Perceptions of private general practitioners on the implementation of the National Health Insurance system in South Africa

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Muneer Valley

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ABSTRACT

Purpose: The purpose of the study was to identify the perceptions of private general practitioners with regard to the implementation of the National Health Insurance system in South Africa.

Research Methodology & Design: To facilitate this research, a qualitative study was undertaken with an exploratory descriptive methodology. The sampling was purposeful and focused on a small group of fourteen General Practitioners (GPs) working in the Cape Town metropole region. Analysis took the form of grouping data into a matrix, and then identifying common themes.

Findings: The study highlighted the fact that GPs welcomed the introduction of the NHI as it would enable access to healthcare for the majority of the population. GPs hoped that the NHI would assist them in regaining their lost title of “gatekeepers” to healthcare. They were concerned about the government’s ability to effectively administer the NHI as well as the capitation based system of payment.

Significance: The study is significant as there is a gap in the literature as to the perceptions of GPs. The study provided insight as to how GPs view the changing healthcare environment and their experiences.

Keywords: National Health Insurance, General Practitioner, Perceptions, South Africa

Paper Type: Research Report
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GLOSSARY OF TERMS

ANC: African National Congress

Capitation: This is a payment to a provider of a fixed fee per-person-per-year for a standard range of services (Donaldson & Gerard, 1993)

CMS: Council for Medical Schemes

Direct Payments: Charges or fees levied for medical services (World Health Organisation, 2010)

Fee-for-service (FFS): This is a payment to a provider per service rendered (Donaldson & Gerard, 1993)

Gatekeeper: A primary-care provider, often in the setting of a managed-care organisation, who coordinated patient care and provides referrals to specialists, hospitals, laboratories, and other medical services (The American Heritage Medical Dictionary, 2007)

General Practitioner (GP): This is a medical doctor, actively registered with the Health Profession Council of South Africa, who provides primary medical care services to the population.

NHI: National Health Insurance

NHS: National Health System

PHC: Primary Health Care

Solo Practitioner: This is a practitioner who works alone in his or her own practice

UC: Universal Coverage

UCS: Universal Coverage Scheme

WHO: World Health Organisation
ACKNOWLEDGEMENT

I wish to express my appreciation to my wife Ieshrit, whose love and encouragement enabled me to persevere through the most trying of times.
CHAPTER 1: INTRODUCTION

1.1. Purpose of the study
The purpose of this study was to explore the perceptions of private general practitioners on the implementation of the National Health Insurance (NHI) system in South Africa.

1.2. Context of the study
The health system in South Africa is under reform and as part of this transformation the government has proposed the introduction of a National Health Insurance (NHI) system that will focus on the provision of primary healthcare through a district healthcare system. Many General Practitioners (GPs) working in the private sector provide healthcare to people that are covered by medical aid as well as those that are not. Remuneration for the GPs can be in the form of re-imbursement from medical aid companies or direct payment from the patient.

Extracts from the Green Paper that introduces the NHI define private practitioner roles as follows:

86. The salient feature of contracting private providers in the delivery of primary health care services will entail the specification of the range of services that will be provided. These may include services by the general practitioners to patients who must get the full range of primary care services required in one facility or a comparable arrangement that does not inconvenience or require travel costs on the part of the patient. (National Department of Health, 2011, p. 86)

99. All health establishments (public and private) that wish to be considered for rendering health services to the population will have to meet set standards of quality. There are six core standards that form part of a comprehensive quality package. These standards deal with key quality principle that will improve safety and facilitate access to healthcare services. These standards will form only one aspect of accreditation, other criteria for accreditation will include service elements, management systems, performance standards and coverage. (National Department of Health, 2011, p. 31)

100. The accreditation standards will specify the minimum range of services to be provided at different levels of care. Central to accreditation is the provision of primary health care services that can demonstrate performance linked to health outcomes. This
will entail involvement of competent health and medical staff with appropriate skills. (National Department of Health, 2011, p. 32)

The aim of the NHI is to strengthen the primary healthcare delivery and enable access to primary healthcare for all the citizens. In order to potentially reduce the disparity in the distribution of human resources, the benefit package may include private sector primary care services (National Department of Health, 2011).

1.3. Problem statement
There is a paucity of recent literature available with regards to the attitudes and perception of GPs in connection with NHI. Blecher, Bachmann, & McIntyre (1995) and Blecher, Jacobs, & McIntyre (1999) studied the attitudes of General Practitioners towards a NHI system. At that stage, there was uncertainty as to details the direction the government would take in providing healthcare for the citizens of South Africa. With the release of the ANC NHI discussion paper (2010) and the NHI Green paper (2011), the plans for a new healthcare system have become public.

Details as to the specific role private general practitioners will play is lacking, and one can only speculate what those could be. GPs have been offering primary healthcare services to both the public and private sectors (Mills, et al., 2004).

Inference has been made that GPs working in the private sector will need to be accredited before they are allowed to contract with the district health system. Discussion is also focused on the fact that accreditation will lean towards practices that can provide a range of primary healthcare services to the public (National Department of Health, 2011). This would favour group practices that are multi-disciplinary in nature. This could impact on the GPs who are working in solo medical practices. Practices will also need healthcare personnel who fit into the category of being “competent health and medical staff with appropriate skills.” (National Department of Health, 2011, p. 32).

This study will highlight the level of understanding GPs have of the NHI, and bring to the surface their concerns, hopes and experiences.
1.4. Aim
The aim of this study is to explore how GPs view the implementation of NHI and what they perceive what their roles are going to be in the healthcare environment after the implementation of the NHI.

1.4.1 Research questions
To assess the views of GPs with regards to the implementation of the NHI, this research will focus on the following research questions:

- How do GPs view the current healthcare system?
- How do they understand the role that the GP will play in the new healthcare system?
- What challenges do they foresee in the implementation of the new healthcare system?

1.5. Significance of the study
The study is significant because the introduction of the National Health Insurance is seen as an important step in the provision of an equitable healthcare system in South Africa. With the shortage of healthcare personnel (National Department of Health, 2011), this research will become important for all medical role players to become involved with the implementation of the NHI system.

The African National Congress’ NHI discussion document (ANC, 2010) and the NHI Green Paper (2011) propose that the first level of care will be at the level of a primary healthcare team (PHC). The PHC team will consist of a doctor or clinical associate, nurse and 3 – 4 community health workers (ANC, 2010). Should this be the case, it is estimated that an additional 16 000 GPs will be required over and above the current number of GPs working in South Africa (Econex, 2011). This indicates the demand on the need for healthcare personnel.

1.6. Delimitations of the study
This study only focused on GPs operating in the private healthcare sector. The sample was taken from the Cape Town Metropole region in South Africa. No other primary healthcare workers, such as nurses or dentists, were interviewed. In addition, the study focuses on the private sector. As such, general practitioners that work in the public sector were not interviewed (i.e. only GPs who owned a medical practice were interviewed). The doctors interviewed worked independently and were not part of a clinic chain of practices and doctors practicing as specialist were not included.

1.7. Assumptions
The assumptions made during this study were that the doctors that were interviewed:
• were familiar with all the proposals of the NHI
• have varying opinions regarding the implementation of NHI
• understand the need for a new healthcare system
• understood the differences between capitation payments and fee-for-service
• treated patients on a variety of cost options (private, medical aid, union)

It is important to note that the NHI Green Paper is a document in progress, and not the final plan for implementation by the South African government.

1.8. Research Ethics
Ethical clearance for the study was obtained from the University of Cape Town prior to the research being undertaken. Informed consent was obtained from all participants. Within the context of this study, all participants are referred to by the use of pseudonyms.
CHAPTER 2: LITERATURE REVIEW

2.1. Introduction
In order to gain a better understanding of healthcare and healthcare reform, this paper will briefly discuss the need for universal healthcare and where its focus lies. Universal healthcare encompasses many forms of healthcare delivery – a national health insurance, as proposed by the government of South Africa, is one such form. Many countries have already embarked on some form of healthcare reform and are at various stages in the development of such systems (World Health Organisation, 2010).

This paper would firstly discuss the current need for healthcare reform in a country, and then determine the experiences of primary healthcare workers working in a reformed healthcare environment. Following on this, this paper details how healthcare is currently delivered in South Africa and broadly identifies what issues the NHI intends to address.

This report will then concentrate on how general practitioners are experiencing healthcare delivery and what their views are with regards to the implementation of the NHI.

The literature review will demonstrate the importance of determining the opinions that general practitioners have.

2.2. Background discussion

2.2.1. Universal Healthcare
Healthcare reform is concerned with improving the quality of care given to patients (Custers, Arah, & Klazinga, 2007). Healthcare reform involves altering the healthcare system from one that provides health cover to a small proportion of the population to one that will provide equity of care to the majority, if not all, of the population.

Figure 1: The main challenges restricting achievement of Universal Coverage (Adapted from World Health Organisation, 2010)
population of a particular country. In 2005, the World Health Organisation committed to develop a health financing system so that all people have access to services and do not have to suffer financial hardship to gain access to these services (WHO, 2010). This goal was Universal Coverage, simply defined as “access to adequate healthcare at an affordable price” (Carrin, & James (2004) cited by McIntyre et al., 2008, p. 873). Low-, middle- and high-income countries across the world are moving closer to Universal Coverage (World Health Organisation, 2010).

The WHO report on Universal Coverage makes note of three challenges that countries face when it comes to the implementation of Universal Coverage (WHO, 2010). These challenges are (a) the availability of resources, (b) the reliance on direct payments at the time of need, and (c) the inefficient and inequitable use of resources. The availability of resources refers to access to healthcare providers, access to technological services to provide improved healthcare, and interventions that may improve health. The reliance on direct payments (also referred to as out-of-pocket payments) refers to the need to pay for a medical service that a medical aid insurer will not cover. These can include payments for medicines, fees for consultations and fees for procedures. This form of payment is seen as a burden to the individual seeking medical attention because it could deplete household finances and, in some cases, discourage the use of health services (WHO, 2010). Inefficient and inequitable use of healthcare resources results in wastage, and reduction of this wastage can improve the quality of services provided, improving health delivery.

There is a great deal of literature that focuses on healthcare reform, specifically connected with the financial viability and stability in implementing healthcare reform. The basis of universal coverage stems from the maximisation of risk pools to provide equitable healthcare systems, where services are available to all (McIntyre, et al., 2008). Risk pooling occurs when all individuals and households share the financing of total health care costs (Carrin & James, 2004). “The larger the degree of risk pooling in a health financing system, the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have access to the care they need.” (Carrin & James, 2004, p. 3)

2.2.2. Primary Healthcare
Primary care is defined as “the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and
community” (Donaldson, Yordy, Lohr, & Vanselow, 1996, cited by Contandriopoulos & Brousselle, 2010, p. 145). Primary healthcare has an effect on the equity and efficiency of health care systems (Busse, Schlette, & Weinbrenner, 2005). The increased availability of primary health services is generally associated with higher patient satisfaction and reduced spending (Busse et al., 2005). Furthermore, Busse et al. (2005) state that if healthcare is orientated around a specialist-based system, the healthcare costs increase, leading to inequitable access to healthcare. Moreover, costs in the primary healthcare setting may also increase if there is a need for improving access to services or as a result of possible increases in service utilisation (Busse et al., 2005).

The American College of Cardiology, a recognised leader in education and quality over the last 60 years, has identified 6 principles that are necessary for healthcare reform (Dove, Weaver, & Lewin, 2009).

![Figure 2: Principles Necessary for Reform (Dove, Weaver, & Lewin, 2009)](image)

According to these principles, the rate of increased spending can be reduced by focusing on the value offering to patients in terms of care (Dove, Weaver, & Lewin, 2009), which will result in a more cost-efficient healthcare system. Factors which would enhance patient care include improved coordination of care, team-based care delivery, and the appropriate use of tests and procedures (Dove, Weaver, & Lewin, 2009). Payment and remuneration to providers
should be done based on the quality of care delivered to the patient, as well as best practice standards. Payment to providers must be patient focused, i.e. providers that work hard to provide total patient care should be adequately rewarded (Dove, Weaver, & Lewin, 2009).

2.2.3. Experience of Primary Healthcare Workers with Universal Coverage

As the introduction of a new healthcare system revolves around changing the way healthcare is delivered, “health care reform will likely require physicians and care providers to adjust the way they practice” (Dove et al. 2009, p. 500). This is particularly true for the primary care physician who will most likely be exposed to an increased in patient turnover. This will in turn affect the way in which they practice their profession. “... [T]he job satisfaction of the primary healthcare physician is a critical factor for health care systems because primary care level is responsible for providing medical care to a greater proportion of the population than any other care level.” (Al-Eisa, Al-Mutar, & Al-Abduljalil, 2005, p. 1). Al-Eisa et al. (2005) confer that job satisfaction levels of general practitioners may be related to the quality and efficiency of care given. Factors that have been shown to affect the satisfaction levels of primary healthcare physicians include the income of practitioners, the variety of work they are exposed to as well as the conditions of the environment they practice in (Al-Eisa, et al. 2005).

Job satisfaction was found to be at an all-time low for GPs in the UK following the introduction of the National Health System during 1990/1991 (Sibbald, Enzer, Cooper, Rout, & Sutherland, 2000). During this time, GPs felt that the changes introduced by the implementation of the new system altered their professional status (Sibbald et al. 2000). Their belief was that the policies to be implemented were meant to curtail their income rather than to improve the health of their patients (Sibbald et al., 2000). In addition, GPs felt that the changes would impact on their clinical autonomy (Sibbald et al., 2000). Despite the fact that the changes to the healthcare system brought about an increase in managerial autonomy, this did not improve their situation. This is because clinical autonomy is important to GPs, more so than managerial autonomy (Lichenstein, R.L. 1998, cited by Sibbald et al., 2000). Nonetheless, subsequent studies have reported an increase in job satisfaction levels (Sibbald et al., 2000). The increase in job satisfaction may be attributed to the reduction of workload as a result of the employment of allied staff into their practices as well as the ability to delegate work to those allied staff members. Therefore, the hiring of allied staff had a positive effect on GPS and enhanced their clinical autonomy (Sibbald et al., 2000). Sibbald et al. (2000) also found that working flexible hours generally increased job satisfaction levels and that
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dissatisfaction was related to little recognition of good work as well as increased stress related to complaints received from patients.

Thoresen and Fielding (2011) studied the Universal Coverage Scheme (UCS) was implemented in Thailand. The UCS initially worked as a two-tiered system, involving both the public and private sectors. The adoption of the UCS led to the increased utilisation of private healthcare services, both in the rural and urban regions (Yiengprugsawan et al., 2010). As a result, the percentage of uninsured individuals dropped from 67.4 % to 9.7 % (Yiengprugsawan, Carmichael, Lim, Seubsman, & Sleigh, 2010). However, Thoresen and Fielding (2011) reported that as a consequence of the increased access to healthcare in Thailand, there has been a subsequent increased in workload experienced by healthcare workers. In particular, public institutions in rural areas were noted to have a doubling in the number of out-patients (Thoresen & Fielding, 2011). Subsequently, the quality of healthcare in Thailand was regarded as poor and many hospital directors were facing budgetary constraints, which have affected patient care (Thoresen & Fielding, 2011).

Moreover, the quality of healthcare in Thailand is further affected by the fact that people tend to seek healthcare inappropriately (e.g. seeking simple medical advice instead of needed medical attention), thereby placing an increased burden on medical personnel and resources. The UCS was prone to abuse because users were reported to try to maximise their benefits by asking for inappropriate medications (Thoresen & Fielding, 2011). This has resulted in the wastage of medical resources, i.e. time was not spent on the delivery of primary healthcare and preventative medicine.

Nevertheless, the financial sustainability of Thailand’s UCS has been seen as a success. However, the human resource factor may affect the system considerably. Many physicians have left their public services posts to seek employment in the private sector (Thoresen & Fielding, 2011). This has led to the inequitable distribution of healthcare personnel between the private and public sectors (Thoresen & Fielding, 2011). The high turnover rate of doctors has had further financial implications for the system, requiring more finance for the development and training of new doctors, especially since these doctors were inexperienced and usually sourced from the newly-qualified medical graduates (Thoresen & Fielding, 2011).

Vanagas and Bihari-Axelsson (2005) have also looked at stress among GPs after healthcare reform had occurred in Lithuania. The focus of the study was the measurement of the level of
psychosocial stress experienced by GPs. This was deemed to have increased with the implementation of the reform initiative. GPs subsequently had the increased responsibility of making more competent decisions with regards to the ongoing management of medical conditions. There was also an increase in paperwork in connection to patient care administration, increased patient loads with a decrease in independence of the GP, as well as flexibility of practice (Vanagas & Bihari-Axelsson, 2005). The increased stress, frustration and tension could lead to inappropriate decision-making as to the management of patients. Therefore, in an effort to develop primary health care activities such as patient needs, continuity, comprehensiveness, health promotion, and disease prevention, the reform has placed increased emphasis on GPs (Vanagas & Bihari-Axelsson, 2005). As a result, there is still a lack of GPs in rural areas (National Department of Health, 2011).

An essential determinant of quality of primary healthcare service delivery is the availability of skilled/qualified health care workers (Richard et al. (2004) cited by Chukwuani et al. (2006). Chukwuani et al., (2006) demonstrated that only 26.7 % of healthcare facilities had the equivalent of a community health officer, which impacted on the quality of service delivery as well as patient satisfaction. While the policy had identified essential services packages to be provided at all levels of healthcare, the lower level facilities did not have the necessary skilled staff to provide the services required (Chukwuani et al., 2006).

In summary, the introduction of Universal Healthcare is seen as a necessary step towards providing equitable healthcare to the population. The main focus is that of primary healthcare, which results in the increase of healthcare delivery to people. Studies have shown that as a result of the increase in workload at this level, primary healthcare providers have been exposed to increased stress levels. This has had a detrimental effect on the quality of care delivered to the patient. Primary healthcare providers, be they primary healthcare workers or doctors, must therefore be prepared for the increased workload.

2.3. Healthcare in South Africa

2.3.1. Introduction
Currently, the healthcare system in SA is divided into the private and public sectors. The private sector provides health services for 16.2% of the population and the public sector, which is reliant on government funds, provides services for the rest (83.8%) of the population (National Department of Health, 2011). There is however a considerable difference between the public and private sector in terms of funding. The budget allocated to the public sector,
obtained from the National Treasury was R21.5 billion in 2010/11, up by 16% from R18 billion in 2009/10 (Government Communication and Information System (GCIS), 2011). Conversely, the income for all medical schemes, obtained by contributions from medical scheme members, was R96.5 billion in 2010, up by 13.7% from R84.9 billion in 2009 (Council for Medical Schemes, 2011). Correspondingly, the quality of healthcare between the two sectors also varies considerably with the public sector lagging far behind the private sector (National Department of Health, 2011).

Generally, the quality of healthcare in the public sector is poor. This can be attributed to the “the lack of cleanliness of facilities, safety and security of staff, long patient waiting times, staff attitudes and infection control and drug stock-outs.” (National Department of Health, 2011, p. 9). As a result, patients often seek care at private facilities where they perceive that the quality of care is better, but are forced to pay “out-of-pocket” for such services (National Department of Health, 2011). As a result, many people that opt for the out-of-pocket payment system to receive their medical treatment for primary healthcare needs are treated at private GPs (Mills, et al., 2004).

Because 42.5% of the population of South Africa live in rural areas (Health Systems Trust, 2011), with little or no access to healthcare services, the introduction of the NHI would result in the development of healthcare facilities in the rural areas, thereby allowing for increased access to healthcare treatment. Thus, the policy to be implemented is along the lines of Universal Coverage (National Department of Health, 2011), where the focus is on primary healthcare, that is equitable. This is in keeping with international trends where the provision is being made to make healthcare more accessible.

2.3.2. Healthcare Personnel in South Africa
In South Africa, the human resource allocation is disproportionate in healthcare, with the majority of healthcare personnel working in the private sector (National Department of Health, 2011). According to the Health Professions Council, there is a total of 37 583 registered medical practitioners in South Africa. Of these, 25 898 are general medical practitioners and 11 685 are specialist medical practitioners (Health Systems Trust, 2010). The number of doctors currently working in the public sector is 12 014 (Health Systems Trust, 2010). This indicates that approximately 32% of the total medical practitioners work in the public health sector which provides health care services for the 83.8%. However, as Dr Nkaki Matlala (chair of the Hospital Association of South Africa) states, it is a well known
fact that the number of healthcare human resources have declined over the past 10 – 15 years (Matlala, 2011). In addition to this, Lloyd, Sanders, and Lehmann (2010) state that the health system in South Africa has failed to transform in recent years as a result of lack of healthcare personnel, as well as the inequitable distribution of healthcare workers between the private and public sectors. Contributing to this has been the lack of appropriate skills of healthcare workers (Lloyd, Sanders, & Lehmann, 2010) and poor planning and management in the system. They further add that

“even if the NHI scheme could enrol the services of doctors currently working in the private sector, it is unlikely that they would relocate to currently underserved rural or peri-urban areas and be available to those who currently reside in those areas.” (Lloyd, et al. 2010).

Even so, the plan envisioned by the government with regards to the NHI would be to operate out of a district health system with specialist services to be made available closer to the patients’ home. This could lead to effective integration of specialist services with that of primary healthcare individuals, enhancing the quality of care delivered to the patient at point of contact (Gruen et al. (2009) cited by National Department of Health, 2011)

The main goal of the NHI is to develop the delivery of primary healthcare in order to bring equitable healthcare to the population. To increase the service delivery in the healthcare sector, attempts have been made to train and develop mid-level primary healthcare workers; however this has slowed down (Lloyd, Sanders, & Lehmann, 2010). Coupled with the reduction in newly qualified medical graduates (Lloyd, Sanders, & Lehmann, 2010), the number of medical personnel has not kept pace with the growing medical needs of the population (Lloyd, Sanders, & Lehmann, 2010). Many feel that it may not be possible for a developing country to implement universal coverage. Nevertheless, implementation in other developing countries has been successful. For example, one of the features that led to a successful district health system in Brazil was the introduction of the Community Healthcare Worker (Lloyd, Sanders, & Lehmann, 2010). The work of the Community Health Worker is supported by nurse practitioners, with the key feature of the success of the program being team work between healthcare personnel (Lloyd, Sanders, & Lehmann, 2010).

Therefore, not only is an increase in healthcare personnel needed to develop successful primary healthcare sites, individuals need to work efficiently together, as a high performance work system is needed for effective service delivery (Leggat, Bartram, & Stanton, 2011).
Thus there has to be a focus on developing the correct individuals and training the managers and empowering health care providers so that an effective high performance system can be implemented (Leggat, Bartram, & Stanton, 2011).

### 2.3.3. Private Sector Medical Costs

Private sector healthcare expenditure has risen considerably over the past decades. Figure 3 demonstrates the rising trends in healthcare expenditure of medical aids operating in the private sector. Most of the sectors have shown a rise in healthcare expenditure, with private hospital expenditure rising considerably from just over R10 billion in 1997 to R31.1 billion in 2010.

![Figure 3: Total healthcare benefits paid: 2010 prices (Source: Council for Medical Schemes, 2011)](image)

Various initiatives have been introduced in legislation to help curb the rising costs. One such initiative was government legislation to control the costs of medicines in the private healthcare system. This was introduced in the period 2001-2003 and has curbed medicine prices, making them more affordable to the public.
By far, the majority (a total of 59%) of benefits paid by medical aids are spent on hospitalisation and medical specialists (Figure 4). Primary health care expenditure only makes up 21% (GP, managed care, dentists and supplementary health workers). With the introduction of managed care, it is envisioned that the gatekeeper system will be effective in managing rising medical costs.

Figure 4: Total healthcare benefits paid 2010 (%)
(Source: Council for Medical Schemes, 2011)

Managed healthcare has been promoted in an attempt to help solve the crisis of rising medical costs (Kinghorn, 1996). Managed care means “clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes” (Council for Medical Schemes, 2003). The aim of managed care is “to control the cost of health care, while the quality is maintained or improved.” (Jurisich & da Silva, nd, p. 4). Members of a managed care scheme have access to medical services through a gatekeeper system (Gotlieb, 1999). The gatekeeper, being the GP, gives restricted access to specialist and special investigations, and authorisations are usually required for referrals, tests and hospitalisations (Gotlieb, 1999).
There are usually varying payment options to reimburse the providers with, the commonest being fee-for-service (FFS), negotiated fee for service, capitation and salary.

A capitation agreement means “an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such a person a pre-negotiated fixed fee in return for the delivery or arrangement for delivery of specified benefits to some or all of members of medical scheme” (Council for Medical Schemes, 2003). The introduction of these strategies is becoming commonplace as funders try to stem the rising costs of healthcare expenditure.

In summary, healthcare in South Africa is under strain. It is inequitable, with the quality of care in the public sector lacking. In addition, there is a shortage of adequately skilled healthcare personnel to effectively deliver primary healthcare and the expenditure in the private healthcare sector is climbing exponentially, making it less accessible to the poor.

2.4. General Practice in South Africa

In the private healthcare sector, primary healthcare is predominantly (but not exclusively) delivered by GPS.

GPs work in the Public sector as well as in the Private Sector. GPs working in the private medical sector derive their income from both fee-paying walk-in-patients and from patients whose lives are insured by medical aid schemes (Mills, et al., 2004). Depending on the product, the medical aid scheme reimburses the doctor either on a fee-for-service or capitation. However, the details on the exact involvement of GPs are limited in the NHI Green Paper. Nevertheless, whatever materialises, there will be an effect on the way healthcare is delivered to all South Africans. In order to meet the requirements of healthcare delivery, speculation exists as to how GPs in the private sector will deliver their services. Hence, the discussion that follows will focus on GPs working in private healthcare setting in South Africa.

2.4.1. Group Practices

The NHI document references the fact that the primary healthcare unit will be the prominent mode of delivery of healthcare. The Green Paper states that

“The salient feature of contracting private providers in the delivery of primary health care services will entail the specification of the range of services that will be provided. These may include services by the general practitioners to patients who must get the full range of primary care services required in one facility.” (National Department of Health, 2011)
The attempts at providing equitable healthcare to the citizens of South Africa dates all the way back to 1928 (REF). In 1942, The Gluckman Commission was formed for the purpose of providing equitable healthcare. Phillips (1993) mentions that the focus of the Gluckman Commission report was the formation of group practices. The report noted 2 important aspects of healthcare. The first aspect is that “the day of individual isolationism in medical practice is past, and that medical practitioner and their auxiliaries can make the most effective contribution to the needs of the people through group or team practice”. The second aspect is that “the primary aim of medical practice should be the promotion and preservation of health.” (Phillips, 1993, p. 1037). This marked the era of a new beginning to healthcare delivery in South Africa, and was followed through with the establishment of 44 multi-disciplinary health centres by 1949. The process, however, was halted with the re-election of the National Party government in 1952.

The current public healthcare system revolves around the group practices, where medical services are delivered at one facility. For an effective service to be rendered, the healthcare providers working at a primary care facility must be efficient at their duties, and be able to work in teams. Chukwuani et al. (2006) cite several authors (Porter-O’Grady, 1996; Rowe, 1996; McClosky, 1995; Purtilo, 1994; Munetz et al., 1993 and Britton et al., 1995) that concur that interdisciplinary health care teams are the model of choice for health care organizations attempting to provide efficient and effective services. An integrated delivery system is defined as “ … large, multispecialty practices, characterized by patient-care teams, defined patient populations, aligned financial and payment incentives, partnership between medicine and management, information technology, and accountability …” (Gillies et al. (2006) cited by Contandriopoulos and Brousselle (2010), p.145). Such a model favours the achievement of primary care-centred, high quality, and efficient care (Contandriopoulos & Brousselle, 2010)

Creating group practices is not the “gold standard” of effective healthcare. It is important for that group of individuals to work as a team. Wagner (2000) defines a patient care team as “a group of diverse clinicians who communicate with each other regularly about the care of a defined group of patients and participate in that care.” (as cited by Grumbach & Bodenheimer, 2004, p. 1246). Having good teamwork in primary care settings has resulted in enhanced continuity of care, better access to care as well as patient satisfaction (Grumbach & Bodenheimer, 2004). However, some drawbacks that are specifically related to the size of the teams exist. As team sizes increase, there is increased interpersonal communication which
may hamper the benefits. Furthermore, there are increased challenges associated with human relationships and personalities (Grumbach & Bodenheimer, 2004). Nonetheless, there is a lack of data that is associated with the number of group practices in the private sector, where GPs operate from and what their experiences are. There is an assumption that the majority of private GPs work from a solo practice, with little or no contact with other GPs. It is, therefore likely that GPs have very little experience in working in group practices.

2.4.2. Current satisfaction level of GPs
During the last decade, the healthcare industry in the private sector has seen many changes. GPs experienced many legislative changes to the way they practiced medicine. The changes that have been most impactful include the introduction of a managed health care, dispensing license requirements for doctors that compound and dispense medicine at their practices, and the introduction of pricing control regulations (i.e. single exit prices) for pharmaceuticals (Pillay, 2008).

Managed care has been a cause of dissatisfaction amongst GPs (Pillay, 2008). These strategies have impacted on the professional autonomy of the doctor, and have had a negative effect on the quality of care given to the patient (Pillay, 2008). Internationally, it is evident that dissatisfaction amongst practitioners would increase if there was an organisational change (Davidson et al., 2000 as cited by Pillay 2008). With the release of the NHI document as well as the imminent implementation of the NHI system, GPs are faced with further impeding changes to their practices, which does not bode well for healthcare in South Africa.

2.4.3. General Practitioners and National Health insurance
The available literature references two quantitative studies that focused on attitudes and perception of GPs regarding the implementation of NHI. The studies were performed in 1995 (focusing only on GPs operating in the Western Cape) and in 1999 (focusing on GPs at a national scale).

Blecher, Bachmann and McIntyre (1995) reported on the acceptability of NHI and capitation by GPs in the Western Cape. A cross-sectional survey and 4 focus group discussions were held where it was found that most of the GPs approved of the introduction of an NHI system. However, this was dependant on the payment mechanisms, workload, income and professional autonomy (Blecher, Bachmann, & McIntyre, 1995). The NHI was regarded as a more equitable system, and this became one of the most important predictors of support (Blecher, Bachmann, & McIntyre, 1995). Furthermore, GPs were supportive of the NHI if it
would increase or at least maintain their current level of income. GPs had mixed reviews of capitation as a reimbursement mechanism (Blecher, Bachmann, & McIntyre, 1995). The concerns reported include the potential to decrease quality of care, and the reduction of clinical independence and continuity of care.

The need for an equitable healthcare system was further supported in a second study in 1999, which focused on the attitude of GPs at a national scale (Blecher, Jacobs, & McIntyre, 1999). GPs believed that an NHI system would possibly lead to a reduction in income and professional autonomy (Blecher, Jacobs, & McIntyre, 1999). Many GPs approved of a system that had a fee-for-service based reimbursement option instead of one using capitation as a form of remuneration (Blecher, Jacobs, & McIntyre, 1999). GPs were also concerned about the lack of access to privately insured patients and the subsequent impact on their income (Blecher, Jacobs, & McIntyre, 1999)

2.5. Conclusion

The GP plays a significant role in the delivery of primary healthcare in both the public and private sectors. An introduction of the NHI will require changes in the method and manner in which healthcare is delivered by a GP. Earlier studies have shown that GPs in the private sector accept the NHI as it would benefit the public, but have concerns around the issues of remuneration as well as the autonomy of practice. More recent studies have shown that GPs are dissatisfied with certain aspects of general practice. With the release of the NHI Green Paper, the context has changed. Information is lacking as to the precise role that GPs will play in the NHI.

This research, therefore, aims to explore the perceptions of GPs with regards to the future implementation of the NHI.
CHAPTER 3: RESEARCH METHODOLOGY

3.1. Research methodology

The purpose of this paper is to qualitatively determine how GPs working in the private sector perceive the implementation of NHI, as well as their preparedness to work within the new health system. In order to answer this we need to ascertain the following:

- Do GPs see a need for a new healthcare system?
- What is their understanding of the role that they will play in the new healthcare system?
- What are the challenges they foresee in the implementation of the new healthcare system?

To assist in answering these proposed questions, a qualitative study design will be employed. A qualitative design was chosen because the analysis will generate non-numerical data (Saunders, Lewis, & Thornhill, 2009).

Research can take one of two designs, quantitative or qualitative. Quantitative is predominantly used as a synonym for a data collection technique or analysis that generates or uses numerical data (Saunders, Lewis, & Thornhill, 2009). Qualitative is used as a synonym for a collection technique or analysis that generates non-numerical data (Saunders, Lewis, & Thornhill, 2009).

Table 1: Distinctions between quantitative and qualitative data (Saunders, Lewis, & Thornhill, 2009)

<table>
<thead>
<tr>
<th>Quantitative Data</th>
<th>Qualitative Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on meanings derived from numbers</td>
<td>Based on meanings expressed through words</td>
</tr>
<tr>
<td>Collection results in numerical and standardised data</td>
<td>Collection results in non-standardised data requiring classification into categories</td>
</tr>
<tr>
<td>Analysis conducted through the use of diagrams and statistics</td>
<td>Analysis conducted through the use of conceptualisation</td>
</tr>
</tbody>
</table>

Quantitative research tends to be focused on how variance in one variable causes variance in another (Maxwell, 2005). Qualitative research, however, tends to focus on how one variable plays a role in causing another, and the process that connects the two variables (Maxwell, 2005).
3.2. Research Approach
Research approach is important as, “[It] is the overall configuration of a piece of research involving questions about what kind of evidence is gathered and from where, and how such evidence is interpreted in order to provide good answers to your initial research question.” (Saunders, Lewis, & Thornhill, 2009, p. 126). The two main research approaches are deduction and induction.

Deduction begins with a statement or assumption that the researcher initially takes to be true, and is valuable for generating research hypotheses and testing theories (Leedy & Ormrod, 2010).

Induction begins with an observation. Researchers “observe a sample and draw conclusions about the population from which the sample has been taken” (Leedy & Ormrod, 2010, p. 33).

This study will look at how GPs perceive in intended implementation of the NHI, and the context wherein this implementation takes place. This study focused on a small sample of GPs, and the data were collected via interviews. Conclusions about the sample were being drawn from the collected data. Thus, the research followed an inductive approach.

3.3. Research Design
3.3.1. Population and sample

3.3.1.1. Population
This study focused on the perceptions of GPs working in the Cape Town Metro-pole region of the Western Cape of South Africa. This provided convenient access to GPs for the researcher because the researcher is also a GP working in the Western Cape. It was also more practical to focus on one region locally, rather than many areas nationally because the environment in which GPs practice may differ considerably. Therefore, this could have resulted in difficulty in assessing common themes. Fourteen GPs that are actively practising (in their own practices) were eventually chosen to participate in the study. In order to reduce the introduction of a research bias, the practices are situated in different socio-economic regions in Cape Town.

3.3.1.2. Sample and sampling method
The sampling method was purposeful with an intentional non-random sample selection. The reason for this is that the individuals (GPs) “will yield the most information about the topic under investigation” (Leedy & Ormrod, 2010).
GPs that operated solo practices (i.e. only one doctor) and those that were part of a group practice were sought. Multidisciplinary practices, where auxiliary medical services were offered, were also considered.

It was also important to determine how long the doctor had been in practice to understand if younger doctors had differing viewpoints to doctors who were established for a longer period of time.

Limiting the study to only one of the categories may have introduced a bias as to how the NHI might be interpreted. The NHI document favours group practices and the needs of the solo GPs needed to be ascertained, as they are the ones to be most affected by the current Green Paper.

3.4. The research instrument
Interviews can be categorised as one of following: structured interviews, semi-structured interviews and finally, unstructured or in-depth interviews (Saunders, Lewis, & Thornhill, 2009). Structured interviews use a set of questions that are pre-determined or standardised (Saunders, Lewis, & Thornhill, 2009). With a semi-structured interview, there are a list of themes and questions to be covered, but these may vary for each interview (Saunders, Lewis, & Thornhill, 2009). Unstructured interviews are informal and used for in-depth exploration of a topic (Saunders, Lewis, & Thornhill, 2009).

For this research, the semi-structured interview approach was used (See appendix). Doctors were asked a few demographic details and questions relating to the implementation of the NHI. As the interviews progressed in numbers, certain themes became evident; these themes were explored to gauge the opinion of the doctors.

3.5. Procedure for data collection
Doctors were initially contacted by telephone and asked if they would like to participate in the survey. A face-face appointment was arranged with some. The interviewee was given the opportunity to suggest a time that was most suitable for them. At the initial contact, the topic and purpose of the study was explained to the interviewee. Verbal consent was asked at the time of initial contact. Some respondents could not give up much of their time, and were subsequently interviewed via the telephone. This was not the researcher preferred method of interview. Face-to-face interviews enable the researcher to establish rapport with respondents, and can therefore gain their cooperation (Leedy & Ormrod, 2010). While face-face interviews
were preferred, the telephonic interview had the advantage of making contact and obtaining an interview with minimal time expense. Some of the GPs were not willing to give up the busy working hours and preferred not to be contacted at night during family time. One of the disadvantages of telephonic interviews is the loss of personal contact and subsequent loss of trust that comes with personal contact. This can affect the reliability of interviews if the participants become less willing to engage in exploratory discussion (Saunders, Lewis, & Thornhill, 2009).

At the start of the interview, respondents were assured of their anonymity. Telephone participants were faxed a consent form before the interview. Informed consent forms were signed at the start of face-face interviews. During the interviews, a few notes were made of important points, attitudes of the respondent, as well as tone and mood. The researcher encouraged the respondents to explain details of their thoughts. Where there was uncertainty as to the meaning or view points of the interviewee, the research repeated the points made to ensure that the essence of what the interviewee was trying to convey had been captured.

### 3.6. Data analysis and interpretation

The interviews were recorded and transcribed immediately. The process of recording interviews is one means to control bias and to ensure that the data for analysis is reliable (Saunders, Lewis, & Thornhill, 2009). Audio recordings have the added advantage of giving the interviewee more attention and for the interviewer to concentrate on what is being said, instead of constantly scribbling notes to capture the essence of what is being conveyed (Saunders, Lewis, & Thornhill, 2009). To ensure familiarity with the content of each interview, the interviews were replayed with the transcripts in hand.

Data analysis is needed to identify themes in people’s descriptions of their experiences (Leedy & Ormrod, 2010). Analysis of data is interactive and occurs during the collection as well as after it. This interactive method helps to shape the direction of data collection (Saunders, Lewis, & Thornhill, 2009). Thus, themes emerge through the process of data collection as well as analysis.

After transcribing the interviews, the researcher followed an approach based on the following phases (Creswell, 2003)

- Data organisation: This included creating a matrix of data within a Database
- Data perusal: Obtaining a “feel” of the data
3.7. Limitations of the study
A total of 17 GPs were approached to participate in the study. Two of the GPs declined due to time commitments and one declined stating that he knew too little about NHI to provide worthwhile input. Despite assurances to the GP that extensive knowledge was not a need, the GP still refused.

Only GPs working in the private sector (and not in the public sector) were interviewed. The sample size is very small and not representative of all GP in the Cape Town metro pole, or for the whole South Africa. Thus the study cannot be generalised to all GPs, or to workers in other healthcare sectors. The GPs interviewed saw patients on a variety of payment options. It is noted that not all GPs working in the Western Cape see patients on this basis, some preferring to see patients on a strictly cash basis only.

3.8. Reactivity and Reliability

3.8.1. Reactivity
To decrease reactivity, respondents were told that the interviews were completely anonymous, that no personal data would be collected, and that they should answer the questions as honestly as possible. The “Hawthorne effect”, is an example of reactivity, a more general phenomenon in which people change their behaviour when they are aware that they are being observed” (Leedy & Ormrod, 2010, p. 98). Maxwell (2005) states that what the respondent says will always be influenced by the interviewer. He advises that it “is important to understand how [the interviewer is] influencing what the informant says, and how this affects the validity of the inferences [the interviewer] can draw from the interview.” (Maxwell, 2005, p. 109)

3.8.2. Reliability
To ensure reliability, which is “concerned with whether alternative researchers would reveal similar information” (Saunders, Lewis, & Thornhill, 2009, p. 326), the process of interview has been discussed in detail above. The interviews were audio recorded and transcribed. The researcher studied the interviews and listened to the recorded interviews to gain an understanding of what was said and the manner in which the information was relayed. A
summary was made of the findings and these were confirmed with the respondent for validation. In the analysis, quotes were not fragmented, resulting in “thick descriptions” (Leedy & Ormrod, 2010, p. 100). In addition, transcriptions were done by an objective third person ensuring reliability.

3.8.3. Research Bias
Bias refers to “any influence, condition or set of conditions that singly or in combination distort the data.” (Leedy & Ormrod, 2010, p. 215). Bias can be very subtle and interviews can be influenced by the personality of the researcher as well as tone of voice (Leedy & Ormrod, 2010).

It is important to note that the researcher himself is a GP working in Cape Town. This introduces an element of bias to the research. However, familiarity with the topic and the current working conditions of GPs could enhance the rapport between researcher and respondent as well as credibility, as it allowed for the participants to be comfortable to answer the interview questions frankly and honestly.

GPs with established practices were targeted. This could introduce a bias towards the perceptions of established practitioners as younger doctors not as established in the community may have different opinions as to the role they might play in the NHI.
CHAPTER 4: RESEARCH FINDINGS AND ANALYSIS

4.1. Demographics of sample
There was a total of 14 GPs interviewed, 8 were interviewed in person and 6 telephonically (Table 2). Of these, 9 were Male and 5 Female with the average length of practice between them being 17.5 years. Eight doctors worked as solo GPs and 6 had more than 1 doctor working in the same practice. Six of the practices were multi-disciplinary and included the medical doctor and auxiliary medical services such as a dietician, dentist, physiotherapist, optometrist or a combination thereof. None of the doctors interviewed employed a staff nurse or primary health care sister.

Table 2: List of Respondents

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Gender: male (M) or female (F)</th>
<th>Years in practice</th>
<th>Number of GPs in the practice</th>
<th>Multi-disciplinary</th>
<th>Interview: personal (P) or telephonic (T)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>F</td>
<td>13</td>
<td>1</td>
<td>No</td>
<td>T</td>
</tr>
<tr>
<td>B</td>
<td>M</td>
<td>15</td>
<td>3</td>
<td>No</td>
<td>P</td>
</tr>
<tr>
<td>C</td>
<td>M</td>
<td>40</td>
<td>1</td>
<td>No</td>
<td>P</td>
</tr>
<tr>
<td>D</td>
<td>M</td>
<td>13</td>
<td>2</td>
<td>Yes</td>
<td>P</td>
</tr>
<tr>
<td>E</td>
<td>F</td>
<td>13</td>
<td>1</td>
<td>No</td>
<td>T</td>
</tr>
<tr>
<td>F</td>
<td>M</td>
<td>17</td>
<td>1</td>
<td>No</td>
<td>P</td>
</tr>
<tr>
<td>G</td>
<td>F</td>
<td>6</td>
<td>1</td>
<td>No</td>
<td>T</td>
</tr>
<tr>
<td>H</td>
<td>F</td>
<td>11</td>
<td>1</td>
<td>Yes</td>
<td>P</td>
</tr>
<tr>
<td>I</td>
<td>M</td>
<td>10</td>
<td>3</td>
<td>Yes</td>
<td>P</td>
</tr>
<tr>
<td>J</td>
<td>M</td>
<td>38</td>
<td>1</td>
<td>No</td>
<td>T</td>
</tr>
<tr>
<td>K</td>
<td>F</td>
<td>26</td>
<td>2</td>
<td>Yes</td>
<td>T</td>
</tr>
<tr>
<td>L</td>
<td>M</td>
<td>15</td>
<td>4</td>
<td>Yes</td>
<td>P</td>
</tr>
<tr>
<td>M</td>
<td>M</td>
<td>12</td>
<td>2</td>
<td>No</td>
<td>T</td>
</tr>
<tr>
<td>N</td>
<td>M</td>
<td>16</td>
<td>1</td>
<td>Yes</td>
<td>P</td>
</tr>
</tbody>
</table>

4.2. The Need for NHI

4.2.1. Healthcare in the Publics Sector
All of doctors agreed that there was a gap in the delivery of an efficient and effective primary healthcare service to the great majority of the population. This gap existed between those that have access to healthcare and those that do not.

They felt the introduction of the NHI would bridge this divide, by providing healthcare to the section of the population that needed it most, i.e. the low-socioeconomic groups. However,
some GPs doubted the success of the NHI, but felt that it was at least a step in the right direction.

Public primary healthcare facilities were not perceived as providing a good service. Dr H comments:

…it’s unfair, I don’t think people have access [to healthcare facilities], they can’t get there, the transport is expensive and even when they do get there, the treatment is not necessarily very good. The waiting lists are exceptionally long in the public hospitals and the referral system is very difficult. It’s very difficult to get access. And a lot of people are dying because they can’t get access to facilities.

Dr B echoed similar sentiments: “The current health service, in terms of how it is available to most of the people, I think that needs to change. It’s been a battle.” He adds that if the NHI could make treatment options more accessible to patients who cannot afford private healthcare, then the battle is already won. Healthcare must not only be accessible to these patients. It must be of a good quality and be target driven.

Dr M explains that

[Y]ou can’t just treat everybody with a blanket policy like they do at the day hospital, where everybody gets the same meds because everybody doesn’t respond, and you must treat to target, and if you not treating to target then what’s the point of treating? So, when we see day hospital patients, and they are not optimally controlled, it’s because they all getting a blanket approach. And I am very worried that with the NHI you going to end up becoming like that. You treat patients to a level that is not optimum at all. Your hands are tied, because that is what happens with the day hospital doctors, their hands are tied.

Patients are not the only ones that experience problems with the public health system. If the NHI is going to succeed, communication between the private and public primary health care workers needs to improve. The two sectors act independently of one another, not as a congruent whole. Dr N mentions that

It’s always this “us” and “them” story, also with referrals to the day hospital ... they don’t even look at the referral letter. There is no courtesy, no letter back. I write a nice letter saying this person needs a blood test or something, they don’t even read that...
One day, if the patient comes back to you, you won’t even get a note back to say what has happened, if they have helped him or nothing.

4.2.2. Healthcare in the Private Sector
The private healthcare system is not without challenges. Dr K echoed the sentiments that can be found in the annual report of the Council for Medical Schemes, that “private healthcare inflation rate is skyrocketing. It is not in keeping with normal CPI, it is becoming hospital centred… and because it is hospital centred, it is going to become more costly, which will become unaffordable for a huge sector of the public.”

Dr N mentions:

Something must change, because it can’t go on like this, because the medical aid system is now unsustainable, because there [aren’t] enough people holding it up… it is actually very scary that the costs of medical care [are] actually pushing up, and it is frustrating from our side, if you look at the pie, how little of the slice we get, 7% or less compared to specialist, hospitals, administrators. Hospitals need to be maintained, they need to be serviced, they need bums in beds, [and] how is it going to be sustained?

4.3. The role of the GP in the NHI
Most (90%) of the GPs had a basic understanding of their role within the NHI. Their knowledge came from articles in the media, summary extracts as well as workshops they attended orientated around information regarding the NHI and GP practice (Bateman, 2010).

All of the doctors understood that the NHI would be focusing on the provision of primary healthcare. Dr H expressed his fear that

GPs, like myself, and in urban areas may possibly be out of the loop, because the way I see it, one is going to have to contract with the National Health Insurance. So in other words, they will say ‘We need the following services in this specific area, can you do it for us at this cost?’ But they will give preference to the existing infrastructure. So my one concern is that if one has a GP practice, next to an existing healthcare centre, then they going to tell you ‘Sorry we are going to use the healthcare centre and we don’t need your services’ which could be a very big blow to doctors who are not anticipating this coming their way.
Not all of the doctors shared this fear. This was confirmed by the statement from Dr B who said that “from a GP point of view, it’s good news, because the primary healthcare model of the NHI hinges around the GP, so it’s going to be a lot more patients to see.”

Dr J also believed that the role of the GP would be enhanced as GPs will become the “gatekeepers, channelling patients upstream if need, but in most cases [patients] can be sorted out at their level.”

Dr L inclined towards the view that the role of the GPs had diminished in healthcare. By strengthening their role as gatekeepers, the perception of the GP in the eyes of others would change. He says “There is that the GP being the gatekeepers to healthcare which should have been the case all along. This is good for us in healthcare so that we can benefit.”

Altruism was a strong trait that was displayed by the GPs. Dr K mentions that

I think it’s a good thing. I feel positive that it’s going to be a good for the underprivileged... for the poorer community and I feel if I can be... part of it, it will enhance me as a doctor, I will be able to give back to the community.

Not only will GPs be seeing more patients, but the type of cases handled will change and be different. Dr I envisions that GPs would be “handling emergency cases, stabilising patients, and then other things, like the day-hospitals, with rehydration centres and that kind of things.”

Dr H confirms this stating that

[T]he way I understand the NHI to be, you are not allowed to refer patients, only under extreme circumstances. But they must be managed in a primary healthcare facility, so your diabetics, advanced diabetics, your renal failure patients, you’re going to have to manage them to a certain extent like they would be managed at a hypertension clinic or a renal clinic...”

But in order for GPs to play a role they would need to be skilled. This poses a problem as Dr K cautions

… [GPs] have allowed themselves to be deskilled...the GP as it stands at the moment, has been marginalised by the public and private healthcare… the role of the GP has been eroded…and I envisage [them] taking back a lot for the future. But I also think that from the GPs side, we also have the responsibility to prepare ourselves to be able
to be taken into that role, to skill ourselves so that we are able to play a meaningful role in that time.”

Having the optimum set of skills, and to be able to run and manage a practice that fulfils this requirement are important if the GP is to have a place in the NHI. Both Dr H and Dr J suggested that this could be done through workshops and Continuous Professional Development classes. The responsibility of ensuring that GPs become more skilled doesn’t only lie with the GP. As Dr J notes, “training and skills development [are] not a single thing, everybody should get involved from Independent Practitioners Associations, GP leaders as well as the government.” Dr I recommended that

If government can say to GPs where there is lack of skills for example... let’s just say you are lacking in emergency medicine, then you can rotate for 1 week in Jooste Hospital, or wherever the case may be, wherever they find the skills lacking ... then you can offer those things later on in your private practice, you will then be fulfilling that role.

Dr K was hopeful that if the NHI is rolled out properly and the infrastructure is created and is there after 5 years, I do think that a lot of GPs will switch and go work with them in the district health set up. But that is if it works out properly. I do think that GPs will be working with a system that will be set up in assisting health promotion, in assisting in taking care of chronic diseases and so on and there will be a contract with us to play that leading role within the primary healthcare environment.

The impression given by most of the GPs was that they saw themselves remaining in their own consulting rooms if the NHI was to be implemented. Dr N mentioned that

… in terms of costing, there should be some sort of outer-screening or triaging¹ and then on to GPs...there [are] not enough doctors to handle all the patients...I think the first port of call will be your primary healthcare sisters...if the patient is more complicated or complex, then the doctor sees to him.

¹ Triage: the sorting of patients (as in an emergency room) according to the urgency of their need for care (Merriam-Webster, 2011)
None of the GPs interviewed saw themselves working in a primary healthcare unit, or within the district hospital system. This could be attributed to doctors not considering the option or not being aware of how the NHI would be functioning. This evidences a lack of clarity and a lack of information regarding the precise role of GPs.

When questioned directly, doctors did not consider moving to state facilities as an alternative option if the NHI was rolled out. Dr H said that her plan

Would be to stay at home, to cut my losses, to cut my expenses, but really going into the public sector would not be a big option for me, not at this stage of my life, no... [It’s] not from a financial point of view but because I built up relationships [with my patients] over the last 10 years, I wouldn’t be able to sever that.

The reason doctors would not like to work in the public health system as primary care givers is related to their belief that it would negatively impact their quality of life. Dr N explains that despite the current need for GPs to work in the public sector,

I don’t have any inclination to go and sit at the day hospital because it’s frustrating working in those sorts of surroundings. You can sometimes do sessions and some doctors do, but I would get frustrated working in that sort of environment, I would rather go and do something else with my family.

4.3.1. Solo vs. Group Practices
The Dr G conveyed concern as to her role as a solo practitioner in the NHI:

I am a bit worried about myself with regard to being a solo practitioner within the NHI…and it seems that they are looking more at practices that are group practices and practices that would have more things to offer than just a small GP.

This concern was coupled with the type of care she gives to her patients, preferring to work on her own at her own time because she had commitments to her family. She believed that her quality of life would change and that the quality of care she would be able to give to the patients would be affected. Dr H echoes similar sentiments:

I am not sure if I will be able to work with somebody else. I have a certain way of doing things, and others have a certain way of doing things, and I don’t know if I will be able to accommodate somebody else in the practice.
This indicates that GPs are also concerned about personality clashes that may occur in a group practice. In addition, GPs working in a solo practice are very independent, and prefer to manage their practice in their particular way.

However, one drawback of working in a solo practice is that it can be very lonely. Dr E relates to this.

…at the moment, if you look at the quality of life for the solo general practitioner, we really are lonely. It’s professionally lonely, I think [we] work from a day to day situation, [we] look after patients [and we] are drowned in administrative work. Everything comes down to you.

Dr N conveyed similar thoughts and hoped that with the NHI there would be more support for doctors to assist them in coping.

…a lot of guys don’t cope, and it affects their quality of care. Alcoholism, drug abuse, suicide. We are the highest group for that stuff. It is part of the stresses and things. It should come into the NHI in terms of support for doctors providing these services, because it can become very isolated, and we are not machines.

Dr M also expressed this sentiment, and would like to work in a group practice.

[B]ut currently I haven’t found anything attractive which I would want to join. I would enjoy a group practice because it takes away that sense of isolation, you’re not working alone, and you can have somebody to bounce things off to and also you can get more time off, you can work shifts and things.

The multi-disciplinary practice approach also offered a degree of satisfaction for the doctors. Six of the doctors interviewed worked in a multi-disciplinary environment where there was some form of allied workers present, most commonly dentists, and physiotherapists, followed by optometrists, psychologists, and dieticians. The presence of allied workers gave doctors a sense of completion to their healthcare service delivery. It allows for the provision of services that enhances the quality of care given to the patient (Dr K, 2011).

While none of the practices operated with a staff nurse, most of the doctors agreed that by employing a skilled staff nurse, the work of the GP would be alleviated. Dr I envisioned that a staff nurse would assist in patient care as well as helping with administration.
There is a role to play for these staff nurses, home based care is important, maybe [they can] go to pensioners, make sure their sugar levels are fine, their insulin levels are fine, and report back [to the doctor]. I think that it is an integral part and if you can integrate it into your practice, it will be great...When you have a busy practice, you have a folder with a family of seven, the [child] comes [to see you], but you don’t know when last the parents were there and if they have diabetes or whatever, if you don’t check through the folder [because you don’t have time] you can’t check to see if they are taking their medication...then [the staff nurse] can [check] and say they should come see the doctor.”

4.3.2. Preparation for the NHI

Dr M explains that because there was no certainty as to what the requirements of the NHI with regard to the GPs are, he planned to “wait a few more years to see what’s happening. At the moment everything is very ‘wishy-washy’. There is no certainty as to what direction they are taking…so I am not going to make any changes yet. I am going to wait for some clarity.”

Similarly, Dr F mentions,

I hear that they’re trying to roll out some pilot studies this year and next year. They’re going to do cost modelling and structures to try and see what works and what doesn’t work, but we will have to wait and see what the offerings are. We have to see what the proposition is from a cost point of view... we will have to see what the state is prepared to assist us with and take it from there.

However, two of the doctors were despondent. Dr K relates that

I think I have reached a stage in my life where if the next 5 years is not going to change dramatically, I am going to consider doing something completely different with my life…the past 20 years has been very much the same, I can’t drive in circles for the rest of my life

Dr F also had little confidence in the future, saying that “I was thinking of leaving general practice to find a hospital job or even a university job because I just am quite despondent with the way things are and the way things look like they going to go”
On the other hand, Dr B mentions that he is gearing his practice up administratively to facilitate the transition into a practice that would be accredited for the NHI. However, he is still to looking for alternative opportunities. He mentions that

If there is money in the system and the budgets can roll out like it is supposed to, no problem. But if there is no money or the money is tight and you’re going to have to balance between patients and you are going to get this demanding group, then it may not even be worth your while. But despite all of that, every day I am on the internet looking at what are the overseas opportunities.

Dr I, however, was in the planning stages of facilitating a merger of practices in his area to form a group practice, as well as preparing his practice to become accredited. Dr I relates his plans:

…the way I am planning things, is to have a multi-disciplinary approach, so you have a dentist, 2 doctors, maybe even 3 depending on how many are in the area, and then you have to do an after-hours or co-op system, so that might be worthwhile... then you are pooling all your patients…. you obviously have got to do it in such a way that you have your physiotherapists, your allied health services...you can have step-down clinics, where you do rehydration [for children] instead of sending [them] to state hospitals, you can put up drips all in-house. But it all depends on how government is going to fund that.

The opinions as to what the future holds for GPs are varied, most likely due do the lack of information. However, the evidence shows that GPs do not find it easy to practice medicine, and the administration involved with seeing patients from low-cost networks causes increased frustration.

### 4.4. Challenges of the NHI

#### 4.4.1. The Effects of Capitation

The NHI Green Paper states that “accredited providers will be reimbursed using a risk-adjusted capitation system linked to a performance based mechanism. The annual capitation amount will be linked to the size of the registered population, epidemiological profile, target utilization and cost-levels.” (pg32)
The GPs were interviewed about their experience regarding capitation products. All the doctors interviewed did not look favourably upon capitation because, from their point of view, it has resulted in increased administration and decreased quality of care to patients.

Dr E mentions that managing capitated and low cost network patients (managed care entities) is frustrating:

The frustration with regard to the administration with the low cost network I think has tripled to what it is on higher plan patients. It is that you are getting paid a little, and they have put in lots of checks and balances to prevent over servicing, to prevent going straight to pathologist, prevent going straight to specialists, so they put in their safety nets… and we are the people who have to carry out their safety nets, because you have to sit on the phone and get authorisation, you have to fill out extra forms, you have to make sure you have got your special forms. You have to do 110 things when you have to service your low cost patient… you are working quadruple for patients that you are getting paid a third of what you would have normally had.

Dr H similarly stated that capitation is

A huge headache, it is a very big headache administratively. It is very time consuming. It takes what you would see two patients then you see one, because of having to phone, getting authorisation, forms to fill in, special forms to fill in for labs test. It’s very, very labour intensive… When they get to the pharmacy, because I don’t dispense, I get calls to say that ‘You have prescribed medicine that the medical aid is not going to cover,” and your whole mindset, when you see them, has to change. “Low cost, low cost, don’t give, don’t give”. And that actually compromises you to a certain extent because you’re not sure if the patient is going to get better…I definitely see a difference between my [capitated] patients and my other patients.

Dr N mentions that,

…capitation is a kopseer\(^2\) and I think they are looking at it. But is it worth seeing those extra numbers for what you are getting paid? And at the moment I would say ‘No, it’s not worth the effort.’ The problem comes in that it has become so administrative heavy in terms of referrals... So I think capitation is an unfortunate

\(^2\) Kop seer: Afrikaans for Headache
thing that is there, you have to just deal with it, but whether I will continue with it, I am still in two minds about it. For now I probably will, and if you think about the patients that are on it, you going to create a hole for them, so I decided to go with it. That sort of perceptual thinking about them, where you’re not thinking about yourself but you [are] thinking of them, and the hole you leave when you’re off [the list of providers]. Because even with the secondary doctor that they use, they will see the secondary doctor and come back to me again and they are not happy with the service, they want to come see you.

Dr N further adds that

The problem [with capitation] also stems from how members perceive their medical aid product...It works if a patient understands how it works and why it works, but otherwise it’s a lot of ... over utilisation, it’s not like you telling the patient to come back every month. They are coming for unnecessary things and it actually takes up your time. You have to bill for your time. You have to work for yourself. That is your commodity. If you’re not billing for your time, what are you doing?

Dr F explains the dynamics of capitation, as he understands it:

I think the calculation for the capitated products is faulty. By that what I mean is the medical aid firms will come to us, and tell us, “We have done our trials and studies. You will see on average a patient, a specific patient, 2.6 times per annum. We will pay you “X” [sic] amount per month, based on 2.6 visits per annum, therefore per year, over the year, you will earn so much for this patient, for looking after the patient”. But where the problem comes in is that the same medical aid tells the patient “You have got ‘unlimited’ visits by the doctor, and you must go there for primary healthcare, for everything that is wrong with you, because medicine is included, and then you must go and see the doctor because he is going to do preventative medicine for you”… and there is absolutely, absolutely, absolutely no way that you are going to find that you see that patient (only) 2.6 times per year. It just doesn’t happen.

From the doctor’s point of view, capitation has affected the autonomy of clinical practice. Dr L mentions “you know that our autonomy is shrinking for many, many years already with regard to the capitation model and others in the private sector...” Dr K mentions “...I think my
right to autonomy is already challenged with regard to the managed care contracts that we have to abide by.”

Dr K felt that the capitation model must be based on proper costing of the inputs required to maintain a medical practice, as well as the professional skill level of doctors. If this did not happen, then “we as professionals [would have allowed] ourselves to be sold out at a low cost.”

To alleviate the costs burden and keep their heads above water, doctors manage by utilising a system of subsidisation. This system involves using the profit obtained when treating a medical aid patient, to offset the loss sustained when treating a capitated patient. Dr F explains:

If you are not going to cover your costs, you are not going to come out; it is as simple as that. And in our practice, our capitated products are subsidised patients. We have cash patients, medical aid patients, capitated patients and some union patients. The union patients, capitated patients, are subsidised. [They] would like to believe that they are getting exactly the same service, same time, same effort, the same understanding, and the same medication. We try, but it is not always like that…If you going to go above your costs, its money out of your pocket.

In order to maintain a decent income, the number of patients that are required to be seen has to increase. As a result, quality of service delivery will decrease. Dr L states that

We [are] going to be churning numbers to be able to make a reasonable income. It could be that the GP is rushed for time. At the end of the day you want quality healthcare, you cannot spend 5 minutes per patient…especially the chronic patients who need a bit of education, and the holistic approach, to solving their problems.

Dr I hoped that the system would not end up like the UK’s NHS.

The flaw in the NHS is that if you have got a capitation system of X Rands a month, you going to get X Rands per month whether you see 5 patients or you see 100 patients, so the incentives for the GP has gone down to work on an appointment system.

This has a potential to impact on the quality of service rendered, as emergencies will most likely have to be referred to the emergency unit.
4.4.2. Administration of the Practices
A typical practice scenario includes one or two receptionists and an accounts administrator that has to make submissions to the medical aids. Having a properly administered practice was seen as important in order to cope with the changes the NHI may bring to practices. Dr B mentions that

So it’s going to be a lot more patients to see, and the downside of it is that you need to have the administration of your practice sorted out. If you are not sorted out yet, get yourself into a position of having a strong administrative practice ... they say gear your current practice to that, so when [NHI] comes, you just carry on with business.

Dr L affirmed this:

You need a dedicated accounts person, that is where the NHI is going to have a big impact because it affects your cash flow to such an extent that if you don’t have a proper billing system... a system in place that you are seeing money that is guaranteed, so you don’t have to suffer the burden of losses incurred by providing a service, I think it is going to be critical in terms of having a proper dedicated accounting department to be running that, and a person with accounting experience, and obviously the more experienced, the more you pay.

Dr K also mentions that having good administration personnel is expensive, but not adequately covered in remuneration costs from medical aids:

...the medical aids expects us to give that over to our practice manager, the problem at the moment is that we don’t see a lot of mark up on those patients to allow us to afford a practice manager firstly, and secondly I don’t think that the pay out to a professional person is enough to validate that high impact on administrative costs. They have to streamline [the administrative costs].

Dr E admits that her practice administration is inadequate, largely a result of time constraints and difficulty in balancing the time spent doing clinical tasks, and time spent doing managerial tasks.

…but I think that I honestly do not have time to do admin and I think a lot of things are falling through the cracks. I think you lose money from stale claims because you
realise ‘Oh! You didn’t resubmit that thing.’ My practice could honestly be a lot better at administration and mostly that is caused by the fact that I have very little time.

It seems as though practices are not effectively administered and those that are, come with a considerable expense to the doctor. If the NHI accredits GP practices to see patients, and the administration involved in seeing these patients increase, the majority of solo practitioners in this study is not capable of handling the increased administrative burden, unless extra staff is hired.

4.4.3. Government Administration
The reason some doctors doubt the success of the NHI relates to the financial viability of the intended system.

All the doctors agreed that they had reservations as to the government’s ability to implement the system. The decision to use the existing tax base was considered to be “unfair to thetaxpaying individuals” (Dr N, 2011), but also not feasible, as the tax base was very small (Dr I, 2011). Suggestions of using a wider tax base, was a more equitable option, which could be attained by raising the VAT by a percentage point (Dr N, 2011)

The administration of funds was another matter that was at the forefront of doctors concerns. Dr N raised his concerns saying that “it’s mind-boggling when you talk about the amount of money that is being raised, and reinvested in the healthcare system that we need. We need to appoint the right people in the right places to roll this thing out.”

It was perceived that the government had not inspired sufficient confidence in private GPs to provide health services.

Dr L confirms this and says:

The problem is how is the state entity going to be run, especially with our experience with the Road Accident Fund and Workers Compensation; those state entities provide health access to people…the Workers Compensation has been running at a loss, we get paid in drips and drabs.

Dr M suggested that in order to remedy the problem with administration, the government might find other ways around that, by contracting companies to manage that part for them.
The past ministers of health have not inspired confidence within the healthcare community either. Dr K mentions that the policies of the Department of Health have not changed much in the past 17 years, but have been short on implementation. However, she notes that the new Minister of Health has inspired confidence in doctors, and appears to have the political will and motivation to follow through with the implementation of the NHI.

Dr N advises that

We have to be looking at other models, what has worked, what hasn’t worked, why it hasn’t worked, what [we can] do better. But for that we need clever people, people in public health, people who have done the research and we hope that the government draws on that sort of resources in business schools, public health schools and draw these people in to work for the NHI, because otherwise it is going to fall flat on its face, and it’s going to be a waste of money...But as they say, they are going to run pilots by next year and we hope that they gain an idea of what they need to do...So it [NHI] is an ambitious plan, something must go, but I suppose that must come in phases, do one thing at a time, see how it goes, they must be open to adjustment.

Accreditation of practices was a concern because GP practices situated in different parts of the country were not all built to the same specifications with regards to the infrastructure of their practices.

Dr N mentions:

I think it’s going to be difficult because there is a vast difference between some guy’s GP practice in the squatter camps, compared the urban areas... there is a vast array of different types of practices and how do you underscore all that, who is going to benefit?

While the finer details of the NHI have not been specified, most doctors highlighted the need for better infrastructure in the healthcare sector, as well as more skilled human resource personnel to assist in running and managing the NHI, especially in primary healthcare and at district health level, where GPs experience a lack of managerial personnel. The shortage of skilled staff nurses and doctors is a concern. Dr M felt that if things do not improve, the country might see an exodus of healthcare professionals, which will result in “those that are left behind, responsible for a huge amount of work.”
Dr L remarked:

Firstly there is a shortage of health practitioners across the board. Then they talk about accrediting facilities. There is a shortage of healthcare facilities and healthcare practitioners, how are they going to implement accreditation, that is going to make the shortage even more dire. There needs to be change I understand, but at what expense is it going to be?

The time line for implementation was also questioned. Most doctors felt that the 15 years projected was too little and too ambitious to implement the national health system. While other countries have taken many years to implement healthcare reform, doing it over 15 years seemed to be unachievable (Dr N, 2011; Dr M, 2011; Dr I, 2011)

4.4.4. Education of patients

Some doctors were concerned about the need to educate patients about capitated medical aids. There were concerns that there may be an element of overuse of the medical aid, hampering effective treatment. Dr N relates his experience

...If you look at the lower level entry capitation product, [the members] treat it like a shopping cart. They come to you for a simple thing, and they don’t come with one problem. They already say they want this; they want that, because their perception is that they are on medical aid... [I] must sit down and explain to them that we only get paid so much and these are the things you are allowed to get and if you look carefully from what I have seen, a couple of visits are going to be allowed to practitioner and to explain that to the people, what’s going to happen to the rest of the times?

Dr A relates her experience:

[If] you look at when they introduced that all the children can go to hospital without paying. I was [working] in hospital; it was so full you couldn’t provide any service because it was for free. So if [the patients] think that it is for free we might not cope because their expectations will be too high. So the management of the whole thing should control the quality and the financial, all these things are very important.

DR H offered further insight:

[If] you looking at the poorer population you are also looking at people who are mainly unemployed so they have nothing else to do but to come and sit at your

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surgery and complain about their toes and their fingers, and I am afraid that it will be open to abuse, and the social problems that they have. ....And I think it’s definitely going to be open to abuse, definitely. And they will definitely prefer [coming to] you than going to the day hospital. And that is my biggest fear ....because the perception is going to be that it is better to see my private doctor and I don’t have to pay. So how do you control that?

Patients need to be educated about the capitation system the NHI will implement and what it affords them. This usually results in the GP spending time on education rather than treating patients.
CHAPTER 5: DISCUSSION

5.1. Introduction
This study examined the.... In this chapter, the findings as they relate to the research questions are discussed in detail.

5.2. The Need for the NHI
There is concern among GPs with regards to the introduction of the NHI and how it will affect the quality of service delivered to patients. GPs are aware of the issues relating to the quality of care given to patients at the level of primary health care units (day hospitals and community clinics) and are concerned that the implementation of the NHI will result in a negative impact on the quality of care that they give to their patients. (Dr H, 2011).

Moreover, there is also concern that if GPs enlist their practices with the NHI, some government measures, such as cost constraints, may be imposed when treating members of the NHI. Practitioners have already experienced problems related to the quality of treatment when treating members of capitated medical aids (Dr B, 2011; Dr H, 2011). These include administration problems. The hiring of extra staff to deal with these issues is costly. GPs appear to be just about managing administratively. Any adverse change to the status quo could negatively affect the cash flow of the practice (Dr L, 2011).

A communication problem exists between the public and private healthcare sectors. GPs find that referring non-insured patient for special investigations and treatment is difficult. These procedures are normally done with a referral letter to a primary healthcare unit in the public system as patients invariably do not have the finances to pay for the treatments or investigations in the private sector. The referral system affects the level of care GPs administer to the non-insured patients (Dr B, 2011; Dr N, 2011). GPs gave a notion that if the NHI is to be implemented; there needs to be measures that would enhance and facilitate the communication between the private and public sectors.

The doctors are frustrated when they refer patients to the public sector. These frustrations stem from the fact that patients do not get the best quality of care at the public facilities. There is an understanding that as primary healthcare facilities are overburdened with work and doctors working at these institutions are unable to deliver an effective service that result in effective treatment of the patient (Dr H, 2011). The GPs hoped that the NHI would resolve some of these quality issues and enhance the quality of patient care. (Dr A, 2011; Dr B, 2011; Dr H, 2011)
GPs are also concerned with the private healthcare environment. Costs are rising year by year, with a large proportion of the costs concentrated around payments to hospital specialists and medical aid administration (Dr K, 2011). This could cause the private healthcare sector to “implode”. There have been initiatives to stem this rising costs with the introduction of managed care, and pricing regulations on medicines, however hospital costs, specialist costs and administrative costs continue to soar. With the focus on primary healthcare, the GPs hoped that that these costs could be controlled (Dr J, 2011; Dr K, 2011). International evidence shows that concentrating on curative medicine (hospital centric) keep medical costs high (Starfield, Shi, & Macinko, 2005). Focusing on primary healthcare though has the ability to bring costs down. Focusing on preventative medication as well as educating patients with regard to lifestyle modification measures is important in controlling disease, and subsequently controlling medical costs (World Health Organisation, 2010).

In summary, GPs were hopeful that the NHI would enhance the access to medical care. The lack of communication between the public and private sectors adds to the frustrations of GPs and needs to be addressed if NHI is to be a success.

5.3. The role of the GP in NHI

Most of the GPs interviewed agreed that the role of the general practitioner will be enhanced with the implementation of the NHI. They believe that the focus of the NHI on primary healthcare places the GP in a position to deliver these services. Dr K (2011) believes that “those GPs will be working with a system that will be set up in assisting health promotion, assisting in taking care of chronic diseases and so on and there will be [a] contract with us to play that leading role within the primary healthcare environment.”

GPs see a brighter future for themselves with the implementation of the NHI than what they presently have, where the role of the GP has been “marginilised” (Dr K, 2011). The CMS report shows that GP costs have been only a small section of the pie of healthcare expenditure for many years (Council for Medical Schemes, 2011). Very little is known about the precise role that GPs will play in the new healthcare system and whether or not the solo GP practice will have a place in new system. This has caused some fear and concern amongst the GPs. Some doctors are being pro-active and are planning ahead to ensure they become accredited, even though details on accreditation are sparse (Dr B, 2011; Dr I, 2011). Others are considering to moving to group practices, but have concerns that their independence and clinical autonomy may suffer. This could relate to inexperience in working with other
professional. This is in contrast to what Sibbaled et al. (2000) concluded, where doctors working in group settings had an improvement in clinical autonomy, and a improved lifestyle.

The vast majority (%) of GPs do not envision themselves entering the public sector for work. This stems from the perception that their own quality of life will suffer, and that the relationships they have with their patients currently, will be affected (Dr G, 2011; Dr H, 2011). With the human resource shortage in the public health sector (National Department of Health, 2011), this does pose a problem. The government may have to offer incentives to private GPs to work in the public sector, perhaps in a public-private initiative to try and balance the inequitable distribution of health care workers (Tumbo, Hugo, & Couper, 2006). Some GPs are already considering moving out of practice, into different business ventures (Dr K, 2011) or even overseas (Dr B, 2011). This would impact negatively on the availability of healthcare personnel.

Even though the NHI will bring changes in the manner in which healthcare is delivered, most doctors have not read the NHI Green Paper. Most of the doctors have gleaned their knowledge from workshops attended or articles read in the journals and media, where summaries are provided on to how the NHI will affect them. This indicates that GPs rely on the guidance and direction of others.

GPs are concerned about their operating environment and would prefer to have a succinct and broad overview of what their role would be. This implies that GPs trust GP-leader organisations. In South Africa these organisations take the form of Independent Practitioner Associations, which look after the concerns of GPs. They also contract with managed care organisations on behalf of GPs to allow for the treatment of patients at their practice (Mills, et al., 2004)

Some doctors that have read the entire Green Paper are in the process of preparing their practice to be accredited (Dr B, 2011; Dr I, 2011). Because the process of accreditation has not been fully defined by the government it is subsequently not easy to determine which direction to take in order to become accredited. This is the reason why most of the GPs, while cognisant of the fact that the NHI will be implemented in some way, are not actively engaged in any preparation process. They prefer to wait and see how the pilot studies pan out, and then decide on an appropriate action. Nevertheless, it is the opinion of the author that the
responsibility of directing the GPs to a suitable path would fall to the relevant leader groups to provide the necessary guidance.

A public-private-initiative, where there is interaction between the different managers in the government and private sector, may in this regard, be beneficial (Dr M, 2011). As well as having suitable managers at the correct level with the roll-out of the NHI, this would hinge on effective communication between the two groups. In addition, a public-private-initiative could enhance the level of communication between the government and the private sector, and allow the public and private sector to work congruently in order to achieve similar goals. Setting up this infrastructure will take time and money, and the government will need to find the funds and resources to accomplish this. This adds to the pressure of obtaining suitable funding for the NHI to ensure that these processes are put in place, as well as paying the people to run them.

Some GPs saw their role extending to educate patients regarding the effects of capitation on service delivery. Even though GPs agree that educating patients about benefits remains the responsibility of the service provider, they are continually forced to educate patients regarding these, without remuneration, extending their role as primary caregivers to educators. This takes up valuable time and would then impinge upon the overall service delivery of all patients. Because GPs are generally seen as trustworthy by the patients they treat, they will most likely have more of an impression on the patient than the representative of the medical aid scheme. Dr N mentions though that the doctor’s credibility has decreased over the years and that Dr’s are seen as “the one who takes money when you are sick”. No longer are doctors seen as the keepers of knowledge, but are seen as service providers or a “network-doctors”. The credibility of GPs has not only suffered locally but internationally (Starfield, Shi, & Macinko, 2005).

In summary, GPs are confident that with the NHI they will regain their rightful place as the gatekeepers in healthcare. It seems that locally, as well as internationally, GPs have lost credibility. Some are becoming disillusioned with the service they provide and are contemplating seeking other avenues of income. Should the NHI marginalise the private GP further, it is likely these GPs will consider leaving for greener pastures.

5.4. Challenges of the NHI
The main concerns that GPs have are with regard to finance: how the government is going to raise the funds for the NHI, and how they are going to be reimbursed.
All of the GPs interviewed were not confident in the government strategy to use the existing tax base as a method of funding. They regarded this as unfair because only the working population (which is small proportion of the population) would be contributing financially towards healthcare for the entire population. This will have some implications for how doctors that would be working in the system will be remunerated. The doctors agree that capitation may be the only sustainable option for the government. They were concerned about what the capitation amount will be because it will need to cover overhead costs, which are seen as high in private practice.

Capitation as an option for payment has also been a concern of doctors internationally (Cave, 1993; Kuusela, Vainiomaki, Hinkka, & Rautava, 2004; Glazier, Klein-Geltink, Kopp, & Sibley, 2009). Doctors in South Africa have some experience with capitated products that are currently on the market. Currently doctors are exposed to managed care products that involve similar principles to capitation. Working with capitation has afforded GPs some experience with these products, and they could provide valuable input relating to their local experiences.

Doctors also find it difficult to deal with the complexities of practice management. Managerial tasks impact on their capacity to perform clinical tasks. The administrative burden is most evident when doctor have to deal with patients who are on a capitation system. In order to contain costs, service providers of capitated products have put many checks and balances in place before patients can be attended to at a primary or secondary level. This usually begins with having to obtain authorisation from the medical insurer to diagnose the patient, and then to refer patients to specialists or hospitals to perform special investigations (Dr E, 2011 Dr H, 2011).

Doctors that work in a solo practice, especially in low-socioeconomic areas, tend to handle administration on their own, and find that these duties are imposing on their clinical autonomy, as they become more involved with the administrative and managerial aspects of the practice. These experiences are similarly reported by Sibbald et al. (2000). Doctors find it expensive to hire extra staff, and the income from low-cost medical aid is often not high enough to justify these expenses. The consideration for hiring extra staff is high, but only if the costs would justify it (Dr B, 2011; Dr K, 2011). This places further emphasis on the need to ensure that the capitation reimbursement of the NHI is based on proper costing studies.
Not only does administration drive practice costs up, but by extrapolation it can be inferred that it will also drive up medical aid insurer costs because GPs will need to have the administrative staff to handle all the queries. What is known though is that an administration costs for medical aids are high (Council for Medical Schemes, 2011). This is in contrast to the Government Employees Medical Scheme (GEMS) that has kept hospital administration costs to a minimum (Council for Medical Schemes, 2011; Rikhotso, 2011). GEMS, which is administered by a combination of external medical scheme administration companies, can boast a non-healthcare expenditure cost of 6.2%, which is less than half the industry average (Rikhotso, 2011). This could be the result of the tender process and the fact that GEMS is administered by multiple medical aid administrators, unlike most medical aids which have a single administrator.

Those GPs that were concerned about the capitation level amount based their concerns on their current experience with capitated products. They believed that their quality of care was impaired as they are forced to consider the costs of performing certain investigations on their patient (Dr F, 2011; Dr H, 2011). This is in contrast to Kuusela et al. (2004) where GPs on a capitation based contract rated their work quality very high.

Currently, GPs have a variety of payment mechanisms in their practice that range from fee-for-service for the medically insured population through capitation to fee-for-service for the private patient. With the NHI, and its suggested tax implication, GPs feel that it is likely that a large proportion of the low to middle class population will not be able to afford secondary or top-up medical aid cover (Innovative Medicines South Africa, 2011). This could negatively impact the cash flows of the GP. It is also not certain how top-up medical aid cover will work, if it will only apply to hospital cover or if it will also cover day-to-day medical needs. If the subsidisation of patients in GP practices does not occur, many GPs will experience difficulties if they only see NHI patients, and are not remunerated sufficiently (Dr F, 2011). This could further increase the frustrations of GPs, possibly causing them to leave GP practice entirely (Dr B, 2011; Dr F, 2011; Dr K, 2011).

GPs appear to want what is best for the patient. They want to deliver quality care to the patients. They have dealt with public sector services and are aware that the public sector is unable to provide a sufficient level of quality of care to the patients. With the financial constraints that patients have, GPs find providing good quality of care is difficult and frustrating.
There is a presumption amongst the GPs that while the NHI will enhance access to healthcare, a strong possibility exists that the level of quality care from the private GP will diminish as their patient numbers increase (Dr A, 2011; Dr H, 2011), or that GPs would struggle to maintain the same standard of care should there be a decrease in the remuneration levels received from the capitation based remuneration (Dr L, 2011).

What is a concern of the author is whether or not practices which qualify for accreditation will actually be willing to contract with the government to see NHI members, while those practices in rural areas which are already rendering a service to the indigent, may not be accredited at all.

Capitation favours the formation of group practices amongst GPs. The GPs mentioned that the practical considerations for group practices include the option of investing and relocating into new premises, or using one doctors’ existing practice, the retention of staff, ownership of equipment etc. A considerable amount of expense would have to be incurred in the formation of these practices, to develop infrastructure, purchase equipment, and train the managerial staff that would be needed. GPs believe that these costs need to be fully subsidised by the government, or that government needs to assist doctors to become accredited to see NHI patients. This places increased pressure on administration of funds by the government.

Some of the GPs have calculated that the formation of group practices has the advantage of pooling patients and as a result there is also the pooling of patients’ capitated funds. The administrative burden will also be spread amongst the doctors and this would in turn reduce the cost of overheads. These factors can enhance the quality of care delivered to patients. This is because the doctors would not have to be involved in managerial tasks, and can thus concentrate on performing the clinical tasks at hand. It is not certain what the range of services are required from group practices, however it is likely that GPs will be required to have advanced clinical skills. With the focus on delivering primary care to a large number of patients, more education of doctors would be needed to ensure they are able to manage a full spectrum of clinical diseases (Dr H, 2011; Dr I, 2011; Dr K, 2011).

Moving from a solo to a group practice was seen as a threat to the GPs’ independence and autonomy. However, doctors could also experience a better quality of life in a group practice (Sibbald, Enzer, Cooper, Rout, & Sutherland, 2000; Feron, et al., 2003). GPs agreed that a group would lend for better support to themselves from peers and work colleagues, having a
better quality of life with better leave options, enabling doctors to spend more time with their families, without the worry of the continuity of care for the patients. This finding was similar to the experience of healthcare workers internationally (Feron, et al., 2003). Much will depend on having a group practice where all doctors work together with no personality clashes. Agreements for such structures need to be put in place and be adhered to.

GP’s favoured the formation of group practice. However, the logistical problem of finding an area that would be suitable for all doctors was a concern. Most of the doctors with established practices felt that it would be difficult to move to another area as they have built up relationships with their patients, and moving out of a community to join a group practice may sever those ties (Dr E, 2011; Dr G, 2011). Practices situated in low-income areas, where transport is a factor will have an effect on the ability of the patients to travel to a new location. One suggestion was to develop a “virtual group practice where there is a person covering (the patients)...but at their specific locality, although you virtually work together as a group” (Dr E, 2011). This affects patient access to healthcare in a different manner, in that they may need to travel a further distance to have access to the medical care they believe in and trust.

In summary, GPs lack confidence in the government’s ability to efficiently administer the NHI. Based on their current experience of capitation, they have a concern as to whether they will be able to survive financially should adequate costing not be taken into account. The implementation of the NHI will result in numerous changes for the GP. As a result, there is a need for further skills training in business as well as clinical methods. Many GPs practice as solo GPs, and lack the experience of working in a group. GPs would need to enhance their business skill to ensure that they are familiar with group practice dynamics. Depending on the range of services required by the NHI, if their practices become accredited, GPs may need to enhance their clinical skills to include items such as emergency medicine.
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

The research presented in this paper explored the perceptions of private GPs with regards to the implementation of the NHI. The study aimed at getting a better understanding of the views of the GP on the current healthcare system, gaining insight into how GPs understood their roles in the NHI, and revealing the challenges that GPs foresee in the implementation of the new healthcare system.

A qualitative methodology was applied in this exploratory research and is premised on the fact that GPs are an integral part of the healthcare system.

The research attempted to gain a better understanding around the research question “what are the perceptions of the private general practitioner on the implementation of the NHI” by focusing on:

- What are the views of the GP on the current healthcare system?
- How do GPs understand their role in the new healthcare system?
- What challenges do they foresee in the implementation of the new healthcare system?

All of the interviewed GPs agreed that the current healthcare system needs to change. They were optimistic that the new system would bring equitable healthcare to the population, but expressed concern that it will affect the level of care their current patients.

GPs felt that their role as the gatekeepers to healthcare had fallen away. With the dominant focus of the NHI being the delivery of primary healthcare, it is the desire of the GP to rightfully regain their role as gatekeepers. They are hesitant to enter the public sector as they perceive the quality of care delivered to patients will be compromised by the frustrations of a public healthcare setting as well as the additional lifestyle changes that may accompany it.

GPs expect many challenges in the implementation of the NHI. These challenges relate to how the NHI will be funded and the feasibility thereof, how GPs will be remunerated (i.e. if the remuneration will be based on accurate costing or capitation) and its burden of administration, the move from solo practices to group practices as well as the education of patients.

In exploring the research questions the author identified three main areas of concern:
Perceptions of private general practitioners on the implementation of the National Health Insurance system in South Africa

The first concern relates to the lack of communication between the role players within the public healthcare system. The NHI Green Paper has exiguous details on the role of GPs in the new system. This lack of communication has allowed GPs to base the perceptions of their future role on current practice experiences. Many assumptions made regarding what will happen under the NHI were based on what they have learnt in workshops, read in articles, or garnered from the media. As a result, proactive decisions cannot be made until more information is forthcoming from the government. It is anticipated that the pilot studies proposed by the government would bring more clarity and insight with reference to the costing and mechanisms of the new system.

The second concern stems from the need for business and clinical skills support for GPs. The NHI will require change in the manner in which GPs currently operate. Solo GPs may find it difficult to survive and may be forced to join group practices. Many GPs may not be prepared for the dynamics of a group practice and may need to increase their knowledge and awareness. The GPs would also need to improve on their clinical skills as the range of services offered at a primary care level may be beyond their current capabilities.

The need for leadership amongst general practitioners was identified as the third concern. All these factors require planning. Consideration needs to be given to the fact that there may be too few leaders capable of leading GPs through this process. GP-leader groups have to assist and guide GPs in the direction they need to take. Workshops have to be held on a regular basis and leaders need to take an active role in motivating GPs to move forward.

These findings could have significant implications for the strategic planning and implementation of the NHI. It would require more coordination and resources in a system that is already under financial strain.

In summation, this paper promotes a better understanding of the factors affecting GP perceptions of the NHI and their role in it. The study is significant in its contribution because this is a largely under researched area of healthcare documentation. However, it is important to note that these conclusions are based on the sample of the GPs chosen. These conclusions cannot be seen to represent the opinions of all GPs working in South Africa. A larger study would need to be undertaken to determine those opinions.

### 6.1. Recommendations

In light of the findings of this research, the following recommendations are made for the Department of Health, GPs, as well as GP-leader groups:
The Department of Health should:

- facilitate the enhancement of the level of communication between GPs working in the public and private healthcare sectors;
- communicate regularly with GPs and advise them fully of the role they will play within the NHI;
- recognise that GPs are experienced in working in the primary healthcare sector and have important views to share; and
- provide more specific details on the implementation of the NHI.

GPs need to:

- enhance their skills in their capacity to provide quality healthcare;
- enhance their business and practice management skills; and
- take initiative to form group practices and learn how to work effectively within a group environment.

GP-leader groups should consider:

- providing sufficient assistance and support to GPs to enable them to cope with the changes that the NHI will bring;
- teaching GPs methods of managing their practices to make them profitable businesses; and
- asking for the GPs’ insight with regards to the implementation of the NHI because GPs can provide valuable insight through experience.

6.2. Future Research

Further studies needs to be carried out with a representative sample of GPs both within the public and private sectors as well as in urban and rural settings in order to:
• investigate the presence of GP leadership;

• determine the value and contribution of GP leaders and existing GP-leader groups; and

• investigate best GP practice models that would most suit the NHI.
Bibliography


http://www.merriam-webster.com/dictionary/triage


Appendix A: Questionnaire
The perceptions of the general practitioner of the future implementation of NHI

Respondent: (A-N)  Gender: (M/F)

Number of years in Practice:

Have you read the Green Paper? (Y/N)

Allied workers in close vicinity? (Y/N)

1) How do you **generally feel** about the implementation of NHI?
   - *Views on the current system*
   - *Government ability to administer the plan*

2) What do you see **your role** as being (**as a general practitioner**) in the new healthcare system?
   - *The impact on your practice*
   - *Changing practice logistics*
   - *Practice administration*
   - *Seeing NHI patients vs. Top-up patients*

3) How do you feel about **capitation based services**?
   - *Practice autonomy*

4) What do you understand about having a **group practice**?

5) Have you contemplated a **plan B** if the NHI does not work? Why?

6) Do you feel that there will be a **change in the delivery of healthcare** to patients, and if so how?

7) How do you think **patient will perceive** NHI, and in what way will they affect you?
Appendix B: Informed Consent Form

Principal Researcher: Muneer Valley

Project Title: Perceptions of the General Medical Practitioner with the future implementation of NHI

Brief overview of the project and its purpose, and what is expected from the respondent:

The National Health Insurance system is to be implemented over the next decade in South Africa. The policy document focuses on providing primary healthcare within the public sector and involved amalgamating the private and public healthcare services.

The aim of this project is to determine the perceptions general practitioners have with regard to their future within the Healthcare system of South Africa, as well as their thoughts on the new health system to be implemented.

The interview is designed to draw out collective themes related the thoughts and perceptions of the general practitioner.

No personal identifiable details are recorded in the interviews.

I acknowledge that I am participating in this study of my own free will. I understand that I may refuse to participate or stop participating at any time without penalty. If I wish, I will be given a copy of this consent form.

Subject's signature:_____________________ Date:_________________