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Ethical issues identified by General Practitioners in private practice in the Johannesburg area as challenges to the successful implementation of the proposed National Health Insurance: Ethical issues identified by medical doctors in private practice in Johannesburg as challenges to the successful implementation of the proposed National Health Insurance

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Ethical issues identified by General Practitioners in private practice in the Johannesburg area as challenges to the successful implementation of the proposed National Health Insurance

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Andrew Jacovides

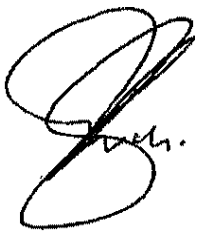
A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Medicine in the field of Bioethics and Health Law.

Johannesburg

June 2017

DECLARATION

I, Andrew Jacovides, declare that this research report is my own work and is being submitted for the degree of Master of Science in Medicine in the field of Bioethics and Health Law to the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university or institution.

Signature: 

Date: 01 June 2017

Student number: 7900983

Ethical clearance number: M140825

DEDICATION

This research report is dedicated to Tracy, my wife, who encouraged me to do the degree and who never stopped making me believe that I could do it despite my time constraints, being self-employed in my own busy private practise.

Thank you for never allowing me to give up and of losing hope. I love you

ABSTRACT

Introduction

National Health Insurance (NHI) has been proposed in South Africa to ensure that everyone has access to appropriate, efficient and quality health services. Involving the private healthcare sector is essential for this to occur because of its resources. Significant changes to the private healthcare structure are anticipated for its incorporation into the NHI plan. This study examines the perceptions of General Practitioners (GPs) from the private sector in the Johannesburg area on the NHI. It examines the challenges they foresee that will impact on their willingness to participate in the NHI and how these might manifest as ethical concerns. These findings will yield effective ways these concerns are addressed with regard to their acceptance of the NHI and any ethical issues they may have regarding the effective delivery thereof.

Study design

The study took the form of an exploratory-descriptive empirical method using semi-structured interviews.

Method

The qualitative data was analysed using thematic content analyses.

Results

The general perception of the NHI by the General Practitioners was negative. The NHI was perceived by the doctors in this study to be an extension of the current public health sector. The current perception of the public health sector is one of inferior care; an over worked and understaffed facility; a poorly maintained system with inadequate supervision; and one that is rampant with corruption.

The key ethical concerns arising from this study is the quality of care for the patients, basic working conditions in government facilities; corruption in, and a general mistrust of the government. Concerns were raised about quality of patient care in the public sector and the possibility of "downgrading" private health care. These factors impose on the patients' right to dignity, equality and freedom as poor quality of health care infringes these rights.

Conclusion and recommendations

To gain "buy-in" from GPs, the establishment of trust, improved communication and an end to mismanagement and corruption are essential for the NHI to be successfully implemented.

Acknowledgements

I am most appreciative to the participants, the General Practitioners, who contributed mostly to this study. Thank you for your time and willingness to be interviewed and to share your knowledge and experiences of your practise of medicine with me. I have learnt a lot from your honesty and frankness and trust that the time and effort you put into this study will result in a national health service that will benefit both health care providers and health care users in a mutually beneficial way.

A special thank you goes to my research supervisors, Louise Bezuidenhout and Jillian Gardner, for their support, guidance and assistance towards this study.

Table of contents **Page number**

Declaration ii

Dedication iii

Abstract iv

Acknowledgements vi

Table of contents vii

List of tables x

Abbreviations xi

Chapter 1: Introduction and Literature review 1

1.1 Introduction and Background to the research question 1

1.2 Literature review 3

1.3 Background to the NHI proposal 9

1.4 Rationale 13

1.5 Aim 14

1.6 Objectives 14

Chapter 2: Materials and methods 16

2.1 Introduction 16

2.2 Research methodology 16

2.2.1 Introduction 16

2.2.2 Research design 17

2.2.3 Participants 18

2.2.4 Inclusion criteria 20

2.3 Data collection 20

2.3.1 Tools 20

2.3.2 Pilot 20

2.3.3. Data collection 21

2.3.4 Research ethics 22

2.3.5 Data Analysis 23

Chapter 3: Results 25

3.1 Demographic analysis 25

3.2 General overview 25

3.3 Major themes 29

3.3 1 Quality of patient care 29

3.3.2 Working conditions in public hospitals 35

3.3.3 Concerns with implementation and roll out of the NHI 39

3.3.4 Corruption and management issues of public hospitals 42

3.3.5 Remuneration concerns 45

3.3.6 Dialogue and autonomy of GPs 47

Chapter 4: Discussion 51

4.1 Limitations of study 62

Chapter 5: Conclusion and recommendations 63

References 66

Appendix 1 – Participant Information Sheet 70

Appendix 2 – Consent form 73

Appendix 3 – Participant Interview Schedule 75

Appendix 4 – Data Collection Sheet 76

Appendix 5 – Ethics Clearance Certificate 80

List of tables

Table 1: Summary of major themes 26

Table 2: Summary of subthemes of major theme 1 29

Table 3: Summary of subthemes of major theme 2 35

Table 4: Summary of subthemes of major theme 3 39

Table 5: Summary of subthemes of major theme 4 42

Table 6: Summary of subthemes of major theme 5 45

Table 7: Summary of subthemes of major theme 6 47

Abbreviations

ANC - African National Congress

DoH - Department of Health

GP - General Practitioner

HPCSA - Health Professions Council of South Africa

NDP - National Development Plan

NHI - National Health Insurance

OHSC - Office of the Health Standards Compliance

PPS - Professional Provident Society

SA -South Africa

SAMA - South African Medical Association

SAPPF - South African Private Practitioners Forum

WHO -World Health Organization

CHAPTER 1: Introduction and Literature review

1.1 Introduction and Background to the research question

Prior to 1994 South Africa's health system was fragmented and designed along racial lines. In this system the highly resourced sector benefited the white minority while the under-resourced sector serviced the black majority. Post 1994 attempts to transform the healthcare system failed in terms of universal health care, resulting in a two-tiered health system, public and private. This system is based on socioeconomic status and continues to perpetuate inequalities where the privileged minority still benefit from a better resourced sector while the poor majority do not.

The perpetuation of such a system is seen by many to be in direct contradiction to the South African Constitution (Constitution, 1996). The Constitution opposes any form of racial discrimination and guarantees the principles of socioeconomic rights which include the right to health.

According to the Constitution of South Africa (Act 108 of 1996) the Government has an obligation to protect the life of every person in South Africa. (Constitution, 1996).[1] Every person has the right to dignity, equality and freedom as well as access to health care (Constitution, 1996, pp.Chapter 2 ,Bill of Rights, Paragraph 7 (1)). Further, Section 27 (3) of the Constitution determines that emergency medical treatment may not be refused in either the private or public sector.

A National Health Insurance (NHI) was proposed by the South African government and first released for public comment in August, 2012 (NHI, 2011). The NHI was to be a solution to address this inequality while at the same time preserving and protecting patients' rights. NHI implementation is in line with the Constitutional commitment for the state *"to take*

[1] www.justice.gov.za/legislation/constitution/SAConstitution-web-eng-0.pdf

reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to have access to health care services" (NHI, 2011).

In 2012 the government took the decision to phase in an NHI over a period of 14 years. This will entail major changes in the service delivery structures, administrative and management systems. One of the key interventions required to successfully implement the NHI is underpinned by a re-engineered Primary Health Care. This requires the services of General Practitioners (GPs) including those from the private sector.

The first stage of NHI rollout was the 2012 establishment of pilot sites in various health districts in South Africa. The initiative met with unprecedented challenges and the result was not the hoped for outcome. The reasons for this setback were investigated. A review of the literature on the status of the NHI pilot programme suggests an overwhelming lack of interest by private sector GPs to participate in these pilot sites. The reasons cited ranged from issues of remuneration to that of uncertainty and mistrust of the whole plan. The discrepancies in standards between the two sectors was thought to be at the heart of this problem, particularly as GPs who currently work in private practices need to convert and adapt their practice methods to that of the public sector.

Nonetheless, reducing the examination of this problem to a discussion on remuneration is also potentially misleading. The differences in working conditions between the public and private health sector may also give rise to legitimate ethical concerns. Indeed, the potential compromises in the standard of patient care arising from public sector resource limitations could be highly influential in influencing the doctors' decisions for their reluctance to participate in the NHI. These possible ethical concerns, however, have not been well examined, a caveat that this study aims to address.

Consequentially, this study offers an empirical examination of the ethical issues or dilemmas that private GPs may have working in the NHI model.

1.2 Literature review

A relationship of mutual trust between patients and their health care practitioner is the essence of the practise of medicine (HPCSA, 2013). Pellegrino (2000) further defines "profession", "as *"a dedication, promise or commitment publicly made"* (Pellegrino, 2000).*To be a health care practitioner requires a life-long commitment to sound professional and ethical practices as well as an overriding dedication to the interests of one's fellow human beings and society"* (HPCSA, 2013, p.i). Every newly qualified doctor entering the profession should aspire to these principles in the interest of patient care. In doing so, the doctor is able to practise from a foundation that allows him/her to act in the best interest of the patient.

In the current healthcare economy equal access to equitable medical diagnosis, management and treatment is denied to many South Africans. In an article on the challenges of health disparities in South Africa, the author states, "Despite certain areas of progress in the country since 1994, disparities in wealth and health are among the widest in the world" (Benatar, 2013). While the NHI has been in the pipeline for many years the rollout has been delayed since the Green Paper[2] was published in 2011 (NHI, 2011).

[2] The process of making a law begins with a discussion document (Green Paper). This is then drafted in the Ministry dealing with the particular issue. It is then published so that interested parties can give comments. The Green Paper is followed by a more refined discussion document (White Paper) which is a broad statement of government policy. This is drafted by a task team designated by the Minister of that department. Comment may again be invited from interested parties. The relevant parliamentary Committees may propose amendments or other proposals and then send the policy paper back to the Ministry for further discussion and final decisions. (Parliamentary Monitoring Group, 2017)

The NHI is a health delivery system that is structured in a way that its financial resources are pooled so that access to quality and affordable health services to all South Africans regardless of their socioeconomic status can be provided. It will ensure that the use of health services does not incur financial hardships for individuals and their families. NHI represents a significant change in policy that will result in a restructuring of the current health care system, both public and private. It is mandated from the National Development Plan (NDP) of the country.

The White Paper (NHI, 2015) was only published in December, 2015, in excess of 4 years from when the Green Paper was released. The White Paper would clarify issues of concern identified in the Green Paper. The South African Private Practitioners Forum (SAPPF) submitted a detailed response on the Green Paper on National Health Insurance and raised many issues and concerns relating to its implementation, hoping these would be resolved in the White Paper.

> *"It is important to note, at the outset, that a great deal of necessary detail is absent from the Green Paper. This absence of detail limits our ability to comment substantively on the proposals contained in the Green Paper, as well as to provide relevant and detailed commentary in this public process. The nature of the omitted detail is critical to a comprehensive understanding of the Minister of Health's intentions, and is necessary for a proper understanding of the NHI model envisaged for South Africa. Importantly, the Green Paper identifies several weaknesses in both the public and private health care systems, yet provides little (if any) substantive detail on how these weaknesses will be addressed under NHI. For example, the Green Paper recognises that management failings are a weakness within the public sector but does not explain how NHI aims to address this fundamental issue*."

It concludes its submission and states this as one of its main conclusions:

> *SAPPF is fully committed to working with all stakeholders to broaden access to health services as a vital and progressive step towards the ultimate goal of improved universal access (both through enhancing the private sector and in undertaking the most pressing task of rehabilitating the public sector*. (South African Private Practitioners Forum, 2011)

The process for the implementation of the NHI has been vague and uncertain because it is not well detailed in either of the Green or White Paper with respect to the appropriation of medical doctors working in the private sector. The detailed submission and recommendations by the SAPPF remain unanswered and these issues remain as such. The White Paper has been described as disappointing given that it took four years to produce. It outlines ambitious plans to implement the NHI but it offers no meaningful new data on what this will cost, how it will be paid for and by whom, nor is it specific on the details of the health care services that will be provided, the future of private medical schemes nor the role of the private health care sector including that of General Practitioners. (BDLive, 2015)[3]

Private sector GPs, whose services are required to improve the provision of health services at public facilities, have become a major hindrance for Health Minister Aaron Motsoaledi as these GPs do not want to work in government clinics (Kahn, 2015). No more than 200 of the 8,000 GPs working in the private sector have signed up to work in public clinics since the NHI pilot programme was launched in 11 of SA's 53 health districts in April 2012.This is despite a national campaign by Motsoaledi to encourage GPs to participate in the project (Kahn, 2015). The NHI is being tested with a number of pilot sites each in different health districts in the country but has proved unsuccessful thus far. Posts were made available to GPs to work in these pilot clinics to provide services emulating the NHI scenario but there

[3] At the time that the interviews were conducted in this study the White Paper was not yet published

was less than expected interest from private GPs (Kahn, 2014 (b)). Poor conditions in some NHI pilot districts have been reported as being the cause GPs do not want to consider working in public health (Mkhwanazi, 2015)**.** In 2015**,** four years after the launch of the NHI pilots programme, only 253 GPs had been employed by the Department of Health to work part-time in the clinics. "Long working hours, equipment failure and lack of leadership are some of the reasons doctors are finding it hard to stay" (Mkhwanazi, 2015)**.**

Dr Motsoaledi concedes that, "conditions in many public-sector clinics are far from ideal and that was also a deterrent for doctors accustomed to being self-employed, controlling their own working environment with well-maintained equipment as opposed to a dysfunctional public health system" (Kahn, 2014 (b)).

The Health Minister defends the government's inability to attract private doctors to work at clinics in NHI pilot districts as, "greed is standing in the way" (Kahn, 2014 (b)). However, such rhetoric is not productive for the successful implemetation of the NHI. Instead of looking for solutions to integrate private and public health sectors in order to enable the NHI to be successfully executed the Health Minister, Aaron Motsoaledi, uses statements like "the White Paper document calls for a complete reform of the health system, how services are to be provided and how doctors and hospitals are paid. He further states that health must not be treated as a commodity but as a social good" (Child, 2015).

The reasons for failure to attract GPs should be ascertained with precision and professionalism rather than to arbitrarily criticize and to judge the doctors for their unwillingness to participate in these pilot districts. There are fears by private practice doctors that their income may be compromised and their basic rights to where and how they work within the framework of the governing bodies' rules of practice guidelines may be impaired (Momentum Health, 2013). There is also mistrust on the reform process as evidenced by

some documents produced by the African National Congress task team on health reform that were not published for discussion and debate by the stakeholders.

This created doubt and speculation that there is a hidden agenda in the process (Ramjee & McLeod, 2010). Nonetheless, few initiatives have explicitly engaged the private sector in discussions about the NHI roll-out. Nor have empirical studies closely investigated concerns within this field.

In defence of the private sector, the South African Medical Association (SAMA), which is South Africa's biggest doctors' union, claims that, *"there hasn't been proper consultation with doctors,"* on the issue of economics of the private sector. They also claim that other issues other than monetary are also important. The average age of doctors in private practice is 58 and at this age doctors are not willing to be subservient in these clinics to the people managing these clinics (Kahn, 2014 (b)).

SAMA reiterates that,

> *"it is willing to contribute towards making NHI a success but only if its members (who comprise both private and public sector doctors) are recognized as the foundation of the healthcare system; treated as equal partners in the planning process and remunerated commensurate to the doctors level of expertise"* (Momentum Health, 2013).

In response to an open letter written by Dr Chris Archer, chief executive of the South African Private Practitioners Forum (SAPPF), where he claims that the Minister of Health is, "painting a picture and creating an aura of hope that simply cannot be – unless that is, one ignores and disregards the realities of South Africa's budgetary and human resource restraints", that "everything proposed in the NHI is impossible," and "that the minister has a

war to wage against the private healthcare sector," the Minister (Motsoaledi) says that "Archer is simply ignorant", "quotes figures that omits crucial information", and that he (the Minister) has the "right to wage war against exorbitant fees in the healthcare sector". (Motsoaledi, 2014)

Further the Minister says that he has "consistently emphasised that the heartbeat of the NHI system is going to be primary healthcare" based on the principles of the Alma Ata Declaration[4] adopted by the World Health Organization in 1978 which states "Health is not just the absence of disease, but it is a state of good physical, mental and social wellbeing" (Hixon & Maskarinec, 2008). "The NHI is not going to be just about isolated service packages" that Archer accuses the minister of but rather, "a total overhaul of the entire healthcare system – one that will be an "equaliser between the rich and the poor" (Motsoaledi, 2014).

This study determines to explore the reasons for the failure of GPs to subscribe to the NHI, especially where primary healthcare is not accessible to all South Africans.

A possible solution to the unconstitutional and unequitable delivery of healthcare in South Africa is being proposed – honouring all right, moral and ethical codes - yet there is a sense of unwillingness to participate in the NHI on the part of doctors in the private sector. There appears to be disharmony and a lack of dialogue between the government and the private sector GPs on the issue. The reasons for this disharmony need to be identified and addressed to enable a positive outcome.

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[4] "*The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. The following is as excerpt from the Declaration"*: (Alma-Ata, 1978).
"The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".

1.3 Background to the NHI proposal

The South African government intends implementing the NHI to ensure equality of health care delivery in South Africa.

The NHI is essentially a unified health system that will provide universal health coverage[5] to everyone residing in South Africa. This would mean that people or patients from the current polarised and unequal health system, the 'public sector' and the 'private sector', will have their health care needs provided for by one universal health care delivery system, the NHI, which is currently under debate.

The objectives of the NHI are:

> *"• To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not*
>
> *• To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund*
>
> *• To procure services on behalf of the entire population and efficiently mobilize and control key financial resources*
>
> *• To strengthen the under-resourced and strained public sector so as to improve health systems performance"* (NHI, 2011)

Nonetheless, it was recognized that in order to successfully transform the current two-tier

[5] *"Universal Coverage – The progressive development of the health system, including its financing mechanisms, into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships linked to accessing these health services. This does not imply that the State must provide everything and anything to the population. Instead, it implies that everyone must be given an equitable and timely opportunity to access needed health services, which must include an appropriate mix of promotion, prevention, curative and rehabilitation care. The World Health Organisation defines a universal health system as one that provides all citizens with adequate health care at an affordable cost"* (WHO, 2013).

health care system in South Africa and to produce an NHI healthcare financial model that covers the whole population, four interventions need to happen concurrently. These interventions are: "*A complete transformation of healthcare service provision and delivery; the total overhaul of the entire healthcare system; the radical change of administration and management; the provision of a comprehensive package of care, underpinned by a re-engineered Primary Health Care*" (NHI, 2011, p.23).

It is proposed that in the future, *"health services will be purchased from accredited public and private providers of services. In the short term, the scope and quality of public services must be improved, with private services contracted where they add value"* (Matsoso & Fryatt, 2013). This means that all medical doctors, those working in the state sector and those self-employed in the private sector, will potentially work for the NHI. They will more than likely still be able to work in the 'private sector', albeit limited (Ramjee & McLeod, 2010). Thus, the current landscape of practice for many private medical doctors will change resulting in unpredictable and potentially unfavourable consequences such as in individual right to self-determination and earning potential.

Four years into implementing pilots sites for the NHI (in 2015), *"the Department of Health (DoH) has failed to persuade significant numbers of private sector GPs to work in its facilities, raising doubts about its feasibility"* (Kahn, 2015 b). Accordingly, it appears that medical doctors working in the private sector are resistant to participate in the NHI. Whether this reluctance is based pragmatically on fears relating to effective implementation or philosophically based on the ethos what the NHI represents remains unclear. Indeed, a national survey in 1999 found that a large majority of General Practitioners would favour an NHI if they were able to maintain their independent status and autonomy (Blecher, 1999). Thus, medical doctors constitute powerful stakeholders whose opinions should be considered in restructuring processes within the health sector (Blecher, 1999).

Despite considerable governmental enthusiasm for the NHI model, questions also arise concerning the financial feasibility of the NHI. The proposed NHI is still being debated by the stakeholders and, although pilot sites are underway, there remains uncertainty as to how and when exactly the NHI will be implemented and how it will impact on GPs' practises in the private sector. Issues being debated are, again, financial; the goals of reform to the NHI and the process that this reform will take (Ramjee & McLeod, 2010).

The minister of health admits that the issue of healthcare financing is a serious one and one that creates the most conflict with people who feel that the NHI can't happen because it will "collapse the economy" (Kahn, 2014 (b)). A further remark by the minister at a summit on healthcare innovation in Cape Town is, *"that the two biggest obstacles to overcome in providing universal healthcare were the poor quality of care in the public sector and the soaring costs in the private sector"* (Kahn, 2014 (b)).

In contrast, the private healthcare sector in South Africa is widely recognized to be well-resourced and of the highest quality. In addition, there is little communication between the public and private healthcare sectors. Thus, how these two sectors would integrate in the face of the problems described above remains difficult to predict. This is particularly complicated by the fact that the government, represented by the Health Minister, Dr Motsoaledi, has said that when the white paper for the NHI comes out, it will explicitly state that NHI is mainly for primary healthcare (Business Day, 2013). How and who will provide this primary care and how it will be integrated in the proposed synopsis is not at all clear. GPs would clearly be best positioned to drive primary care and interface between this, preventative medical practises as well as to engineer appropriate referral for specialist care.

It is clear that the NHI, if implemented carefully and with due consideration, offers an important means to achieving the realisation of this ideal of equitable and accessible quality

healthcare to all South Africans whatever their socioeconomic background. *"However to achieve health for all we also need an affordable, equitable, well-functioning and efficient health system that sees health as a fundamental human right and an essential public good rather than a privilege or a commodity for the privileged few"* (Reynolds, 2013).

The implication of the aforesaid for privately practicing medical doctors is that their practise model will need to change and conform to the transformations proposed by the NHI. They will be required to work within the framework of the NHI. Potentially, they could be employed by the state in their "private" capacity, with the State's regulations and infra-structure rather than be "self-employed" and self-managed. They would be doctors working in the private sector but also having a service-provider contract with the Government to treat "public" patients. They will be medical doctors working for their own account but treating "state" patients as preferred or appointed NHI providers and be paid by government where the fees have not been determined or, are expected to be below expectation (Kahn, 2014 (b)).

The reason for the research interest is that, thus far, the impression given by the media is that private practise doctors are not convinced or satisfied with the NHI roll out strategy thus far and begs the question why? Are there ethical issues contributing to their concerns?

The NHI promises improved and quality health services with the implication that the principles of health care ethics can be adhered to. The principle of distributive justice implies that everyone will have access to the same level of health care as anyone else. The NHI needs to ensure that the entire country, including the rural areas, can be provided with this quality service without bias. The principles of beneficence and non-maleficence implies that the services that will be available or provided for in the NHI health care facilities need to be of such a standard that the health care providers can practise in accordance with these principles so that the best interest of the patient is maintained. The patient will get better treatment and

will suffer no harm. Medicines, equipment, laboratories and nursing staff, to name a few of the services, need to be optimally functioning so that the health care providers are confident in the integrity and the availability of these services otherwise these principles cannot be met and perhaps more harm than good could be inflicted on innocent patients who are expecting a lot more in this "new" dispensation of medical care. Finally the principles of autonomy where the patients' and the health care providers' rights to self –determination are respected. To this extent the patient should be able to accept or refuse treatment at their discretion and they should also be fully informed of treatment offered and any alternatives if applicable. The health care providers' autonomy of where and how they choose to work should also be respected. This is especially so when they feel that they cannot adhere to basic ethical principles in the care they provide in these facilities that clearly undermines these ethical codes.

Can their concerns be identified? Can these concerns be entered into dialogue with policy makers so that, if warranted, can then be incorporated into policy thus enabling more acceptable working conditions and ethical practises for these GPs. The evidence is clear that from both financial and implementation perspective work remains to be done in finalizing the proposed NHI and in alleviating concerns and uncertainty.

1.4 Rationale

The current scenario raises a number of ethical issues that may contribute to the doctor's concerns. In particular private GPs, whether their lack of participation will undermine the implementation of the NHI plan. The provision of equitable healthcare – equitable justice may be in jeopardy. Whether their integration into the NHI will undermine the quality of care currently experienced by their patients – the principle of beneficence and non-maleficence, and whether the diversion of funds away from current health structures is the most just route

for addressing health inequalities in South Africa is unknown (Beauchamp T, 2013). Attempts to address all of these concerns would be considerably assisted by a clear understanding of opinions of private GPs and the ethical impact of these perceptions on just healthcare provision which breaches the principles of autonomy for both the health care provider – the right to make their own choices with regard to where and how they work- as well as to the patients' autonomy of determining the healthcare provider and level of care they so choose. The issues is two-fold: do doctors have a genuine ethical concern about working for the NHI and the public sector because of problems they perceive to be ethical challenges or is it simply that the government hasn't been transparent and clear on how the roll over will actually occur and that the "unknown" or the "uncertainty "is the real issue.

Direct engagement with private GPs on the issue of NHI implementation and roll out remains scarce. Thus, such research is valuable to identify some of these issues and concerns of privately practicing GPs. These issues and concerns can hopefully be addressed by policymakers enabling a more mutually acceptable transition of the private sector to the NHI.

1.5 Aim

The aim of the study is to explore and understand the perceptions of GPs working in private practice on the implementation of the NHI. It aims to identify ways in which these perceptions can effectively be addressed to government so that the transition of private GPs to the NHI can occur as smoothly as possible and that the ethical concerns of the GPs are taken into consideration.

1.6 Objectives

Thus to better understand the doctors' opinions and perceptions of the NHI this study was conducted with the following objectives:

1. To explore privately practising General Practitioners understanding of the proposed NHI and their concerns, if any, in transitioning from a private practice setting and modus operandi to that of a newly formed NHI as it has been proposed by government in the White Paper.

2. To understand what they see as challenges in order for the NHI to be successful (or why they think it will not succeed).

3. To relate these findings back to the current ethical issues inherent in the NHI roll out.

4. To understand how these issues might be adequately addressed so as to facilitate their willingness to be more participant in the NHI.

CHAPTER 2: Materials and Methods

2.1 Introduction

In order to identify the problem of the uncertainty of the how private GPs will be incorporated into the newly proposed NHI a study needed to be undertaken that would enable the direct engagement of the GPs that are being targeted to be employed in the NHI. GPs in the private sector were interviewed to establish their perceptions of the NHI. More specifically, any ethical issues they perceived to be a concern needed to be identified. In order to achieve this objective this research study took the form of an exploratory- descriptive empirical study design. The reason is that exploratory studies are used to make primary investigations into areas of research that is generally unidentified. *"They make use of open, flexible and inductive approach to research as they attempt to look for new insights into phenomena. Descriptive studies aim to describe phenomena accurately through narrative-type descriptions"* (Terre Blanche et al., 2008, pp.47-48)**.** Thus, in order to explore the unknown territory of the perceptions of GPs in the private sector on the implementation of the NHI and their role in it and to describe these findings into accurate narratives, this study design was selected as it was best placed to identify these perceptions. It was however limited as the study was only conducted in the Johannesburg area even though the NHI is intended for the entire country.

2.2 Research Methodology

2.2.1 Introduction

The purpose of this research was to explore and describe the perceptions of GPs working in the private sector in the Johannesburg area on the proposed implementation of the NHI. Their ethical concerns that they see as challenges to the successful implementation of the NHI is of interest. This enquiry will reveal the issues they raise and, if adequately and appropriately

addressed, can be incorporated into the policy decisions to enable a smoother and more acceptable transition of privately practising GPs into the NHI framework. Since the NHI is still under discussion and debate in parliament this is an ideal opportunity to identify any concerns the GPs have. Search of literature reveals little in the way of engagement of individual GPs but more importantly integration of the private sector into the NHI lacks clarity and strategy. Far too much is being blamed on the private sector for the current inequalities in health care provision in South Africa.

There appears to be unilateral decisions from government on how implementation of the NHI is to be achieved. There is no literature supporting that dialogue has occurred where suggestions and decisions were tabled by all stakeholders and mutual resolutions reached.

Since GPs have been targeted as the backbone of the NHI their engagement on the NHI is sought to assess their perceptions and understanding of the NHI and its roll out. In order to achieve this, a study was undertaken with the appropriate research design.

2.2.2 Research Design

The research took the form of an exploratory-descriptive empirical study. This research design was chosen because it enabled the researcher to engage the subjects in exploring their thoughts, understanding and perceptions of the NHI. It gained new insights, discovered ideas and increased the knowledge of the problems the subjects perceived to be challenges to their voluntary participation in the NHI.

The study used semi-structured interviews to explore the perceptions of GPs in private practice in Gauteng in South Africa. It would provide more details and expand on the understanding of how GPs perceived the NHI and identify the ethical challenges that would be at stake. Profuse data was produced on the experiences of these GPs in the private setting

and their perception of how the newly proposed health care system will be implemented as well as the perceived effects on them.

2.2.3 Study Participants

The target population for participation in this study was GPs working in private practice in Johannesburg because of convenience and proximity of the researcher. These doctors were best positioned in the private sector to yield such information and were also those who would most likely be affected by the transition to a universal health care model. They were therefore able to reflect readily on ethical issues and perceptions they have on this proposed model compared to their current practise.

Requirement for participation was registration with the Health Professions Council of South Africa (HPCSA) as GPs.[6] Duration of work experience in the private sector was not a criterion for participation nor was previous experience with a universal healthcare system.

A purposive sampling method was used because this sampling requires the selection of participants who are likely to be knowledgeable about the issue in question, because of their actual involvement in and experience in the situation. They were also best positioned to help the researcher understand the perceptions they had of the NHI and were willing to reflect on and share this knowledge. This is a form of convenience sampling as these GPs volunteered to participate in the research but was also purposive from the sense that not only were they available and willing to participate they were also typical of the population targeted (Terre Blanche, 2008, p.139).

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"The Health Professions Council of South Africa is a statutory body, established in terms of the Health Professions Act and is committed to protecting the public and guiding the professions. In order to safeguard the public and indirectly the professions, registration in terms of the Act is a prerequisite for practising any of the health professions with which Council is concerned" **(HPCSA, 2013)**

The participants were recruited personally by the researcher by means of phoning the GPs that were in private practice in the area surrounding the practice of the investigator. Lists of all the GPs working in private practice were obtained from the register (Medpages) and were contacted based on those in closest proximity to the researcher. The socio-economic status of the area in question is low to middle-class and the majority patients in the area are funded through medical aid schemes. A total of twenty five GPs out of thirty two that met the criteria agreed to participate in the research. Most of the GPs contacted had no problem in participating and those who declined did so because of time restraints or felt that they didn't know enough about the NHI to be of any value to the research. The sample of GPs invited to participate was reasonably well diverse as regards to age, race, gender, years in practise and practise ownership. The rationale for the variable group of GPs is to broaden the possible responses from them and to minimise any bias that could arise if the group was too homogenous.

Of the 25 candidates who agreed to participate in the study only eleven participants were actually interviewed because saturation of data was achieved by then. The selection of the 11 interviewees was based on the fact that they were readily available when called and were in a position to meet the researcher. Participants were given a Participant Information Sheet (Appendix 1) to read prior to giving written consent for participation as well as to have their interviews digitally recorded by signing an Ethics Approved Informed Consent Form (Appendix 2).

2.2.4 Inclusion criteria

The target population needed to meet certain essential criteria in order to fulfil the necessary requirements needed for the research to be conducted effectively

For this study the inclusion criteria were:

- The participants were required to have been qualified medical doctors registered with the Health Professions Council of South Africa
- Currently working as General Practitioners in the private sector in the greater Johannesburg area

2.3 Data collection

2.3.1 Tools

An Interview Schedule was used as a tool during the conduct of the interview (Appendix 3). The interview was recorded and field notes were also taken using a Data Collection Sheet (Appendix 4). The interview was semi-structured because this method of data collection provides participants with the opportunity to fully describe their own perceptions. *"Interviews are also regarded as the best way for exploring and gathering experiential narrative material, which may serve as a resource for developing a richer and deeper understanding of a human phenomenon"* (Streubert, 1999). Therefore for this study, semi-structured interviews was used which yielded profuse data, as the participants were able to voice their views without the influence of the researcher.

2.3.2 Pilot

A pilot interview is essentially a test run of the interview process to assess whether it could effectively be used for the purpose of the study and whether it needed to be adjusted to provide the best information needed for the study. Therefore, its purpose is to obtain information for improving the project and to assess whether it is feasible or not.

A pilot interview was conducted using a volunteer who fit the demographics of the study group (as outlined in section 2.2.3). It was not recorded digitally but notes were taken regarding the structure and flow of the interview schedule. The pilot participant was also asked to comment on any aspects of the interview that they felt pertinent – including the

clarity of the question phrasing and any experienced discomfort. Based on these comments and the researcher notes, no changes were made to the interview schedule. The pilot was discussed with the supervisors, and it was decided that the interviews could proceed as no significant concerns had been raised. Had any such concerns been identified the interview schedule would have been adjusted and re-piloted.

2.3.3 Data collection

The potential subjects were sourced from the area and contacted telephonically initially to assess their level of interest to participate in the research. A brief outline of the aim of the research was discussed and those still interested were given a date by mutual agreement to meet with the researcher for the interview to be conducted. The median time from initial contact to actual interview was 4 weeks. The interview was of a semi-structured format allowing the subjects to speak freely and voice their thoughts unhindered and without the researcher directing them in any bias way. The focus was on the subject's perception and level of knowledge and understanding of the NHI. The perceptions of GPs on the impact of the NHI implementation and NHI rollover on their practice of medicine were also examined. A full list of topics covered is listed in appendix 3.

The interview was recorded and field notes were also taken simultaneously. The interviews were either conducted in the GPs own consulting rooms or in the researcher's consulting rooms which was decided by mutual arrangement. Interviews continued until the data was saturated as revealed by repeated themes and not by the number of interviews conducted. Each subject was interviewed in a single session of between 90 and 120 minutes. All interviews were conducted in English as all participants were well versed in English and all the recorded interviews were transcribed verbatim by the researcher soon after each interview was completed. The written notes were used as an aid to clarify or verify certain points that was either unclear or inaudible from the recording and basically to supplement the analysis.

2.3.4 Research ethics

The researcher obtained prospective approval of the study protocol (Information Sheet – Appendix 1), Consent Form for participation on the Study (Appendix 2), Participant Interview Schedule (Appendix 3) and Data Collection Sheet (Appendix 4) from the Research Ethics Committee (medical) of the University of the Witwatersrand before the study commenced. (Appendix 5) Clearance Certificate Number M140825.

Prior to the interview, participants were provided with an information sheet that clearly explained the purpose of the study (Appendix 1). The participant signed the informed consent form (Appendix 2) prior to any study procedures being performed as well as the consent for digital recording needed to be signed for those consenting to be recorded. Any concerns that the participants had were fully discussed with them prior to the commencement of the interview. Furthermore, each participant was advised of their right to terminate the interview at any point and the voluntary nature of their participation was emphasized. They could withdraw their consent at any time from any further participation in the study. All participants entered and completed all study-related procedures without withdrawing their consent. They were assured of anonymity and that no one would have access to the information provided by them during the study.

The recorded and written information derived from the interviews is stored securely in the researcher's office available only to the researcher and supervisor and will be kept secure for a period of 6 years as per the University of the Witwatersrand policy, after which they will be destroyed.

All parties are to ensure protection of subject personal data and will not include subject names or other identifiable data in any reports, publications or other disclosures. Subject names and other identifiable data were replaced by a numerical coding system to de-identify

the subjects. The researcher will maintain a confidential list of subjects who participated in the study linking their numerical code to the subject's actual identity which will be stored in a secure location separate to the other project documents.

2.3.5 Data analysis

Thematic content analysis was used to explore the themes that emerged from the qualitative data. Themes and sub-themes and the frequency with which they appeared in the material were sought (Terre Blanche, 2008, pp.322-23).

Grounded theory is *"a systematic qualitative research methodology emphasizing generation of theory from data in the process of conducting research,"* (Martin et al, 1986) and was the method of choice in this study.

Data analysis began with initially listening to participants' recorded descriptions followed by reading the transcriptions verbatim repeatedly. Data analysis was conducted using Tesch's method of analysis of qualitative data where, "*the researcher listened to all the audiotapes and read all the transcriptions"*. Some ideas and themes were written down as they emerged. One transcript of the interviews was read at a time. Underlying themes of the data was sought and was documented in a column. As the next transcript was read, similar themes that emerged was documented in the column alongside the first list for similar themes and any new idea or theme was added to the bottom of the list. All the transcripts followed the same pattern until all were analysed clearly indicating in each column which themes each transcript produced. A list of themes was made, and then similar themes were clustered together. The lists were then used to compare the data. The most descriptive words for the topics was allocated and made into the various categories.

The transcription and initial analysis of the data started immediately after the first interview was completed and whist this was being analysed the next interview took place. Once the researcher began to notice saturation in the data being collected, the interviews were collectively re-analysed for key themes.

Topics that were closely related were grouped together in order to obtain a shorter list of categories. Each category was verified and alphabetised. *Data was then analysed and systematically explored to generate meanings* (Tesch, 2013).

In reporting the findings, examples from the participants' verbatim statements (quotations) were included to engage the reader in consensual validation of the text.

CHAPTER 3: Results

3.1 Demographic Analysis

Eleven GPs were interviewed before the saturation point of the data had been reached and no new data was identified from that already identified. Of the 11 subjects interviewed four were Black, two were White, two were Coloured and three were Indian. Of these seven were Female and four were Male. There were five subjects below 40 years of age and six subjects above 40 years of age. Seven South African universities were represented namely, Witwatersrand, Pretoria, Medunsa, KwaZulu Natal, Bloemfontein, University of Cape Town and Stellenbosch. None of the participants had foreign primary medical qualifications.

The demographics did not play any particular role in the themes emerging from the data. All participants had similar general views of the concept of universal health coverage and more specifically, of the proposed NHI.

3.2 General overview

Twenty nine consistent and repetitive themes emerged from these interviews. Some of these themes, by virtue of their similarity, were grouped into broader categories of themes named major themes. Within the major themes, a number of sub-themes were allocated to accordingly. This resulted in six major themes being identified into which these 29 sub-themes could be divided into according to their close association. These major themes are summarized in Table 1.

1	Quality of patient care concerns
2	Working conditions in public hospital
3	Roll out and implementation of the NHI
4	Corruption and mismanagement of public hospitals
5	Remuneration concerns
6	Dialogue and autonomy of GPs

Table 1 Summary of the 6 Major Themes

All the subjects interviewed were currently working in the private sector as GPs in Johannesburg. Their private practice experience ranged from as little as a year to over 40 years of experience. Only one subject specifically had previous universal health care experience in the United Kingdom, however, all the subjects had worked for the public sector in South Africa at one or other time in their careers; whether as interns, community service officers, registrars or medical officers. All of the subjects had the perception that the proposed NHI was nothing more than an extension of the current public health sector. It was also apparent that their entire perception of the NHI was a reflection of the current state of the public health service, either personally experienced or through media exposure, mainly the print media. The NHI was not perceived to be better or different from the current public health service. They all relate their concerns to that of the current situation in the public health service. Interviewee 10 summarizes this in a nutshell by stating:

"If you can make the public sector work well now, then maybe I will trust the NHI"

Interviewee 1 backs this up by saying:

> *"I have always said if the current health system is improved, they probably wouldn't need to think about the NHI. I think they are looking to resolve the problems the wrong way".*

Interviewee 2 says this in reference to the public health service:

> *"I've been there and I don't want to go there again"*

These comments referring to the public service were unanimous and led to the conclusion that this is what the perception of GPs in the private sector perceived of the NHI.

> *"I worry about the standard of health care in the state system, especially in more outlying hospitals."* (Interviewee 3)

and

> *"I don't think there are enough doctors because if you look at the public sector, there are not enough doctors to make it work already."*(Interviewee 4)

They all acknowledged that there will inevitably be involvement of the private sector in the NHI but they do not know to what extent and on how the private sector will contribute or be involved in it. The complimentary role that the private sector GP will bring to the NHI is basically not known to these GPs interviewed. They all lack knowledge of the actual details of the NHI as well as the process of transition will take.

> *"I don't think private doctors have been asked, nor state doctors, which is a problem because you are going to be forcing these people (doctors) to do something they may be reluctant to do or they haven't heard enough evidence or research about it. Either they're going to leave the profession or seek work elsewhere."* (Interviewee 4)

This may be partly due to their disinterest in the NHI per se, which is clearly evident during the interviews, or partly due to the fact that this information pertaining to the NHI has not been clarified clearly and sufficiently or has simply not been made available to them.

> *"With regard to the NHI, they need to make it more attractive for the guys in private to consider even venturing into this type of thing because the reason they left public was because of the inefficiencies in the system,"* remarks Interviewee 6.

The disinterest somehow appears to be that they don't want to really be a part of the NHI and that, if given a choice, they would happily continue as they are in their current practises:

> *"In my opinion private practise is the ideal"* confirms Interviewee 7.

It appears that this small cohort of GPs interviewed had very similar views across the board citing a clear preference to the current private sector within which they work and showing a great deal of reservation about the viability of the entire NHI proposal given the current state of the public sector with its multitude of problems ranging from quality to patient care to corruption and mismanagement of the sector.

3.3 Major Themes

3.3.1 Quality of patient care

The sub-themes within this major theme that were identified are summarized in Table 2.

Sub-theme 1	Understaffing & insufficient resources
Sub-theme 2	Poor quality of patient care
Sub-theme 3	Lack of urgency in emergencies
Sub-theme 4	Unavailability of medicines
Sub-theme 5	Lack of training

Table 2. Summary of sub-themes of Major theme 1 on "Quality of patient care"

Respondents seemed to base their opinions of the NHI on their current opinions of public healthcare provision in the public sector. They commented on insufficient staff, lack of medicines, faulty equipment, poor standards of basic patient care due to being over worked, frustration with laboratory services and other special investigations e.g. MRI scans. They expressed concerns and suggestions that the NHI is, and will be, just what the current public health care sector is right now. They drew on their own personal experiences in the public health sector when they were employed there, their general perceptions of the current state of the public health sector, also reflected in the media ranged from doctors being overworked and risking patients' lives due to exhaustion, to management issues rendering management services at sub-optimal levels (Coalition, 2013) (Kotze, 2014) (Malan, 2012).

Quality of patient care is perceived as unacceptably poor in public hospitals and in the government clinics. Arguably this is different to the basic principles of patient care that all the GPs currently offer and are accustomed to in their current practice. The principal that

patients deserve to be treated with the utmost of dignity and that equality of care is of paramount importance is evident in the opinions and suggestions made by these GPs.

All participants felt that the overall standard of patient care in the public sector was of a poorer quality than that of the private sector. The inference of this is that the NHI would be providing a level of care that they would find unacceptable and this would definitely be a deterrent to them to want to work in such an environment. The interviewees felt that there were too few doctors and nurses working in the public sector with far too many patients to cope with the extraordinary number of patients.

> *"Resources, like medicines and equipment, in the public sector are not at your disposal. It becomes very stressful to work there and it affects your quality of care"* (Interviewee 2) and,

> *"The facilities are not coping with the number of patients that they are seeing and also, the number of patients that the Doctor is responsible for is hectic*" (Interviewee 4).

Unlike the situation in the private sector Interviewee 1 says of the private sector,

> *"You offer quality care to patients because you sit with them for twenty minutes and talk (in the private sector), unlike having to push a queue of 150 patients (in the public sector)."*

The interviewees generally felt that the workload in the state sector, together with the shortage of doctors, as one of their greater concerns regarding providing quality care to patients. They perceived that quality care cannot be provided in the context of being overloaded with work and without the backup of ancillary services like radiology and laboratory services to provide a holistic approach to health care. These services were often

not operational and when they were it would take too long to get results further jeopardising prompt management of patients. They feel that is not possible to provide quality health care, under any circumstances, when there are time constraints and poor back-up services e.g. laboratory services.

Follow-up consultations with patients did not occur and was stated as one of the many problems they encountered in their past experiences. Getting through the queues becomes the objective rather than the quality of the care provided.

> *"It gets frustrating because you're not doing the best you can for patients"* (Interviewee 5).

and

> *"Seeing in excess of 100 patients is going to be difficult to give quality care"* (Interviewee 2).

Interviewee 8 offers this opinion:

> *"Patient volume impacts on quality of care because you are rushing to finish and see a number of people as opposed to going in a more co-ordinated manner where time is allocated per patient"*.

There was a great concern amongst all the subjects that there is a lack of reliability of resources and that the system, as they perceive it to be, could not be trusted. One cannot and, should not, work in isolation – examining a patient, making a diagnosis and treating a patient requires an intricate infra-structure that is functional. Any structure is as strong as its weakest link, so that when a patient is examined and diagnosis is made and should the required medication not be available to treat them with, the service is as good as not being able to treat the patient at all.

"Resources, like medicines and equipment, in the public sector at not at your disposal"

and

"the equipment is old or it is broken or being serviced"

are several of the many and repeat comments made most by the Interviewees. Similarly, if resources like radiology are inconsistent in terms of functionality and availability it may delay a patient's diagnosis resulting in unnecessary morbidity and even mortality. These types of issues are usually not encountered in the private sector due to the abundance of these services in this sector.

"I was not happy when I worked in the public sector mainly because we didn't have stock; X-rays didn't work, having no access to CT scans when you needed it and medication was always out of stock"(Interviewee 1)

and

"When I worked in public patients would not get the drugs I prescribed, they never got results of blood tests or PAP smears done on them. I just fear that we go back there again." (Interviewee 1)

The GPs were concerned that the standard of care was too variable and that some areas, in particular the rural areas, would not have a similar standard of care.

"I worry about the standard of health care in the state system, especially in more outlying hospitals. There are pockets of excellence but they are few and far between and I think the patients are at the mercy of that system so I foresee that those who can afford it will still seek private health care"(Interviewee 3).

and

> *"The nursing standards are shoddy and incredibly poor"* (Interviewee 3).

There was also a general concern that the workload led to insufficient time for proper training for the younger doctors who end up treating beyond their scope of capability. Most of the GPs were of the perception that the state will not be able to cope with a much more demanding universal health care system when it simply cannot cope as it is with an already strained and under-resourced Public Health Sector (Malan, 2012) (Kotze, 2014). The drive of doctors working in the public sector is to simply get through the day by getting through the numbers of patients that they need to treat and this is what the GPs cannot see themselves doing if they were to work in the NHI. Interviewee 6 feels that

> *"The Dr will rather leave for some other place where they can still practise medicine freely and to their own comfort"* (Interviewee 5).

than work under these circumstances.

> *"In the public sector there is a drive just to get through and just manage what is in front of you at the moment"* (Interviewee 5).

If the transition allowed one the opportunity to provide the same level of care that the GP was providing in the private sector, this would certainly play a positive role to accepting an NHI-type scenario.

> *"In my opinion private practise is the ideal, therefore they need to come up to the ideal, not go down to the sub-optimal level of the public sector"* (Interviewee 6).

To drop the standards of the "private sector" to that of the public sector is simply unacceptable and it is not the solution to addressing equitable access to medical care.

> *"They should take a step by step approach and actually build up the infrastructure first (of the public health sector) before actually opening up to provide services when they don't actually have the basic foundations in place"* says Interviewee 5.

This is implying that patients currently been treated in the private sector at the current standard who now are compelled to be treated in the "NHI" – public service – may find the service below that which they currently experience in the public sector:

> *"Every single person that I've spoken to so far , be it from your middle class to your lower socio economic to the very rich, they all have the same opinion of Tembisa hospital, the local public hospital for referral of public sector patients from my practise. People think absolutely nothing about that hospital"* is the opinion offered by Interviewee 4.

Section 27 states that:

> *"We are deeply concerned about the dire state of the health system. The Office of Health Standards Compliance's (OHSC) assessment has indicated that on average health facilities across the country achieved 46% for quality, service and medicine supply at clinics. This suggests that most health facilities are unlikely to be of a standard to support NHI"* (Child, 2016).

The perception is that the quality of medical care in the private sector is readily more available and consistent and that this quality will not be as forthcoming from the public health care sector. This concern was raised by all the GPs interviewed and is the most pronounced concern they have if they were to transition to the NHI. They feel that access for all may be desirable but the cost of doing so would be compromising the patients' rights in terms of their autonomy and the respect and dignity they ought to get will be in jeopardy.

3.3.2 Working conditions in Public Hospitals[7]

The working conditions in public hospitals are perceived to be unacceptable to the GPs interviewed since the NHI is already perceived as an extension of the current public health sector and this is a huge concern for them. Working in that context is neither appealing nor attractive.

The sub-themes identified in this category are summarized in Table 3.

Sub-theme 1	Excessive working hours
Sub-theme 2	Poor facilities limits provision of service to patients
Sub-theme 3	Poor maintenance and management issues of hospital facilities
Sub-theme 4	Working environment is not appealing
Sub-theme 5	Problem with immigrants over burdening the system
Sub-theme 6	Image of public hospitals needs to improve
Sub-theme 7	Assurances from Department of Health is needed
Sub-theme 8	Improve infrastructure of public hospitals

Table 3. Sub-themes for Major theme 2 on "Working conditions"

All the GPs interviewed had perceptions that the environment and working conditions in the public sector health sector facilities were of a poor standard and that the NHI was this aligned.

[7] *"The Office of Health Standards Compliance (OHSC) has been created by the National Health Amendment Act of 2013 and, in terms of section 78 of the Act, the objects of the Office are to protect and promote the health and safety of users of health services by: Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system and ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards for health establishments in a procedurally fair, economical and expeditious manner"*. (OHSC, 2014)

> *"There is a lot of dissatisfaction and bad attitude in government hospitals amongst some of the staff and they are now going to deal with much more patients. I think staff specifically is going to be a problem and this really needs to be addressed"* (Interviewee 2).

The respondents envisage that the proposed NHI would be an extension of the current public health service. They foresee the NHI service being overburdened by the perception of the public that it will be an improvement on the existing service

The GPs were also not sure how the patients currently attending "private" practitioners and who now qualify for the NHI service will be accommodated in this already burdened and under-resourced sector. Naturally, should some of these GPs be employed in the NHI this could alleviate the burden on the doctors working there by increasing the number of GPs. However, the conundrum of supporting the system based on current practice and lack of appeal versus not supporting the system and aggravating an already strained infrastructure is a real issue for the GPs. All the GPs have reservations about working for the government sector for various reasons but most notably the workload, disorganization, working conditions, ailing infrastructure and unreliable medicine supply. Interviewee 4 says,

> "*My concern is that our population is so large and that it [the NHI] would be flooded initially and then people will think it's not working. I'm concerned about the transition"*

and

> *"The crowding, the variability of standards, the variability of accountability"* is a concern for Interviewee 3.

All of the GPs expressed the view that the public sector had to improve its image and develop its infrastructure to attract private GPs to be employed there.

> *"I have always said if the current health system is improved, they probably wouldn't need to think about the NHI. I think they are looking to resolve the problems the wrong way"* (Interviewee 1).

They felt that in order for the NHI to be successful and to gain the support of the public it was important to brand its image in a manner that created it as an attractive and efficient facility.

> *"I would like to see them bringing the public hospitals up to scratch so that you have good equipment and accessibility"* (Interviewee 3).

Their perceptions were quite different from what one is made to believe by the advocates of the NHI. One GP (Interviewee 6) had this to say about their experience when they worked in the public sector,

> *"Public hospitals still have patients standing around in passages waiting for someone to be discharged so that they can get a bed. They sometimes spend nights on the floor. These already say that our public hospitals should be increasing bed capacities and open their pharmacies on a 24-hour basis because patients are seen in casualty at night and have to return the following to collect their medication or even wait overnight for their meds."*

Over 50% of the subjects felt that a large part of the burden in the public sector was on the account of foreigners it served who were benefiting unfairly on the back of a South African contributing public.

> *"The big patient load also is due to the foreigners especially Zimbabweans in the maternity wards. That is a problem that needs to be sorted out. I think the workload in hospitals would be way less*" (Interviewee 1).

Trust remains a continual problem. The GPs felt that promises made by government were not always honoured and they would want assurances of the promises made before they would accept working within the NHI service.

> *"I know of cases where doctors have not been paid for 5 months"* (Interviewee 5).

and

> *"from the experience of other people who have been working with government, non-payment is something that happens frequently"* (Interviewee 6).

and

> *"I think our Government has proven itself over & over again – poor management, no accountability and not good with money"* (Interviewee 11).

are some comments where the GPs just don't believe the credibility of the implementation of the NHI.

Thus, it appears that the working conditions in the public health sector is of great concern for GPs interviewed and they feel that this situation will remain so even with the NHI being implemented with its promises of a better and improved service. They feel that trust was a huge problem and that they do not believe that the promises made are reliable therefor they remain sceptical about this new system.

It appears that the working conditions in the public health sector is of great concern for GPs interviewed and they feel that this situation will remain so even with the NHI being implemented with its promises of a better and improved service. They feel that trust was a huge problem and that they do not believe that the promises made are not reliable therefor they remain sceptical about this new system.

3.3.3 Concerns with Implementation and rollout of the NHI.

The rollout and implementation of the NHI is largely an enigma to the GPs interviewed and its success, as they perceive it to be, is generally doubtful. The sub-themes identified in this category are summarized in Table 4.

Sub-theme 1	Implementation and rollout of NHI
Sub-theme 2	Achievability in terms of skills and timeframe is doubtful
Sub-theme 3	Management issues within hospitals
Sub-theme 4	In theory NHI good but execution doubtful
Sub-theme 5	Not affordable
Sub-theme 6	Lacking of health management skills

Table 4 Sub-themes of major theme 3 on implementation and rollout of the NHI

The majority of the GPs felt that the implementation and rollout programme was too ambitious and is a concern to them. All the GPs interviewed had attended one or more talks by Minister Motsoaledi or by other officials from the DOH on the subject and it was their opinion that the theoretical presentations of the roll out mechanism and what it was offering to a bigger population base than the current "public sector" patient base was an onerous and possibly an impossible task. Most felt that there was a lack of skills by the promotors of the NHI and if the current state hospitals were anything to go by then there is no chance that the NHI could remotely be successful.

> *"If the public sector was running smoothly right now, adequately and efficiently, maybe I would believe in the system. I say if they are struggling to provide basic medication and they don't even have gloves,"* (Interviewee 1).

The NHI was intended to roll out in 2012 and, 3 years down the line there are still no signs of imminent roll out (NHI, 2011). The White Paper was only published in 2015 and has still not been debated in parliament and only once this has been finalised can the process of roll out begin (NHI, 2015). Some of the GPs felt that the success of the private sector should be reason enough to encourage this sector to be involved in making the NHI a success as well. Interviewee 5 had the view that,

> *"They need to incorporate what is happening with the private sector. They need to bring them into the system otherwise not enough health care practitioners"*.

The experience of the majority of the interviewees when they did work in the state health service was that there was poor quality of control. They suggested that there was no consistency and often equipment was faulty and the nursing standards were too variable. This was simply blamed on management, without which, the whole system just falls apart.

> *"I think it all boils down to management. If you fail to plan, you plan to fail. You have got to have a plan and you have got to be able to implement it. If you don't implement it properly it will not have the result that you want and you are going to be throwing a lot of money down a bottomless pit"* (Interviewee 2).

It is without question that the majority of the subjects interviewed had no objection to an NHI-type healthcare system but their perception of its implementation and its execution in the current scenario is the concern they have with it.

> *"Our execution is very poor and it's usually because not the right people are put in positions to execute these things. Usually, it's a lot of talking but very little doing"* (Interviewee 2).

There is a general perception that this is going to cost a lot more than the government can afford because it lacks financial resources. The funding of the NHI is therefore also of great concern to the GPs because this aspect of its implementation is not at all clear as it is not discussed in any detail at the discussions they've attended.

> *"There is very little being said about how it's going to be managed and how much its actually going to cost us"* (Interviewee 2).

There was an overall perception that there was a definite lack of health management skills by those trying to implement the NHI and such skills were imperative to make the NHI or any system successful. Some comments made by the subjects were:

> *"I think we need someone very dynamic and strict to come in and just shake this whole thing up because if you use the same monkeys, you're going to get the same circus act"* (Interviewee 2) and *"But I don't know if they have the resources either financially, talent wise or skill wise to be able to implement it,"* (Interviewee 6).

Therefore, unless all these building blocks are well organized and implemented there is no hope that the NHI can succeed according to the Interviewees.

3.3.4 Corruption and mismanagement of public hospitals

The level of corruption and mismanagement of public hospitals is a concern for the GPs interviewed and they perceive this to be a reflection and manifestation of all government institutions and they felt that it could not be trusted. The sub-themes identified in this category are summarized in Table 5.

Sub-theme 1	Corruption & transparency issues
Sub-theme 2	Trust in the system
Sub-theme 3	Perception of public hospitals image is poor
Sub-theme 4	Accountable for outcomes

Table 5 Sub-themes for major theme 4 on corruption and mismanagement

All of the interviewees cited, to at least some extent, that there was financial mismanagement in the public sector hospitals and that this played a big role in the chaos that prevails in public health facilities. Most felt that the tender system was not "above board" or sufficiently transparent and that this can explain a lot of the stock outs and other management issues in the hospitals they worked at or read about in the media.

> *"I think our Government has proven itself over and over again – poor management, no accountability and not good with money"* says interviewee 11.

The GPs mostly felt that the NHI would not live up to its promises and intentions and that they would find it difficult to accept working in the NHI without guaranteed assurances from the government.

> *"To be honest, my concern is the Government. I don't think they have the know-how to ensure a smooth transition because if you look at other things they do that are*

> *simple, they can't even get that right. How are they going to get something like the NHI correct?"* says interviewee 11.

The image that the public hospitals portray to both doctors and patients was poor and it was generally felt that this image needed to be improved before expecting doctors to want to work there or patients to want to be treated there.

> *"Every single person that I've spoken to so far , be it from your middle class to your lower socio economic to the very rich, they all have the same opinion of public hospitals currently , people think absolutely nothing about these hospitals"* (Interviewee 9).

Hospital management must be accountable for the outcomes of the institutions they run. If this was the case then the majority of the GPs felt that there would be a bigger drive and incentive to make the hospitals more desirable to work in and to be treated at by doctors and patients respectively.

"My concern is that per capita, we spend as much as other countries do on medical care and on schooling but the outcomes are not there. This is due to lack of capacity and the people who are providing it aren't capable. I think that the biggest concern is you just don't have the capacity by virtue of corruption and incompetence", says Interviewee 10.

> *"Patients in Limpopo hospitals are dying because of corruption, mismanagement and lack of basic resources, doctors say*" (Langanparsad, 2016).

and

> *"Sometimes babies are born with cerebral palsy because there was no paper for the heart rate monitor, so doctors did not pick up that the foetus was in distress,"* said

one doctor in a recent expose from Polokwane Hospital in Limpopo (Langanparsad, 2016).

Thus, the various concerns expressed by the GPs interviewed can be held with good credibility based on situations such as this example provided.

3.3.5. Remuneration concerns

The sub-themes identified in this category are summarized in Table 6.

Sub-theme 1	Salary payments unreliable
Sub-theme 1	Private practice more rewarding

Table 6. Sub-themes of major theme 5 on remuneration concerns

Most of the GPs in the study have the perception that the financial rewards in the government sector are not attractive and doesn't meet the level of that of the private sector. The younger GPs appeared to have a greater concern in this area of finances than their older colleagues. Some cited that the payment of salaries was not reliable, non-payment and late payment is a common phenomenon especially with regards overtime pay and rural allowances.

> *"From the experience of other people who have been working with government, non-payment is something that happens frequently,"* says interviewee 6 and
>
> *"I am also worried about the Government actually paying everyone. Another challenge in the public sector is if you work extra hours you never get paid for the extra work done"*, comments interviewee 7.

"Working in the private sector is far more financially rewarding" is the unanimous sentiment of all the subjects interviewed when this question was posed to them. They also state that they can spend more time with their patients, that there are far fewer patient numbers to deal with and that there is a better financial reward at the end of the day.

> *"Improve salaries to be at least comparative with private practise. It should be more of a pleasure to stay in the state system then it would be easy to retain staff. Once you get the volumes right, you basically get the quality of service and care to increase"* is a suggestion offered by interviewee 6.

Thus, the general perception that working for the NHI will not be financially rewarding and payment failure is seen as a realistic concern by the overwhelming majority of the GPs interviewed in this study.

The general perception that working for the NHI will not be financially rewarding and that payment failure will be a realistic concern is the opinion of the overwhelming majority of the GPs interviewed in this study.

3.3.6 Dialogue and autonomy of GPs

Most of the GPs felt that there was insufficient dialogue with them and other doctors in the private sector especially on the subject of what is the expectation from them in order to be participant in the NHI. They express a deep concern for their autonomy of practising good ethical medicine in the manner they are accustomed to in the private sector. This aspect was more evident amongst the older GPs in the study probably reflecting the many more years they have been self-employed in the private sector. The sub-themes identified in this category are summarized in Table 7.

Sub-theme 1	Doctors autonomy is in jeopardy
Sub-theme 2	Method of NHI implementation
Sub-theme 3	How private GPS will be incorporated into NHI
Sub-theme 4	Promises are fulfilled and assurances provided

Table 7.Sub-themes for major theme 6 on dialogue and autonomy of GPs

The majority of the subjects in the study were concerned that the health authorities would be dictatorial in its approach to them as far as their participation in the NHI would be. They generally felt that since the discussions on the NHI largely excluded them in the decision making the concern is that they would just be told where to work and how they should work. This they felt was a violation of their basic right to autonomy and are of a major concern.

> *"I don't think private doctors have been asked, nor state doctors, which is a problem because you are going to be forcing these people (doctors) to do something they may be reluctant to do or they haven't heard enough evidence or research about it. Either they're going to leave the profession or seek work elsewhere"* (Interviewee 4).

Most also had the perception that even if they were recruited into the NHI their autonomy as far as actual medical practise is concerned was at stake. They relate their experiences in their current private practise and compare this with what they perceive will be the case in the NHI as far as their freedom to make choices will be.

> *"I enjoy the fact that if I need to do investigations, I have access to that readily and also that I am able to prescribe what I want to give the patient, not what is available,"* states Interviewee 7 of their private practise experiences.

Interviewee 8 felt similarly with this statement,

> *"it is more of a pleasure to work under these circumstances, that is, private practice"*.

Most of the subjects on the study had very little idea of the details of the NHI and displayed genuine concern for their future. The younger subjects generally felt that they wanted an opportunity to be successful in the private sector and that the threat of the NHI was interfering with this ambition. A lot of them had major debts and other responsibilities and felt that to be forced into the NHI programme was not in their best interest at all. In fact, some where quite upset by it looming at this time in their careers.

Their claims vary from statements like,

> *"When you try to talk to, or ask questions of the Minister at the meetings, he is unable to answer and brushes off the questions by just saying that the NHI is going to happen!"* according to interviewee 9

and

> *"And explain properly how it will work because the Minister doesn't sound like he knows exactly how he's going to do it as well"* (Interviewee 1).

> *"I don't feel it's discussed enough on the radio but I also feel they're not discussing it with relevant people. The Government are not in the field and are far removed from what is happening so they can't give an objective opinion"* (Interviewee 4).

When challenged, all but one of the GPs interviewed admitted that they would be willing to consider providing some degree of service to the NHI but on the condition that they were given assurances that their every need is met and that the promise made by the Minister is fulfilled. However, there appears to be no willingness to contract to the NHI as a service provider with the current knowledge the General Practitioners have of the NHI and with the level of trust they have of government and the state of the Public Health service currently. One of the subjects (Interviewee 4) commented that,

> *"It's a difficult call to make because you have to balance between altruism and also what is going to work in terms of your life , your circumstances and how and where those two meet"*.

Unfortunately, the topic of the NHI has led to some of the GPs becoming rather despondent with medicine as a whole so much so that Interviewee 4 quoted as follows,

> *"I am wondering if being a doctor is such a good idea"*.

Essentially, it appears that GPs prefer to be participant in determining their future career in being doctors and perceive the NHI to be some form of threat to their right to autonomy. Whether due to ignorance of the imminent changes in health care delivery in South Africa that will directly impact on them or whether there is a genuine concern that it is doomed to fail the perception leans on the negative side.

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Chapter 4: Discussion

Since the NHI will require the co-operation of all doctors especially those working at the primary care level to operate successfully it is essential that GPs from the private sector are incorporated to participate in the NHI for it to be sufficiently resourced. It follows that this targeted group of doctors need to be nurtured in order to get them to willingly participate in the NHI health care delivery model. To understand their position on the NHI this study was conducted to assess their perception of the NHI and thereby assist the process of transition to the NHI from the current two-tiered health care delivery model currently in operation in South Africa.

In discussing the findings and results in the previous chapter, the key challenges to a willingness by GPs to participate in a new health care dispensation will be drawn upon. The participants in the study have serious concerns and reservations about being involved in the proposed NHI as they currently perceive it. If the issues that have been identified by them are addressed there would be a genuine willingness by them to consider working in the NHI much more favourably. The implications of these recommendations on acceptability and trust in the NHI appear to be of paramount importance to the subjects in the study.

It emerged from this study that GPs in the private sector hold negative perceptions about the imminent implementation of the NHI. The role that they are expected to play in it is unclear and they simply don't feel they can trust the process as has been discussed or portrayed by the relevant policy makers from government. The media have largely been responsible for fuelling the debates around the issues and problems that the process of implementation is taking as the media appears to be the main source of information on the NHI for these GPs.

The most significant challenge, repeatedly emphasised by the participants, is the quality of care of patients. This perception is based on their personal experiences when they worked in

the public sector as well as the plethora of published cases in medical journals and the media on patient care in state facilities.

Gauteng health MEC Qedani Mahlangu admitted that the biggest hospital in the southern Hemisphere, Chris Hani Baragwanath Academic Hospital in Soweto, Johannesburg, has staff shortages. “There are not enough doctors and nurses," she told reporters at the hospital during a tour of the facility (News24, 2014). Staff shortages imply that those working will be overworked. The participants in the study cited this as a problem which most have personally experienced.

It was felt that the Government ought to address the issue of the staff shortages including doctors to provide quality care rather than attempts to address universal health coverage at all costs including that of quality.

A recent newspaper article titled “Mental patients are thrown hospital pass” (Child, 2015 (b)) describes how up to 2000 psychiatric patients could be forced onto the streets. This is the result of funding cuts by the Gauteng health department who will no longer pay for state mental patients being cared for in various institutions. The Gauteng health department wants patients to be absorbed by NGOs but they do not have the resources to look after many of these patients who require intensive medical supervision. The NGO sector bears most of the burden of the mentally ill and is totally underfunded. It simply lacks capacity for any more patients. (Child, 2015 (b)).

The current private sector is set to diminish with the advent of the NHI because medical aids/funders providing private health care will be reduced to only providing specialized health care not available in the public sector. This area of concern, previously unclear in the green paper but more precisely tabled in the white paper (NHI, 2015) will result in public sector growth and overcrowding of this sector which is already over-burdened.

There are however larger crises in the rural areas as reported in the media. “Rural hospitals are struggling across South Africa - that they function at all is too often not thanks to the state, but the work of Good Samaritans” (Malan, 2012). Malan further states that there is a single physician at Madwaleni Hospital in the Transkei: a Dutch doctor who must serve the needs of a community of more than 260000 people. Just two clinical associates help her. These are health professionals trained at a higher level than nurses, but ranked lower than doctors. They are not permitted to work without a doctor's supervision. The hospital's theatre is no longer active. No emergency caesarean sections can be performed. Patients who need them are referred to the Nelson Mandela Academic Hospital in Mthatha, an hour-and-a-half's drive away. "I can't say what happens to those who don't make it there in time," said a Madwaleni staff member, who asked not to be identified. The hospital has also ceased to perform x-rays. (Malan, 2012)

Not all doctors are as committed as this and having the choice of working in lucrative and efficient private practices in Johannesburg or working in a poor-functioning rural hospital one can understand why the participants would choose the former. All the participants in the study moved away from working in the public health care sector in favour of the more attractive private sector and none would return to working in the public sector unless a dramatic improvement occurred in that sector.

South Africa's healthcare system fails to provide quality care for the majority of citizens, Health Minister Aaron Motsoaledi candidly told a business briefing hosted by The New Age in 2013. The proposed National Health Insurance (NHI) system sought to rectify this, in line with citizens' right to access affordable, good quality healthcare irrespective of socio-economic status, he went on to say (News24, 2013). This is the desire of the NHI but it doesn’t seem achievable given the minister’s admission of the failing current health care system. In 2015, an editorial in the Mail & Guardian states:

> *"Motsoaledi is a rare breed; a minister with exceptional vision. But unless he drastically intervenes in the health system of provinces, his vision will be undermined and ultimately paralysed by incompetent administrators who will make his long-awaited NHI no more than a piece of paper"* (Mail & Guardian Editorial, 2015).

These issues are not specifically addressed by the NHI plan but the minister has conceded that there needs to be a serious upgrading of the Public Health service for it to be properly operational.

The minister has demonstrated a healthy appreciation for the need to fix the state sector as a prerequisite for the successful implementation of the NHI and has adopted appropriate strategies to achieve this. A comprehensive survey by Lifechoice and Medical Chronicle found that the message from the profession is that the fruits of these strategies and initiatives are yet to be seen by them (Good, 2012). In this same survey it found that members of the medical profession also felt strongly that legislative requirements and red tape undermined their ability to focus on patient care. The state of health care in the country and continuing attempts by the government and third-party role players to regulate them and interfere in the doctor-patient relationships are tarnishing their view on the future of the health sector. (Good, 2012).

However, if the state sector were to be rectified (as promised by the minister) this would be attractive for GPs, who are targeted to be the backbone of primary health care provision in the proposed NHI.

Chapter 6, paragraph 158 in the White Paper states:

> *"PHC (Primary Health Care) will be the heart-beat of NHI. The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services"* (NHI, 2015).

A more recent media headline, “Exhausted doctors endanger health” (Kotze, 2014) makes the claim that “Medical interns are leading the battle to reduce the dangerously overlong working hours that compromise the safety of patients” (Kotze, 2014). It is common practice for doctors, particularly medical interns and community service doctors to work shifts of more than 24 hours, and often up to 36 hours or more. South Africa suffers from a shortage of doctors and in many public institutions everyone has to chip in to lighten the load. But this has extremely dangerous consequences. A 2006 review of the evidence, When Policy Meets Physiology, (Lockley et al for the Harvard Work Hours Health and Safety Group), concludes that medical staff who work for more than 24 hours a shift are 36% more likely to make serious medical errors and six times more likely to make serious diagnostic errors than staff whose shifts are limited to 16 hours. Reacting to the situation in South Africa, medical students, interns and community service doctors launched the Safe Working Hours Campaign in 2014. It was started by Stellenbosch University’s medical students and calls on Health Minister Aaron Motsoaledi to review working hours and to limit continuous shifts to 24 hours. He has agreed to talks with the organisers but no date has been set for the meeting. “Doctors and patients deserve better. I have made mistakes out of sheer exhaustion, working 30-hour shifts with no sleep, and have seen others do the same,” said one doctor who signed the petition. (Kotze, 2014). Lack of supervision of young doctors resulting in poor skill development and inability to manage difficult and complicated cases was raised as a serious concern by especially the younger participants who worked more recently in the public sector. Health Professions Council of South Africa (HPCSA) guidelines state that the clinical experience during medical internship should include teaching, supervision and competency in selected logbook procedures. (HPCSA, 2013) In a survey conducted to investigate whether these guidelines were being met for interns across SA, 150 SA doctors who completed their internship between 2010 and 2013 participated (S Bola, 2015). This survey identified

deficiencies of supervision as directed by the HPCSA. It also highlighted difficulties with workload and teaching opportunities. A significant proportion of interns did not feel that patients were safe under their care. A national annual HPCSA survey would highlight hospitals where closer investigation may be required (S Bola, 2015). In conclusion, it goes on to say that medical education for interns is based on the apprenticeship model of 'learning on the job', and supervisors should be available to assess skills and gradually increase responsibility according to interns' developing abilities. According to the survey results, this model is being grossly neglected, with particular concern about supervision. Despite staff shortages in the SA health service and a maldistribution of private and public sector workers, interns must receive the correct clinical supervision, teaching and inspiration to encourage them to continue with public sector work. (S Bola, 2015).

The problems within the public sector are well known to the government but it appears that despite this it continues to be ignored and neglected. The Eastern Cape, in particular, is a crisis where the situation has forced Health Minister Aaron Motsoaledi to intervene by commissioning a five-person task team to investigate issues in the province raised by a civil society coalition. (Green & Skosana, 2013). Motsoaledi's response comes after he got wind of a report put together by the Eastern Cape Health Crisis Action. The report contains details of the appalling conditions of health care facilities in the Eastern Cape. There are stories of women who had their babies delivered by the light of cell phones and people who had to share beds with bleeding and vomiting patients. The report draws attention to the "failing health system" by documenting harrowing personal stories of patients and health care professionals. Baby Ikho, who is the subject of the article, died because of a series of managerial and equipment failures, which were a result of "a broken, inhumane and collapsed health system where accountability is non-existent" (Green & Skosana, 2013). "We would like the state to produce a plan of how and when all these problems will be resolved," said

Zak Yacoob, a former Constitutional judge and a member of the coalition team of this report. (Green & Skosana, 2013).

The participants are concerned about the reliability and consistency of the availability of basic medicines which impacts on the quality of care they can provide to the patients they treat. There is no gratification when you provide the medical care but the lack of medicines defies the objective of quality care. Minister Motsoaledi has equivocated on the primary reasons for public sector stock outs. In a statement on 24 May 2015 that took issue with the media's reportage, Motsoaledi laid the blame for stock outs primarily with suppliers. For example, he said, "In this whole problem of drug supply all over the world is that we source these medicines from companies that are in business and their actions and decisions are not always based on the needs of patients but on what makes business sense." (Geffen & Furlong, 2015).But this is being used as a smokescreen to cover up the reason for the majority of stock-outs. The [KwaZulu-Natal medicine] depot is failing [clinics and hospitals] due to poor management and lack of knowledge of supply chain, the reports continues (Geffen & Furlong, 2015).

The participants felt that the working conditions in the public sector hospitals and clinics were of such a poor standard that it was neither appealing nor enjoyable working under such conditions. The issues cited ranged from malfunctioning equipment, hygienic standards, staff shortages, poor nursing standards, general infrastructure issues and lack of facilities for the doctors themselves e.g. rest rooms. A memorandum was sent to the MEC, Sicelo Gqobana, by the Eastern Cape Health Crises Action Coalition Group. The signatories of this memorandum have been involved in consultations with health care workers and health care users across the Eastern Cape. The consultations revealed serious problems in the system. These problems are not new and have been the subject of correspondence with the health authorities for years. The primary problems identified were:

- **Facilities**-the poor quality of facilities hampers health care delivery with a lack of electricity, running water and inadequate space, the buildings often falling apart.

- **Human Resources** – The combination of a high vacancy rate and an out of date personnel system has catastrophic consequences for the delivery of health care and it frequently takes at least six months for an appointment to be confirmed if at all, with employees not paid.
- **Management** – There is no proper management and the day-to-day functioning of health facilities goes unattended, with chronic under-staffing; facilities falling into disrepair; equipment going unrepaired and new equipment not obtained.
- **Staff accommodation** – Many facilities have no or poor quality and insufficient accommodation and in some no electricity or running water. and the accommodation is filthy and run down. (Coalition, 2013)

It is likely that these GPs are perhaps accustomed to the abundance of resources at their disposal in the private setting when compared to the that of the public setting, but nevertheless, this is what they are accustomed to and most feel that the standard of public health in South Africa should strive to be at a level of the current private sector and that should be the progressive realisation of health care delivery rather than have it regress to that of the public sector.

Several emergency meetings were held with Dr Aaron Motsoaledi, the Minister of Health on this crisis in the Eastern Cape. He was genuinely shocked by some of the horror stories revealed to him. He has assured us that he takes responsibility in terms of the Constitution for when a crisis like this arises. “We will do all we can to mobilise support behind his efforts” says Mark Heywood, executive director of Section 27. But from now on civil society and

health workers will also independently monitor the plan and steps taken to do this, and measure progress clinic by clinic, hospital by hospital, fixed system by fixed system. If necessary we will assert section 27 rights in the courts. (Heywood, 2013).

The Eastern Cape Health Crisis Action Coalition (ECHCAC) was established to demand that the health system be fixed. It has no other agenda. It will campaign for justice for people. It will campaign to end corruption with impunity; it will campaign for the dignified employment of health care workers and the filling of vacant positions; it will campaign to ensure that democratic and effective clinic committees and hospital boards are established; and it will campaign for a plan, timetable and resources to turn around the crisis we describe. (Heywood, 2013)

Even though provision is made for the upgrading of the standard of the public health service in the White paper, the GPs still base their perceptions on the prevailing scenario and their personal experiences of the public sector and are sceptical of any immediate change.

Thus, the perception that the quality of medical care in the private sector is readily more available and consistent and it is perceived that this quality will simply not be forthcoming from the public health care sector. This concern was raised by all the GPs interviewed and is the most pronounced concern they have if they were to transition to the NHI. They feel that universal health provision for all people may be desirable but the cost of doing so would be compromising the patients' rights in terms of their autonomy and the respect and dignity they ought to get will be in jeopardy**.**

The overall knowledge of the general practitioners of the NHI is meagre. This in itself is an issue since this is such a significant development in health care delivery, not only in South Africa but also globally, that it should be in the interest of all participants in universal health

care, including doctors, to understand and discover these changes and implementations of the proposals and to actively engage where it concerns them

There is little or no dignity afforded to patients at state facilities and the treatment they get in the state facilities is generally inferior to that of the private sector that these doctors are accustomed to providing for their patients.

The interviewees also feel that they are not included sufficiently in the dialogue of how the NHI, once implemented, will impact on their practice of medicine, how it will affect their working conditions and how this will affect their income. At a special address by Health Minister Dr Aaron Motsoaledi at the University of Pretoria the opportunity for dialogue with the Minister and stakeholders on the implications of the NHI on health workers was made possible. The programme generated a constant buzz amongst health professionals anxious to know what its implications are (Strydom, 2015). At the same meeting Dr Coetzee, former SAMA general manager, lamented the fact that privately practising GPs had not been widely consulted regarding the NHI, in which they are set to play a central role as gatekeepers to public health care. Furthermore, she indicated that the Department of Health needs to consult directly with GPs in practice, not academics, regarding the shape of the NHI. (Strydom, 2015)

The doctors interviewed are not at all satisfied with the conditions of the public sector hospitals with respect to the supply of medicines and availability of investigations and equipment. They are distrustful of the management of these institutions. Generally they perceive their autonomy concerning their ability and proficiency in practicing medicine to be threatened. Further, decisions they ought to make in the best interest of patient care are compromised.

There was however a general feeling that if there were guarantees to the so-called “promises” by those advocating the NHI, that there was visible proof of public sector facility improvement, that corruption was rooted out, that remuneration was attractive and guaranteed and, that working conditions, including working hours, were all addressed with proper dialogue, there would definitely be an interest in considering working in the NHI system, albeit on a part-time basis to start off with. All the general practitioners agreed that healthcare was a fundamental right to the citizens of a country and that everyone had the right to the same quality of health care.

The problem with immigrants accessing public health facilities is rather a thorny issue. Most of the general practitioners interviewed generally feel that immigrants deplete state resources meant for South Africans and they argue that, without the immigrants utilizing the public sector, the situation would be vastly better.

The White Paper does detail all the necessary requirements the government has to fulfil to implement the NHI and goes into a lot of detail regarding this but on the ground the GPs interviewed have not seen this happening as yet and doubt its achievability.

In section 45 of the White Paper it is succinctly summarized what is needed for the NHI to succeed:

According to the World Health Organization, a health system has six building blocks:

i. Leadership/governance;

ii. Health care financing;

iii. Health workforce;

iv. Medical products and technologies;

v. Information and research; and

vi. Service delivery

And in section 46 it states that, “The absence, weakness and/or inefficiency of any one of these six blocks will render any health care system ineffective and adversely impact on its overall performance” (NHI, 2015).

Therefore, unless all these building blocks are well organized and implemented there is no hope that the NHI can succeed.)Limitations of study

4.1 Limitations of study

Saturation of data was reached after 11 interviewees of GPs. As all the participants worked in close geographic proximity, this early saturation of the data could potentially have been influenced by this. Indeed it is highly likely that the location of the participants urban/rural, province and size of city - could all influence responses. This is important to recognize when considering the limitations of the study, as the responses collected do not necessarily represent the perceptions of GPs across the entire country. A bigger cohort of interviewees that represents all aspects of South Africa could yield more accurate data

Chapter 5.Conclusions and recommendations

South African health care professionals and the general public have finally been given government's blueprint for the implementation of marrying the private and public health sectors – the NHI White paper. However, many areas remain fuzzy, notably how private doctors will be persuaded to work in a system that is likely to mean more work and less pay (Cullinan, 2015). Morally, there can be no argument against a fair and equitable health delivery system. In reality, marrying the two systems is going to be extremely difficult and challenging. It will require a buy-in from a wide variety of people who are not used to working together i.e. health care professionals from the private sector with those from the public sector (Cullinan, 2015). How this will happen is not clear in the White Paper despite a long delay in its delivery (NHI, 2015). It stills fails to explain how the two systems will be integrated. The implementation of the NHI is a reflection of the kind of society we wish to live: one based on the values of justice, fairness and social solidarity (NHI, 2015). According to the White Paper health care, a constitutional right, should be seen as a social investment and should not be subjected to market forces where it is treated as a normal commodity of trade (Cullinan, 2015). The White Paper makes a strong case for why all South Africans need access to the facilities and health care providers locked up in the private sector but it does not make the case for how private GPs will be attracted to work for the NHI. Getting buy-in from private GPs is crucial if the NHI marriage of the public and private sector is to succeed (Cullinan, 2015).

In conclusion, the GPs in this study were sceptical of the NHI and were not convinced that the NHI was near ready for implementation. In addition, they had visions of a chaotic system not dissimilar to the current public health sector which was felt to be mismanaged, understaffed, poorly maintained and poorly remunerated. None of the participants in this study would be willing to take part in the NHI it at this stage of its evolution. Further, all had

reservations about any future participation in the NHI given the Government's track record of mistrust and corruption.

- Since the NHI is being introduced by government in its attempt to meet its Constitutional obligations on "equal rights" and "equitable access" to health care by all South Africans it is mandatory that they create an appropriately suitable and proper platform for such an operation or system to function.
- It is entirely their responsibility to provide hospitals, clinics and health facilities that are managed at the highest standards; staffed appropriately with doctors, nurses and ancillary staff; and equipped accordingly so that it can function efficiently and effectively to provide the patients with good quality and dignified health care.
- It needs to create a working environment that is desirable to the medical staff to work in and that is simultaneously also appealing to patients who feel comfortable enough to want to be treated in it.
- The facilities need to propagate a positive image to attract both the staff and patients alike.

General Practitioners, like everyone else, have the right to autonomy: to choose where and how they conduct their business of practicing medicine that simultaneously will provide the platform that how they practice is ethical and just to the people they serve. As is the nature of the medical profession, doctors are generally drawn to the altruistic aspect of their vocation and have a sense of responsibility to treat and care for the sick. The fact that most doctors have chosen to work in the private sector is testimony that the state sector is undesirous despite this vocational calling. The findings of this study have positively identified what these undesirous elements are and why they have chosen to avoid working in this sector.

Furthermore, it has shown that should these concerns be taken into consideration, there would definitely be a changed attitude towards their participation in the NHI.

The problem rests with the fact that the quality of private sector practice as it is known to the practitioners interviewed, would be the bench mark of quality health care for which they would expect everyone to have access to and what they expect going forward with the NHI.

This, I believe, is not reality and in order to equalize the pool of resources for everyone from both sectors the standard would naturally have to come down for the majority to benefit. Therein lies the problem that the stakeholders are faced with when trying to implement a reform process that is both a constitutional right for the have not's as it is for the haves.

Finally, it makes sense that it would be an ethical responsibility for all stakeholders in the medical profession to meet for discussions on how to find ways to reconcile the starkly contrasting perceptions that these GPs raised regarding the public health sector in order to ensure successful NHI rollout.

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Appendices:

Appendix 1

Participant information sheet

Good day, my name is Dr Andrew Jacovides and I am a student registered for the degree, MSc in Medical Bioethics and Health Law at the Steve Biko Centre for Bioethics, University of the Witwatersrand.

Background

South Africa is in the process of introducing an innovative system of healthcare financing with far reaching consequences on the health of South Africans. The National Health Insurance, commonly referred to as NHI, if implemented, intends to ensure that everyone has equitable access to appropriate, efficient and quality health services. It will be phased-in over 14 years. This will entail major changes in the service delivery structures, administrative and management systems currently available.

The NHI is intended to ensure that all South African citizens and residents will benefit from healthcare financing on an equitable and sustainable basis. (DoH, 2011)

Significant changes to the private healthcare structure is inevitable if the NHI is implemented and this implementation will require the private sector to be involved as it is vital that this sector's resources are made available to the NHI as the public sector alone is not able to meet the demands required to deliver universal coverage as proposed.

Purpose of study

I am conducting research on the perceptions of medical doctors working in the private sector on the NHI. There is uncertainty surrounding the reform process as well as with how this will impact on the practise of medicine as we currently do.

It is hoped that the information derived from the study may enhance knowledge and understanding of your perceptions/opinions of the NHI and potentially could yield recommendations to the policy makers that will improve the transition of Doctors currently working in the private sector to work in the NHI. I therefore wish to invite you to participate in my study.

Procedures and conditions

This project involves semi-structured interviews of privately practicing GPs. Your participation in this interview is entirely voluntary and you have the right to terminate the interview at any point. If you agree to take part, I shall arrange to interview you at a time and place that is convenient for you. The interview will last less than one hour. You may withdraw from the study at any time and you may refuse to answer questions that you feel uncomfortable with answering.

Data management

The data collected will be stored and not released. It will be stored in a locked cabinet.

Confidentiality

With your permission, the interview will be digitally-recorded. If you agree to take part in the study, no one other than my supervisor/s will have access to the interview transcripts. The interview schedules and transcripts will be kept for two years following any publication or for five years if no publications emanate from the study. Please be assured that your name

and personal details will be kept confidential and no identifying information will be included in the final research report.

Queries regarding the study

Please feel free to ask any questions regarding the study. I shall answer them to the best of my ability. I may be contacted on 082 449 8354 or by email andrewjacovides@gmail.com. Alternately, you may contact my supervisor/s, Jillian Gardner, on 011 717 2719 or the Chairperson of the Wits Human Research Ethics Committee (Prof. Peter Cleaton- Jones) on made available on request.

Appendix 2

CONSENT FORM FOR PARTICIPATION IN THE STUDY

- I hereby consent to participate in the research study.
- The purpose and procedures of the project have been explained to me.
- I understand that my participation is voluntary and that I may refuse to answer any particular items or withdraw from the study at any time without any negative consequences.
- I understand that my responses will be kept confidential and that all raw data will be kept for two years following any publications or for five years if no publications emanate from the study.

Name of Participant	Student: Dr A Jacovides
Date	Date
Signature	Signature

Consent for Digital recording

I hereby consent to have the interview digitally-recorded. I understand that the transcripts from the interview will be kept confidential and will be retained for two years following publications or for five years if no publications emanate from the study.

Name of Participant	Student: Dr A Jacovides
Date	Date
Signature	Signature
Witness Name	

Date & Signature

Appendix 3

Participant interview schedule

Welcome of the interview participant, discussion of project information sheet and confirmation of demographic details.

1. How long have you worked in private practice?
2. Have you ever worked in the public sector?
3. Why did you move public to private or vice versa?
4. What type of practice do you work in? e.g. own practice, partnership, association, locum/assistant?
5. Do you enjoy about working in private practice and can you describe this?
6. Do you perceive any weaknesses in your current work position?
7. What do you know or understand about the National Health Insurance which is being proposed by government and is to be implemented in the near future?
8. Do you have any concerns about this model?
9. What positive and negative elements do you perceive the transition to have on your working life?
10. Would you be willing to contract to the NHI as a private health care provider?
11. Would more information on the NHI and the transition influence this perception?
12. Would you like to discuss or do you have any suggestions concerning the NHI that would make it more appealing to you to be a part of?
13. Do you have any other issues you would like to discuss?

Appendix 4

Data Collection Sheet

Participant Enrolment No: NHI _ _ _
Demographic Data

1. Age : < 30 yrs. □
   : 30-40 yrs. □
   : 40-50 yrs. □
   : > 50 yrs. □

2. Gender: Male □ Female □

3. Years worked in private practice? : 0-5 □
   : 5-10 □
   : 10-15 □
   : 15-20 □
   > 20 □

4. Type of practice you work in?

   Own Practice Solo □
   Partnership Practice □
   Assistance in a Practice □
   Only on a locum basis □

5. Have you ever worked in the public sector? Yes □ No □

6. Please explain the reasons for switching from private to public or vice versa:

   a)

   b)

   c)

7. Have you ever worked in a universal healthcare system, e.g. NHS?

   Yes □ No □

   If yes, describe your experience:

8. Describe what you enjoy about working in your private practice:

a)

b)

c)

d)

9. Describe any weakness that you currently experience in private practice:

a)

b)

c)

d)

NHI

10. Please explain what you understand about the NHI currently under discussion for roll out in the near future:

11, What are your concerns about this model of healthcare delivery?

a)

b)

c)

d)

e)

12. What **positive** elements do you perceive the transition will have on your working life:

a)

b)

c)

d)

e)

13. What **negative** elements do you perceive the transition will have on your working life:

a)

b)

c)

d)

e)

14. Would more information on the NHS influence this perception?

Yes □ No □

Explain:

15. What suggestions concerning the NHS do you have that will make it more appealing to you?

a)

b)

c)

d)

e)

f)

16. With your current knowledge of the NHI, would you be willing to enter into a contract as a healthcare provider?

Yes □ No □

17. Is there anything else you would like discuss? Yes □ No □

Details:

Appendix 5

Ethics Clearance Certificate

R14/49 Dr Andreas Jacovides

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140825

NAME: (Principal Investigator)	Dr Andreas Jacovides
DEPARTMENT:	Steve Biko Centre for Bioethics General Practitioners in Johannesburg and Pretoria
PROJECT TITLE:	Ethical Issues Identified by Medical Doctors in Private Practice in Johannesburg as Challenges to the Successful Implementation of the Proposed National Health Insurance
DATE CONSIDERED:	29/08/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Jillian Gardner and Louise Bezuidenhout
APPROVED BY:	Professor A Woodiwiss, Co-Chairperson, HREC (Medical)
DATE OF APPROVAL:	24/10/2014

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and ONE COPY returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit the application to the Committee. I agree to submit a yearly progress report.

Principal Investigator Signature Date 31/10/2014

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES