PERCEPTIONS OF NATIONAL HEALTH INSURANCE REFORMS OF INDEPENDENT PRIVATE GENERAL PRACTITIONERS IN THE CAPE TOWN METROPOLITAN MUNICIPALITY

UNIVERSITY *of the*
WESTERN CAPE

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DEFINITION OF KEY TERMS

Independent Private General Practitioner (GP)

The independent private GP refers to a private medical practitioner who works in a self-owned group or solo practice. The training for an independent private GP in South African requires the completion of a 5- year bachelor's degree in Medicine and Surgery and a term of internship and community service. The GP is then registered with the Health Professions Council of South Africa (HPCSA) to practice in the private or public sector. They may elect to complete further training such as a diploma or specialisation in family medicine.

National Health Insurance (NHI)

NHI is a health financing system that is designed to pool funds for health (from taxes, insurances and other sources) in order to redistribute them equitably for health care provision. The goal is to provide access to quality and affordable personal health services to all South Africans based on their health needs, irrespective of their socio-economic status. NHI is intended to be a fund that will pay for health care for all South Africans. There will be no fees at the point of care for a defined health benefit package covered by the NHI fund (National Department of Health, 2021).

Universal Health Coverage (UHC)

In 2005, member states of the World Health Organization (WHO) committed to develop their health financing systems to allow all people access to health services, without suffering financial hardship (WHO, 2010). This is known as Universal Health Coverage (UHC).

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- The GPs who selflessly gave of their time to participate in this study.

I dedicate this mini-thesis to my husband, Richard and daughter, Lara. Thank-you for your patience and love, always!

DECLARATION

I declare that the *Perceptions of National Health Insurance Reforms of Independent Private General Practitioners in the Western Cape Metropolitan Municipality* is my own work, that it has not been submitted for any degree or examination in any other university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.

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ABSTRACT

Background

National Health Insurance (NHI) is a financing reform that aims to advance Universal Health Coverage (UHC) for all South Africans. The participation of independent private general practitioners (GPs) is of fundamental importance to the successful implementation of such reform. Research has indicated that improved engagement and collaboration between private GPs and policymakers is needed. This is especially relevant since the NHI Bill was tabled in parliament in July 2019, with proposals for the establishment of contracting units for primary healthcare (CUPs). This study aimed to explore current knowledge and perceptions of the NHI reforms of private GPs in the City of Cape Town's Metropolitan Municipality, in order to gain understanding on their views towards the evolving policy, their role in it, and how communication between independent private GPs and public decision makers might be enhanced in the future.

Methods

A qualitative research methodology was adopted. The researcher interviewed a purposively selected sample of nine solo independent GPs of various ages and genders practicing in different socioeconomic environments and practice types in the Cape Metro area. Semi-structured interviews lasting 15 to 45 minutes were conducted in which the researcher explored the GPs' knowledge of the NHI Bill, sources of information on NHI, perceptions of the proposed policy reform, and suggestions on ways to build collaboration between policy makers and themselves going forward. Six interviews were conducted face-to-face and three virtually. As this study took place during the unfolding waves of the COVID-19 pandemic, the researcher was in a position to also observe the experiences of private GPs during this time. This allowed for further exploration of ways in which the pandemic may have influenced the GPs' perceptions on NHI policy and on potential collaborative efforts between the private and public health sectors. All interviews were audio-recorded following signed consent. Interview transcripts were analysed thematically along the study objectives. Ethics approval was obtained from the University of the Western Cape's Biomedical Ethics Committee prior to commencing the study.

Results

The private solo practice GPs in this study all believed the current system to be unfair or unsustainable for the majority of South Africans, and all indicated their support for the idea of greater equity, as outlined in the NHI proposals. There is however an apparent knowledge gap on what their role and that of the existing public primary care facilities will be in a future NHI, including the CUPs. The GPs had received no formal governmental communication on NHI, and their information came mostly from their own online research, Independent Practitioner Associations (IPA's) or Medical Aid funders. Several of the GPs expressed doubts over the financial viability of NHI in the South African context and many regarded it as a policy unlikely to materialise in the near future. While generally in favour of a shift from fee-for-service to capitation payment systems, design concerns were also reported, such as the potential for patient abuse, marginalisation of care for foreign patients, acceptability of the policy by specialists and the fear of a general loss of their autonomy. These concerns were underpinned by an overall mistrust in the public sector to implement and manage NHI.

Conclusion and recommendations

This study concurs with previous research that private GPs are broadly in support of the principles of, and are potential allies, in advancing NHI. However, to achieve this, their long standing concerns and fears about the proposed NHI policy reforms need to be addressed. There is a need for impartial and clear information on the viability of the proposed policy, the progress of pilot projects to date, and future roles of GPs and their relationships with other actors in NHI. There also remains a need to improve communication between the National Department of Health and private GPs, and options explored to share NHI policy developments which are relevant to GPs. Affording private GPs a platform where they can share their concerns and contribute their experiences and knowledge is needed. In the interim, taking active steps to increase collaboration between private and public sectors at local and provincial level through, for example, referral processes and information sharing on patients, may help to build the trust that is necessary between the sectors.

ABBREVIATIONS

CME	Continuing Medical Education
CHW	Community Health Worker
COPC	Community-orientated primary care
COVID -19	Coronavirus disease of 2019
CUPs	Contracting Units for Primary Healthcare
GDP	Gross Domestic Product
GP	General Practitioner
GPCI	General Practitioner Contracting Initiative
IPA	Independent Practice Association
LMIC	Low- and Middle-income countries
NCOP	National Council of Provinces
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NHS	National Health Service
OHSC	Office of Health Standards Compliance
PHC	Primary Health Care
PMG	Parliamentary Monitoring Group
SHI	Social Health Insurance
SAAFP	South African Academy of Family Physicians
UHC	Universal Health Coverage
UK	United Kingdom
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 Background

Promoting and safeguarding health is integral to a country's well-being and sustainable economic and social development. This principle was agreed upon in the Alma-Ata Declaration of Primary Health Care in 1978, more than 40 years ago (WHO, 1978). These commitments and the 2030 Agenda for the Sustainable Development Goals were reaffirmed at the Global Conference on Primary Health Care (PHC) in Astana, Kazakhstan in October 2018. The Declaration of Astana, adopted at the conference pledges to make bold political choices for health across all sectors, build sustainable primary health care, empower individuals and communities and align stakeholder support to national policies, strategies and plans (WHO, 2018).

There are many ways to promote health that lie beyond the health sector. Addressing inequalities in education, housing, employment and access to food are all key action areas for health promotion (WHO, 2008). Access to health services that offer promotive, preventative, curative and rehabilitative care is also crucial (WHO, 1978). A well-functioning health financing system is needed to achieve this. In 2005, member states of the World Health Organization (WHO) committed to develop their health financing systems to allow all people access to health services, without suffering financial hardship (WHO, 2010). This is known as Universal Health Coverage (UHC). PHC is at the heart of UHC (WHO, 2018).

South Africa currently spends 8.9% of Gross Domestic Product (GDP) on health, distributed inequitably between public and private health sectors. Public health expenditure is just under 50% of total health expenditure, for 82.6% of the population (Zondi & Day, 2019). According to Mayosi, Lawn, van Niekerk, Bradshaw, Abdool Karim & Coovadia (2012), the cost of private specialist and hospital care has risen more than the consumer price index and skilled human resources are distributed heavily towards the private sector, whilst the public sector has remained poorly resourced.

To address the inequities of this two-tiered system and move the country towards the realization of UHC, the South African government has proposed National Health Insurance (NHI) as a new financing mechanism. The NHI reforms outlined are premised on the need for a complete transformation of the healthcare service provision and delivery of healthcare as

necessary to remove the two- tiered system where those with the most need having the least access to health services (The National Department of Health, 2021).

The Green Paper on NHI, published in 2011, outlined the changes that need to take place simultaneously for successful implementation of the NHI (The National Department of Health, 2011). The Green Paper indicated that the need for radical change in administration and management were necessary reform to strengthen the healthcare system and improve access to quality healthcare for all. A commitment to a comprehensive package of care underpinned by ‘‘re-engineered primary health care’’ was made. The strengthening of the system should be based on a primary health care philosophy. Practical strategies outlined in the Green Paper were: School-based primary healthcare teams, Municipal Ward-based primary healthcare teams and District Clinical Specialists, later extended to include private GP contracting (The National Department of Health, 2011). The intention of NHI fund is to introduce a single payer system for contracted accredited service providers that will realise every South African’s constitutional right to comprehensive health care based on need rather than their socio-economic status.

NHI is intended to roll out over a 14-year period. The White Paper (Department of Health, 2015) outlined the three phases of NHI implementation. Phase 1 (2012 - 2017), included piloting of health system strengthening focused on PHC, Phase 2 (2018-2022) is concerned with legislation and the necessary structures of the fund and Phase 3 (2023-2026) will complete the implementation of health system strengthening initiatives and introduce mandatory payment to NHI through taxes. The National Health Insurance Bill (2019) lays out the establishment of the NHI Fund.

An essential element in strengthening PHC proposed by NHI is drawing in private sector capacities through contracting-in and contracting-out of private health practitioners. Contracting-in aims to reduce patient-overload in public health facilities. Contracting-out of PHC services requires that multi-disciplinary practices be configured into horizontal networks that are contracted through the Contracting Unit for Primary Health Care (CUPs) (Department of Health, 2015:30). The NHI will provide finance for healthcare by entering into contracts with private or public facilities that have been accredited by an independent body, the Office of Health Standards Compliance (OHSC). The successful implementation of

the NHI, aimed at building a unified and equitable system, requires the buy-in and co-operation of private GPs who are intended to be key stakeholders in CUPs. Effective stakeholder management is essential for the successful advancement of policy reform to achieve UHC by 2026. The learnings from the successes and failures of international experiences in their respective journeys towards UHC have highlighted the importance of effective stakeholder management in the reform process (Nhlabatsi & Vena, 2018).

1.2 Problem statement

Research to date on GP perceptions towards NHI in the South African context suggests that there is a perceived lack of dialogue and consultation by the Department of Health with regards to the implementation of the policy. In his study in the Western Cape, Valley (2011) highlighted poor communication between the provincial health department and the private GPs as a primary concern. In a recent study of GP perceptions towards NHI in the Chris Hani District, Gaqavu and Mash (2019) reported GP uncertainty around government capacity to implement the policy and implications for solo GPs, in particular. The GPs in the study also voiced a need for more information and engagement by government. Mathew and Mash (2019) conducted a similar study in the Western Cape and based on their findings, recommended that dialogue and collaborative engagement is needed to alleviate GPs' fears and uncertainty around the NHI reforms. They also recommended further research to understand how private GPs and practice groups wish to engage with policy makers in the future.

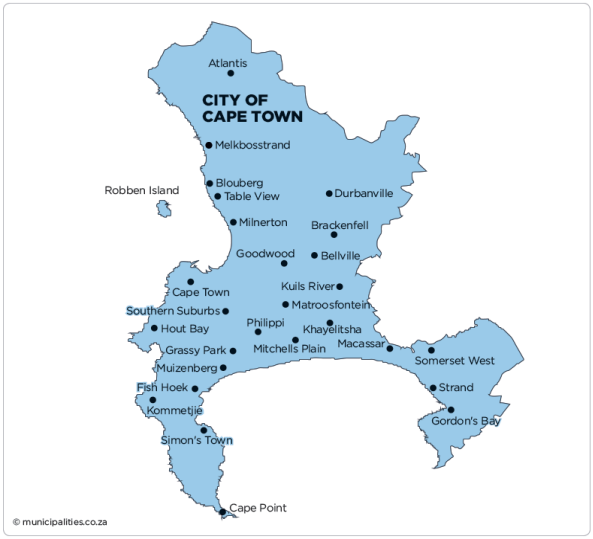
Surender et al. (2014) explain that an understanding of human motivation and behaviour is vital for the successful design of social policy. This study seeks to explore the current perceptions towards NHI of a group of independent private GPs practising in the Cape Town Metropolitan Municipality, with the aim of eliciting their suggestions for policymaker engagement on NHI reform. As the study also took place during the COVID-19 pandemic it provided a unique opportunity for the researcher to explore perceptions of this group of GPs towards NHI policy in an altered environment which has required urgent collaborations between public and private sector to address the healthcare crisis.

1.3 Study Setting and profile of GP community

This study focused on solo GPs operating in the Cape Town Metropolitan Municipality situated in the southern peninsula of the Western Cape Province. The area is 2441 km

squared and includes the suburbs depicted in the map below. The city is South Africa's second-largest economic centre and second most densely populated area after Johannesburg (Municipalities of South Africa, 2022).

Map of City of the Cape Town Metropolitan Municipality



The current population of the region is estimated to be about 4.4 million people with a growth rate of around 2% in 2019. This is significantly higher than the provincial and national averages, indicating continued inward migration into the city. In 2019, 45,9% of the population were living in poverty, using the upper poverty line of R1227 per person. In 2018 the City's Gini Coefficient was 0.62 (Department of Cooperative Governance and Traditional Affairs, 2020). It is estimated that approximately 76% of the population of the Cape Metro were uninsured for the period 2018/19 (source: Provincial Circular H11 of 2018 in Western Cape Government, 2021).

Healthcare provision is through a two-tiered system based on socio-economic lines (Department of Health, 2015). The Cape Metro is divided into 8 sub-districts. Public sector primary healthcare is delivered through both provincial and city clinic services. According to a private database there are approximately 1848 GPs practicing in the private sector in either group or solo practices in the City of Cape Town (Medpages, 2022). Depending on where they practice, these private GPs provide primary healthcare to a varying ratio of insured to cash patients. Referral to either private or public sector facilities for higher levels of care is determined by the financial means of their patients.

CHAPTER 2: LITERATURE REVIEW

2.1 Overview

A review of published research was conducted to explore, firstly, GP perceptions of NHI in the South African Health System; and secondly, international experiences of UHC reform processes in order to draw lessons that may inform introduction of NHI reforms in South Africa. This was supplemented by a review of recent policy developments (notably the NHI hearings) available from online platforms such as the Parliamentary Monitoring Group (PMG) and the National Department of Health. The formal literature was accessed through a search of Pubmed and Google scholar, using the following search terms: ‘‘National Health Insurance and South Africa’’, ‘‘General Practitioners and NHI South Africa’’, ‘‘International lessons and National Health Insurance’’ and ‘‘Universal Coverage and South Africa’’.

2.2 GP perceptions towards the NHI in South Africa

There has been considerable research both within the Western Cape Province and nationally, showing the perceived concerns and positive sentiments of GP’s with regards to the implementation of the National Health Insurance Policy (Blecher, Jacobs, McIntyre, 1999; Valley, 2011; Moosa, Luiz and Carmichael ,2012 ; Surender, Van Niekerk, Hannah, Allan, Shung–King, 2015; Moosa, Luiz, Carmichael, Peersman, Derese, 2016; Surender, Van Niekerk, Alfers, 2016; Mureithi, Burnett, Bertscher, English, 2018; Gaqavu, Mash, 2019; Mathew and Mash, 2019).

Adopting both quantitative and qualitative methodologies, these studies report GP responses to the idea of an NHI over two decades. The first study took place following the establishment of a committee of enquiry into the NHI in 1995 (Blecher et al. 1999). The more recent studies provide feedback on the general practitioner contracting initiative (GPCI) which was piloted in the first phase of NHI implementation (Mureithi et al. 2018, Surender et al. 2016).The national literature indicates that most private GPs agree that there is an urgent need for health reform and do support the principle of UHC and the introduction of an NHI fund. There are however several issues that have been raised consistently through the different studies that are important to highlight as they will contribute to an improved understanding of this group of stakeholder’s positions towards the reform process.

Blecher et al.'s (1999) quantitative study determined attitudes of South African GPs to NHI, Social Health Insurance (SHI) and other health system reforms. Enquiries were made of GP preferences with regards to financing provision, benefits and coverage. The study was conducted as a national postal survey and revealed that of 317 responses analysed, 62.0% approved of a social reform such as NHI. This increased to 81, 6% in favour of the reform if practitioners were assured of staying autonomous. The reasons given by the doctors who agreed with reform was to make healthcare more equitable and accessible for all. Interestingly, 70, 0% of the GPs said that they had the capacity to treat more patients. A high proportion of the GPs approved of increased interaction between the public and private sector and the idea of a District Health Authority. Strengths of this study are its size and national reach.

Following the release of an NHI discussion paper in 2010 and the NHI Green Paper in 2011, Valley (2011), a GP himself, conducted a qualitative study on the perceptions of NHI among 14 private GPs working in the Cape Town Metro. The GPs in the study welcomed the advent of NHI based on its potential to enable access to healthcare for the majority of South Africans. This study identified three prominent areas of concern. Firstly, there appeared to be a lack of communication between the role-players in the public health system and the private GPs. Much of the GPs' information originated from sources such as the media. It was hoped at this stage that the pilot studies would provide more clarity on the evolving role of the GP. The second concern identified was around the skills that the GPs would need to develop in order to practice in a group; and thirdly, a need for GP leadership was noted. Based on the findings in his study, Valley (2011) made several recommendations to the Department of Health with regards to their role in providing specific information on NHI, facilitating regular communication and highlighting the need for recognition of the important role of and inputs from the private GPs.

Moosa, Luiz and Carmichael (2012) carried out a study via a self-administered online questionnaire to explore how solo private GPs regarded service delivery and cost implications to meet NHI requirements. Given the proposed shift away from a fee-for-service system, where the patient pays for the consultation to a reimbursement through capitation, the researchers identified a need to explore how GPs viewed this shift. Possible high utilisation of the service under capitation systems and resulting contractual risk emerged as two of the primary concerns for the solo GPs in this study. Moosa et al. (2016) conducted a further national survey to describe the demographic and practice profile of GPs in South Africa and

evaluate their views on the NHI. The study had a wide reach with a total of 819 private GPs (solo and group practitioners) responding. The analysis of responses from GPs in group practices revealed areas of risk identified earlier by Moosa et al. (2012), namely: patient over-utilisation and concerns with regards to remuneration and fair contracts. In addition, organisational capacity (requiring more staff and space) was identified as an additional risk in the later study. The researchers proposed management strategies to mitigate these risks. Good communication by government was identified as necessary to ensure sound contracts. They authors concluded that GPs in both group and solo practices can contract into the NHI despite the concerns documented, and further that NHI contracting should not be limited to group practices only.

Around the same time as the national study by Moosa et al. (2016), Surender et al. (2016) explored the views of fifty-five purposefully selected General Practitioners participating in a pilot NHI contracting site in Tshwane. The GPs reported problems in infrastructure and equipment, unhappiness with contracts and a sense of lacking professional autonomy. Despite strong support for the principle of NHI, the doctors interviewed were sceptical that private doctors would embrace the NHI scheme as they may be expected to. The authors reiterated that if the government agenda for health care reform is going to be realised, there is a need for the Department of Health to be more engaged with GPs.

More recently, Mash and Mathew (2019) completed a qualitative study to explore the beliefs and attitudes of 11 private GPs from various backgrounds towards NHI in the City of Cape Town. The GPs were supportive of the ideal of NHI although several concerns were raised. The GPs felt excluded from the policy process and expressed that the private sector had knowledge and experience in finance, management and information technology to contribute. There were concerns over the accreditation process, reimbursement and the ability of the public health system to implement the policy. Poor communication was noted as a threat and risks such as higher patient numbers, standard of care and accreditation costs were identified. Some solo GPs in lower socioeconomic areas, although positive, had concerns around being accredited successfully. The researchers concluded that many concerns expressed by the GPs particularly relating to accreditation and reimbursement may be addressed with improved communication both with GP leadership and at a grassroots level.

In summary, these studies share GP sentiments and concerns towards the introduction of an NHI policy over the past twenty years. Blecher et al. (1999) reported that support for NHI

policy increased substantially when there was assurance of professional autonomy. Surender et al. (2016) have subsequently highlighted GP frustrations around a sense of lacking professional autonomy at a pilot site in Tshwane. Concerns regarding accreditation and uncertainty around what practice requirements would mean for the GPs were expressed in several studies (Valley, 2011; Moosa et al. 2016; Mash and Mathew, 2019). The possibility that the capitation reimbursement model may result in significantly higher patient volumes that could compromise the quality of care provided by the GP was a potential risk highlighted by several researchers (Moosa et al.2012; Moosa et al. 2016; Mash and Mathew, 2019). Linked to the reimbursement model were concerns regarding fair contracts. It is important to note that the need for improved communication between GPs in the private sector and the Health Department was raised consistently in the studies reviewed (Blecher et al.1999; Valley, 2011; Moosa et al. ,2012; Moosa et al. 2016; Surender et al.2016; Mathew and Mash, 2019). Communication between private and state sectors was considered to be unfavourable by a high proportion of the GPs in early studies (Blecher et al. 1999) and has subsequently remained a concern throughout the piloting phase (Surender et al. 2016; Mash and Mathew, 2019).

2.3 The General Practitioner Contracting Initiative

Contracting private sector providers to offer services to the uninsured public sector was an element of ‘‘PHC re-engineering’’ to strengthen public primary healthcare, ahead of the introduction of the NHI. The General Practitioner Contracting Initiative (GPCI) was designed to ‘contract in’ GPs in the form of sessions in the public sector. In 2011 and 2012, a National Technical Task Team was formed to drive the GP contracting initiative. The task team comprised of national policymakers, provincial and district NHI coordinators, academics and representatives of professional associations (Mureithi et al. 2018).

A qualitative multiple-case study by Mureithi et al. (2018) described the emergence of three different contracting-in models at three of nine GPCI pilot sites. The models represent three different types of purchasers: (1) the central Ministry of Health, which directly contracts GPs and manages the contract; (2) a contracted service provider that reports to the Ministry while directly contracting GPs and sub-contracting with a variety of organisations that assume various roles and (3) a province that has decentralized the contracting process to the district and the sub-district levels. The researchers were seeking to identify lessons to inform policymaking and health system strengthening to reach UHC using an NHI financing

mechanism. The research revealed that although contracts do need to be clear, flexibility and the ability to adapt to the local context is of vital importance. A decentralised approach requires purchaser capacity, systems and financial management experience.

The NHI system aims to re-engineer primary healthcare (PHC) provision in South Africa, with strategic purchasing of services from both private and public sector providers by the NHI Fund. Girdwood, Govender, Long, Miot and Meyer-Rath (2019) conducted key-informant interviews within private primary health care clinic models that service low-income, uninsured earners with the aim of exploring the role they may play in the change to the NHI. Practices included in the study varied in size and organisations studied included one nurse-led franchise model, one clinical associate-led model, one community practice, one single-GP practice and one GP practice network, one contracted-out GP model, and two NGO-run clinic models. Strategies employed by the practices to keep healthcare costs affordable included task shifting, access to public sector medicines and laboratory tests, and technology use. The practices expressed willingness to contract to NHI as this would increase their patient load.

Earlier this year, Moosa (2022) reported on the Chiawelo Community Practice in Ward 11, Soweto, South Africa. This study demonstrated how the introduction of a community-orientated primary care model (COPC), developed and led by a family physician, had improved access to quality services and patient satisfaction whilst reducing utilisation rates. Four factors were central to the project: engagement with and inclusion of Community Health Workers (CHWs), a community orientated clinic, stakeholder engagement and targeted health promotion.

2.4 Recent Policy Developments

In August 2019, the NHI Bill was tabled in Parliament and is under consideration by the National Assembly's Portfolio Committee on Health. The Bill is moving through the required parliamentary processes, which has included public participation, which might inform some changes to the Bill, before it is put before the National Assembly for a vote. If the National Assembly passes the Bill, it will be referred to the National Council of Provinces (NCOP). If the NCOP passes the Bill, it will then be referred to the President who must give assent and sign it into law (Parliamentary Monitoring Group (PMG), 2019).

At their conference in October 2019, the South African Academy of Family Physicians (SAAFP) was addressed by the Deputy Minister of Health and provided with an opportunity to relay feedback on the NHI Bill. Concerns over the current quality of public health sector services, management, administrative capability, corruption, insufficient funds, financial planning, the legal framework and definition of the Bill were voiced. The impact that the policy may have on both healthcare professionals and ultimately patients was raised. The need to communicate with healthcare providers to address their uncertainties was emphasized. Further suggestions included a need for a review of the NHI Fund governance model, the importance of strengthening the public health sector, and preserving the private system so that these resources may be harnessed to strengthen the public sector (SAAFP, 2019).

Written submissions from various stakeholders submitted to parliament were published in May 2021 (PMG, 2021). As suggested in the reviewed literature on GP perceptions of the NHI reform, professional autonomy and practice accreditation are clear concerns and were raised by the Health Professions Council of South Africa (HPCSA) in their written submission to NCOP. HPCSA have emphasized that the NHI should replace existing funding mechanisms for health and should be responsible for funding and contracting. Matters relating to accreditation, registration, conduct of practices and professionals, and treatment protocols, should remain with the relevant statutory bodies.

In their submission to NCOP, The Public Health Association of South Africa (PHASA) addressed several areas of concern raised by private GPs, including the need for clarity on their role in the new system, capacity issues and the need for leadership. PHASA expressed concern about the feasibility of the establishment of CUPs with regards to articulation on the role of private providers in the system and in particular the availability of all prescribed levels of care, especially in rural areas. PHASA cautioned that strong leadership needs to be a priority and that should CUPs be adopted; the current capacity of the existing District Health System be considered. Furthermore, PHASA suggested that provisions be made for contracting units to have resources to engage not only with health care providers but also actors such as community groups, civil society groups, nongovernmental organisations (NGOs) and government sectors whose actions affect population health. This submission reiterates the need for communication between all sectors and the vital role of primary health care in the health system. The South African Medical and Research Council advised too that

there needs to be further clarity on health promotion and prevention within the NHI context and that it be evidence based, multi-sectoral and sufficiently resourced (PMG, 2021).

The advent of the coronavirus disease 2019 (COVID-19) pandemic has placed public health at the forefront of government agendas globally. In addition, this disease has highlighted inequity both between and within countries. South Africa is no exception. There has been an urgent need for collaborative partnerships between the private and public health sectors and between various state departments. These partnerships have been necessary to increase efficiencies in multiple areas such as track and trace of patients, testing for diagnosis and treatment of patients. There are encouraging examples to illustrate these partnerships including a national vaccine rollout using a common Electronic Vaccination Data System (EVDS) providing a Self Registration Portal.

2.5 International Experiences

A literature search for international evidence of successful efforts of low- to middle-income countries (LMICs) introducing National Health Insurance reform was conducted. The cases of Ghana, Kenya and Thailand are explored as they provide valuable lessons and recommendations to inform the current health reform process in South Africa.

2.51 Ghana and Kenya

A scoping review by Christmals and Aidam (2020) explored an 18-year period during which the National Health Insurance Scheme (NHIS) was introduced into Ghana. The authors of the review were seeking lessons from the experiences in Ghana for LMICs with a similar socio-cultural environment and disease burden, such as South Africa. The researchers state that the introduction of the NHIS has provided healthcare to the Ghanaian people, especially the more vulnerable. Challenges include clarity of policy, political influence, limited coverage, quality of care, corruption and ineffective governance, inadequate stakeholder participation, and poor financing. When considering the concerns expressed by stakeholders such as the private GPs in South Africa over the past twenty years, it is evident that potential barriers may be shared in our local context. As the need for improved communication between policy makers and health care providers was highlighted consistently in the South African literature, studies to illustrate how this challenge may be overcome through stakeholder consultation and participation were reviewed.

Abiro and McIntyre (2012) conducted a stakeholder analysis in Ghana using a case study approach documenting perceptions on the feasibility of a controversial one-time premium policy for National Health Insurance. The authors concluded that lack of stakeholder understanding of the policy and excessive politicization would be obstacles to policy implementation. A lack of understanding of the policy meant that many powerful stakeholders were uncertain about its impact and so reluctant to take a position on the policy. The researchers emphasised that the health policy needed to be clear, depoliticized with further studies and public debate to explore its feasibility and sustainability in the Ghanaian context. This research highlighted that South Africa should ensure that its policy objectives are clear and provide guidance on how objectives will be met (Abiro and McIntyre, 2012). This observation holds a valuable lesson for the South African context since many private GPs remain uncertain as to what their role in the NHI reform will be.

In 2016, a decade after the introduction of Ghana's NHIS, even though progress had been made to increase universal access to basic healthcare services, concerns of quality of care and stakeholder discontentment with the operational and administrative challenges facing the NHIS accredited facilities emerged. The sustainability of the scheme was questioned. Alhassan, Nketiah-Amponsah, Spieker, Arinful & Rinke de Wit (2016) conducted a randomized cluster trial in the greater Accra and Western regions of Ghana to ascertain whether or not Systematic Community Engagement (SCE) interventions would have a significant effect on frontline health workers perspectives on the NHIS and the impact that this would have on the quality of health service delivery. The researchers concluded that community engagement in quality service assessment is a potential means towards empowering communities and promoting frontline health workers active participation in Ghana's NHIS. This study demonstrates the role that staff and patient consultation can play in raising concerns, which ultimately improve the quality of care delivered.

According to Suchman (2018), small private healthcare providers in LMICs are well positioned to fill gaps in services through Social Health Insurance (SHI) schemes. In a qualitative study, she collected data from a range of stakeholders in both Ghana and Kenya on whether they believe participation in a SHI affected the private provider's ability to serve the poorer patients with quality health services. Provider interviews covered reasons for (non) enrolment in the health insurance system, experiences with the accreditation process, and benefits and challenges with the system. Private providers agreed that SHI schemes are beneficial for reducing out-of-pocket costs to patients and many providers felt they had to

become SHI-accredited in order to keep their facilities open. Services were limited at times and delay in reimbursement in Ghana was reported to compromise the provider's ability to cover basic costs without charging patients. Suchman (2018) concluded that the research pointed to significant barriers to SHI access and effectiveness for low -income populations in Ghana and Kenya and the opportunity was identified to improve engagement with private providers serving these populations. Recommendations included a review of the payment system from capitation to a fee-for service based on Diagnosis Related Groups. This study once again highlights the need for sound communication and the importance of administrative capacity to ensure providers are timeously and adequately reimbursed for the services they provide.

2.52 Thailand

Thailand introduced a Universal Coverage Scheme (UCS) in 2001. Evidence indicates that the reform has improved equity of access to healthcare. A tax-financed scheme, a comprehensive benefit package and gradual extension of coverage to illnesses that incur high costs, are features which contributed to the positive outcomes (Tangcharoensathien, Pitayarangsarit, Patcharanarumol, Prakongsai, Sumalee, Tosanguan & Mills, 2013). Blecher, Pillay, Patcharanarumol, Panichkriangkrai, Tangcharoensathien, Teerawattananon, Pannarunothai & Davén (2016) have highlighted several practical lessons observed in Thailand that are relevant to the South Africa context. Thailand has a well-developed purchaser-provider split, with the independent UC Fund established by legislation, with a governing body including private and civil society representatives. The structure, operating systems, procedures and information technology are well established and affordable in the middle-income country context. Tangcharoensathien, Witthayapipopsakul, Panichkriangkrai, Patcharanarumol & Mills (2018), reported that a tax-financed scheme is the most feasible in the context of a large informal sector. A comprehensive benefit package, which has minimal co-payments, protects the population. Well designed strategic purchasing organisations and provider-payment methods support efficiency, cost containment, and equity outcomes. Stringent health technology assessment for inclusion of new medicines and interventions into the benefit package enhances the health systems efficiency. The experience in Thailand indicates that development of efficient well designed tax-financed provider payment methods has been a process which is integral to the success of the fund.

Political will was highlighted as an important factor contributing to the success of the reform in Thailand. In a case study for the Health Systems knowledge network, Tangcharoensathien, Prakongsai, Limwattanon, Patcharanarumol & Jongudomsuk (2007) concluded that political leadership and commitment was needed for agenda setting and the system design, monitoring and evaluation was guided by research. Evidence was a very important foundation for reform, with researchers communicating with reformists and policy makers to translate research into policy and practice. The responsiveness to concerns of stakeholders and influential partners who actively participated in the process was highlighted. An understanding of the political economy of health and the importance of good governance, an active citizenry and civil society, provision of evidence, and ethical leadership serve to safeguard the interests of members of the UHC Scheme (Tangcharoensathien et al. 2018). The fact that there was continued political will to drive the process, collaboration between sectors and evidence based decision making through the reform process are valuable lessons for the South Africa process.

According to Blecher et al. (2016) Thailand uses a CUPs System including primary care centres and aligned district hospitals. In addition to nursing and public health officers, each health centre has 30 community health volunteers who work with local government on disease prevention and health promotion. Tangcharoensathien et al. (2018) summarised lessons learned through the introduction of Thailand's UHC. A functioning primary health care system with a broad reach is needed to implement UHC. Incentives can improve the availability of health care workers to strengthen primary care in areas that require them. The district health system is instrumental in translating policy, and making care available and beneficial for the poor. Tangcharoensathien et al. (2013) concluded that future success of the Thai UCS requires interventions to address both primary and secondary prevention of non-communicable disease and long-term policy that accounts for epidemiological and demographic change. Thailand's prioritisation of preventative and promotive health initiatives is an important lesson for South Africa as we continue health system strengthening and introduce NHI reform.

2.6 Conclusion

The literature reviewed provides several insights to the challenges faced by South Africa, Ghana, Kenya and Thailand during their respective reform processes aimed at achieving

UHC. Many concerns raised in the national studies by the GPs to date are not unique to the South African healthcare environment. The evidence from national and international feedback suggests that implementation of a health reform such as NHI is a process which requires political will and ongoing commitment (Tangcharoensathien et al. 2013). Policy needs to be clear and derived from evidence, and there needs to be collaboration, inclusion and contribution of and by multiple stakeholders in state and private sectors (Abiro & McIntyre, 2012; Tangcharoensathien et al. 2007). Increased interaction between private and state sector stakeholders and their communities with regards to NHI policy may serve to better address their concerns and ultimately support improved quality of care (Alhassan et al. 2016). An established primary healthcare system within which health promotion and prevention are prioritised should be in place. Technology is a tool, which will provide efficiency in implementation of a health insurance policy (Tangcharoensathien et al. 2018). Contractual risk and remuneration remain areas of concern and national evidence suggests that it may be favourable to ensure a degree of flexibility in this area (Mureithi et al. 2018).

NHI policy in South Africa is a strategy to move the country towards UHC and is underpinned by the Sustainable Development Goals (SDGs) related to health (United Nations (UN), 2015). Solidarity and universality are principles key to this reform and McIntyre (2019) suggests that as essentially a redistributive policy, debate with the different stakeholders who have vested interest is to be expected. Regardless, (McIntyre, 2019: 18), proposes the following; ‘‘*The NHI Bill can and must be improved. Greater and faster progress in addressing the serious efficiency and equity challenges facing the South African health system can only happen if the public conversation focuses on how best to achieve a Universal Health System.’’*

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Aims and objectives

The aim of the study was to explore how private solo independent GPs in the Cape Town metropole view the introduction of the NHI and their role in it, following the tabling of the NHI Bill in the South African Parliament in 2019.

The objectives of the study were to explore the GPs':

1. knowledge of the NHI reform process and the provisions of the NHI Bill in particular
2. perceptions of the potential benefits, challenges and threats of the NHI Bill to their practices and their current systems and capacity to adapt
3. experience of engagement with the public sector and role players in the reform process to date
4. vision on how communication may be improved between themselves and the Department of Health with regards to the implementation of the NHI.

3.2 Study design

The study adopted an explorative qualitative methodology as it was seeking to discover the GPs' perceptions, experiences and opinions. According to Robson& McCarten (2011), a typical feature of qualitative research is describing situations from the perspective of those involved. Qualitative research is especially effective in discovering culturally specific information about the values, opinions, behaviours, and social contexts of populations (Mack, Woodsong, Macqueen, Guest & Namey, 2005). This study was interpretive in nature based on the assumption that reality is socially constructed and assumes that the researcher will bring their own values to the study. Subjectivity is considered to be an unavoidable (and even valued) part of the research (Robson & McCarten, 2011), and underpins the importance of reflexivity in the research process. In this regard, the researcher drew on and consciously examined her longstanding relationships built over years of regular engagement with independent private GPs in the Cape Town metro.

3.3 Study Population

Having consulted with private GPs in the area in a professional capacity as a medical representative for the past 12 years, the researcher had tacit knowledge of approximately 250 private independent GP practices within the Cape Town Metro. The study population comprised of private independent GPs in the Cape Town metro and in particular GPs known to the researcher.

3.4 Sampling

GPs were sampled purposively. Ritchie, Lewis & Elam (2003) describe a purposive sample as one that is chosen with a ‘‘purpose’’ to represent a type in relation to a criterion. There are two key goals in purposive sampling: firstly, it allows for all areas relevant to the research to be covered. Secondly, the diversity of the sample allows for the impact of the characteristic to be more fully explored. In purposively selecting the sample, the researcher adopted a number of criteria: firstly, to interview respondents who were likely to be ‘‘information rich’’, namely willing to share their honest opinions on their perceptions on NHI reforms. Secondly, to represent the GP practices in the Cape Town metro, which, as the population they serve, are diverse. Apart from group and solo practices, there are dispensing and non-dispensing practices that see varying ratios of insured and uninsured patients from different socio-economic backgrounds. From the GPs known to her, the researcher purposively sought to select 12 independent GPs of different ages and levels of experience, genders and populations served. Of these 9 were finally interviewed.

Participants were recruited in a two-stage process. The researcher first contacted the GP explaining the purpose and nature of the study and answered any questions the participant had regarding the study. The researcher explained that the interview would be audio-recorded. Once the participant agreed to participate, signed consent was taken. The researcher then arranged a suitable date and time to conduct the interview with the GP.

Despite established relationships with the GP community, recruitment of the study sample proved challenging. GPs were first approached for interview in early October 2020. Although this was after the peak of the first COVID-19 wave, in this initial contact with potential participants the researcher realised the devastating impacts of the first wave on the GPs and their support staff. Access to GP practices was difficult and the researcher realised that

although the GPs expressed a willingness to participate in the study, they still appeared to be under tremendous stress and could not commit to interviews as a result.

Box 1: Researcher experience conducting research during the COVID 19 Pandemic

Since March of 2020, South Africa and the entire global community have been facing the COVID -19 Pandemic. The impact of this health threat has been profound. Conducting a research study during this period has presented the researcher with numerous challenges.

When South Africa was placed into an unprecedented lockdown in March 2021, it seemed impossible to comprehend the nature of the threat that this novel virus would present to our community. Faced with the devastating images from well resourced hospitals in Europe and knowing the scarcity of our own resources, COVID -19 overshadowed everything. It became increasingly difficult to focus on completing a research proposal, whilst faced with the constant distraction of personal and professional concerns relating to the pandemic. When the researcher began to realise that a study of GP perceptions towards NHI had not only remained relevant but had become especially significant at this time, she was able to with support from her study supervisor continue the research journey to obtain Ethics approval for the study in October 2020. Allowances were made in her protocol to use alternative interview methods in the event that it might be necessary.

Expecting that the summer months would present some relief from the devastating impact the COVID -19 pandemic was having on the South African health sector, the unexpected second wave of infections prevented the researcher from meeting with GPs to present her study and obtain consent to commence data collection. The summer wave claimed the lives of several GPs nationally, several well known to the researcher and so the severity of the pandemic became increasingly evident. Data collection would need to wait until the second wave of infections subsided. At the end of January 2021, the researcher began to visit medical practices and managed to conduct the first two in- person interviews.

The researcher kept a diary and recorded notes of observations made following these practice visits. It became very clear that private GPs were and have remained under tremendous stress since the pandemic began. They have dealt with the loss of their patients, colleagues and in some instances their friends and families. Many had spent significant time in intensive care themselves during the past year due to COVID -19. A GP compared working through the pandemic to wading in mud which never dries up, day after day. Struggles reported by GPs have included difficulties screening patients attending their practices, working in protective gear, managing anxiety in patients and their relatives, many administrative challenges and difficulties balancing personal demands. Noting the negative impact that the pandemic was having on GPs, the researcher realised that interviews would need to be shortened and done via video calling or telephonically where necessary. Patience and understanding was required. Access to medical practices has understandably altered. Attempts were made to contact doctors electronically but were not successful.

Following the vaccine roll out for Health Professionals between the second and third waves of the pandemic, it was possible to secure a further two interviews which were done as a video call and telephonically. The doctors who were prepared to participate in the study at that time were all mature solo practitioners. Once COVID-19 cases began to rise in May, it was once again not possible to conduct any further GP interviews. Although remaining cautious ahead of a fourth wave of infections, access to the GPs improved significantly once the winter wave of infections subsided and the researcher was subsequently able to recruit and interview the remaining five participants concluding the 9th interview towards the end of the fourth wave.

Recruitment remained challenging in the early months of 2021. The researcher recruited two participants during the first quarter of 2021 before the arrival of the third wave of infections. Throughout the recruitment process, the researcher identified and approached a total of 20

GPs to participate in the study. The majority of the participants were only successfully recruited following the third and fourth waves of the COVID 19 pandemic. Box 1 is a narrative of the researcher's experience in conducting this study as the COVID-19 pandemic was unfolding. After the nine interviews it was agreed by the researcher and her supervisor that data saturation had been reached.

3.5 Data collection

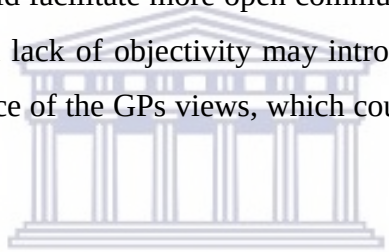
Participants were interviewed in person, via video chat or telephonically whilst they were at their private GP practices in the Western Cape Metro and at a time that was convenient to them. In total, three of the interviews were conducted remotely whilst six were face-to-face interviews. The researcher used a semi-structured interview design (presented in Appendix 3), exploring 'what', 'why' and 'how' questions related to the study objectives to obtain a deeper understanding of GPs' knowledge and perceptions on NHI and how communication and collaboration between themselves and policy makers can be improved. The researcher reviewed earlier studies in the area which helped identify potential knowledge gaps to explore in the interviews. Field notes were kept documenting important practice information immediately after the interview. Notes were recorded about each GP practice based on the researcher's knowledge. Interviews were conducted in English. Face-to-face interviews lasted approximately 45 minutes whilst remote interviews lasted 15 to 30 minutes.

3.6 Data analysis

Each audio-recorded interview was transcribed verbatim by the researcher and checked for errors. Once transcribed, the researcher analysed the data based on Burnard's (1991) model of ''thematic content analyses''. Notes were made during and after each interview of the interviewer's impressions relating to the main topic. Transcripts were read carefully and notes made on emergent themes. The interviewer sought to be immersed in the data at this stage. Open coding was undertaken to identify categories which covered most of the data. The number of categories were reduced and a final list of categories without overlap was produced. This list was validated by the study supervisor. The transcripts were checked again to ensure all categories had been identified. An excel spreadsheet was drawn up to organise the coded sections into categories with sub-headings. At this stage the writing up of results began.

3.7 Trustworthiness / Credibility

Trustworthiness of data and findings is a key measure of rigour in a qualitative study design. Rigour is required throughout the research process and is determined by strategies to achieve trustworthiness through dependability, confirmability and transferability of the study findings (Cooper, SOPH, 2019). Creswell & Miller (2000), describe the importance of disclosure of potential biases and beliefs early in the research process to allow the reader to understand their position and hence contribute to the internal validity and credibility of the study. The researcher is a trained professional nurse and has been employed as both a nurse advisor and medical representative in the Cape Town metro by four global pharmaceutical companies since 2005. Having had long standing professional relationships with GPs in the region, the researcher is naturally empathetic to the concerns raised by the doctors. It was hoped that this familiarity and relationship would facilitate more open communication in the interviews. It is also, however understood that a lack of objectivity may introduce an element of researcher bias, such as uncritical acceptance of the GPs views, which could pose a threat to the validity of the study.



Steps were taken to foster reflexivity during the study process as outlined by Lincoln & Guba (1985). Field notes were taken, and a journal was kept enabling a review and critique after each interview. The researcher recorded thoughts and problems occurring through the data collection and analysis stages and consulted with her supervisor in this regard. Robson & McCarten (2011) describe an audit trail as a full record of activities including raw data such as transcripts, field notes, research journal and details of data analysis. This has been kept for confirmability of the research. Transferability of the study will be achieved through rich description of the context (Cooper, SOPH, 2019).

3.8 Ethical considerations

All interviewees were provided with an information sheet and consent form to participate in the research (Appendix 1 and Appendix 2). The researcher informed the participants of her intent and rationale for conducting the study. Informed consent was attained before the interview was recorded. Participants were advised that they could withdraw from the study at any stage of the interview without consequences. Assurance was given that anonymity and confidentiality will be maintained. Computer files and audio recordings will be kept on the

researcher's device, will be password protected and stored for five years after completion of the study and then destroyed as per standard research ethics practice. Pseudonyms have been used to protect a participant's identity. The researcher ensured that there was no pressure on the GPs to participate in the study. There was no monetary or other incentive offered to participants. The researcher obtained ethics approval to conduct the study from the University of the Western Cape's Biomedical Research Ethics Committee.

CHAPTER 4: RESULTS

4.1 The study participants

The following section provides an overview of the profile of the participants in the study in relation to their age, gender and practice environments. An even sample of male (5) and female (4) respondents participated (Table 1). Ages ranged from 30 to 72 years. All of the GPs interviewed were solo practitioners and represented a mix of predominantly cash and predominantly insured patient profiles. Two of the GPs (P4) and (P5) did sessions in local public sector hospitals and P9 did regular sessions assisting in theatres in a nearby private hospital. P8 did not own her practice but was currently practising in a sessional capacity for an independent private GP. P8 was the only participant who shared practice space, with a Registered Nurse in this instance.

4.2 Table 1: Participant profiles

GP	Gender	Age	Dispensing	Patient profile (majority)	Public sector sessions
P1	Male	50-59	no	cash	no
P2	Male	60-75	yes	insured	no
P3	Male	60-75	yes	insured	no
P4	Female	50-59	yes	insured	yes
P5	Male	50-59	no	insured	yes
P6	Female	40-49	no	insured	no
P7	Male	50-59	no	cash	no
P8	Female	25-39	no	cash	no
P9	Female	60-75	yes	insured	no

4.3 EMERGING THEMES

In analysing the interview transcripts, several common themes emerged, summarised in Table 2 below in four main categories: 1) potential benefits of the NHI policy, 2) concerns over the NHI policy, 3) knowledge of the NHI Bill and 4) recommendations for stakeholder engagement and public-private collaboration. These themes are explored further in the sections that follow.

Table 2: Areas of enquiry and emerging themes from the data

Potential benefits of the NHI Policy	• The provision of equitable healthcare • Potential to advance the primary healthcare service • Increased accountability for private independent GPs
Concerns over the NHI Policy	• Financial viability of NHI in South Africa • Fear of corruption and nepotism • Concerns regarding management and administrative capabilities • Design concerns
Knowledge of the NHI Bill	• Knowledge gap on role of the independent private GP in relation to the existing public primary care facilities and the proposed referral system
Recommendations for stakeholder engagement and public-private collaboration	• Provide opportunities to share experience and skills • Further input on pilot projects and clarity on NHI policy areas affecting independent private GPs needed • Information sharing and referral between private and public sectors

4.3.1 POTENTIAL BENEFITS OF THE NHI POLICY

4.3.1.1 The provision of equitable healthcare

Despite their concerns, all of the GPs interviewed in this study expressed their approval of reform that aims to provide equitable healthcare.

> *So, let's say, obviously as a doctor you want to have access for everybody to healthcare which is 'fair'.* (P5)

> *The proposal, the idealism, I believe it is honourable to be able to allow people who have not been properly assessed and adequately reached you know for their conditions throughout the country due to economic or social disadvantage etc.* (P2)

> *Look, to me bringing in NHI as it looks like in UK would be wonderful because everybody would have access to healthcare.* (P9)

There was an acknowledgement by the majority of GPs that the existing healthcare system is not sustainable and that reform is necessary.

> *I think we definitely should have an NHI because we need to have access to medical care, um for people of all walks of life, from rich to poor. And as things stand when the NHI does come in with its teething problems and it is never perfect, it should hopefully be better than the system that we have now. People are unable to access healthcare. Whether it works as planned, that is another thing, another story. But the idea of NHI is a good one.* (P4)

> *Look, I have always been a person for NHI. I believe in equitable healthcare and I know funding has been and always will be a problem going forward, but I think we must try and find a solution to healthcare now.* (P3)

4.3.1.2 Potential to advance the primary healthcare service

Many of the GPs highlighted the benefit of prioritising PHC through the reform process.

> *Primary care is the basis for this and I would be very keen to be part of that primary care set up.* (P2)

The saddest thing when I was lecturing, the 2nd and 3rd year students at med school were taught preventative medicine, primary care, proper history taking and health promotion and then the minute they are trained it's thrown out. What we are teaching is not being used and therefore it is failing. (P5)

Primary care is still the most important aspect of medicine. (P1)

The importance of the need to consider the social determinants of health was also raised.

*So the basis as the NHI is insisting is the proper funding you know. It takes funding to build good infrastructure like water supply; energy supply, the infrastructure for bulk sewerage and from there you can actually build the requirements or basis or pillars for a healthy society, healthy economy and a healthy environment for the NHI to work. (*P2)

The COVID 19 pandemic highlighted the complexities of managing such a health crisis in a diverse socio-economic environment.

The COVID actually has shown us; look at the earnings of the hospitals, curative advanced medicine, like operations, it had to be stopped and dropped like 80 to 90% where they could not do any operations, so how come an enforced unknown fear could cause them to drop. It was unprecedented. Fearful for their own preservation and maybe the collapse of the system so they could stop and all their earnings dropped. That was done by force of fear. Why can't we do something by force of love? Have a different approach. Because like what we are doing now with a preventative approach with a combination of private and government you know? We do know that we will never have equity when there are so many millions of people who do not have enough to stay isolated ok because in a little RDP house there are people.5 people sleeping, where is the social isolation? (P2)

4.3.1.3 Increased accountability for independent private GPs

A need for accountability of independent private GPs was raised.

In primary healthcare if properly managed, doctors will need regular auditing.

Such as how Discovery is now doing. We need to be accountable for good healthcare. (P3)

I think it is good in terms of communicating with practices in the area and in terms of the quality of medical care we are providing. It's a good way of having a peer review view to make sure the medicine we are practising is up to standard. (P4)

When people are in a solo practice as I mentioned to you before, people can pretty much carry on in their own way and it may become a case of repeating bad habits that become your norm so I think in terms of keeping up to date also group practices or district hospitals will be the ideal way to ensure the quality of care we are practicing is acceptable. (P4)

4.3.2 CONCERNS OVER THE NHI POLICY

4.3.2.1 Financial viability of NHI in South Africa

The affordability of National Health Insurance within the South African context was a clear concern for the GPs interviewed in this study.

Prior to COVID I thought it was impractical and ill advised in a current financial and economic state, even before COVID when we did not have enough capacity to provide ARV treatments on a clinic level, to try and nationalise healthcare would have been moot. Unfortunately, with COVID it has brought it in to sharp relief how improbable it would be. (P6)

So, my first concern is how are these huge amounts of money are going be accessed having a vast discrepancy between the have and have nots. Those, a small number of people who are employed and a vast number who are unemployed. (P2)

The difficulty is with our small tax base, how are they going to fund it? (P3)

The vested interests of stakeholders such as the dominant medical aids and private hospital groups were raised as a potential threat to the successful introduction of NHI.

There are people spinning the best economic brands such as Discovery who are actually tying people into different contracts as far as options are concerned. We can see by their turnover into the billions which they will not give up easily. There are private hospital groups with curative medicine with their bed occupancy that has increased by 120% so it is going a massive step back if they have to give up part of it. The bigger players! (P2)

As a result of their doubts over the financial viability of the NHI policy and vested interests, several of the GPs said that they did not believe that the NHI would be successfully introduced whilst they were still in practice.

Basically, zero as I do not see the NHI happening in my time. (P4)

As I said the other day, my sense is that the reality is that it is going to be many years down the line. This is probably the reason at this stage I am not very enthusiastic. (P3)

4.3.2.2 Fear of corruption and nepotism

The GPs interviewed shared concerns over the potential for corruption and nepotism within NHI.

My first concern is whether the money for NHI will be stolen before it starts. May-be that is not appropriate to say but that is the reality we have to live with here. Will the funds be used as they are supposed to be used? (P4)

Yes, and that is not taking into consideration the horrible concept of corruption. (P6)

Yes, oh, but who decides on which doctors get contracts? (P1)

Let me answer your first question a little better. I feel very worried, very worried about the roll out, about how the NHI is going to work and the reason I feel that way is that the public sector is rife with corruption and is poorly managed from the finance system perspective. (P8)

4.3.2.3 Concerns over anticipated managerial and administrative capabilities

The need for transparency and sound management and administration of the NHI fund was emphasised.

> *Apart from funding, as far as the history of the country and corruption is concerned, that is a big problem. When it comes to people running it, it must be people trained in medical business as such ...not just any person or political appointment to run it. The people appointed must have knowledge of medicine and knowledge of business as such.* (P3)

> *So, when having a government subsidized system, there can be problems if management are not working properly because then you have an oblivious nonexistent supervisor looking after all these different units, they must have the authority and capacity and efficiency to deal with problems that arise.* (P2)

> *I think it sounds fantastic in theory. My concerns will be in the implementation. How is it going to work, what role will GPs play and how will we be funded by the government?* (P8)

> *I do feel that it is good that the government is looking at more holistic ways to treat everyone in the country but integrating the private and state sectors is going to be challenging. I am not sure how they are going to do it.* (P8)

4.3.2.4 Design concerns

The GPs in this study expressed a preference for the proposed capitation remuneration. There was consensus that this was favourable compared to a fee-for-service payment system.

> *I think fee for service is something of the past. I do not think fee- for- service is economically viable. I think that capitation is reasonable. I think you can also you know manage things more cost effectively. We have had some experience with capitation.* (P3)

> *I think in the end ,because of the vast number of people you are dealing with, fee- for-service is not sustainable. If a person is allocated a certain patient*

number to look after for a fee then there is not the temptation for misuse as with fee- for- service where one may ask the patients to come frequently. (P2)

Although the GPs expressed preference for a capitation payment system, they also regarded this payment system as being open to risks that may impact on the quality of care that they will be able to provide to their patients. The GPs identified excessive patient volumes related to the capitation model as a specific obstacle to the provision of optimal care.

I don't know the details of what the amount is that they will be proposing. But for example, with managed health care that is currently available, I have removed myself from those because we have found that they are too restricted in what care you can actually provide the patients with in terms of access to hospital care, where you can send them, what medicine you can prescribe. I think doctors are overwhelmed as they reduce the payment to the doctor but give a stipend each month for each patient on your books even when they don't come. But when they do come, they come at a reduced rate and come as often as they want so it impossible to manage the patients and you actually can't provide good medical care. (P4)

If NHI is going to be run like the day hospitals, you cannot come with three complaints you can do one and then make another booking for the next one. Because that is how they work. It becomes quantity before quality. No, you have got to be doing quality. For me that is not taking care of the patient properly. For me it is expensive to see the doctor so when you get to see the doctor, see them properly! (P5)

Concern over the acceptability of the capitation system for specialists was raised.

Well, I don't mind you know as GPs, but what about specialists because as now with all the super specialists especially like orthopods who only do shoulders and things like that, but they tend to charge a lot more? They will only get a flat rate, so what is going to happen there now? (P1)

Reference was made to the National Health System (NHS) in the United Kingdom (UK) and the possible negative implications for South Africa due to the rationing of healthcare services.

Also, will it be like in other countries where the system becomes so

overwhelmed and we go 10 steps back where people cannot access necessary investigations. Like I , for example, have patients who have moved to the UK and then when they come to South Africa and they say they would like to have a check -up and may need an ultrasound to investigate a pain, where in the UK they were unable to access a GP and were on a waiting list for an ultrasound so long. So sometimes there are disadvantages. (P4)

There is obviously going to be strong limitations on how the other aspect of tertiary healthcare, you know, with investigations access to MRI's etc. It is like even in the UK they have difficulties. It is far better than doing nothing at all. (P3)

A GP queried whether there would be access to healthcare services for foreign nationals under the proposed NHI system.

You know the demographics of the area has changed since I started working here with a lot of foreign nationals, almost half so totally demographic different now. Since NHI is supposed to be for South African citizens only. (P1)

Finally, although loss of autonomy was raised, it was not a primary concern of most of the GPs interviewed.

The problem with South African doctors is that we are notoriously independent so this may be difficult. The selection process will more likely be the larger practices. (P3)

Relating to a loss of autonomy on where GPs could practice in future, the issue of safety for GPs posted in specific areas of the Western Cape was raised.

You can't deploy us to Nyanga, Gugulethu, Manenburg, Heideveld, Bishop Lavis, these are all areas which are a shambles, whereas if you are in Tokai, Wynberg, Sea Point, Somerset, you are fine. So zoning is important. (P7)

4.3.2.5 Anticipated consequences of design concerns

Emigration was anticipated as a possible consequence of inadequate remuneration, poor working conditions and a loss of autonomy, especially for the younger more mobile GPs.

One gets the impression as a practitioner that it is going to go from 'ask to help' to 'instruct', to help and the thing about that is that individuals like myself with a tertiary education with a scarce skill, they do not feel appreciated. So, if you add to that the concept of no appreciation now somewhat of an instruction or force, I don't want to use a word force but something like that but being shoved into a direction, it does inspire a lot of my colleagues to simply go, ''I will leave'', or at least look at their options which is what a lot of them have already done. (P6)

For me, if NHI comes in, a lot of doctors will leave the country because they can't see it working. Look, I am older, I can give it a chance but the youngsters with their lives ahead of them, they are going to emigrate. (P9)

4.3.3 KNOWLEDGE OF THE NHI BILL

The researcher enquired about how the private GPs communicate with the public sector broadly. These enquiries were followed up with a question to understand how the GPs believed the channels for this communication could be facilitated.

4.3.3.1 Sources of information

The GPs reported attaining their information on NHI from a variety of sources. This included Independent Practitioner Associations (IPAs), medical associations, social media or other internet research. The GPs indicated that they had not received any direct formal communication from the Department of Health regarding NHI policy proposals.

Essentially it is what I have actually searched out and read. I have not been given any information. I am obviously on quite a few medical aids, their boards, so essentially as preferred providers, they do give us some information from that perspective. But it is basically me trying to keep informed about what is going on. But I have not actually been found as a practitioner, even our Medical and Dental Council has not gone out of their way to inform practitioners, to say this is where it is going, this is the process, this is how it is looking for the next few years, no one has informed you, which is also part of the logistical nightmare because it appears as if it's going to go from ''oh, we are thinking'' to its there! And you not going to be prepared. (P6)

The only source I can list is when we were medical students in our final year. We did a Module called Health and Diseases in the Community as part of the module we were introduced to the topic of NHI and they wanted us to understand what it is going to cover and how it is going to work. (P8)

However, through their own research, feedback from their IP, CME meetings and medical funders, the GPs had a fair understanding of the proposed NHI policy, as it stands. Areas where further clarity was needed include the role of the GP, the existing public sector clinics and the proposed referral system.

4.3.3.2 Knowledge gap on the role of the independent private GP

The majority of the GPs who were interviewed were uncertain about their actual role in the reformed health system once NHI is implemented. Several GPs expressed uncertainty over how the apparent shift from solo independent GP practices to group practices will be managed.

I do not fully understand where we as private GPs will be able to be contracted and contacted in this vast cog wheel to actually provide a service. I do not believe that it has been outlined yet, whether they will take existing people who are working independently or whether they would encourage groups of people, specialised pools, with an obstetrician, with a paediatrician, an anaesthetist and of course, allied staff in a particular unit, then where would we fit in? (P2)

The thing is and it is historical, we GPs are very isolated with solo practice. In my practice there are at most two-man partnerships in my community as such. There has been a move towards larger group practices such as Medicross and Intercare. So, with national health we would probably be looking at these larger multi party practices with remuneration etc. (P3)

4.3.3.3 Knowledge gap on the role of the existing public sector primary care facilities and the proposed referral system.

The need for clarity on how the existing public sector clinics will function once NHI is introduced was raised.

The one thing I don't understand about the NHI is what is going to happen to the primary healthcare facilities? Yes, how are they going to work? If they keep them and patients are allowed to go to ordinary GPs aren't those places going to be empty? (P1)

There was confusion expressed over the proposed referral system to tertiary healthcare facilities.

Because the other thing is going to be the hospitals, which hospitals will be contracted, will it be the hospitals in your area, or can you decide where you want to go, which hospital you would want to be admitted to? (P1)

4.3.4 RECOMMENDATIONS FOR STAKEHOLDER ENGAGEMENT AND PRIVATE AND PUBLIC SECTOR COLLABORATION

4.3.4.1 Provide opportunities to share experience and skills

Several of the older GPs interviewed did not anticipate that the NHI will be implemented while they are still in practice. However, they expressed a willingness to share their skills and experience to contribute towards the implementation of NHI policy.

We can give input. We may not be part of the process as it happens for the ones leaving. (P4)

It is very important that they communicate with us. We have had no direct communication and often read about NHI on news websites but nothing directly. It is important because we have some input- because we are doing the work! After practicing for 40 years, we have seen the changes and we can see the need. (P9)

4.3.4.2 Further input on pilot projects and clarity on NHI policy areas affecting private independent GPs needed

The GPs expressed that they would like further information on recent NHI policy

developments that is concise, impartial and relevant to their practice as a GP.

> *Most information I get is from social media. I also get information from groups such as my IPA. But I do find this information can be a one –sided view. The difficulty is that there have been pilot studies etc but little feedback on the pilots. I am not aware of the outcome. It is difficult for me to give an opinion without a basis to form an opinion*. (P3)

> *No communication. I have to rely on the news. A few articles from SAMA but nothing much. For example, what happened about the pilot project they were running? You heard about the one pilot they were running and further after that, there was nothing. Well, the feedback was not very positive. That is the problem. It's the government*! (P1)

> *I have not had an active role for past years, but I would like more information.* (P3)

> *I belong to an IPA, that is one and then number two through my own research using Google. Yes, a lot of the information from the department is very technical, so, it takes time to absorb it*. (P2)

> *I think e- mail would be the most efficient way of communicating. My IPA is very good about this issue, even if I do not agree with all their view. I do need to belong to such an organisation and they do help to keep me updated*. (P3)

4.3.4.3 Enable information sharing between private and public sectors

According to the GPs, there is an urgent need for improving collaboration between the public and private sectors. Practical suggestions included sharing patient test results and allowing tools for improved communication on patient outcomes regardless of whether they were seen in the private or public sector.

> *I wanted to say earlier what I think would be a really nice thing to do from now to allow communication between private and public sector in terms of allowing results to be shared. I am not sure how it would work in terms of POPI but for for example, now it is seen as private is them and state is us and never the two shall meet and it is almost as if there is a competition. So, if we send a patient to a clinic because they need a workup and cannot afford it in private the patient*

gets scolded for going to a private doctor even though they don't have the capacity to look after all the people. And we don't get the patient's results. And the patient may say they never heard back and think everything is alright and you don't know if things have fallen between the cracks, what the results were and what tests were done It ties your hands in how to manage the patient. (P4)

So yes, give the private doctors access to state results and the state doctors Access to private results. It is not a competition! (P4)

And there seems to be an animosity when patients come from private and we never get feedback. Very seldom. I would say 1-2% of patients you refer you get a letter back. I know the whole family, children, parents and grandparents. Say I send Granny to the hospital and they ask me what's happened to Granny? I have no idea, is Granny still alive? It does not have to be detailed, simply a summary, seen by so and so and this is what we did. (P9)

For instance, if I want to refer a non-medical aid patient who needs expensive care in the area, you go on to a website and refer, and then you must scroll on and look for the site as there are several websites. Some of the departments are not on VULA. For example, the breast clinic. You have to search which makes it difficult. An easier platform where they are all in. It's helping the poor people. (P9)

CHAPTER 5: DISCUSSION

5.1 Introduction

This research sought to explore the perceptions of independent private GPs in the Western Cape Metropolitan Municipality towards NHI reform, specifically since the NHI Bill was tabled in 2019. This chapter will consider the key findings in relation to the literature, reflecting on the GPs' overall attitudes towards NHI policy, financing and contractual arrangements, engagement with public sector stakeholders and their future intentions. Given that this study unfolded during the period of COVID-19 pandemic, experiences and insights on conducting research during this period will also be discussed. Limitations will be reviewed and finally recommendations made based on the findings of the study.

5.2 Overall attitudes towards NHI policy

The GPs interviewed in this study were keenly aware and shared a broad support for the goals of equity and UHC underpinning the proposed NHI. The GPs were willing to engage and participate in the reform process as they clearly see the potential benefits. Public and private sector collaboration is regarded by the GPs as vital. Most of the GPs agreed that an advantage of the proposed NHI reform would be the potential to advance and strengthen primary healthcare, with an emphasis on preventative and promotive care. This finding is consistent with recent South African studies exploring GP perceptions towards NHI (Gaqavu, Mash, 2019; Mathew, Mash, 2019). Several GPs reported that the COVID-19 pandemic has brought the need to prioritise primary healthcare into sharper focus, also raised by PHASA and SAMA in their submissions to NCOP (PMG, 2021). International evidence from research in Thailand has highlighted the importance of prioritising preventative and promotive care and ensuring policy design that accounts for demographic and epidemiological change (Tangcharoensathien et al. 2013).

The GPs agreed too that the existing health system was neither equitable nor sustainable; however, they remained sceptical on both the feasibility and the likelihood that NHI will be successfully implemented in the South Africa context. Overall, this study reveals a marked mistrust in the state's capacity to uphold principles of good governance such as transparency and probity. Mistrust is based broadly on allegations of corruption and mismanagement within state sector entities generally and more specifically within the public health sector.

5.3 Financing and contractual arrangements

The financial viability of the NHI scheme was notably the most prominent objection voiced by all the GPs interviewed in this study. This is in contrast to Blecher et al.'s (1999) study which reported that only 10, 2% of the GPs interviewed believed that NHI was not financially viable nor practically possible. Most of the subsequent South African studies of GP perceptions have reported on both managerial and administrative capabilities as primary barriers to the successful introduction of NHI, with financial viability of the scheme not appearing to be a predominant issue. However, in a more recent study, Mash and Mathew (2019) raised affordability as a concern for GPs. This trend may be indicative of the current socio-economic environment of crisis and poor confidence in the public sector generally. The COVID-19 pandemic and financial implications thereof may also have played a role. Financial viability of NHI is thus a key issue which needs to be addressed by policy makers in order to gain the trust of independent private GPs.

The GPs also expressed concerns over the technical abilities of state to manage the NHI scheme. These findings are supported by previous studies (Moosa et al. 2012 & Gaqavu and Mash, 2019). The rationale for this perception differed amongst the GPs. In some instances, these fears were founded on previous experience with managed health care and state funded initiatives such as the Workers Compensation Fund where payment for services took several years. A recently qualified GP based their views on experiences of working within the public sector through training and community service. In addition to their concerns over the government's capabilities to manage and administer the scheme, the GPs voiced serious fears of corruption and the fair choice of contractors. Mash and Mathew (2019) reported a similar concern in their study, specifically relating to the appointment of politically affiliated managers who may not be adequately skilled for their position. The implication for policy makers is the need for active steps that will demonstrate transparency of the system and to ensure any cases of corruption and nepotism are dealt with effectively.

While not opposed to ideas such as the capitation payment system, the lack of detail, including the implications for them as independent practitioners is indicative of gaps in the policy. Interestingly, this is also different to Blecher et al.'s (1999) findings that the GPs favoured a fee-for service over a capitation payment model. While the GPs in this study believed renumeration via capitation is preferable, they did nevertheless have clear reservations about the proposed system. Concerns were related primarily to anticipated poor

remuneration and to the consequences of the incentives in the proposed system such as patient abuse, overcrowded practices and eventually a shift from quality of care to quantity of care. Moosa et al. (2016) similarly identified concerns about patient over-utilisation as risks to NHI in their national private GP survey. Good communication by government was proposed as a mitigation strategy to ensure sound contracts. Mureithi et al. (2018) concluded that both clarity and flexibility of contracts is important in their study of emerging contracting models at three GPCI pilot sites.

In the literature of GP perceptions towards NHI spanning the past 20 years, it is evident that professional autonomy has been documented as a primary condition for acceptance of NHI policy reform (Blecher et al. 1999). Surender et al. (2016) raised professional autonomy as a frustration for GPs at a pilot site in Tshwane. In this study, professional autonomy was expressed as the freedom of GPs to choose where to practice and in being able to determine the quality of care they are able to provide for their patients. Conversely, there was also recognition that an advantage of NHI reform could be the increased accountability and auditing it would mean for independent private GPs. The point was also made that the solo practice model may no longer be the most practical one. This finding may partly be explained by the profound effect that the COVID-19 pandemic had on this group of healthcare professionals, both personally and economically. The average age of the participants in the study may also be a factor contributing to this perspective. It is likely that the GPs nearing retirement do not perceive the NHI policy as a significant a threat to their practice and may thus be less invested in protecting their independence compared to a GP in their early years of private practice.

Finally, the GPs interviewed in this study expressed a need for further clarity on what their role will be once NHI is introduced. Concerns regarding accreditation and uncertainty around what practice requirements would mean for the GPs has been expressed in several studies over the past decade (Valley, 2011; Moosa et al. 2016; Mash and Mathew, 2019). There were additional concerns expressed by the GPs in this study on the future roles of other stakeholders such as the current public sector clinics, specialists, medical aids and the referral process to higher levels of care. Abiro and McIntyre (2012) found that a lack of understanding of the policy meant that uncertainty of key stakeholders caused hesitance to take a position on the policy. In their submission to NCOP, PHASA addressed several areas of concern raised by private GPs, including the need for clarity on their role in the new system, concerns regarding capacity and the need for leadership (PMG, 2021). As highlighted by research in

Ghana, the importance of policy clarity in attaining stakeholder support should not be underestimated.

5.4 Engagement with public sector stakeholders

Several earlier studies on GP perceptions towards NHI have recommended the need to increase stakeholder engagement between GPs in the private sector and health authorities on the reform (Blecher et al.1999; Valley, 2011; Moosa et al.2012; Moosa et al. 2016; Surender et al. 2016; Mathew and Mash, 2019). Communication between private and public sectors was also considered to be favourable by a high proportion of the GPs in early studies (Blecher et al. 1999) but has subsequently remained a concern throughout the piloting phase (Surender et al. 2016; Mash and Mathew, 2019). Experience in countries such as Ghana and Thailand indicate that policy needs to be clear, evidenced based and derived from collaboration and inclusion of all stakeholders in both public and private sectors (Abiro & McIntyre, 2012; Tangcharoensathien et al. 2007). Increased interaction between private and public sector stakeholders and their communities with regards to NHI policy may serve to better address their concerns and ultimately support improved quality of care (Alhassan et al. 2016).

The GPs in this study voiced concerns over the 'relational' capacity of the public sector. When asked about where they attained information about NHI, for the most part, GPs reported doing their own research on NHI. Alternative sources included their IPA updates, medical aids and other professional associations. The findings in this study support earlier findings that the majority of the independent GPs in this study would like to receive impartial information on the NHI policy process including developments of the pilot projects. Several indicated that e-mail communication may be a favourable medium. The information should be clear and relevant to the GP. In response to a request for suggestions on ways in which public and private sector can collaborate in the future, concerns were voiced on the limited feedback GPs received from specialists once they had referred patients to a higher level of care in public facilities. Streamlining referral systems and the sharing of patient results were identified as practical ways to improve communication between the sectors.

5.5 Future intentions

Several GPs explained that should NHI be introduced, poor morale amongst the private GP community due to unacceptable working conditions may result in increased emigration of younger mobile GPs. On the other hand, they expressed a clear willingness to participate and

contribute to the NHI policy development given the opportunity to do so. Future intentions thus may depend on the extent to which GPs are given a meaningful voice in the policy process. According to Hirschman (1970) to resort to voice, rather than exit, is an attempt by the member to make changes within an organisation to which they belong. Voice is defined as efforts to make a change, rather than to leave and that choice exists between voice and exit. Loyalty makes exit less likely and depends on how far members are willing to trade off exit for the uncertainty of improvement and then the extent to which they believe they can influence change within the organisation.

5.6 Limitations

On commencing this study, the researcher initially planned to interview a minimum of twelve participants, approached twenty potential participants, and finally succeeded in completing nine interviews in the midst of the constraints of COVID-19. Interviews were conducted until it was agreed by the researcher and her supervisor that saturation had been reached. The researcher needed to shorten the duration of the interviews, which meant prioritising the areas for investigation. Although this may have been limiting, it did encourage the researcher to focus on identified areas requiring further exploration such as seeking recommendations for cross-sector collaboration. As a result of the COVID-19 pandemic, the researcher also encountered challenges recruiting the diversity in age within the GPs as intended. A majority of the participants who were willing to participate in the study were older than 50 years. This was a limitation when it became obvious to the researcher that the mature GPs, especially those nearing retirement did not believe the policy would impact them directly. The younger GPs appeared to be far more apprehensive regarding the impact that the policy would have on their ability to practice privately.

In her role as a Medical Representative, the researcher has established relationships with GPs practising in varying socio-economic situations. However, for safety reasons, she omitted to include GPs practising in areas in close proximity to informal settlements or areas where incidents of crime are known to be high. There were thus no GPs practising in these outlying areas included in the study. This choice of participants reduced the diversity of participants included. Although accustomed to communicating with GPs in her professional capacity, the researcher has had limited experience as a researcher conducting qualitative interviews. Regular consultation with her supervisor for guidance was essential in this regard.

The researcher is cognisant of the fact that having consulted with the participants over many years, her familiarity may have introduced a bias both in the selection of candidates who were willing to participate and potentially in the participant's responses to the researcher regarding aspects such as their attitudes towards equity in healthcare (social desirability).

Working with and being naturally sympathetic to the GP community, necessitated considerable self-reflection and seeking a critical distance on the part of the researcher. The advent of the COVID-19 pandemic also required the researcher to adapt to an altered environment in which to collect the data, remaining mindful of the stress the GPs were faced with on a daily basis. The need to conduct interviews remotely resulted in significantly shorter interviews which did not allow the exploration of the GPs perceptions to the same extent as was possible in face-to face interviews. This limitation may have impacted on the transferability of the study due to a potential reduction of thick data. Despite the challenges that arose due to the pandemic, the researcher was also able to witness the resilience and tenacity of this group of GPs through this period.

Finally, a limitation of the research was the selection of solo practitioners for the study, rather than group practices that may have been both better informed and oriented towards future NHI arrangements such as the CUPs

5.7 Conclusion and Recommendations

South Africa's response to the COVID -19 pandemic, including the introduction of an extensive vaccination programme, has demonstrated that the private and public sectors can work together. The current public participatory process regarding NHI is indicative of the inclusive efforts that policy makers are taking to successfully introduce much needed reform to our healthcare sector. There is however a need to build trust between the private and public sectors. Steps need to be taken be taken to include this group of private independent GPs into the reform process through more direct means of communication and the acknowledgement of the contribution that they can make towards assisting in the development of the NHI policy reform aimed at achieving UHC for South Africans.

Despite the difficult environment in which this study was conducted, the findings support earlier research in this field, yet bring new perspectives for NHI policy development and suggested avenues to facilitate collaboration between the public and private sectors. In addition, this study provides some insight on the impact that the COVID-19 pandemic and

emergency policies have had on this group of independent private GPs. Although some findings may be transferable to other GPs practicing in similar contexts, the data should not be and is not intended to be generalized to all GPs.

Based on the findings of this study, the researcher recommends that amongst the landscape of private sector actors, GPs are allies and should not be considered simply as “interests” which need to be ‘‘managed”. Developing a platform, which encourages interaction between both parties, will provide the added benefit of affording independent private GPs an opportunity to voice recommendations based on their knowledge and experience within the health sector. The advancements of technology developed over the pandemic can be leveraged to enable such communication. Such a platform may also serve to allow for a direct avenue of communication to provide clarity on issues of key concern to the GPs such as financial viability of the scheme, measures taken to ensure transparency and mitigate corruption and to provide clarity on policy developments as they happen.

The researcher recommends further research to gain greater understanding of alternative ways to develop stakeholder engagement with independent private GPs, especially for those in their early years of private practice. This group having recently been active in the state sector and may have valuable insights into possible ways to develop collaborative efforts between the sectors. Active steps to increase collaboration between private and public sectors through, for example, clear referral processes and results sharing were proposed as a viable option by GPs in this study. Co-operation between the two sectors will increase the sense of shared purpose and contribute to building the trust needed to advance NHI reforms.

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APPENDICES

Appendix 1: Information sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Perceptions of the NHI reform of Private General Practitioners in the Cape Town Metro

What is this study about?

This is a research project being conducted by Bridget Perrow at the University of the Western Cape. We are inviting you to participate in this research project because you are currently practicing as a General Practitioner in the Cape Town Metro. The purpose of this research study is to continue to build on the existing findings around General Practitioners perceptions and experiences towards the National Health Insurance Policy in South Africa.

The researcher hopes to discover new perceptions that might assist policy makers within health departments as they introduce the healthcare reforms beyond the existing pilot projects. It is hoped that the research will facilitate improved understanding and communication between the different role players, to ultimately ensure that the objective of Universal Health Coverage which lies behind the National Health Insurance can be realised.

What will I be asked to do if I agree to participate?

You will be asked to participate in an English audio-recorded face-to-face or Skype interview lasting 45 to 60 minutes at your medical practice at a time most convenient to yourself. The interview will be audio recorded, regardless of whether the interview is conducted in person or via a digital medium.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity; your name will not be included on the interview transcripts and other collected data; a code will be placed on the survey and other collected data; through the use

of identification key, the researcher will be able to link your transcript to your identity; and only the researcher will have access to the identification key.
To ensure your confidentiality all research notes and audio tapes will be stored in a locked cabinet. If we write a report or article about this research project, your identity will be protected.

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risk. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about your concerns about the NHI health reforms to achieve Universal Healthcare Coverage. We hope that, in the future, other people might benefit from this study through an improved understanding of the private General Practitioners perceptions and experience and contribute to the development of more collaborative policy making.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide to withdraw from this study or if you stop participating at any time during the study there will be no negative consequences.

What if I have questions?

This research is being conducted by Bridget Lee Perrow at the University of the Western Cape. If you have any questions about the research study itself, please contact Bridget Perrow on cell number 0842545258 or alternatively via e mail 3814679@myuwc.ac.za. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems that you have experienced related to the study, please

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Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
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7535
Tel: 021 959 4111
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This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: BM20/8/10)

Appendix 2: Consent form

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CONSENT FORM

Perceptions of the NHI reform of Private General Practitioners in the Cape Town Metro

The study has been described to me in language that I understand. My questions about the studies have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

___ I agree to be audio taped during my participation in this study.

___ I do not agree to be audio taped during my participation in this study.

Participant's name……..

Participant's signature…….

Date……

Biomedical Research Ethics Committee

University of the Western Cape

Private Bag X17

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7535

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Appendix 3: Interview Guide

1. Explain the purpose and nature of the study again briefly and thank participant for taking time to take part in the study.
2. Confirm receipt and understanding of the signed participant information letter.
3. Give assurance that the participant that personal details will remain anonymous.
4. Assure the participant that there are no wrong or right answers and that we are seeking personal opinions and experiences.
5. Assure participant that they can interrupt and ask for clarification at any point in the interview.
6. Ask if any further questions.
7. Begin interview audio recording.
8. Begin asking research questions

- How do you view the NHI reforms since the Bill was tabled in parliament last year?
- What are your primary concerns about the reform?
- What do you believe is encouraging about the reform to the health system?
- What is your understanding of the contracting units for primary healthcare (CUPs)?
- What do you understand your specific role within CUPs will be?
- What challenges do you anticipate for your practice with the introduction of CUPs?
- What is your understanding of the proposed system of remuneration for your service?
- Where you do obtain most of your information about the NHI reform?
- What opportunities do you envision for your practice when the reform is implemented?
- What preparations have you made within your practice ahead of the reform?
- How do you view your role in the health system reform process?
- What ways do you suggest communication may be improved between GPs such as yourself and policy makers within the National Health Department?
- How do you believe collaboration between state and private sector may be facilitated?
- Is there any aspect of your experience of the NHI reforms that you think that we have not covered and that you would like to mention?