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THE COST MANAGEMENT ROLE OF PRIVATE GENERAL PRACTITIONERS IN ZIMBABWE

BY

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DECLARATION

I, Barnabas Matongera, Student number 692932 am a student registered for the MM-SS in the year 2015. I hereby declare the following**:**

I confirm that this work is my own unaided work. It is submitted in partial fulfilment of the requirements for the degree of Master of Management (in the field of Social Security) to the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university. I have followed the required conventions in referencing the thoughts and ideas of others. I am aware that the correct method for referencing material and a discussion on what plagiarism is are explained in the Wits School of Governance Style Guide and these issues have been discussed in class during Orientation.

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Signature *Barnabas Matongera* Date: February 2016

DEDICATION AND ACKNOWLEDGEMENTS

I am highly indebted to my supervisor, Prof Alex van den Heever for his selfless guidance throughout the research process; to my secretary Mavis for her dedication and commitment in typing and retyping this research report; and to my family for their understanding and unwavering support. Without their selfless commitment and support, this research would not have been possible.

LIST OF ABBREVIATIONS AND ACRONYMS

AHFoz	Association of Healthcare Funders of Zimbabwe
CME	Continuing Medical Education
GP	General Practitioner
MAS	Medical Aid Societies
MDPZ	Medical and Dental Practitioners' Council of Zimbabwe
MRCZ	Medical Research Council of Zimbabwe
OOP	Out Of Pocket
WHO	World Health Organisation
ZIMA	Zimbabwe Medical Doctors' Association

ABSTRACT

Private sector healthcare costs in Zimbabwe have become excessive and are thought to be driven significantly by the failure of general medical practitioners(GPs) to effectively play their gate-keepers' role as caregivers and cost-containment managers.

Increased healthcare costs are attributed to over-diagnosis, over-servicing, overtreatment, inappropriate treatment, and poor patient management (Keogh, 2012; Campbell, Quigley, Collins, Yeracaris & Chaora, 2000). Healthcare costs have become unaffordable to the extent that many patients make use of rural mission hospitals such as Karanda, located deep in rural Mount Darwin in search of cheaper and more effective treatment (Chibaya, 2013).

The purpose of the study is to examine the role GPs are playing and could play in the management of healthcare costs in Zimbabwe. A basic interpretative qualitative research study is applied using a semi-structured interview guide and semi-structured open-ended questions. A small sample of rich cases was used.

The findings of the study reveal that GPs in Zimbabwe are potentially contributing to healthcare cost increases by engaging in unethical conduct such as deliberate over-servicing, inappropriate diagnosis and treatment, fraud and referring patients to conflicted establishments. This has been exacerbated by the collapse of the gate-keeping system with the apparent collusion of Medical Aid Societies, the patients, and specialist physicians.

Healthcare costs could be better managed using modern information technology, involving, *inter alia* the profiling of doctors and diseases and better monitoring of patients. In addition it is possible to improve the regulation of aspects of the private healthcare industry. This would include the enforcement of the patient referral system through the restoration of the GPs role as a gatekeeper.

TABLE OF CONTENTS

CHAPTER 1 - INTRODUCTION

1.1 Overview

Healthcare costs in Zimbabwe have increased to the extent that many patients are using mission hospitals as well as services in South Africa and India in search of affordable specialist treatment (Chibaya, 2013; Sanyanga, 2013). This situation has been worsened by the recent gazetting of new consultation fees through Statutory Instrument 159 of 2014 (*Consultation Fees and Private Hospitals and Associated Units Fees*) by the Ministry of Health and Child Care. The resulting consultation and specialist fees went up by 75% and 50% respectively while the country is experiencing weak economic growth (Ministry of Health and Child Care, 2014).

This is not just unique to Zimbabwe with developed countries like the United States (US) which consumes 20% of its Gross Domestic Product (GDP) on healthcare but with 20-50% of the spending yielding no benefit to patients (Keogh, 2012). Such wasteful spending is attributed to factors over-and-above price increases such as over-diagnosis, over-treatment, inappropriate treatment and poor patient management in terms of treatment co-ordination (Keogh, 2012). Part of the explanation for these increases points to the role of the General Practitioner (GP) as a gate-keeper where doctors are accused of colluding with other service providers to extract higher payments from healthcare funders (Campbell, Quigley, Collins, Yeracaris & Chaora, 2000).

The term gate-keeper arises largely from public health systems and managed care plans[1] where a patient is required to contact their GP before receiving any health care. The GP must then play the important role of providing most of the healthcare needs of the patient. In such systems the GP is the gateway for patients that may require further specialised treatment or hospitalisation. The GP as the gate-keeper therefore has a responsibility not only to advise on the provisional course of treatment but also to refer patients for further diagnosis or treatment where required. The GP can therefore play a critical role in cost management together with supporting and managing the overall

[1] Peter Kongstvedt(1997) defined managed care as "a system of health care delivery that tries to manage the cost of health, the quality of healthcare and access to care."

care cycle and pathway. The only difficulty in Africa, especially in Zimbabwe is that patients are not required to use one GP (Carlson, 2009). However, Medical Aid Societies(MASs) encourage GPs to play a more active role in ensuring that patients that seek treatment from hospitals or from specialists do so only after proper referral by the GP (Campbell et al.,2000). Private healthcare provision in Zimbabwe is mainly accessed through GPs and hospitals. It accounts for 50% of the annual national health care expenditure (with MASs accounting for 80% of private expenditure) although they only cater for 8% of the population (Shamu, Loewenson, Machemedze & Mabika, 2010).

Major sources of private health spending include households through direct OOP payment, private prepayment schemes and contributions from the private sector. Household OOP spending became a crucial source of health financing in the 1990s when Zimbabwe started collecting user charges in government health institutions. Over time, OOP spending has increased sharply from10% of total health expenditure in the 1980s to 36% in 2001 and possibly more in 2010(World Bank, 2015). Funding health care through OOP is the least desirable of all methods as it is both inefficient and regressive. Typically, poor households bear a heavier financial burden, relatively due to their limited resources. If the cost is beyond their capacity to pay, they forgo necessary services or seek care in lower level cheaper services.

Private healthcare provision in Zimbabwe is mainly through GPs and hospitals. It accounts for 50% of annual national health care expenditure with MASs accounting for 80% of the expenditure although they cater for only 8% of the population (Shamu, Loewenson, Machemedze & Mabika, 2010)**.** For Zimbabwe, with a public healthcare system near to collapse due to the hyperinflationary era prior to 2009, the high healthcare costs negatively impact on the provision of affordable healthcare. With an estimated unemployment rate of between 60% and 90% (Murphy, 2013), the inference is that, apart from public funding, a small employed population who belong to MAS carries the largest burden in terms of health care expenditure, with the rest of the population relying on OOP expenditure and therefore facing the risk of catastrophic financial risks. The increased costs therefore represent a failure of the country to advance the right to healthcare. The high costs undermine the sustainability of MASs coverage leaving more people exposed to the risk of OOP health expenses.

1.2 Background

This research report aims to explore how the role played by GPs practices influences healthcare costs in the private sector. The focus is solely on GPs in independent practice in Zimbabwe, particularly those practising in Harare where 56 % of them work (Hongoro & Kumaranayake, 2000). General practitioners belong to an association called the Zimbabwe Medical Doctors Association (ZIMA) while healthcare funders like MASs belong to the Association of Healthcare Funders of Zimbabwe (AHFoz). Both ZIMA and AHFoz are voluntary organisations that attempt to set and agree on healthcare prices but often fail to do so (Shamu et al., 2010).

While MASs are regulated by a Registrar located in the Ministry of Health, the Registrar lacks sufficient staff to properly enforce regulations (Hongoro & Kamaranayake, 2000). In addition, both GPs and MAS are regulated under the Medical and Dental Practitioners' Council of Zimbabwe (MDPCZ). Research has however revealed that for purposes of healthcare provision, the regulations are often out-dated, inadequate with no effective enforcement taking place (Hongoro & Kamaranayake, 2000). This has left the market within which the GPs operate largely self-regulated.

1.3 Research Problem

Private sector healthcare costs have become excessive and are thought to be driven in part by the failure of GPs to play the role of gate-keepers, care-givers and cost-containment managers. Healthcare costs have become so unaffordable to the extent that many patients in Zimbabwe are forced to use mission hospitals in rural areas or to seek care outside Zimbabwe (Chibaya, 2013). Ordinarily, rural healthcare consumers would be expected to travel to urban areas in search of better treatment facilities, however the opposite is true with regards to Zimbabwe. Furthermore, some Zimbabweans are even forced to go to South Africa for treatment, thus demonstrating the enormity of the problem (Doctors withoutborders, 2009).

While the GP has a responsibility to his patients to provide the best medical care available, he is also called upon to ensure resources are used efficiently (Carlsen & Norheim, 2005). It is the latter role that is in dispute, and given the nature of the disagreement between ZIMA and AHFoZ, there is a paucity of information as to whether Zimbabwe GPs accept this role. The situation is compounded by MASs' concerns about possible unethical conduct by doctors, including overcharging and defrauding MASs in collusion with patients (Campbell et al., 2000).

1.4 Purpose of the research

The purpose of the research is to examine the role GPs play and could play in the management of health care costs in Zimbabwe.

The research will also explore the health system models being practiced and their possible impact on health care costs.

The nature and state of regulatory environment will also be examined to understand its contribution to the health care outcomes.

1.5 Research Questions

- How has the role of GP practices influenced healthcare costs in the private sector in Zimbabwe?
- What role should the GP play in managing efficient private healthcare resource use?

CHAPTER 2 – LITERATURE REVIEW

2.1 Introduction

This chapter examines the role and the operating environment in which a general practitioner (GP) in private practice operates in Zimbabwe and other countries but locating the findings in the African and Zimbabwean context. It examines the relationship between GPs and Medical Aid Societies (MASs) as well as Specialists in advancing affordable healthcare to patients. It focusses particularly on the health system models and the role of the GP as a gate-keeper and the influence that he may have in managing healthcare costs.

2.2 Healthcare costs in Zimbabwe and beyond

Healthcare costs the world over have become unsustainable (Gaynor, 2012) to the extent that even in Zimbabwe, many patients are forced to flock from all over the country to rural mission hospitals such as, Karanda Rural Mission Hospital, All Souls Rural Mission Hospital amongst others (Chibaya, 2013), and others are going as far as India in pursuit of cheaper and more efficient health care (Sanyanga, 2013). Health services pricing in the private sector has become so high that it induces a sense of shock. Anecdotal evidence shows that healthcare costs in Zimbabwe rank highest in the region. For example, a hip replacement is reported to cost US$13 000 in Zimbabwe while it only costs US$4500 in Zambia (Chipunza, 2013. It is important to note that health care costs constitute significant expenditure in Zimbabwe with statistics showing that household's funds constituted 39% in funding health expenditure (NHA, 2010). Research carried out in the US and Europe suggests that the high costs are driven by the unethical practises of doctors (Keogh, 2012). These are the same doctors that society is increasingly placing faith in, to not only treat the sick but also help manage the cost of treatment.

Previously in Zimbabwe there was a Relative Value Schedule in place which was a schedule of tariffs that was used to guide funders and providers of health care on the fees they could charge. It used to be produced by a Tariff Liaison Committee made up of AHFoz and ZIMA who represented

the interests of providers. The Relative Value Schedule used to be binding and enforceable on funders and providers. But in 2003, ZIMA formed the New Independent National Tariff and Liaison Committee to devise and set fees independent of MASs due to the differences between AHFOZ and ZIMA on tariff levels and delays in reimbursements. This led to these two associations setting their own different tariffs, with some doctors charging full consultation fees regardless of the patients' paid up membership to MASs or not (Shamu, Loewenson, Machemedze, Mabika, 2010). This pricing war left patients worse off as health costs continued to increase.

It is argued that doctors engage in a range of unethical activities in terms of conduct such as overtreatment, over-diagnosis, inappropriate treatment, prescriptions for expensive drugs and over-servicing of patients (Berenson & Docteur, 2010). Overtreatment can be from duplicated medical services as a result of the generally poor care coordination of patients. Over-diagnosis often results from recommending tests that are not indicated given the patients presenting symptoms. Inappropriate treatment occurs where treatments of no benefit to the patient are provided. Over-servicing of patients occurs when a patient is provided with services more frequently than is necessary, e.g. being requested to attend numerous consultations for treatment of a simple influenza ailment or being provided with a very expensive service when less expensive alternatives are available and would achieve the same result (Berenson & Docteur, 2013).

General Practitioners may also refer patients to providers they have a financial relationship with (Rodwin, 2012). In a fee-for-service system which is prevalent in Zimbabwe, GPs have come under pressure to play a gatekeeper's role but may not be willing to do so. In a perfect gatekeeper's role, the GP is expected to provide initial diagnosis timely to the patient, provide appropriate referrals, provide quality care and consider the appropriate resources needed (Carlson, 2009).

Zimbabwe's case is not unique to Africa. Its southern neighbour South Africa is facing similar problems of increasing private health costs. General practitioners in South Africa have been accused of dispensing expensive medicines and referring patients to conflicted establishments where they are shareholders or are incentivised by the provision of consultation rooms or use of equipment (McIntyre, 2010). Recent studies also reveal that GPs in South Africa are no longer playing an effective gate-keeper role as they are now straying away from their role by seeing

patients that are supposed to be seen and treated by specialists (Van den Heever, 2012). This has an adverse impact on cost-containment. There have also been increasing convictions of GPs for malpractice which has negatively affected cost-containment as doctors now practice defensive medicine, a practice where GPs order more tests than are necessary for fear of litigation (Pepper & Slabbert, 2011).

The healthcare system model may also have an impact on the behaviour of GPs and patients and consequently on costs. Studies in South Africa refer to four models, namely, the *Paternalist* model, *Mutual* relationship, *Consumerist* and the *Default* model (Rowe, 2013). In the paternalist model, a patient is treated like a child with the doctor making all the therapeutic decisions. Under this model, the GP is in dominant control while the patient's control is low. The GP plays the guardian role and determines the goal of the patient visit. The patient's treatment takes centre stage. This model perpetuates the information asymmetry environment, an environment in which the doctor possesses more information and knowledge than the patient (Sloan,2006). This may compromise the information flow between the GP and the patient as inadequate information may be given to the patient (Roter, 2010).

Information is limited as to whether a GP practising under this model can influence cost outcomes given the argument that there is inadequate knowledge of what actual competitive forces are at play which fully explains healthcare costs (Njisane, van Buuren & Blignaut, 2012). However, since the GP occupies a strategic role, his/her practice may actually fail to pay attention to cost-containment issues as the GP's preoccupation in this model is health outcomes.

It can be argued that improved doctor-patient relationship may help improve the chances of a patient adhering to a treatment regime which could positively impact on health care cost management (Mor & Rabinovich-Einy, 2012). Under the "mutual" relationship model, there is mutual trust between the GP and the patient and the GP plays a true doctor's role, who takes into account all the biological, personal and social aspects of the patient in the interaction (Roter, 2010). The level of participation by both the GP and the patient is high and resembles a true partnership arrangement. The GP plays an advisory role and goals of the patient visit are negotiated between the parties. Information is mutually shared and the doctor plays an influential role in reducing the

communication gap. The inclusivity of the relationship and the expanded consideration of the social aspects of the patient's needs allow for costs considerations as part of treatment advice. This model also presents an opportunity for the GP to get to know the patient better and increases the chances that the practice can influence a patient's behaviour and thereby reduce treatment costs (Roter, 2010).

The consumerisms model places more emphasis on patient rights, autonomy, cost control and informed consent (Mor & Rabinovich-Einy, 2012). Unfortunately, under this model, the patient has high control of the relationship while the GP has low control. Health services become commodified, i.e. health services become a commodity with the patient as the consumer. The goal of the patient visit to the GP is driven by technical information which creates a fertile environment for both litigation and patient influence on the course the treatment should take. The GP may end up capitulating to the patient's demands including prescribing certain treatments just to make the patient happy even though the impact is high on costs and ineffectual in terms of the health outcomes (Rowe, 2013).This model therefore has potential for both negatively and positively influencing costs.

The default model is more of an auto-pilot approach where neither the GP nor the patient exerts control over the interaction. It is not known what drives the goal of the patient's visit to the GP and what the GP's role really is. It is therefore hard to understand or to speculate on the impact of this relationship on healthcare costs (Roter, 2010).

Zimbabwe, with a population of 13.1 million (ZimStat, 2012) has a doctor to population density of .069 per 1 000 i.e. one doctor per 14 492 people, which is below World Health Standards. According to WHO, in order to be able to achieve its Millennium Development Goals (MDGS), Zimbabwe should achieve a health worker density of at least 2.5 per 1000 population (Zimbabwe Public Expenditure Notes Report No.3, 2011). In 2010 Zimbabwe only had a total of 2044 registered private practitioners (NHA, 2010,). It is also important to note that largely because of this doctor's shortage, 41.0% of the doctors in Zimbabwe opt for dual employment in both public and private practice (MacKinnon & MacLaren, 2012). Noting the shortage of doctors and the critical role played by the available few in primary health care, MAS through the introduction of

managed care, have therefore placed the heavy burden of cost management on the GP as the gatekeeper.

The conflicting roles of GPs may arise in an environment where provider regulation is poor (Campbell et al., 2000). Zimbabwean doctors are governed by the Health Professions Council (HPC) whose role is to regulate and determine policy regarding the professional conduct of the medical profession. Unfortunately, the MDPCZ is heavily staffed by practicing doctors which brings to the fore issues of regulatory capture. In addition, issues of unethical conduct hearings are not published. Furthermore, both the Minister and the Deputy Minister of Health and Child Care are also practising medical practitioners who may be perceived as having a conflict of interest in gazetting and enforcing the new fees gazetted under Statutory Instrument 159 of 2014. Given the fact that MASs are poorly regulated, these critical social actors largely govern themselves which may undermine the gate-keeping role and cost-containment efforts of GPs(Hongoro & Kamaranayake, 2000). Poor regulation may indeed result in cost increases (Van den Heever, A. 2011).

The doctors acting through ZIMA, have vigorously disagreed with AFHfoz on pricing, with doctors accusing MASs of acquiring hospitals, clinics and pharmacies to get them out of business while MASs accuses doctors of overcharging and colluding with patients to defraud the MASs (Moyo, 2012). While MASs justified their acquisition of own clinics, hospitals and pharmacies as intented to manage costs, studies have shown that in Zimbabwe the costs actually escalated (Shamu et al., 2010). It can be argued that successful gate-keeping practice can materialise in an environment where the health partners cooperate positively, unlike the situation in Zimbabwe.

The GP could be the game changer in cost-containment. All the doctor-patient models examined have the potential to influence healthcare costs. Recent studies in Norway suggest that where a GP has knowledge of his/her patients, the likelihood of the GP being able to influence patient behaviour is high, especially in influencing the GP's role of gate-keeping. Norway has a well developed system of referral and adherence which encourages patients to stick to one family doctor (Roed, Markussen & Rogeberg, 2013).

Literature on these models suggest that there is heavy emphasis on their impact on health outcomes with a limited emphasis on cost management (Rowe, 2013; Mor & Rabinovich-Einy, 2012). Models that therefore promote adherence to one family GP are bound to be more useful in influencing cost-containment. There is very little information on which models GPs have been practicing in Zimbabwe and how GP practices influence healthcare costs. This is compounded by the absence of any law or practice that compels patients to use one GP as a family doctor in order to allow GPs to better manage the relationships and patient histories.

It is also important to note that the number of people seeking care has not only been falling because of increased costs but also because of lack of confidence in the services provided and the availability of health centres. A majority of the poor cannot access health services which are officially free at first contact level i.e. rural health centres, rural hospitals, town clinics and village health workers. This is due to formal and informal[2][3] user-fees charged that the majority of the population (close to 60%) pays to access health care services, especially in urban areas, commercial farming areas and mines (World Bank, 2011). There is an association between utilization and average reported user fees charged. Household Survey Data for 2007 show that 40% of those feeling ill were not visiting any public or private health facilities, with 33% of them claiming that they could not afford to do so (up from 25% in 2001). In urban areas, the situation seems to have become more pronounced with 41% of the urbanites not seeking care in a health facility (ZimStat, 2011) with unaffordability cited as the main reason (World Bank, 2011).

Within Government facilities, a policy exists to exempt everyone from user fees at level one facilities and to exempt pregnant women, pensioners, tuberculosis patients and children under five years old from paying OOP fees in all Government institutions (World Bank, 2011), but very often there are no drugs available and the equipment is absolute forcing patients to seek treatment elsewhere. The Government used to issue free waivers/vouchers through Assisted Medical Treatment Orders (AMTOs) to indigent persons to facilitate access to intermediate and tertiary

[2] Berenson and Rich (2010) defines fee-for-service payment as a medical reimbursement model whereby services are paid for as itemized in the service provider's invoice.
[3] "informal" user-fees are fees which have not been officially approved that providers of health services such as GPs, specialists and hospitals charge patients. They may be in the form of co-payments.

health services, such as provincial or national hospitals or other specialist facilities, however, this scheme is currently underfunded thus giving patients no choice but to fund through OOP.

Out-of-pocket payments could become catastrophic in that individuals may be forced to sell assets or consume below subsistence level to pay health costs when ill. People tend to delay seeking health services due to the cost, and when they eventually go to health facilities, treatable conditions might have worsened, especially for maternal cases. This may be worsened by people delaying to visit GPs or hospital while trying to seek the assistance from faith healers and *sangomas* who charge little or no fees.

2.3 Conclusion

The literature review enriched the researcher on the key role that a GP can play as a gate-keeper in managing patient care and managing health costs by being an important gateway between primary care and specialist doctors. This role can be positive or negative if one considers the allegations of unethical behaviour levelled against GPs. The chapter has also laid bare important healthcare system models in other relevant jurisdiction which can be applicable in Zimbabwe. Of importance is the realisation that the lack of harmony between GPs, Specialists and MASs in Zimbabwe may not contribute positively towards affordable healthcare. However, the review has not revealed the actual GP practices in Zimbabwe and how they affect the health care costs. This therefore requires further exploration, hence justifying the research.

CHAPTER 3 - METHODOLOGY

3.1 Introduction

The research methodology took into account the fact that the research was exploratory with no theory to test. This chapter therefore covers the research methodology based on interpretivist research philosophy and details the research philosophy; strategy; research methods; sampling technique and size; data colletion method and analysis; validity; reliability and ethics. The methodology does recognise the limitations thereof.

3.2 Research Philosophy/Paradigm

The research was based on an interpretivist research philosophy-and epistemological position that requires the social science researcher to have a subjective view of social action from the perspective of the social actors (Saunders, Lewis & Thornhill, 2007). This is unlike positivism which espouses that there is reality waiting to be discovered and to which a scientist can place an objective meaning (Bryman, 2012). This research seeks to understand what meaning the social actors i.e. GPs in independent practice, medical specialists and MAS Administrators, placed on their complex interactions with patients and the social world around them especially in the medical context. The investigation used the researcher as the primary instrument of data collection.

Given the fact that the literature examined suggested that there was inadequate knowledge of what actual competitive forces were at play which fully explained healthcare costs behaviour (Njisane, van Buuren & Blignaut, 2012) the research is exploratory with no theory to test and therefore rendered it better managed by an interpretive approach.

3.3 Research Strategy/Approach

A qualitative research strategy is therefore employed to explore the role of GPs as gate- keepers. It is also pertinent to note that there is information asymmetry in the health care market i.e. consumers know less than the provider (Dulleck & Kerschbamer, 2006) and therefore

understanding the behaviour of GPs in the context of their medical practice was considered difficult for a layman unless rich descriptive information was obtained from the GPs themselves, the specialists to whom patients were referred and the MASs, all sharing their experiences.

General practitioners, specialists and MASs have different perspectives on how the behaviour of GPs may affect healthcare costs which could not easily be explained by numbers and frequencies. A qualitative approach is therefore adopted to best elucidate the interactions which assist the researcher to understand the environment. It also helps the researcher to explore the behaviour of GPs and the reasons for their behaviour from the in-depth perspectives of specialists and MASs, all sharing their experiences. The only assumptions made are that the three target groups knew more about the subject of research than the researcher (Benson & Britten, 1996).

3.4 Research Methods

A basic interpretive qualitative research study is applied. This approach assisted the researcher to gain an understanding of how the three social actors – GPs, specialists and MASs interpreted and placed a meaning on the interactions of the GP which could influence healthcare costs. The study did not seek to approach the research with any established theory but garnered an understanding from the data which was collected using an inductive approach. The researcher is the instrument of data collection (Sharan, 2012) and collects rich descriptive information in the natural environment of the three social actors. Given the time constraints, the use of a basic interpretive research methodology and the selection of a small sample allows for timeous completion of data collection through in-depth interviews.

3.5 Sample

A purposive sampling method was used to select respondents. Purposive sampling is a non-probability form of sampling ideal for picking a sample from which the most can be learned i.e. rich cases which will enable the researcher to answer the research question. It is designed to enhance understanding of selected individuals or groups (McAlearney, 2006). In their role as patient gate-keepers, GPs interact with specialists, MASs and patients. This triangle of interaction

suggests that a sample from the three categories of social actors can provide detailed descriptions of their interactions which could help with answering the research question. A sample is selected from the GPs themselves as a major focus of the investigation, specialist physicians as the point of referral and the MAS as the funders who manage the health costs on behalf of members. The period of research is short and there was no budget to fund the research. These limitations necessitated the selection of a small sample of 12 interviewees, with 4 selected from each sample category. In addition, Marshall, Cardon, Poddar & Fontenot (2013) found a lack of agreement on the size of the sample using qualitative research.

General Practitioners in independent practice *(Obtained from DPCZ register):*
Four GPs were interviewed, selected as follows:

Actively practising male GP	= 1
Actively practising female GP	= 1
Semi-retired male GP	= 1
Semi-Retired female GP	= 1
Total	**= 4**

Specialists *(Obtained from DPCZ register):*

Actively practising male specialist	= 1
Actively practising female specialist	= 1
Retired male specialist	= 1
Retired female specialist	= 1
Total	**= 4**

Medical Aid Societies *(obtained from AHFoz register)*

Medical Aid Societies	= **4**

The selection of retired GPs and specialists is intended to increase the richness of the information in terms of the reservoir of knowledge gained through their many years of experience during practice. They would also have had time to reflect on their social world during practice since retirement and would be less defensive about controversial issues. However, the intended selection

of fully retired practitioners did not materialise as I could not locate any. Medical practitioners in Zimbabwe do not seem to completely retire as I came across a participant who was 93 years old and was still carrying out some limited practice. I therefore had to make do with semi-retired practitioners. However, even with these and specialists I had to use the snowball sampling method as they were either hard to find or were unavailable at the last minute due to work commitments or emergency call outs. Snowball sampling is an opportunistic method which entails the use of the initial sampled participants to propose other participants relevant to the research (Bryman, 2012, p.424).

The equal distribution of the sample among male and female was not intended to test any hypothesis but since this was an exploratory research, certain theories could emerge which could assist with the study.

The funders' sample was based on the most significant membership i.e. the MASs that had the highest population of enrolled members.

3.6 Data Collection and Analysis

3.6.1 Data Collection Method

The research used primary data collected by the researcher as the instrument of data collection using a semi-structured interview guide. In-depth interviews which lasted an average of 40 to 60 minutes were recorded using two voice recording machines while the researcher also took field notes. Two recording machines were deemed necessary in case one machine malfunctioned during an interview. The interview guide composed of open- ended questions with focus on the research question. Open-ended questions allowed for flexibility in the interviews and collection of deep insights. They were employed to allow respondents to tell their own story and also allowed for probing to clarify issues or provide further information. In addition, semi- structured questions were also utilised to ensure that there was consistency in the interviews carried out on the GPs, specialists, and funders (Bryman, 2012). The actual interviews went on smoothly using the questionnaire.

3.6.2 Structure of Interview Guide *(Appendix 1)*

Part A gathers demographic data and as much background information as necessary to allow for data classification in case some themes emerged during data analysis which could point to further exploration or research.

Part B of both research guides helps explore the research questions. For consistency, largely the same questionnaire structure was used for both practising and retired GPs and specialists.

3.6.3 Data Analysis

A detailed summary of the transcripts was produced from the recordings. The researcher used an independent transcriber to produce the transcripts, partly because of time constraints and partly to reduce researcher bias. However, it was realised that the competency of the transcriber had some short comings, largely because the transcriber was not conversant with the subject matter. In future, however, use of computer software to transcribe and help code the data such as NVivo could enhance accuracy. Unfortunately, the price to acquire the program proved prohibitive in Zimbabwe at $20 000.The deficiency was rectified by the researcher listening to the recordings over and over as well as repeatedly reading the transcripts.

Thematic content analysis was used to analyse the data *(see Appendix 2)*. The transcripts were repeatedly read as well as the field notes while sentences were allocated meaningful codes based on themes. Findings were summarised explaining how the study could contribute to the body of knowledge in the area of study as defined by the research question (Hsieh & Shannon, 2005). This was essentially an inductive strategy (Sharan, 2002), noting any themes or theories that emerged. Since this was exploratory research, no specific generation of theories was being pursued.

3.6.4 Validity, Reliability, Ethics

The Qualitative research approach used here is criticised mainly on three points. Findings could not be generalised to an external population because of the non-random sampling method used. In addition, the use of purposive sampling and selection of a small population made it impossible for any generalisation of the results to be made. The research could also not be replicated on the basis that the social setting could not be frozen and the research approach accepted the ontological proposition that the social world is constantly being reconstructed and therefore changing. The other criticism is that in this research, the researcher being the main instrument of data collection, could be prone to biases and therefore could be subjective and unreliable (Merrium,1995).

3.6.5 Internal Validity

From an interpretivist viewpoint, in order to strengthen validity, data triangulation was used to improve the internal validity. Triangulation in this study refers to the use of more than one data source so that the findings could be cross-checked (Bryman, 2012). Multiple data sources were utilised. Although the research focussed on GPs, apart from collecting data from the GPs themselves, data was also collected from specialists and MASs using the interview guide with the same questionnaire thrust focussing on the GPs.

Any relevant experiences that the researcher went through have been disclosed. The use of an independent transcriber was intended to minimise the researcher's bias although there was very little of it as the researcher had no personal interest in the outcome of the research other than for academic purposes. Any disclosures which were necessary to make considering the actual samples selected have been stated. The collection of data from semi-retired GPs and specialists helped improve the richness and quality of data.

3.6.6 Reliability

Although the study could not be replicated, reliability was improved by ensuring that there was consistency between the research findings and the data collected. This was done by ensuring that the in-depth study findings reflected what was collected in the data. Data was collected from multiple sources i.e. from GPs, specialists and MASs to improve the reliability of the data. In addition, an audit trail was created by recording detailed descriptions on steps taken on data collection strategies', procedures, data analysis and findings (Bryman, 2012).

3.6.7 External Validity

To strengthen external validity, detailed, in-depth accounts providing rich insight into the research question were collected. The use of the interview guide, notes and audio recordings as well as independently transcribed transcripts of the interviews ensured availability of a deep description of the data so that knowledge learnt could be justifiable and could be transferable even though the research itself could not be generalised (Merrium, 1995).

3.6.8 Ethics

I had to obtain full ethics clearance certificates from both the Witwatersrand University and the Medical Research Council of Zimbabwe (MRCZ). The process took time. A consent form that conforms to the requirements of MRCZ was used. *Part A* of the form documented the interviewee's special consent to audio record the interview with an understanding that it would be edited to remove any reference to identity and that it would be destroyed as soon as the research was completed and marked. *Part B* of the form addressed the issue of the interviewee's informed consent to the research, giving the interviewee assurance of confidentiality and anonymity. Every participant was also made aware that participation was completely voluntary and that he/she was free to withdraw their consent any time during the interview process in compliance with the University of the Witwatersrand's Code of Ethics (Wits., n.d.).

3.7 Limitation of the study

It was not possible to generalise the findings to the whole population of GPs in independent practice in the private sector because of the research strategy selected, the small purposeful sample the research focussed on and the restriction of the research to Harare only.

3.8 Conclusion

Despite the limitations to the study, from the rich description of data and validation methods used, especially triangulation of data, valuable lessons were drawn that can inform any future interventions.

CHAPTER 4 - RESULTS

4.1 Introduction

This chapter details the results of the interviews of the twelve participants from MASs, General Practitioners and Specialist Physicians. The interview results are further classified into eight themes; namely, Gate-keeping, Practice, Cost Management, Quality Outcomes, Information, Healthcare Models, Unethical Conduct and Interventions.

As the focus of the research was to understand the role of GPs in cost management in the private health care system, cost management then is an important theme as it gave the researcher the opportunity to indicate what the participants felt were the major cost drivers of healthcare. The quality outcome theme allowed classification of indications of what participants believed affected the core business of their profession, the patient care and whether there was any relationship with affordability of care.

The models were considered key in understanding the type of relationship that evolves around the GP/patient interaction and how it may impact on the other themes. The unethical conduct section brought out the issues that are bedevilling the medical profession which could also impact seriously on the other themes, especially cost management. Finally, the interventions section classified those views expressed by participants who felt that there were better ways to improve the role of the GP in positively influencing cost management while at the same time preserving quality outcomes.

4.2 Medical Aid Societies

The sample concentrated on the four largest MASs. Their views largely coincided but there were some very interesting inputs for example, on interventions.

4.2.1 Gate-Keeping

MAS interviewed were of the view that GPs were the patient's first point of call or front-liners. GPs were responsible for primary healthcare and educating patients on preventive care. It is the responsibility of the GP to coordinate patient care, especially between the GPs and specialists or other secondary care and to manage the referrals. Participants also felt that GPs are supposed to see as many patients as possible while referring fewer patients. One MAS termed this relationship "the pyramid of healthcare" (141014-001). The concept of the family doctors role was emphasised.

Of critical importance was the assertion by participants that GPs were accountable for the rationalisation of health care. They also felt that GPs had a major responsibility to save patients money by ensuring that they did not visit specialists who were deemed expensive. One MAS stated that GPs should only refer patients with a working diagnosis i.e. they must carry out initial investigations including required tests (141022-001). Finally, GPs were expected to play a key gatekeeping role as well as to abide by the Zimbabwean Relative Value guidelines- as previously mentioned is a schedule that guides funders and providers of health care on the fees they can charge. Many GPs avoided the role of patient education in preventive care because it does not result in increased income.

4.2.2 Practice

One participant (141014-001) indicated that the GP patient ratio per the World Health Organisation (WHO) was 1:1 500, Zimbabwe's was 1:6 300 but for those under medical aid the ratio was 1:320. Therefore, GPs do not have the numbers as they depend more on the few patients on medical aid, i.e.1% of the country's population. There are few cash patients with enough OOP spending power, therefore GPs hold onto patients pretending to be providing them with a service. In some cases, they may even call a patient for a review for each test even though the tests would have been conducted at the same time.

MASs alleged that GPs are conflicted in managing costs because they are both the player and the referee. They have no contractual obligation to contain costs. Specialists were also holding onto to referred patients. They also see as many patients as GPs see, distorting the pyramid of care. Patients that are referred late lose patience and trust in GPs, motivating them to go straight to Specialists. In addition, the gazetted consultation fees of $35.00 for a GP and $100.00 for a specialist consultation fee has created a huge compensation gap making specialists expensive and GPs feeling underpaid(14102201-001).

4.2.3 Cost Management

The referral system has virtually collapsed. The deteriorating performance of the economy is blamed for most of the doctors' misfortunes. GPs are alleged to be overpricing their services due to fewer cash patients and an overreliance on fewer medical aid patients. Specialists were doing GPs work but charging specialist tariffs. Many patients were self-referring themselves to specialists. The specialists in turn cannot refer them back to GPs because there would not have been an initial referring GP, they therefore hold onto them forever. Even referred patients, once stabilised are not referred back to GPs. When specialists do locum duties at government hospitals, they strictly adhere to guidelines, which points to the fact that the specialists are aware of the correct system to follow, but because of greed, they do not adhere to it in their private practice rooms.

Patients lack enough education on treatment value and processes for them to fully appreciate and respond to costs. Late referrals result in more complications, thereby increasing costs. There is also inappropriate use of emergency rooms. Unfortunately, once there, specialists takeover. GPs would do better by having group practices where they share staff, offices, rentals, ideas and team consultations (141022-0030). They could rotate duties like community education, distribute patients according to their capabilities and interests thereby enhancing specialised care. Quality institutions can produce better outcomes.

4.2.4 Quality Outcomes

It was thought that GPs were compromising quality outcomes by concentrating on treating large numbers of patients and giving them inadequate attention. They miss critical diagnostic information due to inadequate history taking. This may result in partial or inaccurate diagnosis. Quality outcomes can be enhanced with adequate patient and community education on preventive care. There is need to address the GP/patient ratio. When doctors have the numbers, they treat patients effectively, obviating the need for unnecessary reviews.

Another avenue is to apply the doctor procedure codes effectively, coupled with use of incentives for those with a track record of quality outcomes. Doctor Procedure codes will inform patients of exactly how much a particular medical procedure will cost and how much the doctor is being paid and what the service entails. Doctors also need to be adequately trained to gain enough medical knowledge in order to achieve quality outcomes. There is also need to reduce the huge gap between low GP fees and high specialist fees. GPs must be paid well. GPs also need to have adequately maintained equipment and facilities to improve on positive outcomes.

4.2.5 Information

All MASs interviewed viewed the provision of adequate information to patients as of prime importance. Doctors must take complete history of patients which allows them to obtain a differential diagnosis. Apart from the clinical diagnosis used to treat the patient, the other differential diagnosis results are useful for patient and community education as a prevention strategy. Despite the fact that in some cases GPs see too few patients, they still do not have time for patients. They rather spend very little time with patients so that they attend to a large number. The cost of treatment is usually never discussed with patients, especially in respect of patients on medical aid who sometimes demand brand named medicines once they go to GPs. They do not expect to be prescribed the same drugs provided at clinics or government hospitals.

Doctors are expected to spend 15-20 minutes per patient and see ideally 30 patients per day, instead some see 80 to 100 patients a day (141022-003). No adequate history is taken. Doctors need enough time to explain disease causation, a treatment plan and preventive measures. An informed and empowered patient helps reduce disease progression, recurrence of infections,

reduce costs and improves quality of outcomes. Informed patients will stop abusing the healthcare system. Instead, they will not go to GPs and specialists unnecessarily but go to clinics first. Clinics will then act as the gate-keepers. Unfortunately, just as with specialists, the GPs are busy chasing financial rewards. All the GPs indicated that the situation is worsened by the conflict between GPs and specialists over the fees gap and patients capture by specialists.

4.2.6 Models

The mutual model was considered by the participants to be the most ideal as it fosters ownership of illness and a treatment plan by patients thereby guaranteeing quality outcomes. However, participants reckoned very few doctors offered this category except when they meet educated patients. The majority practised paternalism. As some of the patients first seek help from prophets who dominate the prophet/patient interaction, they then relate passively when they meet with the doctor whom they treat as a demi-god (141022-003). Patients do not take ownership of the illness and treatment plan. The illness is considered the doctor's problem. Some doctors do not want to be questioned or challenged by their patients. Patients themselves do not question doctors, even for malpractice. The doctor is considered as the parent who knows what's best for the patient.

The majority of participants believed that a number of patients were now in the consumerist category because of availability of information on the internet. However, they were of the view that this model is as bad as the paternalist model as it is rooted in confrontation. Patients are learning rights without responsibilities. Some of them are even on a first name basis with specialists, making it easier for them to jump the GP queue or demand who to be referred to. Despite this trend in the emergence of patient activism, there is still very little litigation taking place against GPs.

4.2.7 Unethical Conduct

The MASs suggested that unethical conduct was taking place across the industry with the involvement of patients, GPs, specialists, hospitals, pharmacies and laboratories. The more

pervasive activities were fraud, over-servicing of patients, abuse of medical aid cards by members and abuse of the referral system by the doctors and specialists.

Over servicing was more pronounced in the booking of patients for numerous reviews just to get more consultation fees. One participant (141015-001) had this to say:
"What they do is they continue to require a patient to report, to come for consultation. The doctor really sees that the patient has recovered," come after three days. The patient comes after three days and doctor asks, 'any pains?' 'No, I think I am ok'. 'You ok, are you taking water? 'Yes, I am doing that.' 'Okay that's fine, come after a week".
This applied both to GPs and specialists. Some GPs, once they have sent a patient for various diagnostic tests, tend to schedule a review appointment for each subtest in order to justify the number of unnecessary reviews even in the treatment of flu which generally requires one consultation. Other GPs still, make a patient sign for two or three reviews on a claim form when only one visit actually took place (141022-001). Unfortunately the MAS only see the claim form and not the patient, so many of these malpractices go undetected, including signing for tests not done.

Members of MASs also abuse their membership cards (141022-003). Member's cards are utilised for treatment of uninsured relatives due to the high unemployment rate, sometimes with the connivance of GPs, who just turn a blind eye and in some cases without the knowledge of the GPs. In addition, because many MAS do not reimburse costs for wellness check-ups, patients and GPs find a way of circumventing this by recording fictitious treatment. Even the use of the supermarket approach (141022-003) occurs where an indisposed member is accompanied by relatives to see the GP and the rest of the relatives take the opportunity to be examined during completely unscheduled visits.

The MASs also reported cases of abuse of the referral system by physicians where physicians receive patients direct from the street. In order to claim full specialist fees, they insert the name of a GP who would not have even seen the patient as the referring GP. Both GPs and specialists allegedly hold onto patients in contravention of the referral system. The harsh economic environment has induced competition among doctors for the few available patients. MASs

bolstered their case by indicating that there is rampant abuse of emergency rooms by patients and specialists. Patients visit emergency rooms for non-emergency ailments. Emergency rooms charge twice the GP rate (141022-003) and once there, the patient is seen by a specialist, increasing the cost of care.

The more bizarre examples include the alleged abuse of the treatment system by doctors who own grocery shops or butcheries. These doctors allow patients who would have run out of money to sign claim forms and in turn give them an equivalent supply of groceries or meat. Some doctors have interests in pharmacies, laboratories and clinics. They tend to overprescribe drugs which are available at their pharmacy or actively refer patients for tests at facilities they have interests in. The MASs drew the researcher's attention to the fact that the GPs and specialists sometimes create emergencies in order to operate on patients and get a higher tariff. For example, a GP may opt to have a patient deliver birth through caesarean section when a normal delivery would have posed no danger to the patient or child. However, the same GP/physician when presented with the same type of a case at a government hospital where they do locum duties, the 'apparent' emergency disappears, confirming the abuse (141022-001).

Patients collude in these frauds because they are scared of doctors. They are not adequately informed. They have little knowledge of their rights and do not have money to sue the doctors, notwithstanding availability of malpractice insurance in the market which few doctors have taken out.

One participant (141022-001) elaborated abuse as follows:
"A patient can be made to sign for the removal of the thyroid gland just after the doctor having done a biopsy of the lymph node yet only a biopsy would have been done. The biopsy is a very small operation which is not paid much but removal of a thyroid gland is a major operation which is paid a lot"
Some MASs have had to set up an anti-fraud unit to combat fraud.

4.2.8 Interventions

The creation of institutions for group practices of GPs would reign in unethical practices. The proper remuneration of doctors would reduce the need for doctors to cheat. In addition the education of the MAS members would reduce the risks of contracting diseases, limit the progression of diseases, and would contribute to fraud reduction as well as to quality outcomes.

4.3 General Practitioners

4.3.1 Gate-keeping

Of the GPs interviewed, all agreed that they were expected to play a gatekeeping role, being the bridge between the patient, community and the specialist as well as other secondary service providers. The GPs were expected to act as the family doctor and first point of call for a patient in need of care. They were expected to play a key role in preventive medicine to ensure that disease occurrence is managed at the community level. This can aid government in planning health care programmes. They were expected to work with public health practitioners in driving patient education and community awareness. Instead, they spent a lot of time referring patients to specialists. GPs were aware that they needed to fulfil the needs of patients and only refer cases when their ability and experience is inadequate. Responsibility included going the extra mile by carrying out investigative procedures such as blood tests, x-rays, CT scans or ultrasounds for a small commission. It is accepted that they could help rationalise health care services in partnership with MASs, thereby helping to manage costs. The screening of patients and preventive care, for example, of a hypertensive patient, would prevent the degeneration of such a patient from experiencing cardiac failure, congestive cardiac, renal failure, stroke and other complications which will become very expensive to treat. GPs were however expected to carry out minor operations such as surgeries, sutures and other small emergencies. In discharging all these ideal duties the GP was expected to practice good ethics.

4.3.2 Practice

General Practitioners are aggrieved. They consider the MASs as very arrogant, uncommunicative, unwilling to pay them, unwilling to let them see patients and therefore do not care about them. They are also unhappy with the large differentials between the consultation fees paid to the GPs relative to specialists. This is reinforced by the following quote from one participant (141018_001),

"They don't care about us, why should we care about them? I don't believe my opinion is worth 25 % of that of a specialist".

Given the deteriorating economic environment in the country, GPs are furious that MASs are drawing most members to their clinics and hospitals where they do not pay co-payments. With high unemployment, it means very few cash patients can afford to visit GPs. The situation has been compounded by specialists who have been directly accepting patients without referral letters, fuelling fierce competition for patients between GPs and specialists. One participant (141-23-001) described the situation as "a war" thus:

"I think for the GP's role to be meaningful, since there's already a war, we're all after the money, the doctors are not getting the money and the patients are not getting the proper care, because when the funders now have their clinics, we don't know their management, may be there should be a ceasefire…"

Most specialists have opted out of managed care and accept cash patients only. The GPs lamented that with such a scenario, it is impossible for a GP to play the gate keeper's role. They felt that MASs do not appreciate the role of the GP. They do not understand that many patients present themselves late to the GP with complications already setting in, necessitating the need for several diagnostic tests which MAS refuse to reimburse.

The GPs also claimed that the breakdown of the referral system can be blamed squarely on the MASs and the specialists i.e. MASs for failing to pay GPs and Specialists for being greedy by not only accepting patients without referral letters but even capturing referred patients for good. Patient care also suffers from a lack of continuity. Effective patient coordination has failed due to patients hopping from one doctor to another including going straight to Specialists without being referred and the Specialist not communicating with the GPs. MAS do not profile doctors and

diseases in order to monitor treatment cycles and referrals. This is because MASs have not leveraged on technology to keep online records of doctors who provide services to their members and treatment histories.

4.3.3 Cost Management

The GPs pointed out that funders destroyed the gate-keeping role of GPs by taking away the patients and treating them in their hospitals and clinics. The collapse of the referral system has resulted in the remaining cash patients going straight to specialists who accept them without a referral letter and charge high fees. The deterioration of the economy has contributed to a high default rate among patients because of their inability to afford medical tests or buy medication. This has increased complications and costs. Furthermore, regulation of the private healthcare system is weak. One participant (150313-001) suggested that the system should have incentives and punishments as well. Specialists do not write back to GPs about patients they have seen which would ensure better monitoring and supervision of the patients' treatment and ensure better cost and quality outcomes. In addition, GPs do not know how much money MASs are making and so they are not motivated to champion gatekeeping. After all MASs have money to operate clinics, hospitals and pharmacies, but they cannot pay GPs adequately.

4.3.4 Quality Outcomes

The GPs have expressed willingness to play their gatekeeping role provided that their numerous grievances are resolved by both the MAS and the Specialists. Streaming of patients towards one family doctor would ensure continuity of care. The referral system for managed care should be strictly adhered to. Feedback from the specialist to the GPs assists the GPs to manage the cases referred and to gain knowledge about handling future cases. This may include treating the cases themselves.

Doctors must be trained in public health so that they can have a better understanding of their role, the Specialists' role, patients' role and the policy maker's role. Some GPs were of the view that doctors should not be allowed to set up practices as individuals, but only in partnership or create

institutions (1510313-001). This would allow for the sharing of information, knowledge, responsibilities and enable peer reviews.

In addition, in attending patients, doctors must collect detailed history- 80% of the time a detailed history gives the GP the diagnosis (Participant 141018_001). GPs must also examine the patient to get an adequate and accurate diagnosis. One participant (141023-001) remarked that,
"*An examination is very important, especially in an area where we think it's embarrassing*".
All these practices would directly contribute to quality outcomes.

4.3.5 Information

The GPs should give patients as much information as possible after first assessing the patient's ability to cope with the information. Many GPs were of the view that information dissemination depended on the type of patient, the level of education and the doctor's experience (141022-001; 141018-001). Some patients just want treatment and to be out of the GP's office within minutes. In that situation, there is very little time for information dissemination. Information dissemination also depends on the medical practitioner's experience. Experienced doctors can do it faster and with ease. Highly educated patients tend to be better audiences while patients with limited educational background are given instructions – "play by the rules". For accompanied children and the elderly, more information is given to the accompanying relatives to enable adherence to the treatment plan.

Sometimes a GP gets a patient who wants to know everything, and it may take two to three reviews plus the initial visit to do justice to the patient. But the MAS will only pay for the initial visit plus one review. The MASs are not truthful with their members (150313-001), they do not tell them about the limits attached to their medical aid benefits structure. Patients must always be told the technical name of the disease they are afflicted with in case he/she changes doctors or travels to another area. They must also be educated about the lifestyle and what can contribute to quality outcomes.

4.3.6 Models

The GPs were of the view that the dominant patient-doctor model was the paternalist model and that it was dependant largely on the location of the practice with the affluent drifting towards mutualism, while those from poor backgrounds and high density suburbs are being better managed using the paternalist model. The GPs felt that many of the patients accepted being ordered around. They did not question the doctor. The doctor is deemed to be the sole answer to their illness. A few doctors practice mutualism but only when it concerns the educated who stay in low density suburbs and where children or elderly persons are involved. Culture was also deemed to play a role where some patients would think by merely waking into an elderly white doctor's surgery, they are instantly cured, so they do as they are told. Interestingly, one participant felt that most urban dwellers were in a default relationship with their GPs, to quote one participant (150313_001),

"Patients don't care, doctors don't care. They all have different agendas."

All the participants were in agreement that the provision of the right information has a positive impact on life style and quality outcomes and that lack of information leads to high treatment default rates which leads in turn to complications and expensive outcomes. Therefore information on life style, disease causatives and treatment plans must be given. One female participant (141023-001) indicated that sometimes she checks online information in front of the patient for transparency. But patients sometimes take female GPs for granted and so this tended to influence her to want to be in command.

4.3.7 Unethical Conduct

The theme of unethical practice was considered to be wide in spectrum as it encompassed how one treats the patient, the wrong diagnosis, the wrong treatment, influencing the patient's decision in the management of complications, being rude or not giving patients the opportunity to ask questions. Some doctors send patients for unnecessary multiple tests. They hurriedly listen to a

patient, and then order all of the possible tests that cover the patient's narrative instead of digging to obtain an adequate history leading to an accurate diagnosis.

Corruption was also cited as undermining ethics. The wholesale capture of patients by MAS for other clinics has been blamed for the unethical conduct. If patients flock to GPs, the problems will vanish, it is argued. Young doctors were considered particularly susceptible to these ill-advised practices because of the pressure to sustain young families. Some GPs even invent charges by quoting a higher tariff code when the patient is gone; even when the patient is there in some instances, after all patient hardly understand the codes. And yet, one participant (141022-002) revealed that some GPs have been accused of performing illegal abortions, sometimes in unsanitary conditions which could lead to infections and subsequently expensive treatment.

The collapse of the referral system caused by specialists accepting and holding on to self-referred and referred patients was described as a sore point and unethical by participants. The demise of the gatekeeping system has contributed a lot to unethical conduct (participant 141022_001). In addition, the skewed ownership of healthcare facilities which are not as regulated as pharmacies (51% of shareholdings for pharmacies must be held by a pharmacist) is a recipe for disaster, as some rich investors can control the whole investment and dictate the profit and earnings of the practices which ignore the interests of the patients. A young doctor for example, is obliged to implement the investor's desired interests without regard to the patient needs because of lack of resources. Things like the minimum number of days a patient should be admitted and which injections they should receive are applied to each admission to maximise revenue.

There was also a complaint, that doctors representing other doctors were conflicted because many of them are employed by the MASs (141023-001). A lack of business management skills and lack of training in GP practice after houseman ship was also cited as factors fuelling unethical conduct.

4.3.8 Interventions

Participants indicated that training GPs in business management and GP professional practice was critical. Modernisation of practice by incorporating the use of technology, telemedicine, e-

medicine and the linking up of GPs and specialist practices to MASs to allow monitoring of treatment, doctor profiling and disease profiling would improve on quality outcomes as well as help in cost management.

The gap in consultation fees between the GP and Specialist was considered too high and needed to be rationalised. The MASs were also encouraged to pay for wellness programmes as ultimately, the programmes will benefit MAS in cost management as a key preventive measure.

Although institutional practice was suggested as a possible intervention strategy, one participant (141023-001) thought cultural practices could scuttle its effectiveness as the death of one partner could invite an avalanche of relatives who would descent on the practice demanding their departed loved one's share.

4.4 Specialists

4.4.1 Gatekeeping

There was general consensus among specialists that GPs were the first point of call for patients. Words such as 'first protocol', 'first house' and 'frontier for patients' were used. Specialists expected GPs to manage simple conditions i.e. mild and acute cases but refer all hospital admissions and severe cases. The GPs were expected to manage the majority of patients and to monitor patients who would have been attended to by specialists. They were expected to know their knowledge limits and only manage patients within the range of their abilities. Once a GP became uncomfortable with a condition or realised that a patient was not getting better, they must refer them early. In fact, one participant (150312-0020) felt that because many patients present themselves to GPs late already with complications after visiting prophets or *sangomas*, GPs should refer them early and not waste time trying to treat them. However, another school of thought was that where a GP had previously worked at a government district or provincial hospital and had acquired knowledge, even theatre experience, he/she could deal with whatever confronted him/her. No law prevents him/her from doing so, even to operate (150312-001; 150313-002).

In addition, monitoring the development of children and the health of pregnant women was considered their prime responsibility through attending to immunisation but also adhering to WHO guidelines on primary care practice (150312-001). GPs were also expected to keep abreast of primary healthcare developments and work with public health practitioners.

Furthermore, specialists considered the attitude of the MASs as wanting the GPs key role to be one of minimising patient's problems, managing health costs, saving money for the MASs, and hanging on to patients for as long as possible but at the same time expected the GPs to charge as little as possible. On the whole, specialists felt that GPs were important, and that their absence would result in the system collapsing and specialists ending up seeing more patients than they could cope with.

4.4.2 Practice

Specialists largely concurred with GPs and MASs that the referral system had broken down and admitted that they were receiving self-referred patients. Even when they did get referred patients, they did not write back to the referring GPs. They argued that they cannot send patients back to GPs because self-referred cash patients do not have referring GPs and most referred cases do not have names of the GPs indicated but just the name of a private clinic or surgery. Most patients that visit Specialists are on an OOP basis and those with medical aid shortfalls. They cannot afford to pay for the GP and specialist at the same time, so they skip the GP. The bad state of the economy was to blame. Specialists claimed that MASs were also to blame for running their own healthcare facilities and seeing the bulk of the insured patients, leaving GPs and specialists with no patients. Specialists now have to compete for patients with GPs who also run clinics without qualified people and MASs who do not charge a co-payment. It has been realised that GPs in MASs clinics and hospitals do not keep patients, they quickly refer them because they have no incentives to keep patients.

In addition, specialists hold onto their patients generally for better follow-ups but in some cases, also to make a little bit more money. Most specialists have opted out of MAS. They want cash .Patients present themselves to GPs when they are already experiencing complications after having

spent time visiting prophets or *sangomas* who charge fees in kind. Prophets are church leaders who claim to have the power to heal sick people through spiritual divine power whereas *sangomas* are defined as traditional healers or herbalists (thefreedictionery). GPs also order more tests to make money. Thus, when patients eventually get referred, they have lost faith in the GPs and therefore refuse to go back. The GP is therefore blamed for prolonged illnesses. Specialists therefore claim that MASs are largely to blame because they do not adequately pay GPs and physicians especially the big MAS. The situation is worsened by the poor patient/doctor ratio.

Specialists have also pointed out that many GPs did not have adequate general practice training, including training on primary care programmes. However, there are no hard and fast rules on what GPs can do. It depended on their experience, training and area of interest. If a GP gets experienced in his area of training e.g. paediatrics, he may never refer a patient although the tariff he is paid will be lower. Only a minority of specialists (150313-002) thought GPs referred early, but all acknowledged that the referral system had been severely compromised. In addition, poor ethics in the private healthcare sector were also eroding the referral system.

4.4.3 Cost Management

The challenging economy is blamed for many of the deviations by GPs. Specialists reasoned that GPs do not sufficiently diagnose patients because of the need to push volumes. They are more concerned to clear the queue and keep the patient than listen to the patients. Patients are not effectively cured, as a result they drift from one doctor to another, increasing both complications and costs. In five months, one patient was observed to have been seen by six different doctors (150313-003). Patients who self-refer themselves to specialists pay specialists tariffs on a cash basis even though specialists will have done GP work. Some patients even feign new diseases when specialists try to refer them back to a GP after a successful treatment in order to avoid being sent back to the GP.

Some patients also drive costs up by refusing to be referred, having become comfortable with their GP while some refuse because of the inability to afford a specialist. Some GPs hang on to patients because they genuinely believe they are managing well. Many hang on to patients for fear of the

specialists hanging onto their patients if they refer them. This was evidenced by the fact that physicians' rooms were always full of patients (150312-002).

4.4.4 Quality Outcome

Specialists expect GPs to screen patients who need urgent attention in the waiting room. There must be continued education of GPs, perhaps by increasing the current 50 points for Continuing Medical Education (CME)[4] to 100 for renewal of the practicing certificate to compel GPs to attend CME and refresher courses. Doctors must take adequate patient history and actually examine all patients to get an accurate clinical diagnosis. There must be auditing and proper monitoring of GPs practices. At the moment, the private health care system is running itself(i.e. no supervision or regulation).There must be some enforcement of standards including the inspection of practices to ensure that GPs employ qualified persons such as nurses to take the blood pressure or temperature of patients.

Quality outcomes are also affected by late laboratory responses. A quick turnaround of laboratory tests and early referrals would be helpful (150313-002). Patients must be given adequate information on diagnosis, medication, drug side effects and outcomes to improve compliance with treatment plans. Health quality is also compromised by patients who do not disclose their financial incapacity, then default on treatment or operations. Some default because of drug side effects. GPs must get patient feedback from specialists and patients themselves.

4.4.5 Information

Specialists expect GPs to give patients adequate information on diagnosis, medication, drug properties and outcomes. However, some specialists suggested that information dissemination depended on the patient's social and religious background, age, educational level, belief system, and support system, the availability of a cure, the certainty of diagnosis, the GPs' experience and

[4] CME refers to a specific form of continuing education that helps those in the medical field maintain competence and learn about new and developing areas of their field. In Zimbabwe those in the medical field need to attain fifty points in their exams to renew their practising certificates.

the potential impact of the information. Some patients can be suicidal, depression prone or in denial which means more counselling is needed. One needs to ask the right questions.

The majority of patients are scared of the doctor. They do not probe, they do not ask questions. Specialists also claimed that doctors did not also like being questioned by patients. However, informed and empowered patients get more confident in the relationship, co-operate and adhere to their treatment plans. Furthermore, informed patients accept their condition. They psychologically settle down quickly. The default rate is reduced and trust is enhanced. One participant (150312_002) had this to say about trust;

"If you give a referral letter to patient to take to a specialist without disclosing to him his illness, and he only discovers it from the specialist who advises him that your GP knew about it, he will completely lose trust in that GP and he will refuse to ever go back to that GP and will then trust the specialist more. If he had been to a sangoma, he will think the doctor's behaviour meant he is also afraid of the evil spirits he is alleged to have been afflicted with, that is why the doctor would have written a piece of paper without disclosing its contents. Such a patient will not take medicine seriously, he will default."

Doctors need to see patients for 15 to 20 minutes to adequately attend to information needs (150313-003). They should enforce the booking system within their practice rooms. They should impart information on preventive care, life style education, hygiene, good health and good diet. There was consensus that, to be effective, information should be repeatedly given. Effective information enhances better outcomes.

4.4.6 Models

There seemed to have been no consensus among the participants on what they thought were the models operating in the private healthcare industry. One participant (150312-001) was emphatic that paternalism is dominant. Another (150313-002) felt that it depended on the patient, as patients with little knowledge prefer a paternalistic relationship. Mutualism existed where a bit of

discussion took place around costs or the treatment plan. However, the mutual model was considered too lax, with patients thinking the doctor is not sure of themselves, thereby encouraging default on the treatment plan by the patient.

Two participants (150313-003) thought the default model did not exist in Zimbabwe except when dealing with mentally deranged patients. There was acknowledgement that the mutual model would be the best model as it fosters communication and better outcomes. Consumerists patients tend to jump from one doctor to another while elderly patients are not happy if not given an injection.

Another participant (150313-003) was of the view that models depended on the doctor's attitude, location of their practice, attitudes of clients, their socio-economic background and level of education. Poorly educated patients in many cases seemed intimidated when seeing doctors. Patients from high density suburbs do not ask questions, they treat GPs as gods. They are very loyal to the doctor. They believe just being with their doctor cures them. It was observed that for some patients once their regular doctor was away and a substitute doctor was available, a default relationship occurs. They do not want any conversation with the doctor. They prefer to just get a prescription and leave.

A participant (150313-003) whose practice was in the low density suburbs, felt that 60-70 % of her patients were mutual, 20% paternalist and 10-15 % could be consumerist and default but that all 4 models existed. The patients from the low density residential areas were well informed. A few even stated what type of treatment they wanted. One patient demanded antibiotics, which was not given, and then felt offended and left never to return (150313-003). These type of consumeristic patients behaved that way because they believed that they had a right since they were paying. They did not respect the doctor's decision.

4.4.7 Unethical behaviour

Most specialists attribute the erosion of ethics to the harsh economic climate where the cost of living had risen substantially with few patients available to treat. This was worsened by the failure

of the MASs to adequately and timeously pay doctors. Only the very bad ethical practices were thought to be reported while a lot went unreported to the medical council.

Specialists interviewed were of the view that part of the problem was caused by the lack of adequate training of GPs on ethics, discipline and professional practice. A GP may for example see a patient in the morning, and again in the evening just to tell the patient about the test results which could have been given over the phone (150312-001). GPs on houseman ship practice are not adequately monitored and discipline levels have deteriorated. Their bad traits become habit and are not discarded when the young doctor goes into private practice.

The GPs are alleged to be holding onto patients unnecessarily, pretending to be investigating for periods ranging from three to seven months, as long as the patient looks healthy in order to make money. However, once the medical aid benefit runs out, they quickly dump the patient and refer. The GPs are also accused of carrying out specialist work they are ill qualified for and ill-equipped to carry out in their rooms e.g. nebulising a patient in the GP's room without oxygen. They run clinics, prescribe industrial products not specified by the World Health Organisation for child nutrition, thereby compromising outcomes. They preferred referrals to laboratories or pharmacies they have a relationship with. They were also over-prescribing expensive drugs that are found in those establishments they have vested interests in. Some GPs have been known to have patients sign claim forms for fake treatment so that patients could get for example meat from a butchery the GP owns (150312-002). Specialists agree that not writing back to GPs about referred patients is unethical but some also argue that it is because of time constraints and the absence of technology since the mail system does not work well anymore.

The availability of practice insurance has not enticed doctors to be insured. The cover is thought to be inadequate, besides doctors do not trust insurance companies ever since the economic meltdown that preceded the multicurrency regime when many insurance policies became valueless. Very few patients sue doctors. When they do, it is because of the emotions of losing a loved one rather than a doctor's negligence. Doctors have no money to take out insurance and patients have no money to sue the doctors.

4.4.8 Interventions

Specialists were generally agreed that MASs should not run clinics and hospitals. It is a conflict of interest. They should concentrate on providing funding, that way GPs can get the right numbers. Certified GP practice training should be availed to GPs on graduation. CMES must be enforced.

There should be a doctors/MAS truce and dialogue among all GPs, all MAS and patients representatives to discuss what is expected of each stakeholder. Patients tend to blame doctors. MASs must have their own on – call doctors to assist stranded patients with advice. The patient booking system ought to be enforced to enable adequate consultation time. The MAS must conduct workshops for GPs to understand MAS requirements.

In addition, the MASs must adequately pay GPs. Community education programmes on lifestyle and preventive care must be developed and implemented. GPs could be allocated to a specific community, say, Sunningdale suburb to look after, this would address the GP/patient ratio. There should also be a culture change in the doctor/patient relationship to migrate towards mutualism.

4.5 Conclusion

The use of the themes, the models and the interventions helped to clearly articulate the issues that affect GP practices, especially issues such as health costs and patient care. The contribution of health care funders and specialist doctors also came to the fore and so did the economic and regulatory environment.

CHAPTER 5 – DISCUSION OF RESULTS

5.1 Introduction

This chapter relates the research findings to the research questions and the literature review. A review of the findings suggest that the GPs regard themselves as the poor cousins in the private healthcare system in Zimbabwe. Patients blame the GPs for the alleged overpricing of services and unethical conducts while the specialists blame the GP for holding on to patients unnecessarily instead of referring patients early. The MASs also blame the GPs for overcharging and for fraudulent behaviour.

The GPs exonerates themselves by accusing MASs of working to push them out of business through running own clinics and hospitals which offer primary healthcare services and, in addition, by inadequately paying for consultation fees. The GP is also aggrieved by the specialist for accepting self-referring patients and holding onto their referred patients. No wonder, one participant labelled it a "war". This resonates with the findings of previous studies (Campbell et al., 2000) which indicated that, with conflict like this, doctors and MAS never agree on how to manage costs.

The research did confirm Carlson (2009) assertion that MASs, GPs and specialists are well aware of the gatekeeping role of the GP, as being the key to handling primary healthcare issues carrying out initial investigations on patients and referring difficult cases to specialists. While the literature review tended to emphasise the role in terms of clinical-care for already afflicted patients, the research revealed that GPs in private practice were expected to extend their gate-keeping role to patient education and community education on preventive care, wellness programmes and life style behaviour. This extended role would ensure that fewer people visited health care centres for treatment, thereby saving both MASs and patients money.

However, the findings of the research suggest that GPs are not willing to carry out this extended role because it is not necessarily rewarding. The GPs argue, for example, that MASs do not pay for annual medical check-ups. Study findings however suggest that an effective gate-keeping system for both clinical practice and preventive programmes help manage costs (Roed, Markusen & Rogeberg, 2013).

5.2 Referral System

What is clear from the research is that the gate-keeping system has collapsed or been rendered largely dysfunctional, driven by the stakeholders (GPs, specialists, patients and MASs) for their own survival**.** The MASs views were that the GPs should effectively manage the referral system by adequately carrying out accurate diagnosis of patients as far as possible to achieve a 100% cure rate at the GP level. The GP should therefore go the extra mile in commissioning all of the necessary tests including admitting patients to hospitals for non –life- threatening illnesses.

However, the MASs blame GPs for holding onto patients unnecessarily resulting in preventable complications. MASs also blamed the specialists for accepting patients who bypass GPs. Specialists in receiving patients directly without referral letters from GPs, deprive GPs of the opportunity to screen patients at a GP tariff, which is 114% lower than specialist rate. The GPs are also deprived of the opportunity to educate these self-referred patients on preventive care**.** The MASs views are motivated by the desire to manage costs

The specialists on their part blame the patients, MAS, the economic difficulties and GPs for the collapse of the referral system. In their view, the MASs have created the problems by paying doctors late and inadequately. In addition, they have forced patients on medical insurance to be treated at their clinics and hospitals, leaving GPs and specialists with very few patients, mostly cash patients. This has driven GPs to hold onto patients instead of referring them.

Specialists admit receiving self- referring patients as well as holding onto both referred and self-referred patients. The justification was that the GPs were not doing a good job of treating patients and therefore patients preferred to visit Specialists directly without going through the GPs. Patients

were also trying to cut costs. This scenario has resulted in specialists seeing more patients than they would ordinarily see under a working referral system.

The GPs themselves blame the MASs and the specialists for the collapse of the system. The GPs argued that in operating clinics and hospitals, the MASs have taken over most of their patients and that the specialists have also taken over the majority of their cash patients, leaving the GPs with very few patients. This has inevitably bred a culture of holding onto patients to try and earn as much income as possible to survive.

The implications are serious. This has created an environment where patients are over-serviced which in practice increases healthcare costs (Keogh, 2012). Patients who jump to the specialists, in trying to cut out GPs' costs, help to drive up healthcare costs by opting to be treated by specialists for an initial assessment and who charge a specialist tariff of US$75 per consultation for a service that would have been attended to by a GP at a tariff of US$35. The MASs have helped facilitate the compromised environment for GPs by not adequately paying them. This has resulted in GPs feeling aggrieved and paying very little attention to their gate-keeping responsibilities.

"If the MASs don't care about me, why should I care about them" remarked one doctor. *"They are arrogant, remarked another"*. This is clear testimony that the system has broken down.

5.3 Conflicted Referrals

The MASs were of the view that GPs refer patients to conflicted establishments like pharmacies or diagnostic centres where they have financial interests in order to prop up their businesses. For example, they have had cases of patients being made to sign claim forms for drugs from the conflicted pharmacies but only to be given groceries in exchange for the drugs. This view was also supported by the specialists and the GPs themselves. The MASs concerns were the escalation of healthcare costs while the specialists were concerned with the non-clinical impact on patient cure. This is what (Keogh, 2012) referred to as wasteful spending that did not benefit the patient. The GPs themselves blamed the collapse of the referral system on MAS for inadequate reimbursement of GP fees.

The GPs' reaction has been to minimise the referral of patients to specialists by holding on to patients as long as possible. Although this would be in the interest of MAS, some these patients develop complications, multiplying treatment costs which would have been saved by early referral to the Specialists. Both specialists and GPs are aggrieved that MASs are running clinics and hospitals with diagnostic facilities, virtually one-stop shop centres, diverting the majority of patients on medical aid away from GPs to themselves.

With very few patients to attract, GPs have addressed this by seeking to attain large volumes of patients without regard for adequate patient consultation periods and quality of service. Consequently, GPs take on patients with inadequate medical histories, hence resulting in inadequate or partial diagnosis which in turn creates patient dissatisfaction. The patients end up drifting from one doctor to another or self-refer to Specialists. The sum total of the impact of GPs actions is to drive healthcare costs up and undermine quality outcomes. Recurrence of illnesses or prolonged healing becomes common, which in turn adversely affects the cost of treatment.

An important example given was GPs knowingly receiving patients with complications and holding onto them instead of immediately referring. They pretend to be treating the patient by ordering several tests over a long period. By the time a patient is referred, the complications and costs would have multiplied. This has been blamed for the breakdown in trust between patients and GPs and between GPs and specialists, encouraging patients to seek direct treatment by Specialists who demand cash up front. It means patients pay for insurance that they do not benefit from and also pay even for primary healthcare at specialist rates. In addition, increased healthcare costs have also impacted negatively on the MAS who in turn pass on the costs to the patient in the form of increases in subscription fees.

5.4 Cost Management

The views of the MASs were that GPs fuel cost increases by unnecessarily holding onto patients and performing numerous needless reviews just to increase their income. As a result MASs encourage their members to be attended to at their own clinics or hospitals. The specialists concur

with the MASs but argue that because MASs are now drawing many of their members to their clinics or hospitals for initial treatment, without asking for co-payments and many other patients are self-referring to specialists, means that GPs have had to compete for the few available cash patients with specialists.

Once the GPs access patients, they try to hold onto them for as long as possible, booking them for many unnecessary reviews in order to increase revenue. Where they can, because of the large disparity between GP fees and specialist fees, GPs increase patient volumes instead of providing quality services. On the other hand, specialists and GPs argue that MASs do not understand the fact that in some cases, GPs receive patients who already have complications and who would have delayed in getting treatment while seeking to be treated by prophets or Sangomas. There would therefore be need to carry out more tests to arrive at an accurate diagnosis.

There are both clinical and costs implications related to GPs behaviour. Not enough time is available to listen to the patient's story to obtain correct history and reach an accurate diagnosis. As a result, some information is missed which sometimes affects the accuracy of the diagnosis. Inappropriate and ineffective treatment is administered. A patient who does not get well after a long time loses faith in the GP and wanders off to one or more other doctors. This affects patient coordination as patients may then receive varied treatments at a huge cumulative cost. This can be avoided if GPs are diligent enough during the initial consultation.

However, while MASs would want to deliberately make overtures to manage healthcare costs, there was no evidence to suggest that the GPs themselves make that effort. The clinical wellness of their patients seems to be their prime concern. Cost-containment is largely incidental to their medicinal practice. This is also supported by the views of specialists who also indicated that GPs lack training in business management which may point to a lack of appreciation by GPs of the dynamics of treatment costs and impact on MASs funding.

5.5 Enhancing Quality Outcomes

MASs, GPs and the specialists agree that GPs were not taking adequate patient histories. Specialists and GPs went on further to say that GPs were not always physically examining patients. As a result sometimes an inaccurate diagnosis is made, reoccurrence of illness transpires and sometimes complications arise, affecting both quality of outcome and attracting additional costs. Some ailments may remain undetected for a prolonged period and when it finally gets diagnosed, complications occur, some of which require surgery, pushing up the cost of treatment. Incorrect or partial diagnoses result in the GP giving the patient wrong or inadequate information. If patients were well informed at least they can make efforts to prevent contracting preventable diseases, and subsequently cut costs and enhance quality outcomes.

5.6 Information

The MASs were emphatic that GPs should give patients as much information as possible, at least sufficient to educate the patient on the disease diagnosis, treatment plan, medication efficacy and side effects if any, outcomes, preventive care including wellness programmes and life style behaviour. The long list of expectation from the MASs is motivated by the MAS desire to manage or prevent costs.

The GPs themselves were non-committal, pointing out that information dissemination depended on the patient's background and education. Most patients they attended to prefer to spend very little time with the doctor. This view could have been be self-serving given that GPs prefer to push patient volumes to make ends meet(as indicated by the other stakeholders).The specialists tend to concur with the GPs views but suggest that the problem is largely because of reluctance by patients to engage.

The findings point to the need for GPs to give adequate information to patients about their disease diagnosis, medication and expected outcomes. Roed, Markussen & Rogeberg (2013) suggest that informed patients become more confident about their relationship with the doctor. They easily

accept their medical conditions and adhere to treatment plans. Such a relationship promotes better health outcomes and costs.

However, GPs seem not have time to adequately obtain histories from patients, let alone time to give out information. They ration information to patients judging by their social, religious, and educational background; age, patient support system, availability of cure, certainty of diagnosis and their own experience. This suggests that GPs generally give information that they believe the patient should get. Given the fact that GPs largely do not adhere to a patient booking system and hardly devote the required 15-20 minutes per patient but prefer to push volumes, the required communication is therefore inadequately addressed.

Lack of two way communication promotes the paternalist model while adequate communication promotes mutualism. Ill-informed patients do not understand the consequences of not adhering to treatment plans. Patients may not take prescribed drugs seriously or default the moment they experience side effects which they were not warned of. Others simply hop from one doctor to another. By reinforcing paternalistic practices, doctors create conditions for missed diagnoses and patients defaulting on treatment plans. Opportunities to educate the patients on preventive care are lost. These practices increase the prospects of illnesses progressing resulting in complications and increase in costs.

5.7 Models

The MASs interviewed were of the view that GPs practiced paternalism. This they argued was confirmed by the fact that inadequate information is passed on to patients during very short periods of consultation, a view supported by (Sloan, 2006). The MASs would prefer mutualism which is conducive for quality out comes (Roter, 2010). The MASs would prefer this model because it promoted effective treatment of patients and led to less expenditure on healthcare costs. MASs were of the view that the consumerist model was an unsuitable model because it promoted a confrontational doctor/patient relationship and which could lead to more self –referrals by patients.

Although literature suggests that there was no clear evidence as to whether or not the models had any impact on cost management (Rowe, 2013; Mor & Rabinovich-Einy, 2012) the research results suggest that the paternalistic model creates conditions for one sided communication between doctor and patient. With the majority of the patients considered timid, fearful of the doctor and reluctant probers, this model creates risks of missed or incomplete diagnoses and high default rates on treatment plans. Opportunities for educating patients on preventive care are also missed. Ultimately, poor out comes manifest themselves with a negative impact on costs.

At least 70% of Zimbabwe's population live in the rural areas (Fin Mark Trust, 2015) with the majority being less affluent. The GPs practice mutualism on the educated and affluent members of society who are mainly urban based, therefore condemning the majority to paternalism. This therefore means that the application of the paternalist model may be having a significant adverse impact on healthcare costs in Zimbabwe. This is worsened by the fact that cash patients are deemed to operate in the default model. The GPs need to develop a relationship with their patients. This may encourage patients to stick to one family doctor, which will help in gatekeeping and produce better outcomes.

The specialists were in concurrence with the GPs and MASs that paternalism was rife. However, they all agreed that mutualism was the ideal model. The GPs blamed the patients for being unwilling to develop a relationship with their doctor. This GPS's view resonates with the allegations by the MASs and specialists that GPs do not have time for patients but concentrate on processing as many patients as possible. The fewer questions patients ask, the better for consultation time management.

Mutualism is known to promote better health outcomes and consequently better healthcare cost management (Mor & Rabinovich-Einy, 2012).The MASs, the GPs and the specialists all viewed this model as the most suitable model, although some specialists suggested that application of a model sometimes depended on the patient's education and background. The three categories of interviews did not think there were any significant number of GPs who practiced consumerism or the default model.

5.8 Defensive Medicine

Although malpractice insurance was available in the market, few GPs thought it necessary to take it out. Fear of litigation would have been expected to push doctors to practice defensive medicine (Pepper & Slabbert, 2011) by engaging in over referral of patients to ensure that all possible illnesses are detected, without due regard to costs. However, there was no evidence of defensive medicine practice taking place as very little litigation had been reported.

The MASs indicated that GPs over refer patients for diagnostic tests in order to get more money from MASs and not because they would be trying to protect themselves against litigation. They further indicated that patients have neither the financial muscle nor the knowledge to be able to sue doctors. The specialists on the other hand thought no litigation was taking place because the GPs did not have the money to take out insurance and the patient also did not have the money to sue the doctor. Therefore no defensive medicine was being practiced by the GPs.

The patient's difficulties are worsened by the dominant practice of the paternalism model. It is therefore not surprising that there are an insignificant number of litigation cases that have seen the light of the day. Specialists and MASs were however, of the view that many cases went unreported. Therefore one may deduce that there may be improper behaviours taking place within the GPs practices which have a direct impact on healthcare costs. For example, as previously stated, the research has revealed that there are rampant cases of over referrals and inadequate diagnoses. The lack of litigation therefore robs the industry of a deterrent weapon.

5.9 Interventions

There were key interventions suggested which could make a positive contribution to quality outcomes and cost-containment. While recognising that the improvement of the economy was key, GPs could put in place interventions such as education of their patients and the community regarding preventive care e.g. how to prevent malaria? Comprehensive training of GPs in business management and professional practice would engender greater professionalism and enhance quality outcomes.

The use of technology to link MASs, GPs and specialist would be useful to facilitate doctor profiling, disease profiling and patient monitoring, making health care management more transparent, efficient and effective. There must be programmes to bring together MASs, GPs and specialist as well as patient representatives to deliberate on the roles and responsibilities of each stakeholder. Given the fact that patients were allegedly learning rights without responsibilities, this would go a long way to promote a productive partnership, better healthcare outcomes at affordable rates. However, MASs must also rationalise the compensatory gap between GPs and specialists.

5.10 **Summary of findings**

All respondents agreed that GPs were supposed to be patients' first point-of-call. It was their responsibility to coordinate patient care, especially between the GPs and specialists or other secondary care and to manage referrals. All respondents agreed that the referral system in Zimbabwe has virtually collapsed because of the various stakeholders in the health fraternity trying to maximise their own financial return given the deteriorating performance of the economy.

As a result of the collapse of the referral system and independent and individual aspirations by those in the medical fraternity, medical costs have escalated beyond the reach of many. Many patients were self-referring themselves to specialists as a way of cutting costs and because of lack of confidence in GPs. Many patients thought that GPs were compromising quality outcomes by concentrating more on the financial aspect by trying to treat as many patients as possible in as little time as possible without paying adequate attention to the patient's health needs resulting in wrong diagnosis. Unethical conduct was rampant in the private health sector with the involvement of patients, GPs, and specialists. MASs were also considered to blame for the breakdown of the referral system due to their failure to pay GPs and by trying to bypass the services of GPs and specialists by opening up their own hospitals, clinics, laboratories and pharmacies.

5.11 Conclusion

The findings do strengthen the argument that the GPs, specialists and the funders as well as the patients need to collaborate honestly and harmoniously in order to develop mutual relationships and strengthen the GP's role as gate-keeper for the health care system to function efficiently so that costs remain affordable and better outcomes are guaranteed.

CHAPTER 6 – CONCLUSIONS

6.1 Introduction

While GPs make an important contribution to the provision of healthcare in the private sector, they are also adding to increased healthcare costs through unethical conduct. This includes: over-servicing of patients; referring patients to expensive and conflicted establishments; engaging in fraudulent clam submissions; colluding with patients to misuse membership cards and benefit claims; and giving inadequate diagnosis and treatment of patients. The predominant use of the paternalistic GP/patient model has reinforced the stereotype of doctors towards patient care thereby limiting opportunities for better doctor/patient communication, trust, confidence and quality outcomes.

6.2 Recommendations

There are many ways in which a better approach to care can work. GPs can enforce the gatekeeping approach with the help of MASs and specialists. This is critical given the willingness expressed by the GPs to play that role. However, many seem not to have good understanding of role of the gate-keeper. Training will therefore need to be intensified including continuing professional training. GPs can also educate their patients about their diagnoses, treatment plan, drug efficacy and expected outcomes. They can also help reduce future healthcare costs by educating patients and the community in general on preventive care, wellness and lifestyle programmes. This is possible if MASs also incentivise the programmes by paying for them.

Increased usage of technology can give GPs, specialists and MASs better improved capabilities to manage patients and health outcomes. Profiling of diseases, doctors and patients in conjunction with the appropriate use of modern information technology can improve transparency, reduce corruption and unethical conduct. It will also improve on patient monitoring, cost management and quality outcomes.

This research has suggested that the private healthcare industry largely governs itself, therefore requiring a review of current legislation, regulations and enforcement to ensure better governance of the sector. This will ensure that healthcare costs are kept to affordable levels while guaranteeing quality outcomes.

A more structured dialogue between the doctors and the medical funders is paramount and quite urgent so that the parties resolve the grievances among them. Perhaps the government, after reforming the regulatory framework can put in place a proper regulator for the industry who can also mediate between parties. It is important that the fees charged by doctors and specialists and the rate of reimbursement by MASs are rationalised.

The findings also suggest that if mutualism is adopted by all the GPs as a practice model, the health outcomes would improve as there would be better communication with patients, improved health outcomes and perhaps general adherence to one family doctor by patient.

6.3 Conclusion

The research sought to explore the role that GPs play and can play in the management of health care costs in Zimbabwe. It also examined the nature of health system models practiced by the GPs as well as the state of the regulatory environment and its impact on health care in Zimbabwe. The research revealed that because of the weak regulatory environment, poor economic environment and unethical behaviour by doctors, the practicing environment has become a free for all with a complete breakdown of the referral system. This has put paid to the society's ideal healthcare system where the GP plays an effective gate-keeper's role. The GPs are therefore contributing more towards increased health care costs instead of helping contain them. With strengthened

regulatory environment, observance of ethical practice by the doctors, better dialogue between the stakeholders and more empathy towards the patient, the GP can play positive role in containing health costs.

While the results have helped answer the research questions, given the limitations of the study and the small sample used, they do point to the need for a more detailed study to assist stakeholders to better manage the health care system.

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APPENDIX 1

Interview Guide:

General Practitioner/medical aid societies/specialist physicians

Part A

Demographic Information where applicable

Organisation Type …… ……

Location ……

Capacity ..……

Age category

26-35	36-45	46-55	56+

1.1 Gender

Male	Female

1.0 Introduction

a. Self-Introduction
b. Explanation of the research purpose
c. Compliance with ethical issues

Research Questions

2.1 Please give an overview of the role of the General Practitioner (GP) towards patient care.

3.1 What are your views on the role of GPs as gate-keepers*? (In managed care plans patients are expected to contact their GP before receiving health care)*

3.2 What would be required for the GPs gatekeeper role to be meaningful-and its feasibility in the Medium term?

3.3 What structural obstacles exist to the GP as a gatekeeper?

3.4 Were GPs to be installed as gatekeepers-would this solve the cost problem or is the problem too complex? If so, what are the complications?

4.1 What are the expectations of Medical Aid Societies from GPs?

5.1 Please give some indications of the circumstances in which a GP may refer a patient to a specialist or other secondary provider.

5.2 How should quality of service be managed?

6.1 Can you enlighten us on the kind of information that a GP may disclose to a patient during consultation.

6.2 What role is there for the effective use of information?

7.1 Literature suggest that there could be four healthcare models in which GPs interact with patient, i.e. Paternalist, Mutual, Consumerist and Default model(Explain the models).In your view, are there any models or model which you can ascribe to the context in which GPs are operating in Zimbabwe?

8.1 There is international growing concern about the pervasive nature of unethical conduct by GPs, kindly share your thoughts on the relationship between unethical conduct and healthcare costs within the Zimbabwean context.

9.1 Apart from the practice itself, tell us some of the business ventures that GPs venture into (Discuss conflicts of interest and their effects)

10.1 Please give your views on the role of Practice Insurance.

11.1 Any other ideas you believe GPs could assist with in cost management?

12.1 **(Retirees only)**

Hypothetically, if you were to go back into practice, is there anything you would do differently in terms of health care costs management.

Thank you for your time and wealth of information.

APPENDIX 2

Thematic Analysis (views of medical aid societies, general practitioners and specialists)

Views of medical aid societies

Participant No	Themes	Keywords	Transcript page no.	Remarks
141014-001 Recorded 14.10.2014 At 2.05pm	Gate-keeping-ideal	Patient education, primary health care, first point of call. Pyramid of care: GP sees as many patients as possible. Rest see fewer and fewer patients. Rationalisation of health care. Clinics could be gate-keepers.	1	
	Gate keeping current practice	Correct GP/Patient ratio not there WHO – 1:500 Zimbabwe 1:6300 MAS 1:320 GP must have the numbers - Sending them for various tests, reviewing patients separately for each test. Economy not functional. Output of pocket expenditure not available. 1% of population only on medical aid – GPs depend on these. Specialists holding on to referred patients and seeing as many as GP sees. Pyramid distorted.	2 2	
	Cost management obstacles	Deterioration of economy. Overpricing – not enough patients. No of out of pocket expenditure. Referral system broken down. Limitation of right to admit to specialist. Late referrals breed complications.	11	

		Lack of patient education programmes on value and processes.	1 5,4,6	
	Quality outcomes	Correct GP/Patient ratio results in GPs treating them for good. Use of DRG Model. Incentives.	2	
	Information	Should be collected and given -history, differential diagnosis – possibilities, clinical diagnosis, outcomes. As much information as possible be given. Dip tank approach to patients –'in out, in out.' Patients don't probe. GP only concerned with outcome - happy got positive result. Cost of care not discussed – patients on medical aid demand big names prescriptions. Information on differential/diagnosis useful for patient & community education– prevention.	6 7	
	Models	Paternalist consults Sangomas/Prophets first. Illnesses are the doctor's, this is patients' attitude which is conducive for unethical conducts by GPs. Mutual – ideal, ownership by patient of illnesses with better outcomes.	8 8	

	Unethical Conducts	Tests not done signed. Referrals to conflicted businesses – diagnostic services e.g. X-rays, laboratories, incentives from specialists e.g. for CT Scan, GP/Specialist and GP/diagnostic services collusion. Practice Insurance. -no impact. -not obligatory.		
141015-001 Recorded 15.10.2014 At 5.18pm	Gate-Keeper-Ideal	General Management - a lot of conditions. Identify specific specialist. Specialists expensive. Patients have no knowledge. Save patients money for basic conditions from specialist high fees.	2	
	Practice	Pretend to be giving a service holding on to patients-late referrals. GPs want to maximise on income. -Patients lose faith. -No contractual obligation on cost management. -is a player and referee. -double swords. -driven by financial gains.	3	
	Cost Management obstacles	Patient education – uniformed patient.	3 4	

		Patient knowledge. GPs maximising on fees by pretending to be servicing .Weak legislation. GPs getting away with murder. Patient/doctor ratio low. Deteriorating economy. Patients self-refer to specialists. Specialists have become GPs. Specialists charge high fees for GP work like treating flue.	6	
	Quality Outcomes	Need GP medical knowledge. Correct diagnosis if GP well-informed. Incorrect prescription. Inadequate patient time. Pushing numbers and missing information. Patient education- total package. Community preventative education.	6	
	Information	Too few patients but still don't have time to talk to patients. Informed patients don't abuse system can go to clinic, patients won't go to specialists and GPs unnecessarily. -Clinics would be gate keepers. -Conflict between GPs and Specialists. Patients can't tell difference – GP and Specialists seen as just doctors.	6	

	Models	Paternalism – predominant. Majority of patients not informed Doctor dictates, no room for consultation. A bit of mutual – educated lost or informed lot – room for consultation. Consumerism does not exist. Patients don't question or challenge doctors, even for mal-practice. Default doesn't exist. Dr more like a parent knows what child wants to eat, what is good.	8 8	
	Unethical Conduct	Over servicing – repeated unnecessary reviews to get consultation fees, they want to survive. -No additional drugs given. -Pretend to be treating patients. -Late interventions/referrals. -Competition but too few patients. -Conflicted relationship/investment with pharmacies. -over prescribe what is at their pharmacy. -No knowledge of practice insurance. -Patients give up, no knowledge. -Scared of doctors. -Patients not informed. -No money to sue.	9 9 9	

		-No knowledge of their rights.		
141022-001 Recorded 22.10.2014 At 9.05am	Gate Keeping	Family doctor – Zimbabwe Relative Value guidelines. Front liners, primary health care, first port of call, after being to clinic, patient coordination carry out initial investigations. Refer only with working diagnosis.	2 1	
	Practice	Gazetted fees – GP$35, Specialist $100, huge gap. Specialist expensive. Informed patients on ailments can save us a lot. People see Specialist with minor ailments. Consultations plus tests – blood tests, X-rays, medication by Specialists balloon healthcare costs. Recommend GPs investigate all those in need – refer only with working diagnosis. Some patients just want to be managed by Specialist.		
	Cost Management Obstacles	People self-refer to Specialists. -Increase in members going directly to Specialist. -Because of harsh economy, Specialists driven by need for the dollar. -Specialists do not turn away patients without referral letters. -Specialists flouting guidelines. Once referred patient stabilised, Specialist not referring patient to GP.	2 3	

		Self-referred patients kept by Specialist forever, doing GP work for Specialist fees. Can't refer them back to anyone-not referred by anybody.		
		Specialists do locum at Government hospitals -there they strictly adhere to the referral system . -minor ailments seen by junior doctors. -At government hospitals, once issued treatment plan they don't see them, they refuse. -They hold onto to patients. -Allege managing chronic condition. Everyone is chasing the dollar. If the economy improves, chasing reduces.	3 3 3	
	Quality Outcomes	Reduce gap between GP fees and Specialist fees, -Pay GPs well -Adequate financing & maintenance of Facilities. -Address relativity – GP v Specialist.	4	

	Information	GPs need to service, need to see lots of patients -Push volumes. -Reduces quality of service. -Spend less time with patients. -No time to educate members. -Could provide complete package of causation, treatment plan and prevention. -Not doing it, need next patient. -Informed patient improves quality of Outcome - progression of condition reduce non-recurrence, costs reduced. -Dr/Patient ratio still too law – Drs chase the dollar, Specialists also do.	4	No patient loyalty
	Models	Paternalist – high on the list most. Members believe doctor know it all. Have that in a very big way. They just go by whatever doctor would have said. Consumerism coming up. -An element of activism -Patients goggle from internet information now available, gotten into information age. In the past no one would know anything or could read except from medical text by doctors.	5 5	

		-Litigation still very low.		
	Unethical Conduct	Not limited to GPs only. Even the paternalist, consumerism, even the specialist. It's across the board – GPs, specialists, pharmacies, hospitals, laboratories. -Card abuse by members – purchase medication and GP treatment for relatives. -GP make member sign 2 or 3 times for one visit and claim reviews. -Uncalled reviews by GPs even for flu. -Uncalled for reviews and detention of patients by Specialist. -Claim for removal of thyroid yet biopsy done. -Forced us to set up an anti-fraud unit. -You see the claim not the patient. -Diversification not a problem, not unlawful, running bars, hair salons, butcheries – asking patients to sign claim forms in exchange for beer or hairdo, or meat.	6	
	Unethical Conduct	Over-dispense to pharmacies attached to their surgeries. More rampant on GPs than Specialists.		

		Conduct member driven in collaboration with GP. Difficult to eradicate – just see the claim form not the member. -Need for random visits to check on practitioners. Practice Insurance is required. Fund set-up by ZIMA. Litigation low, fear of litigation has no impact Over-diagnosis driven by wanting to draw more from MAS. Non-surgical intervention is low cost. Create emergency to operate but same patient, same condition if taken to Parirenyatwa Government hospitals same physician, urgency disappears.	7	
	Intervention	Educate members. Proper Remuneration for doctors. Will then find time to educate members, empower, reduce risk of contracting diseases, reduce progression of diseases.	8	
141022-003 Recorded 22.10.2014 At 3.24pm	Gate-Keeping	First port of call, Family doctor, primary healthcare, screening level, Preventive role, closer to the community – educate community to take preventative measures e.g. typhoid, malaria, cholera. Reduce visits to GPs and Specialists, save money. Strategically positioned. Prevent ailments from complicating before referral. Early referral – first time cases that present already in a complicated state.	3	

	Practice	Financial hardships. -Has to earn a living. -Avoiding preventive measures not attractive. Self-referral by patient. Referred patients never see the door or the GP again. Specialist keep the patient forever.		
	Cost Management	Group Practice. -Could split duties, community education specialised care, skills utilised to best advantage. -Go institutional. -Reduce operating costs-staff, offices, rentals, utilities. -Referral system broken. Self- referrals. -Inappropriate use of emergency rooms.	1,4 1,4 8	
	Information	Be prepared to spend 15minutes/patient to dig deeper into history, to explain condition, plan, instructions. Average ideal – 30 patients/day. Now – GPs open 2-4 hours/day and see 80-100 patients, chasing numbers, no history taking. No time for patients' history. Informed patient knowledgeable on what to do, follow instructions to the latter. Less patient mistakes, better health outcomes. Patients ask		

		nurses who were not in consultation room what to do. Insufficient doctor /patient time.	5	
	Models	**Paternalist** Doctor demi god 2nd one we are not yet there 2nd one, mutual, is ideal majority of the practitioners, no one should question their decisions. **Mutual** Few slightly shifting into second group (mutual) – there is ownership with direction -ownership of process. Best model ownership of treatment plan, chances of good outcomes very high. Third one – consumerist – disaster confrontational – no different from paternalism. Number of patients now in the consumerism. Patients learning rights without responsibilities. More asking to self-refer. One on first name basis with Specialists.	5 6	

	Unethical Conduct	**Fraud** Everybody rushing for that meagre dollar. One million of 13.15m covered by MA. Effectively, 400-500 covered financially. High unemployment. -MA card loaned to relatives. MAS can't tell whom card used on, assumed its member. -Some medical practitioners turn a blind eye, others don't know what's happening, others connive and encourage. -Inappropriate use of MA – unnecessary use of Emergency rooms – charge twice GP rate. -Medical check-up not a MA benefit – members circumventing that. Supermarket approach consultation, family accompanies one member, and all end up being attended to. - Specialist filling in the name of a GP that never saw patient to claim full specialist fee on claim forms for un-referred to patients. -Owning butcheries or bottle stores and asking patient short of money to sign claim form then get equivalent of meat or groceries.		
	Interventions	Group practice, invest in one building. Ownership of hospitals and clinics by MAS is members' choice. Custodians are not the member nor the funders. Doctors' argument against the clinics and hospitals hold no water.		

	Views of general practitioners			
Participant No	**Theme**	**Key words/Sentences**	**Page No**	**Remarks**
141023-001 Recorded 23.10.2015 at 10.20am	Gate-keeping	Work with public Health practitioners Preventive Care Patient education Patients present themselves late-,makes screening costly. Community awareness vital. Example – blood pressure which can lead to cardiac failure, congestive cardiac, renal failure, stroke. Refer, no matter how small – don't make mistakes.	1 4 1	
	Practice	Funders developed clinics. GP left with no MAS patients. Limited few cash patients. Funders don't appreciate nature of GP work. GP investigates several tests, patient present late with complications. Funders cry foul. Difficult for GP to		

		be gate keeper. Patient comes first, no costs, there is already a war – did not get money, patients not getting proper care MAS don't want patients to see GPs, costly.	2	
	Cost Management	GPs pushed out-no gate-keeping. Funders do everything from GP, specialist tests in-house. Referral system broken down. GPs don't have patients, no one to refer. Specialists accepting patients without referral. Funders controlling everything, gate-keeping ineffective.	3 4	
		GPs want money, extra cash they want to do everything in their private clinics. Don't refer. I refer because I worry too much. We don't know how much money is coming into MAS funds.	5 5 10	over referral
	Quality Outcomes	Good history, dig for information. Public awareness e.g. making a salt-sugar solution. Want to make patient happy. Inadequate treatment. Examine the patient, even in embarrassing areas.		
	Information	Patient should know what is going on doctors mismanaged me (lack of information). Lack of information – high default rate leads to complications (e.g. BP). Give treatment and disease causative information. Also information about life style.	6 6	Doctors problem , not mine

	Models	Paternalism – I think I tend to be more paternalist. Do so when I see if I don't, patient will harm himself. Need to ensure treatment taken. Mutual – where child or other people are involved – explain in detail to the escorts. Consumerism –I have come across it. Check information in books in front of patients. Others discourage it-they say patient would think you haven't gone to school. As female GP, sometimes you are taken for granted.	8 8	Need transparency, honesty
	Unethical Conduct	GPs are after the money. If medical funders let patient visit GPs, malpractice will stop. If I sit for 2-3 hours in a consultation room, I only see 3 patients from medical funders, but MAS clinics are full. GPs holding onto patients. If you are a young doctor with family, school-going children, you don't have patients, what do you do? Our representatives are conflicted – work for the funders. Conflict of interest no gate-keeping is possible at all.		
	Intervention	We don't need funders. Create our own fund. Get rid of the middle man- the funders subscriptions to funders be paid into our fund. It's our money. We then share at month-end. Funders are living good,		

		while doctors are poor. Money is meant for the patient paying doctor directly. Institutional set up wouldn't work. Our Culture. If I die, relatives will claim everything from the partnership inheritance.		
141022-002 Recorded 22.10.2014 At 11.11am	Gate-Keeping	GP does his best and refer with a letter. Starting post. Spend lot of time referring patients to specialists. Don't listen to all their problems – lot of that gone. Family relationship. Family Doctor. I don't attempt now to do surgery on a big scale like I used to. Minor injuries, surgeries, lacerations. Dr in command-decides who to refer.	3 1 2	
	Practice	Patients self-referring, Specialist accepting people off the street keep asking patient to come back unnecessarily, so can earn extra money. They reduce amount of treatment and do unnecessary work. No attempt at closeness. Most doctors not good business-wise.	2	

	Cost Management	Doctors holding on to patients. Too many reviews – keep asking patients to come back. Want extra money. Specialists accepting people from the street. Never even bother to write what they found or done. Hundreds of patients go direct to Specialists. GP to behave in an ethical manner. High rate of default even for tests. Economy problematic	2 3 2;5	
	Quality Outcomes	MAS insist system strictly adhered to. Letter to Specialist and letter from Specialist to GP. Patient comes to you – with knowledge gained from Specialist – able to treat yourself.		Knowledge sharing SP/GP. Better Management
	Information	I try and access patient's background, lives, education. Great difficulty getting hold of either her husband or next of kin. Not a question of giving her pills and a useless injection. It has to be explained to someone who speaks her language. Quantum of information relates to the classification – high levels of education – as equal, limited education and a poor background – just play by the rule. They expect it.	2	
	Models	Paternalist: Dr is the answer to their problems. Culture – because you are white doctor and elder man, you can cure them – by just coming into surgery and given injection.		

		Poor background, limited background – just tell them what I must do –they accept. Patients accept being pushed around. Mutual: has good background, has advantages of life and is intelligent – am open about it – discuss.	2	
	Unethical Conduct	Many MAS gone under. Cheating doctors, Specialists attend to hundreds of patients without referral letter. He will perform an abortion for a fair amount. Patient ends up with infection – done under probably not very a septic conditions. Doctors in a hurry. Just listen to a patient, hand back a form for tests that covers just about everything. The Specialists not referring patients back to GP. Corruption, economy problematic. Just being honest is the answer.	5	Patients
	Intervention	Use of technology – Organised and real-time records. Training in business management (e.g. MBA) "most doctors not very good businesswise".		
	Gate-keeping	First point of contact to. Attend to level of ability and experience. Fulfil needs of patient. Refer if ability and experience inadequate. Good ethics – manage		

141018-001 Recorded 18.10.2014 At 11.05am		cost. Willing to go that extra mile or kilometre. Carryout all the necessary investigative procedure, i.e. blood tests, ultrasound or X-rays, CT Scan for a small commission. Consider their (patients) resources. Managed care plus partnership between insurer and service providers. -family doctor concept.		
	Practice	Most Specialists opted out of medical aid –treat on cash basis. MAS are very arrogant. Don't communicate. Have given up. Not paying us adequately. Don't care about me, why should I care about them (MAS). MAS do not profile doctors. May hold onto patient – Dr has necessary skill but needs more information. Consultation gap between GP/Specialist too high $35 v $100 *(I don't believe my opinion is more important than that of a Specialist". Its dog eat dog situation*). Specialists greedy. Repeated reviews by Specialist, once patient referred, captured patient for good –get patient to keep coming back.	1 7 2	
	Quality outcomes	By Dr- education. Check for history – 80% history gives diagnosis. Ethics. Specialist writing back to GP on referred patients.	5	
	Information	As much as possible but not all. Consider ability to cope with information. Patients scared of doctor's		

		story. Disclose when certain of diagnosis. Pressure to use medication as weapons GP.	"5"	Paternalist not probing. Not communicating
	Models	Lot of them paternalistic because of our society with lower income. I get medicine, I get better. Lot of mutual particularly in the high income group. They also move to the consumerisms. "…she was dictating to me what she wanted, she had seen other doctors. Another lady brought in her daughter – she had seen 8 or 6 doctors in between…" Pyramid of care- Arrogant insurer, aggrieved provider. Default Model-cash patients; just want a fix and is gone, don't care about the consequences.	7	Consumerism. Dr hoping Short-changed consumer Worry more about cure/reduce expenses
	Unethical Conduct	Over servicing – multiple visits to charge extra tariffs. -Inventing charges – change tariff. Patient does not know. -Creating emergencies, being at surgery on Sunday.		

		-Use of emergency rooms for higher tariffs. Lack of practice insurance – cover not high enough. No impact on litigation or GP behaviour. Litigation is because of Dr arrogance. Don't admit mistakes.	8 9	
	Interventions	Doctor profitability. Adequate payment of Doctors.		
150313-001 Recorded 13.03.2015 at 8.07am	Gate – Keeping	Gate keeper, connection/ channel between community and specialists, provide continuity. Family doctor – good for planning for government. Ensure community member stay healthy (prevention), refer patient to specialist with letter. Family doctor/family health practitioner. Give preventive care.	2	
	Practice	No continuity – affect quality of care. People not encouraged to have one GP. People globe trot – bad for pocket and public health, can't get statistical trends. Patients just walk into specialists rooms and they get treatment. Referral system not working. Patient goes straight to specialist.		
	Cost Management	Streaming patients towards one family doctor. Patient education on benefits of one doctor. Globe-trotting affects spending, quality of care and effectiveness of treatment. Specialists charge specialist fees for walk-in clients. System does not check to see whether that		

		was a GP consultation or specialist consultation. System not working (referral). Where it's working – countries have technology. GP, specialist, Medical Aid – are all connected and all follow referral system. Regulations in place – GP, Patients and Specialist will never agree. Use incentives and punishments.		
	Quality of care	Streaming of patients. Patient education. One family doctor. Ensure continuity of care with one GP. Train doctors in public health at Masters level, will understand more objectives of medical aid societies, expectations of clients, GP role, specialist role and policy maker's role. Joint practice, two or more – share skills, information, time and responsibilities.		
	Information	Depends with patient(s). Some are in a hurry. Want to be out of your office in two minutes. Others want to know everything – will need 2 consultation – initial + 2 or 3 reviews but MAS will only pay initial + 1 review – not fair- GP would have worked. MAS don't inform members on limits for GP/year and reviews/year. MAS not telling members the truth on signing up on benefits limits and when they go on cash basis after exhausting limits. Tell patient diagnosis and always	6	Default Long history

		technical name of disease. If patients sees another doctor, he will know where to start. 3 If experienced – information dissemination, can disseminate concisely within a short period. Information impacts positively on life style and quality outcomes.	6	Inexperienced have more wants/needs. Pressure to see more patients
	Models	Paternalist and default as major two. In the rural areas – mainly paternalist and a few sports here and there in towns. Depends on the location of the health care facility. Default – in towns – patients and doctors don't care, got different agendas, just going their separate ways.		70% adults live in the rural areas
	Unethical Conduct	Various classification – way you treat patient; wrong diagnosis; wrong treatment; influencing their decisions; in manner medication is prescribed; in the management of complications; being rude & not offering patients opportunity to ask questions. Should be a proper module on ethics training. Need module on public health, ethics and business management because private practice is a business. Specialist holding on to patients. Specialist not sending letter to GP after seeing the GP's patient, majority do not. Over treatment, bad things happening –can be overcome by training. Not much conflict of interest in business investment. For pharmacy shareholding, regulation says 51% be held by pharmacists, experts in the field. Should also apply to healthcare facilities. It enhances management	8 8	Intervention Lack of knowledge

		by people with interest in the profession. Not sure if malpractice insurance is mandatory. Not much litigation going. Doctors don't think it's important.		
	Intervention	Modernise training curriculum to embrace technology e.g. telemedicine, e-medicine. Regulations on healthcare institutions on majority ownership by medical practitioners little or non-medical. Set undesirable protocols for young doctors – everyone who comes must get an injection, expensive antibiotic, treat and observe for at least 3 hours. They don't have medical ethics, want profit.	10	
		Address gap between GP fee and Specialist fee. GP used to be 70% of specialist fee. MAS to pay for annual wellness check-up – enhances preventive care. Allow GP who start practice to first join another practice – start with one or two others not alone – share information, experience, responsibilities and financial information. Use of technology – connect to GP, Specialist and MAS. Whatever will be happening there will be known.	10	Dr and Disease profiting

Views of specialists

Participant No	Themes	Keywords/phrases	Page No	Remarks
150312-001 (Semi-retired specialist) **Recorded** **12.03.2015** **At 11.57am**	**Gatekeeping**	Managing simple conditions, know their limits (screening), advocacy for prevention e.g. immunisation, primary care physicians, keep up with latest knowledge in primary care, Follow WHO guidelines on primary healthcare.	1	
	Practice	No adequate training for general practice. No adequate training for primary care programmes in the country. They hold onto patients. No hard and fast rule on what GPS can do, depends with experience and interest e.g. physical medicine, surgical, paediatric, obstetrics or gynaecology. If GP gets experience in his area of interest, may never refer but tariff paid is lower.	2	Intervention
	Cost Management	Better for some patients to use clinics	3	
	Quality of Care	Education of doctor (GPs). Patient screening-prioritise the patients, go out there and see who is critically ill (patient management).	3	
	Information	Information on diagnosis, treatment, drug and outcomes. We don't relate to patient any more. Info provides confidence. People scared to ask the doctor any questions, they are scared of nurses, scared to tell even if things going wrong.	3-4	
	Models	Paternalist – I will assume the no 1 said even in era of internet and Google.	4	

	Unethical conducts	There are a lot of unethical conducts brought to the medical council but those reported to Medical Council are tip of the iceberg-the very bad ones. No ethical and professional training and discipline during houseman-ship. Discipline levels not monitored – GPs on houseman-ship, a real racket. GP sees the patient in the morning, the GP would call same patient in the evening for results which could be given over the phone.	4 4	
	Interventions	Training of GPs – on GP practice after houseman-ship	1-2	

Participant No	**Themes**	**Keywords/Phrases**	**Page No**	**Remarks**
150312-002	**Gate keeping**	Minimise health costs, minimise patient's problems, diseases. First protocol. MAS expect to save money at GP level, their saving point. MAS expect GPs to charge as little as possible	1 4 3	Prevention

		MAS expect GPs to hold onto patients as much as possible. Refer early to Specialist when patient not improving, refer all patients that need Specialist investigation	1	
	Practice	MAS (especially big ones) do not pay doctors (GPs, Physicians) adequately. Doctor patient ratio not right. System of referral broken down. Most physicians don't take medical aid, want cash. Patients present to GP very late with complications. First go to Prophets and Sangomas where service is free or pay in kind.GP on presenting order more tests, want to take advantage of large numbers to get little cash. Patients refuse to go back to GP, can't trust after prolonged illness. Prefer to pay Specialist cash since MA wont refund. Even if told, now well, still come with new disease. Specialist not sending patients back to GPs. Specialist not writing back to GPs – would help GPs to be better gatekeepers. GP blamed for everything. Cash patients seen with no referral letters.	1,3 4 2 2	GP the poor cousin Then can't refer to anyone
			1	

	Cost management	Economy bad. Doctors want to see many numbers for small amount to survive, diagnosis missed – doctor in a hurry to clear the queue. Doctor scared to lose patients already there in the line. Patients hop to other practitioners because of missed diagnosis, becomes expensive. Patient paying specialist for GP work – refuse to go back to GP and present new disease, just to remain there. Patients hanging in to GPs – not wanting to be referred – comfortable with their GP. Patients hanging on to GPs because can't afford specialist fees. GPs hanging into patients because they think doing ok. Specialist hanging onto GP patients, so GPS hang onto theirs. If you go around physicians places, they are full.	2 4 5	Direct competition Pyramid distorted
Participant No.	**Themes**	**Keywords/Phrases**	**Page No**	**Remarks**
150312-002 **Cont.**	**Quality outcomes**	Specialist writing back to GPs on referred patients. GP education on GP practice, relationship management and new practices and refresher courses. Patient feed backs, learn from each other.	5	Regulation

		Self-introspections of the doctors – MDPCs. There must be some enforcement. Inspection of GP practice on staffing– is there a nurse to take BP, temperature? Examine patients. Dig into history.	8	
	Information	Everything about themselves – tests results, disease profile, diagnosis. Have time to do counselling, hiding information make patients not to trust doctor. If you give piece of paper to Specialist without telling patient diagnosis on it, and patient told GP knew – he loses trust in the doctor. Informed patient accept condition; comply with treatment plan and medication; psychologically settles down; default rate reduces. If not informed, they see prophets who tell them about evil-spirits. Patient also think doctor afraid of evil spirit that's why piece of paper to Specialist – won't take medication seriously. Spare enough time to educate patients about diet, lifestyle and preventive care. Needs right doctor/patient ratio.	5 6	Patient refuses to go back to GP
	Models	Mutual is good-foster communication. Consumerism – they jump from one doctor to another You must listen to each other – mutual communication.		Couldn't be drawn- doctor mutual

		Dig into history – mutual. Default doesn't exist. Elderly people not happy if not given injection. Examine patient.		
	Unethical conduct	Have heard of a doctor owning a butchery & surgery, maybe make patient sign claim & give meat. Doctor owns laboratory or pharmacy or dispensary – tend to over prescribe a drug. Financial situation of our economy – cost of living high. If MAS were really paying them on time, these things wouldn't be happening. Practice insurance – not many have. Doctors have no money to take out insurance. Patients have no money to sue the doctor. Doctors mistrust insurance companies after previous losses in the past.		
Participant No.	**Themes**	**Keywords/Phrases**	**Page No**	**Remarks**
150312-002 **Cont.**	**Interventions**	MAS should pay GPs adequately. Recognise GPs – allocate to a community/suburb e.g. Sunningdale – will have adequate patients. Educate patients on life style, preventive care.		

		Have GPs-MAS truce and a big Indaba all GPs all MAS and patient reps. Discuss GP expectations from MAS & patients; MAS expectations from patient and doctors. Patients tend to blame doctors. MAS to educate patients about expectations – must have their own on-call doctors to help advise patients. MAS must have workshops to train doctors about MAS expectations – sometimes its ignorance.		
150313-002 **Recorded** **13.03.2015** **At 2.00pm**	**Gatekeeping**	Frontier for care of patients. Managing patients to their ability – are the first house. Knowing when to treat when to refer, able to treat certain things if they have had the extra training. e.g. can operate f they have been operating in a district hospital. Sometimes – deal with whatever comes, no law against, you are trained, got the knowledge. Medical field self-run. Without GPs, system would collapse. Specialists would be forced to see more patients than we would able to see. Screening process. Decide on urgency. Refer when in need of hospitalisation. Refer when uncomfortable, feels can get better care elsewhere.	1 4	Surgery experience Regulation weak
	Practice	GPs don't keep patients and save money. They phone us to do all sorts of things.		Are employed

		GPs in private practice employed by MAS don't keep patients – are quick to refer. Doctors attend continuing medical education (CME) to earn points. MAS want to make money. Have taken all the patients. See the bulk of the patients we should be benefiting from. We have to compete with them. They have no co-payments. Doctors running clinics and little hospitals – employing unqualified people – nurse aids – lower standards, compromise care. Pharmacies are well regulated. No conflict of interest. Medicine Control Authority (MCAZ) inspect doctors in remote areas dispense because no pharmacies but MCAZ inspects. Its strict if patient thinks not benefiting, asks to be referred, he will most likely let go.	2 3 4	Attract cash strapped patients
	Cost management	Early referral, Effective screening. Specialist cost twice as much as GP. Seeing GP & Specialist is seeing two doctors – costly. GPs must have diagnostic machines to prevent expenditure on laboratory tests e.g. blood prick method can cost $1 or $2 instead of $10 to $15 at laboratory.	4 12	Large gap
Participant No.	**Themes**	**Keywords/Phrases**	**Page No**	**Remarks**

150313-002 **Cont.**	**Quality outcomes**	Early treatment; early referral – will reduce need for expensive tests. Quick turnaround in laboratory tests. Don't keep holding into patients. Adequate information to patients – on diagnosis, medication, outcome. Some patients default because of cost. Don't disclose their inability, don't come back for operation. Some default because of side effects. Losing trained doctors.	4 7	
	Information	Up to doctor – his training & experience. GP must ask the right questions – where have you been, what have you done, quarrel or fights. Information needed – to cooperate. Information on diagnoses, medication, drug-side effects. It breeds confidence – doesn't fear. Most give the most brief talk, depends with experience. I can do in sentences. Give adequate information on treatment plan.	6	History
	Models	Depends with patient –Patients are different, with little knowledge – paternalistic. Some discussion around costs, treatment plan in a mutual way take place.	7	

		-But mutual shows too lax, you appear rather not sure of yourself, patient may default. Default rare except for mentally deranged patients.		Prefer paternalist
	Unethical behaviour	More like exceptions, one or two, in the minority. -Insulting a patient. -Sometimes reported in H-Metro, good thing training on ethics and CMEs. Specialist don't write back to GPs because – referral letter has no full name of doctor. -GPs don't have the technology for emails. -Post office now unreliable. -Patients don't deliver issued letters. -Will write if I have not many patients to see. I try to phone. It's a sore point. Practice insurance is not mandatory. Available cover is inadequate, it's ineffective. People sue because of worry and for losing a loved one, not because of doctor negligence, it's more of emotional reaction.	8 9 10	Deterrent preventive It's happening
	Intervention	Training – certification of GP practice training. GPs need other diagnostic gadgets not just BP machines. Provider split – MAS should not build clinics, hospitals, it's conflict of interest.		

Participant No.	Themes	Keywords/Phrases	Page No	Remarks
150313-003 **Recorded** **13.03.2015** **At 3.33pm**	**Gatekeeping**	Manage the majority of patients. Monitor patients after being attend to by Specialists. Works well in the public sector-patients see a GP before referral. MAS expect GPs to see everybody. Refer all severe cases; refer for all hospital admissions. Handle mild and acute cases. Monitor development of children & health of pregnant women.	1 4	
	Practice	Patients self-referring to cut costs can't pay 2 doctors, GP and Specialist. Gatekeeping in private sector affected by ethics and commerce. Hold on to patient for better follow up. Hold on to patient to make more money. Referral system. Patients on OOP and with MAS that has patient paying shortfalls self-refer to Specialists. "You tend to do short cuts because of the economy."	2 3 4	

		Come back for injections at my clinic (GP) – bit unethical. Rely on personal values to refer properly.	5	
	Cost management	Because of the economy – most Specialists employed both in public & private sector. -Actual income comes from the private sector. Not all Specialist willing to let go of their patients. Some MAS limit number of times patient visit Specialist – 9 to Specialist/year and 4 to emergency room. No limit to GP except for chronic conditions. Unnecessary long investigations by GPs. Patient came with funny skin rush and they were treated by 6 people in 5 months.	3	
	Quality Outcomes	Auditing. Private sector is self –run. I wouldn't say there is a proper monitoring of what's going on Continued education – a must to get 50 points to get practicing certificate renewed. Increase points to 100.		Regulation & Monitoring
	Quality Outcome	Enhanced doctor education/upgrading. Check history and do full physical exam to obtain complete diagnosis.	6	

			7	
Participant No.	**Themes**	**Keywords/Phrases**	**Page No**	**Remarks**
150313-003 **Cont.**	**Information**	As much as you can empower patient. Depends on: social background, religious background, age, education level, belief system, their support system, availability of cure-flue-no problem; if chronic liver disease – have to think about it. Patient in denial –needs more counselling. Potential impact of information – depression & suicidal, likely to accelerate disease progression. Race – not same talking to African as opposed to other races. Africans – witchcraft belief even if educated. Manage information to prevent damage. An adolescent who has not been told HIV positive don't adhere, as opposed to one who's been told – adhere. Use simple explanation – no jargon. Help manage conditions better, better outcomes.	5 6	

		Repeat same information several times. -Impact on good health seeking behaviour, good hygiene, good diet. Some see 20 to 30 patients, some 80. Booking system not monitored. Should see patient 15 to 20 minutes. Clearing the bench more important. Doctors don't like to be asked questions.	7 12	
	Models	All 4 models exist Depends on doctor, location of practice and source of clients & attitudes of clients e.g. Kuwadzana clinic – low socio economic background patients intimidated; don't ask questions; almost like you are God; whatever you say they will do; very loyal; once they like you, keep coming back. Think just seeing you get better. If you are substitute doctor – don't want conversation, just prescription & go. Modern couple – get most of clients from Northern suburb read a bit, well informed, internet; shop around for doctors. Trust you if what they read agrees with your diagnosis. Majority of my clients come as a couple. Give them assignments to read about child conditions. We discuss. 60 to 70% are mutual; 20% paternalistic.	8	

		10 to 15% will be the other two. Had a father twice walking in and telling me want an antibiotic because paying, don't respect your decision. Feel offended, never come back	9	Consumerism
	Unethical	Economy really ruined people's ethics. GPs doing Specialist work not equipped to do. Holding on to patients they should have referred e.g. nebulising patient in your rooms without oxygen. GPs run clinics; prescribe industrial products not specified by WHO for child nutrition. When they exhaust their medical aid – you refuse to see, them – you refer them to your hospital. You see a patient 5, 6, 7 days, medical aid runs out – can't see them for last 2 days? Moral & ethical issue. Treating emergencies without right equipment. We haven't made right diagnosis but patient looks healthy, we continue investigations for 3-7 months. One referral to specialist would have solved problem. Practice insurance mandatory for specialists, don't know about GP. I also refer quickly to another specialist for fear of being sued. But would continue to treat and investigate if at a public hospital.	11	

		Doctors get sued because we don't give right information. Tests are expensive – CT scan US$500; MR US$1000, we don't explain it is an investigation not cure. Will hospitalise in case something happens at home.		What they do in private & public hospital Fear …..
	Intervention	Doctor continuous medical education (CMES) (giving treatment from 1976 book when even literature says doesn't work anymore). Patient education on lifestyle. More GP mentoring by specialists at Tuesday meetings. Culture change on Doctor/patient relationship. Specialised General Practice training. -enforce booking system.	2 3	