user has the right to have the benefits, risks, costs and consequences of each suitable treatment explained	0.790
According to Section 7, a user has the right to provide informed consent for the treatment they receive	0.802
According to Section 8, a user has the right to participate in decisions about their health and treatment	0.833
According to Section 14, a user has the right to have the information about his/her health status and treatment kept confidential	0.756

Extraction Method: Principal Component Analysis.

1 components extracted.

Table 5.5 illustrates that the statements concerning awareness and understanding of patient rights contained in the NHA loaded perfectly in a single component. This indicates the statements that constituted this section accurately measured what they intended to measure.

Fundamental consumer rights contained in the CPA

Table 5.6 below indicates the results for consumer rights contained in the CPA.

Table 5.6: Fundamental consumer rights contained in the CPA

D9 - D13. The right to choose The right to disclosure and information The right to fair and honest dealing The right to fair, just and reasonable terms and conditions The right to fair value, good quality and safety	Component				
	1	2	3	4	5
According to Section 13, a consumer has the right to select a supplier such as a healthcare facility or healthcare practitioner	0.292	0.263	0.845	0.104	0.094
According to Section 19, a consumer has the right to services being provided on the agreed date and time or within a reasonable time	0.249	0.265	0.543	0.576	0.101
According to Section 22, a consumer has the right to information in plain and understandable language	0.131	0.175	0.104	0.252	0.908
According to Section 23, a consumer has the right to disclosure of the price of services provided	0.211	0.222	0.082	0.824	0.282
According to Section 47, a consumer has the right to receive goods such as medication at the specified date and time	0.204	0.879	0.184	0.168	0.131
According to Section 47, a consumer has the right to receive services such as treatment at the specified date and time	0.247	0.860	0.194	0.198	0.126
According to Section 50, a consumer has the right to enter a contract based on fair, just and reasonable terms	0.822	0.126	0.208	0.055	0.333
According to Sections 49 and 51, a supplier is not entitled to limit his/her risk or liability in terms of an exclusionary clause in a contract without explaining the nature of the limitation to the consumer	0.751	0.074	0.422	0.105	0.140
According to Section 54, a consumer has a right to the timely performance and completion of services undertaken by a supplier	0.777	0.227	0.118	0.346	0.042
According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect	0.793	0.324	0.083	0.141	-0.085
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.					

a. Rotation converged in 5 iterations.

Themes:

- Yellow: The right to choose
- Blue: The right to disclosure and information
- Green: The right to fair and honest dealing
- Grey: The right to fair, just and reasonable terms
- Pink: The right to fair value, good quality and safety

The variables that constituted section D9: The right to choose, loaded along two components (sub-themes), coded as yellow in Table 5.6. The statement “a consumer has the right to select a supplier such as a healthcare facility or healthcare practitioner” fell in component 3, with a score of 0.843 and “a consumer has the right to services being provided on the agreed date and time or within a reasonable time” loaded along component 4 with a score of 0.576. This means respondents identified different trends within the section.

The variables that constituted section D10: The right to disclosure and information, loaded along two components (sub-themes), coded in blue in Table 5.6. The statement “a consumer has the right to information in plain and understandable language” having the highest score of 0.908 and “a consumer has the right to disclosure of the price of services provided” with a score of 0.824. This means respondents identified different trends within the section.

The variables that constituted the following sections:

- Section D 11: The right to fair and honest dealing, coded in green in Table 5.6;
- Section D 12: The right to fair, just and reasonable terms, coded in grey in Table 5.6 and;
- Section D 13: The right to fair value, good quality and safety, coded in pink in Table 5.6

All loaded perfectly in a single component. This implies the statements that constituted these sections accurately measured what they intended to measure.

Challenges experienced by patients in accessing healthcare services

Patient challenges associated with adequate staffing loaded along two components. The other categories of patient challenges loaded perfectly in a single component. The results are presented in Tables 5.7-5.11 below.

Table 5.7: Adequate staffing

E15. Adequate staffing	Component	
	1	2
I have to wait for a long time before being attended to by a healthcare practitioner	-0.024	0.998
Healthcare practitioners are available to attend to me within a reasonable time	0.926	-0.097
Staff members are helpful and informative	0.931	0.051

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Themes:

- Blue: Waiting periods before being attended to
- Yellow: Helpful and informative staff

It is noted the variables in Table 5.7 above, which constituted the section on challenges associated with adequate staffing, loaded along two components (sub-themes). This indicates that respondents observed various trends within the section, where the splits are colour coded within the section and can be interpreted as follows:

- Component 1, coded in yellow, was identified as challenges associated with adequate staffing, which reflected the sub-themes “healthcare practitioners are available to attend to me within a reasonable time” and “staff members are helpful and informative”.
- Component 2, coded in blue was identified as “I have to wait for a long time before being attended to by a healthcare practitioner”, with a score of 0.998.

The statements concerning the other categories of patient challenges loaded perfectly in a single component. This implies the statements that constituted each of these sections accurately measured what they intended to measure as indicated by the following tables:

Table 5.8: Information management

E17. Information management	Component
	1
My patient file is readily available when I arrive at the healthcare facility	0.785
My patient file is up to date	0.889
The healthcare practitioner explains my health status	0.877
The healthcare practitioner explains the treatment I receive	0.876
The healthcare practitioner speaks to me in a language I understand	0.782
The healthcare facility has an interpreter who assists the healthcare practitioners	0.765

Extraction Method: Principal Component Analysis.

a. 1 components extracted.

Table 5.9: Safety and security

E18. Safety and security	Component
	1
There is sufficient security at the healthcare facility	0.898
I feel safe at the healthcare facility	0.922
The outside areas are well lit at night	0.813

Extraction Method: Principal Component Analysis.

a. 1 components extracted.

Table 5.10: Cleanliness and maintenance of buildings and grounds

E19. Cleanliness and maintenance of buildings and grounds	Component
	1
There is adequate seating available while I wait	0.767
The healthcare facility is clean	0.876
There are toilets at the healthcare facility	0.723
The toilets at the healthcare facility are clean	0.875
The grounds around the healthcare facility are well maintained	0.898

The buildings of the healthcare facility are well maintained	0.867

Extraction Method: Principal Component Analysis.

a. 1 components extracted.

Table 5.11: Facilities and medication

E20. Facilities and medication	Component
	1
The healthcare facility has running water	0.835
The healthcare facility has electricity	0.833
The medication I require is available at the healthcare facility	0.863
The healthcare practitioner explains the side effects of my medication	0.699

Extraction Method: Principal Component Analysis.

a. 1 components extracted.

5.7.4 Cross tabulations

According to Maree (2019: 297), the Chi-square test is applied to examine the association between two nominal variables, the calculations are based on a 2-way cross tabulation. The traditional approach is that a statement of statistical significance is necessary when reporting a result. A test statistic generates a p-value, and a significant outcome is denoted by "p 0.05." A Chi-square test of independence was conducted to ascertain whether there was a statistically significant association between the variables (rows vs columns). According to the null hypothesis, there is no correlation between the two. The alternative hypothesis implies there is a correlation.

5.7.4.1 Cross tabulation between educational qualification and the manner in which respondents currently characterise themselves when accessing healthcare services

Table 5.12 summarises the Chi-square tests results.

Table 5.12: Cross tabulation between educational qualification and the manner in which respondents currently characterise themselves when accessing healthcare services

			Highest educational qualification					
			No formal education	Primary school education	High school education	Matric	Post school qualification such as University or College	Total
When you access healthcare services how do you CURRENTLY describe or characterize yourself?	As a patient	Count	22	19	55	88	68	252
		% within When you access healthcare services how do you CURRENTLY describe or characterize yourself?	8.7%	7.5%	21.8%	34.9%	27.0%	100.0%
		% within Highest educational qualification	68.8 %	59.4%	77.5%	69.8%	65.4%	69.0%
		% of Total	6.0%	5.2%	15.1%	24.1%	18.6%	69.0%
	As a consumer	Count	2	3	9	11	5	30
		% within When you access healthcare services how do you CURRENTLY describe or characterize yourself?	6.7%	10.0%	30.0%	36.7%	16.7%	100.0%
		% within Highest educational qualification	6.3%	9.4%	12.7%	8.7%	4.8%	8.2%
		% of Total	0.5%	0.8%	2.5%	3.0%	1.4%	8.2%
	As both patient and a consumer	Count	3	4	4	9	22	42
		% within When you access healthcare services how do you CURRENTLY describe or characterize yourself?	7.1%	9.5%	9.5%	21.4%	52.4%	100.0%
		% within Highest educational qualification	9.4%	12.5%	5.6%	7.1%	21.2%	11.5%
		% of Total	0.8%	1.1%	1.1%	2.5%	6.0%	11.5%

	I have never thought about this	Count	5	6	3	18	9	41
		% within When you access healthcare services how do you CURRENTLY describe or characterize yourself?	12.2 %	14.6%	7.3%	43.9%	22.0%	100.0%
		% within Highest educational qualification	15.6 %	18.8%	4.2%	14.3%	8.7%	11.2%
		% of Total	1.4%	1.6%	0.8%	4.9%	2.5%	11.2%
Total		Count	32	32	71	126	104	365
		% within When you access healthcare services how do you CURRENTLY describe or characterize yourself?	8.8%	8.8%	19.5%	34.5%	28.5%	100.0%
		% within Highest educational qualification	100.0 %	100.0%	100.0 %	100.0%	100.0%	100.0%
		% of Total	8.8%	8.8%	19.5%	34.5%	28.5%	100.0%

Table 5.12 above reveals significantly more respondents with a post-school qualification who currently characterise themselves as both a patient and a consumer (52, 4 percent). The results show 43,9 percent of respondents with a matric qualification had not thought about how to characterise themselves, and only 8,7 percent of respondents with no formal education currently characterise themselves as both patient and consumer when they access healthcare services.

An analysis of the results of the tables reveals the following significant cross tabulations:

The p-value between “When you access healthcare services how do you CURRENTLY describe or characterize yourself?” and “Highest educational qualification” is 0.020. This indicates a significant relationship between the variables. In other words, the education level of the respondents played a significant role in terms of how respondents currently view themselves when visiting a healthcare facility.

The p-value between “When you access healthcare services HOW WOULD YOU LIKE to be treated?” and “Highest educational qualification” is 0.029. This indicates a significant relationship between the variables. In other words, the education level of the respondents

also played a significant role in terms of how respondents would like to be treated when visiting a healthcare facility.

5.7.5 Correlation Analysis

Correlation analysis was performed on the ordinal data using SPSS version 27.0 to determine the bivariate correlations related to the study.

The findings present the following patterns:
The relationship between the variables is shown to be directly proportional when values are positive and inverse when values are negative. (Sarma *et al.* 2022: 359). A symbol * or ** denotes all significant relationships.

An analysis was conducted on statements deemed significant in the study for correlation purposes. In order to align with the aim of the study, the focus was on the relationship between consumer rights contained in the CPA and the challenges patients' experience. Selected significant correlations are indicated as follows:

Analysis 1: The correlation value between "**According to Section 22, a consumer has the right to information in plain and understandable language**" and "**The healthcare practitioner speaks to me in a language I understand**" is 0.265**. These factors have a significant relationship. The respondents indicated the more the right to information in plain and understandable language is upheld, the more the healthcare practitioners speak to patients in a language they understand, and vice versa.

Analysis 2: The correlation value between "**According to Section 13, a consumer has the right to select a supplier such as a healthcare facility or healthcare practitioner**" and "**My patient file is readily available when I arrive at the healthcare facility**" is 0.368**. These factors have a significant relationship. The respondents indicated the more the patient right to select a supplier, such as a healthcare facility, is recognised, the more they can expect their patient file is readily available when they arrive at the healthcare facility and vice versa.

Analysis 3: The correlation value between **"According to Section 50, a consumer has the right to enter into a contract based on fair, just and reasonable terms"** and **"Staff members are helpful and informative"** is 0.343**. These factors have a significant relationship. The respondents indicated the more the consumer right is recognised to enter a contract based on fair, just and reasonable terms, the more they can expect staff members are helpful and informative and vice versa.

Analysis 4: The correlation value between **"According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect"** and **"The healthcare practitioner explains the side effects of my medication"** is 0.468**. These factors have a significant relationship. The respondents indicated more the consumer right is recognised to enter a contract based on fair, just and reasonable terms, the more they can expect the side effects of their medication is explained and vice versa.

Analysis 5: The correlation value between **"According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect"** and **"The healthcare facility has beds available when I need one"** is 0.277**. These factors have a significant relationship. The respondents indicated the more the consumer right to enter a contract based on fair, just and reasonable terms, is recognised, the more they can expect the healthcare facility has beds available and vice versa.

Analysis 6: The correlation value between **"According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect"** and **"The medication I require is available at the healthcare facility"** is 0.298**. These factors have a significant relationship. The respondents indicated the more the consumer right is recognised to enter a contract based on fair, just and reasonable terms, the more they can expect the medication they require is available and vice versa.

Analysis 7: The correlation value between **"According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect"** and **"There is adequate seating available while I wait"** is 0.363**. These factors have a significant relationship. The respondents indicated the more the consumer right to enter a contract based on fair, just and reasonable terms is recognised, the more they can expect adequate seating is available while they wait and vice versa.

Negative values indicate an inverse relationship, implying that the variables' effect on one another is opposite. Simply stated, while one increases, the other one decreases. The results indicate the following patterns of inverse relationships.

Analysis 8: The correlation value between **"According to Section 19, a consumer has the right to services being provided on the agreed date and time or within a reasonable time"** and **"I have to wait a long time before being attended to by a healthcare practitioner"** is -0.106*. This means the less the right is upheld to services being provided on the agreed date and time or within a reasonable time, the longer the patient has to wait for treatment.

Analysis 9: The correlation value between **"According to Section 47, a consumer has the right to receive goods such as medication at the specified date and time"** and **"I have to wait a long time before being attended to by a healthcare practitioner**" is -0.126*. In other words, the less the right to receive goods such as medication at the specified date and time is recognised, the longer the patient has to wait for treatment.

Analysis 10: The correlation value between **"According to Section 47, a consumer has the right to receive services such as treatment at the specified date and time"** and **"I have to wait a long time before being attended to by a healthcare practitioner"** is -0.144**. Therefore, the less the right is recognised to receive services such as treatment at the specified date and time, the longer the patient has to wait for treatment.

Analysis 11: The correlation value between **"According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect"** and **"I have to wait a long time before being attended to by a healthcare practitioner"** is -0.151**. This means the less the consumer right to the performance of services in a manner and quality the consumer is generally entitled to expect is recognised, the longer the patient has to wait for treatment.

5.8 Conclusion

The results of the empirical study were presented and analysed in this chapter. Data obtained from the responses were analysed using the SPSS package version 27.0 and various statistical methods were employed. Data were analysed with the use of tables, graphs, and pie-charts. Tests of the reliability and validity of the questions were conducted using Cronbach's Alpha and KMO and Bartlett's tests. The Cronbach's Alpha for the questionnaire indicated questions were above the minimum of 0.6, which is regarded as acceptable for a newly developed construct. The reliability scores for all sections exceeded the recommended Cronbach's alpha value, demonstrating a degree of acceptable, consistent scoring. The KMO and Bartlett's test for the questionnaire also indicated the values met all the criteria.

The findings from the analysis of results were corroborated using pertinent and relevant literature. The next chapter discusses the significant findings of the study, and the alignment with the aims and objectives. Conclusions and recommendations, possible further research, and limitations to this study will also be discussed.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The previous chapter presented the results of the data drawn from the respondents. The data collected were presented and analysed using descriptive and inferential statistics. The aim of this study was to investigate the challenges of patients as consumers of public healthcare services in the Inanda district of eThekwini and the role of the CPA in addressing these challenges.

This chapter discusses the significant findings and conclusions of this study, in relation to the study aim and objectives. Thereafter, limitations of the study, recommendations and possible further research will be discussed.

6.2 Objectives and research questions

In order to achieve the aim of this study, the following objectives and research questions were developed:

6.2.1 Objectives

- To examine the extent to which patients as consumers are aware of their rights in terms of the NHA;
- To examine the extent to which patients as consumers are aware of their fundamental consumer rights in terms of the CPA;
- To investigate the challenges of patients as consumers of public healthcare services delivered in the public healthcare sector in the Inanda district of eThekwini; and
- To explore the role of the CPA in addressing the challenges of patients as consumers.

6.2.2 Research questions

1. To what extent are patients as consumers aware of their rights in terms of the NHA?
2. To what extent are patients as consumers of healthcare services aware of their consumer rights in terms of the CPA?
3. What are the challenges of patients as consumers of public healthcare services delivered in the public healthcare sector in the Inanda district of eThekwini?
4. Does the CPA have a role in addressing the challenges of patients as consumers?

The aim and objectives of this study were achieved using both primary and secondary sources of data. Primary data were collected in the empirical study through a survey using a questionnaire. Secondary data were collected from research papers, books, journal articles, and reports, along with websites, government publications, and legislation, as well as government policies. The following section will discuss pertinent findings and conclusions from the literature reviewed.

6.3 Findings and conclusions from the Literature review

This section will discuss pertinent findings and conclusions based on the literature reviewed and considering the research aim and study objectives.

6.3.1 Fundamental role of health in society, patient challenges and the legal framework that aims to advance the right to health

Adopting social justice as a theoretical framework, due to the essential and critical role of health in enabling individuals to exercise all other human rights (WHO 2017: 01), in addition to the central role it occupies in the transformation agenda in SA, Chapter Two examined the important and fundamental role of health in society. This was achieved by exploring both the international and South African regulatory frameworks that seek to protect the right to health as a fundamental human right. Patient challenges were examined from both an historical and current perspective and included both structural and individual challenges. The chapter concluded by discussing three core patient rights contained in the NHA that aim to promote and protect the interest of patients as they access healthcare services.

Based on the literature reviewed, it may be concluded good health is essential, not only for individuals but for society as a whole, because in the absence of good health, individuals are unable to exercise and enjoy other basic human rights (WHO 2017: 01). In SA, the right to health is recognised in the Constitution as a right of access to healthcare services (Section 27(1)(a)). This right is, however, not an unlimited right and Section 27(2) of the Constitution provides the state has a duty to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to healthcare services. The NHA is founded upon the health rights contained in the Constitution and aims to ensure that the people of SA are provided with the "best possible" healthcare services available resources can provide, in an equitable manner (Section 2(a)(i); (ii)).

The ICESCR (UN General Assembly 1966: Art 12(2)) places a legal duty on member states to ensure the progressive realisation of the right to health, which includes executing a national plan founded on human rights principles, with the aim to ensure this right is realised for every person. SA has ratified the ICESCR (UN General Assembly: 1966) and is under a legal obligation to ensure the right to health is progressively realised in the country.

The introduction of the CPA to the healthcare sector can be seen as forming part of SA's national plan to ensure the right to health is realised for every person. The CPA needs to use the authoritative explanation and interpretation of the right to health, used by the CESCR in General Comment 14 (CESCR 2000), to conceptualise health and regulate this market in a manner that promotes health and health equity (Von Staden 2021: 137).

Law is recognised as having the capacity to enhance the right to health (WHO 2017: 1), while legal frameworks have a significant role to ensure the structure of any health system is effective (WHO 2017: 107). However, legal frameworks must ensure advancing health rights is prioritised (WHO 2017: 69). It is essential that the manner in which the CPA is introduced into the healthcare consumer market is done in a way that seeks to further the

aims of this specialised consumer market and does not act as a barrier to health (Von Staden 2021: 5).

The NHA provides patients with a number of rights, including the right to informed consent (Section 7), the right to participate in decision making (Section 6; 8) and the right to confidentiality (Section 14). These rights are part of the legislative measures that aim to achieve the progressive realisation of the Constitutional right of access to healthcare services. The NPRC (SA Department of Health 1999) acknowledges the importance of information for patients in understanding and enforcing their rights; it, therefore, requires all healthcare system users must be informed of their rights. Subsequently, public healthcare facilities are required to display the NPRC (SA Department of Health 1999) in local languages to assist in creating awareness of both patients' rights and the level and quality of healthcare services patients can expect at public healthcare facilities (Hassim, Heywood and Berger 2007: 247).

Despite recognition, both at an international and national level in SA, of the important and critical role of the right to health, patients continue to face challenges in accessing quality healthcare services in the country. The patient challenges reviewed were used as a basis to draft the questionnaire and will be discussed in more detail in the section discussing the findings and conclusions from the empirical study.

6.3.2 The rights of patients as consumers of healthcare services in terms of the CPA

Chapter Three examined the application of the CPA to the healthcare consumer market in SA, with a focus on selected fundamental consumer rights that may have a role to play in addressing challenges patients experience as consumers in the healthcare consumer market. Some of the challenges patients face discussed in Chapter Two were linked to certain fundamental consumer rights and, where applicable, patient rights contained in the NHA were analysed and compared to consumer rights. Finally, the possibility and value of measuring the quality of services delivered was briefly explored.

Based on the literature reviewed, it was concluded the CPA applies the definition of a transaction to public sector healthcare-related transactions in SA, where patients are considered consumers from a legal perspective (Jacobs, Stoop and Van Niekerk 2010: 313; Rowe and Moodley 2013: 01-02; Slabbert and Labuschaigne 2022: 33) and provided rights as patients in terms of the NHA (Dhai and Mahomed 2018: 09) and as consumers under the CPA (Rowe and Moodley 2013: 02). However, characterising patients as consumers of healthcare services may have both legal and ethical implications for the doctor and the patient, because the labels used to describe and classify individuals often shape their identity and influence their behaviour (Rowe and Moodley 2013: 18).

A comparative analysis was conducted between selected, pertinent fundamental consumer rights contained in the CPA and relevant patient rights contained in the NHA. This analysis found a significant degree of duplication between the fundamental consumer right to choose, in terms of Sections 13 of the CPA, and the right of the patient to informed consent, as set out in Section 6 of the NHA, where this right does not provide the patient, as a consumer, with significant additional rights above the patient rights contained in the NHA. Although, the right to choose, as contained in Section 19 of the CPA, appears to provide patients, as consumers, with extra rights, the remedies provided may be counter-productive to ensuring patients receive timeous and appropriate medical treatment. In addition, it is uncertain whether this consumer right will be effective in addressing the health challenges of patients.

Furthermore, the consumer right to disclosure of information was examined in terms Section 22, the right to plain and understandable language, and Section 23, the right to disclosure of the price of goods and services. Both the CPA and the NHA use a “consumer-centred subjective approach” to determine whether information has been provided to patients in plain and understandable language. It is debateable whether the provisions of Section 22 of the CPA extend the patient rights in terms of the NHA in a meaningful and context-appropriate manner, because of the significant informational requirements of the patient’s right to informed consent, as set out in the NHA (Von Staden 2021: 511-512). The CPA may assist patients in making “value-based purchasing

decisions", nevertheless, due to the way patients "pay" for public sector healthcare services, disclosing the price of goods or services does not empower them to any significant extent (Von Staden 2021: 513).

The right to fair and honest dealing was examined based on the regulation of over-selling and over-booking in terms of Section 47. This fundamental consumer right may help patients in the public sector to obtain healthcare services timeously, however, enforcing this right may be problematic, since payment for healthcare services is not related to the actual value of the services provided.

A comparative analysis between the fundamental consumer right to fair and reasonable terms and conditions in the CPA and existing patient rights in terms of the NHA, shows the sections of the CPA that make up this right have added significant rights to the patient as a consumer in the healthcare consumer market, particularly regarding the use of standard form contracts and exclusionary clauses (McQuoid-Mason 2012: 67).

The right to fair value, good quality and safety was examined in terms of Section 54, which provides consumers with the right to demand quality service, including the right to services being performed and completed timeously and, in a manner and quality patients are "generally entitled to expect" (Section 54(1) (a);(b)). However, the remedies provided in terms of this section, requiring the healthcare provider to remedy the defective quality of the services delivered, or refund the patient a reasonable portion of the price paid for the services, may be difficult for patients to enforce and could result in the public healthcare paying "hard-earned taxes" on consumer claims (Letzler 2012: 16-17).

Therefore, it may be concluded, based on the literature reviewed that selected, pertinent fundamental consumer rights contained in the CPA have a role to play in addressing the challenges patients face as consumers of public healthcare services in the healthcare consumer market. Nevertheless, the remedies attached to enforce some of these rights may be difficult to enforce, particularly for patients who have been described as the country's "most vulnerable poor" (Dhai and Mahomed 2018: 08).

One of the ways the CPA aims to promote and advance social and economic consumer welfare, is by “improving consumer awareness and information and encouraging responsible and informed consumer choice and behaviour” (Section 3(1)(e)). It was found, without awareness of their rights, consumers are unable to take advantage of the protection provided by the CPA (Van den Heever 2012: 07) and the NPRC (SA Department of Health 1999) may be used as a guideline to implement a similar method to raise awareness of the fundamental consumer rights patients have in terms of the CPA.

Finally, measuring service quality is an important mechanism for addressing quality related issues, in order to respond to patient needs. SERVQUAL, as a mechanism to measure and monitor service quality in healthcare facilities, may assist in ascertaining areas in which the service quality can be improved (Isik *et al.* 2011: 1921).

6.4 Findings and conclusions from the empirical study

A questionnaire was used to collect data for this study and was distributed to respondents characterised as patients who are consumers of public healthcare services and who reside in Shembes Village in the Inanda district of eThekwini municipality, KZN province, SA. The demographic profile of the majority of respondents is they were younger than 40 years old, have a high educational qualification, such as a matric or post-matric qualification, and access the healthcare facility closest to their home, usually a hospital or clinic, rather than a community healthcare centre.

Due to patients now considered consumers from a legal perspective (Jacobs, Stoop and Van Niekerk 2010: 313; Rowe and Moodley 2013: 01-02; Slabbert and Labuschaigne 2022: 33) and that the labels used to describe and classify individuals often shape their identity and influence their behaviour (Rowe and Moodley 2013: 18), the study investigated how respondents currently characterise themselves when they access healthcare services and how they would like to be characterised or described, as well as the reasons for this characterisation. The following section discusses these findings and conclusions.

6.4.1 The manner in which respondents characterise or describe themselves when accessing healthcare services

Based on the findings of the empirical study, the conclusions that may be drawn are that most of the respondents currently describe or characterise themselves as patients. The reason for this characterisation appears to be linked to preference and whether respondents paid for healthcare services.

The majority of respondents, when asked how they would prefer to be described or characterised, would still rather be referred to as a patient. Once again, there is a perception among respondents that when they do not pay for healthcare services, they are not consumers. Respondents also indicated they were more concerned with the quality of healthcare services delivered, than the labels used to describe them and that payment for healthcare services and quality are linked.

6.4.2 Awareness, understanding and infringement of rights

The study found that, in relation to awareness, understanding and infringement of patient rights contained in both the CPA and the NHA, respondents had higher levels of awareness and understanding and lower levels of infringement.

The study found no significant difference in awareness and understanding of patient rights in terms of the NHA, when compared to fundamental consumer rights contained in the CPA. This is an interesting result, considering public healthcare facilities are required to display the NPRC (SA Department of Health 1999) in an effort to provide information for patients, thereby improving their understanding and the enforcement of their rights in terms of the NHA (Hassim, Heywood and Berger 2007: 247). There is no such corresponding requirement for public healthcare facilities to display information regarding the fundamental consumer rights contained in the CPA.

It must be noted, however, one of the aims of the CPA is to improve “consumer awareness and information”, to encourage “responsible and informed consumer choices and behaviour” (SA Department of Trade and Industry 2008: Section 3(1)(e)). Awareness and

understanding of consumer rights may have originated outside of public healthcare facilities, since consumer rights, unlike patient rights, are not limited to healthcare service provision but have a much wider application.

The higher levels of awareness and understanding may be attributed to the majority of respondents who participated in the survey being educated, having attained a matric or post-matric qualification.

The study found no significant difference between the infringement of patient rights in terms of the NHA and the infringement of fundamental consumer rights contained in the CPA. For both sets of rights, respondents indicated similarly lower levels of infringement.

6.4.3 Challenges experienced by patients in accessing healthcare services

This section was designed to explore the challenges experienced by respondents in accessing healthcare services. The challenges identified and discussed in the literature review were grouped into the headings used in the questionnaire, in an attempt to streamline the challenges and make it easier for respondents to answer the questions.

Based on the study findings, it can be concluded adequate staffing is a concern and manifests as a challenge for patients in extended waiting times, the availability of healthcare practitioners to attend to patients timeously, and staff attitudes.

Some patients also experienced challenges with the manner in which their information is managed and indicated concerns with regard to the availability of patient files and accurate record keeping. However, it was found healthcare providers generally do explain a patient's health status and the treatment the patient will receive, as required by Section 6(1) of the NHA. Furthermore, healthcare providers usually provide information to patients in a language he/she understands, as required by Section 6(2) of the NHA and Section 22 of the CPA.

Despite more respondents indicating positively toward safety and security, showing the healthcare facility has adequate security and they feel safe at the healthcare facility, a significant percentage of respondents expressed concerns about safety and security.

Most of the respondents indicated the healthcare facility had adequate seating, is clean, generally has clean toilets and both the buildings and grounds around the healthcare facility are well-maintained. However, in each of the sub-themes, apart from the availability of toilets, the response rate was clustered around 60 percent, indicating a significant percentage of respondents found the opposite to be true.

The majority of respondents indicated the healthcare facility has basic services, such as running water and electricity, therefore, this was not a challenge. However, the availability of medication and the provision of information regarding the side-effects of the prescribed medication, were a significant challenge for patients. The availability of beds was also identified as a patient challenge.

Lack of privacy and confidentiality were identified as a further challenge, with the literature reviewed in this study also identifying breaches of confidentiality and lack of privacy as a challenge for patients. The right to confidentiality is a fundamental patient right recognised in the NHA (Section 14). However, the right to privacy (Sections 11-12); as contained in (Part B) of the CPA, does not address the challenges of the patient; instead, it focuses on the right to restrict unwanted direct marketing (Section 11) and the regulation of time for contacting consumers (Section 12). Therefore, in terms of the study aim, lack of privacy and confidentiality is a challenge for patients, however, the CPA does not play a role in addressing this challenge.

The results from the empirical study, therefore, generally supported the results from the literature reviewed and it can be concluded patients that access healthcare services in the public sector and who reside in Shembes Village in the Inanda district of eThekwini municipality, KZN, SA, are confronted with a wide and varied range of challenges. In addition, the majority of respondents are not given an opportunity to provide feedback

regarding the quality of services they received, thus providing little opportunity for them to highlight the challenges they encounter.

The aim and objectives set out in this study were achieved and it may be concluded patients as consumers of public healthcare services in the Inanda district of eThekwini do experience challenges, where the CPA has a role to play in addressing some of these challenges. However, there is a degree of duplication in protection provided to patients in terms of the NHA and the CPA.

6.5 Limitations of the study

Due to time and financial constraints, this research has certain limitations. The limitations to this study include:

Limited geographic area: This study focused on adult patients as consumers of public healthcare services who reside in Shembes Village in the Inanda district of eThekwini municipality, KZN province, SA. This is a limited geographic area, which may have resulted in many of the respondents accessing healthcare services at the same healthcare facility, as the majority of respondents indicated they used the healthcare facility closest to their home.

Demographic profile of the respondents: The higher levels of awareness and understanding of both patient and consumer rights may be attributed to most of the respondents being educated to a matric or post-matric level.

6.6 Recommendations

Based on the findings of the study, the following recommendations are made:
An education campaign needs to be implemented in accordance with the aim of the CPA in Section 3(1)(e) to improve “consumer awareness and information” in order to:

1. Address the perception that patients who do not pay directly for healthcare services are not consumers;

2. Raise awareness levels of patients as consumers of healthcare services regarding the link between the fundamental consumer rights in terms of the CPA and how these rights can be used to address the challenges they encounter; and
3. Educate service providers that the CPA applies to the healthcare sector and patients are, as such, consumers and must be afforded the fundamental consumer rights contained in the CPA.

6.7 Recommendations for further research

1. The study found lower levels of infringement of both patient and consumer rights. However, respondents indicated they experience several challenges in public sector healthcare service delivery. Further investigation needs to be conducted into the link between the perception of what constitutes an infringement of both patient and consumer rights, and the challenges experienced by patients as consumers of healthcare services.
2. Further research should be conducted to determine the awareness and understanding of service providers in the healthcare consumer market regarding the aims and fundamental consumer rights contained in the CPA.

6.8 Concluding remarks

The WHO (2017: 01) recognises the right to health as a foundational right that enables individuals to exercise all other human rights. The right to health is also recognised in the Constitution as a right of access to healthcare services (Section 27(1)(a)). Furthermore, the importance of social justice is emphasised in the preambles of the Constitution, the CPA, and the NHA, which highlight the importance of addressing socio-economic inequality and poverty, with the aim of implementing a society based on social justice to improve the quality of life for all citizens.

Despite the recognition of the important role good health plays in achieving social justice in SA, patients that access healthcare services in the public sector have been described as South Africa's "most vulnerable poor" (Dhai and Mahomed 2018: 08). It is critical that every effort is made to address the challenges experienced by these patients including

recognising the role of CPA in addressing the challenges experienced by patients as consumers of healthcare services. This is essential if the aim set out in the Preamble of the Constitution to “[i]mprove the quality of life of all citizens and free the potential of each person” is to be realised.

Reference List

Aderibigbe, K. S. and Chima, S. C. 2019 Knowledge and practice of informed consent by physiotherapists and therapy assistants in KwaZulu-Natal Province. South Africa'. *South African Journal of Physiotherapy, 75*(1): 01-02. Available: https://doi.org/10.4102/sajp.v75i1.1330 (Accessed 21 March 2021).

Aikman, N. 2019. The crisis within the South African healthcare system: A multifactorial disorder. *South African Journal of Bioethics Law*, 12(2): 52-56. Available: https://doi.org/10.7196/SAJBL.2019.V12i2.694 (Accessed 05 October 2020).

.

Ajayi, O. V. 2017. Distinguish between primary sources of data and secondary sources of data. Doctor of Philosophy, Benue State University, Makurdi. Available: DOI: 10.13140/RG.2.2.24292.68481. (Accessed 08 August 2021).

Akaranga, S. I. and Makau, B. K. 2016. Ethical consideration and their applications to research: a case of the university of Nairobi. *Journal of educational policy and entrepreneurial research, 3*(12): 06.

Akhtar, I. 2016. Research design. In: *Research In social science: Interdisciplinary perspectives*. Available: http://dx.doi.org/10.2139/ssrn.2862445 (Accessed 21 June 2020).

Ally, K. D. 2017. A critical examination of Section 61 of the Consumer Protection Act 68 of 2008 and its implications for those in the Supply Chain. Master's in business law. University of KwaZulu-Natal.

Almgren, G. 2013. *Healthcare care politics, policy, and services: A social justice analysis.* 3rd ed. New York: Springer publishing company.

Amukugo, H. J., and Nangombe, J. P. 2017. Quality Health Care Delivery at Health facilities in the Ministry of Health and social services in Namibia. *Nursing and Care open access journal*, *2*(1): 13-19. Available: DOI: 10.15406/ncoaj.2017.02.00026 (Accessed 5 October 2020).

Anwana, E.O. 2018. Corporate social responsibility and corporate governance: Implementation and challenges for companies listed on the Johannesburg securities exchange. Doctoral dissertation. Durban University of Technology. Available: http://hdl.handle.net/10321/3271 (Accessed 18 October 2021).

Archakova, A. 2013. Service quality and customer satisfaction. Case study: company X. Degree Programme in International Business, Saimaa University of Applied science.

Arizon, V. 2010. Service quality delivery in the food and beverage industry in the Western Cape. Magister Technologiae. Cape Peninsula University of Technology. Available: https://core.ac.uk/download/pdf/148365128.pdf (Accessed 2 April 2020).

Armstrong, G. and Kotler, P. 2013. *Marketing: An introduction.* 11th ed. New Jersey: Prentice-Hall.

Azizan, N. A., and Mohamed, B. 2013. The effects of perceived service quality on patient satisfaction at a public hospital in state of Pahang, Malaysia. *Asian Journal of Social Sciences and Humanities, 2*(3): 307-308.

Barapatre, N. B. and Joglekar, V. P. 2016. The right of patient as consumers: An ancient view. *International quarterly journal of research in Ayurveda*, 37(3-4): 05-155. Available: https://www.ayujournal.org/text.asp?2016/37/3/152/224175 (Accessed 08 June 2020).

Barit, A. 2017. The Doctrine of informed consent in South African medical law. MPhil Mini Dissertation, University of Pretoria.

Barkhuizen v Napier. 2007 (5) SA 323 (CC).

Bauling, A., and Nagtegaal, A. 2015. Bread as dignity: The Constitution and the Consumer Protection Act 68 of 2008. *De Jure*, 151-158. Available: http://dx.doi.org/10.17159/2225-7160/2015/v48n1a9 (Accessed 30 February 2020).

Begg, K., Andrews, G., Mamdoo, P., Engelbrecht, J., Dudley, L. and Lebese, L. 2018. Development of a national strategic framework for a high-quality health system in South Africa. *South African Health Review,* 77-85. Available: http://www.hst.org.za/publications/Pages/SAHR2018 (23 July 2021).

Brauns, M. and Stanton, A. 2016. Governance of the public health sector during apartheid: The case of South Africa. *Journal of Governance and Regulation, 5*(1): 23-27.

Brennan, F., Carr, D. B. and Cousins, M. 2007. Pain management: A fundamental human right. *Anesthesia and Analgesia*, *105*(1): 206. Available: DOI: 10.1213/01.ane.0000268145.52345.55 (Accessed 26 June 2020).

Britz, R., and Roux-Kemp, A. L. 2012. Voluntary informed consent and good clinical practice for clinical research in South Africa: Ethical and legal perspectives. *South African Medical Journal, 102*(9): 746. Available: DOI:10/7196.SAMJ.5498 (Accessed 21 March 2021).

Bryman, A. 2012. *Social research methods*. 4th ed. New York: Oxford University Press.

Bryman, A. and Bell, E. 2011. *Business research methods*. 3rd ed. New York: Oxford University Press.

Burger, R, Ranchod, S., Rossouw, L., and Smith, A. 2016. Strengthening the measurement of quality of care. *South African Health Review,* 191-200. Available:

https://www.researchgate.net/publication/303073282_Strengthening_the_measurement_of_quality_of_care/citation/download (Accessed 15 March 2020).

Burger, R. and Christian, C. 2018. Access to health care in post-apartheid South Africa: availability, affordability, acceptability. *Health Economics, Policy and Law*, 35(2): 1. Available: doi:10.1017/S1744133118000300 (Accessed 5 March 2020).

Callahan, D. 2008. Consumer-Directed Health Care: Promise of Puffery? *Health, Economics, Policy and Law, 3*(3): 302. Available: doi:10.1017/S1744133108004490 (Accessed 2 September 2021).

Carstens, P. and Pearmain, D. L. 2007. *Foundational Principles of South African Medical Law*. South Africa: LexisNexis.

Cawthra, T., Aslam, V., King, B., Henderson, S., Ellis, N., Donald, A., Nortjie, A. 2017. *Research in Practice*. 3rd ed. Cape Town: Edge Education.

Chahal, H., and Kumari, N. 2012. Service quality and performance in the public health-care sector. *Health Marketing Quarterly*, *29*(3): 182-188. Available: DOI: 10.1080/07359683.2012.704837 (Accessed 26 November 2020).

Chaudhary, A. K. and Israel, G. D. 2014. *The survey #8: pilot testing and pretesting questionnaires*. Available: https://eids.ifas.ufls.edu/pdf/PD/PD07200.pdf (Accessed 20 May 2020).

Chima, S. C. 2013. Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study. *BMC Medical Ethics, 14*(1)(Suppl.): 1. Available: http://www.biomedcentral.com/1472-6939/14/S1/S3 (Accessed 07 March 2021).

Christensen, L. B., Johnson, R and Turner, L. A. 2014. *Research Methods, Design, and Analysis.* 12th ed. New Jersey: Pearson Education Limited.

Churchill, L. R. 2007. The Hegemony of Money: Commercialism and Professionalism in American Medicine. Special Section: Commercialism in Medicine. *Cambridge Quarterly of Healthcare Ethics*, 16: 411. Available: DOI: 10.1017/S0963180107070508 (Accessed 3 August 2020).

Commission on the Social Determinants of Health (CSDH). 2008. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva.

Committee on Economic, Social and Cultural Rights (CESCR). 2000. *General Comment No 14: The right to the highest attainable standard of health*. Available: https://www.refworld.org/pdfid/4538838d0.pdf (Accessed 5 February 2020).

Competition Commission of South Africa. 2018. *Health Market Inquiry- Provisional Findings and Recommendations Report.* Pretoria: Government Printer. Available: https://www.compcom.co.za/wp-content/uploads/2018/07/Health-Market-inquiry-1.pdf (Accessed 24 February 2021).

Competition Commission of South Africa. 2019. *Health Market Inquiry- Final Findings and Recommendations Report.* Pretoria: Government Printer. Available: https://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf (Accessed 19 March 2021).

Coovadia, H., Jewkes, R., Barron, R., Sanders, D. and McIntyre, D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet, 374*(5): 817. Available: DOI: 10.1016/S0140-6736(09)60951-X (Accessed 16 March 2020).

Creswell, J. W. 2009. *Research design: qualitative, quantitative and mixed method approaches*. 3rd ed. California: SAGE Publications.

Daniel, E. 2016. The usefulness of qualitative and quantitative approach and methods in researching problem-solving ability in science education curriculum. *Journal of education and practice*, *7*(15): 92-98.

Davis, D. M. and Klare, K. 2010. Transformative Constitutionalism and the common and customary law. *South African Journal on Human Rights*, 26(3): 404. Available: https://hdl.handle.net/10520/EJC53384 (Accessed 12 April 2020).

De Jager, J. W., Du Plooy, A. T. and Femi Ayadi, M. 2010. Delivering quality service to in- and out-patients in a South African public hospital. *African Journal of Business Management*, *4*(2): 132-135.

De Stadler, E. 2013. *Consumer Law Unlocked*. Cape Town South Africa: Siber Ink.

de Villiers, K. 2021. Bridging the health inequality gap: an examination of South Africa's social innovation in health landscape. *Infectious Diseases of Poverty*, *10*(1): 2-3. Available: https://doi.org/10.1186/s40249-021-00804-9 (Accessed 25 May 2022).

Deber, R. B., Kraetschmer, N., Urowitz, S. and Sharpe, N. 2005. Patient, consumer, client, or customer: what do people want to be called? *Health Expectations, 8*(4): 350. Available: https://doi.org/10.1111/j.1369-7625.2005.00352.x (Accessed 20 July 2020).

DeCarlo, M., Cummings, C., and Agnelli, K. 2020 *Graduate research methods in social work. A project-based approach.* Pressbooks. Available: https://viva.pressbooks.pub/mswresearch/chapter/10-quantitative-sampling/ (Accessed 25 October 2021).

Delobelle, P. 2013 The health system in South Africa Historical perceptive and current challenges. In; *South Africa in Focus: Economic, Political and social Issues*. New York:

Nova Science Publishers, Inc, 160-163. Available: https://www.researchgate.net/publication/287764503 (Accessed 05 March 2020).

Devi, B., Mor, K., Lochab, A. and Kumar, P. 2022. A Study on Factor Analysis For Leadership Effectiveness In Selected Organisations Delhi-NCR. *Journal of Positive School Psychology*, 6(6): 8686. Available: https://www.journalppw.com/index.php/jpsp/article/view/9163/5964 (Available: 16 September 2022).

Dhai, A. 2008. Informed Consent. *South African Journal of Bioethics and Law*, *1*(1): 27.

Dhai, A. 2015. Medico legal litigation: Balancing spiralling costs with fair compensation. *South African Journal of Bioethics and law*, *8*(1): 02. Available: DOI: 10.7196/SAJBL.407 (Accessed 24 June 2020).

Dhai, A. 2020. Justice in healthcare: the South African promise. *Social Dynamics*, 46(3): 435-447. Available: https://doi.org/10.1080/02533952.2020.1853953 (Accessed 25 May 2022).

Dhai, A. and Mahomed, S. 2018. Healthcare in crisis: A shameful disrespect of our Constitution. *South African Journal of Bioethics and law, 11*(1): 8-9. Available: DOI:10.7196/SAJBL.2018.v11i1.649 (Accessed 19 March 2020).

Du Preez, M. L. 2009. The Consumer Protection Bill: a few preliminary comments. *Journal of South African Law/Tydskrif vir die Suid-Afrikaanse Reg*, 2009(1): 75-76. Available: https://hdl.handle.net/10520/EJC55230 (Accessed 23 May 2021).

Du Toit, K. and van Eeden, E. 2014. The impact of the Consumer protection Act on pharmacists. *South African Medical Journal (SAMJ*), *104*(11): 738-739.

Edmonds, W. A. and Kennedy, T. D. 2017. *An applied guide to research designs: Quantitative, qualitative, and mixed methods*. 2nd ed. London. Sage Publications.

Eskom Holdings Ltd v Halstead-Cleak. 2017 (1) SA 333 (SCA).

Etikan, I., Musa, A. and Alkassim, R. S. 2016. Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics,* 05 (01): 02.

Flood, C. M., and Gross, A. 2014a. Conclusion: Contexts for the Promise and Peril of the Right to Health. In: Flood, C. M., and Gross, A. eds. *The Right to Health at the Public/Private Divide. A Global Comparative Study.* New York: Cambridge University Press, 04.

Flood, C. M., and Gross, A. 2014b. Introduction: Marrying Human Rights and Health Care Systems: Contexts for a Power to Improve Access and Equity. In: Flood, C. M., and Gross, A. eds. *The Right to Health at the Public/Private Divide. A Global Comparative Study.* New York: Cambridge University Press, 453.

Forman, L. and Singh, J. A. 2014. The Role of Rights and Litigation in Assuring More Equitable Access to Health Care in South Africa. In: Flood, C. M., and Gross, A. eds. *The Right to Health at the Public/Private Divide. A Global Comparative Study*. New York: Cambridge University Press, 317.

Foxcroft, C. and Roodt, G. 2006. *An Introduction to Psychological assessment in the Southern Africa context*. 4th ed. South Africa: Oxford University Press.

Garg R. 2016. Methodology of Research. *Indian Journal of Anaesthesia*, *60*(9): 642. Available: DOI: 10.4103/0019-5049.190619 (Accessed 18 October 2021).

Gazana, O. 2015. The role of telehealth in enhancing access to healthcare services in an under-resourced setting: A case of Mantunzeleni in Eastern Cape Province. M.Tech. Cape Peninsula University of Technology.

Ghauri, P. and Grønhaug, K. 2002. *Research methods in business studies: a practical guide*. 2nd ed. New Jersey: Prentice Hall.

Goldstein, M. M. and Bowers, D. G. 2015. The patient as consumer: Empowerment or Commodification. *Journal of Law, Medicine & Ethics*, Spring *43*(1): 163. Available: doi:10.1111/jlme.12203 (Accessed 15 October 2021).

Gordon, E. J. and Prohaska, T. R., 2006. The ethics of withdrawal from study participation. *Accountability in Research*, *13*(4): 286. Available: DOI: 10.1080/08989620600848645 (Accessed 09 August 2021).
Gorsuch, R. L. 2015. *Factor analysis*. New York: Routledge.

Gothan, A. J. 2009. A critical appraisal of the customer service and service quality in appliance sales departments in prominent South African retail stores. Doctoral dissertation, University of Pretoria. Available: http://hdl.handle.net/2263/29432 (Accessed 7 November 2021).

Gounder, S. 2013. *Research methodology and research method.* Available: https://www.researchgate.net/publication/333015026. (Accessed 20 March 2021).

Govender, V. 2017. Consumer Protection and service delivery by the retail industry in the greater Durban area: The legal implications of the Consumer Protection Act 68 of 2008. Master's Degree in Marketing, Durban University of Technology.

Grobler, C. and Dhai, A. 2016. Social media in the healthcare context: Ethical challenges and recommendations. *South African Journal of Bioethics and law*, *9*(1): 23. Available: DOI:10.7196/SAJBL.2016.v9i1.464 (Accessed 12 March 2020).

Gumede, P., Green, P. and Dlamini, B. 2015. Evaluation of healthcare service: cross-sectional case in KwaZulu-Natal, South Africa. *Journal of Human Ecology, 52*(1,2): 32-33.

Ha, B. T. T., Mirzoev, T. and Morgan. 2015. Patient complaints in healthcare services in Vietnam's health system. *Sage Open Medicine,* 3: 01. Available: DOI: 10.1177/2050312115610127 (Accessed 13 March 2020).

Habibzadeh, H. Jasemi, M. and Hosseinzadegan, F. 2021. Social justice in health system; a neglected component of academic nursing education: a qualitative study. *BMC Nursing,* 20(16): 01-02. Available: https://doi.org/10.1186/s12912-021-00534-1 (Accessed 15 April 2022).

Harlow, A. 2010. Online surveys-possibilities, pitfalls and practicalities: The experience of the Tela evaluation. *Journal of Education,* 15(2): 97.

Harris, B., Goudge, J., Ataguba, J. E., McIntyre, D., Nxumalo, N., Jikwana, S., and Chersich, M. 2011. Inequities in access to health care in South Africa. *Journal of Public Health Policy, 32*(1): 102-116. Available: https://www.jstor.org/stable/20868835 (Accessed 05 February 2021).

Hassim, A., Heywood, M. and Berger, J. 2007. *Health and Democracy: A guide to Human Rights, Health Law and Policy in Post- apartheid South Africa*. Cape Town: Siber Inc. CC.

Hawthorne, L. 2012. Public governance: Unpacking the Consumer Protection Act 68 of 2008. *THRHR,* 361-362.

Health Economics Unit (HEU). 2012. Community preferences for improving public sector health services in South Africa What aspects of public sector health service quality improvements should be prioritised? *HEU Policy Brief*. March 2012. Available:

http://www.uct.ac.za/sites/default/files/image_tool/images/17/Community%20preferences%20for%20improving%20public.pdf (Accessed 17 May 2020).

.

Herxheimer, A., and Goodare, H. 1999. Who are you, and who are we? Looking through some key words. *Health Expectations*, *2*(1): 3. Available: https://doi.org/10.1046/j.1369-6513.1999.00034.x (Accessed 20 July 2020).

Hilton, C. E. 2015. The importance of pretesting questionnaires: a field research example of cognitive pretesting the Exercise Referral Quality of Life Scale (ER-QLS). *International journal of social research methodology, 20*(1): 01. https://doi.org/10.1080/13645579.2015.1091640 (Accessed 21 June 2020).

Horn, L. 2015. Public health and social justice: Forging the links. *South African Journal of Bioethics and Law*, 8(2): 26-29. Available: DOI:10.7196/SAJBL.437 (Accessed 12 May 2020).

Howard, C. 2021. *Advantages and Disadvantages of Online Surveys*. Available: https://www.cvent.com/ae/blog/events/advantages-disadvantages-online-surveys (Accessed 20 June 2021).

Howarth, D. and Davidow, R. 2010. The Consumer Protection Act: another arrow for the dissatisfied patient's quiver. *South African Journal Anaesthesiology and* Analgesia, *16*(5): 5. Available: https://hdl.handle.net/10520/EJC73804 (Accessed 2 September 2021).

Hussain, S. N. and Rehman, S. U. 2012. Patient satisfaction regarding hospital services: A study of Umea Hospital service. Master's. Umea University.

Hutchinson, T. and Duncan, N. 2012. Defining and describing what we do: Doctrinal Legal Research. *Deakin Law Review*, *17*(1): 107. Available: DOI: https://doi.org/10.21153/dlr2012vol17no1art70 (Accessed 07 March 2021).

Igwenagu, C. 2016. *Fundamental of research methodology and data collection*. Available: https://www.studocu.com/ph/document/saint-louis-university-philippines/psychology/fundamentalsof-research-methodologyand-data-collection/5321332 (Accessed 19 April 2020).

Isik, O. Tengilimoglu, D., and Akbolat. M. 2011. Measuring health care quality with the SERVQUAL method: A comparison in public and private hospitals. *Journal of Society for development in new net environment in B and H, 5*(6): 1921.

Jacobs, W., Stoop, P. N. and van Niekerk, R. 2010. Fundamental consumer rights under the Consumer Protection Act 68 of 2008: A critical overview and Analysis. *Potchefstroom Electronic Law Journal*, *13*(3): 313-384. Available: https://hdl.handle.net/10520/EJC86778 (Accessed 21 March 2020).

Johnston, M. P. 2014. Secondary data analysis: A method of which the time has come. *Qualitative and Quantitative Methods in Libraries, 3*(3): 620. *Available:* http://www.qqml-journal.net/index.php/qqml/article/view/169 (Accessed 08 August 2021).

Joshi, M.D. and Pandya, H. 2019. 5.2 Quality Assesment of Education Procedures: A Study of Selected Self-Financed Management Institutions. In: Ludwikowska, L. eds. *Professional development of instructors in higher education and training institutions*. Poland: Wisdom Publications, 108. Available: https://www.researchgate.net/profile/Manisha-Pathak-5/publication/354270317_PROFESSIONAL_DEVELOPMENT_OF_INSTRUCTORS_IN_HIGHER_EDUCATION_AND_TRAINING_INSTITUTIONS_Edited_by_Kamila_Ludwikowska/links/612f25af0360302a006f7da0/PROFESSIONAL-DEVELOPMENT-OF-INST (Accessed 25 June 2022).

Kabir, S. M. S. 2016. Research design. In: Kabir, S. M.S. *Basic guideline for research: An Introductory approach for all disciplines.* Chittagong: Book Zone Publication,124.

Kenya, B. O. 2016. Factors influencing service delivery in public hospitals: A case of Nairobi County, Kenya. Doctoral dissertation, University of Nairobi. Available: http://erepository.uonbi.ac.ke/bitstream/handle/11295/97284/Final%20Report-Brian%20Kenya.pdf?sequence=4 (Accessed 24 September 2020).

Khademi, M., Mohammadi, E. and Vanaki, Z. 2019. On the violation of hospitalized patients' rights: A qualitative study. *Nursing Ethics*, *26*(2): 576-577. Available: DOI: 10.1177/0969733017709334 (Accessed 10 February 2021).

Kirby, N. 2012. Consumerism and Healthcare. *Legal Brief*. Werksmans Attorneys.

Kiumarsi, S., Isa, S. M. and Jayaraman, K. 2015. Determinants of service quality on service loyalty: the mediating role of customers' satisfaction and brand equity. *Problems and Perspectives in Management*, *13*(2): 349.

Komape, L. J. 2013. Exploring public perceptions of South Africa private and public hospitals and preferences for health care providers. Master of Public Health. University of the Witwatersrand.

Kothari, C. R. 2004. *Research methodology: methods and techniques*. 2nd ed. New Delhi: New Age International (P) limited, Publishers.

Kumar, R. 2011. *Research methodology: a step-by-step guide for beginners.* 3rd. ed. London: SAGE.

Langford, M. 2014. Introduction: Civil society and Socio-economic rights. In: Langford, M., Cousins, B., Dugards, J. and Madlingozi, T. eds. *Socio-economic rights in South Africa Symbols or Substance?* New York: Cambridge University Press, 05.

Lavrakas, P. L. 2008. *Encyclopedia of survey research methods*. Thousand Oaks, California: SAGE.

Le Roux-Kemp, A. 2010. A legal perspective on the power imbalances in the doctor-patient relationship. Doctor of Law. Stellenbosch University.

Leach, L. M. 2018. A framework for factoring citizen perceptions into local public service value systems to improve service quality. Doctor of Philosophy in Economic and Management Science, Stellenbosch University.

Leedy, P. D. and Ormrod, J. E. 2005. *Practical Research: Planning and Design*. 8th ed. Upper Saddle River: Prentice Hall.

Letzler, M. 2012. The law of contract, the Consumer Protection Act and medical malpractice. *De Rebus*. 22: 16-22.

Liebenberg, S. 2010. *Socio-economic rights: adjudication under a transformative constitution*. Claremont: Juta.

Mabitsela, N. A. 2012. The impact of service delivery on the quality of lives of the community of Protea south, Soweto in Johannesburg in Gauteng Province, South Africa. Master's in development. University of Limpopo.

Mack, S. 2020. *What is the difference between the target population and the experimentally accessible population?* Available: https://smallbusiness.chron.com/difference-between-target-population-experimentally-accessible-population-70637.html (Accessed 08 June 2020).

Madlabana, C. Z. 2019. The performance management and development system and its unintended influence on quality of care in re-engineered primary health care health facilities. Doctor of Philosophy. University of KwaZulu-Natal.

Magnusson, R. 2017. *Advancing the Right to Health: The Vital Role of Law*, World Health Organization, Switzerland.

Majid, U. 2018. Research fundamentals: Study Design, Population, and sample size. *URNCST Journal*, *2*(1): 01. Available: https://doi.org/10.26685/urncst.16 (Accessed 08 June 2020).

Malakoane, B., Heunis, J. C., Chikobvu, P., Kigozi, N. G. and Kruger, W. H. 2020. Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening. *BMC Health Services Research, 20*(1): 01. Available: https://doi.org/10.1186/s12913-019-4862-y (Accessed 24 September 2020).

Mamad, F. 2013. The right to health as a human right in Mozambique. In: Jorens, Y. ed. *HIV and social security law: The SADC region.* Cape Town/Claremont: JUTA, 28.

Manyonga, H., Howarth, G., Dinwoodie, M., Nisselle, P. and Whitehouse, S. 2014. From informed consent to shared decision-making. *South African Medical Journal, 104*(8): 561. Available: DOI:10.7196/SAMJ.8287 (Accessed 15 June 2020).

Maphumulo, W. T. and Bhengu, B. R. 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review*. Curationis, 42*(1): 01-03. Available: https://doi.org/10.4102/curationis.v42i1.1901 (Accessed 18 February 2020).

Maree, K. ed. 2019. *First steps in research.* 3rd ed. Pretoria: Van Schaik Publishers.

Maseko, L and Harris, M. A. 2018. People-centeredness in health system reform. Public perceptions of private and public hospitals in South Africa. *South African Journal of Occupational Therapy*, *48*(1): 22-24. Available: http://dx.org/10.17159/2310-383/2017/vol48n1a5 (Accessed 24 January 2021).

Mayoux, L. 2006. Quantitative, qualitative or participatory? Which method, for what and when? In: Potter, R. and Desai, V. *Doing development research*. London: SAGE, 117.

McGregor, S. L. 2017. *Conceptualizing Consumer Justice*. Available https://www.consultmcgregor.com/documents/publications/consumer_justice_2017.pdf (Accessed 22 June 2021).

McIntyre, D. and Ataguba, J. 2017. Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge. *Parliament of South Africa*.

McIntyre, D., Thiede, M., Nkosi, M., Mutyambizi, V., Castillo-Riquelme, M., Gilson, L., Erasmus, E. and Goudge, J. 2007. A critical analysis of the current South African health system. *Shield work package* 1 Report: ii.

McQuoid-Mason, D. 2012. Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: What is the effect of the Consumer Protection Act? *South African Journal of Bioethics and law*, 5(2): 65-68. Available: DOI:10.7196/SAJBL.202 (Accessed 28 February 2021).

Meadows, K. A. 2003. So you want to do research? 5: Questionnaire design. *British journal of community nursing, 8*(12): 563.

Modiba, M. T. 2015. The influence of the consumer protection Act 68 of 2008 on the concept of plain language in standards-form contracts. Master of Law, University of Pretoria.

Mohamed, B., Mohamed, M. and Azizan, N. A. 2017. Technical quality and patient perception of hospital care quality. *Journal of Service Science and Management Research*, *1*. 02-05. Available: https://www.researchgate.net/publication/320869182_TECHNICAL_QUALITY_AND_PA

TIENT_PERCEPTION_OF_HOSPITAL_CARE_QUALITY (Accessed 04 February 2021).

Mohsin, A. 2016. *A manual for selecting sampling techniques in research*. Available: https://mpra.ub.uni-muenchen.de/70218/ (Accessed 06 June 2020).

Mokgoko, M. M. 2013. Health care users' experiences and perceptions of waiting time at a diabetes clinic in an academic hospital. Master of Science in nursing. University of Witwatersrand.

Moletsane, M. A. 2012. Community expectations and perceptions of municipal service delivery: A case study in the Emfuleni local Area. Magister of commerce business management, North-West University.

Moult, K. and Müller, A. 2016. Navigating conflicting laws in sexual and reproductive health service provision for teenagers', *Curationis*, *39*(1): 02. Available: http://dx.doi.org/10.4102/curationis.v39i1.1565 (Accessed 25 March 2021).

Moyakhe, N. P. 2014. Quality healthcare: An attainable goal for all South Africa? *South African Journal of Bioethics and law*, *7*(2): 80.

Moyo, K. 2016. *Realising the right to health in South Africa*. Available: https://www.fhr-mirror.org.za/files/7215/1247/1732/Health.pdf (Accessed 24 September 2020).

Msosa, S. K. 2015. Assessing customer service in the Malawian public postal service. Masters of marketing. Durban University of Technology.

Mthanti, S. M. 2015. Exploring the healthcare service quality in a provincial hospital. Master of Business Administration. North-West University.

Mugobo, V. and Malunga, V. 2015. Consumer protection in South Africa. Challenges and opportunities for future retailers in Cape Town, *South Africa, 6*(1): 226.

Mulaik, S. A. 2009. *Foundations of factor analysis*. 2nd ed. New York: Taylor and Francis Group.

Muller, A. 2017. Scrambling for access: availability, accessibility and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa. *International Health and Human Rights, 17*(16): 04. Available: DOI: 10.1186/s12914-017-0124-4 (Accessed 20 June 2020).

Muller, M. E. 1996. Quality Improvement in health care – A fundamental analysis and South African perspective. *Curationis*, *19*(4): 67. Available: DOI: 10.4102/curationis.v19i4.1340 (Accessed 18 February 2020).

Mupangavanhu, Y. 2015. Fairness a slippery concept: The common law of contract and the Consumer Protection Act 68 of 2008. *De Jure*, *48*(1): 117-120. Available: http://dx.doi.org/10.17159/2225-7160/2015/v48n1a7 (Accessed 24 February 2021).

Musoga, B., Ngugi, L. and Wanjau, K.L., 2021. Moderating role of service innovation on the relationship between corporate reputation and performance of hotels in Kenya. *International Journal of Research in Business and Social Science*, 10(1): 51.

National Department of Health Office of Standard Compliance Directorate: Quality Assurance. National Complaints Management Protocol for the Public Health Sector of South Africa. Pretoria, 2013. Available: https://sahivsoc.org/Files/National%20Complaints%20Management%20Protocol%20_May%202013.pdf (Accessed 2 April 2021).

National Patients" Rights Charter, 1999. Department of Health, Pretoria.

National Planning Commission (NPC). 2012. *National Development Plan 2030. Our Future-make it work*. Available: https://www.gov.za/issues/national-development-plan-2030 (Accessed 01 November 2020).

Naudé, T. 2006. Unfair contract terms legislation: the implications of why we need it for its formulation and application. *Stellenbosch law review*, *17*(3): 363.

Nayak, S. D. and Narayan, K. A. 2019. Strengths and weaknesses of online surveys. *Journal of Humanities and Social Sciences, 24(5): 36. Available:* DOI: 10.9790/0837-2405053138 (Accessed 19 October 2021).

Ndlovu, S. E. 2012. Evaluating public sector service delivery at KwaZulu-Natal provincial hospitals: a case study of the Durban metropolitan and Ilembe region. Doctor of Public Administration (PhD), University of KwaZulu-Natal (UKZN). Available: http://hdl.handle.net/10413/11841 (Accessed 17 October 2020.

Nemetchek, B. 2019. A concept analysis of social justice in global health. *Nursing Outlook*, *67*(3): 244-246.

Nesengani, T.V, Downing, C., Poggenpoel, M. and Stein, C. 2021 Perceptions of strategies to facilitate caring for patients in primary health care clinics. *African Journal of Primary Health Care and Family Medicine, 13(1):* 2071-2936. Available: https://doi.org/10.4102/phcfm.v13i1.2652 (Accessed 08 October 2022).

Nijhawan, L, P, Janodia, M. D., Muddukrishna, B. S., Bhat, K. M., Bairy, K. L. Udupa, N. and Musmade, P. B. 2013. Informed consent: Issues and challenges. *Journal of Advanced Pharmaceutical Technology & Research, 4*(3): 134. Available: DOI: 10.4103/2231-4040.116779.

Njanjobea, I. L. 2016. An investigation into talent management and employee retention in the higher education sector of South Africa: A case of the Durban University of Technology. Master's in management sciences: Human Resource management.

Njotini, M. N. 2018. Preserving the integrity of medical-related information – how "informed" is consent? *Potchefstroom Electronic Law Journal*, *20*(1): 14. Available: DOI: 10.17159/1727-3781/2018/v21i0a3400 (Accessed 28 April 2021).

O'Donnell, O. 2007. Access to health care in developing countries breaking down demand side barriers. *Cad Saude Publica*, *23*(12): 2821-2826. Available: DOI: 10.1590/s0102-311x2007001200003 (Accessed 24 September 2020).

O'Mathúna, P. D., Scott, P. A., McAuley, A., Walsh-Daneshmandi, A. and Daly, B. 2005. *Health care rights and responsibility: A review of the European charter of patients' rights.* Dublin: Irish Patients' Association.

Okeng Ebi, E. A. 2016. Enforcing the right of access to healthcare services in South Africa. Master of Law, University of South Africa.

Ornstein, M. 2013. *A Companion to Survey Research.* London: SAGE Publications Ltd. Available: https://dx.doi.org/10.4135/9781473913943 (Accessed 15 October 2021).

Pandey, P. and Pandey, M. M. 2015. *Research methodology: tools and techniques*. Buzau: Bridge Center.

Parveen, H. and Showkat, N. 2017. *Contents analysis*. Available: https://www.researchgate.net/publication/318815342 (Accessed 08 June 2020).

Patel, S. 2019a. *How do you ensure your survey questions are valid and reliable?* Available: http://www.salmapatel.co.uk/academia/survey-questions-valid-reliable/ (Accessed 20 May 2020).

Patel, S. 2019b. *Pilot study and pre-test (study guide). Methodology of research in sociology (RMS 06).* Department of sociology, university of Hyderabad. Available: http://www.net.nih.ac.uk/glossary (Accessed 20 May 2020).

Patino, C. M. and Ferreira, J. C. 2018. Inclusion and exclusion criteria in research studies: definitions and why they matter. *J. bras. pneumol. 44*(02): 84*. Available: https://doi.org/10.1590/S1806-37562018000000088* (Accessed 17 October 2021*).*

Pearmain, D. L. 2004. A critical analysis of the law on health service delivery in South Africa. Doctoral dissertation, University of Pretoria.

Pelser, A. J. 2012. The health, environment and development nexus in South Africa. In: Van Rensburg, H.C.J. ed. 2012. *Health and Health care in South Africa*. 2nd ed. Pretoria: Van Schaik, 226.

Peñaranda, F. 2015. The individual, social justice and public health. *Ciencia and saude coletiva*, *20*(4): 993-988. Available: DOI: 10.1590/1413-81232015204.00552014 (Accessed 02 June 2021).

Pieterse, M. 2010. Legislative and executive translation of the right to have access to health care services. *Law, Democracy and Development,* 11-14: Available: http://dx.doi.org/10.4314/ldd.v14i1.7 (Accessed 25 February 2021).

Potter, S. J. and McKinlay, J. B. 2005. From a relationship to encounter: an examination of longitudinal and lateral dimensions in the doctor–patient relationship. *Social Science & Medicine, 61*(2): 468. Available: doi:10.1016/j.socscimed.2004.11.067 (Accessed 20 July 2020).

Rambaruth, A. 2021. Strategic management in construction firms with focus on small and medium enterprises. Doctoral dissertation, Durban University of Technology.

Ranchod, S., Adams, C., Burger, R., Carvounes, A., Dreyer, K., Smith, A., Stewart, J. and van Biljon, C. 2017. South Africa's hospital sector: old divisions and new developments. *South African Health Review*: 107. Available: http://www.hst.org.za/publication/south-african-health-review-2017 (Accessed 05 April 2021).

Republic of South Africa. 1999 *Patients' rights charter.* Pretoria: Quality assurance Directorate, Department of health.

Richards, D.R. 2019. The impact of the consumer protection act 68 of 2008 on the enforceability of exemption clauses. Master of laws, University of South Africa.

Rogers, A., Karlsen, S. and Addington-Hall, L. 2000. Dying for care: the experiences of terminally ill cancer patients in hospital in an inner-city health district. *Palliative Medicine, 14*(1): 31. Available: DOI: 10.1191/026921600667197684 (Accessed 11 November 2020).

Roodbeen, R., Vreke, A., Boland, G., Rademakers, J., van den Muijsenbergh, M., Noordman, J., and van Dulmen, S. 2020. Communication and shared decision-making with patients with limited health literacy; helpful strategies, barriers and suggestions for improvement reported by hospital-based palliative care providers. *PLOS ONE, 15*(6): 02. Available: https://doi.org/10.1371/journal.pone.0234926 (Accessed 09 May 2021).

Rowe, K and Moodley, K. 2013. Patients as consumers of health care in South Africa: The Ethical and legal implications. *BMC Medical Ethics, 14*(1): 02-22. Available: DOI: 10.1186/1472-6939-14-15 (Accessed 3 March 2020).

Ruger, J. P. 2004. Health and social justice. *The Lancet*, *364*(9439): 1075. Available: DOI: 10.1016/S0140-6736(04)17064-5 (Accessed 22 June 2021).

Ruland, C. M., Bakken, R. N. and Røislien, J. 2007. Reliability and validity issues related to interactive tailored patient assessments: A case study. *Journal of Medical internet*

research, *9*(3): 04. Available: http://www.jmir.org/2007/3/e22/pdf (Accessed 15 June 2020).

Rural Health Advocacy Project. n.d. *A Health care providers guide to reporting healthcare challenges: Principles, tools and strategies*. Available: http://www.kznhealth.gov.za/family/health-care-providers-guide-to-reporting-healthcare-challenges.pdf (Accessed 24 September 2020).

Sarma, H. K. D., Balas, V. E., Bhuyan, B. and Dutta, N. 2022. Contemporary Issues in Communication, Cloud and Big Data Analytics: Proceedings of CCB 2020. Springer Singapore: Singapore. 359. Available: https://doi.org/10.1007/978-981-16-4244-9 Accessed (10 September 2022)

Sekaran, U. and Bougie, R. 2013. *Research methods for business.* 6th ed. West Sussex: Wiley and Sons.

Sekaran, U. and Bougie, R. 2016. *Research methods for business*. 7th ed. West Sussex: Wiley and Sons.

Sharma, S. 2019. Descriptive statistics and factorial design. PhD in International Management. Horizons University.

Sileyew, K. J. 2019. Research design and methodology. In: Abu-Taieh, E., Al Hadid, I. H. and Mouatasim, E. I. eds. *Cyberspace*. United Kingdom (Rijeka): IntechOpen, 35.

Sim, J. and Waterfield, J. 2019. Focus group methodology: some ethical challenge. *Quality and quantity: International journal of methodology, 53*(6): 3011. Available: http://doi.org/10.1007/s11135-019-00914-5 (Accessed 19 June 2020).

Singh, J. A. 2017. Law and the health professional in South Africa. In: Moodley, K. ed. *Medical ethics, law and human rights A South African perspective.* 2nd ed. Pretoria: Van Schaik, 136-317.

Slabbert, M. and Labuschaigne, M. 2022. Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance. *South African Journal of Bioethics Law,* 15(1): 31-35. Available: https://doi.org/10.7196/SAJBL.2022.v15i1.786 (Accessed 28 September 2022).

Slabbert, M. N. and Pepper, M. S. 2011. The Consumer Protection Act: No-fault liability of health care providers. *SAMJ: South African Medical Journal*, *101*(11), 800.
Soetewey, A. 2020. *What is the difference between population and sample?* Available: https://www.statsandr.com (Accessed 08 June 2020).

Soobramoney v Minister of Health, KwaZulu Natal. 1998 (1) SA 765 (CC).

South Africa (SA), Department of Health. 2003. *National Health Act 61 of 2003*. Pretoria: Government Printer.

South Africa (SA), National Department of Health. 2011. *National Department of Health Strategic Plan:* Foreword by Motsoaledi, Dr. P. A., Minister of Health, 2010/2011–2012/2013. Pretoria: NDOH.
.
South Africa (SA), Department of Health. 2017. *Revised White Paper: National Health Insurance Policy: Towards universal health coverage.* Government Notice No. 627, Government Gazette No. 40955, 30 June 2017. Pretoria: Government Printer.

South Africa (SA), Department of Health. 2017. *White paper on universal health coverage*. Pretoria: Department of health.

South Africa (SA), Department of Justice and Constitutional Development. 1996. *The Constitution of South Africa Act 108 of 1996*. Pretoria: Government Printer.

South Africa (SA), Department of Trade and Industry. 2008. *Consumer Protection Act 68 of 2008*. Pretoria: Government Printer.

South Africa, Department of Trade and Industry. 2011. *Consumer Protection Act: Regulations.* Government Notice No. R293, Government Gazette No. 34180, 1 April 2011.

South African Government. 2019. Strengthening the South African health system towards an integrated and unified health system, *Presidential Health Summit Compact*, 25 July 2019. Available: https://www.thepresidency.gov.za/download/file/fid/1650 (Accessed 17 May 2020).

Spicker, P. 2011. Ethical covert research. *Sociology*, *45*(1): 133.

Statistics South Africa (StatsSA). 2011. *Census*. Available: https://census2011.adrianfrith.com/place/599037009 (Accessed 28 June 2022).

Stoop, P. N. 2008. The current status of the enforceability of contractual exemption clauses for the exclusion of liability in the South African law of contract. *SA Mercantile Law Journal, 20*(4): 496. Available: https://hdl.handle.net/10520/EJC54319 (Accessed 26 November 2021).

Stoop, P. N. 2015. The Consumer Protection Act 68 of 2008 and procedural fairness in consumer contracts. *Potchefstroom Electronic Law Review*, *18*(4): 1089-1104. Available: http://dx.org/10.4314/pelj.v18i4.10 (Accessed 05 April 2021).

Stoop, P. N. 2017. Revisiting the right to information in plain and understandable language in the Consumer Protection Act. University of South Africa. Date delivered: 21-08-2017. Available: http://hdl.handle.net/10500/23191 (Accessed 19 October 2021).

Stronks, K., Toebes, B., Hendriks, A., Ikram, U. and Venkatapuram, S. 2016. *Social justice and human rights as a framework for addressing social determinants of health*. World Health Organization. Available: https://www.euro.who.int/__data/assets/pdf_file/0006/334356/HR-task-report.pdf (Accessed 22 June 2021).

Taekema, S. 2018. Theoretical and Normative Frameworks for Legal Research: Putting Theory into Practice. *Law and Method*. February 2018: 1-5. DOI 10.5553/REM/.000031 (Accessed 08 March 2021).

Tait, M., 2020. Judicial guidance on the application of section 49 of the consumer protection act 68 of 2008-Van Wyk t/a Skydive Mossel Bay v UPS SCS South Africa (Pty) Ltd [2020] 1 All SA 857 (WCC). *Obiter,* 41(4): 948-960. Available https://journals.co.za/doi/pdf/10.10520/ejc-obiter-v41-n4-a14 (Accessed 21 October 2021).

Tlapana, T. P. 2017. Customer services as a strategic tool amongst independent retail foods chains in KwaZulu-Natal. Doctor of Philosophy: Management Sciences (Marketing), Durban University of Technology.

Tuff, K. and Tuff, T. 2012. Introduction to population demographics. *Nature education knowledge*, *3*(11): 01. Available: http://www.nature.com/scitable/knowlwdge/library/introduction-to-population-demographics-8303 (Accessed 19 June 2020).

Umuhoza, S. M. and Ataguba, J. E. 2018. Inequalities in health and health risk factors in the Southern African Development Community: evidence from World Health Surveys.

International Journal for Equity in Health, 17: 53. Available: https://doi.org/10.1186/s12939-018-0762-8 (Accessed 13 November 2021).

United Nations (UN) General Assembly. 1948. *The Universal Declaration of Human Rights*. Available: http://www.un.org/en/documents/udhr (Accessed 12 February 2021).

United Nations (UN) General Assembly. 1966. *International Covenant on Economic, Social and Cultural Rights*. Available: https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (Accessed 12 February 2021).

Uddin, M. M., Sakaline, G., Meem, S. N., and Das, R. P., 2021. Assessing Implicit Causes of Fast-Food Demand Fluctuation Through Facilitating an Exploratory Factor Analysis. *American Journal of Applied Mathematics and Statistics*, 9(3): 85. Available: http://article.sciappliedmathematics.com/pdf/AJAMS-9-3-2.pdf (Accessed 13 September 2022).

Van den Berg, E. 2011. The Consumer Protection Act: implications for medical practice. *South African Family Practice*, *53*(6): 598. Available: https://hdl.handle.net/10520/EJC80666 (Accessed 3 August 2021).

Van den Berg, V. L. 2016. Still lost in translation: language barriers in South African health care remain. *South African Family Practice*, *58*(6) 229. Available: https://doi.org/10.1080/20786190.2016.1223795 (Accessed 15 June 2020).

Van Den Heever, P. 2012 *Impact of the Consumer Protection Act in the Health Care Context. De Rebus.* Available: http://www.derebus.org.za/impact-consumer-protection-act-health-care-context (Accessed 12 April 2020).

Van Deventer, S. M. 2020. Regulating the form and substance of online contracts South African and foreign perspectives. Doctor of Philosophy. Stellenbosch University.

Van Eeden, E. and Barnard, D. 2017. *Consumer Protection Law in South Africa*. 2nd ed. South Africa: LexisNexis.

Van Hoecke, M. 2011. Legal Doctrine: Which Method(s) for What Kind of Discipline? In: Van Hoecke, M. ed. 2011. *Methodologies of Legal Research Which Kind of Method for What Kind of Discipline?* Oregon: Hart Publishing, 14.

Van Rensburg, H. C. J. and Engelbrecht, M. C. 2012. Transformation of the South African health system: post 1994. In: Van Rensburg, H.C.J. ed. *Health and Health care in South Africa. 2nd ed.* Pretoria: Van Schaik, 121-179.

Van Rensburg, R. 2021. *Healthcare in South Africa: how inequity is contributing to inefficiency.* Available: https://theconversation.com/healthcare-in-south-africa-how-inequity-is-contributing-to-inefficiency-163753 (Accessed 03 May 2022).

Von Staden, R. E. 2021. The patient as a consumer: The role of the Consumer Protection Act 68 of 2008 in advancing the right to health in South Africa. Doctor of Philosophy, Durban University of Technology.

Wadood, F., Akbar, F. and Ullah, I., 2021. The importance and essential steps of pilot testing in management studies: a quantitative survey results. *Journal of Contemporary Issues in Business and Government* 27(5): 2423. Available: https://www.cibgp.com/article_16160_6baf28fff8efa53e531bbad85d0f87bf.pdf (Accessed 1 August 2022).

Wagner, C., Kawulich, B, and Garner, M. 2012. *Doing social research: a global perspective*. New York: McGraw-Hill.

Welman, C., Kruger, F. and Mitchell, B. 2005. *Research Methodology*. 3rd ed. Cape Town: Oxford University Press.

Wesso, A. D. 2014. The perceived quality of healthcare services and patient satisfaction in South African public hospitals. Masters. Economics. University of Ljiubljana.

Wiles, R., Crow, G., Sue Heath, S. and Charles, V. 2008. The Management of Confidentiality and Anonymity in Social Research. *International Journal of Social Research Methodology*, *11*(5): 417. Available: DOI: 10.1080/13645570701622231 (Accessed 15 July 2020).

Woker, T. 2010. Why the need for consumer protection legislation? A look at some of the reasons behind the promulgation of the National Credit Act and the Consumer Protection Act. *Obiter*, *31*(2): 230. Available: https://hdl.handle.net/10520/EJC85368 (Accessed 25 March 2020).

Wolf, J. A. 2018. *Consumer Perspectives on patients' experience*. July 2018. Available: www.theberylinstitute.org/page/pxconsumerstudy (Accessed 23 February 2020).

World Bank. 2018. *South Africa - Systematic country diagnostic: an incomplete transition - overcoming the legacy of exclusion in South Africa*. Available: http://documets.worldbank.org/cuarted/en/815401525706928690/South-Africa-Systematic-country-diagnostic-an-incomplete-transition-overcoming-the-legacy-of-eclusion-in-South-Africa (Accessed 4 September 2020).

World Health Organisation (WHO). 1948. *Constitution*. Available: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1 (Accessed 13 November 2021).

World Health Organisation (WHO). 2007. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: Available: http://www.who.int/healthsystems (Accessed 05 October 2020).

World Health Organisation (WHO). 2017. *Advancing the right to health: the vital role of law*. Geneva: Available: http://www.who.int/healthssystems/topics/health_law-report/en/ (Accessed 11 September 2020).

World Health Organization (WHO). 2018. *Delivering quality health services: a global imperative for universal health coverage.* World Health Organization, Organization for Economic Co-operation and Development and International Bank for Reconstruction and Development/The World Bank, Available: https://apps.who.int/iris/handle/10665/272465 (Accessed 24 June 2020).

Wright, K. B. 2005. Researching internet-based populations: Advantages and disadvantages of online survey research, online questionnaire authoring software packages, and web survey services. *Journal of Computer-Mediated Communication*, *10*(3): 10. Available: https://doi.org/10.1111/j.1083-6101.2005.tb00259.x (Accessed 19 October 2021).

Young, M., 2016. Private vs. public healthcare in South Africa. Honors Theses 2741. Available: https://scholarworks.wmich.edu/honors_theses/2741 (Accessed 30 April 2020).

APPENDIX A: ETHICAL CLEARANCE

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwin Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lawishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

30 November 2021

Ms N W Ngcobo
558 Dubevillage
18 street Ohlange
iNanda

Dear Ms Ngcobo

The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers
Ethics Clearance Number: 189/21

The Institutional Research Ethics Committee acknowledges receipt of your final data collection tool for review.

We are pleased to inform you that the data collection tool has been approved. Kindly ensure that participants used for the pilot study are not part of the main study.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Prof J K Adam
Chairperson: IREC

APPENDIX B: LETTER OF INFORMATION (English)

LETTER OF

INFORMATION

Title of the Research Study: The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers.

Principal Investigator/s/researcher: Nolwandle Witness Ngcobo (Diploma in Management science: business law, Degree of Bachelor of Technology in Business law).

Co-Investigator/s/supervisor/s: Ronwyn Elizabeth Von Staden (BA, LLB, LLM, PhD)

Brief Introduction and Purpose of the Study: The researcher is researching the challenges of patients as consumers of healthcare services and the role of the Consumer Protection Act 68 of 2008 (CPA) in addressing these challenges. The study is to examine the challenges of patients as consumers of healthcare services, awareness of patients as consumers of their rights in terms of the National Health Act 61 of 2003, the National Patients' Rights Charter (SA. Department of Health 1999) and the CPA. This study further seeks to promote awareness about the fundamental consumer rights contained in the CPA and the role of CPA in advancing the rights of patients as consumers of healthcare services.

Greeting: Hello, hope you are well.

Introduce yourself to the participant My name is Nolwandle Witness Ngcobo. I am conducting a research study for my Masters Degree in Managements Sciences specializing in Business law, at the Durban University of Technology.

Invitation to the potential participant You are hereby requested to participate in a research study. This research will be conducted as part of my studies at the Durban University of Technology.

What is Research: Research is a creative and systematic work undertaken to increase the stock of information and to develop further knowledge on a topic or education. It involves the collection and analysis of information.

Outline of the Procedures: You have been selected to voluntary participate for this study. Your co-operation and participation in providing relevant information established on your experiences of being a patient as a consumer will enable the researcher, health bodies and consumer bodies in addressing the deficits and challenges faced by patients as consumers at healthcare facilities on daily basis. If you agree to participate, Questionnaires will be distributed with a request to be returned after completion. It is anticipated that the entire survey task will take approximately 10-15 minutes to complete.

Risks or Discomforts to the Participant: Participation will be completely voluntary and intends to be no dishonesty as respondent will not be in a position to be forced to participate. There will be no anticipated risks or discomfort, a respondent may withdraw from the survey, at any time, if he or she should feel uncomfortable with continuing.

Explain to the participant the reasons he/she may be withdraw from the Study: Participation in the survey is entirely voluntary. Indicating that you are free to refuse participation in the research or withdraw from the study at any point in time due to any discomfort and participant will not incur any penalty should they choose to withdraw. Confidentiality will be maintained throughout, this indicates that even after withdrawal the

participant will continue to receive confidential standard of care, the information obtained will be used for research purposes only.

Benefits: The information collected from this survey will assist in highlighting challenges of patients as consumers of public healthcare, provide protection to consumers, particularly vulnerable consumers, promote consumer awareness about the fundamental consumer rights contained in the CPA and the role of CPA in advancing the rights of patients as consumers of healthcare services.

Remuneration: None

Costs of the Study: None

Confidentiality: Everyone has the right to privacy, Confidentiality is closely allied with anonymity, Confidentiality will be maintained throughout this survey. Participant names and any form of identification will be omitted.

Results: The information provided will be used for research purpose only, the collected data will be accessible to the researcher and supervisors of this study only. There will also be publications from the study. The results will be made available to anyone who is interested. The study will be available in DUT libraries for public scrutiny.

Research-related Injury: Not applicable to this study.

Storage of all electronic and hard copies including tape recordings: The completed questionnaire will be collected and will be stored and ultimately disposed of in a manner that will ensure confidentiality. The electronic and hard copy questionnaires will be stored for a period of five years after final publication of the study and thereafter will be destroyed. The study will be available in DUT libraries for public scrutiny. This study will follow an approach to confidentiality. Respondents will not be identified, and any information shared will be kept confidential.

Persons to contact in the Event of Any Problems or Queries:

Nolwandle Witness Ngcobo (**Researcher**)
0844071009
Email: lwandlewzn13@gmail.com

Dr R E Von Staden (**Supervisor**)
082 856 1864
Email: ronwyn@dut.ac.za

The Institutional Research Ethics Administrator
031 373 2375
Complaints can be reported to the Director: Research and Postgraduate Support Dr L Linganiso 031 373 2577 or researchdirector@dut.ac.za.

APPENDIX C: LETTER OF INFORMATION (isiZulu)

Incwadi Yolwazi

Isihloko se-Research Study: Indima yoMthetho Wokuvikelwa Kwabathengi u-68 ka-2008 (Consumer Protection Act 68 of 2008) ekubhekaneni nezinselelo zeziguli ezinakekela ezempilo njengabathengi.

Umphenyi / umcwaningi oyinhloko: uNolwandle Witness Ngcobo (okwibanga lemfundo ephakeme, kwiDiploma yeManagements Sciences egxile kwezomthetho weBusiness, iDegree leBachelor yeTechnology ngezemithetho yama bhiziznisi - Business law).
Umphathi**:** Dr Ronwyn Elizabeth Von Staden (BA, LLB, LLM, PhD).

Isingeniso Esifushane Nenjongo Yocwaningo: Umcwaningi ucwaninga izinselelo zeziguli njengabathengi bezinsizakalo zezempilo kanye neqhaza loMthetho Wokuvikelwa Kwabathengi 68 ka-2008 (CPA) ekubhekaneni nalezi zinselelo. Lolu cwaningo luzobheka izinselelo zeziguli njengabathengi bezinsizakalo zokunakekelwa kwezempilo, ukuqwashiswa kweziguli njengabathengi bamalungelo abo ngokoMthetho Wezempilo Kazwelonke wama-61 ka-2003, iNational Charter 'Rights Charter kanye neCPA. Lolu cwaningo luqhubeka nokukhuthaza ukwaziswa ngamalungelo ayisisekelo abathengi aqukethwe yi-CPA kanye nendima ye-CPA ekuthuthukiseni amalungelo eziguli njengabathengi bezinsizakalo zezempilo.

isibingelelo: Sawubona, ngiyethemba uyaphila.

Igama lami nginguNolwandle Witness Ngcobo. Ngenza ucwaningo ngeMasters Degree yami yeManagements Sciences egxile kwezomthetho weBusiness, eDurban University of Technology.

Lesi Isimemo kulowo ongaba yingxenye yalokhu Uyacelwa ukuthi ubambe iqhaza ocwaningweni locwaningo. Lolu cwaningo luzokwenziwa njengengxenye yezifundo zami eDurban University of Technology.

Kuyini ukucwaningo: Ucwaningo ngumsebenzi wobuciko futhi ohlelekile owenziwe ukukhulisa isitokwe solwazi nokuthuthukisa ulwazi olwengeziwe ngesihloko noma ngemfundo. Kubandakanya ukuqoqwa nokuhlaziywa kolwazi.

Uhlaka Lwezinqubo: Ukhethwe ukuba ubambe iqhaza ngokuzithandela kulolu cwaningo. Ukubambisana kwakho nokubamba iqhaza ekuhlinzekeni imininingwane efanelekile esungulwe kokuhlangenwe nakho kwakho kokuba yisiguli njengomthengi kuzokwenza umcwaningi, izinhlaka zezempilo kanye nemizimba yabathengi ekubhekaneni nokusilela nezinselelo ezibhekene neziguli njengabathengi ezikhungweni zezempilo nsuku zonke. Uma uvuma ukubamba iqhaza, ama-Questionnaire (Uhlu lwemibuzo) azosatshalaliswa, ngesicelo sokubuyiselwa emuva kokuphothulwa. Kulindeleke ukuthi wonke umsebenzi wokuhlola uzothatha cishe imizuzu eyi-10 kuya ku15 ukuqeda.

Ubungozi noma ukungahambi kahle kubambinqaza: Ukubamba iqhaza kuzoba ngokuzithandela ngokuphelele futhi kuhlose ukuthi kungabi ukungathembeki njengoba ophendulayo engeke abe sesimweni sokuphoqeleka ukuthi abambe iqhaza. Ngeke kube khona ubungozi obulindelekile noma ukungaphatheki kahle, ophendulayo angahoxa ocwaningweni, nganoma yisiphi isikhathi, uma ezizwa engakhululekile ngokuqhubeka.

Izizathu ezingadala obambe iqhaza kuthi ahoxe ocwaningweni: Ukubamba iqhaza ocwaningweni kwenziwa ngokuzithandela ngokuphelele. Okukhombisa ukuthi ukhululekile ukwenqaba ukubamba iqhaza ocwaningweni noma ukuhoxa ocwaningweni

nganoma yisiphi isikhathi ngenxa yanoma ikuphi ukungaphatheki kahle futhi obambe iqhaza ngeke athole isijeziso uma bekhetha ukuhoxa. Zonke Izimpendulo zomcwaningi zizogcinwa ziyiimfihlo, lokhu kukhombisa ukuthi noma ngemuva kokuhoxa umhlanganyeli uzoqhubeka nokuthola izinga lokunakekelwa kanye nokuyvikeleka okuyimfihlo, imininingwane etholakele izosetshenziselwa izinhloso zocwaningo kuphela.

Izinzuzo: Imininingwane eqoqwe kulolu cwaningo izosiza ekuqhakambiseni izinselelo zeziguli njengabathengi bezokunakekelwa kwezempilo komphakathi, inikeze ukuvikelwa kubathengi, ikakhulukazi abathengi abasengozini, ukukhuthaza ukuqwashiswa kwabathengi ngamalungelo ayisisekelo abathengi aqukethwe yiCPA kanye nendima yeCPA ekuthuthukiseni amalungelo eziguli njengabathengi bezinsizakalo zezempilo.

Umkomelo/ umholo: Awukho umholo noma umkomelo ohlelelwe lolu cwaningo.

Izindleko Zokufunda: Azikho izindleko

Ukugcina okuyimfihlo: wonke umuntu unelungelo lokugcinwa okuyimfihlo, ukugcinwa kwemfihlo kuhambisana kakhulu nokungaziwa, ukugcinwa kwemfihlo kuzogcinwa kulo lonke lolu cwaningo. Amagama ababambiqhaza nanoma yiluphi uhlobo lokuhlonza luzokhishwa.

Imiphumela: Imininingwane ethunyelwe/enikeziwe izosetshenziselwa ucwaningo kuphela, imininingwane eqoqiwe izotholakala kumcwaningi nakubaphathi balolu cwaningo kuphela. Kuzoba khona nokushicilelwa okuvela ocwaningweni. Imiphumela izotholakala kunoma ngubani onentshisekelo. Ucwaningo luzotholakala emitatsheni yezincwadi yase-DUT ukuze luhlolisiswe ngumphakathi

Ukulimala okuhlobene nocwaningo: Akusebenzi kulolu cwaningo.

Ukugcinwa kwawo wonke amakhophi kagesi, naphathekayo nawamakhompiyutha afaka okuqoshiwe kwetheyiphu: Uhlu lwemibuzo olugcwalisiwe luzoqoqwa futhi

luzogcinwa futhi ekugcineni lulahlwe ngendlela ezoqinisekisa imfihlo. Ama-questionnae we-elekthronikhi namakhophi aphathekayo azogcinwa isikhathi esiyiminyaka emihlanu ngemuva kokushicilelwa kokugcina kocwaningo, bese ngemuva kwalokho abhujiswa. Ucwaningo luzotholakala emitatsheni yezincwadi yase-DUT ukuze luhlolisiswe ngumphakathi. Lolu cwaningo luzolandela indlela yokugcina imfihlo. Abaphenduli ngeke bakhonjwe, futhi noma yiluphi ulwazi olwabiwe luzogcinwa luyimfihlo.

Abantu ongathintana nabo kwisehlakalo Sanoma Iziphi Izinkinga noma Imibuzo:

Nolwandle Witness Ngcobo (**Umcwaningi**)
0844071009
Email: lwandlewzn13@gmail.com

Dr R E Von Staden (**umphathi**)
082 856 1864
Email: ronwyn@dut.ac.za

The Institutional Research Ethics Administrator 031 373 2375
Izikhalazo zingabikwa kuMqondisi wakwa-Graduate Research and Support uDr L Linganiso
031 373 2577 or researchdirector@dut.ac.za.

APPENDIX D: LETTER OF CONSENT (English)

CONSENT

Full Title of the Study: The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers.

Names of Researcher/s: Nolwandle Witness Ngcobo

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ _____about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature/RightThumbprint**

I **Nolwandle Witness Ngcobo** herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher	**Date**	**Signature**
Full Name of Witness (If applicable)	**Date**	**Signature**
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

APPENDIX E: LETTER OF CONSENT (isiZulu)

Imvume/isivumelwano

Isihloko Esigcwele Socwaningo: Iqhaza loMthetho Consumer Protection Act u-68 ka-2008 ekubhekaneni nezinselelo zeziguli ezinakekela ezempilo njengabathengi. (The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers.)

Amagama oMcwaningi: uNolwandle Witness Ngcobo.

Isitatimende Sesivumelwano Sokubamba iqhaza Esifundweni Sokucwaninga:

- Ngiyaqinisekisa ukuthi ngazisiwe ngumcwaningi _____mayelana nohlobo, ukuziphatha, izinzuzo nezingozi zalolu cwaningo - Inombolo ye-Research Ethics clearance _____,
- Ngithole, ngafunda futhi ngaluqonda ulwazi olubhaliwe olungenhla (Incwadi yolwazi Yomhlanganyeli/yombambiqhaza ye-minininingwane) maqondana nesifundo.
- Ngiyazi ukuthi imiphumela yocwaningo, kufaka phakathi imininingwane yomuntu mayelana nobulili bami, iminyaka, usuku lokuzalwa, ama-initials kanye nokuxilongwa kuzocutshungulwa kungaziwa kube wumbiko wocwaningo.
- Ngenxa yezidingo zocwaningo, ngiyavuma ukuthi idatha eqoqwe phakathi nalolu cwaningo ingacutshungulwa ngohlelo lwekhompyutha ngumcwaningi.
- Ngingahle, noma ngasiphi isigaba, ngaphandle kokubandlululwa, ngihoxise imvume yami yokubamba iqhaza esifundweni.

- Ngibe nethuba elanele lokubuza imibuzo futhi (ngentando yami) ngithi ngizilungiselele ukubamba iqhaza ocwaningweni.
- Ngiyaqonda ukuthi okutholakele okusha okuphawulekayo okwenziwe phakathi nalolu cwaningo okungahle kuhambisane nokubamba kwami iqhaza kuzotholakala kimi.

_____ _____ _____ _____

Igama lalowo obambe iqhaza Usuku/Date Isikhathi/Time Isignisha/Signature
I-Thumbprint engakwesokudla

Mina, **<u>Nolwandle Witness Ngcobo</u>** ngalokhu ngiyaqinisekisa ukuthi umhlanganyeli ongenhla waziswe ngokugcwele ngohlobo, ukuziphatha kanye nobungozi besifundo esingenhla.

_____ _____ _____

Igama lika mcwaningi
Full Name of Researcher **Usuku/Date** **Sayina/Signatue**

_____ _____ _____

Full Name of Witness
Igaman lika fakazi (uma ekhona) **Usuku/Date** **Sayina/Signature**

_____ _____ _____

Full Name of Legal Guardian
Igama lika nogada (uma ekhona) **Usuku/Date** **Sayina/Signature**

APPENDIX F: QUESTIONNAIRE (English)

Questionnaire

This survey is being conducted to determine the challenges of patients as consumers of healthcare services and the role of the Consumer Protection Act 68 of 2008 in addressing these challenges

This survey will take approximately 10-15 minutes to complete.

Your participation is voluntary; hence you may withdraw from the study at any time during the duration of this study without incurring any disadvantages. All data collected will be confidential and will be used only for the purposes of this study, and the reporting thereof.

SECTION A – DEMOGRAPHIC PROFILE

Please mark an X in the appropriate block to indicate your answer

1. **Age group**

1.1 18- 29 years old	
1.2 30-39	
1.3 40-49	
1.4 50-59	
1.5 60-69	
1.6 70-79	
1.7 80 years old and above	

2. **Highest educational qualification**

2.1 No formal education	

2.2 Primary school education	
2.3 High school education	
2.4 Matric	
2.5 Post school qualification such as University or College	

3. At what type of Public Healthcare facility or facilities do you regularly access healthcare services? Please mark an X in the appropriate block to indicate your answer

3.1 Hospital	
3.2 Clinic	
3.3 Community Healthcare Centre	

4. Please indicate the reason you access healthcare services at this facility. Please mark an X in the appropriate block to indicate your answer

4.1 The healthcare facility is the closest facility to my home	
4.2 The healthcare facility is the closest facility to my workplace	
4.3 In my opinion the healthcare facility provides quality healthcare services	
4.4 Other reason	

SECTION B- Characterisation as a user of healthcare services

Please mark an X in the appropriate block to indicate your answer.

5. When you access healthcare services how do you CURRENTLY describe or characterize yourself?

5.1 As a patient	
5.2 As a consumer	
5.3 As both patient and a consumer	
5.4 I have never thought about this	

5.5 Please provide a reason for your answer

6. When you access healthcare services HOW WOULD YOU LIKE TO BE TREATED by the healthcare providers at the healthcare facility?

6.1 As a patient	
6.2 As a consumer	
6.3 As both patient and a consumer	
6.4 I don't mind provided I get quality healthcare services	

6.5 Please provide a reason for your answer

SECTION C- Awareness and understanding of patient rights contained in the National Health Act 61 of 2003

The National Health Act 61 of 2003 provides users a number of rights. These rights include:

The right to participate in decision making

The right to informed consent

The right to confidentiality

7. Please indicate your awareness and understanding of the following rights by placing an X in the appropriate block.

	I am aware of and understand this right	**I am aware of but do not understand this right**	**I have never heard of this right**	**I am aware of this right but it has been infringed**
7.1 According to Section 6, a user has the right to have his/her health status explained				
7.2 According to Section 6, a user has the right to have the range of available treatments explained				
7.3 According to Section 6, a user has the right to have the benefits, risks, costs and consequences of each suitable treatment explained				
7.4 According to Section 7, a user has the right to provide informed consent				

for the treatment they receive				
7.5 According to Section 8, a user has the right to participate in decisions about their health and treatment				
7.6 According to Section 14, a user has the right to have the information about his/her health status and treatment kept confidential				

8. Should you wish to do so, please explain how your rights have been infringed.

SECTION D- Awareness and understanding of the fundamental rights contained in the Consumer Protection Act 68 of 2008

The Consumer Protection Act 68 of 2008 provides consumers with a number of fundamental consumer rights. These rights include:

The right to choose
The right to disclosure and information
The right to fair and honest dealing
The right to fair, just and reasonable terms and conditions
The right to fair value, good quality and safety

Please indicate your awareness and understanding of the following rights by placing an X in the appropriate block.

9. The right to choose

	I am aware of and understand this fundamental consumer right	I am aware of but do not understand this fundamental consumer right	I have never heard of this fundamental consumer right	I am aware of this right but it has been infringed
9.1 According to Section 13, a consumer has the right to select a supplier such as a healthcare facility or healthcare practitioner.				
9.2 According to Section 19, a consumer has the right to services being provided on the agreed date and time or within a reasonable time				

10. The right to disclosure and information

	I am aware of and understand this fundamental consumer right	I am aware of but do not understand this fundamental consumer right	I have never heard of this fundamental consumer right	I am aware of this right but it has been infringed
10.1 According to Section 22, a consumer has the right to information in plain and understandable language				
10.2 According to Section 23, a consumer				

has the right to disclosure of the price of services provided				

11. The right to fair and honest dealing

	I am aware of and understand this fundamental consumer right	**I am aware of but do not understand this fundamental consumer right**	**I have never heard of this fundamental consumer right**	**I am aware of this right but it has been infringed**
11.1 According to Section 47, a consumer has the right to receive goods such as medication at the specified date and time				
11.2 According to Section 47, a consumer has the right to receive services such as treatment at the specified date and time				

12. The right to fair, just and reasonable terms and conditions

	I am aware of and understand this fundamental consumer right	**I am aware of but do not understand this**	**I have never heard of this fundamental consumer right**	**I am aware of this right but it has**

		fundamental consumer right		**been infringed**
12.1 According to Section 50, a consumer has the right to enter into a contract based on fair, just and reasonable terms				
12.2 According to Sections 49 and 51, a supplier is not entitled to limit his/her risk or liability in terms of an exclusionary clause in a contract without explaining the nature of the limitation to the consumer				

13. The right to fair value, good quality and safety

	I am aware of and understand this fundamental consumer right	**I am aware of but do not understand this fundamental consumer right**	**I have never heard of this fundamental consumer right**	**I am aware of this right but it has been infringed**
13.1 According to Section 54, a consumer has a right to the timely performance and completion of				

services undertaken by a supplier				
13.2 According to Section 54, a consumer has a right to the performance of services in a manner and quality that the consumer is generally entitled to expect				

14. Should you wish to do so, please explain how your rights in sections 9-13 have been infringed.

SECTION E- Challenges experienced by patients in accessing healthcare services

Please note the challenges you have experienced in accessing healthcare services by indicating your level of agreement or disagreement with each of the following statements:

15. Adequate staffing

When I visit the healthcare facility:	**Strongly agree**	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
15.1 I have to wait for a long time before being attended to by a healthcare practitioner					
15.2 Healthcare practitioners are available to attend to me within a reasonable time					

15.3 Staff members are helpful and informative					

16. Following my arrival at the healthcare facility, the average time I have to wait before being attended to by a healthcare practitioner is:

16.1 Did not have to wait	
16.2 Less than 30 min	
16.3 At least 30min to 1 hour	
16.4 At least 1 hour but less than 2 hours	
16.5 At least 3 hours but less than 6 hours	
16.6 Cannot remember	

17. Information management

	Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
17.1 My patient file is readily available when I arrive at the healthcare facility					
17.2 My patient file is up to date					
17.3 The healthcare practitioner explains my health status					
17.4 The healthcare practitioner explains the treatment I receive					
17.5 The healthcare					

practitioner speaks to me in a language I understand					
17.6 The healthcare facility has an interpreter who assists the healthcare practitioners					

18. Safety and security

	Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
18.1 There is sufficient security at the healthcare facility					
18.2 I feel safe at the healthcare facility					
18.3 The outside areas are well lit at night					

19. Cleanliness and maintenance of buildings and grounds

	Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
19.1 There is adequate seating available while I wait					
19.2 The healthcare facility is clean					

19.3 There are toilets at the healthcare facility					
19.4 The toilets at the healthcare facility are clean					
19.5 The grounds around the healthcare facility are well maintained					
19.6 The buildings of the healthcare facility are well maintained					

20. Facilities and medication

	Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
20.1 The healthcare facility has running water					
20.2 The healthcare facility has electricity					
20.3 The medication I require is available at the healthcare facility					
20.4 The healthcare practitioner explains the side					

effects of my medication					

21. Availability of beds

	Strongly agree	**Agree**	**Uncertain**	**Disagree**	**Strongly disagree**
21.1 The healthcare facility has beds available when I need one					

22. Please provide any additional challenges that you may have experienced

23. Once I have accessed healthcare services at the facility I am provided with an opportunity to provide feedback about the quality of the services I received.

23.1 YES	
23.1 NO	

APPENDIX G: QUESTIONNAIRE (IsiZulu)

Uhlu lwemibuzo

Lolu cwaningo lwenzelwe ukuthola izinselelo zeziguli njengabathengi nezinsizakalo zezempilo kanye neqhaza noma indima yoMthetho Wokuvikelwa Kwabathengi eyaziwa ngeConsumer Protection Act 68 ka 2008, ekubhekaneni nalezi zinselelo.

Lolu cwaningo luzothatha cishe imizuzu eyi-10-15 ukuphothulwa.

Ukubamba kwakho iqhaza kungokuzithandela, yingakho ungahoxa ocwaningweni nganoma yisiphi isikhathi ngesikhathi salolu cwaningo, ngaphandle kokuthola ubunzima. Yonke imininingwane eqoqiwe izoba yimfihlo futhi izosetshenziselwa izinhloso zalolu cwaningo kuphela, kanye nokubikwa kwalo.

ISIQEPHU A Iphrofayili ye-demograhy

Sicela umake u-X ebhokisini elifanele ukukhombisa impendulo yakho

1. Iqembu leminyaka yobudala

1.1 18- 29 ubudala beminyaka	
1.2 30-39	
1.3 40-49	
1.4 50-59	
1.5 60-69	
1.6 70-79	
1.7 80 ubudala beminyaka nangaphezulu	

2. Iziqu Zemfundo

2.1 Akukho Mfundo ehlelekile	
2.2 Imfundo yamabanga aphansi	
2.3 Imfundo yamabanga aphezulu	
2.4 UMatikuletsheni	
2.5 Iziqu zesikole asiphakeme njengeYunivesithi noma i-college.	

3 Kukuluphi uhlobo lwesikhungo noma izikhungo zezempilo Zomphakathi ofinyelela kuzo, othola kuzo izinsizakalo zezempilo? Sicela umake u-X ebhokisini elifanele ukukhombisa impendulo yakho

3.1 Isibhedlela	
3.2 Umthola Mpilo(Clinic)	
3.3 Isikhungo Sokunakekelwa Kwezempilo Somphakathi	

4 Sicela wethule ukuthi kungani uthola izinsizakalo zokunakekelwa kwezempilo kulesi sikhungo. Sicela umake u-X ebhokisini elifanele ukukhombisa impendulo yakho

4.1 Isikhungo sokunakekelwa kwezempilo yisikhungo esiseduze kakhulu nekhaya lami	
4.2 Indawo yokunakekelwa kwezempilo iyisikhungo esiseduzane kakhulu nendawo engisebenza kuyo	

4.3 Ngokubona kwami isikhungo sezempilo sihlinzeka ngemisebenzi esezingeni elifanele yezempilo	
4.2 Esinye isizathu….	

ISIQEPHU B- Ukuchaza njengomsebenzisi wezinsizakalo zokunakekelwa kwezempilo.

Uyacelwa ukuthi umake u-X ebhokisini elifanele ukukhombisa impendulo yakho.

5 Uma ufinyelela ezinsizakalweni zezempilo uzichaza kanjani njengamanje noma uzibonakalisa kanjani?

5.1 Njengesiguli	
5.2 Njengomthengi	
5.3 Njengesiguli nomthengi	
5.4 Angikaze ngicabange ngalokhu	

5.5 Uyacelwa ukuthi unikeze isizathu sempendulo yakho

_____

_____

_____

_____

6 Uma ufinyelela ezinsizakalweni zezempilo UNGATHANDA UKUTHI UPhathwe KANJANI ngabahlinzeki bezokunakekelwa kwempilo esikhungweni sezempilo?

6.1 Njengesiguli	
6.2 Njengomthengi	
6.3 Njengesiguli nomthengi	
6.4 Anginankinga uma nje ngithola izinsizakalo zezempilo ezisezingeni	

6.5 Uyacelwa ukuthi unikeze isizathu sempendulo yakho

ISIQEPHU C- Ukuqwashisa nokuqondwa kwamalungelo eziguli okuqukethwe uMthetho Wezempilo Kazwelonke owaziwa ngokuthi iNational health Act 61 ka-2003.

UMthetho weNational Health Act 61 ka-2003 uhlinzeka abasebenzisi bezempilo ngamalungelo amaningi. Lawa malungelo afaka:

Ilungelo lokubamba iqhaza ekuthathweni kwezinqumo
Ilungelo lokuthola ithuba lokumvuma unolwazi
Ilungelo lokugcina imfihlo

7 Sicela ukhombise ukuqwashisa kwakho nokuqonda kwakho kulama lungelo alandelayo ngokubeka u-X ebhokisini elifanele.

	Ngiyalazi futhi ngiliqonda kahle leli lungelo	**Ngiyalazi kodwa angiliqondi leli lungelo**	**Angikaze ngizwe ngaleli lungelo**	**Ngiyalazi lelilungelo. Kodwa alilandelwa noma liphuliwe**
7.1 Ngokwesigaba 6, isiguli sinelungelo lokuchazelwa ngesimo saso sempilo				
7.2 Ngokwesigaba 6, isiguli sinelungelo lokuba sichazelwe ngobubanzi kuchazwe uhla lwezindlela				

zokwelashwa olutholakalayo				
7.3 Ngokwesigaba 6, isiguli sinelungelo lokuthi kuchazwe izinzuzo, ubungozi, izindleko kanye nemiphumela yokwelashwa ngakunye okufanelekile				
7.4 Ngokwesigaba 7, isisguli sinelungelo lokunikeza imvume ngokwelashwa akutholayo				
7.5 Ngokwesigaba 8, isiguli sinelungelo lokubamba iqhaza ezinqumweni ezimayelana nempilo kanye nokwelashwa kwaso				
7.6 Ngokwesigaba 14, isiguli sinelungelo lokuba nolwazi/nemininingwane emayelana nesimo saso sempilo, nokwelashwa kwaso kugcinwe kuyimfihlo				

8 Uma unesifiso, sicela usethulele ukuthi amalungelo akho aphulwa kanjani.

ISIQEPHU D- Ukuqwashisa nokuqondwa kwamalungelo ayisisekelo aqukethwe uMthetho Wokuvikelwa Kwabathengi owaziwa ngokuthi iConsumer Protection Act 68 ka-2008.

Umthetho We-Consumer Protection Act 68 ka-2008 uhlinzeka abathengi ngamalungelo amaningi abalulekile kubathengi. Lawa amalungelo afaka:

Ilungelo lokuzikhethela
Ilungelo lokudalulwa kanye nemininingwane
Ilungelo lokuphathwa ngokungenzeleli nangokuthembeka
Ilungelo lokuthola imigomo nemibandela enobulungiswa, enobulungiswa futhi enengqondo
Ilungelo lenani elifanelekile, ilungelo lekhwalithi enhle kanye nelungelo lokuphepha
Uyacelwa ukuthi ukhombise ukuqwashisa kwakho nokuqonda kwakho la malungelo alandelayo ngokubeka u-X ebhokisini elifanele.

9 Ilungelo lokuzikhethela

	Ngiyawazi futhi ngiyawaqonda la malungelo ayisisekelo sabathengi	**Ngiyawazi kodwa angiwaqondi la malungelo abathengi ayisisekelo**	**Angikaze ngizwe ngaleli lungelo Eliyisisekelo lomthengi**	**Ngiyalazi lelilungelo. Kodwa alilandelwa noma liphuliwe**
9.1 Ngokwesigaba 13, umthengi unelungelo lokukhetha umhlinzeki kanjalo				

nasesikhungweni sokunakekelwa kwezempilo unelungelo lokuzikhethela umhlengikazi wezempilo.				
9.2 Ngokwesigaba 19, umthengi unelungelo lokuhlinzekwa ngezinsizakalo ngosuku nesikhathi okuvunyelwene ngaso noma ngesikhathi esifanele				

10 Unelungelo lokwethulelwa ulwazi nemininingwane

	Ngiyawazi futhi ngiyawaqonda la malungelo ayisisekelo sabathengi	**Ngiyawazi kodwa angiwaqondi la malungelo abathengi ayisisekelo**	**Angikaze ngizwe ngaleli lungelo Eliyisisekelo lomthengi**	**Ngiyalazi lelilungelo. Kodwa alilandelwa noma liphuliwe**
10.1 Ngokwesigaba 22, umthengi unelungelo lokuthola ulwazi				

ngolimi olucacile noluzwisisekayo				
10.2 Ngokwesigaba 23, umthengi unelungelo lokudalulelwa kwenani lamasevisi atholakalayo				

11 Ilungelo lobuqotho nokwethembeka

	Ngiyawazi futhi ngiyawaqonda la malungelo ayisisekelo sabathengi	**Ngiyawazi kodwa angiwaqondi la malungelo abathengi ayisisekelo**	**Angikaze ngizwe ngaleli lungelo Eliyisisekelo lomthengi**	**Ngiyalazi lelilungelo. Kodwa alilandelwa noma liphuliwe**
11.1 NgokweSigaba 47, umthengi unelungelo lokuthola izimpahla ezifana nemithi ngosuku nesikhathi esibekiwe				
11.2 Ngokwesigaba 47, umthengi unelungelo lokuthola				

izinsizakalo ezifana nokwelashwa ngosuku nesikhathi esibekiwe				

12 Ilungelo lokuthola imigomo nemibandela engenzeleli, enobulungisa futhi enomqondo.

	Ngiyawazi futhi ngiyawaqonda la malungelo ayisisekelo sabathengi	**Ngiyawazi kodwa angiwaqondi la malungelo abathengi ayisisekelo**	**Angikaze ngizwe ngaleli lungelo Eliyisisekelo lomthengi**	**Ngiyalazi lelilungelo. Kodwa alilandelwa noma liphuliwe**
12.1 NgokweSigaba 50, umthengi unelungelo lokungena enkontilekeni ngokuya ngemibandela enobulungiswa, futhi enomqondo				
12.2 NgokweSigaba 49 no-51, umthengisisi akanalungelo lokunciphisa isehlakalo noma umonakalo wakhe ngokwemibandela				

yesigatshana sokukhishwa esivumelwaneni ngaphandle kokuchaza uhlobo lomkhawulo kumthengi				

13 Ilungelo lenani elifanelekile, ikhwalithi enhle kanye nokuphepha

	Ngiyawazi futhi ngiyawaqonda la malungelo ayisisekelo sabathengi	**Ngiyawazi kodwa angiwaqondi la malungelo abathengi ayisisekelo**	**Angikaze ngizwe ngaleli lungelo Eliyisisekelo lomthengi**	**Ngiyalazi lelilungelo. Kodwa alilandelwa noma liphuliwe**
13.1 NgokweSigaba 54, umthengi unelungelo lokuthola isevisi futhi iqedwe ngesikhathi esifanele noma elindelekile kumhlinzeki				
13.2 Ngokwesigaba 54, umthengi unelungelo lokusizwa ngendlela ehloniphekile, esezingeni futhi nangekhwalithi				

elindelekile kumthengi.				

14 Uma unesifiso, sicela usethulele ukuthi amalungelo akho aphulwa kanjani.

ISIQEPHU E- Izinselelo ezibhekana neziguli ekutholeni usizo lwezempilo

Uyacelwa ukuthi uqaphele izinselelo oke noma oseke wahlangabezane nazo ekutholeni izinsizakalo zezempilo, ngokukhombisa izinga lakho lesivumelwano noma ukungavumelani nesitatimende ngasinye kulezi ezilandelayo:

15 abahlinzeki bezempilo

Uma ngivakashela isikhungo sezempilo:	**Ngivuma kakhulu**	**Ngiyavuma**	**Anginaso isiqinseko**	**Angivumi**	**Angivumelani neze**
15.1 Kufanele ngilinde isikhathi eside ngaphambi kokuba nginakwe noma ngihanjelwe abasebenzi bezempilo noma ngudokotela					
15.2 Abasebenzi bezempilo bayatholakala					

ukunginakekela ngesikhathi esikahle					
15.3 Amalunga abasebenzi ayasiza futhi ayaku hlinzeka ngolwazi oluwusizo.					

16 Ngemuva kokufika kwami esikhungweni sokunakekelwa kwezempilo, isikhathi engisi linda ngingaphakathi, okufanele ngisilinde ngaphambi kokuba ngihanjelwe/nginakwe ngumhlengikazi noma ngudokotela:

16.1 Akudingekanga ukuthi ngilinde	
16.2 Ngaphansi kwemizuzu ewu-30	
16.3 Okungenani imizuzu ewu-30 kuya kwiihora	
16.4 Okungenani ihora elilodwa kepha ngaphansi kwamahora ama-2	
16.5 Okungenani amahora amathathu kepha ngaphansi kwamahora ayisithupha	
16.6 Angisikhumbuli isikhathi engasilindiswa	

17 Ukuphathwa nokugcinwa kwemininingwane

	Ngivuma kakhulu	**Ngiyavuma**	**Anginaso isiqinseko**	**Angivumi**	**Angivumelani neze**
17.1 Ifayela lami leziguli litholakala kalula uma					

ngifika esikhungweni sezempilo					
17.2 ifayeli lami njengesiguli lisesimweni					
17.3 Udokotela naba sebenzi bezempilo bayangi chazela nge simo sami sempilo					
17.4 Udokotela naba sebenzi bezempilo bayangichazela ngo kwelashwa engikutholayo					
17.5 Umsebenzi wezempilo ukhuluma nami ngolimi engiluzwayo					
17.6 Isikhungo sokunakekelwa kwezempilo sinotolika osiza abasebenza kwezempilo					

18 Ukuphepha nokuvikeleka

	Ngivuma kakhulu	Ngiyavuma	Anginaso isiqinseko	Angivumi	Angivumelani neze
18.1 Kukhona ukuphepha okwanele esikhungweni sokunakekelwa kwezempilo					
18.2 Ngizizwa ngiphephile esikhungweni sezempilo					
18.3 Izindawo ezingaphandle zikhanya kahle ebusuku					

19 Ukuhlanzeka nokunakekelwa kwezakhiwo namagceke

	Ngivuma kakhulu	Ngiyavuma	Anginaso isiqinseko	Angivumi	Angivum elani neze
19.1 Kukhona izihlalo ezanele ezitholakalayo ngenkathi ngilindile					
19.2 Indawo yokunakekelw					

a kwezempilo ihlanzekile					
19.3 Kunamathoyile thi esikhungweni sezempilo					
19.4 Amathoyilethi asesikhungwe ni sezempilo ahlanzekile					
19.5 igceke lesikhungo sokunakekelw a kwezempilo liyanakekelwa kahle					
19.6 Izakhiwo zesikhungo sokunakekelw a kwezempilo zigcinwa kahle ziyanakekelwa					

20 iZinsiza, kanye nemithi yokwelapha

	Ngivuma kakhulu	**Ngiyavuma**	**Anginaso isiqinseko**	**Angivumi**	**Angivumelani neze**
20.1 Isikhungo sokunakekelwa					

kwezempilo sinamanzi ahambayo					
20.2 Isikhungo sokunakekelwa kwezempilo sinogesi					
20.3 Imithi engiyidingayo iyatholakala esikhungweni sokunakekelwa kwezempilo					
20.4 Udokotela uyangichazela ngemiphumela emibi yemithi yami					

21 Ukutholakala kwemibhede

	Ngivuma kakhulu	**Ngiyavuma**	**Anginaso isiqinseko**	**Angivumi**	**Angivumelani neze**
21.1 Isikhungo sokunakekelwa kwezempilo sinemibhede etholakalayo lapho ngiyidinga khona					

22 Sicela unikeze noma yiziphi izinselelo ezake zenzeka noma okungenzeka ukuthi wake wahlangabezana nazo

23 Uma sengithole izinsizakalo zezempilo kulesi sikhungo, nginikezwa ithuba lokuzibika mayelana nekhwalithi yezinsizakalo engizitholile.

23.1 Yebo	
23.1 Cha	

APPENDIX H: CHI-SQUARE GOODNESS OF FIT TEST: Awareness and understanding of the fundamental rights contained in the CPA

The right to choose

		I am aware of and understand this right		I am aware of but do not understand this right		I have never heard of this right		I am aware of this right but it has been infringed		Chi-Square p-value
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	
According to Section 13, a consumer has the right to select a supplier such as a healthcare facility or healthcare practitioner	D9.1	238	64.0%	53	14.2%	67	18.0%	14	3.8%	< 0.001
According to Section 19, a consumer has the right to services being provided on the agreed date and time or within a reasonable time	D9.2	250	67.0%	62	16.6%	46	12.3%	15	4.0%	< 0.001

The right to disclosure and information

I am aware of and understand this right	I am aware of but do not understand this right	I have never heard of this right	I am aware of this right but it has been infringed	Chi-Square p-value

		Count	Percent	Count	Percent	Count	Percent	Count	Percent	
According to Section 22, a consumer has the right to information in plain and understandable language	D10.1	290	78.0%	38	10.2%	30	8.1%	14	3.8%	< 0.001
According to Section 23, a consumer has the right to disclosure of the price of services provided	D10.2	256	69.4%	61	16.5%	47	12.7%	5	1.4%	< 0.001

The right to fair and honest dealing

		I am aware of and understand this right		I am aware of but do not understand this right		I have never heard of this right		I am aware of this right but it has been infringed		Chi-Square p-value
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	
According to Section 47, a consumer has the right to receive goods such as medication at the specified date and time	D11.1	278	74.5%	42	11.3%	40	10.7%	13	3.5%	< 0.001
According to Section 47, a consumer has the right to receive services such as treatment at the specified date and time	D11.2	263	70.9%	52	14.0%	38	10.2%	18	4.9%	< 0.001

The right to fair, just and reasonable terms and conditions

		I am aware of and understand this right		I am aware of but do not understand this right		I have never heard of this right		I am aware of this right but it has been infringed		Chi-Square p-value
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	
According to Section 50, a consumer has the right to enter into a contract based on fair, just and reasonable terms	D12.1	206	55.8%	67	18.2%	72	19.5%	24	6.5%	< 0.001
According to Sections 49 and 51, a supplier is not entitled to limit his/her risk or liability in terms of an exclusionary clause in a contract without explaining the nature of the limitation to the consumer	D12.2	193	52.2%	67	18.1%	102	27.6%	8	2.2%	< 0.001

The right to fair value, good quality and safety

		I am aware of and understand this right		I am aware of but do not understand this right		I have never heard of this right		I am aware of this right but it has been infringed		Chi-Square p-value
		Count	Percent	Count	Percent	Count	Percent	Count	Percent	
According to Section 54, a consumer has a right to the timely performance and completion of services undertaken by a supplier	D13.1	220	59.6%	64	17.3%	66	17.9%	19	5.1%	< 0.001
According to Section 54, a consumer has a right to the performance of services in a manner and quality that the	D13.2	219	59.2%	56	15.1%	51	13.8%	44	11.9%	< 0.001

consumer is generally entitled to expect										

APPENDIX I: EDITORS CERTIFICATE

Helen Richter
Advanced Editing, Proofreading
& Copywriting
feetjieding@gmail.com
+27 729538169

4 October 2022

To whom it may concern:

CERTIFICATE OF EDITING & AUTHENTICATION

I have proofread and language edited the Master's thesis submitted by Nolwandle Ngcobo, titled:

"The role of the Consumer Protection Act 68 of 2008 in addressing
the challenges of healthcare patients as consumers"

To the best of my knowledge, the work is free of spelling, grammar, structural and stylistic errors, and the contents are certified as the author's own work.

With thanks,

H S Richter (Ms)

APPENDIX J: TURNITIN REPORT

Supervisor: R Von Staden

The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers

ORIGINALITY REPORT

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APPENDIX K: STATISTICIAN CERTIFICATE

Vidhan Singh
15 Fourth Street
Hillary
4094
Email: vidhan@hotmail.co.za

27 October 2022

To whom it may concern

STATISTICIAN DECLARATION FOR CONSULTATION

This is to confirm that I have given appropriate recommendations relating to the following student's research:
Name: Ms Nolwandle Ngcobo
Student Number: 21627113
Faculty: Management Sciences
Department: Applied law
Topic: The role of the Consumer Protection Act 68 of 2008 in addressing the challenges of healthcare patients as consumers

Sincerely

Vidhan Singh