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Private doctors' responses on the implementation of a National Health Insurance Scheme (NHIS)

Botha, Cecilia Liza

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PRIVATE DOCTORS' RESPONSES ON THE IMPLEMENTATION OF A NATIONAL HEALTH INSURANCE SCHEME (NHIS)

Cecelia Liza Botha

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 Nursing

Johannesburg 2018

DECLARATION

I, Cecelia Liza Botha, declare that this Research Report is my own work. This Research Report is being submitted for partial fulfilment of the requirements for the degree of Master of Science in Nursing at the University of the Witwatersrand, Johannesburg.

This Research Report has not been submitted before for any degree or examination at this or any other university.

Signature 

11th day of June 2018

DEDICATION

IN MEMORY OF MY LATE PARENTS

"In you I have found Inner peace and the will to endure through extremely difficult times"

ACKNOWLEDGEMENTS

I want to Thank God Almighty for giving me the much needed strength, knowledge and wisdom to carry out this study.

I would like to express my heartfelt, sincere gratitude and appreciation to the following individuals.

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My husband, Kenneth Botha, thank you for the book you gave me in 2014 "Chicken Soup for the Soul" it attested to your unconditional love, patience, wisdom and support.

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To my dearest most gracious and kind mother-in-law for all her unfailing love and encouragement.

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My employer Clinix Tshepo- Themba Hospital for all their support.

Professor Lize Maree, Head of Department of Nursing Faculty at the University Of the Witwatersrand.

Viv Herbert, Lecturer in the Department of Nursing Education, University of the Witwatersrand.

ABSTRACT

There are numerous challenges and concerns, about a future mandatory National Health Insurance Scheme. The proposed South African NHI scheme, is that of capitation and a single-payer model in order to achieve Universal Health Coverage.

The objectives of this study, focused on exploring opinions and responses of medical doctors working in two private health care institutions.

The Research Methodology applied in this study is a quantitative, exploratory, descriptive survey design. A 25 item questionnaire was developed by the researcher and used for the study. One hundred and twenty questionnaires (n=120) were distributed and ninety questionnaires' (n=90) were returned (75%). A survey method was carried out in this study, which captured attitudinal type data (opinions, awareness, knowledge, preferences, perception, intentions, and motivations).

Doctors familiar with the objectives of NHIS totalled 93% of the sample. A significant finding was that only 43% of doctors supported the government proposal with 50% agreeing that the NHIS is inevitable and only 32% stated that they would support the NHIS. The doctors within the age-group of 41- 60 years, showed the highest percentage on knowledge regarding capitation, between the ages of 21- 40 years, 39% rated that they did not understand the concept capitation. Within the sample 86% of doctors understood the concept single – payer system with 14 % being unfamiliar with the concept. The latter percentage of doctors, were specialists within the 0- 15 years in practice. A further finding was that 76% of doctors stated that government will not manage a single- payer system and 90% stated that government cannot manage the health care system effectively. Within the sample 60% of the doctors completely disagreed that a single-payer system controlled by the government would be viable. A total of 41% of the doctors completely disagreed, that a mandatory capitation system could overhaul the health care system of South Africa.

The results indicated that doctors seem to be knowledgeable about NHI implementation however the majority of the doctors do not have confidence in government being able to manage the proposed NHI, in terms of capitation and a single- payer system. The majority are not in support of the proposed NHI.

Several recommendations for future research can be drawn from this study. It is therefore recommended that from the main findings of the study the following can be replicated:

- A larger study to assess the knowledge of private doctors on the implementation of the NHIS
- Using this study as a pilot.
- Using a larger population of private doctors.
- The instrument used in collecting data for this study was used for the first time and could therefore be tested for validity.

This therefore demands a well-researched NHI implementation strategy, from both private and public health sectors to be able to achieve Universal Health Coverage.

In conclusion the results seem to suggest that a mutually financially viable NHIS would be the most beneficial proposal to embark on. This study has not been researched before and seems to be an area to serve as a pilot study for future research.

TABLE OF CONTENTS

		Page
DECLARATION		ii
DEDICATION		iii
ACKNOWLEDGEMENTS		iv
ABSTRACT		v
TABLE OF CONTENTS		vii
LIST OF FIGURES		x
LIST OF TABLES		xii
LIST OF ABBREVIATIONS		xiii
LIST OF ANNEXURES		xiv
CHAPTER ONE: ORIENTATION TO THE STUDY		
1.1	INTRODUCTION	1
1.2	BACKGROUND TO THE STUDY	1
1.2.1	The Foundation of a National Health Insurance	1
1.2.2	The Relevance of a National Health Insurance Scheme	1
1.3	PROBLEM STATEMENT	3
1.4	RATIONALE OF THE STYDY	3
1.5	PURPOSE OF THE STUDY	3
1.6	RESEARCH QUESTION	3
1.7	RESEARCH OBJECTIVES	3
1.8	DEFINITION OF VARIABLES	4
1.9	OVERVIEW OF RESEARCH METHODS	5
1.9.1	Research design	5
1.9.2	Research setting	5
1.9.3	Population	5
1.9.4	Sample and sampling method	5
1.9.5	Inclusion criteria	6
1.10	DATA COLLECTION	6

1.11 SIGNIFICANCE OF THE STUDY 6
1.12 ETHICAL CONSIDERATIONS 6
1.13 CONCLUSION 6
1.14 OUTLINE OF THE STUDY 7

CHAPTER TWO: LITERATURE REVIEW
2.1 INTRODUCTION 8
2.2 INTERNATIONAL PERSPECTIVE 8
2.3 THE AFRICAN PRESPECTIVE 11
2.4 THE SOUTH AFRICAN PERSPECTIVE 13
2.4.1 History and background 13
2.4.2 Government policies 14
2.5 SUMMARY 16

CHAPTER THREE: RESEARCH METHODOLOGY
3.1 INTRODUCTION 17
3.2 RESEARCH DESIGN 17
3.3 RESEARCH METHODS 17
3.3.1 Research Setting 17
3.3.2 Population and Sampling 18
3.3.3 Data collection technique 18
3.3.3.1 The instrument 18
3.3.3.2 Data collection Procedure 18
3.4 PILOT STUDY 18
3.5 VALIDITY AND RELIABILITY OF THE INSTRUMENT 19
3.5.1 Validity 19
3.5.2 Reliability 19
3.6 DATA ANALYSIS 19
3.7 ETHICAL CONSIDERATIONS 20
3.8 SUMMARY 20

CHAPTER FOUR: DATA ANALYSIS AND RESULTS
4.1 INTRODUCTION 21
4.2 APPROACH TO DATA ANALYSIS 21

4.3	DATA RESULTS	22
4.3.1	Section One: Demographic Data	22
4.3.2	Section Two: Participants knowledge about NHIS	24
4.3.3	Section Three: Participants opinion regarding the NHIS	37
4.4	SUMMARY	56

CHAPTER FIVE: DISCUSSION OF MAIN FINDINGS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1	INTRODUCTION	57
5.2	SUMMARY OF THE STUDY	57
5.3	DISCUSSION ON MAIN FINDINGS	58
5.3.1	Section one: participant's demographic data	59
5.3.2	Section two: participant's knowledge about the NHIS.	59
5.3.3	Section three: participant's opinion regarding the NHIS.	61
5.4	STUDY LIMITATIONS	64
5.5	RECOMMENDATIONS	64
5.6	CONCLUSION	64

REFERENCE LIST	66
ANNEXURES	70

LIST OF FIGURES

Figure		Page
4.1	Awareness of NHIS proposed by the government.	25
4.2	Total sample of access to information about NHIS	25
4.3	Access to information and age group	26
4.4	Access to information by speciality	27
4.5	Access to information by years in practice	28
4.6	Understanding the objectives of NHIS by age group	29
4.7	Understanding the objectives of NHIS by speciality	29
4.8	Understanding the objectives of NHIS by years in practice	30
4.9	Understanding the concept of capitation by age group	31
4.10	Understanding the concept of capitation by speciality	32
4.11	Understanding the concept of capitation by number of years in practice	33
4.12	Understanding the concept of single-payer system by age group	34
4.13	Understanding the concept of a single-payer system by speciality	35
4.14	Understanding the concept of a single-payer system by number of years in practice.	36
4.15	Total sample - support of the government proposal	38
4.16	Total sample - NHIS inevitable.	39
4.17	Total sample- can government manage a single- payer system	40
4.18	Total sample – doctors' support of the NHIS.	41
4.19	Total sample- can government manage the health care system effectively.	42
4.20	Total sample - confident that government would meet objectives of NHIS by 2025.	43
4.21	Total sample - should private GPs be the key stakeholders for a NHIS	44
4.22	Total sample - should PHC be the fundamental focus for the NHIS	45
4.23	Total sample - recommend a personalised data scheme to participate in NHI policy making.	46
4.24	Total sample - would a single-payer system controlled by the government be viable.	47
4.25	Total sample - must pricing in the private sector be regulated	48
4.26	Total sample- can a mandatory capitation overhaul the healthcare system in South Africa.	49
4.27	Total sample -autonomy in their practices.	51

4.28 Total sample would prefer to treat private and medical aid eligible patients only. 52

4.29 Total sample - would prefer to treat private and medical aid eligible patients contracted to NHIS. 53

4.30 Total sample would the NHIS have a negative effect on the financial aspect of their practices. 54

4.31 Total sample - should incentives be offered to accredited practice. 55

LIST OF TABLES

Table		Page
4.1	Frequencies of gender and age group.	22
4.2	Speciality and gender distribution.	23
4.3	Years in practice and gender.	23
4.4	Access to information and years in practise.	27
4.5	Understand objectives of the NHIS / age group	28
4.6	Illustrates the percentages of agreement amongst doctors in years of practice that they are confident the government would meet objectives of NHIS by 2025.	44
4.7	Illustrates the percentages of agreement amongst doctors in years of practice that GPs should be the key stakeholders for a NHIS.	45
4.8	Illustrates the percentages of agreement amongst doctors and years in practice that and a Single- Payer System controlled by the government being viable.	48
4.9	Illustrates the percentages of agreement amongst doctors and age group and that a mandatory capitation can overhaul the health care system in South Africa.	50
4.10	Illustrates the percentages of agreement amongst doctors and years in practice and that a mandatory capitation can overhaul the health care system in South Africa.	50

ABBREVIATIONS

ANC: African National Congress

NHI: National Health Insurance

NHIS: National Health Insurance Scheme

WHO: World Health Organization

UHC: Universal Health Coverage

PPACA: Patient Protection and Affordable Care Act

FTE: Full time equivalents

CCG: Clinical Commissioning Groups

PHC: Primary Health Care

RDP: Reconstruction and Development Plan

GDP: Gross Domestic Product

HMO: Health Maintenance Organisations

CD: completely disagree

PD: partially disagree

PA: partially agree

CA: completely agree.

LIST OF ANNEXURES

Annexure		Page
A	Permission letter to conduct study at a Private Netcare Health Facility	70
B	Permission letter to conduct study at a Private Day Clinic	71
C	Approval letter from Netcare Private Facility to conduct the study	73
D	Approval letter from a Private Day clinic to conduct the study	74
E	Proposal letter for the study and approved by the Postgraduate Committee of the Faculty of Health Sciences.	75
F	Permission letter granted by Human Research Ethics Committee of the University	76
G	Information sheet to the participants, describing the study	77
H	Consent form	78
I	27 items structured questionnaire	79
J	Gill Smithies Proof reading and Language Editting Services	81
K	Turnitin Plagiarism Detection Report	82

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Chapter One outlines the overview of the study and includes the background, the problem statement, the purpose and significance of the study, as well as the research methodology and ethical considerations. The objectives of the research have guided the researcher throughout the study together with relevant definitions.

1.2 BACKGROUND

National Health Insurance (NHI) aims at providing every member of society with available, affordable, healthcare. The implementation of such a scheme is under consideration in South Africa and has therefore become a major goal for health reform.

1.2.1 The Foundation of a National Health Insurance

Universal Health Coverage (UHC) dictates the conditions required, for the execution of the National Health Insurance Scheme (NHIS). According to the World Health Organization (WHO 2013: 1-2), UHC is defined as a concept where all citizens have access to promotive, preventive, curative and rehabilitative health services. Furthermore, the quality of such care should be effective when paying for these services. Care should be taken to avoid hardships.

1.2.2 The Relevance of a National Health Insurance Scheme.

Molathegi, (2009:40-41) agreed the public sector had to capitalise on strengthening fiscal responsibilities, looking at the redistribution of profits to the minority group rather than to those individuals who own medical aid schemes and private hospitals. The goal is to progress to an economic system where healthcare benefits both the advantaged and the disadvantaged. Molathegi, (2009:40-41) stated that for equity to be successful, a one-pool funding model, incorporating public and private healthcare through disciplined methodical management and good governance of the NHI scheme, had to be investigated.

The Guardian Gate (2012:1-4) reported that in 2009, the Minister of Health gave his budget speech during a difficult time of public health sector strikes. In the Guardian Gate (2012: 1-4), it was further reported that the Health Minister outlined the Government's ten-point action plan

specifically addressing the problems and needs the country's healthcare system is confronted with. The Health Minister announced that future implementation of the NHI is a reality, emphasising that in order for the NHI to be realised, the country will have to approach health financing from a different angle. The WHO, an organisation actively promoting and embracing UHC, supported this motion. The WHO's aim is to access to affordable quality healthcare and this is the aim in the provision of a NHI. The report further stated, Guardian Gate (2012) that a great level of scepticism exists, as people think the concept of health financing is a myth fabricated by the African National Congress (ANC). The Health minister confirmed that the NHI is an internationally accepted healthcare solution and not South African specific.

National Health Insurance proposes to close the huge disparities between public healthcare and costly private healthcare. According to Baletta (2012:118), South Africa is considered to have one of the world's most unequal health care approaches, largely due to the private healthcare sector enjoying high quality and expensive health care.
Approximately 80% of South Africans are unable to pay for private medical insurance, only being able to afford the sub-standard services from public hospitals. It was further stated in this report that universal coverage would cost R255 billion (US$33 billion) by 2025, or escalate from 2.2% to 6.2 % of the Gross Domestic Product (GDP).

NHI could take between 15 to 25 years to be implemented successfully and would require a robust cooperation between the public and private healthcare sections (National Health Insurance Policy Paper, 2011:1-59). As indicated by Baletta (2012:1185), the success and sustainability of the private sector is largely attributed to the contribution from 60% of doctors in relation to the minority doctors in the public sector.

According to the Health Systems Trust (Matsebula; 2007:159-173), private doctors and private healthcare institutions work on a fee-for-service basis and their income streams come from medical schemes, cash payments, foreign patients and from medical tourism.
In the proposed policy on NHI (Policy on National Health Insurance, 2011:1-59) future contracted private practitioners and institutions to the NHI would be reimbursed through capitation, meaning doctors would no longer bill on a fee-for-service. As stated (Policy on National Health Insurance, 2011: 1-59), a fee-for-service would only apply those who are not insured. In a Sunday Times (2010:2) article, it was said that doctors are not just in the business of providing healthcare, but of also making money. However, Bateman, (2012:1-3) argued that irrespective of how the NHI model turned out, private doctors, once enrolled, would have to

adjust their current structure of functioning of a pay-for-service to a payment structure predetermined by a particular provider for a distinct set of services for a fixed period of time. Bateman (2012) further stated that private doctors need to look at enhancing their business processes, participating in primary healthcare, focusing on preventative medicine and perhaps subcontracting work place administration.

Although the two sectors operate in their own unique ways, they still need each other's support in order to ensure universal coverage and to complement each other where health provision falls short. Private doctors work independently and generate their own income, whilst the National Health Insurance (NHI) aim is for government to control the scheme through citizen taxation.

1.3 PROBLEM STATEMENT

There is no available information on private doctors' responses regarding their opinion or knowledge on the NHIS and the government's proposal to introduce a capitation model and single-payer system. The implementation of a NHIS in South Africa is imminent. South Africa is still far from achieving Universal Health Coverage and private doctors, working independently, compound the problem. The information sought from doctors working in the private sector could statistically be an indication of their understanding of a NHIS. South African private doctors' income is mostly on a fee-for-service basis and this could influence the inevitable introduction of a capitation model and a single-payer system, as well as the achievement of the principle of Universal Health Coverage.

1.4 RATIONALE FOR THE STUDY

The rationale for this study is to gain insight, in terms of knowledge and opinion, on the responses of private doctors, regarding the implementation of the NHIS, the proposed capitation model and the single-payer system. Furthermore, data will be collected to assess the private doctors' willingness to embrace the scheme. The study could serve as a pilot study, to augment the NHIS policy making and research in South Africa.

1.5 PURPOSE OF THE STUDY

The purpose of the study was to determine the responses of private doctors in relation to the implementation of a National Health Insurance Scheme.

1.6 RESEARCH QUESTION

What are private doctors responses regarding the implementation of a NHIS?

1.7 RESEARCH OBJECTIVES

- To explore the responses in terms of knowledge and opinions of private doctors relating to the implementation of the NHIS, the proposed capitation model and the single-payer system.
- To describe private doctors' responses regarding the NHIS, the proposed capitation model and the single-payer system.
- To assess private doctors' willingness to embrace the scheme.

1.8 DEFINITION OF VARIABLES

National Health Insurance:

"A health insurance scheme managed by government, using tax collecting revenue to finance the insurance fund, in order to provide a wide range of health care services that is equitable and accessible to all its citizens of that country."(The National Department of Health of the Republic of South Africa, 2012: 1-59).

Private Doctor: A professional person who has their own business and does not work for the government. (Cambridge Advanced Learners Dictionary. Third Edition, 2008)

Private Health Sector: Run with the goal of making money, called for profit and does not work for the government. (Cambridge Advanced Learners Dictionary. Third Edition, 2008)

Capitation:

An initial pre-arranged reimbursement, for a distinct number of services, for a permanent period of time, eligible to all individuals enrolled with the provider. (Econex. Health Reform Note 6, 2010:4)

Single-Payer System:

One entity (usually the government) responsible for pooling of all funds mainly from tax collection in order to pay providers in the health system. (Econex Health Reform Note 6, 2010:1)

Fee-for-Service:

The provider receives payment for each individual procedure or care rendered. (Econex. Health Reform Note 6, 2010:3)

Green Paper:

A baseline document drawn up on a specific policy area, with the inclusivity of certain individuals to discuss and deliberate and/or agree on, before finalisation to an official policy document called a White Paper. (Business Dictionary, 2010)

Opinions:

Views or judgements formed about something and not necessarily based on fact or knowledge, and can be statements of advice given by experts on a professional matter. (Oxford Dictionary, 2016)

1.9 OVERVIEW OF RESEARCH METHODS

Research approaches refer to the methodological viewpoints of the study and address the research questions and objectives, samples, data collection, instruments and procedures, data analysis and the test of validity and reliability. (Burns, Grove and Gray 2013:704).

1.9.1 Research design

This study used a quantitative explorative, descriptive survey design. According to Burns, Grove and Gray (2013:704), quantitative research is a formal, objective, methodological procedure, in which numerical statistics are used to define and examine associations amongst variables.

This design allowed the researcher to collect data of a broad scope.

1.9.2 Research setting

The settings used in this study are two private healthcare institutions in the South West Region of Gauteng.

1.9.3 Population

The target population refers to the entire set of individuals or elements who meet the sampling criteria (Burns, Grove and Gray 2013:703). The sampling criteria, according to Burns, Grove and Gray (2013:703), are a number of features or characteristics for inclusivity as a fit in the target population.

The target population comprised of private doctors working independently from the government in private practice. In this study, the total population of private doctors practising at two independent private healthcare facilities in the Gauteng South West Region were selected (N=156).

1.9.4 Sample and sampling method

A statistician from the Medical Research Council, determined that the sample size should include the total population (N=156).

1.9.5 Inclusion criteria

The respondents included in this study were private doctors working at two independent private healthcare facilities willing to participate in the study.

1.10 DATA COLLECTION

The researcher and statistician designed a 27-item structured questionnaire. A pilot study was conducted to test the questionnaire.

1.11 SIGNIFICANCE OF THE STUDY

The findings of this study can provide valuable information regarding the opinions of doctors practicing in the private sector concerning the implementation of the NHIS. Furthermore, it will provide information regarding the co-operation these doctors give to the successful implementation of the scheme.

1.12 ETHICAL CONSIDERATION

The researcher obtained permission from the directors of two private healthcare institutions, Private Day Clinic and Netcare Private Hospital, to obtain data. The study's proposal was submitted to the Postgraduate Committee of the Faculty of Health Sciences and approved accordingly; the Human Research Ethics Committee of the University also granted permission. The participants received an information sheet describing the study to ensure they understood the conditions of the study and the voluntary nature of participation. Measures were taken to ensure anonymity and confidentiality, and only the researcher and supervisor had access to the raw data. Doctors agreeing to participate received consent forms to sign before participation. Data were kept in a locked cupboard.

1.13 SUMMARY

This chapter provided an overview of the study. The background illustrated the significance of Universal Health Coverage, which explains why the Minister of Health proposed the implementation of the scheme. An explanation into the role and relevance of private doctors in the South African health industry followed. Also presented were the problem statement, purpose and significance of the study, together with study objectives and an overview of the methodology. Chapter Two focuses on the literature review.

1.14 OUTLINE OF THE STUDY

Chapter One: Overview of the study

Chapter Two: Literature review

Chapter Three: Research methodology

Chapter Four: Data analysis

Chapter Five: Summary of study, Main findings, Recommendations, Limitations, Conclusion

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a review of the literature that will provide an overview of the fundamentals of a National Health Insurance Scheme from an International, African and South African perspective. Furthermore, literature provides information on the impact of the NHI on the South African healthcare system and in particular, on healthcare practitioners.

2.2 INTERNATIONAL PERSPECTIVE

In National Health Insurance schemes in the worlds most developed industrialised countries, such as the United States of America (USA), Senger (2013:1-3) stated that the new system as introduced in the USA, referred to as the 'Patient Protection and Affordable Care Act (PPACA) also known as Obamacare,' will have an undesirable effect on doctors' practices. According to Senger (2013:3), the medical profession will be compromised by the loss of independence and integrity, as a result of third party payment arrangements. Obamacare supports negative features, such as the dependence on government reimbursement for medical services that are not always reliable and the government regulations physicians are subjected to. According to Senger (2013:3), doctors are under a great deal of pressure and anticipate their jobs becoming more stressful and difficult. It was illustrated by Senger (2013:3) that with the inception of Obamacare, the doctors that were registered with "Medicaid" (the doctors payment system), would deliver cover netting up to 138% of the state poverty index, equating to 15.586 dollars per person in 2013; an additional 12 million citizens were added by 2015. This was conceded by the Congressional Budget Office. According to Senger (2013:3), this was contradictory and raised much concern from the Medicaid doctors re-imbursement structure, as they only received 58% of the total cost owed to them. Deliberations from physicians were as a result of intolerable conditions such as inaccessibility, unaffordable healthcare as well as overcrowding in emergency departments. One in three primary care physicians declined to see Medicaid patients largely due to restrictions on reimbursement to physicians. Senger (2013:3) stated that doctors practicing in healthcare deprived areas, were given a 10% bonus, however, this was much less than the increased Medicaid payment to primary care physicians for 2013 and 2014. The federal taxpayer sponsored Medicaid physicians financially, as it addressed the shortfalls from Medicaid funding and the higher Medicare payment rates, as Medicare paid significantly less than the private sector. It was further stated by Senger (2013), in comparison to 2009, 80% of the physician's private sector expenses were paid. Senger (2013:1-3) stated the state funding

would be stopped passed the two years and the Medicaid physicians have to look at adjusting their overheads. Medicaid doctors can expect a substantial drop in their payments after 2014 as tax payments will be used to finance higher Medicaid overheads.

Alger (2014:1), following a Physicians Foundation Survey amongst a sample of 20,000 physicians, concluded that 81% of physicians described themselves as being over-worked, 44% stated they will reduce patient access and see less patients, terminate their working career, will work less hours, decline to see new patients and resort to non-clinical career. Alger (2014:1) further argued that this type of response would have a huge negative impact on human resources, as it would give way to a loss in full time equivalents (FTEs). Levels of Medicare and Medicaid patients increased in 2011 by more than 75 million, largely due to many patients turning 65 and therefore eligible to qualify for Medicare and subsequent increased healthcare and policy challenges. This however resulted in millions of new patients being covered through Affordable Care Act (ACA) (Obamacare). Alger (2014: 1) listed certain written comments from the survey:

- Health reform would receive better co-operation if a reduction in policy making and bureaucrats could be seen, instead of being added to.
- Permitting private insurance firms to offer assistance across state lines in order to decrease the cost of health insurance.
- Exclude government from healthcare.

In the United Kingdom, according to a UK-BBC Health Article (2013:1-9), the health secretary is liable for compiling policies such as waiting times for the National Health Scheme (NHS). According to the UK-BBC Health Article (2013), the United Kingdom Health structure functions on the following basis: Legislative policies are formulated by the Department of Health and handed down to ten strategic healthcare ruling parties and then to a group called Primary Care Trusts (PCT), who are ultimately responsible for the implementation and execution of these policies. The Department of Health also has a clinical commissioning board who oversee the management and control of the NHS. Purchasing Specialist Services Planning, to look at the entire health budget, as well as the management of the budget of the Clinical Commissioning Groups (CCG) are some of the functions the Clinical Commissioning Board will oversee. According to BBC Health (2013), local councils will concentrate and have more control in rendering public healthcare service, specifically focusing on problems such as weight gain and preventative programmes working closely with Clinical Commissioning Groups. It

was stated in the article that the public citizens have also been granted a platform, i.e. a National Body called 'Health Watch' to cast or express their opinions about the NHS.

According to National Health Services-NHS Choices (2015:1-2), England's National Health Scheme, implemented in 1948, is one of the biggest and oldest single-payer healthcare systems worldwide. Its success and achievements came from major effort and challenges and good governance and legislation. As stated in NHS Choices (2015), England's NHS was entirely financed through taxation and was changed in 2013 to a more forceful NHS legislation, to improve their funding system. It was further illustrated in NHS Choices (2015), that on the inception of the NHS in 1948, it operated on an estimated budget of 437 million pounds (estimated at 9 billion pounds at current rate) and from 2015 to 2016, this figures stands at 115.4 billion pounds. According to NHS Choices (2015), in an update analysis done in 2014 comparing esteemed first world countries such as Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the USA, England was recognised and affirmed, as having one of the most inspiring sought after NHS system.

According to the Oxfam Briefing Paper (2013: 1-35), it was argued that taking from the poor, who were unable to afford to pay health insurance premiums, should be abolished and rather look at the principles of Universal Health Coverage, which are equity and universality. The Oxfam Briefing Paper (2013) showed that Sri Lanka, Malaysia and Brazil source income tax contribution funds from all their citizens, on all income levels, to fund Universal Health Coverage. This was attributed to the citizens receiving maximum financial risk protection from the tax-aided health schemes in these countries.

During the late 1980s in Brazil, almost half of its population had no health protection and after 20 years the country implemented a tax-financed Universal Health Coverage system. In the Oxfam Briefing Paper, (2013) it was stated nearly 70% of Brazil's 200 million citizens were dependent on the new healthcare system. It was further noted in the Oxfam Briefing Paper (2013), that it is only through tax financing that poor countries can achieve universal and equitable health coverage. Another approach, as stated in the Oxfam Briefing Paper (2013), is the collection of insurance premiums from citizens who are formally employed through taxation, however this method will cover all its citizens irrespective whether they are working or not. This UHC method was successfully implemented in countries such as Thailand, Mexico and Kyrgyzstan, however, it was mentioned that Thailand was also reliant on 12% of their citizen's payroll contribution and the remainder aided by government revenues to finance their UHC. It was further stated that in Thailand, within ten year period, a huge decline was noted

in the number of people without healthcare coverage. This percentage dropped from 30% to under 4% of inhabitants. In spite of this decline, it was revealed that the poorest citizens of Thailand still benefitted the most and the government's goal to breach healthcare fragmentation and disparities of expensive healthcare benefits was achieved by merging the various schemes to those in the formal sector. Furthermore, steps have been taken in Thailand to merge different schemes that would overcome the current fragmentation of grander healthcare benefits for those in formal employment. The Oxfam Briefing Paper (2013), stated Kyrgyzstan used reforms of their healthcare system. They drew funds from taxation, payroll contributions and the countries development aid. This type of single-payer system drastically curtailed Kyrgyzstan fragmentation and inequity and produced better-quality healthcare. The Brief for Universal Health Coverage for South Africa proposed that its people must have legal citizenship before looking at financial contributions. It was argued in the Briefing Paper (2013) that for Universal Health Coverage to be successful, the most paramount course to take was through tax financing, however, countries should look at options on how to produce more tax revenues for healthcare. Oxfam explained that it was possible, as poor countries entered into increasing domestic revenue for health, by having superior systems in place for tax collection such as: tax rate adjustments, implementation of new liberal taxes as well as advanced financing options. These radical methods of fiscal tax administration were proven in approximately 52 emerging countries, which showed astounding revenue collection with an additional 31% to 269 billion dollars incline in domestic resources.

2.3 THE AFRICAN PERSPECTIVE

Eagle (2012:1-5) reported nine developing countries in Asia and Africa improved remarkably when they implemented universal healthcare coverage - Ghana, Rwanda, Nigeria, Mali, Kenya, Indonesia, the Philippines and Vietnam. According to Eagle (2012), Universal Health Coverage achievements come from collaborative healthcare approaches, from the private sector and private service providers. This was largely due to the improvement and access and equity to healthcare.

Spreeuwers and Dinant (2012:1-7) stated that Ghana is the only Sub-Saharan African country, whose success of Universal Health Coverage derived from the implementation of a National Social Health Insurance, with a primary focus on ensuring accessibility and improving health care for all its citizens. Spreeuwers et al. (2012:1-7) mentioned the two countries of Uganda and South Africa, who are still in the process of implementing a National Health Insurance, appear to be failing. The failure is largely as a result of the excessive number of healthcare

insurances in South Africa (SA), estimated at approximately 120 private healthcare insurance companies, compared to Ghana, which has significantly less. According to Spreeuwers et al. (2012), these private health insurance coverage systems, are not in support of National Health Insurance as the introduction of this scheme brings about a strong concern that business will be lost.

Adebimpe, Olelekan, Adebukola (2010:123-125) stated that Nigeria implemented its NHIS in 2005 and its success was largely due to it being reliable and affordable. Their method is through the collection of premium and accepted health services for formal sector employees, with the goal to expand at a later stage to other sectors. Adebimpe et al (2010) added that the Health Maintenance Organizations (HMO) act as custodians, operating and managing the NHIS of Nigeria. They mostly procure both capitation and fee-for-services, although there are still a few operating only on a fee-for-service, and have the function of mediating between prospective contributors and the healthcare providers. It was stated that healthcare providers have a good standing with HMOs, due to their good financial capabilities and service coverage. However some HMOs also failed to pay their monthly payments resulting in poor delivery of services to clients. Adebimpe et al (2010) stated that client opinions about HMOs are now under scrutiny for a continued successful NHIS of Nigeria.

According to Saidat (2013: 1-7), in 2011 Ghana's population was close to 25 million people and whilst it is a small, lower to middle income country, poverty remains a high concern for the country. It was indicated by Saidat (2013) that since the inception of Ghana's National Health Insurance Scheme in 2003, the health of its citizens has been profoundly well maintained, compared to other Sub- Saharan countries; this was received with much admiration and inspiration around the world. Gajate-Garrido and Owusua (2013:1-33) indicated their much acclaimed insurance method is through universal coverage and increasing healthcare utilisation. Substantial progress is still required to obtain optimal potential in areas such as: facilities and equipment, administration, managerial and technical human capacity, technical tools for processing and reimbursing claims and the management of public expectations. Gajate-Garridi and Owasa, (2013) submitted recommendations to equity concerns such as sufficient permanent infrastructure and upskilling of personnel, a computerised claims processing centre, an option for children to enrol for free in the scheme without their parents being enrolled, management and control of corruption, surveys should be administered with education given to the public together with, key stakeholders and community leaders, leniency in the payment of premiums for the poor, to promote registrations (by giving the members the option to pay premiums by instalments on a date suitable for them), cover large community registrations on the onset of

implementation, and do a pilot study first with low income groups to test the scheme before implementation. Gajate- Garridi and Owasa, (2013), maintained that in spite of the latter recommendations, Ghana's NHIS continues to prosper in accomplishing these goals.

2.4 THE SOUTH AFRICAN PERSPECTIVE

2.4.1 History and background

Shishana (2006:814-818) reported that the attainment of universal coverage will be a lengthy duration, and will require robust expediency to overhaul the current health care system for NHI to be successful. The factors identified by Shishana (2006: 814-818) are: effective political will-power with strong government stewardship; organisational and good legislative requirements; understanding the principles and standards of equity and universality of the people; the trust and buy-in from the people in government and its organisations; adequate and readiness of competent human resources; overhauling healthcare infrastructures.

According to Shishana (2006: 814-818), universal health coverage will only be achievable if critical fiscal restructuring and strong leadership within in government can be driven.

Bump (2010:40-41) recommended the following ideas for the advancement of policy-making towards Universal Health Coverage:

1. Processes involved in UHC must take into account that it is lengthy process and policy makers should approach the situation with patience, in that a rushed decision may lead to social mayhem.

2. Policy learning, sharing of ideas and policy solutions nationally.

3. The change over for UHC will be based on a strong political will; the present situation of local health operations must be readdressed, focusing on social contracts and management and responsibilities of financial operations.

4. Seek assistance and guidance from developed countries, notwithstanding that other countries have moved towards UHC without assistance.

It was stated in the Health and Democracy Paper, Chapter 1 (2010: 2-15), that the African National Congress (ANC), in 1994, would undertake to follow the principles of the Freedom Charter and Primary Healthcare (PHC), both of which were recognised by the Reconstruction and Development Plan (RDP). In the paper, the mental and physical health to underprivileged South Africans were compromised by the unacceptable apartheid policies. This fragmentation

resulted in, inefficient and poor healthcare services to its citizens. As revealed in the Health and Democracy Paper (2010), the current healthcare wastage was mainly due to the South African Government and attested to the enormous expenditure of R550 per capita per annum on healthcare. Comparative to this statistic, it was further stated that this figure, is about ten times that which the World Bank estimated it would cost to deliver basic public healthcare services and crucial clinical care for all. Due to these statistics, masses of people appear to be suffering and deprived from essential healthcare. This resulted in the Public Inquiry Report.

2.4.2 Government Policies

The government is currently developing a National Health Insurance System that will offer affordable healthcare. This is outlined in the National Health Insurance Green Paper (2011:1-38), that health services are skewed, inefficient and ineffective due to gross inadequate healthcare management and delivery of resources. According to the National Health Insurance Green Paper (2011), primary healthcare for the prevention of disease and promotion of health care, will be the central focus towards achieving UHC. According to the Green Paper, objectives of the scheme will address the following:

- Providing right of entry to better-quality healthcare services for all South Africans, irrespective whether they are working or not
- The creation of a single-fund is to pool risks and funds to ensure equity and social solidarity. The single-fund aim will be to acquire or procure services for the entire South African population, through fiscal mobilisation and key financial resources
- Overhauling deprived and poor public healthcare services by improving and strengthening healthcare systems. The biggest drive will be on Primary Healthcare, focusing on clinics, schools, community healthcare centres, hospitals to homes and the private sector.

Inclusivity and cooperation would primarily be needed from private general practitioners, accredited and contracted to NHI, to be able to provide this wide range of services to the population in order to attain UHC.

The focus on primary healthcare, as reported by Fraser, Taylor and Kelly (2011:1-30), for South Africa to strengthen and revitalise the health system effectively and successfully, will require inclusive firm policy making, specifically focusing on the primary healthcare approach. If primary health approach is used as the first point of entry to the health system, it will aid in improving and contributing to better access to quality health.

Baletta (2012:1185) suggested that to plan and revitalise or overhaul the entire healthcare system for the inception of a NHI would come at multi-billion dollar expenditure. According to Baletta (2012), a pilot project has to be launched and rolled out in 10 districts in South Africa, which could take up to five years. The projects according to the Health Minister, Aaron Motsoaledi, will comprise of focusing on fixing management, human resources, infrastructure and resources at these pilot facilities in preparation for the National Health Insurance fund set up. The planning for these projects to be rolled out was estimated to take up to 14 years.

According to Keeton (2010:803-804), a few concerns were raised where analysts reported that NHI proposals could transfer a significant part of the burden of the public health problems to the private sector sphere. In Keetons (2010) study, it was stated that a private economic consultancy, Econex, reported and assessed costings envisaged in the health systems proposals. It was reported by Nicola Theron, Director of Econex, that NHI funding could relate to R216 billion per annum, this despite other attempts of a NHI funding model, which amounted to approximately R197 billion. Astounding to say, this equates to South Africa's all-inclusive population income tax contribution. Keeton (2010) said lessons must be learned from global practices, where funding from providers needs to be looked at and different strategies accrued, in order to secure maximum financial gain. A key element, according to Keeton (2010), is to have a unified pool of funds to guarantee that all accessible human resources are used optimally, effectively and efficiently. This however, will be the notion that people will be afforded access to health services on the basis of their need of care and not be discriminated on the need or ability to pay.

Matsebula and Willie (2007:159-173) argued that private doctors are seen as indirect sellers of care in private hospital services, however they play a vital and mutual role to make decisions in the regulation of private hospital care. It is further mentioned by Bateman (2012:1-3) that comparative data was demonstrated amongst countries where 5% of Gross Domestic Product (GDP) was spent on health, with 5% catering for 7 million people in private healthcare and the remaining 3.5 % providing for 41 million people in State health. This data suggested South Africa was ranked 175th of 191 countries in the WHO overall health system performance, and the likelihood future model for South Africa would be single-payer model. Bateman, (2012), describes that this model will possibly allow for supplemental top up health insurance with a further merging of medical aid schemes and private healthcare members to pay additional fees. Bateman (2012) further illustrated that estimated calculations done under the capitation model, could reimburse already well-established General Practitioners; this could amount to well over R1.5 million per annum in relation to their current earnings of approximately R750.000 gross

turnover. According to Bateman, medical aid rates presently worked on an estimated calculation of 3.5 fee-for-service consults per annum, per patient, (at R228 VAT included per consult), equalled R798. 000 annually, and under capitation, dividing this by 12, gave a monthly capped rate of R66.50 per patient per month. If the NHI allocated a practitioner 2000 patients per annum (numbers based on the old Trans-Med capitation model), this added up to R130.000 per practitioner, paid up in advance monthly, totalling R1.560 million per annum.

It is evident that striving for UHC still appears to be dominated by the current situation of private and public health sector inequalities despite numerous attempts of liberation. The efforts of renewal of public hospitals appears to be the start of a new era, to provide accessible and equitable healthcare to all citizens of South Africa. NHIS will only thrive with collaboration from both public and private healthcare sectors. According to the Health Minister, NHI intentions are not to extinguish the private sector, but to make the sector more sustainable by making tariffs more reasonable and cost effective in order to work towards UHC. Much debate will continue and there are numbers of issues and challenges that require further investigations and research. Naidoo (2012:149-150) suggested that some of the challenges for NHI to succeed were the worsening quadruple burden of disease, a shortage of key human resources and the present underperformance of public institutions, and further mentioned that the primary focus will however remain the capitation model and the impact it would have on the private sector.

2.5 SUMMARY

In this chapter literature was reviewed in relation to a NHS in countries internationally, African countries and South Africa.The South African context of Universal Health Coverage, the role of a National Health Insurance Scheme in SA and the relevance of primary healthcare was discussed in more detail. The next chapter will describe the methodology used in the study.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter describes research methodology, which includes research design, study setting, sampling process, sampling criteria and data collection procedure. A pilot study, validity and reliability, together with the ethical considerations of the study are described. Polit and Beck (2012:707) refer to research methodology as a process or plan for conducting the specific steps of the study.

3.2 RESEARCH DESIGN

This study used a quantitative explorative, descriptive survey design. Burns, Grove and Gray (2013:704) explain quantitative research as a formal, objective, systematic process in which numerical data describes and tests relationships amongst variables. A survey, which is generally associated with the collection of a wide range of data from large representative sample, was conducted using a structured standardised descriptive questionnaire to collect data. According to Polit and Beck (2012:264), surveys obtain information about peoples' actions, knowledge, intentions, opinions, and attitudes whereby participants respond to a set of questions.

3.3 RESEARCH METHODS

Research methods refer to the methodological perspectives of the study used to address the research question including decisions about population and sampling, data collection, instruments used and data analysis, together with measures of validity and reliability (Burns, Grove and Gray; 2013:25).

3.3.1 Research Setting

The settings used in this study are two private healthcare institutions in the South West Region of Gauteng.

3.3.2 Population and Sampling

The target population comprised of private doctors working independently from the government. In this study, the total population of private doctors practising at two independent private healthcare facilities in the Gauteng South West Region were selected (N=156).

A statistician from the Medical Research Council, determined the sample should include the total population (N=156).

3.3.3 Data collection technique

Data were obtained using a survey technique and a structured questionnaire as the data collection instrument.

3.3.3.1 The instrument

The researcher, together with a statistician from the Medical Research Council, developed a 27-item structured questionnaire (Annexure I). The questionnaire was divided into three sections: Section One elicited the participant's responses about their demographic data; Section Two elicited responses regarding their knowledge about the National Health Insurance Scheme; Section Three gauged the participants opinion about the National Health Insurance Scheme.

3.3.3.2 Data collection Procedure

Two sets of data were collected over a period of five months, from February 2015 to August 2015; the first set of data to conduct a pilot study, and the second set for the main study. The researcher administered the questionnaires to all the doctors working at the two private independent institutions. On completion, the questionnaires were posted in a box within the hospitals. The researcher used a numbering system to control the completed returned questionnaires.

3.4 PILOT STUDY

A pilot study is defined by Burns, Grove and Gray (2013:44) as a smaller version of a proposed study, conducted to refine the methodology. A pilot study was done to test and refine the instrument for clarity and accuracy and ensure reliability.

The pilot study was conducted on doctors (n=5) working part time at one of the chosen sessional rooms. The researcher invited the doctors to participate and those who agreed to participate were administered the questionnaire. The respondents were given the opportunity to raise

concerns about the questionnaire. The pilot study commenced February 2015. An additional five doctors working in the support services departments (Radiology, Nuclear Medicine and Laboratories) were invited to participate, to increase the sample size for the pilot study. The researcher took into consideration the nature of the participants work schedule and a one week time line was agreed upon to complete the questionnaires. The participants reported it took them no longer than ten minutes to complete the questionnaire. No issues were raised from the participants and the questions were found to be adequate, in terms of clarity and accuracy. The observations were noted and data collection commenced. The data collected from the pilot questionnaires were not part of the study.

3.5 VALIDITY AND RELIABILITY OF INSTRUMENT

3.5.1 Validity

Validity of the instrument is described as something that measures what it is supposed to be measuring, according to Polit and Beck (2012:264), and content validity relates to the adequacy of coverage of the content being measured.

The content of the questionnaire was designed by taking the research variables and the literature on the National Health Insurance into consideration. The instrument measured and described responses in terms of knowledge and opinions of private doctors relating to the implementation of the NHIS, the proposed capitation model and the single-payer system, as well as an assessment into their willingness to embrace the scheme.

A statistician was consulted and checked the instrument for feasibility of the variables and objectives of the study, which was found to be adequate in terms of the criteria.

3.5.2 Reliability

Reliability refers to the consistency of the measure obtained Burns, Grove and Gray (2013:707). The instrument was evaluated by a statistician for coding to enhance capture and data analysis and was found to be adequate. A pilot study was then conducted in order to test the instrument for clarity and accuracy to ensure reliability. The statistician recommended that the researcher recode the variables of the instrument into smaller groups to reduce data that repetitively produced the same results. According to the researcher, the recoding of the variables had no impact on the participant's responses.

3.6 DATA ANALYSIS

Data were entered onto an Excel spreadsheet and sent for statistical analysis. Descriptive statistical analysis was used to explore the data. All the data were categorical and summarised as frequencies and percentages. Data files were set within the computer statistical package 'STATA' version 11 and analysed by a biomedical statistician from the Medical Research Council. The Fischer Exact Test was applied to test independence and interpret tables at the 0.05 level of significance($p<0.05$), and the Pearson chi-squared test statistic(x^2) was used to test for independence of association between two categorical variables as well as for the equality of proportions across the populations under study.

3.7 ETHICAL CONSIDERATIONS

The researcher sought and obtained permission from the directors of two private healthcare institutions - Private Day Clinics (Annexure A and Annexure B) and Netcare Private Hospital (Annexure C and Annexure D). A proposal for the study was submitted to the Postgraduate Committee of the Faculty of Health Sciences and approved (Annexure E), and the Human Research Ethics Committee of the university granted permission (Annexure F). The participants received an information sheet describing the study (Annexure G) to ensure they understood the conditions of the study and the voluntary nature of participation. Measures to ensure anonymity and confidentiality were used, with only the researcher and supervisor having access to the raw data. Doctors agreeing to participate received consent forms to sign before participation, (Annexure H). Data were kept in a locked cupboard.

3.8 SUMMARY

In this chapter the methodology of the study was described. Research design, study setting, sampling process, sampling criteria and data collection procedure, the instrument, reliability and validity of the instrument, the pilot study and ethical considerations were discussed. Chapter four presents data analysis and results.

CHAPTER FOUR

DATA ANALYSIS

4.1 INTRODUCTION

This chapter describes the analysis of data, using descriptive and comparative statistical tests together, with an interpretation of the findings. Results are presented in Tables and Figures and discussed according to the three sections of the questionnaire. **Section One** presents the results on the participants' demographic data. **Section Two** presents the results on the participants' knowledge about the National Health Insurance Scheme. **Section Three** presents the results related to the participants' opinion regarding the National Health Insurance Scheme. One hundred and twenty questionnaires (n=120) were distributed and 90 (n=90) were returned (75%). The survey method carried out in this study, captured attitudinal type data (opinions, awareness, knowledge, preferences, perception, intentions and motivations).

4.2 APPROACH TO DATA ANALYSIS

Data files were set within the computer statistical package 'STATA' version 11 and analysed by a biomedical statistician from the Medical Research Council.

Descriptive tests were used to achieve the study objectives and synthesise the data in **Sections One, Two and Three.** Descriptive statistics, as stated by Wegner (2013:7-8), are used to extract information from the research variables, to measure the profiles, patterns, trends and the relationships within the data.

The Fischer Exact Test was applied, to test independence and interpret tables at a 0.05 level of significance ($p<0.05$), together with determining the differences in the frequencies of the participants responses.

Pearson's chi-square test statistic (x^2) was used to test for independence of association between two categorical variables, as well as to test for the equality of proportions across the private doctors under study.

4.3 DATA RESULTS

4.3.1 Section One: Demographic Data

This section relates to the demographic profile that includes gender, age group, speciality, number of years in practise, and type of practise pertaining to the respondents, participating in the study. Results are presented in tables relating to both specific gender and the total sample (n=90).

Table 4.1 presents the gender and age group frequencies of the respondents

Table 4.1: Frequencies of gender and age group

Age group Years	Frequencies Female	Frequencies Male	n	%
21-40	5 (23)	13 (19)	18	20.00
41-60	16 (73)	49 (72)	65	72.00
Over 60	1 (5)	6 (9)	7	8.00
Total	22	68	90	100

The total number of male and female respondents in the age group of 21 to 40 years represented 20% (n= 18) of the sample and of this number, males 19% (n=13) were dominant with females 23% (n=5). Total male and female respondents in the age group of 41-60 years accounted for 72% (n=65) of the sample were dominant females representing 73% (n=16) and males with 72% (n=49). Total male and female respondents in the age group of over 60 were 8% (n= 7) with female 5% (n=1) and males 9% (n=6).

A chi-square test indicated there was no significant association between age group and gender

Pearson chi^2 (2) = 0.5005 Pr = 0.779
Fishers Exact Test = 0.847

Speciality relative to Gender

The field of practice or speciality is an important variable, as stated in primary healthcare literature (National Health Insurance Green Paper, 2011:1-38). This would be the focus for the first point of healthcare by the General Practitioner, as well as a comparison with other variables in the study. The variables were reduced to specialised and non-specialised fields of practice.

The specialised categories were General Surgery, Physicians, Obstetrics and Gynaecology, Paediatrics, Speciality Surgery, Psychiatry and Other. The Primary Healthcare GPs were categorised under non-specialised.

Table 4.2 represents a distribution of speciality and gender of the respondents.

Table 4.2: Speciality and gender distribution

Speciality	Frequencies Female	Frequencies Male	n	%
Specialised	22 (100)	64 (94)	86	96
Non- Specialised	0 (0)	4 (6)	4	4
Total	22	68	90	100

The results show that 100% (n=22) of female doctors and 94% (n=64) of male doctors have specialised, accounting for 96% (n= 86) of the total sample. Non-specialists in the female category were 0% (n=0) and in the male category, 6% (n=4), therefore 4% (n= 4) of the sample.

A chi-square test indicated there was no significant association between **Speciality** and Gender

Pearson chi^2 (1) = 1.3543 Pr = 0.245
Fishers Exact Test = 0.569
1-sided Fishers Exact = 0. 319

Years in Practice and Gender

The number of years doctors spent in private practice was important to ascertain, as this could reflect possible changes to the South African Healthcare System when NHIS is implemented together with the other variables in the study.

Table 4.3 presents a comparison of years in practise versus gender of the respondent.

Table 4.3: Years in practice and gender

Years in Practice	Frequencies Female	Frequencies Male	n	%
0-15	14 (63)	24 (35)	38	42
16-30	7(32)	35 (51)	42	47
31-45	1 (5)	9 (13)	10	11
Total	22	68	90	100

Results show that doctors practicing from 0 to 15 years accounted for 42% (n=38) of the sample, with females being 63% (n=14) and males 35% (n= 24). Doctors practicing from 16 to 30 years represented 47% (n=42) of the sample, with females representing 32% (n=7) and males 51% (n=35). Doctors practicing from 31to 45 years represented 11% (n=10) of the sample, with females being 5% (n=1) and males 13% (n=9).

A chi-square test indicated there was significant association between **Years** in practice and Gender

Pearson chi^2 (2) = 5.6677 Pr = 0.059
Fishers exact test = 0.065

4.3.2. Section Two: Participants knowledge about NHIS

To establish the private doctor's knowledge regarding the National Health Insurance Scheme, five questions were set out in Section Two of the questionnaire as follows:

1. Awareness that a NHIS has been proposed by the government.

2. Accessed information about NHIS associated by gender, age group, type of speciality and years in practice.

3. Understanding the objectives of NHIS associated by associated by gender, age group, gender, type of speciality and years in practice.

4. Understand the concept capitation associated by associated by gender, age group, gender, type of speciality and years in practice.

5. Understand the concept single-payer system, associated by gender, age group, gender, type of speciality and years in practice.

Question 1: Awareness that a NHIS has been proposed by the government?

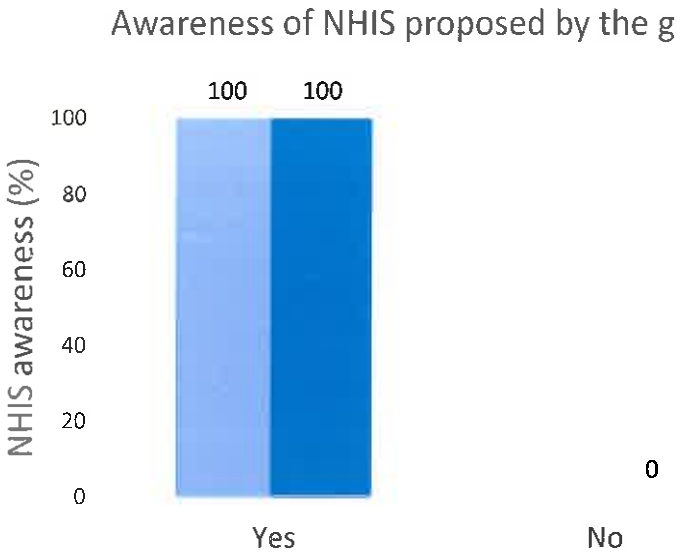


Figure 4.1: Awareness of NHIS proposed by the government.

The total sample of doctors (100%; n= 90) were aware that a NHIS has been proposed by the government. A chi-square indicates chi^2 column exact.

Question 2: Have you accessed information about the NHIS?

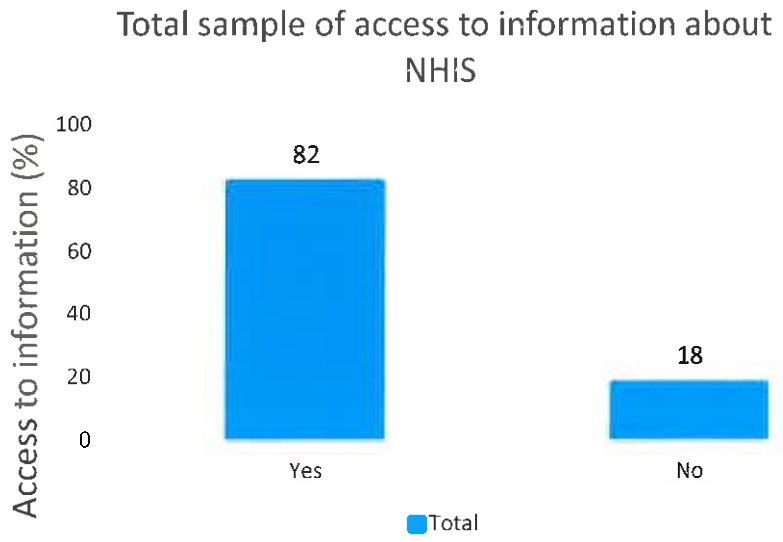


Figure 4.2: Total sample of access to information about NHIS

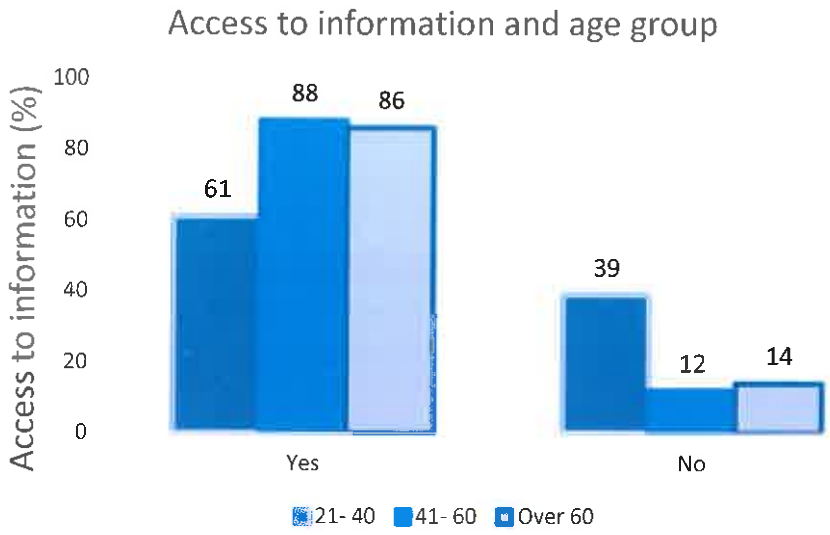


Figure 4.3: Access to information and age group

Within the age group of 21to 40 years, representing (n=18) of the sample, 39% stated they had not accessed information regarding the NHIS, whilst 61% had accessed relevant information on the subject. The age group 41to 60 years, representing (n= 7) of the sample, showed that 88% of doctors had acquired information regarding the implementation of the NHIS, with 12% stating that they had not done so. The remainder of the sample representing the over 60 age group (n=7), 14% had not accessed information and 86% had accessed further information regarding the NHIS.

Across the age groups representing the total sample, 82% (n=74) indicated they had accessed information relating to the implementation of the NHIS, whilst 18% (n= 16) had not .

A chi-square test indicated there was significant association between **Age group** and having accessed information about the NHIS.

Pearson chi^2 (2) = 6.8771 Pr = 0.032

Fishers Exact Test = 0.041.

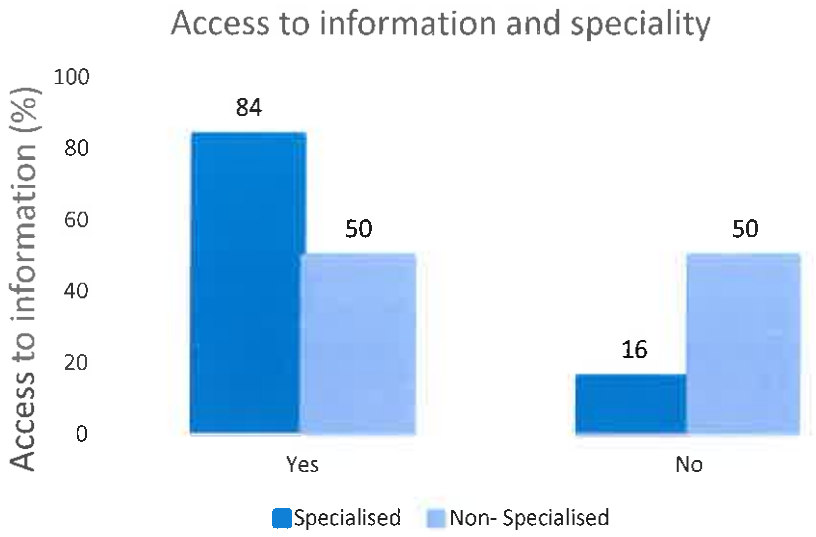


Figure 4.4: Access to information by speciality

Within the group of specialised doctors, representing (n=86) of the sample, 16% stated they had not accessed information regarding the NHIS, whilst 84% had accessed relevant information on the subject. The group of general practitioners representing (n= 4) of the sample showed that 50% had acquired information regarding the implementation of the NHIS, whilst 50% had not.

Across the total sample, 18% (n=16) indicated they had not accessed information and 82% (n=74) had accessed information relating to the implementation of the NHIS.

A chi-square test indicated there was no significant association between Access to information and **Speciality**.

Pearson chi^2 (2) = 2.9734 Pr = 0.085
Fishers Exact Test = 0.144 1-sided Fishers Exact Test = 0.144
Table 4.4 presents access to information and years in practise.

Table 4.4: Access to information and years in practise

Years in practice	Frequencies Yes	Frequencies No	n	%
0-15	25 (66)	13 (34)	38	100
16-30	40 (95)	2 (5)	42	100
31-45	9 (90)	1 (10)	10	100
Total	74 (82)	16 (18)	90	100

In the 0 to15 years in practice group (n=38), 34% stated they had not accessed information regarding the NHIS and 66% had done so. In the group 16 to 30 years in practice (n=42), 95%

of doctors had acquired information regarding the implementation of the NHIS with 5% stating they had not. The remaining group, representing (n=10) of the sample, indicated that 10% had not accessed information and 90% had accessed further information regarding the NHIS.

A chi-square test indicated there was significant association between Access to information and **Years in practice**.

A Pearson chi^2 (2) = 12.3016 Pr 0.002

Fishers Exact Test= 0.002

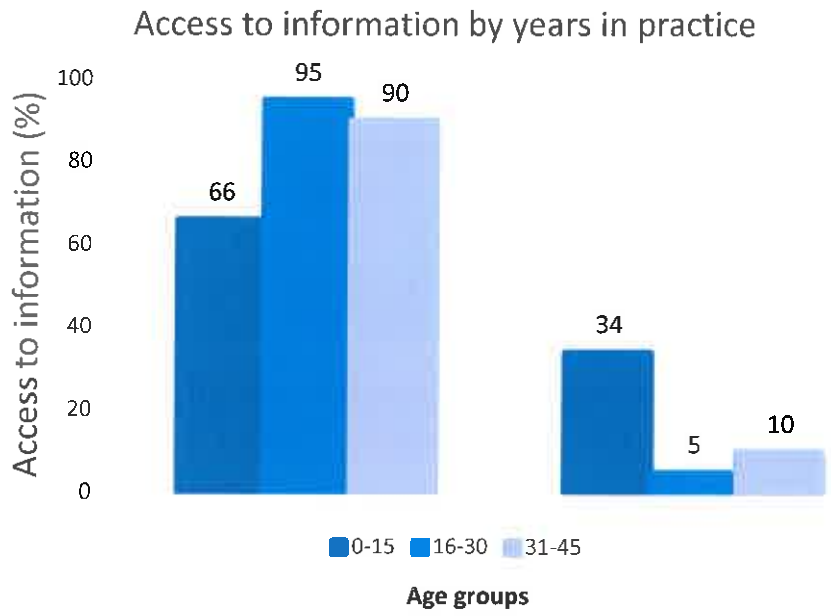


Figure 4.5: Access to information by years in practice

Question 3: Do you understand the objectives of the NHIS?

Table 4.5 presents a comparison of understanding objectives of the NHIS and age group.

Table 4.5: Understand objectives of the NHIS/age group

Age Group	Frequencies No	Frequencies Yes	n	%
21- 40	3 (17)	15 (83)	18	100
41- 60	2 (3)	63 (97)	65	100
Over 60	1(14)	6 (86)	7	100
Total	6 (7)	84 (93)	90	100

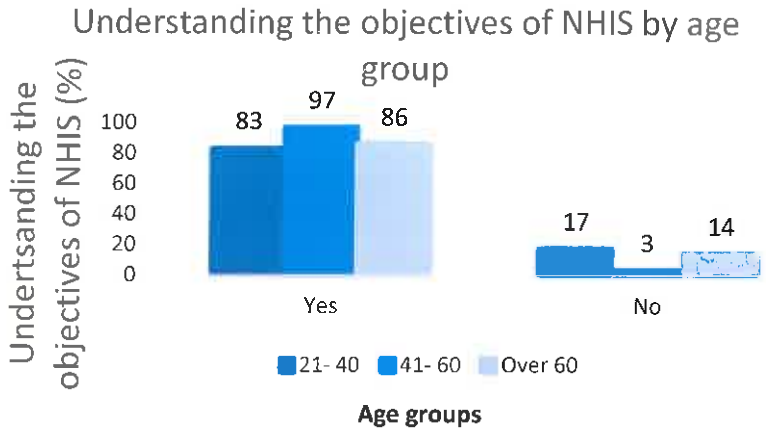


Figure 4.6: Understanding the objectives of NHIS by age group

Within the age group 21to 40 years, representing (n=18) of the sample, 17% stated they were unfamiliar with the objectives of the NHIS, whilst 83% were familiar. The age group 41to 60 years, representing (n=65), showed that 97% of doctors had acquired information regarding the objectives of the NHIS, with 3% stating they had not accessed information and were not familiar with the objectives. The remaining (n=7) of the sample represented the over 60 year age group and 14% had not accessed information and 86% were familiar with the objectives regarding the NHIS.

A chi-square test indicates there was significant association between Understanding the objectives of NHIS and Age group.

A Pearson chi^2 (2) = 4.891 Pr =0.087

Fishers Exact Ttest = 0.051.

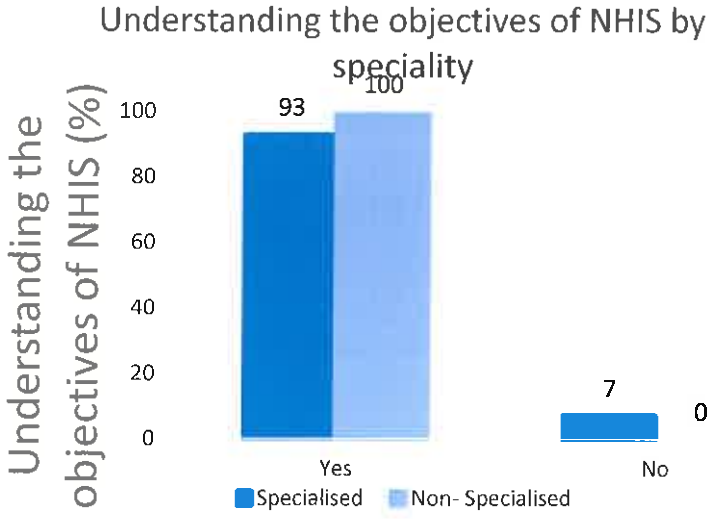


Figure 4.7: Understanding the objectives of NHIS by speciality

Within the group of doctors who have specialised, representing (n=86) of the sample, 7% stated they had not accessed information regarding the objectives of the NHIS whilst 93% had. The group of general practitioners representing (n=4) of the sample showed that 100% had acquired information regarding the objectives of the NHIS.

Across the total sample, 7% (n=6) indicated they had not accessed information, with 93% (n=84) indicating they had accessed information relating to the objectives of the NHIS.

A chi-square test indicated there was no significant association between Understanding the objectives and **Speciality**.

Pearson chi^2 (1) = 0.2990 Pr = 0.585

Fishers Exact Test = 1.000 1 – sided Fishers Exact = 0.755

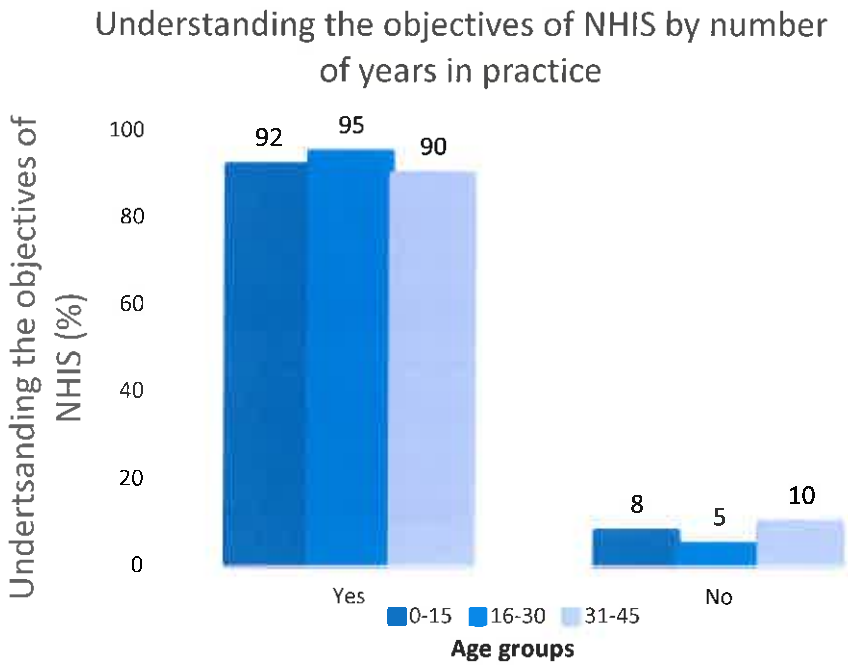


Figure 4.8 Understanding the objectives of NHIS by years in practice

Within the 0 to15 years in practice group, representing (n=38) of the sample, 8% stated they had not accessed information regarding the objectives of the NHIS, whilst 92% had done so. The group 16 to 30 years in practice, representing (n=42) of the sample, showed that 95% of doctors had acquired information regarding the objectives of the NHIS, with 5% stating they had not accessed information. The remaining group, 31 to 45 years, representing (n=10) of the

sample indicated that 10% had not accessed information and 90% had accessed further information regarding the objectives of the NHIS.

Results indicate that in the total sample of practicing doctors, 93% (n=84) were familiar with the objectives relating to the NHIS and 7% (n=6) were unfamiliar.

A chi-square test indicated there was no significant association between Understanding the objectives and **Years in practice**.

Pearson chi^2 (2) = 0.5156 Pr = 0.773
Fishers Exact Test = 0.588.

Question 4: Do you understand the concept of Capitation?

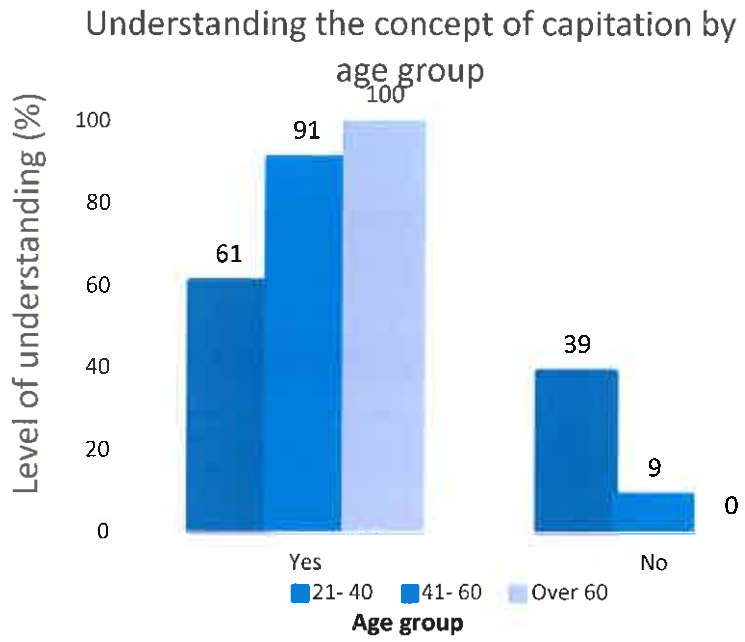


Figure 4.9: Understanding the concept of capitation by age group

Within the age group 21to 40 years, representing (n=18) of the sample, 39% stated they did not understand the concept of capitation and 61% were familiar with the concept. The age group 41 to 60 years, representing (n=65) of the sample, showed that 91% of doctors had acquired information regarding the concept of capitation, whilst 9% stated they had not accessed information and were not familiar with the concept. The remaining (n=7) of the sample represented the over 60 year age group, where 100% were familiar with the concept of capitation.

A chi-square test indicated there was significant association between understanding the Concept of capitation and Age group.

Pearson chi^2 (2) = 11.3148 Pr = 0.003

Fishers Exact Test = 0.009.

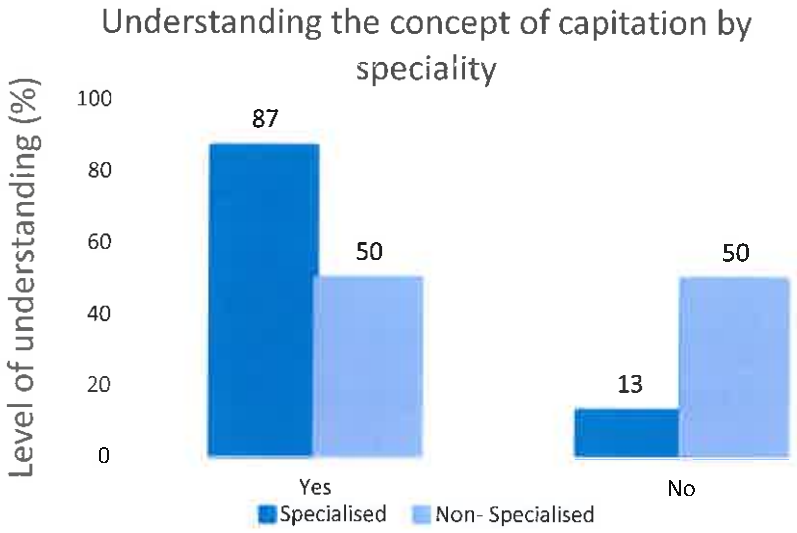


Figure 4.10: Understanding the concept of capitation by speciality

Within the group of doctors who have specialised, representing (n=86) of the sample, 13% stated they had not accessed information regarding the concept of capitation, whilst 87% had. The group of general practitioners, representing (n=4) of the sample, showed that 50% had acquired information with 50% not being familiar with the concept of capitation.

Across the total sample, 14% (n=13) indicated they had not accessed information, whilst 86% (n=77) had accessed information relating to the concept of capitation.

A chi-square test indicated there was significant association between Understanding the concept capitation and **Speciality**.

A Pearson chi^2 (1) = 4.2822 Pr = 0.039

Fishers Exact Test = 0.098 and 1 – sided Fishers Exact Test = 0.098.

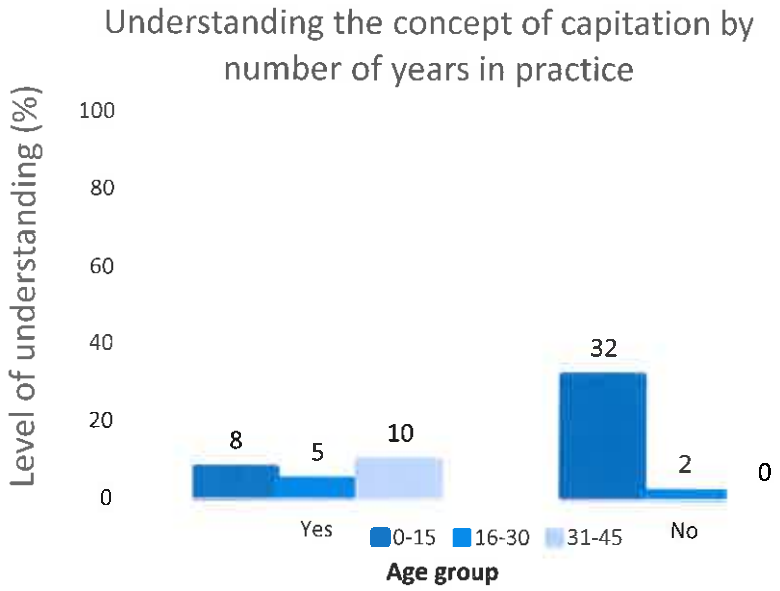


Figure 4.11: Understanding the concept of capitation by number of years in practice

Within the 0 to 15 years in practice group, representing (n= 38) of the sample, 32% stated they had not accessed information regarding capitation and 68% had done so. The group 16 to 30 years in practice, representing (n=42) of the sample, showed that 98% of doctors had acquired information regarding the concept of capitation, whilst 2% stated they had not. The remaining group, 31 to 45, representing (n= 10) of the sample indicated that 100% had accessed information regarding the concept of capitation.

Results indicated that in the total sample of practicing doctors, 86% (n=77) were familiar with and 14% (n=13) were unfamiliar with the concept of capitation.

A chi-square test indicated there was significant association between Understanding the concept capitation and **Years in practice**.

A Pearson chi^2 (2) = 15.6619 Pr = 0.000
Fishers Exact Test = 0.000.

Question 5: Do you understand the concept of the Single-Payer System?

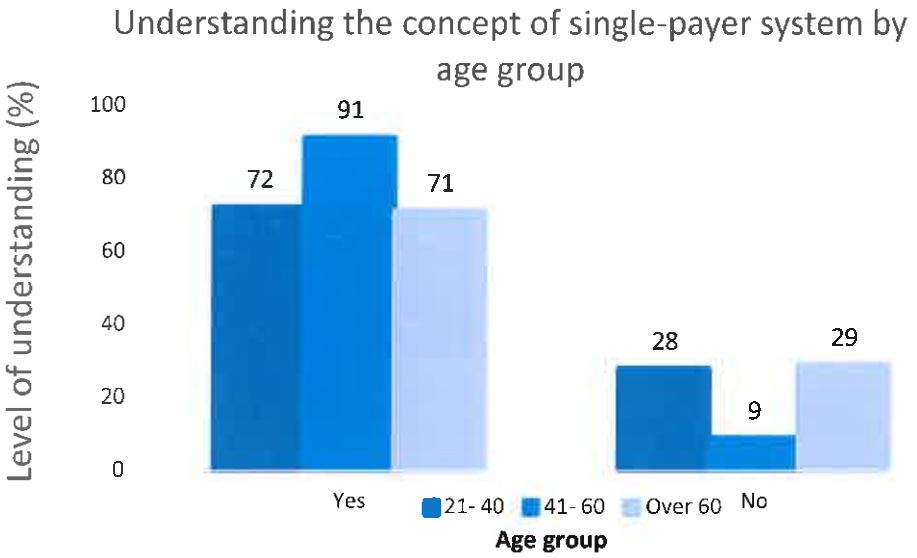


Figure 4.12: Understanding the concept of single-payer system by age group

Within the age group of 21 to 40 years, representing (n=18) of the sample, 28% stated they did not know the single-payer system concept, whilst 72% were familiar with the concept. The age group 41 to 60 years, representing (n=65) of the sample, showed that 91% of doctors had acquired information regarding the single-payer concept of the NHIS, whilst 9% had not accessed information and were not familiar with the concept. The remaining (n=7) of the sample represented the over 60 year age group and 29% had not accessed information and 71% were familiar with the concept.

Results indicated, through all the age groups, that 86% (n=77) of the doctors were familiar with the single-payer system and 14% (n=13) were unfamiliar with the concept.

A chi-square test indicated there was significant association between Understanding the concept single-payer system and **Age group**.

A Pearson chi^2 (2) = 5.1496 Pr = 0.076

Fishers Exact Test = 0.047.

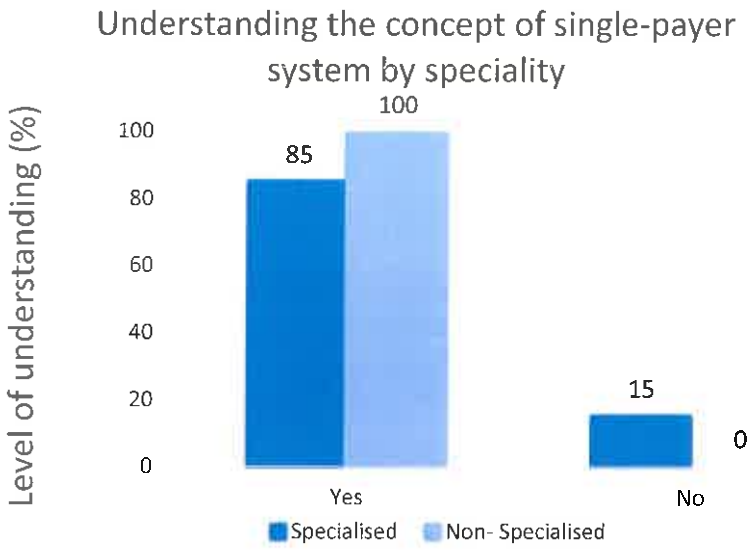


Figure 4.13: Understanding the concept of a single-payer system by speciality

Within the group of doctors who have specialised, representing (n=86) of the sample, 15% stated they had not accessed information regarding the concept of the single-payer system, whilst 85% had done so. The group of general practitioners, representing (n=4) of the sample, showed that 100% had acquired information regarding the concept of the single-payer system.

Across the total sample, 14% (n=13) indicated they had not accessed information and 86% (n=77) indicated they had accessed information relating to the concept of the single-payer system.

A Pearson chi-square indicated that there is no significant association between Understanding the concept single-payer and **Speciality**.

Pearson chi^2 (1) = 0.7067 Pr = 0.401

Fishers Exact Test = 1.000. 1 – sided Fishers Exact Test = 0.530.

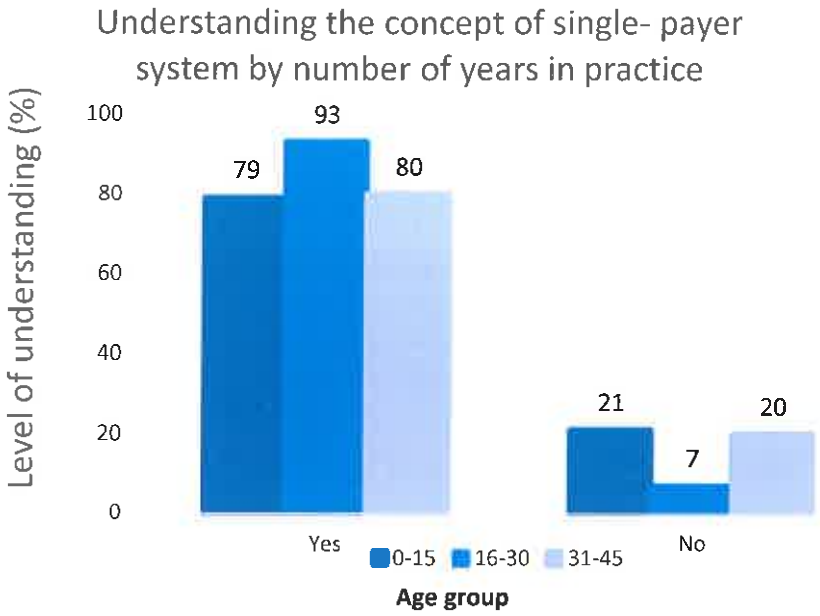


Figure 4.14: Understanding the concept of a single-payer system by number of years in practice.

Within the 0 to15 years in practice group, representing (n=38) of the sample, 21% stated they had not accessed information regarding the concept of the single payer system whilst 79% had. The group 16 to 30 years in practice, representing (n=42) of the sample, showed that 93% of doctors had acquired information regarding the concept, with 7% stating they had done so. The remaining group, 31to 45, representing (n=10) of the sample indicated 80% had accessed information, with 20% being unfamiliar regarding the concept of the single-payer system.

Results indicate that in the total sample of practicing doctors, 86% (n=77) were familiar with and 14% (n=13) were unfamiliar with the concept of the single-payer system.

A Pearson chi-square indicates there is no significant association between Understanding the concept single-payer system and **Years in practice**.

Pearson chi^2 (2) = 3.4044 Pr = 0.182

Fishers Exact Test = 0.132.

4.3 3. Section Three: Participants opinion regarding the NHIS

To establish the private doctor's opinion regarding the National Health Insurance Scheme in relation to age group, speciality and years in practice, 17 statements requiring a rating on a four point Likert scale were set out as follows:

1. Would you support the Government proposal?
2. Is NHIS inevitable?
3. Can Government manage a single- payer system?
4. Would they support the NHIS?
5. Can Government manage the healthcare system effectively?
6. Are they confident that Government would meet objectives of NHIS by 2025?
7. Should private GPs be the key stakeholders for a NHIS?
8. Should PHC be the fundamental focus for the NHIS?
9. Would they recommend a personalised data scheme to participate in NHI policy making,
10. Would a Single-Payer System controlled by the Government be viable?
11. Must pricing in the private sector be regulated?
12. Can a mandatory capitation overhaul the healthcare system in South Africa?
13. Would they still have autonomy in their practises?
14. Would they prefer to treat private and medical aid eligible patients only?
15. Would they prefer to treat private, medical aid eligible patients contracted to NHIS.
16 Would the NHIS have a negative effect on their financial aspect of their practices?
17 Should incentives be offered to accredited practises and institutions?

Bar graphs illustrate the results to the above questions.

A legend representing each bar graph is set out as follows:

Legend:

CD = completely disagree
PD= partially disagree
PA= partially agree
CA= completely agree.

Question 1: Would you support the government proposal?

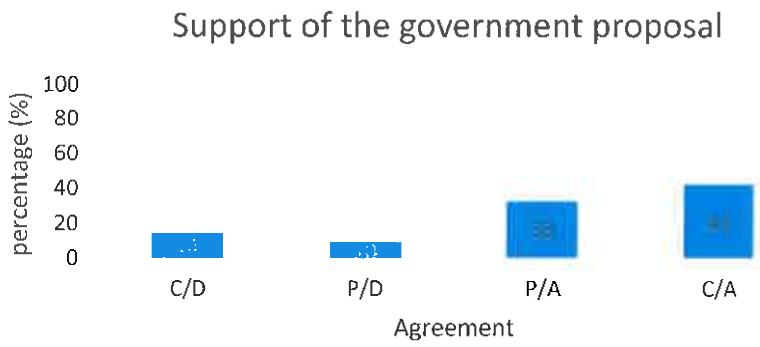


Figure 4.15: Total sample - support of the government proposal

Across the age groups, speciality and years of practice, 14% (n= 13) indicated they completely disagreed to supporting the government proposal, 10% (n= 8) partially disagreed, 33% (n= 30) partially agreed and 43% (n= 39) completely agreed.

A chi-square test indicated there was no significant association between **Age group** and Support of the government proposal.

Pearson chi 2(6) = 8.8457 Pr = 0.182
Fishers Exact Test = 0.094

A chi-square test indicated there was significant association between **Speciality** and Support of the government proposal.

Pearson chi 2(3) = 8.9758 Pr = 0.030
Fishers Exact Test = 0.087

A chi-square test indicated there was significant association between **Years in practice** and Support of the government proposal.

Pearson chi 2(6) = 11.9831 Pr = 0.062

Fishers Exact Test = 0.076

Question 2: Is NHIS inevitable?

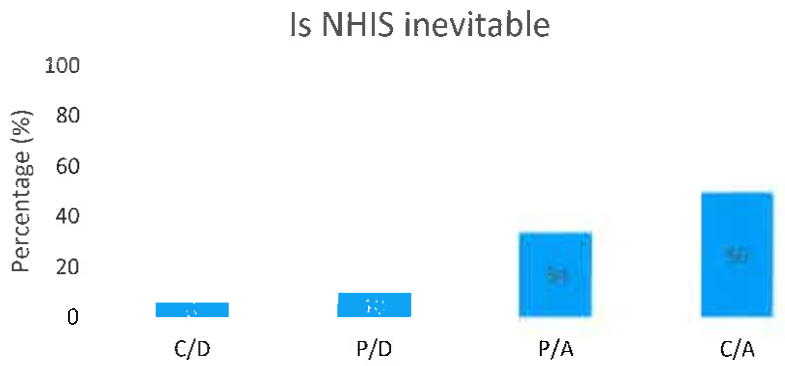


Figure 4.16: Total sample - NHIS inevitable.

The overall response from doctors across all age groups, speciality and years of practice indicated 6% completely disagreed that NHIS was inevitable, 10% partially disagreed, 34% partially agreed and 50% completely agreed, implying that most doctors are aware that NHIS was inevitable.

A chi-square test indicated there was significant association between **Age group** and if NHIS was inevitable.

Pearson chi^2 (6) = 11.2675 Pr = 0.080

Fishers Exact Test = 0.026

A chi-square test indicated there was significant association between **Speciality** and if NHIS was inevitable.

Pearson chi^2 (3) = 7.9670 Pr = 0.047

Fishers Exact Test = 0.058

A chi-square test indicated that there was no significant association between **years in practice** and if NHIS is inevitable.

Pearson chi^2 (6) = 14455 Pr = 0.963

Fishers Exact Test = 0.937

Question 3: Can government manage a single-payer system?

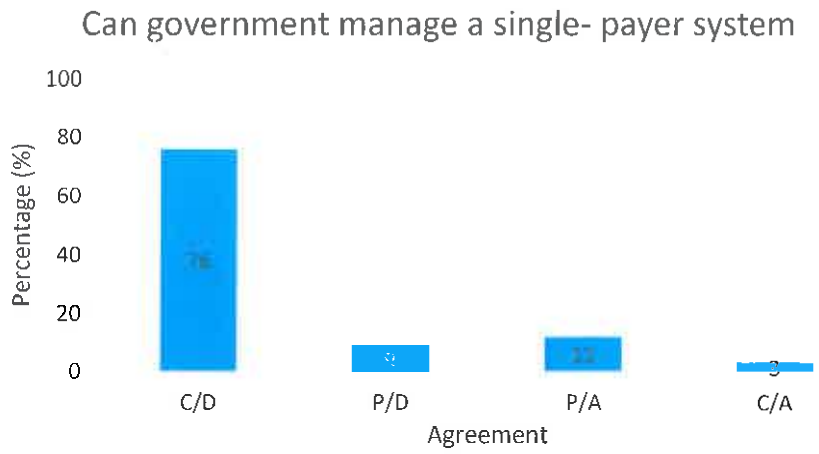


Figure 4.17: Total sample- can government manage a single- payer system

These results show that 76% of doctors completely disagree that Government will be able to fulfil this role.

A chi-square test indicated there was no significant association between **Age group** and the Government's ability to manage a single- payer system.

Pearson chi^2 (6) = 6.5349 Pr = 0.366

Fishers Exact Test = 0.340

A chi-square test indicated there was no significant association between **Speciality** and the Government's ability to manage a single-payer system.

Pearson chi^2 (3) = 1.3543 Pr = 0.716

Fishers Exact Test = 1.000

A chi-square test indicated there was significant association between **Years in practice** and the Government's ability to manage a single-payer system.

Pearson chi^2 (6) = 18.6906 Pr = 0.0005

Fishers Exact Test = 0.007

Question 4: Would they support the NHIS?

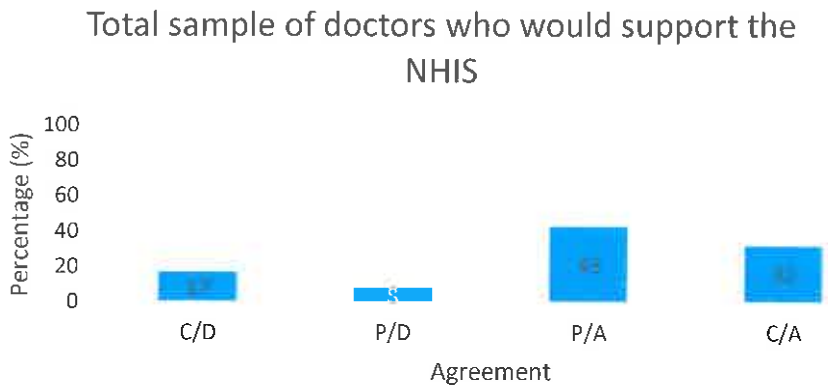


Figure 4.18: Total sample – doctors' support of the NHIS

Across all age groups, speciality and years of practice, 17 % of doctors completely disagreed that they would support the NHIS, 8% partially disagreed, 43% partially agreed and 32 % completely agreed.

A chi-square test indicated there was no significant association between **Age group** and the Doctors' support of the NHIS.

Pearson chi^2 (6) = 8.2355 Pr = 0.221

Fishers Exact Test = 0.123

A chi-square test indicated there was significant association between **Speciality** and the Doctors' support of the NHIS.

Pearson chi^2 (3) = 11.6841 Pr = 0.009

Fishers Exact Test = 0.027

A chi-square test indicated there was no significant association between **Years in practice** and the Doctors' support of the NHIS.

Pearson chi^2 (6) = 8.8014 Pr = 0.185

Fishers Exact Test = 0.259

Question 5: Can government manage the health care system effectively?

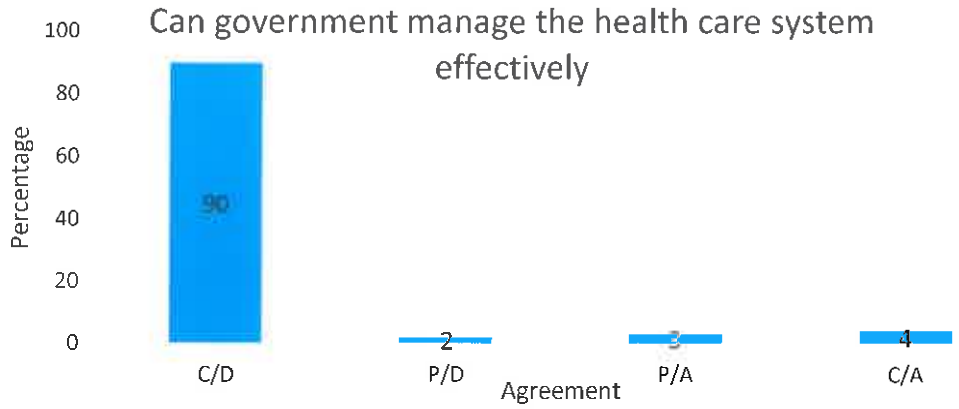


Figure 4.19: Total sample- can government manage the health care system effectively

Across the sample, 90% completely disagreed that Government can manage the healthcare system effectively and of the remainder, 2% partially disagreed, 3% partially agreed and 4% completely agreed.

A chi-square test indicated there was no significant association between **Age group** and the Government's ability to manage the healthcare system effectively

Pearson chi^2 (6) = 10.6087 Pr = 0.101
Fishers Exact Test = 0.106

A chi-square test indicated there was no significant association between **Speciality** and the Government's ability to manage the healthcare system effectively.

Pearson chi^2 (3) = 0.4651 Pr = 0.926
Fishers Exact Test = 1.000

A chi-square test indicated there was no significant association between **Years in practice** and the Government's ability to manage the healthcare system effectively.

Pearson chi^2 (6) = 7.6597 Pr = 0.264
Fishers Exact Test = 0.313

Question 6: Confident that government would meet objectives of NHIS by 2025?

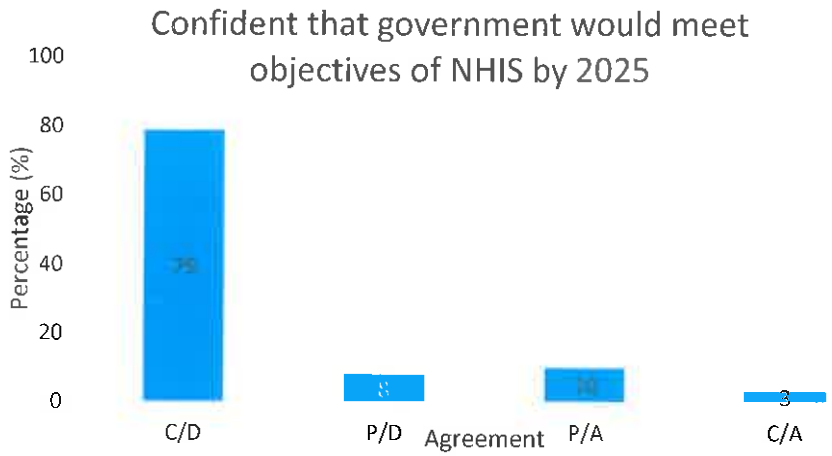


Figure 4.20: Total sample - confident that government would meet objectives of NHIS by 2025

Across the sample, 79% completely disagreed that they are confident Government would meet the objectives of NHIS by 2025; of the remainder, 8% partially disagreed, 10 % partially agreed and 3% completely agreed.

A chi-square test indicated there was no significant association between **Age group** and if doctors are confident that Government would meet objectives of NHIS by 2025.

Pearson chi^2 (6) = 6.5701 Pr = 0.362
Fishers Exact Test = 0.241

A chi-square test indicated there was no significant association between **Speciality** and being confident that Government would meet objectives of the NHIS by 2025.

Pearson chi^2 (3) = 1.1202 Pr = 0. 772
Fishers Exact Test = 1.000

A chi-square test indicated there was a significant association between **Years in practice** and confidence that Government would meet objectives of the NHIS by 2025.

Pearson chi^2 (6) = 23.0120 Pr = 0.001
Fishers Exact Test = 0.002

Table 4.6 illustrates the percentages of agreement amongst doctors in Years of practice that they are confident the Government would meet the objectives of NHIS by 2025.

Table 4.6 The percentages of agreement amongst doctors

Years in practice	CD	PD	PA	CA
0-15	87%	8%	0%	5%
16-30	81%	7%	10%	2%
31-45	40%	10%	50%	0%

Question 7: Should private GPs be the key stakeholders for a NHIS?

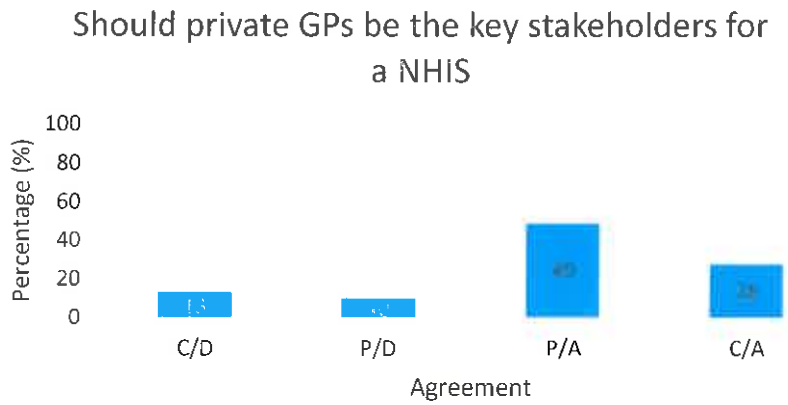


Figure 4.21: Total sample - should private GPs be the key stakeholders for a NHIS

Within the sample of doctors across all age groups, speciality and years of practice, 13% completely disagreed that private General Practitioners should be the key stakeholders for a NHIS, 10% partially disagreed, 49% partially agreed and 28% completely agreed. The majority of doctors partially and completely agreed. According to the Green Paper, this is one of the recommendations that private general practitioners be accredited and contracted to NHI in order to provide a range of stipulated services to meet the needs of the population.

A chi-square test indicated there was significant association between **Age group** and private GPs being the key stakeholders for a NHIS.

Pearson chi^2 (6) = 15.3137 Pr = 0.018
Fishers Exact Test = 0.014

A chi-square test indicated there was no significant association between **Speciality** and private GPs being the key stakeholders for a NHIS.

Pearson chi^2 (3) = 1.5721 Pr = 0.666

Fishers Exact Test = 1.000

A chi-square test indicated there was significant association between **Years in practice** and private GPs being the key stakeholders for a NHIS.

Pearson chi^2 (6) = 20.2815 Pr = 0.002
Fishers Exact Test = 0.001

Table 4.7 Illustrate the percentages of agreement amongst doctors in Years of practice that GPs should be the key stakeholders for a NHIS.

Table 4.7 The percentages of agreement amongst doctors

Years in practice	CD	PD	PA	CA
0-15	18%	11%	66%	5%
16-30	12%	12%	36%	60%
31-45	0%	0%	40%	60%

Question 8: Should PHC be the fundamental focus for the NHIS?

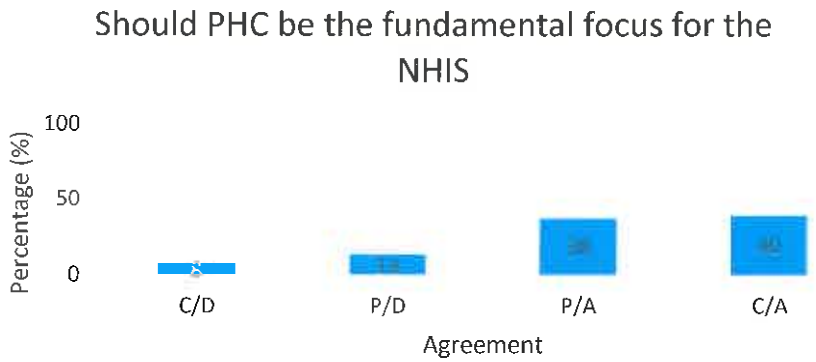


Figure 4.22: Total sample - should PHC be the fundamental focus for the NHIS

The sample of doctors across all age groups, speciality and years of practice shows that 8% completely disagreed PHC should be the fundamental focus for the NHIS, with 14% partially disagreeing, 38% partially agreeing and 40% completely agreeing. The results indicated that majority of respondents partially and completely agreed that PHC should be the fundamental focus for the NHIS,

A chi-square test indicated there was no significant association between **Age group** and PHC being the fundamental focus for the NHIS.

Pearson chi^2 (6) = 8.6264 Pr = 0.196

Fishers Exact Test = 0.154

A chi-square test indicated there was no significant association between **Speciality** and PHC being the fundamental focus for the NHIS.

Pearson chi^2 (3) = 5.4106 Pr = 0.144

Fishers Exact Test = 0.069

A chi-square test indicated there was significant association between **Years in practice** and PHC being the fundamental focus for the NHIS.

Pearson chi^2 (6) = 12. 0521 Pr = 0.061

Fishers Exact Test = 0.072

Question 9: Would they recommend a personalised data scheme to participate in NHI policy making?

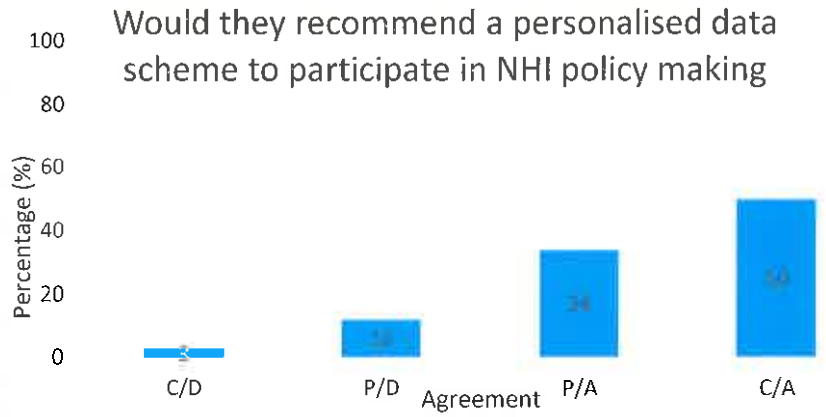


Figure 4.23: Total sample - recommend a personalised data scheme to participate in NHI policy making

Within the sample of doctors across all age groups, speciality and years of practice, 3% completely disagreed that they would recommend a personalised data scheme to participate in NHI policy making; of the remainder, 12% partially disagreed, 34% partially agreed and 50% completely agreed to have a personalised data scheme to participate in NHI policy making to create a much needed successful NHI scheme.

A chi-square test indicated there was no significant association between **Age group** and Recommending a personalised data scheme to participate in NHI policy making.

Pearson chi^2 (6) = 4.7310 Pr = 0.579

Fishers Exact Test = 0.553

A chi-square test indicated there was no significant association between **Speciality** and Recommending a personalised data scheme to participate in NHI policy making.

Pearson chi^2 (3) = 3.1733 Pr = 0.366

Fishers Exact Test = 0.425

A chi-square test indicated there was no significant association between **Years in practice** and Recommending a personalised data scheme to participate in NHI policy making.

Pearson chi^2 (6) = 12. 0521 Pr = 0.061

Fishers Exact Test = 0.072

Question 10: Would a Single-Payer System controlled by the government be viable?

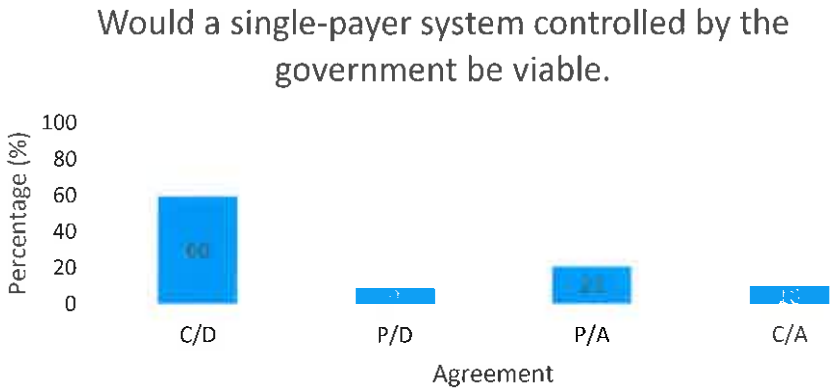


Figure 4.24: Total sample - would a single-payer system controlled by the government be viable.

Of the total sample of doctors across all age groups, speciality and years of practice, 60% completely disagreed, 9% partially disagreed, 21% partially agreed and the remainder, 10%, completely agreed that a single-payer system controlled by the Government would be viable.

A chi-square test indicated there was no significant association between **Age group** and a Single-Payer System controlled by the Government being viable.

Pearson chi^2 (6) = 7.7625 Pr = 0.256

Fishers Exact Test = 0.150

A chi-square test indicated there was no significant association between **Speciality** and a Single-Payer System controlled by the Government being viable.

Pearson chi^2 (3) = 2.7907 Pr = 0.425

Fishers Exact Test = 0.816

A chi-square test indicated there was a significant association between **Years in practice** and a Single-Payer System controlled by the Government being viable.

Pearson chi^2 (6) = 26.6504 Pr = 0.000

Fishers Exact Test = 0.000

Table 4.8 illustrates the percentages of agreement amongst Doctors and Years of practice that a Single-Payer System controlled by the Government would be viable.

Table 4.8: The percentages of agreement amongst doctors and years in practice

Years in practice	CD	PD	PA	CA
0-15	82%	13%	0%	5%
16-30	50%	32%	18%	0%
31-45	20%	10%	60%	10%

Question 11: Must pricing in the private sector be regulated?

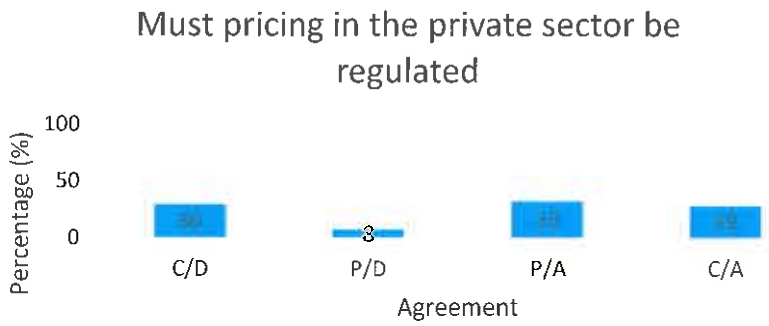


Figure 4.25: Total sample - must pricing in the private sector be regulated.

Of the total sample of doctors across all age groups, speciality and years of practice, 30% completely disagreed that pricing in the private sector should be regulated, 8% partially disagreed, 33% partially agreed and 29% completely agreed.

A chi-square test indicated there was no significant association between **Age group** and Pricing in the private sector being regulated.

Pearson chi^2 (6) = 11.8759 Pr = 0.065

Fishers Exact Test = 0.016

A chi-square test indicated there was no significant association between **Speciality** and Pricing in the private sector being regulated.

Pearson chi^2 (3) = 2.7907 Pr = 0.425
Fishers Exact Test = 0.816

A chi-square test indicated there was no significant association between **Years in practice** and Pricing in the private sector being regulated.

Pearson chi^2 (6) = 11.6481 Pr = 0.070
Fishers Exact Test = 0.072

Question 12: Can a mandatory capitation overhaul the healthcare system in South Africa?

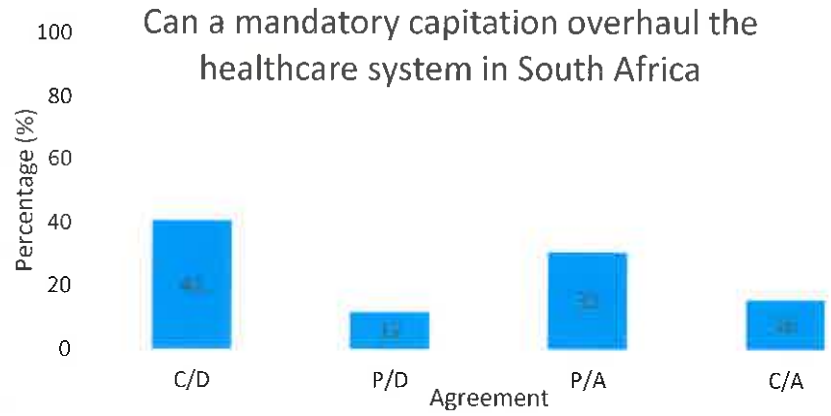


Figure 4.26: Total sample- can a mandatory capitation overhaul the healthcare system in South Africa.

Of the total sample of doctors across all age groups, speciality and years of practice, 41% completely disagreed that a mandatory capitation can overhaul the healthcare system in South Africa, 12% partially disagreed, 31% partially agreed and 15% completely agreed.

A chi-square test indicated there was a significant association between Age group and that a Mandatory capitation can overhaul the healthcare system in South Africa.

Pearson chi^2 (6) = 28.4547 Pr = 0.000
Fishers Exact Test = 0.001

Table 4.9 illustrates the percentages of agreement amongst doctors and age group that a mandatory capitation can overhaul the healthcare system in South Africa.

Table 4.9: The percentages of agreement amongst doctors and age group

Age group	CD	PD	PA	CA
21-40	50%	11%	33%	5%
41-60	43%	6%	31%	20%
Above 60	0%	71%	29%	0%

A chi-square test indicated there was no significant association between **Speciality** and that a Mandatory capitation can overhaul the healthcare system in South Africa.

Pearson chi^2 (3) = 5.0644 Pr = 0.167

Fishers Exact Test = 0.139

A chi-square test indicated there was a significant association between Years in practice and that a Mandatory capitation can overhaul the healthcare system in South Africa.

Pearson chi^2 (6) = 22.7129 Pr = 0.001

Fishers Exact Test = 0.002

Table 4.10 illustrates the percentages of agreement amongst doctors and years in practice that a mandatory capitation can overhaul the healthcare system in South Africa.

Table 4.10: The percentages of agreement amongst doctors and years in practice

Years in practice	CD	PD	PA	CA
0-15	55%	11%	29%	5%
16-30	38%	12%	36%	14%
31-45	0%	20%	20%	60%

Question 13: Would I still have autonomy in my practice?

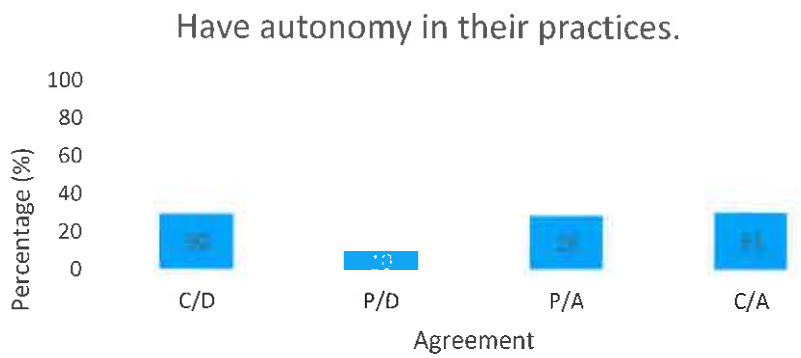


Figure 4.27: Total sample -autonomy in their practices.

Of the total sample across all age groups, speciality and years of practice, 30% completely disagreed that they would still have autonomy in their practices, 10% partially disagreed, 29% partially agreed and 31% completely agreed.

A chi-square test indicated there was no significant association between **Age group** and Autonomy in their practices.

Pearson chi^2 (6) = 8.2486 Pr = 0.220
Fishers Exact Test = 0.164

A chi-square test indicated there was no significant association between **Speciality** and Autonomy in their practices.

Pearson chi^2 (3) = 4.8056 Pr = 0.187
Fishers Exact Test = 0.156

A chi-square test indicated there was no significant association between **Years in practice** and Autonomy in their practices.

Pearson chi^2 (6) = 5.8482 Pr = 0.440
Fishers Exact Test = 0.479

Question 14: Would prefer to treat private and medical aid eligible patients only?

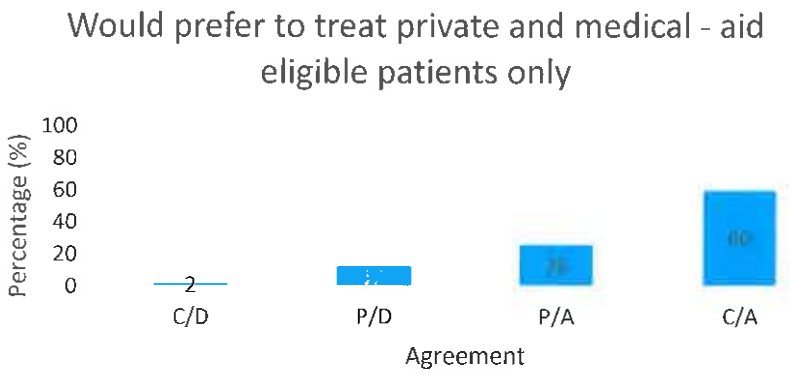


Figure 4.28: Total sample would prefer to treat private and medical aid eligible patients only.

Of the total sample of doctors across all age groups, speciality and years of practice, 2% completely disagreed, 12% partially disagreed, 26% partially agreed and 60% completely agreed they would prefer to treat private and medical aid eligible patients only.

A chi-square test indicated there was no significant association between **Age group** and the Preference to treat private and medical aid eligible patients only.

Pearson chi^2 (6) = 1.8387 Pr = 0.934
Fishers Exact Test = 0.870

A chi-square test indicated there was no significant association between **Speciality** and the Preference to treat private and medical aid eligible patients only.

Pearson chi^2 (3) = 4.8056 Pr = 0.187
Fishers Exact Test = 0.156

A chi-square test indicated there was no significant association between **Years in practice** and the Preference to treat private and medical aid eligible patients only.

Pearson chi^2 (6) = 5.8482 Pr = 0.440
Fishers Exact Test = 0.479

Question 15: Would prefer to treat private and medical aid eligible patients contracted to NHIS

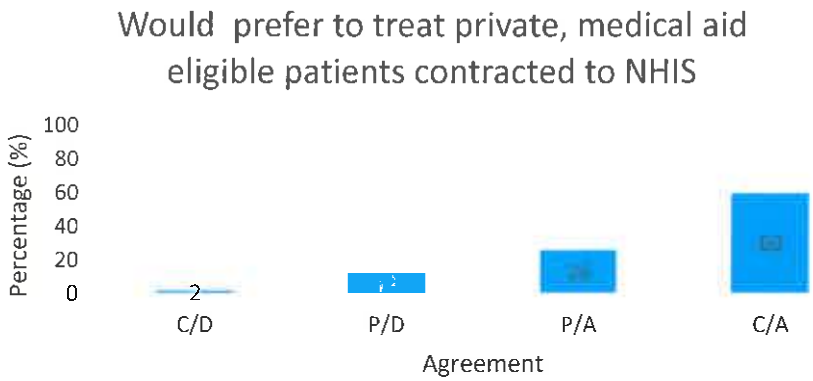


Figure 4.29: Total sample - would prefer to treat private and medical aid eligible patients contracted to NHIS.

Of the total sample across all age groups, speciality and years of practice, 2% completely disagreed, 12% partially disagreed, 26% partially agreed, and 60% completely agreed to treat private, medical aid eligible patients contracted to NHIS.

A chi-square test indicated there was no significant association between **Age group** and Preference to treat private, medical aid eligible patients contracted to NHIS.

Pearson chi^2 (6) = 1.8387 Pr = 0.934
Fishers Exact Test = 0870

A chi-square test indicated there was no significant association between **Speciality** and Preference to treat private, medical aid eligible patients contracted to NHIS.

Pearson chi^2 (3) = 5.4639 Pr = 0.141
Fishers Exact Test = 0.204

A chi-square test indicated there was significant association between **Years in practice** and Preference to treat private, medical aid eligible patients contracted to NHIS.

Pearson chi^2 (6) = 16.1271 Pr = 0.013
Fishers Exact Test = 0.006

Question 16: Would the NHIS have a negative effect on their financial aspect of their practices?

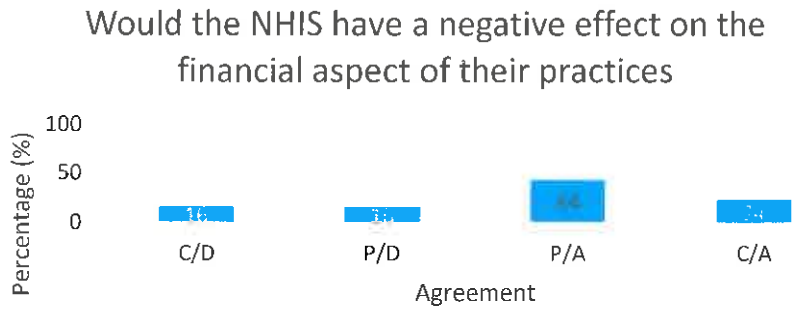


Figure 4.30: Total sample - would the NHIS have a negative effect on the financial aspect of their practices

Of the total sample of doctors across all age groups, speciality and years of practice, 16% completely disagreed that NHIS would have a negative effect on their financial aspect of their practices, 16% partially disagreed, 44% partially agreed and 24% completely agreed.

A chi-square test indicated there was no significant association between **Age group** and the Negative effect the NHIS would have on the financial aspect of their practices.

Pearson chi^2 (6) = 1.9569 Pr = 0.924

Fishers Exact Test = 0.963

A chi-square test indicated there was no significant association between **Speciality** and the Negative effect the NHIS would have on the financial aspect of their practices.

Pearson chi^2 (3) = 2.7038 Pr = 0.425

Fishers Exact Test = 0.529

A chi-square test indicated there was no significant association between **Years in practice** and the Negative effect the NHIS would have on the financial aspect of their practices.

Pearson chi^2 (6) = 5.2885 Pr = 0.507

Fishers Exact Test = 0.447

Question 17: Should incentives be offered to accredited practices and institutions?

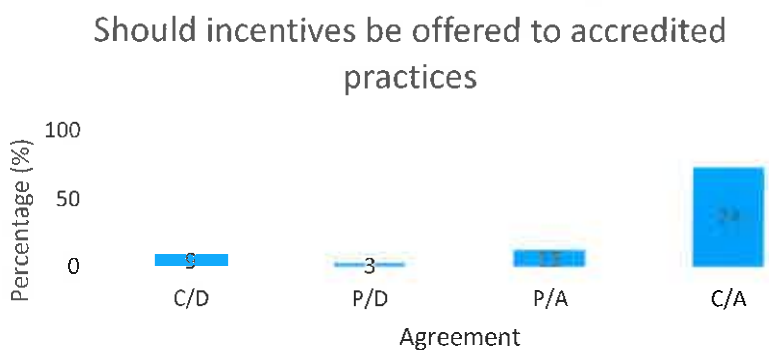


Figure 4.31: Total sample - should incentives be offered to accredited practices.

Of the total sample across all age groups, speciality and years of practice, 9% of doctors completely disagreed that incentives should be offered to accredited practices, 3% partially disagreed, 13% partially agreed, and 74% completely agreed.

A chi-square test indicated there was no significant association between **Age group** and whether Incentives should be offered to accredited practices and institutions.

Pearson chi^2 (6) = 4.6506 Pr = 0.589
Fishers Exact Test = 0.352

A chi-square test indicated there was no significant association between **Speciality** and whether Incentives should be offered to accredited practices and institutions.

Pearson chi^2 (3) = 2.7907 Pr = 0.425
Fishers Exact Test = 0.816

A chi-square test indicated there was no significant association between **Years in practice** and whether Incentives should be offered to accredited practices and institutions.

Pearson chi^2 (6) = 2.3748 Pr = 0.882
Fishers Exact Test = 0.97

4.4 SUMMARY

This chapter presented the results of the study. Statistical tests were applied to identify, analyse and synthesise data. The results were presented in tables and graphs to allow for clarity of interpretation. The next chapter presents a discussion on main findings, recommendations, limitations and a conclusion.

CHAPTER FIVE

DISCUSSION OF MAIN FINDINGS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

In the final chapter, a summary of study and a discussion of the results are presented. This is followed by a presentation of the main findings together with the recommendations regarding the implementation of the NHI. Limitations of the study are set out and the chapter closes with the conclusion of the study.

5.2 SUMMARY OF THE STUDY

This study used a quantitative explorative, descriptive survey design. Two private healthcare institutions in the South West Region of Gauteng were used for the study and the target population was private doctors working independently from the Government. The total population practicing at both independent facilities were (N=156). The researcher and a statistician developed a 27-item, structured questionnaire. The questionnaire comprised three sections: Section One elicited the participant's responses about their demographic data, Section Two elicited their responses regarding their knowledge about the National Health Insurance Scheme and Section Three, gauged the participants opinion about the National Health Insurance Scheme.

A pilot study was conducted to test and refine the questionnaire. Private doctors (n=10) working part-time at one of the chosen sessional rooms and from support services (Radiology, Nuclear Medicine) were purposively selected to participate in the pilot study. No issues were raised from the participants and the questions were found to be adequate in terms of clarity and accuracy. Data were collected for the main study from the two private clinics

Data were analysed and descriptive and comparative statistical tests were used to interpret the findings. Results were presented in Tables and Figures and discussed according to the three sections of the questionnaire. Section One presented the results of the participants' demographic data, Section Two presented the results on the participants' knowledge about the National Health Insurance Scheme and Section Three presented the results related to the participants' opinion regarding the National Health Insurance Scheme. One hundred and twenty questionnaires (n=120) were distributed and 90 (n=90) were returned (75%). The survey

method carried out in this study, captured attitudinal type data (opinions, awareness, knowledge, preferences, perception, intentions and motivations).

5.3 DISCUSSION ON MAIN FINDINGS

5.3.1 Section One

The demographic profile obtained were gender, age group, speciality and number of years in practice as well as type of practice. The demographic findings are important as they can influence the guidelines on the implementation of NHIS. The NHI could take between 15 and 25 years to be successfully implemented (National Health Insurance Policy Paper, 2011:1-59). The findings extrapolated from studies conducted on the NHIS could prove valuable. Balettta (2012:1185) stated that 60% of doctors work in the private sector and the remainder in the public sector. In this study, the total population of private doctors practising at two independent private healthcare facilities in the Gauteng South West Region were selected (N=156). The findings showed the majority of the total sample (n=90) were male doctors (76%; n=68) with 24% females (n=22). Pertaining to age-group, 72% of the practitioners were between the ages of 41 and 60 years. Chi^2 test indicated there was only significance in the association of the number of years in practice and age group.

Specialised private practitioners accounted for 96% of the sample, with non-specialised private practitioners accounting for 4%. Private practitioners practicing from 0 to 15 years equalled 42%, 16 to 30 years 47% and 31to 45yrs 11%. The findings showed that 10% of the practitioners worked in GP rooms, with 70% in private hospital and 20% in a private clinic. According to the literature, General Practitioners are the primary focus for the NHI (National Health Insurance Green paper, 2011:1-38), however in this study, only 10% of the sample represented General Practitioners. Government should not only focus on General Practitioners but also acknowledge the contributions from private practitioners in general for the NHI to succeed. A robust cooperation is needed from private practitioners in support of the government proposal (National Health Insurance Policy Paper, 2011:1-59). Due to the small sample size, the Fishers exact test was applied and showed no significance of association with speciality and gender.

5.3.2 Section Two

The total sample of private doctors (100%) indicated they were aware of the implementation of the NHIS. Private doctors will be the main focus of the National Health Scheme and their cooperation is essential as a good focal point for NHI implementation. As stated in the literature, robust cooperation is needed from private practitioners in support of the government proposal, (National Health Insurance Policy Paper, 2011:1-59).

Within the sample, 82% of doctors accessed information about NHIS as opposed to 18% who did not. It could be the minority did not know where or how to access information or possibly lacked interest. A chi-square test indicated there was significant association between age groups and accessing information. This is a significant point and information should be disseminated in such a way, so that it is available to all.

Within the group 16 to 30 years in practice, 95% of doctors had accessed information. This finding suggests that 5% of the respondents were doctors that had been practicing for 1 to15yrs and more than 31 years. According to Bump (2010:40-41), all doctors should have inclusive and an active role in accessing information. A chi-square test indicated there was significant association with years in practice and accessing information. This will assist in the development of a strategy towards Universal Health Coverage, which is the foundation of NHIS.

Doctors familiar with the objectives of NHIS totalled 93% of the sample. The remaining 7% of doctors unfamiliar with the objectives were those within the 21 to 40 year age group. This finding seems to imply that this group of private practitioners regard the objectives of NHIS as futile, based on the existing fragmented healthcare system. A chi-square test indicated there was significant association between understanding the objectives of NHIS and age group. This finding seems to raise concern, as the origin of NHIS objectives for a successful implementation is through the provision of Universal Health Coverage, according to WHO, (2013: 1-2).

The doctors within the age-group 41 and 60 years showed the highest percentage on knowledge regarding capitation, whilst among those between the ages of 21and 40 years, 39% stated they did not understand the concept capitation. A chi-square test indicated a significant association between age-group and capitation. Across all age groups, the majority of respondents understood the concept of capitation within the NHIS. A chi-square test indicated a significant association between years in practice and understanding the concept capitation. According to the policy on National Health Insurance (2011:1-59), it was stated that the contracted private practitioners and institutions to the NHI would be reimbursed through capitation. This would

mean the doctors would no longer bill on a fee-for-service as this would only be applicable to the non-insured. Within the sample, 50% of those with knowledge on capitation were specialist doctors and 50% were GPs. A chi-square test indicated there was significant association between understanding the concept capitation and speciality. This finding seems to indicate that across all years in practice, knowledge on capitation was well understood.

Within the sample, 86% of doctors understood the concept single–payer system with 14% being unfamiliar with the concept. The latter percentage of doctors, were specialists within the 0 to 15 years in practice. A chi-square test indicated there was significant association between understanding the concept single-payer system and age group. A single-payer is one entity, usually the Government, that will be collecting all contributions and be responsible for reimbursement, to all providers in the health system (Econex. Health Reform Note 6, 2010:1). The South African Healthcare System aims to look at citizen tax contribution for NHI funding, which implies that the minority doctors who were not familiar with capitation are not aware that they personally will be affected by this approach.

The findings indicate, across all age groups, speciality and years of practice, that the majority of doctors (76%) CD believed government can manage a single-payer system. As stated in the literature, single-payer system is described as one entity (usually the government) that collects all contributions and is responsible for reimbursement of all providers in the health system". (Econex. Health Reform Note 6, 2010:1).

After detailed data analysis, a summary of the findings was given. The demographic data profile elicited were gender, age–group, speciality, number of years in practice and type of practice. It can be implied that the majority of respondents were in the 41to 60 age group category. In terms of speciality, the majority of male and female doctors work in a speciality field and the minority work as private general practitioners, which indicated the two private institutions mainly functioned with specialist doctors. The highest proportion was predominantly in the years of practice, 16 to 30 years, with the majority working in private hospitals and the minority practicing in a clinic and private GP rooms. The second section established the private doctor's knowledge regarding the National Health Insurance Scheme. It can be implied that the majority of doctors were knowledgeable in terms of awareness that a NHIS has been proposed by the Government and had accessed information about the subject; however a minority group of doctors indicated they did not understand the concept of capitation. This can be generalised to imply that doctors were aware, in terms of knowledge, about the NHIS.

5.3.3 Section Three

Section three elicited the opinions of private doctors regarding the NHIS.

A significant finding was that only 43% of doctors supported the government proposal, with 50% agreeing the NHIS was inevitable and 32% stating they would support the NHIS. A chi-square test indicated a significant association between speciality and doctors supporting the government proposal. Another chi-square test indicated there was significant association between years in practice and support of the government proposal. Without the support of private doctors, the NHIS will not be viable. Furthermore, the chi-square test indicated there was significant association with doctor's age group and speciality and their response to NHIS being inevitable. The latter findings could suggest the NHI may negatively impact on private doctor's financial income, as they largely operate on a fee-for-service, when referring to age group, the field of speciality and how long they have been practicing.

A further finding was that 76% and 90% of doctors, respectively, stated Government could not manage a single-payer system nor manage the healthcare system effectively. Molathegi, (2009:40-41) maintained the success to equity would be a one-pool funding model, through integration of public and private healthcare and proper governance and management of NHI. From the findings, the overall response rate from doctors was of low confidence levels in government to manage the healthcare system effectively. Furthermore in the Guardian Gate (2012:1-4), the health minister outlined the governments ten-point plan to address the needs and problems facing the country's public healthcare system and also stated the country needed to approach health financing from a new angle. This seems to suggest that the management of the healthcare system is reliant on the buy-in from the private doctors.

Within the sample, 79% stated that Government would not meet the objectives by 2025. There was a significant association between years in practice and meeting objectives through each age group, implying the majority of doctors are not confident Government can meet the objectives by 2025. Baletta (2012:1185) states that multi-billion dollar projects in 10 districts have been launched to re-engineer the health systems. The NHI could take up to 15 to 25 years to be implemented successfully and would require a robust cooperation between the public and private healthcare sections (National Health Insurance Policy Paper, 2011:1-59). According to the Health Minister, Aaron Motsoaledi, these projects would take up to five critical years in which the management, staffing, infrastructure and equipment at public health facilities would be overhauled and a National Health Insurance fund set up, with the entire roll-out being phased in over 14 years (Baletta; 2012:1185).

The majority of the doctors partially agreed and completely agreed that private GPs should be the key stakeholders of the NHIS and that primary healthcare should be the fundamental focus of NHIS. A significant chi-square test indicated a significant association between age group and private GPs being the key stakeholders for a NHIS. A further chi-square test finding indicated there was significant association between years in practice and PHC being the fundamental focus for the NHIS. This seems to suggest doctors are aware of the importance of PHC as the primary focus for NHIS. One of the objectives of the NHI, to manage fragmented healthcare services especially amongst the poor, would be to focus on primary healthcare, i.e. from clinics, schools, community health centres and hospitals to homes and the private sector (National Health Insurance Green Paper, 2011:1-38).

Within the sample, 60% of the doctors completely disagreed that a single-payer system controlled by the Government would be viable. The findings suggest the majority of doctors did not view the single-payer system controlled by the Government to be feasible, which leads to concern, as the most likely future model would be a single-payer system, as stated in the literature (Bateman; 2012:1-3). This model is further supported by the World Health Organization as it voices the inequalities in the health system. Furthermore, Naidoo, (2012:149-150) stated the primary focus would remain the capitation model, and that it would have an impact on the private sector.

A total of 41% of the doctors completely disagreed that a mandatory capitation system could overhaul the healthcare system of South Africa. A chi-square test indicated there was a significant association between age group and years of practice in relation to the mandatory capitation system. Bateman (2012:1-3) suggests that private doctors could stand to benefit financially, through a capitation model. The loss of autonomy in their practices however was of concern amongst 30% of the doctors

The results showed that 60% of doctors completely agreed on preferring to treat private and medical aid eligible patients on a fee-for-service basis through private payments and medical-aid payments. These doctors stated they would treat private and medical-aid eligible patients contracted to NHIS. A chi-square test indicated there was significant association between years in practice and preference to treat medical aid eligible patients contracted to NHIS. Of interest is this finding suggests that private doctor's financial viability is developed over time on a fee-for-service basis. It is encouraging to realise that patients contracted to NHIS would be treated by private doctors.

The majority of doctors (44%) partially agreed that the NHIS would have a negative effect on the financial aspect of their practices. Bateman (2012:1-3) stated that under the capitation model, as calculated by Behrman, well organised GPs stood to turn over R1.5 million per annum versus the R750,000 per annum currently being grossed. Medical aid rates currently work on approximately 3.5 fee-for-service consults per patient (at R228, VAT) including per consult, added to R798 annually. Under capitation, dividing this by 12 gives a monthly capped rate of R66.50 per patient per month. If the NHI allocated a practitioner 2000 patients per annum (numbers based on the old TransMed capitation model) this equals R130.000 per practitioner, paid up-front monthly in advance, totalling R1.560 million per annum. This seems to suggest that private doctors are not aware that they could gain financially through NHIS.

Seventy-four percent of the doctors completely agreed that incentives should be offered. Private doctors are largely driven by financial gains, as the majority completely agreed that incentives should be offered to accredited practices. According to Molathegi (2009:40- 41), based on a humanitarian approach, we need to move towards an economic system that seeks to achieve pareto-efficiency, a concept that makes someone better without making the other person worse off. This seems to suggest that the global response for success to equity is a one-pool funding model, through integration of public and private healthcare and proper governance and management of NHI.

The objectives of the study were:

- To explore the responses in terms of knowledge and opinions of private doctors relating to the implementation of the NHIS, the proposed capitation model and the single-payer system.
- To describe private doctors responses regarding the NHIS, the proposed capitation model and the single-payer system.
- To assess private doctors willingness to embrace the scheme.

Results showed that doctors familiar with the objectives of NHIS totalled 93% of the sample. A significant finding was that only 43% of doctors supported the government proposal, with 50% agreeing the NHIS was inevitable and only 32% stating they would support the NHIS. The doctors within the age-group of 41 to 60 years showed the highest percentage on knowledge regarding capitation; between the ages of 21 to 40 years, 39% rated they did not understand the concept capitation. Within the sample, 86% of doctors understood the concept single–payer system, with 14% being unfamiliar with the concept; the latter percentage of doctors were

specialists within the 0 to 15 years in practice. A further finding was that 76% of doctors stated that Government would not manage a single- payer system and 90% stating that Government cannot manage the healthcare system effectively. Within the sample, 60% of the doctors completely disagreed that a single-payer system controlled by the Government would be viable. A total of 41% of the doctors completely disagreed that a mandatory capitation system could overhaul the healthcare system of South Africa.

The findings indicated that doctors seem to be knowledgeable about NHI implementation, however the majority have no confidence in Government being able to manage the proposed NHI, in terms of capitation and a single-payer system. The majority are not in support of the proposed NHI.

5.4 STUDY LIMITATIONS

The study was conducted at two private hospitals and two private clinics, thus the findings cannot be generalised beyond the study population. Although the total population of private doctors was used in both the hospitals and clinics, the sample was small, which could be a potential weakness in the study.

5.5 RECOMMENDATIONS

Several recommendations for future research, based on the main findings, can be drawn from this study.

- A larger study is needed to assess the knowledge of private doctors on the implementation of the NHIS.
- A study should be conducted using this study as a pilot.
- A follow up on this research could include a larger population of private doctors.
- The instrument used in collecting data for this study was used for the first time and could be tested for validity.

5.6 CONCLUSION

The conclusion drawn from the study, suggests that doctors seem to be knowledgeable about NHI implementation, but not in support of the proposed system. The majority of the doctors seem to lack confidence in the Government's ability to manage the proposed NHI, in terms of capitation and a single-payer system.

From the literature review, the success of National Health Insurance Schemes are perceived in many different ways. In some countries, doctors display a negative attitude towards National

Health Schemes, which could result in failure to achieve Universal Health Coverage, particularly in African Countries still battling to overcome poverty, burden of disease, unemployment, lack of skilled human resources, lack of supplies/resources, corruption and health fragmentation. However, there are countries where doctors, together with citizens, have a positive perception about the scheme. This is largely due to continued participation and inclusivity from the private and government healthcare sectors' drive to improve in the management and control of National Health Insurance Scheme. This success can be attributed to the adherence to the core principle of universal health coverage, such as free healthcare for all, continual research in the management of National Health Care, appropriate and accessible primary healthcare, amongst others. Furthermore, if SA doctors and citizens continue to make positive contributions and have a role in NHI policy making, a successful NHI implementation can be achieved. Given the current economic status in South Africa, NHI funding remains a controversial topic. Private doctors primarily work on a fee-for-service basis, if Government's proposal is that of capitation and a single-payer system, fiscal legislative strategies should be undertaken to ensure reasonable and reliable re-imbursement payment systems. This therefore demands a well-researched NHI implementation strategy, from both private and public health sectors to be able to achieve Universal Health Coverage.

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ANNEXURE A

Department of Nursing Education
University of the Witwatersrand
7 York Road
Parktown, 2193

The Director /General Manager
Netcare Health

Dear Sir /Madam

RE: Research at a Netcare Health Hospital

I am a student registered for a Master of Science (Nursing) Degree at the Faculty of Health Sciences, University of the Witwatersrand. As part of the course requirements, I am required to conduct research under supervision. The title of my research is "Private Doctors' Responses On The Implementation Of A National Health Insurance Scheme."

The Purpose of my study is:

- To gain insight on the responses of private doctors on the implementation of the NHIS, re the proposed capitation model and the single-payer system.
- To serve as a pilot study, as it has not been researched before, to augment to NHIS policy making and research in South Africa.

I would like to conduct this study, as I believe a National Health Insurance scheme has to be embraced by both the private and public healthcare sectors irrespective of the challenges and hereby apply for permission to undertake research in your private hospital. The name of your institution and medical practitioner involved will remain anonymous.

Yours Sincerely
Cecelia Botha
Cell – 082 411 6330
(H) – 011 760 2861
(W) – 011 495 5015

ANNEXURE B

Department of Nursing Education
University of the Witwatersrand
7 York Road
Parktown, 2193

The Director /General Manager
Fordsburg Private Day Clinic

Dear Sir /Madam

RE: Research at Fordsburg Day Clinic

I am a student registered for a Master of Science (Nursing) Degree at the Faculty of Health Sciences, University of the Witwatersrand. As part of the course requirements, I am expected to conduct research under supervision. The title of my research is "Private Doctors Responses On The Implementation Of A National Health Insurance Scheme."

The Purpose of my study is:

- To gain insight into the responses of private doctors on the implementation of the NHIS, re the proposed capitation model and the single-payer system.
- To serve as a pilot study, as it has not been researched before, to augment to NHIS policy making and research in South Africa.

I would like to conduct this study, as I believe a National Health Insurance system has to be embraced by both private and public healthcare sectors irrespective of the challenges, therefore apply for permission to undertake research in your private hospital. The name of your institution, medical practitioner involved, will remain anonymous.

Yours Sincerely
Cecelia Botha
Cell – 082 411 6330
(H) – 011 760 2861
(W) – 011 495 5015

ANNEXURE C

Tel: +27 (0) 11 495 5000
Fax: +27 (0) 11 495 5055
35 Bartlett Road, Mayfair West, South Africa
P O Box 45175, Mayfair, 2108, South Africa

LETTER CONFIRMING KNOWLEDGE OF NON-CLINICAL FOCUS RESEARCH TO BE CONDUCTED IN THIS NETCARE FACILITY

Dear Cecelia Botha,

Re: "Private Doctors Responses On The Implementation Of A National Health Insurance Scheme"

We hereby confirm knowledge of the above named research application to be made to the Netcare Research Committee and in principle agree to the research application for Netcare Garden City Hospital, subject to the following:

i) That the research may not commence prior to receipt of FINAL APPROVAL from the Academic Board of Netcare (Research Committee).

ii) That the researcher will notify the Academic Board of Netcare (Research Committee) of the proposed date of commencement of the project, in writing.

iii) A copy of the research report will be provided to Netcare once it is finally approved by the tertiary institution, or once complete.

iv) Netcare has the right to implement any Best Practice recommendations from the research.

v) That the Hospital Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects / Netcare or should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully,

5/05/2014

Signed by Hospital Management **Date**

HGM

(Specify designation)

ANNEXURE D

FORDSBURG CLINIC

PR. No. 7700083
Reg. No. 1986/002106/06

16th July 2014

Dear Ms Botha

(Student Number: 0210997H)

RE - Research at Fordsburg Day Clinic

Thank you for selecting Fordsburg Day Clinic as the institution in which to conduct your research. We are pleased to grant you permission to proceed with the said research at our clinic.

Should you require any assistance, please don't hesitate to ask.

We wish you well and hope this investigation will prove to be a success. Furthermore, we would like to wish you everything of the best with your studies and future endeavours.

Kind regards,

DR BASIL BICK

(Director)

Physical Address: 22 Bonanza Street, Selby Extension 19, 2092
Postal Address: P.O. Box 42510, Fordsburg, 2033
Telephone: (011) 834-4015/6 Telefacsimile: (011) 834-2468 E-mail Address: fordsburgclinic@fordsburgclinic.co.za

Directors: Dr Yusuf Bamjee, Dr Bazil S Fick, Mr Ismail S Gattoo, Ms Nazeema Hill, Dr Fahmeeda Peer, Dr Riaz Mohamed, Mr Mohsin Suliman

ANNEXURE E

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Ms Thokozile Nhlapo
E-mail: thokozile.nhlapo@wits.ac.za

20 January 2016
Person No: 0210997H
PAG

Mrs CL Botha
24 Sonop Street
Horizon View
Roodepoort
1724
South Africa

Dear Mrs Botha

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *Private doctors responses on the implementation of a national health insurance scheme (NHIS)* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

R14/49 Ms Cecelia Liza Botha

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M140880

NAME: (Principal Investigator)	Ms Cecelia Liza Botha
DEPARTMENT:	Nursing Education Netcare Garden City Hospital Fordsburg Private Day Clinic
PROJECT TITLE:	Private Doctors Responses on the Implementation of a National Insurance Scheme (NHIS)
DATE CONSIDERED:	29/08/2014
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Melanie Lack
APPROVED BY:	Professor P Cleaton-Jones, Co-Chairperson, HREC (Medical)
DATE OF APPROVAL:	08/09/2014

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 8.9.2014

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE G

Study Title: Private Doctors Responses On The Implementation Of A National Health Insurance Scheme

INFORMATION LETTER

Dear Respondent

I am a student registered for a Master of Science (Nursing) Degree at the Faculty of Health Sciences, University of the Witwatersrand. As part of the course requirements, I am expected to conduct research under supervision. The title of my research is "Private Doctors Responses On The Implementation Of A National Health Insurance Scheme."

The purpose of my study is:

- To gain insight into the responses of private doctors on the implementation of the NHIS, re the proposed capitation model and the single-payer system.
- To serve as a pilot study, as it has not been researched before, to augment to NHIS policy making and research in South Africa.

I would like to invite you to consider participating in this research study by completing a questionnaire. The first part of the questionnaire is your demographic information; your name is not required to ensure confidentiality. The second and third parts consist of closed-ended questions on topics relating to knowledge and opinions. Participation is voluntary, whether you choose to participate or not is entirely your choice. There are no benefits or risks if you decide to participate and no consequences if you do not. I will ask for a signed consent, however you will not be identified or be identifiable. Once posted, the questionnaires cannot be withdrawn from the study as all posted papers must remain confidential.

Thank you for taking the time to read this and for considering participating in the study.

Yours Sincerely

Cecelia Botha

Contact Numbers (011)495 5015 /082 411 6330

ANNEXURE H

CONSENT FORM

Study Title: Private Doctors Responses On The Implementation Of A National Health Insurance Scheme

I, hereby agree to participate in the above-mentioned study.

Dated……

Signature of participant.....

Signature of witness……..

ANNEXURE I

Study Title: Private Doctors Responses On The Implementation Of A National Health Insurance Scheme

Human Research Ethics Committee (Medical): Clearance Certificate No.M140880

QUESTIONNAIRE

SECTION ONE:

PARTICIPANT DEMOGRAPHICS

(Place tick in box)

A	Gender	M (1)	F (0)

B	Age Group	21-30 yrs. (1)	31-40 yrs. (2)	41-50 yrs. (3)	51-60 yrs. (4)	Over 60 yrs. (5)

C	Speciality	Primary Care GP (1)	General Surgery (2)	Physician (3)	Obstetrics Gynaecology (4)	Paediatrics (5)	Speciality Surgery (6)	Psychiatry (7)	Other (8)

D	Years in Practice	0-5 (1)	6-10 (2)	11- 15 (3)	16-20 (4)	21-25 (5)	26-30 (6)	31-35 (7)	36-40 (8)	41-45 (9)

E	Practice	Private GP rooms (1)	Hospital (2)	Clinic (3)

SECTION TWO:

PARTICIPANTS' KNOWLEDGE ABOUT THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)

(Place tick in box)

A		Yes (1)	No (0)
1.	Are you aware that a NHIS has been proposed by the government		
2	Have you accessed information about the NHIS		
3	Do you understand the objectives of the NHIS		
4	Do you understand the concept of Capitation		
5	Do you understand the concept of the Single-Payer System		

SECTION THREE:

PARTICIPANTS' OPINION REGARDING THE NATIONAL HEALTH INSURANCE SCHEME (NHIS)

Rating Scale:

1	**Complete disagreement**
2	**Partial disagreement**
3	**Partial agreement**
4	**Complete agreement**

(Place tick in box)

		1	2	3	4
1.	Will you support the government proposal				
2	Is NHIS inevitable				
3	Can government manage a single–payer system				
4	Will you support the NHIS				
5	Government manages the Healthcare System effectively				
6	I am confident that government will meet objectives of NHIS by 2025				
7	Private GP's are the key stakeholders for a NHIS				
8	PHC must be the fundamental focus for the NHIS				
9	I recommend a personalised data scheme to participate in NHI policy making				
10	A single-payer system controlled by the government will be viable				
11	The pricing in the private healthcare sector must be regulated				
12	A mandatory capitation system will overhaul healthcare system in South Africa				
13	I will still have autonomy in my practice with the implementation of the NHIS				
14	I prefer to treat private and medical aid eligible patients				
15	I prefer to treat private and medical aid eligible patients contracted to NHIS				
16	The NHIS will have a negative effect on the financial aspect of my practice				
17	Incentives should be offered to accredited practices and institutions				

ANNEXURE J

Gill Smithies

Proofreading & Language Editing Services

59, Lewis Drive, Amanzimtoti, 4126, Kwazulu Natal

Cell: 071 352 5410 E-mail: moramist@vodamail.co.za

Work Certificate

To	Prof L. Maree, RN DCUR (Pret)
Address	Wits Dept of Nursing Education
Date	5/12/2017
Subject	Research Report: Private Doctors Responses On The Implementation Of A National Health Insurance Scheme.
Ref	LM/GS/053

I, Gill Smithies, certify that I have edited the following for language and style,

Research Report: Private Doctors Responses On The Implementation Of A National Health Insurance Scheme,

to the standard as required by Wits Dept. of Nursing Education.

Gill Smithies

5/12/2017

Originality Report

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