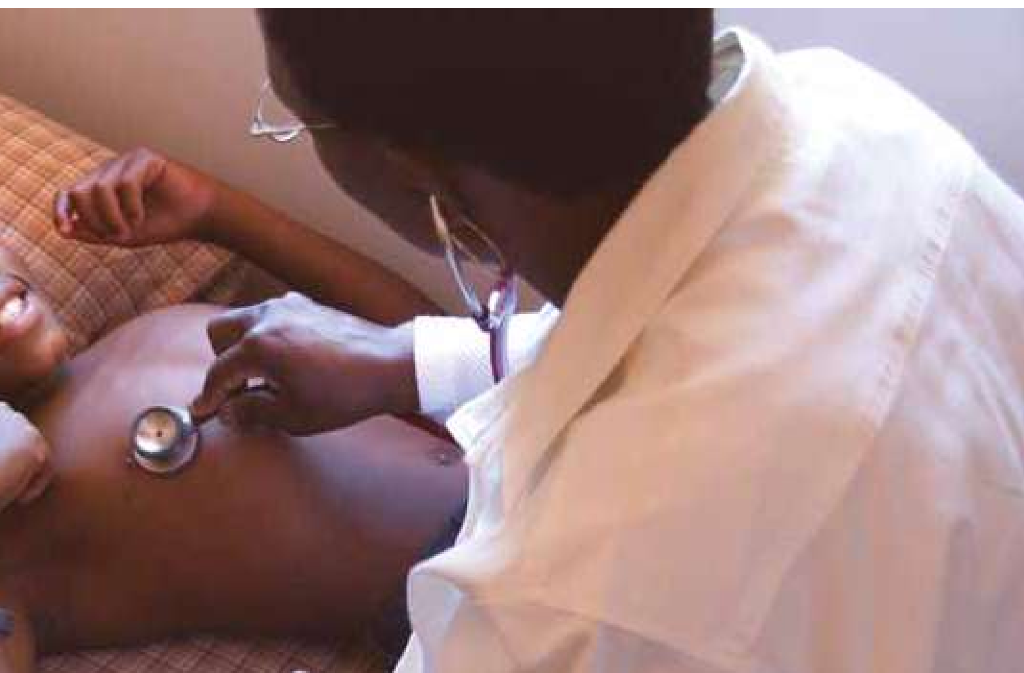
	Male	22 (52.4%)
	Female	20 (47.6%)
	Mean	43.3 years (30 – 62 years)
	MBchB	30 (73.2%)
	BSc + MBchB	5 (12.2%
	MBchB +Diploma	3 (7.3%)
	MBchB+MMED	1 (2.4%)
	BSc + MBchB + MMED	2 (4.8%)
t Practitioner	Mean	12.7 (1 – 37)
n	Mean	11.1 (1 – 30)
on	Mean	10.7 (1 – 37)
	Yes	14 (33%)
	No (renting)	28 (67%)
	Mean	8.8 (1 – 21)

the slow uptake was that the
oroughly explained.

existing licences were renewable, with only 14 (33%) GPs indicating that their licences were continuous (i.e. with no expiry date).

Availability of human resources

All practices had at least a receptionist, with the majority having one or two support staff (78.6%). Overall, all GP practices were equipped with and/or had access to basic and functional equipment required to provide general practitioner services which included the following index equipment: otoscope, ophthalmoscope, electrocardiography, ultra-sound scan, spirometer and audiometer. In addition to these index pieces of equipment, most facilities met the basic infrastructure requirements to be registered as practice settings in South Africa.



Practice registration	Yes	38 (90.5%)
	No	4 (95%)
Practice form	Solo	36 (87.8%)
	Solo with locum/ salaried doctors*	2 (2.4%)
	Group as partnership	4 (9.8%)
Cash fee adult uninsured	Mean	R311.46 (R130 – R400)
	Mode	R300.00
Cash fee children uninsured	Mean	R247.86 (R95 – R320)
	Mode	R250.00
Dispensing licences	Yes	36 (85.7%)
	No	6 (14.3%)
Average number of patients seen per day	Mean	30.9
	Mode	30.0
	Mode	25.0

*Notes: * Doctors working in a solo practice either as locums or salaried.*

Source: C Hongoro, 2016

Low uptake of government general practice contract

At the time of the study, none of the GPs interviewed in the district had signed up to the national GP contract. A myriad of reasons for the slow uptake were provided, but the key reason for the slow uptake was that the contract was never thoroughly explained to them and attempts to do so were more information sessions, with very little interaction between the public officials and the potential private contractor GPs.

Most GPs were uncertain about the conditions of the contract, while a few respondents indicated that the contract remuneration was indeed very low. A notable number of the GPs indicated that they were not offered the contract, which corroborates the aforementioned finding of lack of information about the proposed contract.

Despite the fact that most doctors did not sign the new contract, the state contracts (70.7%): with the district (51.6%), regional hospital (11.9%), central hospital (16.1%) or a combination of these (9.6%). Only two GPs acknowledged having service contracts with a community health centre in the district.

Those who had state contracts indicated that they were contracted for an average of 23.93 hours per week, ranging from 6 to 80 hours. The reported mean hourly contract rate was R308.64, with a minimum and maximum of R75 and R850 respectively.

Responses to a question of how satisfied they were with their existing contracts were overwhelmingly positive, which is surprising given the non-uptake of the NHI or national contract. Over 66.7% of the GPs agreed or strongly agreed that they were satisfied with their existing state contracts, with the remainder somewhat indifferent or disagreeing. Within the existing other state contracts, GPs reported consulting on average 30 patients per day, ranging

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The study showed that there is a sufficient number of independent doctors that could be engaged to support primary care services in the district.

average of 31 patients seen per day, the proposed NHI per capita primary care utilisation target of 3 to 3.5 visits per year is likely to be met through such contractual arrangements.

An advantage was that the majority of the general practitioners in the districts originally came from that district and fully understood the local socio-economic-cultural context and were therefore more likely to stay in those communities if their employment and business expectations were met through the proposed national contract.

Overall, the capacity to deliver clinical services on behalf of the state at primary care level was evidently available as most GPs had the basic supportive human resources, equipment and health information infrastructure to even support other forms of contracting, such as contracting out public patients to GP practices.

For a district with a population of 1.4 million people, the possibility of having 1 GP per 22 000 population, although normatively not ideal, is significant for a rural district.

The critical question is how these GPs would be distributed or located to ensure that they are accessible to all who need their services. Contracting provides the opportunity for the government to purchase services from GPs for specific areas where there is need.

Addressing the low uptake

Low uptake of the national GP contract was largely due to a variety of factors that can be explained by inadequate communication and consultations with the local GPs on contract details; that is, on services to be rendered, payment levels and additional compensation for related expenses such as travel, working regime, contracting-in and -out options.

Misunderstandings create mistrust and apprehension, which are fundamental antitheses of an effective GP contractual arrangement. Most GPs are interested in signing a national GP contract provided it is flexible and allows them to continue with their practice and the remuneration remains competitive.

Engagements with the GPs ought to be based on mutual respect whilst providing for wider contractual choices. The findings suggest that whilst GPs are interested in contracting with government, they had variable preference of contract design, which means that a one-size-fits-all contract is not advisable.

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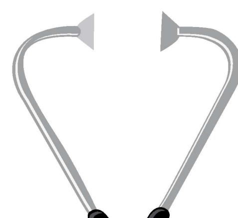

This article is based on Hongoro, C., Funani, I.N., Chitha, W. & Godlimpi, L. (2016) An assessment of private general practitioners contracting for public health services delivery in O.R. Tambo district, South Africa. Investment choices for South African education. 6(525):73 – 79.

Author: Professor Charles Hongoro, director

Suggestions for improvement of the curr...

- Improve availability of basic equipment, drugs ... and stock management)
- Improve working conditions by employing mor... and spread the workload
- Improve staff time management in patient care...
- Administrative support units such as HR must ... staff
- Provide decent accommodation and recreationa...
- Improve the referral system and decongest refe...
- Provide opportunities for staff to develop them... training