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Managed Health Care and the Professional Autonomy of Medical Doctors in South Africa: A Normative Assessment

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the degree of MSc (Med) in Bioethics & Health Law

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Declaration

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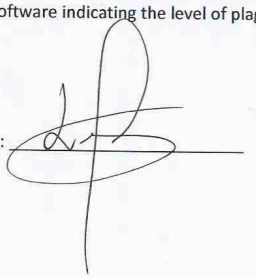
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I dedicate this work to my wife, Sarona Lengana, who has been my source of inspiration and support throughout this time.

Abstract

Spiraling health care costs have posed a threat to access to health care for scheme members, as more has to be done with even less. Managed care programmes were introduced to control the health care costs by reducing medical doctors autonomy. My aim was to ascertain the extent to which the managed care processes impede medical doctors' autonomy. Principled conditions were identified where the limitation of doctors' autonomy as a result of managed care could be morally justified which include where implementation would result in a just distribution of resources and a limitation of medically futile treatment.

However principled conditions where these managed care tools would not ethically be justified included where they would result in adverse patient outcomes, where they result in a loss of medical doctors morale or where they result in reduced trust in the patient doctor relationship.

Acknowledgements

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1. INTRODUCTION

1.1. Introduction

In an open letter to key stake holders in the public and private health care sectors, Grobler (2013) highlights some of the difficulties medical specialists are experiencing due to health management policies which he feels are impeding the doctor-patient relationship. He goes on further to claim that these policies risk ruining clinical medicine, diminishing clinical autonomy and compromising patients' well being. The concerns expressed do not apply to medical specialists alone, but have also been expressed by medical doctors in other fields (Venter, 2004). The views expressed are those of mistrust and hostility towards managed care policies.

The Medical Schemes Act governs private health care funding in South Africa. The Act has Regulations that guide medical schemes in their implementation of managed care. The regulation defines managed care as:

> An arrangement through which utilization of health care is monitored through the use of mechanisms which are designed to monitor appropriateness, promote efficacy, quality and cost effectiveness of the delivery of relevant health services (Regulations in Terms the Medical Schemes Act, 1999:4).

Some of the tools or mechanisms that are used to provide managed health care include formularies, clinical protocols, and provider contracts. The intention of implementing these managed care tools is—at the end of the day —to ensure that health services are delivered within a framework that marries best clinical outcomes with cost effectiveness. The implementation of these tools has been denounced by some Medical Doctors who have argued that these have increased their administrative burden and pose a threat to their clinical autonomy (Grobler, 2013; Venter, 2004).

In the light of the controversy surrounding managed health care, I propose in this research report to normatively assess the impact of current Managed Health Care practices in South Africa on the professional autonomy of medical doctors. My aim is to ascertain the extent to which the managed care processes impede medical doctors' autonomy and to evaluate whether these impediments are ethically justifiable.

1.2. Rationale and Importance of the Study

Recognition of the importance of the right kind of patient-doctor relationship dates far back in time, and a fundamental ethical imperative for any medical doctor has always been to put his or her patient first at all times. Managed care poses a new ethical dilemma for medical doctors, as doctors now often find themselves having to choose between putting their patient's best interest first or making financially beneficial decisions. The nature of the patient-doctor relationship is highly dependent on maintaining trust between the treating medical doctor and their patient. Managed care

could be seen as a threat to this trust relationship, since patients could come to doubt that their well being is being given priority.

Medical doctors' (professional) autonomy is one of most important factors contributing towards their professionalism. It is important that their professional autonomy is safeguarded, as it is a source of pride for many physicians, is an essential factor in Medical doctors' job satisfaction, and it enables doctors to perform their professional duties with confidence. Medical doctors' motivation and job satisfaction is essential for ensuring good patient-doctor relationships and provision of a good health care service. It is clear that if medical doctors' professional autonomy is not protected, we risk poor health outcomes for many patients. Professional Autonomy is an essential component of job satisfaction for medical doctors and some have equated an attack on medical professional autonomy as an attack on the profession itself (Grobler, 2013; Holsinger and Beaton, 2006). Whilst the principles that form the foundation of managed care are necessary and justified (efficient resource utilization), we need to be alert to the fact that these managed care processes can have a detrimental effect on patient medical outcomes and this must be safeguarded against.

It is, therefore, important to seek to establish in what ways doctors' professional autonomy is impeded by managed health care practices, and to establish a principled basis on which to ethically evaluate the extent to which such impediments of autonomy are morally justifiable. This will enable me to propose guidelines for managed health practice.

Whilst internationally studies have been done and papers have been written around this subject, little work has been done which focuses on the issue specifically in the South African context. My research will add to the body of knowledge relating to this topic in South Africa.

1.3. Overview of the Literature

In this section, I briefly discuss some of the existing literature that is of relevance to my question and which I will need to draw on in my research.

Autonomy is defined as the freedom to independently rule or govern oneself without control from somebody else (Oxford Advanced Learner's Dictionary, 2010).

There is a strong emphasis in the literature on certain standards that the medical profession needs to live up to if it is to maintain its status as a profession (Hargraves, Reed and Vratil, 2001). These include professionals putting the interests of their patients above theirs, maintaining an ethical and moral standard that is beyond reproach, endeavoring to continue with personal development, and having a system in place where members of the profession can be held accountable. For as long as these criteria are met the profession will be allowed to maintain the autonomy that it enjoys (Swick, 2000). It is widely accepted that this autonomy should have boundaries; it can't mean that medical doctors are free to do as they please. A difficult question to answer would be how much autonomy do medical doctors need in order to provide good healthcare? For instance, medical doctors' clinical autonomy is essential in allowing doctors the freedom to deviate from medical guidelines when faced with

patients that are non-responders to guideline protocols (Morreim, 2002). Autonomy for medical doctors allows the profession to not only self-regulate by setting its own standards but also allows medical doctors to make independent clinical decisions (Hargraves, Reed and Vratil, 2001).

Kronebusch, Schlesinger and Thomas (2009) looked at managed care's impact on physicians' perceived utilization constraints, clinical interactions and clinical practice autonomy in the United States of America They did this by comparing physicians working in States which had adopted managed care regulations versus those working in States which had not adopted these regulations

Their findings showed that medical doctors who were more exposed to a greater degree of managed healthcare organizations complained of greater impeding of their clinical autonomy, decreased quality of their interactions with patients and decreased ability to get further clinical services as compared with medical doctors who were less exposed (Kronebusch, Schlesinger and Thomas, 2009).

In Mexico a similar study was conducted which compared Family Physicians who were working in environments with varying degrees of exposure to managed care processes. Again it was found that there was an inverse relationship in the physicians' perception of professional autonomy when compared with their working environment's exposure to managed health care processes (García-Peña et al., 2000). Waddimba et al. (2010) looked at the compliance rate to evidence based guidelines by primary care physicians working in a health management environment. Again they showed that the attitude to compliance to the guidelines had an inverse relationship to perceived clinical autonomy. In Switzerland a similar study to assess physicians'

attitudes towards managed health care tools was done, and again the physicians expressed that the managed care tools impeded their clinical autonomy to varying degrees. What was of interest, though, was that in this study the attitude towards guidelines was a positive one (Deom et al., 2010); this in comparison to other studies which had found that physicians perceived guidelines to be a hindrance to clinical autonomy.

Blume (1997) writes that managed care has posed a new ethical dilemma for medical doctors as they are becoming increasingly caught between autonomous clinical decisions based on their patients' best interest and the restrictions placed upon them by these managed care tools. Meyers (1999) acknowledges that the managed health care tools have posed an ethical conflict for physicians, but he argues that that the ethical conflicts presented are not new in the history of medicine and do not pose a threat to the traditional doctor-patient relationship. The same sentiments are echoed by Mechanic (2000) who also argues that there will be a need to review the ethical approach in resolving this dilemma for physicians.

1.4. Aim and Research Questions

The aim of my research is:

To normatively assess the impact of current Managed Health Care practices in South Africa on the professional autonomy of medical doctors.

In seeking to fulfill this aim, I will address the following research questions:

1. What is meant by the notion of the professional autonomy of doctors and why is it an important ethical consideration?
2. In what ways do current Managed Health Care Practices in SA impede medical doctors' professional autonomy?
3. In what ways are impediments of doctors' professional autonomy resulting from current Managed Health Care Practices in SA ethically justifiable, and in what ways are they not?
4. What guidelines can be proposed that would assist in ensuring that Managed Health Care practices do not unjustifiably impede the professional autonomy of doctors?

1.5. Research Objectives

The following are the main objectives of my study:

i. To give an account of the notion of the professional autonomy of Medical Doctors and of its ethical importance
ii. To identify ways in which Managed Health Care Practices in SA impede medical doctors' professional autonomy
iii. To identify principled conditions under which impediments of Medical Doctors' professional autonomy would be morally justified and principled conditions under which they would not

iv. To normatively evaluate the impediments of doctors' professional autonomy resulting from current Managed Health Care Practices in SA in terms of the principled conditions identified in (iii) above

2. AN ACCOUNT OF THE NOTION OF THE PROFESSIONAL AUTONOMY OF MEDICAL DOCTORS AND OF ITS ETHICAL IMPORTANCE

2.1. Introduction

In this chapter I will define professional autonomy with regards to the medical profession and then demonstrate the important role that professional autonomy plays. I will do this by first highlighting the role that professional autonomy plays as evidence as to why it is important. I will then compare these findings with the findings of detractors of professional autonomy.

Immanuel Kant noted that human beings have an intrinsic value which put them high above all creation, because of this intrinsic value we should never use them as a mere means to an end (Rachels and Rachels, 1987). As rational beings each human has his or her own ambitions, thoughts, and actions, which are guided by reason. As moral agents if we are to respect the rule of never using them a means to an end we should then respect their independent thinking and promote it.

Autonomy is best described as ones ability to self-rule or self govern (Dhai and McQuoid-Mason, 2011).

A profession is defined as a field of work that requires specialized training, mostly related to one that needs an advanced education (Oxford Advanced Learner's Dictionary 2010, 1159).

Professional autonomy thus would then be best described as a profession's ability to self-rule and self regulate. The World Medical Association describes two key levels concerning Medical Doctors' professional autonomy.
The first is at an individual level, where each medical doctor should be free to make professional decisions on the management and treatment options when with his or her patients. The second is at the level of the group of medical doctors. The profession as a whole should be free to regulate itself, setting its own standards and being responsible for the professional conduct of its members (The World Medical Association, 1987).

The importance of Professional autonomy would be best appreciated by grasping the importance of clinical freedom at an individual level and the importance of self-regulation at a professional group level for medical doctors.

2.2. Autonomy and Trust

To grasp the importance of clinical freedom one would have to reflect on the code of ethics that guide the individual medical professional. From the days of Hippocrates medical doctors have been making a public oath to treat their patients to the best of their skill and knowledge (Perkin, 1980) . The World Medical Association makes mention that medical doctors should always place the health of their patients as a priority and that no financial, social or medical matter should interfere with this duty (The World Medical Association, 2009) . The Health Professions Council of South Africa also reiterates that medical doctors have a moral duty to place their patients best interests as a priority (The Health Professions Council of South Africa, 1982) . Other ethical obligations to patients include not to harm the patient and to respect the self-determination of all patients (The Health Professions Council of South Africa, 1982) .

These ethical obligations are at the core of the doctor patient relationship.

The patient-doctor relationship is like no other service provider and client relationship. The medical doctor is the expert in a field of science; his client usually has minimal knowledge of this science. The sheer complexity of the interactions between physiology and pathology on ones anatomy resulting in the presenting symptoms means that whilst the patient may perhaps want to get better clarity on the treatment plan more often than not he or she would not be able to fully appreciate the gravity of the situation and more often than not is reliant on the expert service provider's opinion. The client approaches the doctor in hope for a cure for his or her symptoms or disease and is fully aware that the medical doctor at times wields the power of life or death (Matthews , 1982).

In this relationship there is a big aspect of trust that the service provider is competent and makes the correct life saving decisions.

Trust in the doctor patient relationship has been shown to be instrumental in determining patient health outcomes (Hall et al., 2001) . Trust has a direct impact on patient behavior, where there is trust patients are more likely to consult a medical doctor about their ailments, reveal more about their ailments during consultations, adhere to the prescribed treatment plans from their doctor, have an improved placebo effect and return for review appointments, remain loyal to their treating doctor thus improving continued care (Becker and Roblin, 2008; Davies and Rundall, 2000).

Mechanic highlights five dimensions of trust in the patient doctor relationship which are that patients trust that their treating physician is appropriately skilled to do his job, that he will always act in the patient's best interest, he has control over the environment which will allow for optimal care, he will uphold the patients confidentiality and that the treating doctor will disclose all the necessary information to allow the patient to make a fully informed decision this is not limited to just the disclosure pertaining to the treatment plan but also inclusive of financial interests which may later give rise to questions of conflicts of interest (Mechanic, 1998) .

Trust is the underlying substance that gives the patient doctor relationship meaning. Medical doctors have an ethical imperative to place their patients health as a priority and this should be done without undue influence. Professional autonomy should be safeguarded to avert the erosion of trust between the medical doctor and his patient.

2.3. Physician Autonomy and the Retaining Of Professionals

Autonomy has been shown to play a significant role in physician job satisfaction (Scheurer et al, 2009). The shortage of doctors in South Africa, including their departure for 'greener pastures' has been a topic of great concern to the department of health and the general public alike. Hudson (2011), noted the dire situation that the country was in with shortages not only in the public sector but also the private sector. The doctor shortage was starting to have a negative impact on patient care even within the private sector where less qualified personal were doing procedures which risk patient care being compromised.. The push factors that resulted in doctors departing from practice in South Africa were more important than the pull factors. Whilst the departure of doctors from South Africa is multifactorial amongst these factors includes job satisfaction (Bezuidenhout et al, 2009). The sense of having autonomy was a positive contributor to the doctors' job satisfaction. Schultz and Schultz, 1988 demonstrated the relationship between physician autonomy and job satisfaction. That perceived autonomy played a significant role in job satisfaction for medical doctors. This was also demonstrated amongst British general practitioners (Cooper et al, 1989). Pillay (2008) demonstrated that within the South African private health care sector job satisfaction was greatly influenced by having a sense of autonomy.

2.4. Physician Autonomy and Physician Stress Management

Physician autonomy has been shown to be an essential stress management tool for doctors. Autonomy serves as protection against the high stress and pressured environment that doctors find themselves practicing in. For as a long there is a perceived measure of autonomy doctors are able to cope with this testing environment, however as the doctor's autonomy is reduced so does the their ability to cope with their environment (Sutherland and Cooper, 1992). One of the consequences to of this increased stress was to the usage of sick leave, where doctors are taking days off not because of acute illness but rather to recuperate from the increased stress (Virtanen et al, 2008).

The price paid for physician job dissatisfaction can be extremely high. Dissatisfied physicians may experience loss of income and health problems. The dissatisfied physician may also cut their working hours, leave their places of work and also retire early from clinical work (Quinn et al, 2009).

Because physician autonomy is closely related to physician job satisfaction one can note that physician autonomy then plays an important role in the physician mental well being, retention at work and also a longer career where physicians are able to serve the public.

2.5. Job Satisfaction and Patient Outcomes

Patient satisfaction has been shown to be linked to physician satisfaction. (Linn et al, 1985). DeVoe et al (2007) demonstrated that amongst the factors that were responsible for the overall patient satisfaction with their experience of the health system, physician satisfaction had a large role to play. Patient perceived satisfaction is an important determinant of treatment outcomes as it governs patients health seeking behavior, for instance the patients willingness to adhere to treatment plans and follow up instructions. A lack of co-operative behavior from the patient may nullify the treatment actions of his doctor (Schneider and Ulrich, 2008). If autonomy is an essential factor in physician job satisfaction and physician job satisfaction is related to patient satisfaction then one may infer that physician autonomy is essential in patient satisfaction also and that compromising physician autonomy may result in physician dissatisfaction and which will also translate into patient dissatisfaction. Patient dissatisfaction will result in not only poor health outcomes for the individual patient but also risks adding an additional burden to the health system due to duplication of services and resultant increased wasteful expenditure by the health system. Thus physician autonomy also plays a role in the determination of patient satisfaction and related to that the patients' health outcomes. Weakening physician autonomy may have the unintended consequence of dissatisfied patients and poor health outcomes as a result.

2.6. Physician Autonomy and Patient Responsibility

Medical doctors are fully responsible for their patients' treatment plan. This is more evident in the case of medical litigation when the desired treatment has not gone according to plan and there are undesired consequences as a result there of (Sacristán, 2010). This setting reminds us of the importance of the respect of the attending physicians' autonomy as the burden of responsibility ultimately lies on him. Physician autonomy is part and parcel of accountability (Timmermans, 2005).

Restrictions to medical autonomy arise from the fact that health is developing as a public good (Leenen, 1985). Similarly in relation to medical schemes, health becomes the good of the population that is covered by the scheme. As such there is an obligation by the scheme in the setting of limited resources to make sure that these resources serve the needs of the insured population and that these services are in line with the ideals of the scheme. As a result thereof will be policy development by schemes that will be at loggerheads with the autonomy of medical professionals.

Dupuis 2000 argues against professional autonomy citing three main points:

1. Whilst the actions of doctors are based on certain values and these actions may at times result in some sort of ethical discussion this in no way infers that medical doctors are moral experts. Instead Dupuis argues further that medical doctors are not moral experts and lack ethical training and insight.
2. Actions of medical doctors are not always in the best interest of the patient as most of the therapeutic interventions in fact have demonstrated a neutral

effect and have proven dangerous when instituted against incorrect indications.

3. Wide inter-doctor variance suggesting a weak scientific basis for medicine and over-servicing of patients for financial gain.

Hampton (2011) similarly argued against the clinical autonomy of doctors citing that for too long it has been used as a cover allowing medical doctors to give patients treatment which was not beneficial and not based on any science. He argues that in the setting of restricted resources clinical autonomy should be removed and only treatment of proven value should be considered.

Whilst it is reasonable and correct that non-beneficial therapy should not be administered to patients the answer is not really through the out right removal of clinical autonomy.

Clinical autonomy does not merely mean that doctors should be free to do as they please, but that their clinical decisions should take place without undue influence from external parties.

In this chapter I have demonstrated that physician autonomy plays a vital role within the health care sector. It not only is a historical right that has been given to physicians by society based on their complex studies but also is an essential glue in the patient doctor trust relationship. It is also a necessary component of physician sense of self-esteem and sense of self worth, this is demonstrated in the role that autonomy contributes to physician job satisfaction and stress management. Autonomy then also

becomes essential in patient satisfaction. Thus the whole medical ecosystem benefits from the upholding of physician autonomy. Those that have argued against physician autonomy have only done so from the narrow perspective of wasteful expenditure from unnecessary interventions from medical doctors. Their arguments however fail to consider the other contributions of autonomy outside of the doctor making a decision that results in an unnecessary treatment. They fail to consider the consequences of the dissatisfied physician and how that may lead to less doctors being available to the health system, thus limiting patient access to care, or the dissatisfied patient where trust in the patient doctor relationship which results in poor patient compliance, duplication of services and ultimately increased health care costs. Physician autonomy serves a vital role in the maintenance of physician job satisfaction and contributes not only to the trust relationship between doctors and patients which is at the core of the physician patient relationship but also contributes to improved health outcomes as patients are more likely to follow their doctors' treatment plans.

3. WAYS IN WHICH MANAGED HEALTH CARE PRACTICES IN SOUTH AFRICA IMPEDE MEDICAL DOCTORS' PROFESSIONAL AUTONOMY

3.1. Introduction

The doctor patient relationship encompasses a wide range of interactions between the medical doctor and his or her patient. The interactions can take place in the public or privately funded sector. Within the privately funded sector this may or may not involve funding from a health insurance company. The interactions range from the planned appointment in the medical doctors rooms to the emergency procedure in theatre.

This chapter will focus on the private healthcare setting and interactions with patients who are covered by a health insurance product. In most of these interactions there will be a need to involve the health care funder to get an approval of some sort for funding. This chapter will seek to identify a few circumstances where managed health care may impede medical doctors' autonomy.

Managed care programmes were introduced by health insurance funders and government in an attempt to control what was then perceived as spiraling private health care cost (Rimler and Morisson, 1993).

These managed care programs took many forms which included drug formularies, disease management protocols, and hospital and service provider networks.

3.2. Drug Formularies

Most medical schemes in South Africa employ a closed medical formulary (Motheral and Henderson, 1999/2000, 481), which means that they have a set of prescribed drugs that they fund for. Drugs outside of this list can attract a copayment or not be funded for at all if prescribed.

Rucker and Schiff (1990) describe the ideal formulary as having the following characteristics:

> Drug inclusion based on proven drug safety profile and its efficacy
>
> Where necessary alternatives to the first choice drugs have to be included
>
> Unnecessary pharmacological duplication should be avoided and drugs of inferior class or efficacy should be excluded
>
> Drug inclusion should be based on a good balance between cost effectiveness and quality patient care.

Moore and Newman (1993) note that drug formularies are employed as a means of restricting physician choice of the drug they want to prescribe and rather forces them into prescribing cheaper alternative drugs and revising their prescription behavior. They further suggest that it has been argued that the underlying basis for the introduction of formularies is that medical doctors opt for the more expensive newer

drugs due to lack of knowledge and being overcome by the marketing and promises of drug companies.

The difficulty with the limited drug formulary is that finding the appropriate agent for a patients chronic condition can at times prove to be a difficult path filled with trial and error as the treating doctor and patient find the correct drug or combination of drugs that yield (Harding Et al, 1985).

Drug formularies may also have the undesired consequence of resulting in poor health outcomes as drugs are excluded on the basis of cost and not effectiveness. Thus patients are not able to make an out of pocket purchase of the effective drug resulting in poorer health outcomes (Moore and Newman). The consequence then is that whilst the cost of drug expenditure comes down there is a resultant rise in other costs within the health system as patients now need to be treated for their poorer health condition, often at a higher cost than the initial cost of the drugs (Bloom and Jacobs, 1985).

3.3. Treatment Protocols

Managed care companies use treatment protocols as a means of containing costs in the treatment of specific conditions. These are prescribed treatment guidelines that the treating doctor should not deviate from if funding is to be authorized (Eastman, Eastman and Tolson, 2001: 211). The guidelines are implanted as an evidence based and cost effective option for managing a patient with a particular diagnosis. In general these prescribed guidelines are more than adequate for the average patient.

Treatment guidelines have been criticized as lacking applicability in normal everyday working due to limitations of their design (Grol et al. 2010, 395). They are designed for an ideal patient generally presenting with only a single complaint, they do not factor in that patients may present with more than one problem at time and that patients want to be involved in the decisions that affect their health.

Guideline development is usually based on cost effective analyses that may be flawed in certain special patient groups. The measurable scientific outcomes may unfairly bias against important immeasurable outcomes that the treating doctor and patient are aiming for. This becomes problematic if the basis for funding from managed care providers is based on these guidelines as this may inadvertently force medical doctors to these immeasurable outcomes that are essential for patient well-being (Berghmans et al., 2004). Norheim (1999) described guidelines as a means of restricting potentially useful treatment to a patient.

3.4. Utilization Management

Utilization management involves pre-authorization of non-emergency admissions, anticipated expensive treatment plans, expensive treatments and prolonged and or expensive admissions (Fairfield et al. 2007). An example of utilization management would be the review of a high cost admission by the managed care organization's case manager, who would work to minimize the costs of the admission by finding cost effective treatment alternatives and limiting the length of the admission.

3.5. Preferred Provider Networks

Preferred provider networks relate to a network of doctors and facilities that are contracted to the health management organization to render a service at a discounted or fixed amount, in return the organization ‘guarantees’ a certain amount of traffic to these doctors that make the agreement economically profitable. Members of these schemes then are encouraged to make use of these network, with incentives of that include having the service being fully funded by the scheme. Patients are not restricted to seeing providers outside of the network but are discouraged with either a co-payment or at times having to pay for the entire service out of their own pocket.

Individual schemes have networks that may encompass the following providers:

- General practitioners; schemes will employ a network of general practitioners. Individual patients are then encouraged to only use general practitioners within this network. Within the network there could also be restrictions placed on movement between general practitioners.
- Specialist; schemes can also employ a network of specialist doctors that their members can be referred to. The process can also be further restricted that first an authorization must be given by the scheme before the patient sees the specialist within the network. The scheme can refuse to fund or impose a co-payment if the patient sees the specialist without the authorization.

- Hospitals: schemes can also establish networks with different hospitals or health facilities where there is an agreement that the schemes patients are charged discounted rates. The consequence though is that patients are then encouraged to use these network facilities. If patients go out of network then co-payments may be imposed.

Historically patients would present to their treating doctor with a particular ailment requesting assistance from their doctor. The attending doctor would apply his/her knowledge and introduce a treatment plan based on multiple inputs including his /her knowledge and experience. This is viewed as a more individualized treatment plan. The problem with this is that whilst treating doctors were free to make autonomous decisions on management plans for their patients it led to wide variation in treatment that had varying outcomes for the patients. The above-mentioned managed care tools are meant to minimize the variation in treatment plans by limiting the choice that treating doctors have on the treatment plan.

The managed care tools remove individualization and replace it with a more standardized approach (Timmerman and Oh, 2010). Compliance with these tools is enforced through punitive measures for the patient or threats of non re-imbursement for the doctor. Thus if a doctor still wants to persue a particular non funded drug or treatment then the patient is forced to foot the bill themselves or the doctor has to go through lengthy authorization processes (Moore and Newman, 1993). Patients and Doctors may enjoy one hundred percent funding if the above-mentioned tools are complied with. However where there is deviation from these protocols and doctors

exercise their autonomy in prescribing a treatment plan as they see suitable may result in adverse financial consequences for the doctor or patients. The patients may be subjected to co-payment or no payment at all for the treatment strategy (Council for Medical Schemes, 2003). The doctor also risks non-payment for a service rendered if he/she also deviates from protocols or if he/she does not request a pre-authorization for a planned procedure.

Co-payments, for instance, have been documented as a driver of decreased drug utilization (Harris et al., 1990). This is mainly due to the fact that patients then shy away from out of pocket expenditures and opt for the funded alternative.

The financial restrictions directly impact physician autonomy by risking reimbursement or indirectly due to patient out of pocket payments.

4. PRINCIPLED CONDITIONS UNDER WHICH IMPEDIMENTS OF MEDICAL DOCTORS' PROFESSIONAL AUTONOMY WOULD BE MORALLY JUSTIFIED AND PRINCIPLED CONDITIONS UNDER WHICH THEY WOULD NOT

4.1. Introduction

In this chapter I will identify and discuss principled conditions under which the impediment of medical doctor's autonomy may and may not be morally justified.

4.2. Principled Conditions Under Which the Autonomy of Medical Doctors could be Restricted

I now turn my attention to two principled conditions under which it might be morally permissible for doctors' autonomy to be limited. These are, firstly, the condition that the purpose of restricting professional autonomy is to prevent futile treatment or a wastage of resources. Secondly, autonomy might be justifiably restricted in the interests of the just distribution of resources.

4.2.1. Prevention of Futile or Wasteful Treatment

Managed care organizations aim to curb the wasteful expenditures and spiraling cost and redistribute health resources where they are most needed at the most cost effective manner (Maynard and Bloor, 1998).

In a world where resources are constrained it only makes sense that inefficient and wasteful health spending would result in resources not being available for medically necessary interventions.

Mohindra (2007) defines medical futility as a state in which the intended medical care will neither result in a positive or negative health outcome for the patient.

Futility is viewed from two perspectives. It can either be qualitative or quantitative. Qualitative futility is when a treatment has a proven medical effect but there is no guarantee that the patient will be in a position to appreciate the benefit from the medical effect (Halliday, 1997). Quantitative futility relates to therapy that has been scientifically demonstrated to result in no benefit to the patient as it won't have any desired medical effect on the patient (Dhai and McQuoid-Mason, 2011). This is well summed up by Ardagh (2000) who describes futility as treatment that will have no benefit.

Impeding medical doctor's professional autonomy to prevent futile care is the most palatable of the principled conditions and seems the most acceptable principled condition of them all. It is ethically justifiable that medical doctors should be not be in

a position where they could give futile treatment and this goes unquestioned due to a respect for the medical professional's autonomy.

Futile care is highlighted in end of life discussion debates. End of life discussions have been a topic of debate, especially in the setting of advanced directives (Higgs, 1987). Medical doctors find themselves in a conundrum where their will to preserve life at all costs may be directly opposing that of the terminally ill patient who no longer wishes to suffer, this perhaps having been expressed in a form of a living will. The prevention of futile care under these circumstances will certainly result in the promotion of the patient's autonomy if they have had their wishes expressed in such a document.

Preventing futile care will result in the promotion of beneficence not only for the individual patient concerned but also to the rest of the insured population in the medical scheme. By limiting care which serves no medical benefit one can redirect those saved funds in paying for additional care to those who can benefit thus increasing access to benefits or care for all insured in the scheme

Futile care could be viewed as a form of therapy that only prolongs life without medically benefiting the patient. In those patients who are terminally ill and suffering from pain, futile care could be viewed as therapy which may have an unintended consequence of prolonging suffering and pain in these patients (Campbell & McHaffie 1995). The prevention of futile care in these patients will result in the promotion of non-maleficence.

Preventing futile care will promote justice for all members in the medical scheme, as they will see more efficient use of their contributed premiums and less wastage.

Limiting of physician autonomy in order to prevent futile care is morally justified as it will result in the promotion of patient autonomy, prevent prolonged patient suffering, result in reduced wastage and improved distribution of health resources.

4.2.2. Justice in the Distribution of Resources

The Council of Medical Schemes (2013) describes managed health care as necessary for the appropriate rationing of health resources.

Resource distribution should achieve either increased patient inclusion within the healthcare system or an increase in benefits realized by patients or both (Emanuel, 2000).

Maynard (2001) mentions that in the resource constrained health sector rationing will have to take place and the ethical debate is not whether rationing should take place or not but rather which principles should be applied when rationing.

Emanuel (2000) mentions four principles that need to be satisfied if the distribution of health care is to be deemed as being just. These include:

1. The overall improvement of health should be the main goal.

2. Patients or members should be kept abreast and should know how resources are allocated and the justifications for these allocations.
3. Patients or members should have the opportunity and should be involved in the decision making of which benefits will be granted and which wont be granted by the managed care organization
4. Managed care organizations should be certain that resource allocation decisions should not take place under circumstances where they can be undully influnced .

The just distribution of resources could result in the promotion of patient autonomy in the setting where the patients are fully infomed of all the treatment options and thus make a decision together with the treating physician on the best treatment plan. The just distribution of resources will have a positive contribution to beneficene as it could result in increased access to health for all members. The intentions of just distribution is to increase access to health care for all insured members however this should not be at the expense of health outcomes for the individual patient. Whilst redistribution of resources is good it is essential that patients still be afforded the health benefits that they have paid for. Promotion of justice for the patient would be to ensure that the patients also getting a level of care which is contractually due to them. The promotion of justice also requires that these actions serve their purpose, ie that there should be a realisation of cost containment and that there should be increased access to care. Konetzka et al. (2008) notes that initially managed care policies had resulted in control of hospital costs and there fore control of health care expenditure but this control was only short lived as hospitals gained further increasing bargaining power.

This was noted as hospitals no longer concerned themselves with managed care contract participation and in fact resulted in managed care resulting in a rise in health care costs.

Limiting of physician autonomy is morally justified where it results in justice in the distribution of resources as there will be equitable distribution of resources and may even result in improved health outcomes for patients who are now recipients of the distributed health resources.

4.3. Principled Conditions Under which the Autonomy of Medical Doctors should not be Restricted.

I now turn my attention to principled conditions under which it might not be morally permissible for doctors' autonomy to be limited. These are, firstly, the condition that the limiting of medical doctors autonomy would result in reduced morale of medical doctors. Secondly, the reduction of medical doctors autonomy might not be justifiable if it result in reduced patient outcomes. Thirdly, the condition that the limiting of medical doctors autonomy would result in the reduction of trust in the patient doctor relationship. Fourthly, the reduction of medical doctors autonomy may not be justifiable where it results in a reduction of patient autonomy.

4.3.1. Reduction of doctor morale

The implementation of managed care should not come at the cost of reducing the morale of doctors. It has been documented that doctors autonomy is an essential component of morale and a reduction in medical doctor morale results in poor patient outcomes, a decreased sense of satisfaction from patient s and decreased desire by the medical doctor to carry on in the practice of medicine (Hadley and Mitchell 2002).

Reduced doctor morale may have an indirect negative effect on patient autonomy. Patient education in the doctors' room forms an essential component of informed consent, allowing patients to play an increased participatory role in medical decision making and thus increasing their autonomy. The consequence of reduced doctor morale will result in the loss of health professional to the health sector; this in turn will result in increased strain to the doctors who are still in the system. This could possibly have a negative impact on the patient physician relationship resulting in suboptimal patient education taking place in the doctor's rooms and negatively impacting on patient autonomy. Rogers (1999) describes beneficence as a moral duty which doctors have to their patients, a duty to do good to their patients. Whether it may be medical advice or a treatment plan, doctors have a duty to do what would be in the best interest of their patients. The consequences of reduced physician morale include negative health outcomes not only for individual patients but also for the general population due to the risk of decreased access to health care. These consequences would not serve any beneficence to patients. Thus actions that result in a reduced physician morale would not be able to satisfy patient beneficence. A

reduced morale may directly hamper a doctor's ability to care for his patient. This may result in the doctor unintentionally harming his patient. To reduce maleficence there needs to be a limitation or minimizing of decisions that could result in the reduced morale of doctors. One of the consequences of reduced doctors morale is decreased medical doctor job satisfaction and the resultant consequence may be their complete loss from the health system (Scheurer et al., 2009). The loss of doctors morale could effectively result in decreased access to health care for the entire ensured population as there would be less and less doctors to assist them. Thus the reduction of morale could negatively impact on justice.

The impediment of doctors' autonomy which result in the reduction of doctors morale may not be ethically justifiable as the risk of job dissatisfaction and loss of doctors in the health system may not justify the ends of limiting costs in the health system. If anything as opposed to increasing access to heath-care for the managed care members it may instead limit access to health care for all members as there will be fewer doctors to deliver a health service.

4.3.2. Suboptimal patient outcomes

There has been a fear that managed care tools may result in suboptimal patient outcomes for instance where less effective treatment is selected due to managed care constraints on physician autonomy.

This has been highlighted amongst special groups that are more vulnerable to managed care tools, for example children, psychiatric patients and the elderly (Anderson, 1998).

Special groups like those suffering with chronic disease can have improved health outcomes as long as managed care tools can avert the following that may result in poor health outcomes, such as:

- Missed identification of worsening symptoms due to sub-optimal review
- Poor patient education resulting in the patient being poorly educated on their condition and its complications
- Cost saving measures that result in the overlooking of proven treatments or that encourage the use of less effective treatment strategies.
- Overlooking the psychosocial aspects of disease (Wagner et al 1996)

Baker and McClellan, 2001 notes that whilst managed care did not result in suboptimal or reduced patient outcomes as compared to traditional health funding it did how ever contribute to a negative perceived health outcome. This is due to the fact that for instance under managed care hospital admission length of stays may be reduced resulting in early discharge from hospital and continued care at home until the patient is fully healed.

There is a fear that managed care tools would have a negative impact on health outcomes as service providers would put cost containment above patient care. Davidson et al (2003) has found that within certain special groups suffering from

chronic conditions managed care tools in fact contributed positively to health outcomes resulting in a reduced visit to the emergency department for the chronic conditions and better control of disease.

There has been concern that health care rationing will result in suboptimal patient outcomes, as medically necessary treatment will be sacrificed for prudent spending. However Ubel and Goold (1998) mention that that the savings gained from limiting medically useful but not medical necessary treatment can be redistributed back into the health funding pool and result in funding of even more health benefits for the patients. This will result in an actual gain in health out comes for the patients. Thus health care rationing will rather contribute to improved general health benefits and outcomes for patients, thus promoting overall patient beneficence. Ethical delivery of healthcare requires the promotion of maleficence, and decisions that may result in suboptimal patient outcomes may not be ethically justifiable. The offering of a level of care that would result in substandard outcomes would not result in the promotion of maleficence and would be rejected. Patients have a contract with their managed care company for certain benefits that are promised to the patient. Promoting justice would require that the patient should realize the health benefits that he/she has paid for. For the reasons stated, the limiting of patient autonomy may not be justifiable where it leads to suboptimal patient outcomes.

4.3.3. Reduction of trust in the patient doctor relationship

Trust is an essential component of the patient's health experience (Gilson, Palmer and Schneider 2005).

The successful delivery of health care requires not only that some form of health service be supplied but that the end user (the patient) also accepts this; trust plays a fundamental role in achieving this (Gilson, 2003). It has been showed that a reduced level of trust results in poorer health seeking behavior by patients and worse of health outcomes in these patients as they are also least likely to follow medical instructions or stringent follow-up plans (Mohseni and Lindstrom, 2007).

Hall et al (2002) conceptualize that general trust in physicians encapsulates 5 domains:

1. Fidelity, this relates to the doctors responsibility as a patient advocate and always putting his or her patient first.
2. Competence, competence that the doctor is knowledgeable or an expert in the field, thus he/she can be entrusted to key health decisions.
3. Honesty, the doctor is expected to be honest and not lie to his patient.
4. Confidentiality, it is expected that the doctor will keep his patients' secrets safe and would only use that information when clinically warranted
5. Global trust, a combination of the above domains that results in the fabric which that trust is interwoven in.

Trust plays an essential role in the doctor patient relationship and has an impact on health seeking behavior of patients. Where trust is reduced patients are less like to seek medical advice on time, and rather present their complaints to medical doctors when their disease is at an advanced stage. By reducing trust one essentially limits patients autonomy. This perhaps is best captured by Entwistle et al. (2010) who describe group of vulnerable patients who, though they may be competent, may not be able to fully exercise their autonomy due to certain factors e.g. patients who are uncertain of which treatment option to choose, patients who are not able to back themselves or those who want to avoid having to blame themselves should their chosen treatment option fail. In such patients a reduction in trust in the doctor patient relationship will result in a negative impact on their autonomy. As previously noted one of the consequences of reduced trust in the patient doctor relationship is the reduced health seeking behavior of patients and thus resulting in them presenting when their condition is at an advanced state. The reduction of trust will result in no beneficence to the patient. Following on from the previously mentioned statements the reduction of trust would equally have a negative impact on maleficence. A reduced trust in the patient doctor relationship has a negative impact on patient autonomy, beneficence and maleficence. As a consequence of these it would be hard to see justice for patients prevailing. Poor health outcomes as a result of poor health seeking behavior would not result in justice for patients. A reduced trust in the patient doctor relationship would have negative implication for justice for patients.

Actions that have a negative impact on trust between the patient and his treating doctor would be attacking the very soul of the patient doctor relationship and thus threaten the delivery of health care as a whole. Managed care principles that threaten

trust between doctors and their patients would have far reaching consequences for the delivery of health care as a whole and in fact may rather have a negative impact on cost containment when one considers that the health seeking behavior is modified by trust with the doctor patient relationship. Poor health seeking behavior results in patients presenting far more advanced disease which may much more expansive to manage.

Limiting medical doctor autonomy would not be morally justifiable if it resulted in a reduction of trust in the patient doctor relationship as this would negatively impact on the patient doctor relationship and result in a near collapse of the health system.

4.3.4. Erosion of patient autonomy

The patient doctor relationship has evolved from the historic paternal relationship of old to one where there has been encouragement of greater patient participation in treatment planning (Buetow, 1998). This may present a problem where patients may disagree about the treatment plan rather requesting the newest treatment which they feel may be better, an example is in the setting of drug company direct marketing to patients which results in patients demanding the newest drug as they perceive that this would be the best for them (Graber & Tansey, 2005). This may create a situation where there could be a clash of treatment plans and the doctor as a respecter of patient autonomy yielding to the patient's wishes. Increased patient

involvement in decision-making could have a positive influence on patient outcomes. Patients take ownership of their conditions and would be more involved in the treatment strategies. A more involved patient would have better understanding of their condition and would thus have improved health-seeking behavior. A more involved patient would also have better compliance as they are far better informed of the consequences of poor compliance to the agreed to treatment plan. By creating an environment where there is a promotion of patient autonomy there would be an enhancement on beneficence to the patient.

It goes to say that the erosion of patient autonomy would have negative consequences for health delivery and would go against the legal and ethical obligations of the treating doctor, which are to promote patient autonomy. For these reasons the limiting of medical doctors autonomy that results in the erosion of patient autonomy could not be justifiable.

5. NORMATIVE EVALUATION OF MANAGED CARE TOOLS

In this chapter we will look at some of the managed care tools and give examples of circumstances where they would be ethically justifiable or not justifiable.

5.1. Drug Formularies

Super-bugs have been a major source of morbidity and mortality for patients who have been admitted to hospitals. These super-bugs are extremely resistant to widely available antibiotics. These super-bugs infect patients during their admission in the hospital, mainly in the ICU setting. The growth of these super-bugs has been mainly attributed to incorrect antibiotic prescription practices by treating physicians. The antibiotic stewardship program was a form of drug formulary specifically for antibiotics that was introduced in an attempt to modify physician-prescribing behavior to reduce the growth of the super-bug formulation (Reed et al., 2013). This functions by restricting access to antibiotics that may not be indicted. This a great example of an ethical drug formulary which has centered in its existence patient care and outcomes for the entire population. In this instance the implementation of the formulary will result in a reduction of futile expenditure of antibiotics that are not indicated. Under these circumstances drug formulary enforcement resulting in the limitation of professional autonomy would be morally permissible.

Drug side effects are a source of serious morbidity for patients and can be serious enough to force patients to completely withdraw from the prescribed drugs as the side effects start to be greater than the pharmaco-therapeutic benefits of the drugs (Sathasivam and Lecky, 2008). Restricted formularies become unethical where the treating doctor is then forced to persist with drug side effects or to try alternative drugs within the particular class in hope that the patient does not react to the different brand generic. This is done in order to protect the patient from the financial penalties that come with drugs that fall outside of those within the formulary. The enforcement of drug formularies on patients who are suffering from adverse side effects would be deemed to be ethically unjustifiable as it would result in suboptimal patient outcomes and risks an erosion of trust between the medical doctor and patients. The enforcement of drug formularies resulting in the limitation of professional autonomy under these circumstances would not ethically justifiable.

5.2. Treatment Protocols

There may be groups of doctors who are not keeping up to date with the latest evidence on how to manage a particular condition and still offering treatments which have now proven to be suboptimal (O'Dowd and Wilson, 1991). Clinical freedom would suggest that the doctors be left to continue with this line of care that may no longer be benefiting their patients. The introduction of a treatment protocol based on the latest evidence would be ethically justified as a tool to encourage the doctors to adopt the new standard of care which in the end not only realizes cost savings to the

members of the scheme but also in improved health outcomes. The enforcement of treatment protocols would then result in the eradication of old and outdated practices that may no longer benefit the patient thus promoting the prevention of futile care. The enforcement of treatment protocols under these circumstances would also satisfy the promotion of just distribution of resources as funds become more efficiently spent on scientifically backed outcomes.

Patients however are not a uniform group of people and all will respond individually to different therapeutic interventions. A challenge for treatment protocols is patients who are non-responders to the protocol interventions. A protocol that does not consider possible non-responders is ethically not acceptable. Patients and their treating doctors cannot be forced to continue with therapy that does not work for the sake of the protocol. The treatment protocol in non-responders would result in suboptimal patient outcomes as patients would be getting treatment that is not effective, this would result in an erosion of trust in the patient doctor relationship, as patients would be improving clinically. Treatment protocols where patients are not responding may also reduce doctors' morale as they are forced to continue with treatment plans that are not working. In this instance the limitation of medical doctors' autonomy through treatment protocols would not be morally justified.

5.3. Utilization Management

Preauthorization processes fall under utilization review.

This process involves getting approval first from the managed care organization before a treatment plan can be admitted. The preauthorization process is ethically

acceptable under cases of inappropriate admissions. These may include unnecessary hospitalization or inappropriate levels of care for admitted patients (Antón et al., 2007). An example would be the use of a private or isolation ward in the hospital. Sometimes patients choose these isolation wards not out of medical necessity (medical need for isolation due to a highly infectious condition) but rather because they want privacy. Their conditions could be managed in a standard ward. Under these circumstances the use if the preauthorization process is warranted as unnecessary hospital admission costs could be prevented for a level of care that is not medically indicated. The utilization management process under these circumstances would satisfy the promotion of justice in the distribution of care.

Hospital admissions and some surgical procedures are amongst the services that need preauthorization prior to a patient being able to have access to those benefits, added further to that may also be certain cost drugs. Whilst the intention of this process is to prevent wasteful expenditure there are however certain circumstances where this process may have undesired effects include severely ill psychiatric patients. Farley (2010) mentions how the preauthorization process may result in adverse consequences for the patient:

i. Poor treatment compliance as patients within this group do not necessarily respond identically to the drugs thus there is a lot of trial and error with individual patients to find the drug that works. If working drugs are then subjected to preauthorization process patients and their treating doctors may be forced to try alternative drugs first prior to pre-authorization being approved.

ii. The process to gain the preauthorization for a particular drug may be too cumbersome for the treating doctor resulting in a decreased likelihood that the motivation will be correctly filled in and thus rejection of the authorization request.

This example demonstrates how the preauthorization process can be unethical as it negatively impacts patient care, may in fact result in increased costs for the scheme as patients conditions worsens resulting in increased need for health services. Utilization management under these circumstances will result in suboptimal patient outcomes and a reduction in medical doctors morale as their time is consumed by administrative process and not actual patient care.

5.4. Preferred Provider Networks

Preferred provider networks involve network contracts that are developed by a managed care where there is a preferred payment rate for health services for their members. The networks may involve general practitioners, specialists and hospitals. Scheme members are encouraged to use these referral systems for their health needs. In the ideal situation the member would see his preferred network general practitioner. The general practitioner would assess his patient and if necessary will refer the patient to the medically appropriate specialist. The specialist would assess the patient and if necessitated admit the patient for further in hospital care in the network hospital. Under this ideal situation patient care would not be compromised and cost savings would be realized whilst the patient underwent standard process to

receive their health care. Under these circumstances the preferred provider network would be morally justifiable, as it would satisfy the just distribution of resources.

There is however certain circumstances that would result in the enforcement of provider networks as unethical. These include an emergency situation where there is no realistic time for a patient to seek a network referral specialist or hospital. Under these circumstances patient care and outcomes would be compromised if medically necessary healthcare were to be stopped so that the appropriate provider could be contacted. Another circumstances is where there are no appropriate specialists within the network. It may not be possible for a medical scheme to have contractual relationships with specialists in all fields. It would not be ethically justifiable if patients were forced to only consult within their network when the required health professional is not available, this again would result in not suboptimal but rather inappropriate patient care. Both these circumstances bring to light how the enforcement of preferred provider networks could be ethically unjustifiable, as they would result in suboptimal patient outcomes and a reduction of medical doctors' morale.

6. CONCLUSION AND RECOMMENDATIONS

Limited resources are a reality in the private health system. From this defined pool of resources members need to access benefits for their health needs. Spiraling health care costs have posed a threat to these benefits risking limiting access to health care for scheme members, as more has to be done with even less.

The rise in health care costs has been largely attributed to actions of medical doctors who were acting without restraint. Managed care programs were thus introduced in an attempt to control the spiraling health care costs by reducing medical doctors autonomy.

Whilst the prize for limiting costs is increased access to health care for members there are however anticipated consequences of a reduction in medical doctors autonomy that include a reduced medical doctor moral, suboptimal patient care, increased work dissatisfaction and a loss of doctors to the health system.

Some of the managed care tools that were identified include the use of drug formularies, treatment protocols, utilization reviews and provider networks.

We identified principled conditions where the limitation of doctors' autonomy as a result of these managed care could be morally justified. These include where the implementation of the tools would result in a just distribution of resources and a limitation of medically futile treatment.

However principled conditions where these managed care tools would not ethically justified included where they would result in adverse patient outcomes, where they

result in a loss of medical doctors moral or where they result in reduced trust in the patient doctor relationship.

DeMarco 2005, offers an approach to the moral dilemma where there are two competing moral interests both justified but where only one can be served. Using the example of a doctor who has to choose between breaking a promise to his child and attending to a critically ill patient DeMarcor offers an alternative that whilst only one of these interests may be served by applying the mutuality principle, there now is a moral obligation by the doctor to enhance both interests in future by thinking up of solutions which would avoid the same dilemma from taking place.

Having normatively assessed these principles in light of the four ethical principles of health care delivery, autonomy, beneficence, maleficence and justice we are able to come up with the following recommendations:

6.1. Improving Just Distribution of Resources

4 principles are mentioned by Emmanuel (2000) that we can adapt to make resource allocation more just:

(i) Health improvement must be the first aim

(ii) The individual patients and members should be well informed of benefits

(iii) Members should be given the opportunity to consent to benefit allocations that are made to them.

(iv) Those making decisions on benefit allocation should do their best avoid potential conflicts of interests.

6.2. Improving Patient Education.

Patient autonomy is central to the delivery of healthcare and enjoys protection in law. Enhancing patient autonomy not only involves informing patients of the medical condition possible treatment strategies but also will invariably need education on social justice. Graber and Tansy (2005) suggest that this should form part of the consenting process during the consultation. It is also recommended that the managed care company also take an active role in teaching their members on social responsibility and their health plan benefits. This would result in less conflict in the doctors' rooms; aid the doctor patient relationship and still lead to increased cost savings.

6.3. Improving Trust in the Doctor Patient Relationship

Managed care organizations though third parties in this doctor patient relationship can foster the trust in this relationship by adopting a more open policy on communication of the basis of treatment of cover and the extent of cover from the purchased product (Pover G et al., 2004). It is advisable that funders not merely make rules about what is covered and not covered but

should rather involve a collective discussion between funders, patients and doctors on what would be a basic standard of care which should be funded. This approach will reduce the burden on medical doctors to ration allow them rather to focus on making sure that this standard is met (Baily, 2003).

6.4. Improving Trust Between Medical Professionals and Managed Care Companies.

The relationship between treating medical doctors and managed care companies can be improved as suggested by Randel et al, (2001) by managed care companies applying a more open approach on funding policies and reason for coverage. This would lead to less frustrations and take away the perceived wall of secrecy surrounding these decision.

This will be essential in improving trust between medical professionals and managed care companies. Managed care companies should be more open about their decision making process. An additional benefit of improved doctor satisfaction is that even patient satisfaction will be improved (Linn et al., 1985).

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8. APPENDICES

8.1. Appendix 1 - Ethics Waiver

University
of the Witwatersrand,
Johannesburg

Human Research Ethics Committee (Medical)
(formerly Committee for Research on Human Subjects (Medical))

Secretariat: Research Office, Room SH10005, 10th floor, Senate House • Telephone: +27 11 717-1234 • Fax: +27 11 339-5708
Private Bag 3, Wits 2050, South Africa

Ref: W-CJ-130830-1

30/08/2013

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator: **Mr T Lengana (student no 0104765Y).**

Project title: **Managed health care and the professional autonomy of medical doctors in South Africa.**

Reason: This is a analysis of information in the public domain. There are no human participants.

UNIVERSITY OF THE WITWATERSRAND
PROF PE CLEATON-JONES
HREC (MEDICAL)
2013 -08- 30
JOHANNESBURG

Professor Peter Cleaton-Jones
Chair: Human Research Ethics Committee (Medical)

copy: Anisa Keshav, Zanele Ndlovu, Wits Research Office

8.2. Appendix 2 - Turnitin Report Front Page

turnitin **Turnitin Originality Report**

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