The Medical Profession and the Universalisation of South African Health Care:

Analysing the Response of Eastern Cape General Practitioners to the National Health Insurance proposals

A thesis submitted in requirement for the degree of

MASTERS IN SOCIAL POLICY

in the

INSTITUTE FOR ECONOMIC AND SOCIAL RESEARCH

RHODES UNIVERSITY

by

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Date of Submission: October 2016

Declaration

I, Bridget Hannah, declare that the contents of this thesis represent my own original work (except where acknowledgements indicate otherwise), and that the thesis has not previously been submitted for academic examination towards any qualification at any other University. Furthermore, this thesis represents my own views and opinions and not necessarily those of Rhodes University.

_____ 13th October 2016 _____

Signed Date

Abstract

In 2011, the Green Paper on National Health Insurance (NHI) in South Africa was released, committing the South African government to a 14-year plan to radically transform the currently inequitable health system towards providing comprehensive quality health care free at point of access to all citizens. The pursuit of universal health coverage (UHC) in South Africa forms part of a global aspiration to achieve more equitable healthcare delivery. One of the critical issues emerging from the Green Paper was how the NHI would be staffed. The NHI is unlikely to be adequately staffed without GPs but evidence suggests that private sector doctors have always been resistant to nationalisation or socialisation as a threat to their occupational power and professional status. The core work of this thesis is a study undertaken of 78 doctors in the Eastern Cape, focusing on private sector general practitioners (GPs), as the largest constituency of medical professionals in the country. The interview schedule was designed to gauge doctors' responses to the NHI, encourage discussion on their reactions to the reforms, and its implications in their view for private medical practice. The responses of the doctors are analysed through application of two theoretical themes, namely: (i) actor-centred policy creation, discussed through application of Walt and Gilson's (1994) shared focus on content, context, process and actors in the policy process, and (ii) the debate on medical professionalism, espoused by Freidson (1973, 1994) and argued against by Haug and Sussman (1969), and McKinlay (1972, 1993). Thus, if the process of policy making must take into account key actors in order to deliver a successful policy transition, what are the implications if these actors are actively excluded, or do not willingly cooperate? Does this indicate anything telling about the private sector's role to play in the pursuit of universal healthcare?

Key Words: Actor, Actor-centred policy, Eastern Cape, General Practitioner, Private healthcare, Public healthcare, Health care reform, Medical professional, National Health Insurance, Policy process, South Africa, Universal Health Coverage

Acknowledgements

Thank you to Professors Robert van Niekerk, Rebecca Surender and Gavin Williams. At any time it would be a privilege to have one esteemed academic investing their precious time in you, and I have been lucky at some point through the years to have all three share their valuable inputs. Thanks for your patience and continued encouragement. This project took longer than any of us could have imagined.

Thank you to the Sandisa Imbewu Fund for financing the first two years of this project, and the staff at the Institute of Social and Economic Research for always making room for me. Also, thank you to the 78 doctors that took part in this study and openly shared their opinions – I hope you feel honestly reflected.

Nina Butler, there are many things to thank you for in this process, but helping me with editing was a critical step towards finishing. You are truly valued.

To the many friends that have supported this process – thanks for you all believing this was going to eventually come to a conclusion, even when there were no results to indicate as such. In particular thank you to Romi Reinecke, Claire Keet, Raisa Meiswinkel and Carina Truyts who were always checking in, reminding me that I had a community to remain accountable to.

To my family, the wolfpack– Ronnie, Alex and Frances – your good humour means that no challenge is insurmountable. I am so proud to be a sister and daughter to such dynamic women. To Colin, you are never far from our thoughts and our successes are a continued tribute to our everlasting love for you. The years pass, but your presence in our lives does not fade.

Mike Tigere Mavura – thank you for providing a continually supportive space within which to edge ever closer and mostly, thank you for joining me at the finish line! I am so proud we both finally made it and I am so looking forward to the next (non-academic) chapter of our lives together!

If this project has taught me anything it is that the community of support found in family, friends and colleagues is the only reason most of us ever get round to completing half the things we dream up. This thesis is dedicated to Chris Pietersen who passed away in the last week of finishing this project. The loyalty, kindness and compassion you showed my mother is the purest form of loving friendship I've witnessed – thank you for your legacy.

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List of Tables and Figures

List of Acronyms

AMA	–	Australian Medical Association
ANC	–	African National Congress
ART	–	Anti-retroviral Treatment
CDE	–	Centre for Development and Enterprise
COSATU	–	Congress of South African Trade Unions
DA	–	Democratic Alliance
EC	–	Eastern Cape
GDP	–	Gross Domestic Product
GP	–	General Practitioner
GPPPC	–	General Private Practice Practitioners Committee
HPCSA	–	Health Professions Council of South Africa
HSF	–	Helen Suzman Foundation
ILO	–	International Labour Organisation
IPA	–	Independent Practitioners Association
NDoH	–	National Department of Health
NEHAWU	–	National Education, Health and Allied Workers Union
NGO	–	Non-Government Organisation
NHI	–	National Health Insurance
NHS	–	National Health Service
NSDA	–	Negotiated Service Delivery Agreement
OECD	–	Organisation for Economic Co-operation and Development
PHC	–	Primary Health Care
PHI	–	Private Health Insurance
RuDASA	–	Rural Doctors Association of South Africa
SACP	–	South African Communist Party
SAHR	–	South African Health Review
SAMA	–	South African Medical Association
SAMJ	–	South African Medical Journal
SAPPF	–	South African Private Practitioners Forum
SHI	–	Social Health Insurance
TAC	–	Treatment Action Campaign
UDIPA	–	Uitenhage and Dispatch Independent Practitioners Association
UHC	–	Universal Health Coverage
UK	–	United Kingdom
WC DoH	–	Western Cape Department of Health
WHO	–	World Health Organisation

Chapter One: Introduction and Context

1.1. Introduction

This introductory chapter outlines the thesis structure and introduces the various themes that the dissertation will cover. This first chapter covers six broad aspects, namely: (i) setting the context for the research; (ii) describing the overall thesis methodology; (iii) introducing the literature review methodology; (iv) stating the research questions and objectives of the thesis; (v) a description of what each chapter will cover; and (vi) to explore the interview methods for the field work component of this thesis. In summary this chapter seeks to introduce the reader to the thesis plan, providing the first step towards analysing the role of the medical profession as policy actors in the South African National Health Insurance (NHI). The thesis focuses specifically on the responses of Eastern Cape private sector GPs to the proposed NHI reforms as articulated in the Green Paper on NHI, released in August, 2011 concluding with a brief reference to how this relates to the release of the White Paper on NHI in December 2015.

1.2 Statement of the research problem: Understanding the obstacles and challenges in the policy process aimed at universalising health care in South Africa

The thesis provides an analysis of the contested, complex and intrinsically political process of policy making by examining the attempts by the government to establish an NHI in South Africa. In South Africa there are political factors that make the process of health policy implementation difficult to achieve. This is especially pertinent in the case of the comprehensive degree of reform proposed by the NHI which has a policy commitment to providing universal health coverage (UHC) that is free at point of access for all citizens.

1.2.1 Locating South African health policy objectives in the global drive to universalise health care

The universalisation of health care is on the global policy agenda, and the pursuit of universal health coverage (UHC) in South Africa forms part of a global aspiration to achieve more equitable healthcare delivery. WHO Director General Margaret Chan's assertion that UHC is "the single most powerful concept that public health has to offer" (Schmidt et al., 2015) attests to the increasing worldwide attention given to universal coverage — being pursued in both more and less affluent countries as a method to reduce financial impoverishment caused by health spending, and to increase access to key health services for all citizens. The World Health Organisation (WHO, 2015) defines UHC as, "ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that

the use of these services does not expose the user to financial hardship." There are various methods and routes to attaining UHC; the Lancet Commission on Investing in Health recommends 'progressive universalism' as a means to achieving UHC, suggesting that some countries have begun the process with a minimum package that is increasing incrementally over time, while others have defined a comprehensive healthcare service package that is available for a subset of the public at first and then expanded to other subpopulations (Hofman et al. 2015: 739). In South Africa, the National Department of Health (NDoH, 2011a: 24) supports the global policy agenda on universalisation of health care and in the Green Paper on the NHI the department committed itself to the objective that "all members of the population will be entitled to a defined comprehensive package of health services at all levels of care namely: primary, secondary, tertiary and quaternary with guaranteed continuity of healthcare benefits." According to the Green Paper (NDoH, 2011a: 44) the South African NHI will be implemented in a "phased and systematic manner at both the national and sub-national levels." The migration period to NHI will occur in three phases over the fourteen years of implementation and a critical site for learning will be the experiences emerging from the eleven pilot sites around the country which will test various aspects of the NHI, including the contracting of private sector doctors.

1.3 Background to the research problem

South Africa's Constitution (Act 108 of 1996) is considered one of the most progressive in the world, entitling every citizen "the right to have access to health care services". However, health care in South Africa remains deeply unequal with "marked differences in rates of disease and mortality between races, which reflect racial differences in the access to basic household living conditions and other determinants of health" (Coovadia et al., 2009: 824). While the roots of inequality in access to health care can be traced back to the colonial period, unequal access was systematised since 1948 on a statutory basis with the establishment of racially and spatially differentiated systems of health care under the apartheid regime lead by the National Party. This inequity was evidenced in low per capita financing of health for the black African[1] population, significantly less than that provided for the white population, with concomitant poor health outcomes for the prior (Allan et al., 2004: 7; Price, 1988: 705; Sanders & Chopra, 2006: 73). Moreover, this racial bias contributed to health services being targeted towards "curative and higher level services … inequitably biased towards

[1] This thesis notes the problematic division of South African society into four distinct racial categories – 'Whites', 'Coloureds', 'Indians' and 'Black Africans' – reinforcing the systematic segregation of the population by racial categories perpetuated by successive government administrations during apartheid (Posel, 2001). Acknowledging the problematic nature of racialised language this thesis has employed use of the above categories as they have appeared in the literature concerning racially differentiated aspects of healthcare access in the country.

historically white areas … and inequitably biased towards the wealthy minority who use the private sector" (Benatar, 1997: 892; Coovadia et al., 2009: 823; McIntyre & Gilson, 2002: 1640). By the end of the apartheid era, "there were 14 separate health departments in South Africa (including one from structures reporting to each of the three parliaments), health services were focused on the hospital sector, and primary level services were underdeveloped" (Coovadia et al., 2009: 825).

Presently, the current health system still operates on inherited systems, premised on racialised segregation and other forms of discrimination – for example, those who live in rural areas still remain the most disadvantaged as reform is often directed toward urban areas where monitoring the improvement of health outcomes is more effective due to the concentration of health care resources.

1.4 Thesis methodology

1.4.1 Background and context

This thesis forms one part of a larger research project entitled 'Understanding health reform and policy implementation in a democratic South Africa: the Medical Professions' Response to the Proposal for a Universal System of Health Care'. The project was funded by Rhodes University's Sandisa Imbewu Fund, intended to seed and fund new academic initiatives. The qualitative research undertaken for this thesis is based on data which was gathered from detailed interviews with 78 medical professionals within the four districts of Cacadu, Amatole, Nelson Mandela Metropole, and OR Tambo within the Eastern Cape in April-May 2012. It is from this larger project that the material relevant to this particular dissertation has been distilled and extracted to allow for a holistic but concentrated and context-specific analysis. The research team consisted of Professor Rebecca Surender, Professor Robert Van Niekerk, Dr Lucie Allan, Dr Maylene Shung-King and myself. The team jointly authored and published a journal article entitled 'The drive for universal healthcare in South Africa: views from private general practitioners' which was published in the journal *Health Policy and Planning* in June, 2014. As a post-graduate research assistant in the six-person, multi-university research team, I was involved in developing the study from the outset. My responsibilities on the project were to assist in formulating the interview schedule, contacting doctors and organising the majority of the interview schedule, conducting eleven individual interviews, chairing a breakfast meeting with six doctors who were members of both local and national medical practitioner representative bodies, and co-chairing in a further fifteen interviews. Once the interview process was complete I was further responsible for administrating systems to organise the data gathered, sorting and coding all the interviews, creating a range of outputs from the data (i.e.

queries, statistics, graphs), and engaging in analysis of the data with the research team. Qualitative coding software was utilised for initial thematic classification of the data (Nvivo 10).

1.4.2 The research methods

The chosen research design is a mixed methods approach that incorporates qualitative, historical, and case study methods. These methods will be applied through the selected approaches of i) in-depth interviews and ii) documentary analysis (Bowen, 2009; Hanney et al, 2003; Varvasovszky & Brugha, 2000). In terms of textual sampling, this thesis will review relevant historical policy documents relating to health aims by successive South African governments, ending most notably on analysis of the Green Paper on the NHI, alongside documentary analysis on a range of responses to the NHI Green Paper, from political parties, the private sector (i.e. medical aid schemes), medical associations (i.e. South African Medical Association) and other interested parties.

1.5 Methodological Approach to the Literature Review

The literature review pertaining to the thesis has been integrated into each chapter, forming part of the research that grounds each theme. The NHI Green Paper (NDoH, 2011) and analysis of health policy analysis in Low and Middle Income Countries (LMICs), through the lens of Walt (1994), and Walt and Gilson (1994) were used to initiate the research process (Mouton, 2009; Randolph, 2009). Further, searches were undertaken at the Rhodes University and University of Cape Town libraries, as well as Google Scholar and the Web of Knowledge for peer-reviewed books, journals and news articles related to the fields of:

- Actor-network theory
- Actor-centred policy theory
- Conceptualising and implementing National Health Insurance (NHI) in South Africa
- Health care reform in developed and developing countries
- Health policy
- Health policy process (Context, Content, Actors)
- Health systems
- Historical and present day role of the medical profession in health care reform
- Policy perspectives in the developing world
- Professionalism among medical doctors
- Public consultation in health care
- Public versus private sector perspectives on healthcare
- Removal of user fees in healthcare

- Universalisation of health care

In addition, keyword searches were conducted, as was as a back-and-forwards search into the literature related to the relevant articles, as proposed by Webster and Watson (2002). I collated my resource library using the software programme, Mendeley.

1.5.1 Preliminary literature review

1.5.1.1 The NHI in South Africa

Following the establishment of a democratic government in 1994, the ruling African National Congress (ANC) party published a 'Health Vision' within the Health Plan, aimed at redressing the healthcare inequalities inherited from the apartheid era. The objective of the health vision was that "the Health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development" (Department of Health, 1994: 9).

In August 2011, seventeen years after the 'Health Vision' was first articulated, the government released the Green Paper on the NHI outlining the policy direction of the government on health care reform. The NHI reforms have committed the government to ensuring "that everyone has access to appropriate, efficient and quality health services" (Department of Health [NDoH], 2011: 1). The aim was to bring health services "within reach of all sections of the population, according to their needs, and without regard to race, colour, means or station in life" (NDoH, 2011: 13). The proposed NHI suggests a radical re-structuring in the way that health care is provided, aimed at providing universal health coverage "free at the point of use" for all South Africa's citizens (NDoH, 2011: 16).

While the NHI proposes a radical policy agenda for health care in South Africa, with significant objectives aimed at transforming the unequal health structures of South Africa, implementation of the NHI faces numerous challenges and obstacles. The consequence of apartheid policies has left a racially and economically differentiated health care system, and although health care consumes 8.3% of the South African Gross Domestic Product (GDP), which is comparable to the GDP expenditure of many wealthy developed countries in the world, this expenditure has resulted in starkly unequal outputs (McIntyre & Van den Heever, 2007; Musgrove et al., 2002; Naidoo, 2012). The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2 % in the public sector. The 4.1% spend covers 16.2 % of the population, (8.2 million people) who are largely on private medical schemes. The remaining 4.2% is spent on 84% of the population who rely on public healthcare to service their health requirements (NDoH, 2011: 9-10). To illustrate this inequality further, in 2009 per capita spending in the private sector was approximately R9,500 a year, at a ratio of one doctor to every 590 patients, serving only 15 percent of the population, while the remaining

medical work force catered to 85 percent of the country's population, at a ratio of one doctor to every 4200 patients and at a per capita expense of no more than R1500 a year (Alcorn, 2009).

Mayosi et al., (2012) note that in South Africa 16% of individuals pay to see private doctors and dentists, but use public hospitals for serious illnesses, as many people cannot afford high health-care expenses. Most out-of-pocket expenditure is in the form of co-payments for private insurance, and while the private sector maintains that they claim for these individuals who make co-payments, Mayosi et al., (2012) argue that this is inaccurate. Figure 1 below illustrates the pressure on the public system given its share of funding, further compounded by the portion of out-of pocket payments for less serious illnesses that then transfer back to the public system when patients' poor health persists, and private healthcare costs become unmanageable.

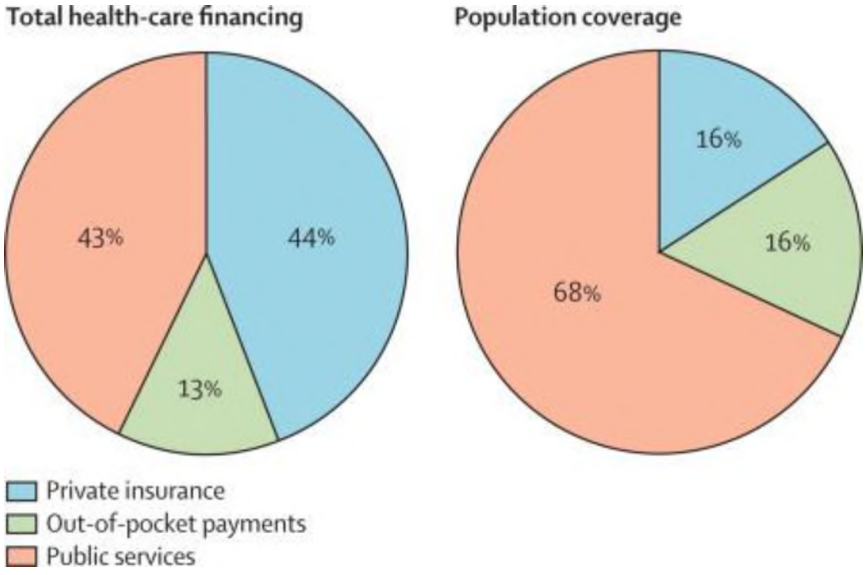

Figure 1: Health financing and population coverage

Source: Mayosi et al., (2012: 13)

Added to the levels of inequity in financial terms depicted above, private health care practitioners generally have the freedom of choice to provide health care services in urban towns and cities where there are greater levels of access to specialists, facilities, and equipment. Practitioners can also choose where they are geographically situated within the city, further influencing the demography of their patient population. This stands in stark contrast with the expectation and duty of public healthcare to reach the majority of South Africa's population living on the under-served outskirts of urban areas, as well as the large proportion of the population living in rural South Africa. McIntyre & Van den Heever (2007: 76; also see Harris et al, 2011) provide evidence of the imbalances between provision in the private and public sectors, indicating that each pharmacist in the public sector serves up to 30 times more people than those in the private sector, and each generalist doctor in the

public sector up to 17 times more than in the private sector. There is a six fold difference of the number of people served per nurse in favour of the private sector and a 23 times difference in favour of the private sector of the number of people served per specialist doctor. Thus with only 16% of the population covered by medical schemes, 84% of the population remains uninsured and reliant on the public system or liable for out of pocket health expenses (Ataguba & McIntyre, 2013: 35). This evidence reveals the scale of disparity in accessibility of the lower income members of society to health care. Akazili et al. (2012: i13) state that "to attain an equitable health system and fully achieve universal coverage...must ensure that the poor...are financially protected, and it must address the many access barriers to health care." This is the challenge that the NHI seeks to address.

1.5.1.2 Academic work on the NHI

There have been a number of academic dissertations written on the topic of the NHI in South Africa, mostly postdating the release in 2011 of the Green Paper on the NHI. A review of the academic dissertations that have been written on the NHI in the last five years reveal engagement from a diverse range of disciplines including: Commerce and Economics, Law, Public and Business Management, Sciences, Public Health and Health Policy. Three themes that emerged examined the constitutionality of the NHI (Wayburne, 2014); financing mechanisms of the NHI (Stevens, 2012) and two theses which engaged concerns of public participation, firstly through surveys conducted through mobile applications e.g. Mxit (Weimann, 2013); and secondly, nurses' experiences of changing practice in relation to the use of evidence-based knowledge in the implementation of the NHI (Nkomo, 2014). From the review undertaken to ascertain the academic contributions on the subject there was however no student research focused specifically on medical practitioners' responses to the NHI at the time of the preparation for this thesis.

With regards to the published academic literature, a review of publications and citations revealed that peer-reviewed journal articles on the subject of the NHI and health reform reflect similarly little research on the area of health practitioners and the NHI. From the published material that was available two academic research articles focused on the role of the practitioner. The most relevant article, entitled 'The drive for universal healthcare in South Africa: views from private general practitioners' (Surender et al., 2014) is a journal article from the same project that this thesis emerged from. In the second practitioner-centred article entitled, 'An overview of the National Health Insurance and its possible impact on eye healthcare services in South Africa' (Sithole, 2015), eye healthcare professionals expressed the view that the NHI would offer them the opportunity to get the professional recognition they feel that their field deserves. Aside from these two articles, the

literature review revealed that little research existed which focused on the role of the medical practitioner in the NHI reforms.

1.5.1.3 Health Policy in Low and Middle Income Countries (LMICs)

In a comprehensive and systematic review of literature analysing the health policy processes in Low and Middle Income Countries (LMICs), Gilson and Raphaely (2008) found that the body of published work on health policy processes in LMICs was small, diverse, fragmented, largely descriptive in nature, and dominated by academics located in the North. Gilson and Raphaely (2008: 304) concluded that literature on health policy analysis in LMICs demonstrated that politics, process and power must be integrated into the study of health policies and the practice of health system development.

The South African NHI is just one example of an LMIC undertaking fundamental transformation of its health system. LMICs pursuing UHC face a range of emerging issues particular to their own socio-political contexts. Key themes of health care reform in LMIC countries include: the effects of strong and dominant political actors in relation to weak civil society engagement as characterised by the experience of Ghana (Agyepong & Adjei, 2008; McIntyre, 2008), the mixed experience of performance-based financing overseen by local community groups in Rwanda (Soeters et al., 2006; Sekabaraga, et al., 2011), lessons learned in Thailand in challenging the inequitable distribution of doctors biased towards urban areas (Wibulpolprasert & Pengpaibon, 2003), the political effects and impacts of health reform in Mexico (Knaul et al., 2012), the significant role of civil society in driving health care reform in Colombia, Peru, Uruguay, and Venezuela (Paim et al, 2011; Victora et al, 2011) and the difficulty of achieving successful health reforms on the basis of the existing health care infrastructure as evidenced in Venezuela (Atun et al, 2015; Cancel, 2007). The literature review revealed that each country has to be responsive to its own political and socio-economic conditions if it to achieve its health reform objectives.

1.6. Research questions

The research in this thesis will engage with the following questions:

- How has the South African government interacted with the viewpoints of private general practitioners (GPs) on the proposed NHI reforms? How have the GPs responded to the government's engagement over the proposed NHI health policies? What does this suggest about the government's approach to including these key actors in the health policy-making process?

- How is the Green Paper on the NHI located in the health policy trajectory in South Africa, particularly focused on whether the nature of the relationship between government and private healthcare is static or evolving?
- What is the nature and extent of private GPs engagement with, and their mobilisation regarding the NHI reform process? Specifically, what is the nature and extent of the communication between private GPs, with their Medical Associations (i.e. SAMA) that purport to represent their views, and the separate but interconnected relationship of those associations and government?
- What are the possibilities and limits of an 'actor-centred' approach for understanding health policy reform in South Africa? Are there unique characteristics of the medical profession that guide their actions?

1.7 Objectives of the research

The objective of the research analysis is to gain an understanding of the policy formation process, the extent of the interaction between the different actors involved in health policy reform, as well as the power relations present within such interactions between the key actors. This thesis locates its analysis in an 'actor-centred theory' approach to the health policy making process, based on an analysis of the responses to the South African government's NHI proposals by private GPs.

1.8 Significance of the research

The research is based on the role of the private sector GPs in health care reform in the country. As the largest constituency of medical professionals in the country, the NHI is unlikely to be adequately staffed without their co-operation. It is a key argument of the thesis that the process of policy making must take into account the role of GPs as key actors in order to deliver a successful health policy transition.

1.9 Thesis Structure

This thesis is divided into six chapters and the layout is as follows:

Chapter Two will introduce and describe the theoretical framework used to discuss the Green Paper on NHI in South Africa. Walt's (1994) theoretical approach to process and power will be used as the framework to understand the complex power relations in the policy process. Within the overall framework, this thesis will pursue two theoretical themes that will be initially explored in chapter two namely, actor-centred policy creation, discussed through application of Walt and Gilson's (1994) focus on content, context, process and actors in the policy process. This perspective is complemented by Lipsky (1980) who conceived of the notion of 'street level bureaucracy' to refer to

actors who work on the front line of policy delivery. The second theme introduced in chapter two is that of the medical doctor viewed as a professional, espoused by Freidson (1973, 1994). The contrary arguments of Haug and Sussman (1969), and McKinlay (1972, 1993) are examined as well as the contributions to the debate on the medical profession by scholars such as Le Grand (2003, 2007) Klein (2010), Salter (2001) and Rodwin (2001, 2011).

Chapter Three is predominantly a documentary analysis chapter providing an in-depth review of policy documents on the creation of an NHI in South Africa, including a review of submissions made on the NHI Green Paper by various interested parties. One of the aims of this chapter is to assess the role identified for the private sector practitioner in government initiated health reform, including the role envisioned for them in the rollout of the NHI.

Chapter Four is the first of two chapters focused on analysing the interview data gathered through field work. The interview data with the doctors is a focal point of the thesis and is focused on three areas of analysis: (i) doctor's perceptions of government commitment and capacity to institute the reforms; (ii) impact of the reforms on doctors' personal daily practice; and (iii) conflicts of interest that could emerge within the profession. Analysis of the participants' responses to the NHI is guided by established literature on traditional responses of the medical profession to major health reform, as introduced in chapter two.

Chapter Five offers the second part of the examination of the interview data, focused on four areas of analysis: (i) the degree of doctor's engagement with the health reforms; (ii) the relationships of doctors with their medical representative bodies, (iii) the perceived impact of the medical associations' influence on government policy, and; (iv) the fragmentation within the medical profession in response to the NHI proposals. The analysis is framed by a discussion on actor-centred theory and the role of the medical profession as actors in health reform.

Chapter Six revisits the original research questions and attempts to draw conclusions about the degree to which GPs feelings of exclusion have been acknowledged by the South African government, and whether in fact the perceived lack of acknowledgement is indicative of who the government intends to include in the policy conversation, i.e. is it necessary for an actor to have a stake in building the machine if their interests are seen to be fundamentally against the very principles of universal health reform?

1.10 Interview Methodology

As this thesis is empirically driven, significant emphasis has been placed throughout on analysing interview data collected from a case study (Yin 1984; Stark and Torrance 2005) on doctors in the Eastern Cape undertaken in 2012, shortly after the release of the Green paper.

The study was conducted across four of the nine districts in the Eastern Cape: Amatole, Nelson Mandela Metropole, Cacadu and Oliver Reginald (OR) Tambo, the last of which is also one of the 11 national pilot sites for the NHI. As described previously, the Eastern Cape is a province with high levels of poverty and poor health outcomes. The province incorporates the previous Bantustans of the Ciskei and Transkei, which were systematically under resourced throughout apartheid. For the interview sample, the main criterion for selection was to speak to private sector doctors. However, efforts were made to achieve a balanced mix of respondents in terms of race, gender, varied practice types, geographical location and socio-economic status of the populations served, in order to give voice to as wide a range of experiences and views as possible (see Figure 2 for respondent characteristics). In total, seventy-eight interviews were conducted. As the focus of the study was to primarily explore the views of private sector GPs, they formed the majority of interviewees (54/69%). It is important to note that several of the GPs were working in the public sector (in sessions) at the time of their interviews, or had previously worked for the public sector and could therefore speak knowledgeably on experience in both sectors. In addition to the private sector GPs, a small sample was made up of 10 public sector GPs, 8 private hospital doctors, an NGO doctor, a teaching doctor and a few hospital and administrative managers who were also interviewed for their opinions, most of whom also had experience in both sectors. Although not included in the overall interview count, a small number of interviews were held with various policy makers and other interested parties including a breakfast meeting with 6 representatives of prominent professional associations, namely the South African Medical Association (SAMA), and local Independent Practitioner Associations (IPAs) in the Eastern Cape.

To begin with, individual interviewees were identified via medical practitioner lists available online, such as 'Medpages'[2], as well as by means of internet searches in which a number of solo practices, group practices and local IPAs were identified. The doctors were invited to participate in the study via email and telephone, at times also suggesting other doctors to contact for an interview. Although some doctors initially showed hesitancy to give time during work hours, there was generally a

[2] 'Medpages' is an online database of health practitioners that purports to be the "definitive source of healthcare contact information in Africa." The database was a key resource in identifying a diverse interview sample. (http://www.medpages.co.za/)

positive response to the study, and doctors were willing to engage in discussion on the NHI. The interview schedule was extensively work shopped, developed, piloted and administered by the study researchers. Interviews ranged in length from 30 – 90 minutes, were taped and transcribed, and the transcripts were coded and analysed using the software package NViVo 10, in which a thematic approach to analysis was adopted with major themes ranked according to frequency and intensity of responses. The process conformed to standard rules for qualitative analysis (Auerbach & Silverstein 2003; Grbich 2007). The research team (comprising a clinician, a pharmacist, and four social science researchers) worked closely together at all stages of the study including the development of the interview guide, conducting the interviews and especially during the process of data analysis to ensure consistency and to share assumptions and conclusions made from the data.

In order to ensure both anonymity and to assist in nuanced discussion of the different responses emerging from various practice sizes and locations, doctors have been catalogued and identified by their organisational type, divided into solo/small private practice (S/SPP), consisting of 1 to 3 partners, a medium private practice (MPP) consisting of 4 to 6 partners, and large private practice (LPP) consisting of 7 plus partners. Interviews were then further categorised by their geographical location, divided into rural (R), town (T) or metropolitan (M) areas of the Eastern Cape.

The informed consent of all the research participants was crucial (Ali & Kelly, 2004: 127; Babbie & Mouton, 2001: 104). All participants received and signed a written declaration of the nature and purpose of the research along with their full rights as participants, including full anonymity. Ethical clearance has been attained for all interviews completed, although the issues and themes under investigation were not thought to be "located beyond the discursive range of the socially acceptable or the politically correct" (Kelly, 2006b: 296).

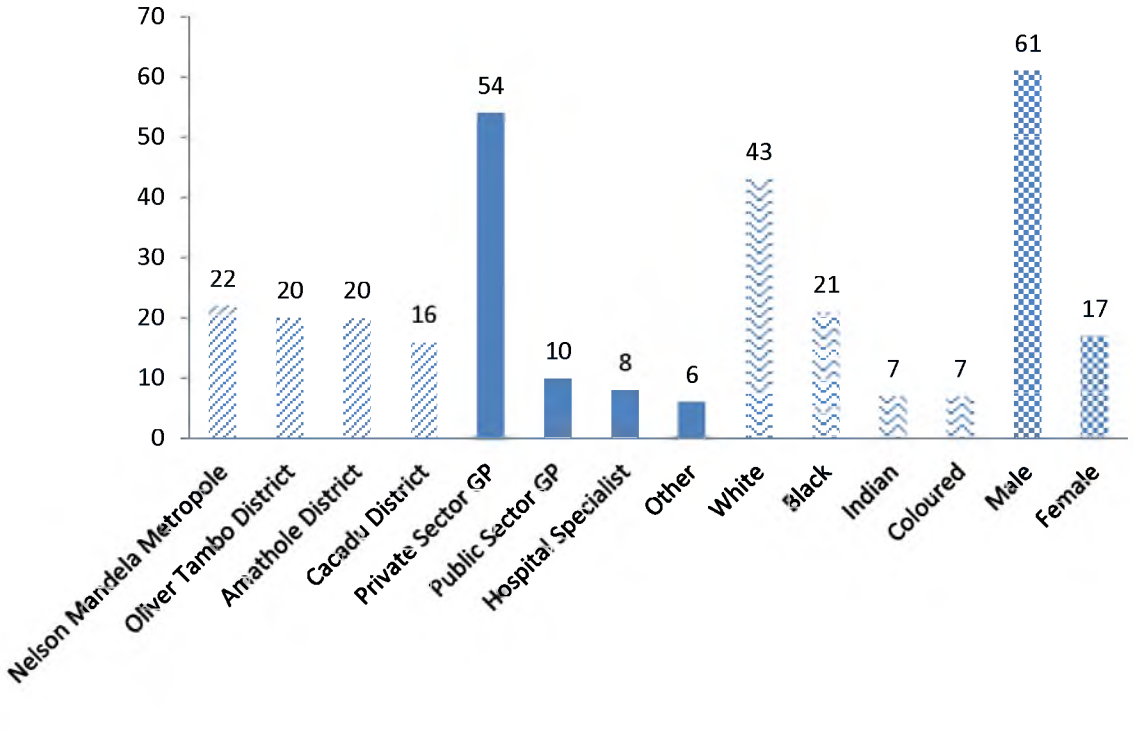

Figure 2: Description of Study Respondents

Source: Surender, R., Van Niekerk, R., Hannah, B., Allan, L. & Shung-King, M. (2014: 4)

1.11 Summary

Emerging from the discourse on NHI and UHC, and in the context of the state of South African health, it is clear that reform of the health system is necessary because of historical injustices which have translated into inequitable service delivery. The proposed NHI does not only look at improvements in the public health sector, and provision for those that cannot afford private health care, but also considers the impacts on those who cannot afford to keep up with the cost increases in the private health sector. The NHI is a comprehensive attempt to reform the entire South African health sector, and this thesis reviews some of the challenges that it may come up against, including the role of the private medical fraternity, who have historically shown little support for universalisation of the health system.

Chapter Two: Locating private sector GPs in a theoretical context: The role of the South African medical profession as policy actors in the NHI proposals

2.1. Introduction

This chapter seeks to lay the theoretical and methodological foundation for the thesis. The chapter has two aims: (i) to describe and explain the particular methodology chosen for this thesis; and (ii) to locate the medical profession and the NHI in a theoretical context. Cumulatively, this chapter is intended to engage the theorisation of 'policy actors' and their position in the power dynamics of the policy process, through a close application to a South African case study, in which the 'actors' considered are private sector GPs in the context of the introduction of a NHI in South Africa. As this thesis utilises a number of different theories under Walt's (1994) broad framework, this chapter will introduce, clarify and explain how they will be used to bolster an understanding of the NHI that argues for the inclusion of actors in the policy process.

2.2. Theoretical Methodology

The theoretical framework that will inform this paper is that of the 'actor-centred' approach to policy-making (Blanchet & James, 2011; Lipsky, 1980; Thomas, 2004; Walt & Gilson, 1994: 353; Walt, 1994b). While there exists a substantial body of literature on health policy analysis and health reform with case studies focused on Northern hemisphere high income countries, (Exworthy et al., 2012; Hudson & Lowe, 2004; Scharpf, 1997; Titmuss, 1973) there is a scarcity of literature on health reform in LMICs, even less on engagement with actors, and less again on the experiences of private GPs.

Gill Walt's book entitled *Health Policy: An Introduction to Process and Power* (1994) and Gill Walt and Lucy Gilson's journal article written in the same year, *Reforming the health sector in developing countries: the central role of policy analysis* were two of the first academic projects to call for greater application of actor-centred analysis in health policy work in LMICs. These works form the springboard for this dissertation. Walt and Gilson (1994: 358) argued that "the actors involved in policy reform, the processes contingent on developing and implementing change, and the context within which policy is developed" were as important as a focus on policy content, and that understanding the importance of process could have a beneficial impact on the success of policy outcomes. This shift in focus to 'context' and 'actors' raised new avenues of academic inquiry in the policy field, and has since encouraged further work on LMICs and the role of actors (see Agyepong &

Adjei, 2008; De Vos et al., 2006; Hercot et al., 2011; Knaul et al., 2012; Walker & Gilson, 2004). In Walt's (1994; Walt & Gilson, 1994) theoretical approach she analysed the complex power relations in the policy process and its applicability to various contexts within Southern Africa. The theoretical methodology driving this thesis draws from Walt's (1994: 3) own approach of engaging with the insights from a range of disciplines and ideas with the intention of constructing an "over-arching framework for analysis…to develop a way of understanding the complex world of health policy." To this end this largely empirical thesis is bound together by a network of ideas on the role of the medical professional as an actor in health reform.

Walt & Gilson (1994: 354) argue that the practice of health policy, and indeed any policy making, is a "profoundly political process, affecting the origins, formulation and implementation of policy" which has over time shifted from being consensus-based to an arena characterised by conflict and uncertainty. While traditional definitions of health policy analysis focus on content, namely the 'what' questions (Paul et al, 1989: 1; Scharpf, 1997: 36), Buse et al. (2012: 7) argue further that a framework that acknowledges the need to incorporate politics into health policy must go beyond a focus on content. The process of creating health policy has thus been challenged to develop from traditionally linear analysis and processes, abstracted from implementation, to responsive policy, with an expectation of a tangible policy outcome (Black, N., & Donald, A., 2001; Gilson et al., 2006; McCoy et al, 2011). This continuous shift in the policy environment foregrounds the need for deeper policy analysis to take place in the health policy context, particularly as health outcomes affect such a high number of diverse citizens with a broad and highly variable set of needs. Mkandawire (2004: 18) also identifies the importance of context, arguing that policies which "conflict fundamentally and consistently with principles of the dominant economic system and power relations" will have little chance to flourish and will fail to be institutionalised. While this thesis does not have the scope to explore the various works of Titmuss (1974) on the 'good society'; Hall and Midgley (2004) on 'developmental' social policy; and Mkandawire (2001; 2005a; 2005b) and Adesina's (2007; 2011) views on 'transformative' social policy, their contributions to the study of social policy provide valuable insights into the complex power relations involved in policy making and the implications for transforming health care to serve more inclusive purposes.

Walt's (1994: 1) theoretical approach favours 'process' and 'power' as the central tenets to policy formation chiefly concerned with "who influences whom in the making of policy and how that happens". Furthermore, Walt argues that there appears to have been little attention paid to "how countries should carry out reforms, much less who is likely to favour or resist such policies" (Walt & Gilson, 1994: 354). The work initially undertaken in the early 1990s is contemporised in various

works, continuously expanding the capacity for the application of 'actor-centred' policy analysis (Gilson et al., 2012; Gilson and Raphaely, 2008; McIntyre, 2010a; Walt et al, 2008).

Walt (1994: 5) draws on theories from both society-centred and state-centred approaches, with the intention to explore the state, "nationally and internationally, the actors within it, the external forces influencing it, and the mechanisms within the political system for participation in decision making". Walt also attempts to understand the policy environment in its entirety rather than just a portion thereof. While Walt does place value on content as one area of concern within the policy process, it is 'who' not 'what' that forms her main preoccupation. Walt's broad framework, which includes some issues and considerations exogenous to the concerns of this dissertation (largely to do with policy in the international arena), complements the major theoretical tool for this thesis, namely, Walt and Gilson's (1994) journal article documenting their approach to policy analysis in LMICs. While this thesis does not focus primarily on a comparative study of developing health contexts, there is cognisance that the discussion of the NHI in South Africa forms part of a global health context. It is within this approach that the importance of actor network theory and stakeholder analysis is emphasised and elaborated upon to better understand the process of health reform and to promote effective implementation of those reforms.

2.3. Actor-centred policy theory

Walt and Gilson (1994: 354) utilise a model (see Figure 3) to illustrate the importance of the concepts of *content, context, process* and *actors*, which they believe can be used to better understand the process of health policy reform, and to assist planning for more effective implementation.

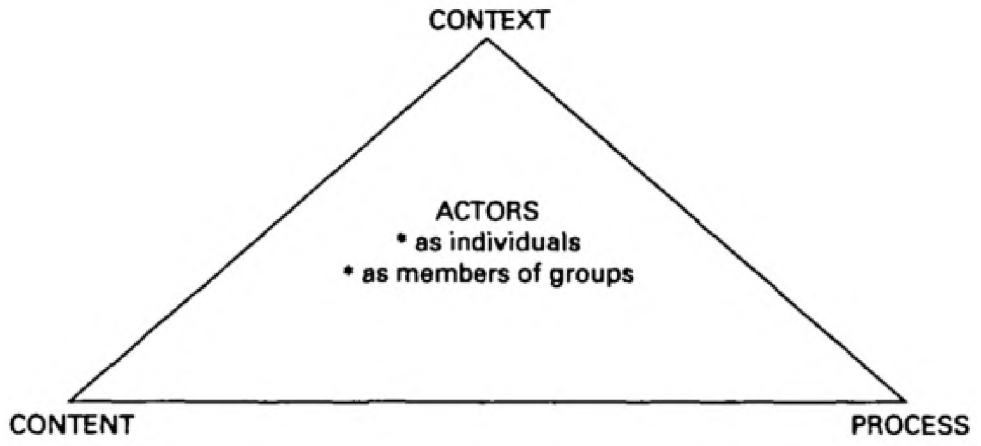

Figure 3: Walt and Gilson's model for health policy analysis

Source: Walt &Gilson (1994: 354)

Before the 1990s, health policy was predominantly viewed as a consensus driven process, or at least the preservation of consensus, led by the belief that medicine 'held the answers'. It was largely controlled by the medical elite who managed and organised accessibility, affordability and availability with little input from the population (Brown, 2005; Marmor, 2005). During the 1980s, as neo-liberal ideas started to pervade the policy space, and the market became the incentive for rationalising health spending, conflict arose between those who stood for "public purpose, public morality and public accountability" (Walt and Gilson, 1994: 356) and those pursuing market-related ideals such as 'cost sharing' and the promotion of private health care. Walt and Gilson argue that these debates, and the resultant conflict and lack of consensus that has since emerged, moved health policy from a state of 'low' priority on the agenda to the domain of 'high' politics which is where it continues to play out in the present day, impacting directly on the general public as well as concerning powerful policy actors[3] (Buse et al. 2012; Gilson et al., 2012). Importantly this shift from consensus to conflict in health policy served to heighten awareness about the failure of past policies, and promoted innovation in the field (Walt & Gilson, 1994: 357). That said, the effects of a complex mix of factors such as structural adjustment, issues of sovereignty, unequal power relations, bureaucracies and policy-makers responses to pressure indicated that improved technologies and technique alone were not comprehensive enough in their approach to improving health gains. Twenty odd years later these complexities persist and deepen, and new analytical approaches offering a better understanding and more complete explanation of the policy environment are consistently required.

As such, while significant gains have been made in the area of policy analysis recognising the importance of historical *context* and *actors,* and the area of study "is diffuse and rich in its diversity and complexity" it has been criticised for its "lack of consistency and rigour" (De Vos and Van der Stuyft, 2015; Walt & Gilson, 1994: 363-364). In short, vast and diverse economic reform has led to increased attention on the policy environment as a whole which is positive, but health policy as an area of concern still requires a lot more research and attention. Walt and Gilson (1994: 364) argue

[3] Walt differentiates the general policy approach into two categories, engaging either 'high' or 'low' politics. For much of history, health policy has been regarded as an area of 'high politics', engaging only elite persons on issues that are 'crisis determined' and based on the "maintenance of core values – including national self-preservation – and the long term objectives of the state." On the other hand, 'low politics' deals with a host of more ordinary issues, engaging various special interest groups on policy issues that are not considered to involve "fundamental or key questions relating to a state's national interests, or those of important and significant groups within the state" (Evans and Newnham 1992: 184 in Walt 1994: 42). Interpreting health policy as a mix of both high and low politics, Walt argues that the discussion can viably incorporate a number of different actors and interest groups towards the aim of creating lasting policy formation.

that some of the reasons why the health sector is a tougher policy area to navigate may be due to factors such as "the peculiarities of the health care market, the status of health professionals, conflicts over values about coverage, access to high technology, and control over quality of life." This thesis focuses specifically on the characteristics of health professionals and values linked to coverage.

To further engage Walt and Gilson's policy triangle (Figure 3), Figure 4 considers the same input factors of *content, context, process* and *actors* to illustrate that they produce both intended and unintended consequences, further obscuring the ideal that policy process is by any means linear (found in Hercot et al., 2012, and supported by Meessen et al., 2011).

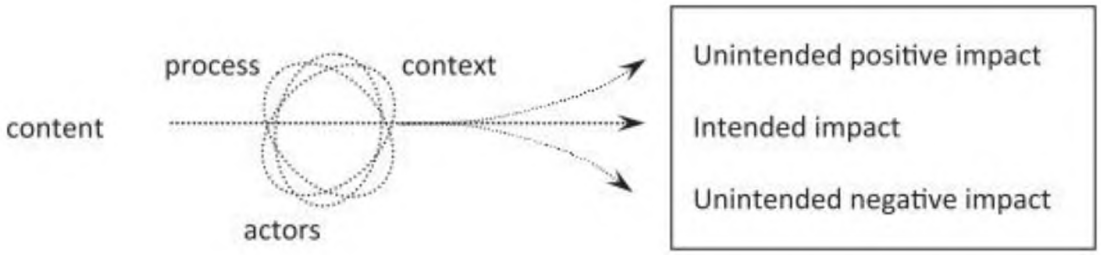

Figure 4: Ridde and Diarra's five elements of the policy analysis framework

Source: Hercot et al., (2011: ii6)

To further expand upon the participation and involvement of various groups and organisations of actors alongside government, the study of 'stakeholder analysis', emphasises the importance of discovering who the important stakeholders in the NHI policy process are, as well as the role that important stakeholders could and/or should have in the policy process (Abiiro 2012, Brugha and Varvasovszky 2000, Walt et al. 2008). There are many other methods and ways to look at actors in the study of health policy analysis, including within the conceptual social network as put forward by Blanchet & James (2011), and the various methods of actor engagement explored by Thomas & Gilson (2004). A key project in this respect is the SHIELD (Strategies for Health Insurance for Equity in Less Developed countries) project carried out in Ghana, Tanzania and South Africa, in which Gilson et al. (2012: i64) reflected that variances in context and in the nature of reform proposals generate differences in the particular interests of stakeholders and their likely positioning on reform, as well as in their relative balance of power. However, despite these extremely localised influencers the study argued that "cross-national policy learning is possible around the approach to analysis, the factors influencing judgements and the implications for, and possible approaches to, management of policy processes." This is important when trying to draw lessons across different LMIC contexts within the field of health policy analysis.

Accepting that the sphere of health policy analysis is complex, and the varying parts therein are interconnected, the study of health systems offers another crucial tool to understanding why 'policy resistance' exists and why many well-intentioned policies and managerial decisions as well as non-decisions that are aimed at improving health systems do not achieve desired outcomes, but instead lead to unexpected or unintended consequences (Atun, 2012: iV4; Gilson et al., 2008; Gilson & Raphaely, 2008: 303). While the study of health systems is a broad area of study in itself which will not be explored in detail, for the purposes of this dissertation it is useful to use the ideals of 'innovation' and 'diffusion' as approaches to health policy formation in order to improve both method and outcomes.

Atun (2012: iV6) explains that:

> ...the reasons for slow adoption and diffusion of health innovations are less to do with the perceived benefits of the innovation, but the way the problem, which the innovation is designed to address, is perceived by the individuals and the adoption system within health institutions, the health system and the broad context.

This is conceptually appropriate as it explains why some very obviously well-meaning policies never take off but instead have adverse results on the area of intended impact. This discussion on health systems also challenges policy makers to think dynamically and to be aware of the effects of linear and reductionist approaches which fail to give an "accurate representation of the real world by ignoring possible wider impacts of policies and decisions" (Atun, 2012: iV5; Gilson et al., 2006).

The study of health systems highlights the importance of understanding the landscape that gives rise to the issues that policy seeks to attend to, in order for those resultant policies to have the greatest influence and impact. An important aspect to understanding this landscape is the centrality of the health worker in the delivery of health care. Anand & Bärnighausen (2012: 190) propose a health system framework that places health workers as the core concern. They maintain that health workers are:

> ...the foundation of the health system. Every function of the health system is either undertaken by or mediated through the health worker. Health workers play a critical role in the choice of treatments, and in curative and preventive care. Much of health-system financing is directed to health workers (through salaries and associated payments) and most other spending decisions are directed by health workers (through prescriptions, referrals and equipment purchase).

Arguing for the inextricability of the health worker from the health system, Anand & Bärnighausen further distinguish the roles of the private and public sector through an explanation of health 'needs'

and health 'demands'. They explain that "needs may be expressed or not expressed, and demands may or may not be based on needs. Needs arise from a variety of demographic and health conditions – such as infancy, pregnancy and illness" (Anand & Bärnighausen, 2012: 188). Governments generally assume responsibility to meet needs but not necessarily demands, therefore shifting the expectation of demands-service to the private sector. As such, the government prioritises meeting healthcare needs as opposed to healthcare demands. A vital role of health workers is to go further than just meeting healthcare needs but also by "helping to generate demand for unexpressed needs – e.g. by informing people about their objective health conditions and risks. Such supplier-induced demand can clearly improve individual and population health" (Anand & Bärnighausen, 2012: 188; Harrison, 2009). Due to resource scarcity in a country like South Africa, the role of picking up on 'unexpressed health needs' may fall on the private sector doctors who have more time with each patient. This essential watch-post must be distinguished from demand created mainly to generate profit for the health worker without contributing to meeting needs. In the past the private sector has also been able to assist by overcoming constraints faced by the public sector. For example, treatment not available in the public sector may be available in the private sector, as in the case of life-saving HIV antiretroviral treatment (ART) was provided to thousands of patients by private-sector physicians in South Africa before it became available in the public sector (Anand & Bärnighausen, 2012: 188). Alternatively, there may be increased ability to be responsive or flexible in reacting to the patient need, evidenced by Harrison & Dowswell (2002: 215) who showcased the barriers practitioners faced in the United Kingdom (UK) after guidelines for care were instituted by the National Institute for Clinical Excellence.

2.4. Universal coverage and the NHI

Article 25 of The Universal Declaration of Human Rights, (United Nations, 1948) states that, "everyone has the right to a standard of living adequate for health, including medical care, and the right to security in the event of sickness or disability." In the same year, the Constitution of the World Health Organization (1948) came into force, declaring that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. These declarations are supported by The South African Constitution (Act 108 of 1996), which entitles every citizen "the right to have access to health care services".

As outlined by the South African National Department of Health (NDoH, 2011: 1), "the policy objective of NHI is to ensure that everyone has access to appropriate, efficient and quality health services," with the concomitant aim of bringing health services "within reach of all sections of the

population, according to their needs, and without regard to race, colour, means or station in life" (NDoH, 2011: 13). The proposed NHI suggests a radical re-structuring in the way that health care is provided, aimed at providing universal health coverage "free at the point of use" for all South African citizens (NDoH, 2011: 16). In response to descriptions of the NHI reforms as introducing universal healthcare free at the point of service, private doctors readily described the current system as already providing functionally free healthcare to much of the population, while flagging issues such as accessibility and consistency of care as limiting factors.

As such, in narrow conceptions of 'free' healthcare many issues can be overlooked. For example, in poor households choices relating to healthcare options are unrealistic, this being "especially true for out-of pocket costs at point of service" (Sachs, 2012: 944). This lack of available alternatives can assist in understanding the South African government's push for healthcare that provides free and accessible quality care for all citizens.

In parts of the Eastern Cape, one of the former Bantustans[4] of the apartheid government, the effects of racial segregation and the divisive landscape of healthcare provision are still clearly illustrated as a palpable reminder of the systematic and consistent underdevelopment of the province over decades, a system which means that the Eastern Cape now carries much of the ill-health burden of the country. Sanders & Chopra (2006: 73) reported that in 2006 average infant mortality in the Eastern Cape sat at 61 per 1000 live births compared to a rate of 30 in the Western Cape, which during apartheid did not have a Bantustan but was a locus of industry and government. They also reported a great deal of variation within the Eastern Cape, stating that for the 3 to 4 million people who still live in the former rural Transkei Homeland area the infant mortality rate was 99 per 1000 live births, compared with a rate of 28 in the largest metropolitan area within the province, the Nelson Mandela Metropole. These vast differences in health status between provinces and within the Eastern Cape work to illustrate not only a need for holistic implementation of universal health care, but also in addressing the unequal historical backlogs that exist in the country.

Thus, in response to comments about South Africa's current functionally free healthcare system, what emerges is that free healthcare in itself is not a constructive goal, but rather that universal healthcare needs to be perceived as a comprehensive suite of interventions and provisions,

[4] After the National Party came to power in 1948 black people were denied citizenship in South Africa and millions were forcibly removed to areas of land centred on rural labour reserves and designated as bantustans (homelands), each with its own health department. People were forced to carry passes recording permission to work and reside in urban areas, a requirement that was ruthlessly policed. As a consequence, the bantustans were vast, highly impoverished areas inhabited for most of the year by those who were very young, elderly, sick, or disabled, and women who were unemployed (Coovadia et al., 2009; WHO, 1983).

supported by the South African medical profession, in order for it to positively affect all citizens' lives.

Overall, there is a historical backlog in the contributions of the global South to defining mainstream health policy discourse, although this is being rectified in the increasing literature written about the pursuit of universal coverage in Africa, Latin America and Asia (Gilson et al., 2012; Lagomarsino et al., 2012; McIntyre, 2008; Paim et al., 2011). As a result, in the practises of formulating and analysing policy in diverse regions of the world, it is often the same dominant policy perspectives created in developed country contexts such as Europe and Northern America that are employed to interpret dissimilar contexts. As a consequence, if policy is designed by means of a blanket format that does not take the needs and demands of local context and stakeholders such as medical practitioners, the result is that policy is not created in a suitable context. In the South African case this approach risks excluding critical actors in the NHI whose views and experiences need to be researched and engaged with in order for appropriate decisions to be made towards successful implementation of the NHI.

2.5. The medical profession

The main unit of study throughout this thesis is the medical profession, particularly private sector GPs. In terms of the distribution of human resources in South Africa, the health profession structure is dominated by private practitioners who make up 59% of doctors, 93% of dentists, and 89% of pharmacists (McIntyre, 2010b; Ruiters & Van Niekerk, 2012). Early theorists such as Freidson (1973, 1994), McKinlay (1972, 1993) and Haug (1969) conceptualised the medical profession in contestation with the state as regards autonomy and power. Freidson (1994: 10) argued that the medical profession should be viewed as a special case in relation to the validity of preserving their autonomy and power from the state. He believed that the medical profession was "an occupation that controls its own work, organised by a special set of institutions sustained in part by a particular ideology of expertise and service". Freidson's normative understanding of professionalism and its prioritisation was, and still is, widely challenged, initially and most notably by McKinlay (1972) and Haug (1969) who both argued that the medical profession was in a state of decline, a theme which is expanded upon in Chapter Four.

Freidson continued to respond to these critiques throughout his career, maintaining that despite changes within society and the profession, arguments about the decline of the profession were not persuasive. Even later on in his career Freidson (1994: 9) maintained that while the position of professionals and the nature of their practices were changing, he still did not view that as "evidence of the decline of professionalism". Notably, while Freidson (1994: 194) placed much importance on

the autonomy of the professional, he also warned that the health system could not "be left in the hands of physicians without careful checks and balances" but that all steps should be taken to not "destroy or seriously weaken what is desirable in professionalism."

Although these discussions took place using industrialised nations as units of analysis, after the inception of the UK National Health Service (NHS) in 1948, and US Medicaid in 1968, they offer highly relevant perspectives into the professional, viewed as either powerful autonomous entities who construct their own work paradigms, or as more proletarianised-style workers operating within a system which they do not control, and what effect this has lack of control has on their work. These concepts are contemporarily discussed by theorists Le Grand (2003, 2007) Klein (2010), Salter (2001) and Rodwin (2001, 2011) whose work shows that discourses around the profession have commonalities across time, space and different country settings.

A further perspective is that private sector healthcare driven by market forces implies that the practice of medicine can be viewed as an economic transaction, not a professional calling. This raises the question of whether medicine, driven by the market and not medical need, is in the process of deprofessionalisation (Blumenthal, 1996: 172). Given the entrenched and deep-rooted market culture which presently exists, a key challenge will be to achieve a shift in culture and norms, in particular to instil a more cooperative model of care with patient-centred values (Surender, 2014: 21).

2.6. Discussion

Evidence suggests that private sector doctors have always been resistant to nationalisation or socialisation as a threat to their occupational power and professional status (Freidson, 1973; Gray, 2002; Klein, 2010). Moreover, historical and comparative evidence also suggests that whenever health systems have undergone radical reform, the role of the medical profession has remained crucial in determining its eventual success and character (Klein, 2010; Rodwin, 2011). Thus, Klein (2010: 42) argues that although professionalism is a 'slippery concept', the power of the medical profession in the 1950s determined issues for the policy agenda, and succeeded in outlining certain areas as out-of-bounds for non-professionals, thus "shaping the perceptions of policy problems...and incorporating a professional bias into the assumptive-worlds of the policy makers".

Reflecting on the medical profession's role in the UK NHS, Le Grand (2003) extensively employs the metaphor of Knights, Knaves, Pawns and Queens in theorising the identifying traits of both professionals and users of health services. He questions the different assumptions made about human behaviour in crafting policy instruments, as he argues these assumptions determine the way

that public policy is constructed. Le Grand differentiates between the public-spirited or altruistic, knight, and the knave who is motivated primarily by self-interest. In a discussion on 'incentives, motivation, and empowerment', Le Grand (2003: 96) questions how "incentives can be structured so that agents who work within the NHS are motivated to use its resources to achieve the best possible health and health service outcomes". He argues that professionals are given immense power in their treatment of users, opening them to more 'knavish' or 'knightly' decisions at their discretion. The 'knavish' need to secure income is offset against "personal ties to patients and a genuine knightly concern for them." These principles of professionalism could play an important role in mediating conflicts of interest, as "whatever institutions and rules society uses to cope with conflicts of interest will be more effective if physicians not only respect them but are also guided by an ethos of public service, fidelity to patients, and commitment to knowledge and excellence" (Rodwin, 2011: 2). This is complementary to the point argued by Freidson (1994) and supported by Hunter (1997: 56 in Bury and Gabe, 2004: 350) that while doctors' specialist knowledge remains irreplaceable...specialist's knowledge can be – and often is – subjected to clinical standards, guidelines and protocols developed by teams of specialists." As such, there is an understanding of the profession as acting under a moral duty, core to the 'knightly' imperative of doctors Hippocratic Oath, while acknowledgement that 'Knavish' self-interest is reined in by their joined 'social capital' as termed by Coleman (1988, in Freidson, 1994: 195).

Salter (2001) argues that the recent politicisation of medical regulation in the United Kingdom has destabilised the historic relationship between medicine, society and the state, agreeing with Le Grand (2007), Klein (2010), and Rodwin (2001), who all argue the inextricability of politics from medicine. These discussions on professionalism create a relevant introduction to the interview data, in which one is able to see how the doctors view their own position and profession in relation to how the NHI would impact on their daily work.

2.7. Conclusion

Health Policy embraces courses of action that "affect the set of institutions, organisations, services, and funding arrangements of the health care system. However, it goes beyond health service, and includes actions or intended actions by public, private and voluntary organisations that have an impact on health" (Walt, 1994b: 41). In a study where *actors, process* and *context* are seen to have a benefit in the formation of policy, actor network theory, health systems analysis and stakeholder analysis all offer vital insights and tools through which to view the health policy process.

Chapter Three: Situating the private sector in the proposed NHI reforms: a review of the policy trajectory leading up to, and submissions on, the NHI Green Paper

3.1. Introduction

This chapter is the first of three data analysis chapters. These three chapters analyse the role of private sector GPs in the NHI proposals, both from the viewpoint of policy makers (government) and practitioners (private sector GPs). This chapter provides an overview of government health policy reform and the policy trajectory of health reform in South Africa until the release of the Green Paper on NHI in South Africa in 2011. The detailed focus on recent health policy history is intended to provide a contextual background for the introduction of the NHI policy reforms. This overview will be discussed alongside various submissions on the Green Paper submitted by political parties, the private sector, and medical organisations. Drawing from this analysis, the perceived role of the private sector, in particular private sector GPs, in the NHI reforms will be evaluated.

3.2. The historical trajectory towards National Health Insurance

The equitable reform of the health sector and pursuit of a health insurance for South Africa is not a new policy proposal. Indeed, numerous policy initiatives have investigated the possibility of NHI options for South Africa since as early as the 1920s (NDoH, 2011a: 12; Helen Suzman Foundation (HSF), 2011: 23). In 1928, a Commission on Old Age Pension and National Insurance recommended the establishment of a health insurance scheme to cover medical, maternity and funeral benefits for all low-income formal sector employees in urban areas. In 1935, similar proposals were recommended by the Committee of Enquiry into National Health Insurance (Dhai, 2011: 48). Perhaps the most notable early reference to universal healthcare was in the 1942-1944 National Health Service Commission, also known as the Gluckman Commission, the aims of which can be understood by the following brief:

> To inquire into, report and advise upon: 1. The provision of an organised national health service, in conformity with the modern conception of health, which will ensure adequate medical, dental, nursing and hospital services for *all* sections of the people of the Union of South Africa" (Report of the Commission on National Health Services, 1942 in van Niekerk, 2007: 87; emphasis in original brief).

The Gluckman Commission realised the need for incentivising private doctors to partake in public health and thus agreed that:

> ...there should be no compulsion on medical and other workers to enter the planned national health scheme. The object should be to make the scheme so attractive and so efficient that it will inevitably draw in all. Those doctors and nurses who wish to remain in private practice should be allowed to do so (SAMJ, 9 October 1943: 297 in Van Niekerk, R., 2007: 91).

The proposals ran aground on vested institutional interests. They were rejected by Jan Smuts, Prime Minister and leader of the United Party supported by the provincial administrators who viewed the proposals as an attempt to centralise power and undermine provincial control of tertiary hospital services, a significant source of revenue for provincial health services. The proposals were also viewed as a threat to private practitioners, who were wary of potential competition (Van Niekerk, R., 2007: 91). The few recommendations that had been implemented were reversed after the election of the National Party in 1948.

A decade later, in the midst of legalised apartheid, the African National Congress (ANC) drafted and released the Freedom Charter (1955). A section of the Charter made a commitment to "a preventative health scheme" that would be run by the state with "free medical care and hospitalisation provided for all." The key underpinning of this political document in the post-apartheid "good society" of the ANC and its allies was an emphasis on the universal extension of the franchise and the de-racialisation and equitable redistribution of essential education, health, welfare and housing services. The Freedom Charter called for a state organised national health service, a demand that was consistent with the ANC's policy on health continued from the preceding decade as reflected in the 1943 policy document African Claims (Van Niekerk, 2013).

Statutory apartheid ended in 1994 when the first democratic government in South Africa, led by the ANC was voted into power. Reference to a mandatory social or NHI system for South Africa has been especially consistent in almost all health care policy initiatives post-1994 (HSF, 2011: 9; McIntyre & van den Heever, 2007; NDoH, 2011a; Ramjee and McLeod, 2010: 181). In the first year of South Africa's democracy, reform of private health care was outlined in the ANC National Health Plan (NDoH, 1994; Ramjee and McLeod, 2010: 181). This document was written in collaboration with the World Health Organisation (WHO) and broadly committed the government to establishing an equitable national health service for the whole population:

> ...a single comprehensive, equitable and integrated National Health System (NHS)... dealing with health, based on national guidelines, priorities and standards...coordinat[ing] all aspects of both public and private health care delivery (ANC, 1994: 9).

In the Health Plan there was acknowledgement that success relied upon political will on the part of the government, and commitment from communities and the health workforce (ANC, 1994: 11).

This holistic approach favoured inclusivity towards implementation of a health system representing the context of a newly democratic South Africa. Furthermore, it emphasised the centrality of political will to engage stakeholders and to encourage support for the health reform proposals. The first time mandatory health insurance was incorporated into a formal policy related document was in the National Health Plan, recommending the introduction of compulsory SHI contributions by all formal sector employees (and their employers), which would be used to cover a relatively comprehensive package of benefits (i.e. primary care services as well as hospital care) for contributors and their dependants (McIntyre & Van den Heever, 2007: 76; Ramjee and McLeod, 2010: 181). In the early years of democratic rule the principles of the Health Plan were further developed by the work of the Health Care Finance Committee (1994) and the Broomberg-Shisana Committee of Inquiry (1995).

In 'Section 27' of the new South African Constitution (Act 108 of 1996, (Section 27, 1(a)) health care access was enshrined as a fundamental human right. In 1997, the ANC released the White Paper on Health Systems Transformation (NDoH, 2007a) which provided a detailed account of the key elements of a reformed and equitable public health care system. These included: the decentralisation of health care services through the district health system, the need for improving quality and standards of health care in the public and private sectors, the need for human resource planning and development, and increasing access to health care services for everyone. This policy agenda of health reform was also reflected in the policy work of the National Department of Health's Social Health Insurance (SHI) Working Group (NDoH, 1997a; NDoH, 1997b), the Taylor Committee (NDoH, 2002; National Department of Social Development, 2002) and the Ministerial Task Team on SHI (2005).

McIntyre and Van den Heever (2007: 74) note considerable consistency in the core objectives of the mandatory health insurance proposals advanced over the years, largely as a mechanism for addressing key problems facing private health insurance and for dealing with the massive public-private health sector mix disparities in South Africa. In the 1990s the two tabled options were either: (i) a mandatory health insurance system that would take the form of a single insurance scheme, with the role of existing medical schemes being restricted to 'top up' cover for health services not covered in the basic benefit package, or (ii) for medical schemes to be the financial intermediaries for a mandatory health insurance system (i.e. it is mandatory to contribute to health insurance, but one can choose which scheme to belong to).

The National Health Act (2003) was one of the strongest expressions of the ANC government's intention to ensure access to health care for all South Africans. In this Act one could arguably see

explicit seeds of the transformative NHI being sown. Interestingly, government policy documents from the early 2000s also reflected a shift away from more general mention of medical schemes to more explicit reference to the private sector's involvement in health care reform. Nevertheless, this was not without inconsistencies in its sentiment towards the sector. While the National Health Act (2003: 45(1)) committed itself to "enabling a coordinated relationship between private and public health establishments in the delivery of health services," inconsistencies can be interpreted as indication of mixed sentiment amongst policy makers on private sector involvement in provision of equitable health coverage and their commitment to the removal of all user fees. Throughout the reform trajectory, the private sector has remained largely untouched by efforts to restructure the public health care system and provide free primary health care for all. Rather, in the private sector the organisation and delivery of care have remained predominantly under the influence of entrepreneurs and market forces (Benatar, 1997: 892).

In December 2007 at the ANC national policy conference at Polokwane, Resolution 53 called for the establishment of the NHI. The conference marked a turning point in the move from health insurance for citizens, to a full commitment to universal healthcare, aimed at eliminating the currently tiered health service[5] (NDoH, 2011a: 15). Notably, for defendants of the private sector another outcome of the conference was "an escalation of rhetoric against private sector healthcare in the ANC Alliance" (Centre for Development and Enterprise, 2011: 38). From this point onwards, the tension between the aims of universal health care and private sector interests has remained a particularly contentious issue in the policy discussion.

In February 2009 the draft NHI proposal from the ANC task team was released. At the time, "comments by alliance partners suggested that private health insurance, that is medical schemes, could be closed down completely" (Ramjee and McLeod, 2010: 182). Just a few months later, engagement with the private sector was back on the table. The June 2009 NHI proposal from the ANC task team "dealt with medical schemes extensively and their perceived role in the problems in health care financing in South Africa" (Ramjee and McLeod, 2010: 182). In July 2009 the administration of the new President, Jacob Zuma, released a Programme of Action which included a ten-point plan for the improvement of the health sector (2010-2014). The programme referred to

[5] The earlier vision of mandatory insurance was that cover would be provided for contributors and their dependants, whilst the more recent NHI proposals have argued for universal coverage. There has been a policy shift away from the retention of the current two-tier system (whereby formal-sector workers access a different package of benefits to those who receive their care from tax-funded public sector health services) to the creation of a single tier in which the entire population has access to the same levels of care (Ramjee et al., 2014: 96).

the private sector's role in health provision which was mentioned most commonly in conjunction with Public Private Partnerships (PPPs) and accountability frameworks (NDoH, 2010b). By September 2010 these policy intentions were formalised with the signing of the Negotiated Service Delivery Agreement (NSDA) by the national Minister of Health and seven other Cabinet Ministers, reflecting the commitment of key partners to achieving the goals of the government's Programme of Action (NDoH, 2010a). With regards to the health sector, priority was placed in improving the health status of the entire population and contributions to the government's vision of 'A Long and Healthy Life for All South Africans'. Within the NSDA, the NHI was mentioned to effectively oversee the "strategic implementation of infrastructure development and maintenance initiatives, including the use of public private partnerships" (NDoH, 2010a: 3), and to overhaul "key components within the spheres of financing, pooling of resources and purchasing and provision of health services" (NDoH, 2010a: 5). In this key document the collaboration between the public and private sector was strongly emphasised.

This thesis argues that although government has not always acted consistently in inclusion of the private sector in health policy reform, mention of public-private partnerships is consistently reflected in policy documentation. This has been sustained especially post-1994, a period in which health reform evolved from gradual health coverage starting with contributors and their dependents, to a mandatory tax, most likely an income tax with universal coverage regardless of contributions[6].

3.3. The Green Paper on National Health Insurance in South Africa

In August 2011 the long-awaited Green Paper on the NHI was released. The document clearly stated the strategic policy objective of the NHI, "[To] ensure that everyone has access to appropriate, efficient and quality health services, phased in over a period of 14 years" with the caveat that "such a system will require significant overhaul of existing service delivery structures, administrative and management systems" (NDoH, 2011a: 4). A number of additional concerns were also noted in the Green Paper concerning the scale of the health reform challenge which included the worsening quadruple burden of disease, shortages of key human resources, alongside underperforming institutions, underfunding, and deteriorating infrastructure (NDoH, 2011a: 6).

While the Green Paper remained vague on many issues, there was clear indication of the intention to enable a role for the private sector in public healthcare. Examples in this regards are as follows:

[6] The White Paper on NHI details the various methods to raise the revenue required to fund the NHI, with careful attention paid to progressive versus regressive funding systems (NDoH, 2015b: 48).

> The covered healthcare services will be provided through appropriately accredited and contracted public and *private providers* (NDoH, 2011a: 16, emphasis added).
>
> It has been shown that there is a strong support for inclusion of Primary Health Care services within the benefit package for mandatory insurance. This should *include private sector primary care services* (NDoH, 2011a: 24, emphasis added).
>
> In addition to the three streams, *Primary Health Care services will be delivered through accredited and contracted private providers practicing within a District* (NDoH, 2011a: 28, emphasis added).
>
> *...there are several ways in which private providers could participate in PHC services to the population*, [within a specified] range of services (NDoH, 2011a: 28, emphasis added).

It could be summarised that while the Green Paper contained explicit mention of the private sector, there was little discussion on the role of the private sector in NHI and areas for potential collaboration. While the introduction of NHI is bound to have a significant impact on the private health sector, engagement between the National Department of Health (NDoH) and private health sector players on relevant issues has thus far been limited, and the details of the private sector's involvement in the NHI have been vague. In its submission on the NHI, the SAMA General Private Practice Practitioners Committee (GPPPC) (SAMA, 2011: 49) noted the paucity of engagement with the private sector and further detailed how they see GPs being able to assist in capacitating the NHI. Notably, although human resources were highlighted as a core issue, the Green Paper was vague about how the South African government was planning to overcome the current shortfall of medical practitioners in the country required to staff the envisioned new health care system. The Human Resources for Health (HRH) Strategy - which was released in October 2011 - was offered as a guide to support workforce planning in the health service. The strategy included plans to develop systems to accurately track the number of medical workers in the country (NDoH, 2011b: 63).

3.4. Submissions on the Green Paper

Comments on the NHI Green Paper were submitted by a range of organisations,[7] namely, private medical schemes, political parties, action groups, the NGO sector and interested members of the public. While canvassing a wide number of viewpoints, the following four recurring themes were captured by nearly all the submissions: lack of public consultation, human resource shortages,

[7]Civil Society Discussion Document (People's Health Movement (PHM-SA), Section 27, Treatment Action Campaign (TAC), Black Sash and others; Rural Doctors Association of South Africa (RUDASA); SAPPF (South African Private Practitioners Forum); South African Medical Association (SAMA); Medi-Clinic; Discovery; Professor Alex van den Heever; Helen Suzman Foundation (HSF); Congress of South African Trade Unions (COSATU)/ National Education, Health and Allied Workers Union (NEHAWU); South African Communist Party (SACP); Democratic Alliance (DA)

conflicting public versus private interests, and governance issues. Some outlying but strongly voiced concerns considered whether the NHI is fundamentally the best vehicle through which to deliver improved health outcomes and also cautioned the low levels of availability and access to reliable data.

3.4.1. Lack of public consultation

Originally, the period given for comment on the Green Paper was two months. Various organisations argued that this was too short a period to allow for proper consultation and the NDoH responded by extending comment for a further two months (SAnews, 2011). However, even with the extended deadline an overwhelming majority of organisations argued that the government had made very little effort to engage with the public, and this was a common theme raised throughout almost every submission on the Green Paper.

The HSF (2011:5) argued that the proposal was far too "defined" with "minimal public and stakeholder consultation". The HSF called for greater public consultation as "engagement with key stakeholders and constant communication and dialogue is vital in order that civil society is provided with a true reflection of developments in the health care debate so as to avoid misinformation and disaffected public opinion" (HSF, 2011: 7). Similarly, the Civil Society Coalition (People's Health Movement – South Africa (PHM-SA) 2011: 1) called the consultation process "closed and non-transparent". In contrast, and representing a minority view, the insurance firm Discovery (2011: 6), acknowledged significant efforts by the NDoH and the Ministry of Health to explain the NHI Green Paper in numerous fora and to consult on its contents, including a National Health Consultative Forum. Discovery did, however, recommend (2011: 8) that the NDoH should be inclusive in the legislative process following the White Paper and that such engagements "should ideally include meetings with all relevant industry groups, business associations, policy institutions, healthcare professional associations, community representative bodies, and Non-Governmental Organisations (NGOs) as well as individual companies and organisations." In solidarity with the PHM-SA, the Rural Doctors Association of South Africa (RuDASA) (2011: 14) similarly called for "mechanisms and structures [to be] established which provide an avenue for community and civil society input to determining what goes into the package."

Interestingly, although acknowledging low levels of involvement from the non-government sector, the South African Health Review (SAHR) (2010: 183; 2013: 101) both preceding and following the circulation of the Green Paper noted that there was a persistent sense of goodwill from the private

sector to participate in the NHI reforms. These inconsistencies in the relationship between the sectors emerge as a predominant characteristic in large portions of the dialogue on the NHI.

3.4.2. Human Resources

In any discussion regarding the NHI the constraints on human resource capacity is often positioned as one of the foremost reasons as to why the reforms will face serious challenges in implementation, especially given the wide-ranging evidence that there exists a shortage of doctors to implement the comprehensive reforms envisioned (Medi-Clinic, 2011; SAHR, 2011; South African Medical Association (SAMA), 2011).

In its introduction the Green Paper states that "a larger part of the financial and human resources for health is located in the private health sector serving a minority of the population … The public sector has disproportionately less human resources than the private sector yet it has to manage significantly higher patient numbers" (NDoH, 2011a: 4). Problematically, the Green Paper did not clearly indicate the total figure of medical practitioners upon which its statistics were based upon, nor the source of its figures. This led to a contestation over the accuracy of figures for practicing medical practitioners in the country. The ANC later responded that the NDoH used a total of 28,636 doctors practicing in South Africa, with 56% working in the public sector and that that in planning over long periods of time there is a margin of 10-15% error allowed in forecasting long term policy proposals[8] (Mthembu, 2011). This personnel figure was disputed by Econex (2010: 1-2), a private sector affiliated policy think tank, who argued that the Green Paper used figures based on the much higher numbers of 36, 912 practicing doctors in the country.

Interest groups within the private sector who questioned the figures and lack of clarity on available human resources, put forward by the state in the Green Paper, decided to commission their own research on health human resources, led by Econex. In the course of completing this research, data from additional sources was utilised by Econex, including the public service payroll system (Persal), various medical schemes, and the College of Medicines, all of whom found evidence that there were only 27 432 doctors working in the system (17, 802 GPs and 9 630 specialists). These numbers are closely supported by figures in the South African Health Review (2011) and health economist Alex van den Heever (2011). Summarily, although Econex disagree with the figures put forward by the

[8] The Green Paper personnel figures relied upon the registration information for health professionals from the Health Professions Council of South Africa (HPCSA), the South African Nursing Council and the South African Pharmacy Council. The number known to work in the public sector is then deducted from the total registered to obtain an approximation of doctors working in the private sector. The ANC conceded that these figures are often overstated due to the very high numbers on the professional registers who are no longer working as professionals or have emigrated (Ramjee and McLeod, 2010: 184; NDoH, 2011a; Mthembu, 2011).

NDoH, the difference between the official ANC figures and that of the private research is far less dramatic then what Econex had originally argued for, and does not show a massive difference in the overall numbers of health professionals practicing in the country.

Regardless of the overall number of health professionals, in arguing for a comprehensive approach to implementing the NHI, the Green Paper states that the "ratio of patients to health professionals is lower in the private sector than in the public sector [and that] there are more professionals per patient in the private sector than the public sector" (NDoH, 2011a: 10). Van den Heever (2011, 107) disagrees with the statement by the NDoH, arguing that "factually incorrect information appears to have resulted from a deliberate attempt to exaggerate flaws in the system of medical schemes and the private health sector." The South African Private Practitioners Forum (SAPPF), an organisation with a membership of 2500 private sector specialists, references Econex (2010: 5) who further contest the statistics that the Green Paper uses for GPs and specialists, finding "an almost equal distribution of GPs between the two sectors: 2,861 people per GP in the public sector and 2,723 people per GP in the private sector[9]. Econex's resultant argument is to make the point that the private sector sees an equitable portion of patients (if not the same as the public sector) and should therefore be permitted to continue with delivery of health care for patients who could afford private health care without the need for reform. This finding is almost directly challenged by the findings of the SAMA General Private Practice Practitioners Committee (GPPPC) that "80% of GPs have capacity to see more patients" (SAMA, 2011: 50).

The conflict underpinning the dispute over reliable data on human resources is a fundamental one about whether the private sector has an obligation to extend health care to those outside the private sector who are currently reliant on the public health care system. This thesis contends that notwithstanding the conflict over reliable data, there remains a critical lack of medical professionals in the country to adequately support the implementation of the health reforms. Furthermore, what private lobby groups fail to acknowledge is that the population base that private doctors cater for is entirely different. The evidence of higher patient to doctor ratios in public hospitals fundamentally undermines the argument that private sector doctors see the same burden of disease and patients in the same quantities as the public sector (Coovadia et al., 2009; Daviaud & Chopra, 2008). If anything, these differences indicate the inequalities in human resourcing and the need for a more equitable distribution of medical practitioners in the country.

[9] These figures are hard to double-check as they are estimated using a range of data from the public service payroll system (Persal), Discovery Health Ltd and the Colleges of Medicine of South Africa.

The South African Private Practitioners Forum (SAPPF) (2011: 50) formally tabled their objection to the NHI with a headline entitled 'Minister's war on private healthcare'. However, the organisation did acknowledge the need for health reform with suggestions on how private specialists and the private sector can contribute, in general, to the reforms. For instance, they have made the suggestion that the return of retired doctors could be advantageous to public health care provision. Retired doctors, it is advised, could provide services on a contractual basis in the public sector, thereby creating larger practices with a number of GPs and specialists, to be contracted out as required.

Human resource shortages similarly formed the main component of the Democratic Alliance's (DA) submission, entitled "Alternative to the NHI", in which they argued that South Africa does not have the human resources to staff a NHI of the scale imagined. The DA shadow health minister at the time, Patricia Kopane, stated that South Africa needed at least triple the number of doctors to implement the NHI (Kahn, 2012). The DA (2011: 8) drew attention to the affordability of the proposed new system of health care, arguing that it would cost R40 billion just to fill the healthcare vacancies that are currently listed, and that the country does not have the resources to train the required healthcare professionals. The DA also made a comparison with other countries who have committed to similar health reforms. The political party (2011: 27) concluded that while Brazil has done well to improve its healthcare system over the years, the country boasts 185 doctors per 100,000 people, compared to South Africa's paltry 55 doctors per 100, 000 people. As such, in order to match the level Brazil has achieved, South Africa would need another 65,000 doctors on top of the 27,500 it presently has, indicating a massive challenge facing the NHI.

With human resources acknowledged as a serious issue in most submissions on the Green paper, many organisations attempted to offer solutions to try and ameliorate the situation. RuDasa (2011: 11) proposed "attracting foreign-qualified doctors as a resource with which to make up the shortfall". SAMA (2011: 11) suggested a re-engineering of the medical system, arguing that as "South Africa cannot populate a *doctor-based system*, found in Cuba, Brazil and the UK… the NHI Primary Health Care (PHC) services must be *doctor-led*." SAMA further highlighted the importance of GPs as recognised "coordinators or clinical leaders of inter-professional teams providing primary health care (PHC)." While the HSF (2011: 52) drew attention to the lack of a systematic human resources plan over the past 16 years, they also expressed approval of the draft Human Resources Strategy for the Health Sector - to be read in conjunction with the Green Paper – aimed at addressing the key problems facing the public sector.

3.4.3. Public versus Private Sector

Discourse regarding the human resources driving healthcare is closely related to a discussion of single versus multi-tier provision of healthcare, with a similar split in perspectives between interest groups. The Green Paper (NDoH, 2011: 6) cites the two-tiered health system, and related inequalities between the public and the private sector as the root causes of the majority of South Africa's poor health outcomes. Defendants of private healthcare argue that this critique does not allow for the structural mismanagement and other issues present in both the public and private systems.

While some organisations regard the private sector as a "national asset" (Centre for Development and Enterprise (CDE), 2011: 39; Medi-Clinic, 2011; SAMA, 2011: 9), the role that the private sector will play in the NHI was not clarified in the Green Paper. Notwithstanding this ambiguity, the private sector has received continuous public support from the national Minister of Health, Dr Aaron Motsoaledi and his office (Kahn, 2013b). Moreover, the debate over the advantages and disadvantages of single and multi-tier health systems, with single or multiple payers, remains contested between defendants of public and private health sectors interests. While the Congress of South African Trade Unions (COSATU) and the Civil Society Coalition[10] do not support a multi-tier, multi-payer[11] system (COSATU, 2011; PHM-SA, 2011: 10), private health care organisations such as Medi-Clinic strongly support such a model. Both the International Labour Organisation (ILO) and the Organisation for Economic Co-operation and Development (OECD) have recognised a potential role for private health insurance, stating that several OECD countries have used or considered using Private Health Insurance (PHI) as a policy lever to promote health system goals such as reducing financing pressures on public health systems, promoting individual choice and improving efficiency (Ramjee et al. 2013: 98).

Various submissions highlighted what they viewed as the key challenges facing the public and private health care sectors. The Green Paper expressed doubt in the sustainability of the private sector in the medium to long term, largely attributed to high costs (NDoH, 2011: 7). The HSF (2011:

[10] The Civil Society Coaliton's Discussion Document was developed and endorsed by the following organisations: People's Health Movement (PHM-SA), Section 27, Treatment Action Campaign (TAC), Black Sash; Rural Health Advocacy Project (RHAP);Rural Rehab; Rural Doctor's Association of South Africa (RuDASA); Passop; EarthLife Africa, and Africa Health Placements (AHP)

[11] "In single-payer systems, one organisation, typically the government, collects and pools revenues and purchases health services for the entire population, while in multi-payer systems several organisations carry out these roles for specific segments of the population. Single-payer systems include all citizens within a single risk pool, while multi-payer systems have pools at potentially different levels of health risk. Single-payer insurers have monopsony power in purchasing health services; multi-payer systems offer the possibility of consumer choice of insurer" (Hussey and Anderson, 2003, 215-6).

22) noted the challenges in the private sector related to lack of regulation, non-price competition, market imperfections and inefficiency. Ramjee et al. (2013: 94) attempted to argue more positively that "the concentration of resources in the private sector, servicing a relatively small proportion of the population, poses a challenge in terms of equity and efficiency, but also an opportunity to make better use of the high-quality capacity that is available in the country." In spite of its investment in the commodified private healthcare industry, the Council for Medical Schemes (2011: 15) further criticised the increase in medical scheme fees which have not provided improved service quality or access to benefits for its members, often attributed to ineffective regulation of its practices. In comparison, the problems facing the public sector were identified in the following way: "lack of governance and accountability, ineffective monitoring and evaluation, poor management (leading to shortages of staff and medicines), over-centralisation (large distances to health facilities), lack of implementation of existing policies, and corruption" (Black Sash, 2010; HSF, 2011: 4; RuDASA, 2011: 14). Brinkerhoff (2004: 377) argues that 'accountability' is a complex matter encompassing areas of 'financial', 'performance' and 'political/democratic' which affect both the public and private sector in different ways, as public providers, health ministries, finance ministries, parliamentary health committees, insurance fund agencies and hospital boards are often linked, requiring frameworks in order to make systems of accountability functional and more than just a buzzword.

Upon the release of the Green Paper, the national Minister of Health (Motsoaledi, 2011:3) issued a media statement reflecting attempts to respond to questions regarding private sector involvement in the NHI. He stated that the NHI is not intended to destroy the private sector, conversely arguing that the sector will gain a larger degree of sustainability "by making it levy reasonable fees". Moreover, he said that the government has no intentions to abolish private medical schemes should individuals wish to maintain their contracts. These views by Minister Motsoaledi indicated that individual healthcare providers would have unhindered choice over their degree of participation in NHI. The South African Medical Association (2011: 9) went a step further in their submission by arguing that the "public and private sectors must work in harmony towards the common goal of equitable and quality healthcare."

SAMA (2011: 6) describes itself as a professional association established to represent all South African public and private sector doctors, and their interests, reporting that it "serves as a trade union for its public sector members and a lobbying agent for its private practitioners." SAMA (2011: 9) noted in their submission that they were encouraged by the "recognition of the need for co-operation and partnership between the private health sector and the public health sector in the provision of services under the umbrella of the NHI." Notwithstanding this acknowledgement, SAMA

raised concerns about the Green Paper's lack of details on private-public health sector partnerships and how these would function under the new arrangements. The DA (2011: 16, see also HSF, 2011: 39) argued that although it does not feel that the public sector can blame its failures on the private system, there are partnership models that could be established in which the private sector could assist with public sector efficiency, such as providing managerial and administrative support, the twinning of facilities, or provision of in-service training by the private sector. SAMA (2011: 9) has made the observation that in not clearly communicating specific details in the Green Paper regarding the roles of the private and public health professionals, the NDoH has caused a lot of speculation within the profession, with private sector doctors anxious that they will be effectively absorbed into the public sector and that the private healthcare system would cease to exist.[12]

Medi-Clinic (2011), a private sector health care provider, has explicitly advocated however for a multi-tier healthcare system as the most efficient strategy to ensure universal access to quality healthcare for all. They argue that:

> [...] developing countries by their very nature cannot afford single tier healthcare systems. Research shows that given the income distribution in the country and the resultant narrow tax base, funding from taxes will not be adequate to provide care to meet the demands of everyone. This is further evidenced by the successful healthcare reforms in Mexico, Thailand, Colombia and Brazil which are all based on multi-tiered systems.

In contrast while COSATU and the National Education, Health and Allied Workers Union (NEHAWU) endorse the NHI proposals they argue that the private sector should not be given any role in the NHI (COSATU, 2011 and 2013). In particular, COSATU is opposed to the proposal to introduce a 'multi-payer' system, under which private medical schemes will be allowed to charge the government for a proportion of the treatment they deliver to their clients. COSATU (2011) argues that these sorts of concessions fundamentally contradict the ANC's commitment to "create a publicly administered and publicly funded NHI Fund, which will be a single-payer that receives funds, pools resources and purchases services on behalf of the entire population." In fact COSATU further admonished the ANC's willingness to bring the private sector on board and thus to allow a 'multi-payer' system, warning that this allowance "smuggled into the Green Paper by the Treasury, threatens to undermine the whole basis of the NHI and allows the discredited private medical schemes to continue to rip off their clients and even to be subsidised by the tax-payers" (COASATU, 2011). While COSATU opposes any private sector participation, the union avoids offering any solution and has also

[12] In the following Chapters, 4 and 5, which reflect on the qualitative interview data, the argument is made for a far more nuanced explanation for doctors feelings of uncertainty, expressed by so many of the doctors interviewed within our own research study.

avoided offering alternative policy proposals regarding administrative and managerial systems and how to overcome shortages of health practitioners in the country.

Although the national Minister of Health has made commitments on the inclusion of the private sector, policy documents do not discuss the role of the private sector or medical schemes as key partners. Ramjee et al. (2013: 98) defend the necessary inclusion of the private sector in the NHI, arguing that the NHI Green Paper sees the introduction of NHI as a means of introducing social solidarity into the health system, without fully considering the role that the private sector can play in achieving such an aim instead, "view[ing] subsidiarity in contrast to social solidarity, and not as a mechanism for achieving it." However, this viewpoint does little to excuse for the market driven incentives behind medical schemes and the 'for profit' private sector, at odds with the principle of universalisation of health care.

3.4.4. Governance

Governance can be identified as a common theme raised in nearly all the submissions on the NHI. Two particular aspects of governance were explicitly discussed by doctors who were interviewed: over-centralisation of decision making and lack of implementation of previous policies.

Firstly this thesis will discuss the concern from the submissions that healthcare is becoming overly centralised. Many health organisations who made submissions on the NHI shared this concern, including those that have been in support of the NHI. RuDasa (2011: 13) argued that the NHI fund will be wasted if there continues to be a "lack of efficient, effective and accountable management at all levels of the health service, and that the continued failure to devolve authority and responsibility to the appropriate level (districts and hospitals) is a major problem." The HSF (2011: 7) similarly argued against centralisation, maintaining that the constitutional rights and decision-making powers of the provinces should be upheld. The Civil Society Coalition (PHM-SA, 2011: 10) argued in their submission on the Green Paper that district level health authorities as well as major secondary and tertiary hospitals need to have the authority to deal directly with the central fund without having to engage cumbersome reporting structures. The widely held view that doctors and managers should be able to make decisions about their own healthcare provision was strongly expressed by a number of organisations with otherwise divergent perspectives.

The second governance issue, however, remains an issue of contention. Organisations that were not convinced of the appropriateness of the NHI have argued that South Africa already provides universal coverage by virtue of the current two-tiered health system, and as such the problem is "rather one of access and quality than lack of coverage" (HSF, 2011: 5). Their primary concern is that

focusing on the NHI without considering deeper structural problems which greatly influence the health care system, including problems such as poor management and corruption, will be ineffective. However, the view that the country already provides universal coverage and that access is the fundamental issue is inaccurate. Access is not the only issue, there exists a complete lack of sufficient, quality public care facilities for those individuals who cannot afford private medical rates.

3.5. Discussion

The policy analysis in this chapter has grouped four themes arising from the various submissions on the NHI Green Paper. These are: lack of public consultation; human resource shortages; conflicting public versus private interests; and governance issues.

The one indisputable concern that resonated with all organisations who submitted comments was that the current health system is inadequate to serve the needs of the whole population. Notwithstanding this point of agreement, the methods proposed to improve health outcomes differ fundamentally on single or multi-tier provision, and single or multi-payer financing mechanisms. The social justice and trade union organisations (COSATU, NEHAWU, Civil Society Coalition) find it unacceptable to have anything other than single tier, single payer provision. Conversely, commercial organisations support a multi-tier, multi-payer system that they argue has the potential to encourage opportunity in access to a wider range of services over and above the foundational services offered by the state.

Despite the claims of SAPPF, Medi-Clinic and the findings of Econex, that there is inadequate recognition by the government of the human resource shortages in the country (Van den Heever, 2011: 55-7; SAPPF, 2011: 7; Medi-Clinic, 2011; Econex, 2010), defendants of the NHI are not blind to the personnel challenges facing the public sector. There exists an overwhelming amount of literature supporting the assertion that there is a paucity of human resources in the public sector. The issue was acknowledged in the Green Paper on NHI, and supported by a WHO Bulletin that argued that "policy-makers in South Africa are aware of the shortage of public-sector doctors and nurses, especially in rural areas" (Chopra and Daviaud 2008: 49; see also Harrison, 2009).

This chapter maintains the perspective that the private sector is a major player in maintaining the health of South Africans, and in the success of the NHI. Indeed, the substantial size and financial strength of private healthcare delivery in South Africa is illustrated in a report by Econex (2013), estimating that the private sector employs approximately 37% of GPs, 59% of specialists, and 38% of nurses, and that 35% of hospitals and 28% of hospital beds are situated in the private sector.

Thus, the opposition to the inclusive historical commitment of the ANC towards universal healthcare is indicative of the deep vested interests of the private sector. This point has been expanded upon instructively in an interview with a member of the technical committee on the NHI:

> ...most of the components of the private sector are opposed to NHI [for] various reasons. The funding industry obviously because now once you create this pool, a similar administration, a common pool, and one fund, it means their role is going to diminish and although they allege that they are not a profit-oriented sector, there are elements of that sector that are profit orientated, for example the administration side, they are listed on the stock exchange (Anonymous member of NHI Technical Committee, 2013).

The same member of the technical committee added that there is a concerted effort to lobby the ANC for more active inclusion of the private sector:

> They have identified other former employees of the Department [of Health] or people that are closely linked to the ANC and they give them very, very powerful positions in their entities to neutralise the process and say no we will present you as a face and you must operate in a particular fashion so that you influence the direction that the policy process is taking. Similarly with the hospital groups they have done the same thing. Deliberately and strategically... (Anonymous member of NHI Technical Committee, 2013).

Just over four years after the release of the Green Paper on NHI, the White Paper on NHI was released in December 2015. The White Paper made a strong case for collaboration between the public and private sectors (NDoH, 2015). While there has been clarification on some issues raised in the Green Paper, issues of centralisation, incentivising private sector involvement in the NHI, and building government capacity are still not resolved. Alex van den Heever, a fierce opponent of the NHI, argues that "government needs to start working from the bottom up. Right now they think that by centralising everything all the problems are resolved, but they are wrong," he said, adding that if "local clinics and hospitals are not empowered to take their own decisions, everything will fail" (Cullinan, 2015).

3.6. Conclusion

This chapter has focused on gaining an understanding of the health reform trajectory in South Africa, drawing on the history of health policy reform and with a specific focus on the inclusion of the private sector. It has been argued that while the private sector is a key player in health provision in South Africa, its role is contested in the policy-making process. Further, this chapter considered the perspectives of the different interest groups that have emerged in response to the NHI Green Paper, reflecting on the multiple stakeholders involved in the policy space.

Chapter Four: Doctors' Responses to the National Health Insurance Proposals: Findings from interviews with doctors in the Eastern Cape Province

4.1. Introduction

The previous chapter situated the private sector in the proposed NHI reforms through a review of the policy trajectory leading up to the NHI Green Paper, and through analysis of submissions made from a wide variety of stakeholders.

This chapter is focused on the views of GPs on the NHI proposals. The chapter will offer an analysis of (i) the findings of interviews conducted with private GPs in the Eastern Cape Province; (ii) interviews with public sector GPs and hospital specialists in order to triangulate findings; and (iii) a comparison of responses between the different sectors. The intention of this chapter is to examine and analyse the response of GPs to the NHI proposals.

As outlined in the methodology section of Chapter One[13], the interviews undertaken in this study present the responses of 78 doctors interviewed during April-May 2012 in select areas in rural and urban Eastern Cape. The interview schedule was designed to gauge doctors' responses to the NHI and to encourage a discussion on their reactions to the reforms. The interviews were furthermore intended to record the doctors' perceptions of the NHI and its implications in their view for private medical practice. The core elements of the questionnaire focused on (a) doctors' daily practice; (b) doctors' beliefs in the government's capacity to institute the reforms; and (c) conflicts of interest that could emerge within the profession. In order to both ensure anonymity and assist nuanced discussion of the different responses emerging from various practice sizes and locations, doctors have been catalogued and identified by their organisational type, divided into solo/small private practice (S/SPP), consisting of 1 to 3 partners, a medium private practice (MPP) consisting of 4 to 6 partners, and large private practice (LPP) consisting of 7 plus partners. Doctor's geographical location has been divided into rural (R), town (T) or metropolitan (M) areas of the Eastern Cape. For the purposes of geographical classification, the population groupings closer to the two metropolitan cities have been considered towns while further from the Nelson Mandela Bay and Buffalo City municipalities have been regarded as rural. This is important in the case of the OR Tambo district in

[13] A full explanation detailing the interview methodology can be located in Chapter One, page 20.

which the Eastern Cape NHI pilot site is located and which falls into the rural area of the Eastern Cape.

4.2. Theoretical Context

Analysis of participant's responses to the NHI was guided by established literature on traditional responses of the medical profession to major health reform, predominantly focused on the United Kingdom and North America (Gilson, L. & Raphaely, N., 2008). Freidson (1973, 1994), McKinlay (1972, 1993) and Haug (1969) conceptualised the medical profession as in contestation with the state over autonomy and power[14]. This thesis applies this theoretical and conceptual framework to South Africa and analyses the doctor's responses to health reform within this context, remaining mindful of the unique characteristics of reform in low and middle income countries (LMICs) and that there are lessons to be learnt about doctor's responses to health reform that remain common across time, space, and across different country settings, as indicated in Irvine (1997).

Part of the study questionnaire requested doctors to respond to how they felt the NHI would affect the nature of their work, raising possible issues of increased administrative focus and changes to doctors' clinical and professional autonomy. These are core features that Freidson considered important to the medical profession.

Freidson's normative understanding of professionalism and its prioritisation was, and still is, widely challenged, notably by McKinlay (1972) and Haug (1969) who both argued that the medical profession was in a state of decline. Using a Marxian analytic framework, McKinlay argued that doctors were becoming 'proleterianised' with physicians acting more like employees than independent professionals. Haug and Sussman (1969: 54) developed the 'de-professionalisation thesis' arguing that professional power was actively weakened by the 'revolt of the client'. This 'revolt' occurred in the context of rising levels of lay education and societal change which enabled citizens to challenge the traditional authority of a professional. The client, thus, can be understood as having become increasingly critical in their dealings with professionals.

In other words, the medical profession is seen as either a burgeoning and powerful constituency with unique and particular contributions to reform processes, or as an occupation subject to the same changes and managerial constraints as any other occupation subjected to reform.

[14] The theme of the doctor's as professionals is a concept introduced earlier in Chapter 2. This was further guided by theories of policy process and power regarding the medical profession (Walt and Gilson, 1994; Le Grand, 2003).

4.3. Interview results

Questions on the first section of the interview schedule aimed at gauging doctors' thoughts about the NHI reforms and their impact on the medical profession. The focus was on three broad areas of analysis: doctors' perceptions of government commitment and capacity to institute the reforms; impact of the reforms on doctors' personal daily practice; and conflicts of interest that could emerge within the profession.

For the most part, interview respondents conveyed a good grasp of the objectives of the NHI which they had gathered from fairly general sources. Only a few doctors had heard about the NHI through ministerial road shows advertised by medical associations, while the majority relied on their medical associations' internal circulations, media and conversations with other doctors to keep current with proceedings. The majority of respondents appeared interested and engaged with NHI progress and debates, with only a minority expressing little interest in having followed proceedings at all.

On the whole interviewees agreed that the current healthcare system needed improvement and that quality healthcare needed to be extended to the entire population, with a small number of doctors stating that the NHI was 'ideologically a better system'. While most doctors agreed on the need for incremental changes to the current health system, most doctors felt that this did not necessarily relate to the specific NHI model being proposed, advocating instead for better management of the existing system of health care provision.

4.3.1. General scepticism about feasibility and motivation for NHI

While almost all doctors interviewed agreed that the health system required urgent interventions to improve health care delivery, there was a strong view expressed from the respondents that the NHI was not the mechanism that would resolve the existing health care system problems. Several doctors felt that the private system worked more efficiently than the current public sector service, and expressed concern that NHI would have a negative impact on healthcare in general:

> I think the idea is fantastic, but I think it should have been done in different way, a more affordable way and a more realistic way. (LPP, M)

> I think it will be disastrous for the country and it will be disastrous for the health system. Because what you're going to do is drag everything down to the level of the public sector as it is now. (MPP, T)

Moreover, from their perspective, it was not a solution that the South African government could realistically succeed in implementing:

> They are going ahead with the pilot project, and obviously one expects them to fail, and they are going to fail. Then they will go back to the drawing board, and they will probably consult the doctors and get their opinion. (LPP, M)

> My concern is that it's not going to improve health care delivery but rather actually cause more detriment to health care in South Africa. (LPP, M)

These responses were representative of a common view by respondents that first the reforms would fail and only after that failure, would the government realise the importance of GPs contributions and consult them and fully integrate their needs into the system of health care delivery. This represented the view of many doctors that their professional opinion provided insights on what were desirable medical practices and which was not provided by the current public health system. The implication of this view was that if doctors were not systematically consulted, it would have adverse effects on the implementation of the new health care system. The overwhelmingly negative sentiments expressed towards the NHI were focused on concerns around lack of management, funding, political willpower to effect a change to the health care system and staffing capacity. In addition, doctors also conveyed the view they did not feel that reform of the health care system was a process that they would be able to opt out of but that they would be compelled to contract their services, regardless of their support for the health reform initiatives:

> Ideally they should give you a choice, ja, so the moment there's no choices it makes it difficult. (MPP, M)

> So for the ANC to come and say they want to make a national health, to force health, private health to come to the state – it's absolute, it's crazy, it's madness. (MPP, R)

Doctors' feelings of hesitancy about being coerced into the NHI system were connected to the belief that the NHI was a result of "politicking" within government. This view was shared widely across different practice sizes, sectors, racial and gender divides, and in metro and rural areas. Doctors perceived the reforms as a means for the governing party, the ANC, to gain more political ground and to consolidate their political position, rather than a realistic response to the health issues confronting the country. This in turn led to other concerns being expressed about the likelihood of long-term political commitment after the current national Minister of Health announced that it would take 14 years to implement the NHI:

> What's happening is a political agenda, that is being rolled out and nothing is actually being fixed on the ground. (S/SPP, R)

> ...it's a political decision, because what better way of keeping your place than to take [on] something that's going to take you a long time? (Public Sector GP, R)

> There is a lot of suspicion, because of the politicisation of a lot of the ideological health decisions. (MPP, M)

In addition to consolidating political support, some doctors argued that the NHI White Paper was largely motivated by electioneering on the part of the ANC. They expressed the view that it was a populist policy aimed at gaining voter's ballots ahead of the 2014 election cycle, once again highlighting what they perceived as a coercive aspect to their participation:

> They are not trying. I mean, this is, the way I see it, this is just politicking. I mean to buy in votes and get votes and all that... This thing is coming from politicians, and it's going to be thrown down our throats whether we like it or not. (LPP, M)

> Health appointees have become political puppets. There is always in-fighting, one is trying to shaft the other one, it's all about who is who you know, what the next ANC conference is going to do and who is going to be in power and all of this rubbish. (LPP, M)

For the most part, the view conveyed by the cross-section of doctors in this sample was that they did not sense long-term planning by government on how broad-based health care reform could be instituted. When doctors were asked however whether it was the right moment to institute an NHI the majority agreed that reform of the health care system was required. This was best expressed by a public sector GP, speaking in context of the current pressures on the public sector:

> I think looking at the current health service...talking universal coverage, I think those of us who work in the health sector are aware...is there ever going to be a better time? (Public Sector GP, T)

It was apparent that for some doctors working in the public sector, they needed assistance, no matter how it is packaged, and the sooner it arrives, in whatever form, the better.

4.3.1.1. Fiscal affordability and sustainability of the NHI

Concerns of fiscal affordability were raised by a significant number of GPs. A repeated view concerned the perceived inability of national government to implement the reforms due to this seemingly insurmountable obstacle:

> ...if you look at South Africa, with about four million tax payers and you're looking at a population of fifty million people, there is an imbalance there. Four million people cannot be paying for fifty million. It cannot work. (Public Sector GP, T)

> Government will pay for it yes but the money has got to come from somewhere. Where is the money going to come from? Who is going to pay for it? (LPP, M)

> In the first place I can't see how it will be fiscally affordable or sustainable – we have such a small tax base here – so few of the population pay taxes – how can we achieve a national health system that is tax funded... (Public Sector GP, M)

Whilst this view of the reforms was articulated by a significant number of doctors in all geographical settings, urban-based doctors were particularly concerned over this issue. A few doctors expressed the view that the NHI reforms were not only fiscally unsustainable at a national level, but that the expectation for a small tax base to carry the health care burden of the country was also an unacceptable request:

> Four million people cannot be paying for fifty million, it cannot work. So based on that I will be frustrated as a tax payer to pay so much money for other people's health care. (Public Sector GP, T)

This concern about compulsory, involuntary contributions towards the NHI revealed the diversity of views and attitudes about the meaning of universal healthcare.

4.3.1.2. International Comparisons and Experiences

A significant proportion of doctors defended their view on South Africa's inability to afford an NHI-type system of health care through reference to countries with much higher income levels who had implemented a universal system of health care, arguing that their income base made a universal system more fiscally sustainable than in the case of South Africa. In this regard doctors frequently expressed concern about the high burden of unemployment in South Africa, currently sitting at 26.5% (Statistics South Africa, 2017: 9).

A significant proportion of doctors currently working in the public and private sectors had experience working in health care systems abroad. These doctors drew on their personal experiences of working in universal health care systems in more developed economies. In some instances, doctors expressed confidence about their experiences of universal healthcare systems. A private sector doctor from a large urban practice expressed the opinion that if health reform was instituted correctly it could have a significant impact on healthcare provision in South Africa:

> I had the pleasure to work in England and while [the NHS] does have its own shortcomings it's a good system. It's a good system and if all goes well in South Africa with the NHI, and if we do that at that level, on the primary level... (LPP, M)

Some doctors also argued however that even in countries with a high tax base the universal health care reforms implemented had 'taken years' and in many cases, still faced multiple obstacles:

> The UK has tried, it's faltering. Canada has tried it's not doing too great. The only place where it's going well is mostly [in] your Scandinavian countries. And if you look at that you have an 80 plus percent pool of tax payers. (Public Sector GP, T)

> ...we must remember that it took Canada 25 years, and they are wonderfully resourced versus this country. We've got a lot of poor people to look after, which they don't have. Their tax base is so much stronger. (Public Sector Manager, T)

A doctor running his own private practice in a township on the outskirts of one of the metropolitan municipalities explained that much of the negative reaction from doctors was a natural reaction to something new and different:

> I think all of our misgivings are sort of a normal response to something new and a change. I mean if you looked at Australia when they brought it in, there were lots of, they were walking the streets and picketing saying they didn't want the system. I think in Britain they had the same. (S/SPP, M)

4.3.1.3. Human Resource Capacity

General practitioners' scepticism of the feasibility of the reforms also related to issues such as human resource capacity. Many doctors surmised that even if funding the NHI was not an insurmountable obstacle, the lack of skilled personnel to provide good quality health care was of critical concern in their view.

> We're not even talking about money yet, okay, we're talking about health care personnel, and there isn't enough. (MPP, M)

Added to perceptions about the lack of properly skilled doctors, doctors highlighted that the average age of practitioners in Port Elizabeth, the largest city in the Province, was relatively high. The implication being that there were not enough medical students choosing to practice in the Eastern Cape. It is possible that this is indicative of a national problem:

> I mean without general practitioners around it can't work and there's a huge shortage of [them]. The average age of general practitioners in Port Elizabeth is fifty nine! So it just means people do not want to become general practitioners. (MPP, M)

Some doctors also expressed the view the state's efforts to remedy personnel shortages by importing doctors from abroad was unhelpful and pointed to the issue of the inadequate training system for doctors:

> ...doctors that come from Cuba just can't cope with the setup that we've got here. So training is also something that seems to be wrong with our system. (S/P, M)

Doctors' perception of understaffing was not only limited to shortages of medical practitioners and clinical staff, but also included medical support staff:

> It's not [only] about patients, it's about the patient, the nurse, the doctor, the pharmacist, the radiologist, I mean, it involves a lot of stake holders. (LPP, M)

The lack of required personnel was reported as exacerbating a problem of critical shortages of primary level caregivers and attendant problems of providing primary health care in rural areas.

> [Providing] primary healthcare, where are the sisters going to come from? There are no sisters in South Africa. All the sisters are going as well. We are sorely pressed to have sisters and we are sorely pressed to have doctors. (MPP, M)

Further concerns were raised about the lack of correctly qualified personnel and allied staff in the rural areas, an issue of particular concern in provinces with large rural areas such as the Eastern Cape:

> Do we have enough personnel there, skilled people? Do we have a radiologist in Bizana? Do we have lab technicians there? There are facilities there, but they don't have personnel there. (LPP, M)

These issues of human resource capacity were raised as areas of present concern which doctors forecasted would be further exacerbated by the pressure of migrating to broader, more comprehensive health reform. Rural doctors sternly argued that the system would not cope if they were not supported with the necessary human resource systems required to staff the wide-ranging suite of services envisioned by the National Department of Health.

4.3.1.4. Infrastructural Weaknesses

A number of doctors expressed the view that lack of infrastructure for the new health care system was a serious concern. According to these doctors the problem was both the maintenance of facilities and equipment and the training of staff to maintain the equipment:

> ...if they say major infrastructural changes, I'm not sure what they mean by that. You can build hospitals, but maintenance is important. (MPP, M)

> ...so a lot of the machines are just lying there... we have a huge collection of ventilators, but no maintenance... we can't have such expensive equipment without a maintenance plan. (MPP, R)

A few private sector doctors felt that access to appropriate medical equipment was a reasonable demand to be made if private doctors were to be expected to leave their own private practices to locum in government hospitals:

> I'm not going to work in place and then do an operation and then the tools are inadequate or so, if they want us to go work over there they must have the hospitals functioning and it must be good conditions, it must be a good salary. (MPP, M)

Infrastructure was a predominant concern even among doctors who expressed positive views about the reforms, an added anxiety for doctors practicing in rural areas of the Eastern Cape:

> It's a noble policy and it's very important, I believe in it, but unfortunately without the infrastructure for it, how are you going to dispense it? (MPP, R)

This historical context in the Eastern Cape was seen by some doctors as a contributing factor towards a culture of 'neglect' and 'unaccountability' in health care delivery which adversely affected the quality of healthcare provision:

> This part of the world was targeted for underdevelopment for the better part of a generation, more than a generation... schools were neglected, infrastructure was neglected, people were neglected... (Public Sector GP, R)

> The Eastern Cape is particularly bad in that respect because of, I am not sure why or how it happened but there is just this culture of underperforming, people won't go the extra mile to make sure that the job gets done. (MPP, R)

4.3.1.5. Lack of governmental management

A number of doctors expressed a lack of confidence in the administrative capabilities of the government. Cases of non-payment reported by GPs from the Nelson Mandela Metropole, the most urbanised area in the Eastern Cape, illustrated issues of mistrust of the Eastern Cape provincial government. Due to their experiences, doctors expressed scepticism over whether they would receive payment. They also expressed scepticism on the state's ability to deliver timeous and fair payment once in a contractual agreement with doctors. While the tensions between private doctor's market interests and the state are evidenced elsewhere in the thesis, these responses proved an interesting case study in evaluating the culture of distrust that has grown between the profession and provincial government:

> [A doctor] has been working at one of the state clinics and he hasn't been paid since January. It is now April and he [still] hasn't been paid. He has been working full time at the clinic and he hasn't had any income for four months. (Manager, LPP, M)

> I think most private sector doctors would be quite happy to go along with it, if they saw management improving. I'm not going to work for Bisho. The day you say to me, you're getting a cheque from Bisho, that's the day I say goodbye. You know, I refuse. I'll work for national government, but I won't work for Bisho. It must be done at government level. It can't be done at local...they can't do it. You've just got to walk through the Frere Hospital[15]. (LPP, M)

> ...if you are going to delegate say for example payment to the Eastern Cape government, nobody is going to work for the NHI I can tell you right now because we will never get paid, it is as simple as that. (LPP, M)

Doctors also expressed concerns about maladministration and a poorly trained workforce:

[15] Frere Hospital is one of two large public hospitals in East London, Buffalo City Metropole, Eastern Cape

> You're going to have the same untrained people and the same people who are taking chances, the same people that are mis-managing us, not spending their budget, under spending the budget, going to work and taking salaries, and that's really what's going to ruin the system. (MPP, T)

> I think that the point is what they are trying to do is they are shoring up a crumbling infrastructure by trying to pull sort of more revenue into it. And I would be much happier, we would all be much happier, if they would restructure the Department of Health and correct the deficiency and the bad organisation and the maladministration and then propose NHI. (MPP, T)

Some doctors expressed a strongly held perception on corrupt practices in the public sector arguing that it undermined any new health reforms:

> There is [already] endemic corruption with the much smaller pots of money...it's just going to go haywire ...not just administrators but doctors also – public health – everyone! Salaries are so low that they'd just see it as skimming a bit off the top – just topping up their wages. (Public Sector GP, M)

> One of my biggest concerns with the NHI is that it doesn't really help us getting a ton of extra money when we can't spend the money wisely. (Public Sector GP, R)

In a number of interviews, doctors referred to the incumbent Superintendent-General in the Provincial Department of Health at the time (Dr Siva Pillay) for his role in improving health services in the province.

> ...it is unfortunate that Eastern Cape is also well known for its corruption. It's also known that Siva is uprooting all the corruption, he's becoming quite famous for that. There's still a lot of worms coming out of the wood work... (MPP, T)

4.3.2. Impact of NHI on Doctors' Remuneration

One of the most contentious issues highlighted by interview respondents was the concern that reimbursement in the public sector was 'skimpy' and not comparable to current private sector earnings. These responses provided the clearest evidence of the tensions between private doctors' interests in the market related provision of health care and the necessary concessions required by the medical profession to provide public healthcare to the population:

> ...it would have to be a reasonable fee to get doctors to buy into the whole thing, I mean you've got to have doctors willing to make the thing work as well, and if you're not going to pay them then they are not going to be interested, it's as simple as that. (MPP, M)

> I am not willing to compromise [on remuneration] because my practice overhead has got to be covered first, so the moment I lose time...I might just end up working just for my overheads and making no money so they will have to match what I make here [in private practice]. (LPP, M)

Some doctors demonstrated their lack of support for the NHI by not participating in consultations on the NHI held by the National Department of Health, confident that their lucrative private patient base would not diminish. A solo private practice doctor positive about the reforms reported his experience of other doctors that he had interacted with:

> They think that they have a certain type of patient who will be able to afford the more expensive medical aid, who will be able to pay cash if they need to because they earn enough...if you are seeing that type of patient, you can refuse, you don't have to see NHI patients....I'm sure there are a lot of those doctors. (S/SP, T)

A sample of doctors claimed that without the incentives found within private sector practice (such as choosing ones place of work, number of patients and working hours), government couldn't expect doctors to be satisfied with payment at a set rate regardless of experience and reputation:

> I know what type of service they get from government clinics and from the government hospitals, so my feeling is what I have to offer is my personal knowledge and expertise and they have to refund me properly for that. (S/SP, M)

The language of commerce and the financial market played a strong role in responses, including increased competition, private practice overheads and how the proposed NHI would affect the private practice business model. To some doctors, finance structures such as capitation were viewed as a business opportunity while others already anticipated 'gaming' any system to work for their needs:

> The bottom line is going to be the money...if the NHI wants to say we're not gonna pay you per patient we're going to pay you for x amount of hours that you work ... I can say oh well they're gonna be paying me eight hours so I'll see a patient in an hour, as slow as I possibly can work and take my time and it doesn't matter. (LPP, M)

> ...if they pay me fifty per cent less than what I charge at the moment that would be acceptable if they don't charge me VAT on my income and because it's a necessary service that we render, they take the taxes away. (S/SPP, M)

Public sector doctors also conveyed opinions linked closely to market incentives when considering future possible remuneration systems. This was the case despite the fact that their remuneration package is unlikely to change very much when the NHI is instituted:

> As a medical practitioner I'd like to be honest with you: if it means more money in my pocket at the end of the day I don't have a problem with it – I'll go with it. (Public Sector GP, T)

> If you are a practitioner, and you're looking to keep your glass of milk and your piece of steak, private practice will be the place to go....if it's a purely 'let's exchange cash' sort of basis then you have more chances of actually, I guess, benefitting financially from it. (Public Sector GP, T)

A small minority of doctors explained that their concerns around remuneration was not as a result of what they felt entitled to as a personal fee for service, but rather voiced concerns in relation to how their remuneration affected their ability to cover the high costs of running a private practice. For many private sector GPs 'meeting and managing their overheads' in their existing private practices was linked to the number of patients they needed to attract through the door, paying a market-related fee. Although these views were often cased in the language of profit and business, many doctors emphasised that they were not making large profits in their practices:

> ...at the moment we're very, very finely balanced. We are not making huge profits. We really aren't. We're just, just getting through. Suddenly removing one sale from this practice to go and work at a cheaper remuneration, at a smaller remuneration could make the practice non-viable and what will then happen? The doctors will leave. The practice will stop existing. (MPP, M)

> ...a lot of doctors will say... I'm gonna see all my private patients that can pay me first and everybody else will have to sort of wait. I'll still see you but probably not straight away. The reason being is your overhead in private practice is actually higher than people realise. It was a lot higher than I realised. (MPP, M)

A small sample of doctors from historically privileged, predominantly white, large and medium private practices proposed that they were open to change. This was often based upon the belief that they were in the business of healthcare and not in the medical profession as business people:

> I've actually come from the public sector and I'm not a businessman, so I would actually much prefer a salary. I would welcome a full NHI where I get a salary and I get given a patient base and I can just get on and practice medicine. So I'm actually more than happy to work in an NHI system. (MPP, T)

> The remuneration will always be less than what people in private practice will expect. I think people are prepared to make some sacrifices to do some good. (LPP, T)

4.3.3. Increased Workload and Working Conditions

Interviewees located predominantly in rural areas of the Eastern Cape complained that the lack of infrastructure and equipment has resulted in poor working conditions and has had a significant impact on the ability of doctors to do their clinical work. This sentiment was expressed both by private and public sector doctors:

> I don't know with the other parts of the country but with the Eastern Cape, mostly the problem is the working conditions – very, very poor working conditions with no equipment, that's the major, major problem with the Eastern Cape. (SPP, R)

For many of the doctors, the NHI suggested an increase in the patient workload but at a lower rate of remuneration and which would lead, it was perceived, to 'conveyer belt medicine'. The doctors

made repeated references to the public sector's current struggles to cope with pressures on service providers which had a direct effect on patient care. The analogy was made to pushing patients through the system like a 'sausage factory':

> ...if I have got to go a lower fee I have to go higher numbers, and then I have to compromise their healthcare, or the level of healthcare. No doubt about that. (MPP, M)

> ...if we force more feet into one door, we will decrease the quality of care because you've got so many more patients to see, but the same amount of doctors, then you start having to rush through them and not doing the right things. (S/SP, R)

> ...when you have such a load of patients, it is very difficult to spend time on a patient, psychologically you get tired at the end of the day and it is very difficult to maintain that level of concentration on your patients. (MPP, R)

Demonstrating the diversity of opinions within the profession, a number of public doctor respondents predicted a possible positive outcome of the NHI. They felt that the NHI may enforce a better gate keeping role with nurses on the front line, allowing doctors currently performing under immense pressure the freedom to deal with cases requiring urgent attention:

> ...that the appropriate people will see the appropriate level of care is more likely in the new system...what people go to their general practitioner for, on a private basis, I do think that is not a good use of a resources in that many of those could actually be handled by a primary health care trained professional nurse. (Public Sector GP, T)

> I think a referral system would be a good idea. I don't think that [in] the current private system, which is using so much of the health expenditure, people necessarily have to see a doctor. (Public Sector GP, T)

Public sector doctors further articulated that importance lies in receiving feedback on the value of their work. Moreover, they proposed that a necessary support system should be put in place for doctors working under pressure:

> The thing that really matters is the soft stuff...feeling appreciated, feeling part of the team, feeling like they can make an impact, giving them scope to do that...being heard when they have issues and that when there are problems on the ground that there is a good structure. (Public Sector GP, R)

A small sample of private sector doctors who had experience working in the public sector argued unequivocally that their hesitation to work in the public sector had little to do with the offer of lower remuneration. Instead, emphasis was placed firmly on the issue of poor working conditions:

> I don't think remuneration is really my sense of the problem why people aren't working in the public sector, we aren't working in the public sector because it's actually horrible to work there. (MPP, M)

4.3.4. Autonomy

Underpinning all the different issues of remuneration, workload and concerns about government management, was a widely held concern about the NHI reforms potentially eroding doctors professional autonomy. Private sector doctors often defended a level of autonomy and control over their working lives in interviews. This was linked to the provision of 'quality of care' which they perceived was reduced in public sector healthcare.

4.3.4.1. Clinical Autonomy

While the sense of independence valued by private GPs was not free of restrictions altogether, autonomy was evaluated relative to general perceptions they had of work in the public sector. Doctors repeatedly conveyed concerns over already being 'squeezed' by medical aid prescriptions and 'punch drunk' from being told what to do by medical aids, the government and hospitals.

> We get done in by the medical aids. The first people they come to when they want to do cost cutting or trying to save on things, are the GPs. We know the people that are the expensive guys are the hospitals and the specialists. (S/SPP, M)

> Make no mistake I don't think that there are many doctors in this country that are pro medical aids because we feel they are robbing the patients and not paying the doctors.... (MPP/M)

This fed into the view that the NHI would represent an additional pressure 'eroding clinical freedom'. Alongside the high costs of personal malpractice, insurance costs and private practice overheads, some doctors saw a migration of the profession to larger corporate practices were there is less financial and personal risk:

> I mean, a young doctor can't start up a practice now because of the astronomical costs, so they want to join like a Medi-Cross-type facility. (MPP, M)

A consistent concern regarding the NHI was the foreseeable powerlessness to prescribe medicines preferred by the doctors. Instead, it was feared that they would be required to administer medications using a 'prescribed drug list', a characteristic already commonplace with many medical aids:

> We already lose our autonomy with what they call managed healthcare systems...medical aids dictate what I can and cannot prescribe for a patient. I fight with them quite frequently where I say this is a medical decision I want to give the patient drug x and they all say no, first try drug Y... (LPP, M)

> ...it comes back to the same story of the dispensing law, where we did pharmacology in med-school. We did medication and everything and all of a sudden they come out and they

> say 'you're not allowed to take a tablet off that and give it to the patient', it's rubbish. (MPP, R)

4.3.4.2. Professional/managerial autonomy

Repeatedly doctors expressed worry as to whether they would have the 'choice' to join the NHI or whether they would be 'forced' to take part:

> If I've got the choice I would say no, I would not like to be forced into doing something...I will rather stop working as a general practitioner and I would find other ways to fund myself. (S/SP, M)

> I don't see that I've got any choice in the matter, whether I'm willing or unwilling it's going ahead, it's like, coming! Ready or not?! (S/SP, M)

In further instances in which the execution of professional choice was discussed alongside issues of quality of care, doctors felt they had more authority to protect their patients' welfare in the private system:

> ...now [when] the patient complains to me about the private care he is getting I can talk to the hospital about that and something can get done about it. What is going to happen now in the new system? Who am I going to complain about if my patient is not happy? Do I have to strike? Do I have to toi toi? (Public Sector GP, R)

A small public hospital in rural Eastern Cape claimed to have separated itself from the 'disappointing' levels of care in public rural health. This outstanding example is said to have distinguished itself as a centre for care. The head doctor at the institution argued that while financial incentives were important in drawing doctors to work in the rural areas, it had more to do with:

> ...learning to actually recognise professionals for the skills that they bring and about trying to build a team, and look after people, and get their salaries paid, and make them feel valued, and tend to their needs. (Public Sector GP, R)

4.3.4.3. Value linked to their identity as doctors

A sample of private sector doctors argued against the equalisation of pay. They felt that remuneration was representative of their relative value as professionals. Amongst these doctors there is a robustly held view that differing levels of experience and skill sets should be rewarded differently, allowing for room to flourish and practice freely without prescribed working conditions:

> ...we try and give a better level of care than you get even from the other doctors in town, you know, you try and be the best. Now all of a sudden you're just going to be all equal, and not all doctors are created equal. (MPP, M)

> I want my freedom because I went through university, I was empowered, so that I should be able to function independently and make a change...we should be diverse in unity. (MPP, T)

Moreover, there was a sense that for specialists and highly qualified doctors there was no incentive to stay and work in the NHI when they were already in demand all over the world:

> ...people leave here and go in work in the rural areas of Canada because of incentives... If they want to tell the nurses to work there [the NHI], they need to come up with a strategy to retain the doctor's, to retain the nurses, because doctors and nurses are professionals. (LPP, M)

4.3.5. Conflict within the Profession

Many doctors expressed a strongly held view on expanding state-led healthcare that professional conflicts would erupt among doctors for a multitude of reasons. Some doctors predicted conflicts that would arise between the public and private sectors related to remuneration which is more secure in the public sector:

> I think there will be tensions between the purely private people and the public sector doctors because with all, it will seem that the public sector doctors are getting a better deal, it's a perception, the private people are now already saying the consulting public sector practice are getting much higher salaries then they get and they do private work on top of it so they take home more money than the full time private people. (Private Sector Manager, R)

> Tension, like both sides will say the other side is not doing a good job, I suppose. Because public health your patient load is very high and then obviously you are paid a salary, so whether you see twenty patients or thirty patients doesn't really matter. (Public Sector GP, R)

A doctor from a large private practice relayed his own experience from practicing in the UK National Health System (NHS). In demonstrating their 'right to choose', a sector of medical practitioners continued to defend their private sector interests against the public sector:

> In England, they despise the doctors who work in the private sector. It's like, he works in the private sector, you know, he does private, he gets money for his consultations. It's like despised. A lot of them despise it. But of course, all the ones working in the private sector say, to hell with you, we've tried the NHS and it didn't work. (LPP, M)

Some of the doctors interviewed who had expressed their unwillingness to partake in the NHI, and who did not support the principle of equality of access to healthcare, expressed concerns that there would be increased competition between providers. These doctors viewed NHI patients as an 'interference' that would have to be tolerated as a distraction from the real business of keeping their private patient base content. It was warned that the consequence of not appeasing private patients would result in losing them to practices that refused to see NHI patients:

> ...if they say okay you can see private patients during your NHI sessions if it's emergencies then it probably won't cause a problem but if...when you're seeing national health insurance

> patients you only have to see them, you're going to alienate your private patients. And the minute you alienate your private patients they will go and see someone else and then you'll then end up having people that are gonna be doctors that only exclusively see private patients. (MPP, M)
>
> I think definitely, there's going to be conflict. When I look at some of my colleagues, I see they're very antagonistic towards it, and I think there's potential for a battleground where they're going to hang on to their private work and don't want to get involved in any public sector work, so I'm sure there potentially is a battleground there. (MPP, T)

Conflict among doctors along racial lines was not easily determined from the interview data. Regardless of their social background, almost all doctors unequivocally asserted that in their treatment of patients, race was not an issue. It is important to note that 55% of the doctor's interviewed were white, and 80% male, a fairly homogenous group in their fifties, which is reflective of the medical profession in the Eastern Cape. One white, male doctor referred to the fact that young black doctors would never accept low reimbursement, as they had flashy lifestyles to maintain:

> We mostly look after the white community. And the black doctors in Mdantsane look after the black community. So we look after like 5% of the population. They're looking after the other private patients. Man, it's their opinion that matters, hey. It's their opinion. ...they all come to the meeting, they're all wearing fancy Hugo Boss jackets, leather jackets, they're all driving fancy 3 litre BMWs, they're all in debt up to their ears ... It's no use saying to them listen, you're now going to get a salary of R30 000 a month. They're going to say, 'Sorry, I can't manage on that.' (LPP, M)

This offensive comment racialising accumulation was characteristic of the kind of rhetoric common in interviews. On the whole comments about race were often embedded in responses that were not related to the NHI at all. As such, the comments did not necessarily signal conflict between doctors, but did reflect a bias by some of the older, white doctors.

The doctors that were more positive about NHI reforms foresaw that potential conflict could reflect a positive sense of competition. This conflict has the potential to incentivise doctors to keep their practice standards high in lieu of maintaining a government contract:

> My understanding [is that] in city areas it's going to be much more competitive, that if you don't shape up you are going to lose your contract so that makes sense and that's good because that will keep things lean. (Public Sector GP, R)

This same sense of competition over standards was, furthermore, predicted to produce winners and losers among practices. The Office of Health Standards Compliance, which intends to manage standardisation and quality assurance of healthcare services nationally, was flagged as a possible threat to small township and rural practices that do not 'tick boxes' in terms of regulatory

requirements. These rural practices currently offer an important point of intervention in preventative and curative healthcare:

> I think if you want to improve the level of care that's fine, because you must have those standards, I have no problem they come here and tick all my boxes, but essentially then they must understand that they are going to compromise twenty five percent of people that... I don't know what level of care they are giving but they are giving some level of care. (MPP, M)

4.4. Discussion

This chapter's findings indicate that the South African government's decision to plan for and implement an integrated, universal public health system is going to face significant challenges from the private medical fraternity. The majority of doctors interviewed shared the sentiment that access to quality healthcare is currently unequal and unfairly apportioned, requiring change. That said, many of the doctors in this study differed from the government's solution in how health services could be best improved, and the role that they should be expected to perform.

The doctors' concerns, ranging widely between worries of lower remuneration to impact on their workload, coalesce with the position that doctors do not favour nationalisation of their profession.

The three broad areas of analysis during the interviews were: doctors' responses to government commitment and capacity to institute the reforms; impact of the reforms on doctors' personal daily practice; and conflicts of interest that could emerge within the profession.

Doctors widely reported scepticism about the commitment of government to the proposed health reforms, some arguing that the proposals were just 'politicking', or as a strategy to gain votes in the next election. Doctors were also highly critical of the government's ability to manage the reforms correctly, raising issues of infrastructural weaknesses and the ability to adequately staff the NHI, to reliably and efficiently remunerating doctors for their work. To some extent these concerns are all evidence of typical fears about loss of professional power, as evidenced by Klein (2007, 49), Freidson (1984: 3) et al. However, the views of some doctors in the Eastern Cape are influenced to some degree by a personal negative experience with the Eastern Cape provincial government which could have contributed to a heightened sense of foreboding regarding reliable implementation of reform. The doctors concerns also reflected general feelings of managerial inefficiencies in the national government which informed their sceptical views on the capability of provincial government to manage the proposed new health care reforms.

The personal impact of the proposed reforms on doctors' private practices was perceived differently between, and even within, the public and private sectors. Doctors at large private practices articulated the strongest concern that their practice might become inundated with NHI patients. Smaller practices responded more positively to possible new opportunities represented by the reforms, including some doctors suggesting the possibility of off-premises consultations if they could not absorb higher numbers in their current practice space. Public sector GPs were more positive about the reforms. They had expectations of lower workloads and increased remuneration while private sector GPs were apprehensive about remuneration which they were convinced would be unduly low, thereby stifling competition. In addition, private sector GPs envisaged an increased workload which they would not have any autonomy to control.

The final area of analysis of the doctors' view of the NHI and its implications dealt with concerns arising from potential conflicts within the profession. A general view expressed was that conflict initially emerged out of feelings of coercion to join the NHI. Doctors in larger, urban-based practices expressed an anxiety that they would be compelled to absorb new NHI patients. They felt that smaller practices would not be as pressurised to make room for the influx of patients. This was an especially contentious issue for doctors who were not interested in participating in the NHI scheme, preferring to maintain an exclusively private sector oriented practice. For smaller, less equipped practices, some based in rural areas, concerns were raised that if the compliance standard for practicing required by NHI could not be met they would be forced out the system. Conversely, some doctors in larger practices felt that there would be a larger burden placed on well-equipped facilities and medical centres to absorb patients from the NHI which they were not supportive of.

Cumulatively the interview findings reflected a strong sense of scepticism and hesitancy among doctors on the NHI reforms. Core to Freidson's argument (1973, 1994) of the medical professionals enduring significance were the particular characteristics of 'autonomy', 'expertise' and 'service' that he argued defined their practice, unique from features present in other occupations. Issues raised by doctors during interviews spoke directly to concerns about the effects on their professional status, which they perceived would be eroded by the state-proposed NHI reforms. While Freidson was widely challenged about this theory regarding the dominance of professional power, notably by McKinlay (1972: 61) and Haug (1969) who argued conversely that the "myth or ideology" of the profession was in fact in a state of decline, all the theorists nonetheless agreed that the state remained a potential threat to clinical independence. Consistent with McKinlay's argument about the 'proletarianisation' of the medical profession, loss of control over remuneration and working conditions to the state was a prominently expressed concern in the interviews. Doctors reported

that they had to 'do what they're told', adhering to strict protocols and guidelines, either 'managed' by government policy on one hand or medical schemes and health organisation's on the other. Doctors feared that they would not be able to exercise their own judgment based on their expertise and training, undermining what Coleman (1988, in Freidson, 1994: 195) calls the "social capital" of professionals. Coleman argued that this "social capital facilitate[s] the development of norms and sanctions that can motivate people to work for the public rather than their individual good." It could be argued that as the NHI reforms were viewed as a potential attack on some doctors' autonomy, which could have negative implications on the medical profession's ability to collectively cohere around medical practice as a form of public service.

The potential for conflict was an issue of particular concern for interviewees, reflecting the divided character of the profession along lines of practice size, geographical location and racial divides. Significantly, Freidson (2001: 215) argued that, "perhaps the most important [parts of professional codes of ethics] ... are those that deal with ...conflicts of interest... This is the critical test of professionalism in that in order to justify a monopoly over practice it must be assumed that it will not be used for selfish advantage." Similarly, Rodwin (2011:2) agreed with the notion of professionalism as a tool for service, arguing that principles of professionalism could play an important role in mediating conflicts of interest. Rodwin elaborates that "whatever institutions and rules society uses to cope with conflicts of interest will be more effective if physicians not only respect them but are also guided by an ethos of public service, fidelity to patients, and commitment to knowledge and excellence."

The Office of Health Standards Compliance, established to ensure standardised levels of care, is arguably the body that most closely approximates such an in institution in the South African context. Salter (2001: 873) reported a similar trend in the UK NHS, when in 1998 the UK Department of Health argued that "medical self-regulation is no longer regarded as sufficient guarantee of high-quality health-care provision and there is to be a comprehensive, management-led system of clinical governance to set, monitor and, where necessary, correct clinical standards."

Even Freidson (1994) who argued for the autonomy of the medical profession agreed that doctors required regulation. Hunter (in Bury and Gabe, 2004: 350) similarly argued that "while doctors' specialist knowledge remains irreplaceable...specialist's knowledge can be – and is – subjected to clinical standards, guidelines and protocols developed by teams of specialists."

Klein's (2013: 248) basic premise (supported by Le Grand, 2007 and Klein, 2010) is that "policy-making in the health arena can only be understood in the wider political context". To this extent, the

Eastern Cape offers a particular context to the doctor's responses, imparting a particular experience and attitude toward the State. Statistics SA released data from the their 2011 General Household Survey illustrating that while 62% of households in the Western Cape take less than fifteen minutes to reach their nearest health facility, only 28% of households in the Eastern Cape enjoy this level of accessibility (Davis: 2013). The weight of need on the Eastern Cape provincial health system is immense. Effective service delivery is further challenged by widespread issues of maladministration and difficulties arising from the fact that much of the population is situated in rural and traditionally under-serviced areas (Van Niekerk, 2012: Davis, 2013).

Due to widely differing levels of infrastructure around the country, the NHI reforms are thus likely to result in uneven degrees of success among the eleven pilot sites situated nationally. It should be noted in addition, however, that anecdotal evidence suggests that Eastern Cape doctors do echo general sentiments of the South African medical community at large. Salter (2001) argues that the recent politicisation of medical regulation in the United Kingdom has destabilised the historic relationship between medicine, society and the state. It could be argued that the political context of the Eastern Cape may have had an effect on some of the doctors entrenched feelings of resistance to state interference, away from purely traditional concerns of autonomy to more service-oriented fears of diminished standards of care.

4.5. Conclusion

Health policy analysis suggests that the state, market and professions exist in a delicate balance and that the power of the medical profession has in many other health reform contexts been an important interest group in shaping the policy landscape (Surender et al. 2014: 8). The interview findings from this study suggest that the government has not yet been able to convince the majority of private medical doctors, in particular GPs, that the NHI scheme is a viable, or indeed, a desirable alternative to their current practice. At the time the interviews took place in the first part of 2012, it could be argued that it was too early to expect doctors to respond convincingly to the reforms as they had not felt their impact yet. Their skepticism could also have been based on uncertainty that the proposed reforms would even be implemented.

Chapter Five: Doctors' Responses to the NHI Proposals: Perceptions of their ability to influence the direction of the NHI

5.1. Introduction

The previous chapter evaluated a sample of Eastern Cape doctors' responses to the NHI proposals. The examination of individual considerations was intended to gain both an overall sense of the Eastern Cape medical professions' sentiment towards the NHI and to observe different views and perspectives. This chapter explores how doctors engaged the NHI consultative process to assert their influence and defend their interests. The focus in this chapter is on four areas of analysis: i) the degree of doctors' engagement with the health reforms; ii) the relationship of doctors with their medical representative bodies, iii) the perceived impact of the medical associations' influence on government policy, and; iv) the fragmentation within the medical profession in relation to the NHI proposals.

5.2. Context and background

Analysis of the doctors' responses in this chapter is guided by two theoretical initially introduced in Chapter Two. Firstly, the doctors' responses are considered through the contested idea that there are unique attributes to individuals in the medical profession, introduced earlier in the thesis by Freidson (1973, 1994), and challenged by McKinlay (1972), and Haug and Sussman (1969). In this chapter this debate is contemporised by Klein (2006; 2010; 2013) and others. Secondly, doctors' perception of their influence in policy design is analysed. This draws on Walt and Gilson (1994: 354) who argue that the political context in policy making is crucial in understanding which policy actors are likely to favour or resist reforms. [16] The analysis by Walt and Gilson is complemented by Lipsky (1971) in his seminal work on front line implementers as 'street level bureaucrats.

While implementation of policy is not a focus of this study, the policy process inevitably involves the participation and involvement of various groups and organisations. This thesis examines the hypothesis that front line implementers, due to their direct knowledge of service delivery, can contribute significantly to developing policy that has a greater likelihood of being successfully implemented.

[16] Thomas & Gilson, (2008:280; Crosby 1992; Walt 1994) describe an actor as "an individual or organisation that has an interest in reform and has some power to affect policy's progress".

Policy outcomes are highly affected by environmental factors and the assumption that a policy decision made at central government can be smoothly implemented at lower levels has been questioned by, most notably, Pulzl and Treib (2006: 90). A large body of research exists focused on the extent, meaning, and sources of policy divergence between policy principles, often decided upon by a central government, and the final implementation of the policy (Hupe & Hill, 2007; May & Winter, 2007). Lipsky (1980) analysed the behaviour of public service workers[17], who he referred to as 'street level bureaucrats', reflecting that employees already created practices that enabled workers to cope with problems encountered in their everyday work. While there has been a substantial critique of this view (May, 2007; Evans, 2011), Hill and Hupe (in Pulzl and Treib, 2006: 93) credit Lipsky with developing methodological strategies that provide insights on street-level actors demonstrating that top-down approaches "failed to take into account that a hierarchical chain of command and well-defined policy objectives are not enough to guarantee successful implementation." This chapter draws on Lipsky's conception of street-level bureaucrats in relation to the role of private sector GPs, as the largest medical constituency in the country, in the development of the NHI.

5.3. Interview Findings

5.3.1. Degree of doctors' engagement with the reforms

The evidence suggests that only a small minority of doctors reported that they have actively engaged the state and/or private sector on policy concerns related to the NHI. This engagement was carried out either in their personal capacity or through their professional representative bodies:

> Doctors are a certain personality type, they make a lot of noise, but they do very little apart from what they do. You get the odd guy who comes out and wants to be the administrator and ends up on the board of SAMA (South African Medical Association), great, but for most of us, it's just not our thing. (LPP, M)

> I don't go to their meetings, so I don't know what's going on, you know, I just, sort, of, just see there's an AGM, I'm sure they're discussing a way forward... (S/SPP, M)

Many of the views expressed by the GPs supported the idea that doctors were not active agents in the policy process and that this was a shared characteristic common among doctors, who were more focused on their private practices than the professional environment in which they were located:

[17] Although Lipsky refers to public sector workers in his work on 'street-level bureaucrats', Hill and Hupe (2007: 283) interpret that "street-level bureaucrats may be either formal government employees or work in organisations that are seen as part of civil society...as public actors acting in the public domain, they are held publicly accountable for the results of their work." Therefore, for the purposes of this thesis there are lessons that are applicable to the medical profession, and private sector GPs.

> You know, I don't have time for [being an active member]. That's a major issue. I like my patients, my clinical work, my research work, I like to be there in those kinds of scenes. (MPP, R)

> ...not a lot of doctors are interested in the management of the whole system, they are interested in their practices. (Manager, R)

There was only very limited evidence of doctor's independent engagement with reform in their professional environment:

> I think doctors generally don't get their views out there. I think we're notoriously bad at that – we all sit and grumble in our own little consulting rooms or practices, and we're not unified, and it's come across in many other aspects...we're not proactive. (MPP, T)

Most doctors interviewed were not willing to take on responsibility for the low levels of engagement in their profession. They interpreted the low level of involvement primarily as a result of policy makers' disregard for doctors' point of view:

> ...I don't think government gives a toss about our point of view, I really don't. (LPP, M)

> I feel they're going to do whatever they want to do anyways, you know I can jump up and down, and cause myself a lot of stress, but I don't know whether it's going to make a difference. (SPP, M)

> Do they want to listen, or do they just want to pretend they are listening? At this stage they are not even pretending to listen so it is a big frustration. (MPP, T)

Those doctors understood government's disinterest as politically motivated[18] and that health sector considerations were secondary. Doctor's felt that this was particularly problematic as it indicated that health policy is being created at a distance from those who are meant to implement it:

> I know it's impossible to consult everyone but at the same time I think there are a lot of people who have been involved in various sectors for a long time and I think they probably have some useful insights in terms of potential stumbling blocks. (MPP, T)

> ...we so often get policy from people who aren't at the coalface – they're very bright and studied it all, but they've never actually worked at the coalface...they tell me the policy, and I just wish we'd had a say in it. (S/ SPP, T)

There was also fatigue and resentment at doctors having to adapt to a new system of health care provision:

[18] In Chapter Four interview respondents referred to the NHI health reforms as driven by a political agenda and as a result of politicking more than an effort to fundamentally restructure health care. In this Chapter, comments regarding political motivation had more to do with an interpretation by doctors that the reforms failed to acknowledge the role of multiple actors in the health reform environment, and thus the inability to consider the important contribution private sector GPs could make.

> I think that we are pawns, I think that we get told what to do and we do it. (Mixed Public and Private Sector GP, M)
>
> I think sometimes the medical profession feels like the enemy or feels like things are brought in and they are told to, 'Get on with it!' I think that sometimes breeds bad feeling where it's not necessary. (MPP, T)
>
> ...we've been told what to do for such a long time...medical aids tell us what to do, government tells us what to do, hospitals tell us what to do, and we don't have any financial clout at all.... (Mixed Public and Private Sector GP, M)

Younger female doctors from geographically diverse backgrounds raised concerns about the political context in which their views were considered and how this affected their inclusion:

> I want to be involved and make this thing work. What I'm scared of is that our opinion on the ground is not going to count for anything...I think the frustration is that unfortunately all the decisions are pushed through by politicians and a political agenda. (NGO Sector GP, R)
>
> I think we need to be actively involved too and finding out. It's become so politicised though, so one has to be very careful that one's not seeing it through those kinds of spectacles. (MPP, M)

A small percentage of the doctors did however feel that their independent inputs were valued and called for doctors to work collectively to make themselves heard. These responses emerged predominantly from the metropolitan areas:

> I think the government is listening to private healthcare, they are definitely very open about it...I think the [Minister of Health] knows he has got to work hand in hand with private health care because you know private healthcare makes it work, that's the bottom line. (MPP, M)
>
> If as a united body we speak with a single voice we have a greater chance of being heard. I think with our current health Minister who seems fairly pragmatic there's many of us who have hope... (MPP, M)
>
> ...it has been a very strong ally for us to be continuously inputting into policy and we have now built good relationships with the Deputy Director General (DDG) and the Director General (DG) who are in with the Minister of Health, we have got good links and they know about us...and they are keen to hear what we have to say which is a really great place to be. (LPP, M)

Furthermore, sensing the need to act decisively in order to proactively defend their profession a small sample of doctors argued for an active role in policy determination:

> I think if we just sit back and don't open our mouths it's being a bit naïve you know. (MPP, M)
>
> I think there are doctors that want to get involved...so for me, yeah, lets create a bit of tension, let's get people to get involved, and wake up, and start saying hold on, I don't like this, or I don't want this, and then what do you think we're going to do, how do you think we're going to solve these issues. (NGO Sector GP, R)

Nonetheless, although some doctors felt that it was necessary for the private sector to mobilise and become politically active many more doctors felt that they collectively lacked the organisational capability to do so. A small group of doctors warned that should they mobilise it would in all likelihood be disorganised and incoherent:

> ... [Doctors] who feel more threatened by it [will act], but nothing substantial. It will be an un-coordinated, tough semi protest and confusion as always, that's how it is. (MPP, T)

An interesting minority view of interviewees acknowledged that despite the lack of a unified position, doctors were still significant actors in the successful implementation of the reforms:

> Unfortunately we are not united...Be that as it may, if the doctors overwhelmingly are against [the NHI] it is going to affect the roll out, the implementation of the NHI. (MPP, T)

In contrast to the popular view that doctors did not organise effectively around political issues, a group of public and private GPs in Uitenhage[19] reported that they were well-organised, with 95% of doctors taking part in their local representative body, the Uitenhage and Dispatch Independent Practitioners Association (UDIPA). Doctors from the area described the set of circumstances that have given rise to their high levels of collaboration:

> ...we have a group of [private] GPs in town that are involved with the hospital... they were trained here, they did their internships here, they still have that link, and sometimes they will treat poor patients that cannot afford the private facility. (Manager, T)

> We have this managed care thing going where we supply a basket of services to a scheme, to local industry, and it works on a capitation basis. The more you save, you know the more cost effective you are, the better for the whole scheme. So we've got this group so we speak regularly and we discuss and we plan and strategise... (MPP, T)

During the interviews the UDIPA doctors explained the details regarding the 'basket of services' that they had been successfully running for sixteen years. The group spoke about their preparation of the Nelson Mandela Metropole as the Eastern Cape pilot site for the NHI, expressing their disappointment at not being chosen, although viewing their failure not as a result of their own doing, but rather as an unjust outcome of political meddling:

> ...it was a surprise when [the] nine areas were mentioned, nothing about Nelson Mandela Metro. And I suspect it may be because there was this politics, when it comes to the municipality here, the mayor and all that. But that shouldn't really be influencing how health should be run. (S/SPP, T)

[19] Uitenhage is a small industrial town on the outskirts of Port Elizabeth, the largest city in the Eastern Cape. Although still within the geographical boundaries of the Nelson Mandela Metropole, the practice dynamics, and demographic make-up of the medical profession is quite different to that experienced in Port Elizabeth.

The case study in Uitenhage is of great significance as these doctors were not only organised but had also structured a package of health care that was affordable to the surrounding population. They attributed the success of the scheme to a coordinated team effort. In the period leading to the launch of the NHI pilot in 2012, the UDIPA doctors were preparing to become an NHI pilot site and had managed to drastically reduce queuing times, while the main hospital was seeing up to 60% less patients who were instead being serviced by the surrounding primary level healthcare services.

5.3.2. Professional Representative Bodies: Relationships and Communication

To a large extent doctors' perspectives on policy related concerns were channelled through organised representative bodies such as local Independent Practitioners Associations (IPAs), national organisations such as the South African Medical Association (SAMA), and the Health Professionals Council of South Africa (HPCSA). These professional bodies maintain varying levels of activity and policy influence but serve as an important vehicle for relaying information to doctors about the latest developments affecting the profession. As a result of most individual doctor's unsuccessful history of mobilisation, they rely on their professional bodies to act as the link between government and the profession:

> The medical association is a voluntary association that most doctors belong to. If you don't you should. They've got a group for hospital doctors, a group for rural doctors, a group for junior doctors, a group for GPs. (LPP, M)

> ...that's probably where something like SAMA comes in, because there isn't really anything else. (MPP, M)

> ...we also have contact with the IPA so soon as something positive happens or something definite happens we will get knowledge of that... (MPP, M)

> And I know not everybody belongs to SAMA, but SAMA is more vocal when it comes to this. I'm hoping that as there are more vigorous debates, and people are challenging this thing. (MPP, T)

Doctors reported that in the last few years there has been a noticeable increase in engagement with medical representative bodies, especially SAMA. There was a broad consensus that they were gaining in prominence and audibility:

> I do have confidence in SAMA. Yeah. I do have confidence that they will represent me... (Public Sector GP, R)

> I think they [SAMA] are [communicating] now... they've repeatedly, and I remember when I've been at meetings, they've asked for people to make suggestions and things. My perception is we are being asked about it, we just need to support. (S/SPP, M)

Despite this heavy reliance on professional organisations to represent their views in the policy process, the few doctors that could speak of their involvement as active members of IPA's and/or other medical representative bodies spoke of low turnout to organised events:

> ...doctors aren't very good at sort of communication amongst themselves to be fair. I mean really honestly you call a SAMA meeting and even the annual general meeting and you have a twenty five per cent turnout so it's difficult say well have you been consulted when a lot of us don't even come if invited. (S/SPP, M)

The lack of interest was evidenced in the response of one particular doctor, who worked both for the public and private sectors, and already had some degree of flexibility in his work schedule:

> ...I had the advantage of been invited to one of the meetings through our IPA...but it was awkward because it was very windy and most all it was at 11:00...so it's a bit of a challenge because most of us we had to hire people to come for work. (Mixed Public and Private Sector GP, T)

Still other doctors felt that even though they personally communicated with their medical association and attended events, they were not convinced that their opinion was meaningfully considered by the organisation or further up the ladder, for reasons political or otherwise:

> I don't think SAMA represents my views very much... I tend to get the feelings sometimes that they are just pursuing their own [political] agendas...statements that they make on things that are not really the core business of SAMA. (Public Sector GP, R)

> I left my practice to go and attend that session, but when I left there I was good as somebody who had not attended... I asked specifically what is the role of the GPs in the NHI, [and] he said that will come in four years' time when the NHI will be implemented, that was his answer. (S/ SPP, M)

5.3.3. Influence of the professional representative bodies on government

Another significant issue was doctors' scepticism about their representative bodies' ability to represent them in policy discussions at a national level. In the doctors' opinions, this was reflected in the critically low levels of information that was distributed through these channels:

> I think SAMA has made a huge drive to become more in touch with their members...it didn't used to be like that so I think they have made a huge effort to try to keep people more informed, but I think with the NHI the problem is I don't think there is much information. (LPP/M)

> ...one only gets information through either medical journals or medical associations, groups practices, you know, so nothing sort of official from the government. (MPP/M)

A doctor who worked in both the private and public sectors explained that even if the medical profession and their medical professional bodies were aligned, they did not feel that these bodies

had the influence to represent the views of doctors. Instead, the lobbies for the private medical aids were considered to be more powerful:

> I think SAMA's toothless; I don't think they've got any power or voice really. I don't think that the PE general practitioners have much voice either, I think the main stakeholder drivers are the medical aid companies and the private hospital companies. (Mixed Public and Private Sector GP, M)

As private practice doctors are dispersed all over the province the process of public consultation does require a special effort in order for it to claim to be representative of professional sentiment on the NHI. Nonetheless, with only fifteen percent of interviewees reporting active participation in their local IPA or any other representative body, interview data evidenced very little to support a consistent, concerted effort to engage from the profession, a decision which could conceivably have a notable impact on doctor's subsequent feelings of exclusion.

5.3.4. Fragmentation of the Medical Fraternity

The lack of a mobilised response to the NHI could be attributed to a number of factors, perhaps most notably the fragmented nature of the profession along various fault lines, namely: specialist/general, geographical, racial, and public/private sector differences. While Chapter Four considered a number of conflicts arising from within the profession, predominantly regarding issues of autonomy and remuneration, there are also other concerns that may have contributed to the divisions within the profession. For example, the diverse backgrounds of doctors could be argued to have hindered the ability to convey a cohesive, common position:

> I think that we just don't seem to be able to spend that time organising ourselves, and a big factor is that we've all got such different views and come from such different standpoints, it's very hard to get a unified voice. (S/ SPP, T)

> ...it's a complex relationship... At the moment the medical fraternity in SA doesn't have a feeling as a whole community... there's no such thing as a uniform medical community, it's very splintered. (Public Sector GP, R)

> ...we don't really have much power or clout, or very good at actually unionising or getting together in South Africa, but it's always been like that. (MPP, T)

In addition to not being organised, a significant number of doctors referred to the 'lone wolf', 'isolated' nature of private practice as an obstacle to unified action. A further point raised was that of scheduling and the lack of time available beyond immediate practice responsibilities:

> Everybody sits, and looks into their little houses and rooms, and looks out their window, and nobody communicates, and, and there's this isolation in the way that medicine works in South Africa. (NGO Sector GP, R)

> ...we have admin to do we have patients to see, I mean I don't have any spare time to go asking around what's happening, what's expected of me. (MPP, M)

Moreover, some doctors made specific mention of the fragmentation along practice lines, linked to a particular vision of health care in the country:

> ...there's such a lack of unity amongst general practitioners that if one person stands up and says no I won't be a part of this system, you will just lose you patient base [to them] and you can't survive. (Mixed Public and Private Sector GP, M)

> I think that we're often quite arrogant, so we kind of feel 'well, we're in a good position, and let's see what they throw at us and we'll challenge it if it doesn't suit us'. (S/ SPP, T)

A regular comment made by private sector GPs, who were the majority of respondents, was the preferential treatment offered to specialists. There was a fear that if GPs did not defend their specific section of the medical profession, they would be disregarded altogether. This particular issue seemed to ignite a strong impetus to mobilise action, expressed most vocally by small and solo practices:

> The first people they come to when they want to do cost cutting or trying to save on things, are the GPs. We know the people that are the expensive guys, hospitals and the specialists. We need to prevent something like that happening as well, by negotiating strongly, that we get paid for doing the work. (S/ SPP, M)

> GPs lose skills because the specialists are doing everything...there's a lot more that can be done on a GP level...unfortunately what happens is well is there is inter-specialist referral. You go to a specialist for this and he says 'Oh you've got diabetes. Go to a specialist for diabetes,' instead of back to the GP, who's been looking after his diabetes for 10 years...and now all of a sudden he ends up at a specialist for his diabetes, not because he's got a problem... (S/ SPP, M)

Regarding fragmentation along geographical lines, doctors did not convey that there was a natural split between rural and urban practices, but rather an honest appreciation that life was much more challenging in the rural areas, where services are generally lacking. Employment in rural areas was an unfavourable prospect amongst young doctors, especially those with families:

> Rural areas are always going to have more challenges and they are going to struggle to attract more staff.... there are no easy answers to those things. (Public Sector GP, R)

> The medical aids often look at us and say 'well why are you giving so many things?' and I say 'well hello! I'm dealing with 20 different problems!', because we're dealing with rural patients that want to make it a one-stop-shop. (S/SPP, T)

A further example of fragmentation in the medical fraternity was revealed by a minority of doctors who overtly referred to the racialised nature of responses to the NHI proposals. This did not appear to extend to differentiated treatment of patients on the basis of their race. Instead, there was an

undertone that doctors' views of the NHI reforms as necessary or not were considered to be linked to their racial status:

> I think generally, I think the black doctors are more committed to it than the white doctors. I think already there is a bit of a divide anyway...I think the black people will generally be more committed to NHI than white doctors. (MPP, T)

> I get frustrated dealing with a lot of white people because they do have different views to me, and some of them are more conservative. Similarly, in medical circles I would have exactly the same frustrations...But certainly I get the sense that medical doctors, people in medicine are able to treat 'patients'...rather than race and class etc. (S/SPP, T)

Finally, when considering doctors' responses to fragmentation within the profession, divisions along public and private sector lines were generally explained as doctors from the two sectors holding fundamentally different perspectives on healthcare:

> I think that obviously private doctors and public sector doctors have very different perspectives on things and different priorities about healthcare...and speak different languages. I mean, I speak complete different language to my colleagues who are in private [practice]. (Public Sector GP, R)

> ...generally [public] doctors are overworked...and then this [NHI] is going to overwork them, unless those private guys join in...but it's going to be a challenge. Because apparently [the private GPs] make a killing, and then if they come here, how are they going to sort that out? (Mixed Public and Private Sector GP, T)

Although divisions within the public and private sectors could be expected, with oft-reported feelings from the private sector that they would lose the autonomy of choosing their own working hours, patients and salaries, there were notable exceptions. A few interviewees felt that the NHI might actually bring the public/ private divide closer together, illustrated by one particular comment from a Metro-based doctor:

> I think we are all in the same boat, everybody will be introduced to the same rules and regulations so I don't think there will be conflict between the doctors as colleagues, I think they will be more united than anything else. (MPP, M)

5.3.4.1. Effects of Fragmentation on Representation

The fragmentation reported on above has been represented as a hindrance to the independent organisation of doctors. In addition, these divisions were also described as a significant factor undermining the ability of professional organisations to promote the views of the GPs:

> SAMA can't represent doctors' views as a whole, because...they all have different needs. Private-sector doctors feel very differently about this than those of us working in rural health...if my priority is access to healthcare, that's a very different issue than if you've got a thriving private practice in the centre of town. (NGO Sector GP, R)

> I just think we are scattered at the moment, because everybody is running their own practice day to day, so government needs to either go to the IPAs and say go to your doctors, or get all the doctors together at some stage. (MPP, T)
>
> ...they are often very strong, vocal, dynamic people who want things to be done their way, so they get very easily bleak with SAMA if they feel like the private side is undermined. (LPP, M)

Exemplifying the enduring impact of apartheid spatial planning, which forced citizens to inhabit exclusive racial enclaves in urban environments, a young black doctor who was running a private solo practice in a lower income, mostly black part of East London noted that:

> We have had about seven meetings with the Minister [of Health]. Let's say this that (*gesturing opposite side of town to himself*) side of town, guys didn't come at all, they weren't bothered about it, whereas a lot of guys from this (*gesturing his area)* side of town were at the meeting. (S/SPP, T) (Emphasis added)

In this particular interview response the doctor was referring to the doctors on the side of town where his practice was located as engaged with the reforms, while he observed that doctors from the opposite side of town, historically dominated by medical practices run by white males, serving predominantly white clients, showed little interest in attending meetings. This stark expression of disengagement with the reforms, viewed by this doctor as due to the historical privilege of white doctors based in the country, was reflected in other comments. The first comment was expressed by a young white female doctor, the second by a young black male doctor:

> The problem with doctors is, they're not getting engaged... and its unfortunately an inheritance of our rich private background – I grew up out of a family of rich private doctors all running private practice – and in that you start losing your vision of what medicine is about. (NGO Sector GP, R)
>
> ... those other doctors that I talked about that didn't come to meetings, they think that they have a certain type of patient who will be able to afford the more expensive medical aid, who will be able to pay cash if they need to because they earn enough. So if you are seeing that type of patient, you can refuse, you don't have to see NHI patients. (S/SPP, T)

The comments quoted in this chapter reveal that there are diverse, and at times conflicting, reasons for doctor's lack of engagement in health policy making in South Africa. This is broadly consistent with literature on doctors' participation in health reform globally (Murray & Elston, 2005: 716; Cancel, 2007). Notwithstanding this similarity, it must be noted that the particular patterns of racial exclusion and societal division was a consistent feature of this thesis' interview data. Most notable was the relative distance private sector white doctors felt from the concerns of public medical facilities and concerns. It could be argued that the historical and spatial cleavages of apartheid have fundamentally impacted the present-day divides in the medical profession (Harris et al., 2011; Kon & Lackan, 2008).

5.4. Discussion

This chapter has evaluated the views of doctors on the health policy process in South Africa, alongside perspectives on their ability to influence the direction of the NHI. The interview findings revealed that doctors do not have a homogenous approach to the NHI reforms, with responses ranging from a minority of highly engaged doctors to a majority of uninvolved individuals and practices. Thus, quantifying doctors' overall willingness and ability to affect the policy direction of the NHI reforms must consider a complex variety of perspectives, including widespread fragmented representation within the profession.

The three broad areas of analysis in this chapter were: (a) the degree of doctors' engagement with the reforms; (b) doctors' relationships with their medical representative bodies and the perceived impact of the medical associations' influence on government policy; and (c) the effects of fragmentation within the profession.

In the first section, analysis was aimed at assessing doctors' engagement with the NHI reforms. There was a generalised view expressed that the medical profession were not involved in policy deliberations on the NHI, and for those doctors who reported interest in engagement, a significant proportion felt discouraged, believing that their views were not valued. In the interview data this latter viewpoint was largely justified as a result of the reforms being politicised and the outcomes of the NHI pre-determined. A minority of doctors who were more positive about their ability to influence the policy reforms engaged, partnered, and relied upon larger representative bodies, although widespread disorganisation of the profession often hampered efforts at collaboration. Notably, doctors referred to instances where lack of a unified position had resulted in doctors reacting very slowly to reforms which had an impact on their practices. In this respect many doctors used the example of government legislation which now restricts practice level dispensing of medication, and the introduction of dispensing licenses, an issue which they came to later fiercely defend (Gilbert, 1998). Surender et al. (2014) refer to the reactive nature of the South African profession, rather than being proactive, reflecting that doctors appear to spend more time opposing reform than initiating it. The doctors' interview responses concurred with Surender et al., reflecting initially dramatic responses to the unknown before they "moaned and grumbled, dealt with it and got on" regarding changes affecting their immediate working environment. In addition, as a result of the last two decades of health reform (summarised in Chapter Three), it is possible that policy fatigue could have a role in explaining the passivity of doctors in relation to engagement in policy processes. Similar expressions of political fatigue were reported by doctors confronting legislative

changes in the UK NHS, viewing themselves as "victims of Ministers in a hurry, having to take the blame for the government's miscalculations" (Klein, 2006: 412).

The second section of the chapter addressed the expectation that doctors' relationships with their medical representative bodies would be vital as a conduit to maintaining influence, given the fragmentation and disorganisation within the profession. While doctors generally conveyed the view that SAMA had increased its legitimacy in the last decade (Kahn, 2015a) there was no widespread reporting of the organisation's involvement in policy discussions. Furthermore, doctors also shared that there was no strongly held belief that SAMA had influence with policy makers in government.

This position can be contrasted with that of Ghana where, faced with severe political wrangling, health networks attempted to go beyond traditional methods of engagement with national government and instead engaged organised labour in the health sector, ultimately asserting their interests in the face of a state-driven policy agenda regarding the NHI (Agyepong, 2007: 155; Shiffman et al., 2014). However, this type of mobilisation requires a strong sense of community. Adler et al. (2008: 361) argue that the doctors' ability to organise is contingent on their collegial relations and high "claim to professional status" using community networks as an influential principle in organising the groups work. Particularly salient for South Africa's NHI policy process are findings from case studies which show that the most successful 'part-time district surgeons' (PDS) schemes in South Africa were those that used a more 'relational' rather than formal contractual approach (PRICON Study, 2000). In Australia, when Medibank health insurance proposals were presented, government leaders faced fierce opposition from key players within the health policy sector. Prior to this turning point, one of the key health policy players—the Australian Medical Association (AMA)—had developed a corporate partnership with the non-Labour government. When the Medibank proposal emerged, power structures in the health policy arena were re-aligned. The political role of the AMA shifted from a corporate partner to a pressure group, reflecting the collective power of a group aligned to the same goals (De Voea & Short, 2003). In South Africa, the low levels of organisation reflected in the interview findings in which doctors report feelings of isolation could contribute to why they doubt their ability as a profession to influence the direction of the NHI.

The third section addressed the significant fragmentation within the profession in order to explain the lack of organisation among doctors. Fragmentation was reported along practice lines, sector differences, racial schisms, and geographical disparities among others. McIntyre et al. (2003: 49) argue that the public–private health sector disparities are one of the most serious impediments to developing an equitable health system in South Africa. As previously discussed in Chapter Two, it is

possible that some of the issues highlighted by the doctors could be more pronounced in the Eastern Cape, due to the damaging apartheid legacy of the province's fragmented and under-resourced health care system. However, this fragmentation is also reported in other international studies and has affected the ability of doctors to mobilise in multiple circumstances, including in Chile (Murray & Elston, 2005: 716), and Venezuela (Cancel, 2007). These international experiences contribute to a perception that the profession is vulnerable to divisions, which in the South African context have been accentuated, particularly given the specificities of race and spatially differentiated practice settings in the Eastern Cape.

Acknowledging the above, and linking the fragmentation expressed in the interviews to Lipsky's core belief that front line workers are key to policy development, Anand and Bärnighausen (2012) argue that the traditional health systems frameworks fail to place health care workers as the core consideration. They maintain that this is counter-intuitive as health workers are the foundation of the health system:

> Every function of the health system is either undertaken by or mediated through the health worker. Health workers play a critical role in the choice of treatments, and in curative and preventive care. Much of health-system financing is directed to health workers (through salaries and associated payments) and most other spending decisions are directed by health workers (through prescriptions, referrals and equipment purchase) (Anand & Bärnighausen, 2012: 190).

This viewpoint was reflected by some of the doctors in the interview data who reflected that the policy process had not incorporated the viewpoints of some highly experienced doctors in the reform process. Following this perspective, the doctors' role is not restricted to that of actors in a policy making process, but that to a significant extent they are also implementers of policy. The political character of this role is implied by the fact that the tasks of 'street-level-bureaucrats' ultimately involves "the allocation of particular goods and services in the society" (Lipsky 1980: 84). In another context, and perhaps in response to this sense of exclusion, the American College of Cardiology (guided by a professional ethic) have taken the initiative to get involved in health reform and improve the quality of health care as they feel that physicians on the front line have a particular responsibility to be proactive (Dove et al. 2009). However, not all systems have struggled to encourage professional participation. Klein (2013: 34) argued that in the early days of the National Health Service (NHS) in the United Kingdom, professional views of what services were needed and how quality should be assessed were highly valued, and doctors concerns were received with "perverse incentives" allowing doctors to permeate decision-making of the NHS at every level (Klein, 2010: 40-2).

McIntyre et al. (2003) also reflect on Southern African examples of attempts to incorporate the views of the profession, cautioning that the trade-offs that are made to accommodate key actors' views have the ability to undermine the achievement of key policy objectives. Thus, considering Klein's (2013: 248; supported by Walt & Gilson, 1994) basic premise that policy-making in the health arena can only be understood in the wider political context, it follows that determining key actors is not only limited to those who align to the key objectives of policy, but also those who will contribute to its successful implementation.

In actor-centred policy analysis, local bureaucrats can be seen as valuable actors in policy delivery, questioning the idea that policies are defined at a central level and that implementers are merely subject to these (Pulzl and Treib, 2006: 90-3). The SA medical profession has not been totally inactive however, and has exerted its authority in recent years, including delaying government attempts to issue a 'Licence or Certificate of Need' in 2004, and the court victory for the profession in the 2001 'dispensing row' (Pretorius et al., 2012). Nonetheless, despite the large numbers of GPs in South Africa, they are by no means a cohesive and well-organised single body. Representation of doctors and the various bodies that purport to stand for the profession, agree that doctors' general attitudes towards activism, constructive engagement, and communication convey a lack of will power, organisation and focus. While the state should actively seek the engagement of all possible stakeholders in order to make policy work, it could also be argued that as professionals who have valuable experience and knowledge to impart, that the profession itself is also responsible for sharing their views and opinions, and to challenge policy makers to listen to their inputs. Wuyts (in Walt and Gilson, 1994: 365) argues that "State institutions are influenced by public action, and in turn provide the means through which this action is sustained or modified." It is arguably a powerful tool for mobilisation to identify the particular characteristics inherent in the profession that will facilitate the development of norms and sanctions that can motivate doctors to work for the public rather than their individual good. Inclusion of the medical profession in policy deliberations supports contemporary defendants of professionalism who argue that recognition and appreciation of the medical professions' unique characteristics of "expertise, ethics and service" (van Mook et al., 2009: 81) may positively align with financial incentives in motivating doctors to engage in public health reform (Willis-Shattuck et al., 2008: 3; Cruess et al., 2000).

5.5. Conclusion

The interview findings from this study suggest that the South African government has not yet been able to convince the majority of private medical doctors, in particular GPs, that the NHI scheme is a viable, or indeed desirable, alternative to their current practice. In addition, although there are

complex factors affecting cohesion of the South African medical community, interview findings suggest that the South African government has failed to make the medical profession feel that they have an influence in determining its direction, whether independently or through their medical representative associations. As doctors working in private practice constitute nearly 70% of the total number of GPs working in SA, there is a strong argument to be made in support of the view that they will need to be convinced of the reform proposals, and their role to play, if the NHI scheme is to be effectively implemented.

Chapter Six: Recommendations and Conclusion

6.1. Introduction

This concluding chapter seeks to revisit some of the original research questions, attempting to summarise and contextualise the key findings of the thesis. The conclusion will reflect on the following questions, (i) What can be inferred from the responses of the GPs interviewed about the nature of consultation by government?; (ii) How useful are the theoretical frameworks employed in this thesis for understanding and explaining the responses of the South African GPs interviewed about the proposals contained in the Green Paper? And finally; (iii) What are the possibilities and limits of an 'actor-centred' approach for understanding health policy reform in South Africa? Are there unique characteristics of the medical profession that guide their actions?

This thesis will then offer some recommendations based on the research findings laid out in the previous three empirical chapters, before making some concluding comments.

6.2. Summary of research problem and objective

The main research focus of this thesis is the role of the private practitioner in plans to develop a universal system of healthcare, as analysed through a series of 78 detailed interviews. Sub-questions and themes interrogate the degree to which GPs feelings of exclusion have been acknowledged by the South African government, whether in fact the perceived lack of acknowledgement is indicative of who the government intends to include in the policy conversation, and what literature exists that can assist in understanding the role of the private sector in redistributive healthcare reform.

The health landscape in South Africa is complex, largely as a result of the racialised polices the South African government implemented during apartheid. Faced with the socio-economically differentiated levels of access to healthcare, the objective of this thesis was to use the interviews with doctors to gain an understanding of the policy formation process, the extent of the interaction between the different actors involved in health policy reform, as well as power relations present within such interactions between the key actors, particularly using the lens of actor-centred policy analysis.

6.3. Summary of research findings

Doctors reported on a wide range of concerns across the two qualitative research chapters. Chapter Four focused on general issues of the NHI regarding: doctors' perceptions of government

commitment and capacity to institute the reforms; impact of the reforms on doctors' personal daily practice; and conflicts of interest that could emerge within the profession. In Chapter Five doctors gave detailed inputs on their perceptions of the extent to which they were able to influence the direction of the NHI under the following sub-themes: the degree of doctors' engagement with the proposed health policy reforms; the relationships of doctors with their medical representative bodies; the perceived impact of the medical associations' influence on government policy, and; the fragmentation within the medical profession in relation to the NHI proposals. Preceding the two interview data chapters, Chapter Three detailed a desktop research study of the health policy trajectory in the country, and a review of submissions on the Green Paper in order to contextualise the interviews and offer a broader sample of responses to the NHI Green Paper.

The information emerging from the interviews with doctors was rich and multifarious, with strong recurrent themes. The majority of the doctors interviewed spoke frankly about their perceptions of the proposed NHI reforms as well as their current, and future, envisioned positions in the system. The interviews were conducted just as the first NHI pilot sites started to contract private doctors, and doctors conveyed strong opinions about how they could foresee contributing to better health aims in the country, with all doctors acknowledging that the current health system was inequitable. However, while acknowledging the faults within the current health structure, most doctors framed redress in ways that would not have much of an effect on their current autonomy, income and range of choice. Low levels of remuneration and poor working conditions were consistently cited across the different thematic areas in the interview schedule as detractors against entering the public health sector. Above all, despite doctors strong views on the NHI, one omnipresent concern expressed across the interview cohort was the lack of agency doctors felt they had to influence the NHI, with the resigned opinion that the policy course had already been plotted. By and large, the NHI was not considered by the majority of doctors interviewed to be the most efficient way to address the poor health outcomes in the country.

6.3.1 What can be inferred from the responses of the GP's interviewed about the nature of consultation by government?

Gauging from the responses of GPs interviewed, the nature of consultation by government was considered inadequate. This was strongly supported by many of the other submissions on the Green Paper on NHI from a range of civil society and private organisations who submitted comments. Among those who criticised the low levels of engagement was the South African Medical Association (SAMA, 2011:6), an organisation with a membership of more than 17 000 doctors, making it the largest representative body for medical professionals in South Africa. Despite the SAMA

representing such a large number of doctors it also complained about the poor consultation and the 'lack of detail' specifying where GPs would fit in the NHI (SAMA, 2011: 9; SAMA, 2011: 15). Given the significant network of doctors that SAMA manages, it is striking that they have the same complaint as the medical profession themselves. Considering that concerns of low levels of public participation extended beyond the private GPs, it does appear that on the issue of consultation and conveying clarity, the South African government did not invest enough time and resources into engaging with the public regarding the reforms. Thus, it could be ventured that the private medical profession themselves were not excluded on principle, but rather that their exclusion was one part of a low information campaign run by the government. Furthermore, given the high levels of fragmentation reported by the doctors, it is unsurprising that when the national medical association representing the 'interests of doctors' does not feel informed that there will be a consequent lack of investment in the outcomes of the NHI.

In addition to the interview data, analysis of the post-apartheid health policy trajectory of the country reveals that there is no single, clear position regarding the South African government's engagement with the private health sector. While public-private partnerships have often been a site of tension, they have remained a feature of the policy discourse of the country. This unstable partnership has persisted despite fundamental differences in policy approach among the state's core alliances, with the Congress of South African Trade Unions (COSATU) vocally expressing their disagreement with the increasing involvement of the private sector in directing the policy direction of the state. The lack of clarity in the policy space does appear to have caused some confusion in the public policy arena, also making it difficult to conclude whether the private sector have been completely excluded from the process or whether they will be brought in at some stage on state-defined terms. With an inconsistent policy approach it is thus difficult for GPs and representative bodies to determine what their position is in the policy space can and should be.

6.3.2 How useful are the theoretical frameworks employed in this thesis for understanding and explaining the response of the South African GPs interviewed about the proposals contained in the Green Paper?

The theoretical frameworks employed in this thesis have attempted to map out the stakeholders in health policy reform and to ascertain where private doctors locate themselves, where the state places them, and what that means for the NHI. The concepts of power and influence are present themes throughout the discussions both regarding the policy process (Walt, 1994; Walt and Gilson, 1994), and the discussion on professionalism (Freidson, 1994: 10; challenged by McKinlay (1972) and Haug (1969); Klein (2013)). Given the examples presented of health reform globally, both the state and the medical profession have proven to be powerful stakeholders in the process. In the case of

the South African NHI, assessing who holds the balance of power and influence is a complex matter. The available evidence suggests that the state appears to be driving a redistribution agenda, necessitated by the overt deficiencies in the delivery of health care to the country's poor. Conversely, private doctors have conveyed that they feel they do not hold power, and are subjected to state policy, which they view as pre-determined. The complexity is that ultimately the NHI cannot be resourced without employing the services of the existing doctors in the country to take on more of the work load. As such, the redistributive aims of universal health coverage, and the motivations driving the private sector health will need to be reconciled. This thesis has produced evidence suggesting that private sector doctors have always been resistant to nationalisation or socialisation as a threat to their occupational power and professional status (Freidson, 1973; Gray, 2002; Klein, 2010).However, historical and comparative evidence also suggests that whenever health systems have undergone radical reform, the role of the medical profession has remained crucial in determining its eventual success and character (Klein, 2010; Rodwin, 2011).

The SAMA General Private Practice Practitioners Committee (GPPPC) (SAMA, 2011: 50) noted in their input on the NHI Green paper that 55% percent of GPs would apply for the NHI, and that for 38% of GPs, enhanced remuneration would be an immediate incentive to move to the public sector. Based on these statistics, for over half of private doctors registered with SAMA the NHI was a viable opportunity in financial terms. Atun (2012: iV6) argues that in health systems, a helpful tool for understanding the resistance of the private sector GPs is to contrast the ideals of 'innovation' and 'diffusion' in improving both method and outcomes. Atun explains that adoption of any innovation, which the NHI could be categorised as, has a large amount to do with how it is perceived, which is directly related to how it is communicated or diffused. If the dynamism and innovation of the NHI is not properly communicated, and significant stakeholders are not brought on board, the unintended consequences, as described by Ridde and Diarra's five elements of the policy analysis framework (in Hercot et al., 2011: ii6) could outweigh the originally intended outcomes.

6.3.3 What are the possibilities and limits of an 'actor-centred' approach for understanding health policy reform in South Africa? Are there unique characteristics of the medical profession that guide their actions?

To echo Walt's (1994: 1) assertion at the beginning of the thesis, one of the central tenets to policy formation is chiefly concerned with "who influences whom in the making of policy and how that happens". Given that influence is a key determinant in shaping policy outcomes that will suit the private sector, it is striking that doctors widely reported a mixture of both exclusion and apathy in relation to the policy process. While it does appear that the consultative process in general lacked rigour and application, there has also been a lack of action and an extremely low level of

involvement from the medical profession. Lipsky (1980) placed immense importance on the front line actors in healthcare, as they physically shape policy in their daily practice. Doctors are important stakeholders in the South African NHI and it is important to understand their apathy. Given the evidence produced in this thesis that doctors coalesce together when experiencing threats to their professional status, it is possible that private doctors do not feel significantly threatened by the NHI. This is evidenced in the low belief in government ability, but also links to another, more insidious characteristic of the profession. In Chapter Three, which details the varied policy positions of the numerous parties who submitted comments on the NHI Green Paper, representative bodies such as the SAPPF, Econex, Discovery and Medi-Clinic were highly protective of the interests and independence of the private sector. Indeed, this thesis was able to engage with a member of the technical committee on NHI, who preferred to remain anonymous. In their interview they spoke of the intense mobilisation of the lobbies to avoid the negative effects of the NHI on the private sector, including offering powerful positions within the private sector to state officials in order to neutralise their opposition. Put in the context of the deeply divided moral imperatives of the private versus public sector in the healthcare lobby, the lack of urgency around the private sector to mobilise around the NHI becomes more understandable.

The possibilities of using an 'actor-centred' approach to analysing the NHI provides insights on the actors who need to be mobilised on the front lines to make the policy reforms work. In this vein, McIntyre et al. (2003) reflect on Southern African examples of previous attempts to incorporate the views of the profession, cautioning that the trade-offs that are made to accommodate key actors' views have the ability to undermine the achievement of key policy objectives. One cannot, and should not, ignore the racially divided history in South Africa which necessitates the need for radical transformation of the health system, disrupting the traditionally racially segregated private sector which has for a very long time excluded the well-being of the country's most needy. However, this reveals the limits of using 'actor-centred' approach in South Africa: if the most important actors view themselves as somewhat apart from the aims of the NHI, a view which is reinforced in a large proportion of the interview data analysed, then focusing time on winning them over is unlikely to be particularly productive.

The doctor's views on the NHI are by no means cohesive, and although the majority of doctors did speak about their practice in terms of market-related language, there were doctors who had a more inclusive view of healthcare in the country.

Many of the doctors' more negative responses were influenced by the low levels of belief in the state's ability to convincingly hold the space, often from experience working in the public health

service in the Eastern Cape particularly. SAMA has stated that many of the assertions made about the private sector and its interests are:

> ...unsubstantiated and are a reflection of the deep seated negativity that exists in certain sections of our society towards the sector. We respectfully submit that the current state of the problem calls for a lot of pragmatism from all stakeholders. The ideological rhetoric that characterises some of the debates and some of the assertions made in the Green Paper are indeed not helpful. It is also not helpful to attribute the current failings of our Public Health Care system to the Private Sector only. A case has been made that the Private Sector should be viewed as a national asset. We would therefore propose that the current debate should be about how the resources in the Private Sector can be accessed. (SAMA, 2011: 65)

6.4. Recommendations

This thesis has explored the role of doctors in the NHI from a perspective of policy, theory and analysing doctors' interview responses on the NHI. With the release of the White Paper on NHI in December 2015, the South African government recommitted themselves to the ideals of the NHI, and notably given a fiscal environment in which there have been drastic budgetary cuts, the NHI has remained largely unscathed (Forslund, 2015). Thus, reaffirming its commitment to proceed, the state has had to decide how it will staff the comprehensive health reforms, and have indicated that they will bring on the private sector on a sessional basis. Responses from the private sector have been relatively negative both to the conditions of work, as well as the levels of reimbursement that they have been offered. This does not bode well for incentivising private sector practitioners to leave private practice to contract their services to the state.

Gilson (2012: 28) states that while health policy is most commonly understood as the formal, written documents, rules, and guidelines that present policy-makers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health, this is a one dimensional view of policy in implementation. Formal policies are then translated through the decision-making of policy actors in their daily practices, for example through doctors. Ultimately these daily practices become health policy as it is experienced, which may differ from the intentions of the original documents (see Lipsky, 1980). Therefore, "policy can be seen not only as the formal statements of intent but also as the informal, unwritten practices" (Buse, Mays & Walt, 2012).

There are varied reports that conditions in the pilots have been very challenging, in Gert Sibande district in Mpumalanga, doctors have reported anonymously that equipment was broken or missing, patient files were a mess and there was no district leadership to support them. "At the moment we have no drips at this clinic, meaning if a patient can come in here bleeding I won't be able to help them," said one doctor, who quit working for the district because it was impossible to give proper care (Cullinan, 2015b; Mkhwanazi, 2015). Some of the challenging realities of the NHI pilots may

require a more urgent and concerted effort by government, as "fewer than 200 of the 8,000 GPs working in private practice have agreed to work in public clinics" since the NHI pilot programme was launched" (Kahn, 2015b). In Umzinyathi district in KwaZulu-Natal officials said that a number of GPs felt that the R381 hourly rate being offered by the department was too low so declined to work in the public sector (Cullinan, 2015b; Mkhwanazi, 2015). These low levels of buy-in persist despite a national roadshow by the national Minister of Health to talk up the benefits of the project.

In the case of the implementation of the NHI, the policies will not get implemented without enough doctors being brought on board. Earlier in Chapter Two, Walt and Gilson's policy triangle placed actors at the centre of the policy process, distinguishing between individual actors, and actors in groups. There needs to be a level of understanding from the side of government that they need doctors to staff the laudable health reforms proposed and for that reason there must be space to incentivise the private sector. That said, it is also important to maintain the policy intention, and to not allow the market-related interests of the private sector, based on profit, to corrupt the intention of universal health coverage which is affordable, quality public health care, free at point of service.

As stated in the White Paper on NHI, it is important that "healthcare should be seen as a social investment and should not be subjected to market forces where it is treated as a normal commodity of trade" (NDoH, 2015b: 1). As such, it will require careful management on the side of the policy decision makers to balance the original policy intent with the necessary methods in order to attain the goals.

6.5. Concluding remarks

In the context of relevant literature, many of the doctors' sentiments expressing lack of influence and control in the NHI reforms do not appear unique either to the Eastern Cape Province or to South Africa (Joudrey & Robson, 2010, Willis-Shattuck et al., 2008). The evidence suggests that until such a stage that GPs feel that they are valued, and that their professional autonomy, training and specialised knowledge is respected, the NHI will struggle to convey its message convincingly, and in a manner that will encourage private sector buy-in. While this tension complicates the implementation of the NHI, it could also be argued that while government should always strive to be inclusive in its policy processes, it cannot be held solely responsible for including stakeholders who themselves express disinterest in being involved in what they agree is a necessary health reform. The private sector lobbies are already working tirelessly to mitigate the effects of the NHI on their businesses, and at the point that doctors feel pressure, they too will enter the fray to defend their interests.

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