

Moving towards universal health coverage in South Africa: the role of private sector GPs

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Intended to address the country's large inequalities in access to health care, South Africa's National Health Insurance (NHI) promises a universal tax funded system which is comprehensive, integrated and available to all South Africans. Since the release of the 2011 NHI Green Paper (1) considerable debate and analysis has occurred regarding the politics and economics of the proposed scheme. However, relatively little attention has been paid to the important role played by frontline providers tasked with implementing the reforms, and whose services the scheme will rely on in order to function on the ground.

In particular, the 'contracting in' of private sector general practitioners (GPs) into the public health services is a key aspect of the NHI which deserves more attention. Whilst only 16 percent of the South African population belong to private medical schemes, they consume over 50 percent of total health care funds which means that over R11,150 per capita is spent on private patients compared to the R2,776 per capita that is spent on public sector patients. The skewed distribution of health human resources also means that currently the system is dominated by private practitioners, with 70% of GPs and 59% of all doctors being in private practice (Ruiters and van Niekerk, 2012 cited in (2)). They are therefore central if the reform is to more equitably redistribute resources from the well-resourced private sector to the public sector. Moreover, historically and internationally, it is clear that the role of the medical profession in health reform has been an important one. Repeated evidence demonstrates the power of the medical profession in extracting concessions from the State at times of major system change and in ultimately shaping the scheme in ways that were not always anticipated by policy makers (3). The perceptions of private sector GPs may therefore provide an insight not only into the possible practical challenges the NHI scheme may face in implementation, but also into the broader political challenge that policy makers face.

Recent evidence

One of the few studies to specifically examine these issues comes from a team of researchers from Oxford and Rhodes universities and explores the views and experiences of almost 80 clinicians in the Eastern Cape Province (2). Although overall there was substantial resistance to the NHI proposals, there were some important differences within the profession. Amongst the GPs interviewed, the study found a divide in opinion between well-resourced private GPs, and smaller, single-person practices often located in less affluent areas. While the majority of

GPs from better resourced practices felt that the proposed reforms were detrimental, doctors running smaller practices were more likely to welcome the idea of NHI as a means by which to bolster and stabilise their incomes. Public sector GPs were also generally supportive of the reform, feeling that an expansion of the private sector would lessen their workload. Almost all clinicians, however, did acknowledge that there was a need for change in the current health system, which faces a crisis of affordability and sustainability. Medical aid costs have increased by 120 percent over the past 10 years, and contributions have increased from 7 percent of average wages in 1980 to 14 percent in 2008, with increasing co-payments (1). Nevertheless, critics of the reforms argued that this would be better solved through improved management of existing arrangements and resources, rather than a radical overhaul of the health system and most interviewees were ideologically opposed to the implementation of a 'nationalised' UK-style single-payer system.

Private sector GPs who were opposed to the scheme justified their opposition on a number of different grounds. Chief among these was that the scheme was financially unaffordable – that the cost of providing “first world medicine” on a universal basis could not be borne in South Africa, where the taxpaying population is a relatively small percentage of the total population. Lack of human resources and institutional capacity especially in rural areas where health systems are very weak, were also highlighted as major barriers. Additionally, private sector GPs were concerned about the impact of the NHI on their own remuneration and working conditions. Doctors insisted that they were not “charity workers,” and predicted that being paid at state approved private rates would lead to a significant decline in their earnings, and would ultimately lead to many doctors retiring or emigrating. There was particular opposition to the idea of a flat rate fee, the concern being that this would not recognise differing skills and experience, and that it may lead to adverse incentives to “game the system.” Working conditions in poorly equipped facilities was a major concern, as were worries about a loss of clinical autonomy, and the ability to decide their own methods of practice and work balances. Some also expressed the fear that the quality of health care services in South Africa might suffer as a result of government contracts bolstering poor quality private practices, making them viable despite their poor services.

The study also revealed a general discontent by GPs who felt that they had not been sufficiently included in the consultation process around the NHI; that the reforms were being “forced down throats” and that government was “riding roughshod” over them. Some suggested that this was a result of passivity on the part of GPs themselves to engage in the policy process, arising from a lack of time, pessimism about their ability to change anything, and the individualistic culture of private practice. Others felt that it was because it was too difficult to organise doctors into a unified voice; citing institutional (public versus private), geographical, and socioeconomic (race and size of practice) fragmentations and divisions as the main barriers. Several respondents were also cynical about perceived anti-private sector sentiments of the Ministry of Health, which generated hostility and mistrust and unwillingness to engage with the process of reform.

Current developments

Since the completion of this study, there have been a number of important developments in relation to the NHI. The most significant of these has been the roll out, in 11 selected districts, of NHI pilot schemes (4). Initial reports suggest that the pilot programmes are having mixed success. While outreach programmes focused on health education and preventive health measures, such as the community and school health teams, are reportedly

functioning well in some districts (5) the recruitment of private sector GPs into the pilots has been much less successful. The government's initial target to recruit 600 GPs in the first year was drastically missed with less than 100 GPs signing contracts between 2013 and 2014. Revised targets to have 900 GPs nationally contracted into the NHI by March 2015 have equally failed, with only approximately 200 out of the 8000 private sector GPs working in South Africa joining up by March 2015 (6). Particularly depleted is the Eastern Cape's OR Tambo District (the site of the Surrender study) where only one doctor has contracted, and the Northern Cape's Pixley kaSeme District, with only 10 recruits (7). The South African Medical Association (SAMA) has also cautioned that many of the doctors who have signed up are newly qualified and have little general practice experience (6). The failure to attract the required number of GPs has had negative ramifications for the NHI's budget. The fact that only a small proportion of the previous allocation for the NHI – 9 percent of R388 million – had been spent by December 2014 (6) has resulted in a cut of R767 million from the National Health Grant over the next three years.

In addition to problems of recruitment, the NHI pilots are reported to be struggling to hold onto many of the additional doctors who have joined. Reflecting many of the concerns anticipated in the Surrender 2014 study, doctors have cited poor working conditions (long hours and poor equipment), ineptitude of the provincial health department, (8) and lack of flexibility in contracts as primary challenges to recruitment and retention. In particular, the model currently in operation requires doctors to operate from public clinics, rather than operating from their own practices, as preferred by many (6).

The low number of GP recruits was possibly predictable considering the opposition the NHI has faced from the professions' major medical associations. In 2013 SAMA, which represents the largest proportion of the medical workforce, argued that the proposed NHI would be "economic suicide" for doctors unless they were paid much higher rates than the public sector rates proposed (9). In 2014, Chris Archer from the South African Private Practitioners Forum publicly attacked the NHI, arguing that it was not affordable in the South African context, and pleading for Health Minister Aaron Motsoaledi to "enter into dialogue" with the private sector (10). A public acrimonious dispute has resulted in polarisation and mistrust on both sides.

Moving forward: the need for evidence based policy making

In response to the shortage of GPs the government has turned for assistance to the Foundation for Professional Development (FPD), an organisation affiliated to SAMA, to assist with recruitment. There are early indications that FPD have been successful in increasing the number of GPs participating in the NHI pilots, for example, bolstering the numbers in Mpumalanga's Gert Sibande District, from 10 to 35 GPs in four months (7). Nevertheless nationally, numbers still remain well short of the target and little is yet known about the quality or retention rates of these new recruits. Furthermore, there is some evidence (Surrender, et al. forthcoming) that many are being recruited from within the public primary care sector rather than the private sector as envisioned (and needed).

It seems then that preliminary reports from the NHI pilots appear to confirm the concerns anticipated in earlier studies, in particular the cautions from Surrender et al. that the DoH may face significant challenges in garnering the support of private GPs. Opposition to the NHI from the private sector appears to remain strong, and the initial difficulties in implementation on the ground are unlikely to have assuaged this. It is crucial then that ongoing research

contributes to the evidence base about how to overcome these barriers in order to be of practical use to those tasked with developing and implementing policy. A formal stated goal for the pilots is to '*assess the feasibility, acceptability, effectiveness and affordability of engaging with the private sector*' (4). It is therefore disappointing that a rigorous and comprehensive evaluation of GP contracting has not yet been instituted. It is imperative that further research is undertaken to contribute to a better understanding of the role of private sector resources in the public health sector and the extent to which it can be engaged for public benefit.

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