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IS THE FEE-FOR-SERVICE MODEL FOR REMUNERATION OF MEDICAL PRACTITIONERS IN PRIVATE PRACTICE MORALLY JUSTIFIABLE?

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Submitted in partial fulfillment of the degree of MSc (Med) in Bioethics and Health Law

Steve Biko Centre for Bioethics, University of the Witwatersrand

Johannesburg, 10 April 2015

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DECLARATION

This research report - entitled “Is the fee-for-service model for remuneration of medical practitioners in private practice morally justifiable?” – is my own unaided work, except where I have explicitly indicated otherwise. I have followed the required conventions in referencing the thoughts and ideas of others. It is being submitted for the degree of MSc Med (Bioethics and Health Law) to the University of the Witwatersrand, Johannesburg. It has not been submitted before, for any degree or examination, at this or any other University.

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TO WHOM IT MAY CONCERN:

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

Investigator: **Gregory Green (student no 9508306V)**

Project title: **Is the fee-for-service model for remuneration of medical practitioners in private practice morally justifiable?**

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

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ABSTRACT

In this research report I defend the thesis that the fee-for-service remuneration model for private medical practitioners is not morally justifiable as it does not promote a paying patient's best interests. A review of the salary, capitation, pay-for-performance and fee-for-service payment models is followed by a review of the philosophical fundamentals of caring for patients and promoting their best interests. The suitability of the fee-for-service model as it is applied to private practice is analysed with respect to its compliance / non-compliance with these fundamentals. Particular reference is given to principlism, consequentialism and virtue ethics as well as the South African health care environment. In the absence of specific and viable alternatives I propose how a moral checklist could be applied to payment models generally in order to safeguard promotion of a patient's best interests.

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I would like to thank my supervisor, Dr Kevin Behrens, for his invaluable, constructive and insightful assistance. Throughout it was his clarity of thought and efficient feedback which enabled this research to remain focused on its primary objective.

I also wish to acknowledge my wife and family who have unquestioningly provided the pockets of space necessary for this project's careful assembly.

There are many bad ways to pay doctors, and no particularly good ones.

Himmelstein and Woolhandler 2014: 695

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1. INTRODUCTION

This report evaluates the moral justifications (if any) for the fee-for-service model as a basis for private practitioner remuneration in South Africa. I evaluate the suitability of any payment model from a purely moral perspective - as a model - rather than limit this to a criticism based primarily on its various clinical and economic consequences. More specifically, the predominant fee-for-service model applied in private practice in South Africa is subjected to such a normative evaluation.

First the various payment models in health care are described and classified. This is followed by an account of the ethical fundamentals of caring for patients and promoting their best interests. The suitability of the fee-for-service model as it is applied to private practice is then analysed with respect to its compliance / non-compliance with these philosophical fundamentals.

In this report I defend the thesis that the current fee-for-service remuneration model for private medical practitioners is not morally justifiable as it does not promote a paying patient's best interests. In the absence of specific and viable alternatives I propose how a moral checklist could be applied to payment models generally in order to safeguard promotion of a patient's best interests.

1.1 Definitions

Clinical

The term ‘clinical’ is understood to refer to the practical application of a medical practitioner’s professional skill and training. This could include history-taking, examination, performing of medical interventions and interpretation of results requiring the specific professional skills of the treating medical practitioner.

Fee-for-service

Fee-for-service refers to the service-dependant payment model most often relied upon in private health care in South Africa, where the fee paid to a medical practitioner is based on the service rendered (Houle *et al*. 2012: W-319). It has also proven to be a very popular payment model internationally (Berenson and Rich 2010: 613). Many also argue that it will continue to be at very least a necessary constituent of future payment models (Ginsburg 2012: 1981, Goroll and Schoenbaum 2012: 578). References to ‘fee-for-service’, ‘fee-for-service model’, and ‘fee-for-service payment model’ are used interchangeably in this research. A more detailed definition follows in chapter 2.

Gaming

When clinical risk adjustment forms the basis of payment to medical practitioners, manipulation of diagnosis and the relative severity of a patient's clinical condition in order to maximise payment is termed 'gaming'. Gaming-induced overpayments have been a criticism of managed health care services which encourage refinement of risk-adjustment (Himmelstein and Woolhandler 2014: 694). It is possible for practitioners to 'cherry-pick' specific patients and adjust their diagnoses and management in order to select for an optimal profile and thereby maximise their own remuneration (*ibid*).

Good medical practice

In this report reference to good medical practice primarily entails compliance with the Health Professions Council of South Africa's formal guidelines for good practice for health practitioners (HPCSA (1) and (2): 2008).

Health insurer

I use this term synonymously with the term 'medical aid' to describe medical funding organisations who collect premiums from members in return for as required utilisation of health services.

Patient

The Consumer Protection Act 68 of 2008 refers to consumers as persons entering into transactions with suppliers. The National Health Act 61 of 2003 refers neither to patients or consumers, but rather to users of health care. In my opinion, interchangeable use of the term patient and consumer is often counter-productive outside the context of the Consumer Protection Act. This is especially so given its negative connotation with respect to commodification in health care. For this reason, unless the discussion specifically refers to consumers in the more general legal interpretation just described, I generally refer to patients in this report,

Payment

Payment is used to describe remuneration received by a practitioner for the rendering of a health service. This could be in the form of direct payment from a patient, indirect payment from their health insurer or payment via a third party. I do not always make a clear distinction between them unless specifically relevant.

Payment debate

The focus of this report is on the fee-for-service model, which in turn represents just one popular theory amongst others on which payment for

health care services is conceptually modelled. Broadly speaking, the "payment debate" refers to an ongoing international academic discussion as to which model, combination of models or proposed novel approach to payment in health care is most appropriate, effective and therefore suitable. For the purposes of this research, while the term primarily refers to the overall debate, I occasionally refer to a much narrower interpretation synonymous with what we could term the "fee-for-service debate". Where the appropriate context demands it, I clarify a more specific interpretation.

Practice and private practice

The term 'practice' is used to refer to a medical practitioner practice in the private sector. The terms 'practice' and 'private practice' are understood interchangeably. Private practices can consist of single or multiple participating practitioners. Regardless of the number of practitioners in a practice, practices in South Africa operate their business with and receive payments to a single legal entity with a unique practice number. For more specific context, local health insurers and payment systems usually recognise and interact with practices by their practice numbers, and not necessarily always the specific practitioners who have rendered specific services. Agreements are often therefore entered into between health insurers and practices, and not necessarily between health insurers and individual practitioners unless they happen to be a single-man practice.

Practitioner

In this report a practitioner is understood fairly loosely as a medical practitioner, doctor, physician or medical specialist. These terms are used interchangeably. While this research focuses on medical practitioners, the central themes, arguments and findings are potentially relevant to any professional health care provider who renders a health care service in return for payment.

1.2 Purpose of study

To critically defend the thesis that the fee-for-service model of remuneration for doctors in private practice in South Africa is morally unjustified, as it fails to promote the patient's best interest.

1.3 Outcome

To develop a set of ethical criteria and principles as a fundamental basis upon which to evaluate the moral justification of any payment model, including alternatives to the fee-for-service model.

1.4 Outline of chapters

The next chapter (chapter 2) outlines the context for my research question, provides an overview of the literature relevant to the fee-for-service payment debate and introduces the four principal models for medical practitioner remuneration. Chapters 3 and 4 provide the theoretical background for the application to, and critical discussion of, the fee-for-service payment model. In chapter 3, I provide a basic review of basic moral theory in health care which includes principlism, consequentialism and virtue ethics. This is followed in chapter 4 by a description of relevant South African health care legislation as well as ethical guidelines for medical practitioners.

Chapter 5 provides an overview of medical professionalism and the social contract before proposing some basic tenets of an ideal payment model. Chapter 6 describes the context of private practice in South Africa, and proposes some important assumptions for the moral evaluation of fee-for-service. The fee-for-service model of remuneration is critically evaluated in chapter 7 by highlighting the moral weaknesses of the fee-for-service model, as well as some of the difficulties involved with health care regulation.

In the absence of specific or viable alternatives I propose a moral checklist in chapter 8 which could be applied to either the design or evaluation of payment

models generally in order to safeguard promotion of a patient's best interests. The discussion in chapter 9 identifies some of the possible limitations with this research, but simultaneously argues its unique advantages and moral importance. Chapter 10 concludes that the fee-for-service model of remuneration for doctors in private practice in South Africa is morally unjustified, as it fails to promote the patient's best interest.

2. BACKGROUND AND RATIONALE

In order to critically examine the fee-for-service model of remuneration I have briefly described the context of the payment debate, defined the specific objective of this report and outlined some of the fundamental concepts required for an informed discussion. This chapter expands on some of the core issues which characterise the payment debate. An overview of relevant academic literature is provided, followed by a description of the principal model designs which currently inform international medical practitioner remuneration strategy and policies.

Local and international studies have shown how fee-for-service contributes to elevated and wasteful healthcare spending (Schroeder and Frist 2013: 2029), incentivises increased patient visit frequency (Broomberg and Price 1990: 134, Vahidi *et al*. 2013: 58) and dis-incentivises holistic, follow-up and health-promotion interventions (Vahidi *et al.* 2013: 58). Despite mature debate, acknowledgement of the difficulties of fee-for-service, and serial policy recommendations, countries such as the United States have failed to reach broad consensus, and continue to be dominated by this payment model (Schroeder and Frist 2013: 2029).

The existing literature focusing on payment systems in private health care is dominated by research into actual or potential outcomes of various payment models. The economic, cost-benefit, financial sustainability and clinical outcomes-based

benefits and disadvantages of payment policies are therefore well-debated. The basic, principled ethical justification for the conceptual architecture of various payment models is, however, not usually adequately considered. Health care exists primarily because people or patients require it. The principal motivation for testing payment models in this way is to hopefully protect and promote their best interest. This paper therefore responds to a moral and logical requirement incumbent on health systems to examine whether the needs of patients and the model employed to remunerate doctors are suitably aligned.

In South Africa, comparatively little research attention has been given to the important aspects of the payment debate. Furthermore, neither internationally nor locally, has appropriate attention been given to the basic ethical justification for the conceptual architecture of various payment models. The prevailing noise in academic literature is focused on the economic, cost-benefit, financial sustainability and clinical outcomes-based benefits and disadvantages of payment policies.

The focus of the current payment debate is not always obviously guided by the reason why healthcare exists at all: to attend, as far as possible, to a patient's healthcare needs, consistent with their best interests. This paper therefore responds to a moral requirement incumbent on health systems to examine whether the needs of patients and the model employed to remunerate doctors are suitably aligned. A South African perspective will be maintained with respect to our

particular challenges with fee-for-service. In a rapidly changing health care environment, policy-makers in South Africa are bound by the Constitution (1996) to promote a patient's right to dignity (s 10), bodily integrity (s 12(2)) and the progressive realisation of their right to health care services (s 27(1)(a), s 27(2)). Given the advent of significant change, particularly planning for National Health Insurance (NHI), the need for a robust moral standard in South African health care is not only apparent, but in addition relatively urgent.

2.1 Overview of the literature

As early as the 1970s an active debate began over the suitability of the fee-for-service payment system in North American health care (Ellwood *et al.* 1971: 291). This debate was instrumental in the development of capitation[1] and the emergence of managed health care in general (Himmelstein and Woolhandler 2014: 693). In response to a continued need to provide guidance for policymakers, a report commissioned in the United States on 'physician payment reform' provides an overview of the various payment systems and criticises their various contributions to rising health care costs (Frist and Schroeder 2013: 1-21). Fee-for-service features prominently as a principal

[1] A payment arrangement which pays medical practitioners a set amount for each (usually health-insured) patient assigned to them, per month or year, independent of whether the patient consults the practitioner or not.

driver for inefficiency and undesirable financial incentives (Frist and Schroeder 2013: 3). The commission concluded:

> …our nation [United States] cannot control runaway medical spending without fundamentally changing how physicians are paid, including the inherent incentives built into the current fee-for-service pay system (*ibid*).

Some modern researchers have encouraged a more proactive approach to payment reform by applying ethical principles early and at policy level (Corbett 2013: 47). Attention given by Corbett, in his review, to vulnerable populations who need protection at the payment reform level is particularly relevant in the South African context (*ibid*).

Other key theorists who have engaged in the debate about payment models include Bailey (2004: 231-235), Daschle *et al*. (2013: 471-474), Goroll *et al*. (2007: 410-415), Goroll and Schoenbaum (2012: 577-578), Ginsburg (2012: 1977-1983), Maynard *et al*. (1986: 1438–1440), Nelson (2007: 16-18) and Saint-Lary *et al*. (2007: 485–491).

There is very little South African literature on the ethics of payment systems. On the basis of one early retrospective analysis it has been argued that the fee-for-service model was unjustified in the context of existing resource constraints at the time (Broomberg and Price 1990: 136). The study showed how cost patterns differed for equivalent health care encounters between the economical salaried environment of a Health Maintenance Organisation (HMO) and the comparatively expensive fee-for-service environment of private medical schemes. A current perspective on fee-for-service provided by the South African health insurer, Discovery Health, reflects on how doctors' remuneration is, unfortunately, necessarily tied to the decisions they make for their patients (Bateman 2013: 443). Legislative reform enabling hospitals to 'employ' doctors and assign roles more efficiently and link salaries to the total costs and benefits of the system is proposed (*ibid*). Rowe and Moodley (2013: 8) critically evaluate the Consumer Protection Act (No. 68 of 2008) and consider the ethical and legal implications of the shift from paternalism towards an increasingly consumerist model in healthcare in South Africa. They argue that it potentially encourages the commodification of our already complex, pluralistic health system (*ibid*).

In addition to the literature that specifically deals with the ethics of payment models, another source of pertinent scholarship of relevance to this study relates to medical professionalism and the traditional social contract, which

potentially informs the moral framework of the payment debate (Creuss *et al*. 2000: 1189-1194, Dhai and McQuoid-Mason 2008: 2-3, Williams 2009: 48-50). Furthermore, it is necessary to take into account the generally adopted moral norms and standards in health care reflected in relevant sections of South African health law and professional guidelines for medical practitioners (Constitution of South Africa 1996, Consumer Protection Act 68 of 2008, HPCSA 2005, HPCSA 2008 (Booklet 1), HPCSA 2008 (Booklet 5), Dhai and McQuoid-Mason 2011, National Health Act 61 of 2003).

2.2 The basic payment models

There are four principal models for medical practitioner remuneration – salary, capitation, fee-for-service and pay-for-performance. The payment systems differ widely in their advantages, disadvantages and suitability to health care. All four models have been widely debated in the academic literature and will not be analysed in any significant detail here. I will merely outline their basic characteristics here in order to assist the reader with a working understanding of their similarities and differences.

Salary model

The salary model is no different in many ways from the same in other professions or industries: a monthly salary agreed between a medical

practitioner and their employer. With regard to the medical profession, salaries have generally been criticised for providing insufficient incentives to improve the quality of patient care. Salaries which are not linked to performance have similarly been criticised for their failure to discourage the practice of sub-standard care.

Capitation

Capitation refers to a set remuneration (usually monthly) per practice-registered patient, which is independent of the facility utilisation in a specified time period. From a health insurer or state perspective, it is a very predictable and stable financial model. The fee is often all-inclusive, meaning that medical practitioners must provide whatever services, consultations or consumables from it (Houle *et al*. 2012: W-319).

Under capitation, the doctor's income is dependent on three main factors: (1) how many patients are registered with the practice, (2) how efficiently the practice services those patients, and (3) how efficiently the practice is administered in general. Capitation has therefore been criticised for its tendency to encourage under-servicing (Berenson and Rich 2012: 617). For this reason it has even been referred to as a "fee-for-non-service" arrangement (Himmelstein and Woolhandler 2014: 695).

Fee-for-service

Fee-for-service is a payment model where, in return for delivering a medical service the doctor charges a monetary fee for the particular service – either to the patient or the patient's health insurer. The health-provider's income is therefore entirely dependent on the total number and value of invoices they have raised, as well as the efficiency with which such fees are collected. Fee-for-service has been criticised for encouraging over-servicing due to its reliance on volume-based payments (Berenson and Rich 2012: 617, Goroll and Schoenbaum 2012: 577).

Pay-for-performance

Pay-for-performance represents a range of essentially customised combinations of the above three models. Pioneered in the United States as an attempt to overcome some of the weaknesses of the other models, it assigns performance-rated variables to practitioners and patients, monitors the actual performance and adjusts a practitioner's income accordingly (Berenson and Rich 2010: 616, Houde *et al.* 2012: W-319, Snyder and Neubauer 2007: 792).

The principal difficulties encountered in the pay-for-performance model simultaneously represent its primary criticisms. Since clinical risk adjustment

is necessary for the reasonable measure of performance, in the absence of strict governance the pay-for-performance model is by definition open to gaming (Himmelstein and Woolhandler 2014: 693-4). Assuming risk adjustment is accurately recorded, who decides, and what criteria are used to decide, which variables best represent performance? How are the relative weightings of such variables assigned to an overall performance score and why? Unless a comprehensive set of performance variables are measured, the reward of a narrow band of clinical intervention for selected patient profiles might actually weaken a practitioner's autonomy and impair overall quality of care (Himmelstein and Woolhandler 2014: 694). Probably the most important difficulty is this: in order to maintain validity, how can such factors be reliably measured both over time and in multiple localities? Notwithstanding the criticisms described, the complex differences between communities make it unlikely that a pay-for-performance model could be reproduced with reasonable validity across a variety of culturally, socio-economically and geographically distinct populations.

Despite ongoing, international academic, moral and policy debate this chapter highlights how there does not appear to be meaningful consensus with respect to how best to remunerate doctors. It is also evident how the four principal models just described differ significantly with respect to their basic design and intent. There is a need for South Africa-focussed research which considers

the strengths and weaknesses of payment models in application to our specific context. Whilst these four payment models exist, it is fee-for-service that is the adopted model for private practice in South Africa. For this reason, it is this model that is the focus of my research. Before evaluating it in any specific detail, I will review some basic moral fundamentals in health care as well as the regulatory environment in which the model finds itself in South Africa.

3. REVIEW OF MORAL FUNDAMENTALS IN HEALTH CARE

In this chapter some fundamental ethical theories will be reviewed. Nevertheless, I do not provide an extensive review of the suite of moral theories which influence health care. Rather I provide a brief overview of how just three basic theories find particular application in the payment debate – namely principlism, consequentialism and virtue ethics. The three theories together illustrate many of the fundamental standards with which any health care service should as far as possible comply. Later I will reflect on the common principles discussed in this chapter to critically illustrate how the fee-for-service payment model fares with regard to compliance with the basic moral standards in health care.

3.1 Principlism

Medical students all over the world are taught the four principles approach proposed by Beauchamp and Childress (1994) in their seminal work, *Principles of Biomedical Ethics*, which form the basis of what we now commonly refer to as 'principlism'. They are no less relevant in the payment model debate than in any other facet of health care. The four principles are intended to reflect what Beauchamp and Childress call the 'common morality' and are therefore applicable in all contexts. The principles are: respect for autonomy, beneficence, non-maleficence and justice.

Respect for Autonomy

Autonomy embodies considerations of informed consent, confidentiality and self-determination (Dhai and McQuoid-Mason 2008: 14). In addition, autonomy could refer equally to the patient as well as the health care provider. It seems uncontroversial that patients should in principle not only be informed about what health services they receive, but what the cost *and value* implications of such services are. Only once all the reasonable and necessary facts are known to patients could they ever make informed choices whether or not to accept the performance of various health services. This is also clearly stipulated by the National Health Act (2003: s 6(1)) where it states that the user is to have full knowledge of kind and cost of care that they receive, and should be given the right to accept or refuse treatment.

I think it is clear that in health care, precise advance costing is not always possible – for example in emergencies, or when unforeseen complications of routine services or procedures arise. What is important, however, is that a reasonable attempt should be made to inform patients as accurately as possible about the foreseeable costs of current and future services (National Health Act 61 of 2003: s 6(1)(c), Health Professions Act 56 of 1974: s 53(1), McQuoid-Mason and Dada 2011: 63). Lastly it is clear that overlap exists between the principle of autonomy and legislation designed specifically to protect patients – such as the Constitution (1996) and the Consumer

Protection Act (2008). What is less apparent is how the principle of patient autonomy and professional autonomy should properly and consistently co-exist. It is not unreasonable to appreciate how the variable pull of these two forms of autonomy can result in instances of dual loyalty. In my own professional experience, instances where a patient's wishes oppose the expectation of medical professionalism (and the responsibilities this entails) are fairly commonplace. Williams (2009: 8) describes how there are times when the responsibilities of the health care provider to two or more such external parties mentioned above may appear to be divergent or incompatible. A good example of this is where hospital and regional policies are designed using utilitarian principles based upon the distribution and sustainability of available resources. In specific instances practitioners can be faced with decisions to either comply with the prescriptive mandate by withholding the best available care from certain patients, or to provide best available care to their patients against prevailing policy because they believe this to be in their patients' best interests (London 2005: 9).

Beneficence

The principle of 'doing good', promoting health and acting in the best interests of patients is the second principle central to morally desirable health care provision. While largely intuitive, this principle serves a second function: to emphasise that medical practitioners should act in their patients' best interests

even when these are contrary to their own (HPCSA (2) 2008: s 2(3)(2)). It is understandable why the beneficence principle often finds itself at the heart of the payment debate. It is, however, not obvious how the application of beneficence simultaneously allows provision for the interests of the health care provider. It could even be argued that a strict interpretation of the beneficence principle may minimise the practitioner's right to fair remuneration in favour of providing the best possible care to patients.

Non-maleficence

Quite simply this refers to the avoidance of harm wherever possible. It is one of the oldest principles of medical ethics, dating back to the Hippocratic Oath. In a sense, avoiding harm is probably tightly correlated with proper attention to the other three principles, in particular adequate consideration for the well-being and best interests of patients as described in the beneficence principle above, and later in chapter 6.

The principle's application applies to the payment debate on multiple levels. Payment models that encourage over- or under-servicing, hurried consultations or poor accountability in care are at risk for non-compliance with the non-maleficence principle to the extent that they may not actively encourage or select for good medical practice. It could be argued that any

payment system which does not simultaneously align with a patient's best interests runs the risk of failing to provide for this basic moral protection.

Justice

The justice principle often refers to resource and skills allocation in health care - otherwise referred to as *distributive justice* (Dhai and McQuoid-Mason 2008: 15). In contrast to the first three principles, the evaluation of justice in health care applies less to individuals than it does to societies (*ibid*). While implicit to a proper understanding of the justice principle is that the needs of societies emanate directly from those of its individuals, it may be criticised for its simultaneously poor application to individual scenarios. Similarly it could be argued that by virtue of their individual patient focus, autonomy, non-maleficence and beneficence ignore much of the contextual relevance required for payment model design.

Commentators have emphasised how policies in health care should prioritise the common good, and how commodification poses fundamental ethical problems for societies (Pellegrino 1999: 261). The fee-for-service payment model is almost by definition individualistic in design. As I alluded to in the description of autonomy, the model is conceptually designed with the monetary value of particular professional services (to individual patients) in mind. It is

therefore not obvious how fee-for-service addresses principles of justice, and especially distributive justice.

3.2 Consequentialism

This normative ethical theory morally evaluates action or inaction based on their consequences, and not on any evaluation of the actual action itself – making it an example of a *teleological* theory[2] (Jackson 2013: 10). For consequentialism, actions are neither intrinsically right nor wrong, but are judged according to their aggregate outcomes. It follows that in order to evaluate the morality of actions there must be a set of outcomes that are morally valued, and others which are less desirable. In health care well-being is such an outcome that consequentialists would say needs to be maximised. Furthermore, it is difficult to apply the theory appropriately without first agreeing to a method of ranking such outcomes (Jackson 2013:11).

By virtue of the outcome-focused nature of health care, it is unsurprising that consequentialist moral theory is a significant influence. In essence, the concept of what is in the best interests of a patient is actually an embodiment of a largely consequentialist principle, and a highly-ranked moral outcome.

[2] In Greek *telos* means consequences.

Interventions are morally evaluated contingent upon promotion of the beneficial consequences or *best interests* of a patient. Since they are so dependent on the best interests' principle, it could be argued that both beneficence and non-maleficence are similarly consistent with many aspects of consequentialism.

Interestingly, since consequences can in addition be experienced by communities, this theory appears elegantly adapted for application to patient populations as well as individuals. For this reason, consequentialist thinking often informs the design of public health policies which aim to promote the aggregate good of communities for which they exist (Dhai and McQuoid-Mason 2008: 11). To the extent that we assume public policy *appropriately* relies on consequentialism, it seems intuitive that payment model designs (essentially a less obvious form of public policy) should also be subjected to a similar kind of 'consequentialist stress-test'. Later I will illustrate how from a consequentialist viewpoint the fee-for-service model tends to favour outcomes for medical practitioners above those for patients or patient populations – particularly in the South African private practice environment.

3.3 Virtue ethics

In concert with our traditionally held views on the kind of moral fibre doctors ought to have, Aristotle described and prioritised the specific 'virtues' of

character that are pivotal to the evaluation of what has come to be known as virtue ethics (Rachels 2003: 173). The theory proposes a list of so-called moral virtues, and in contrast to consequentialism values the virtuous intent of actions preferentially to their actual consequences (Dhai and McQuoid-Mason 2008: 11). Choosing the right thing for the right reason is central to virtue theory because it reflects the moral quality of one's character (Jackson 2013: 13).

Particular focus on a moral agent's character and intent resonates with both a traditional interpretation of medicine and the social contract (Cruess *et al*. 2000: 1189, Dhai and McQuoid-Mason 2008: 2, Williams 2009: 48), as well as a modern understanding of medical professionalism (Cruess *et al*. 2000: 1190, Dhai and McQuoid-Mason 2008: 2, Swick 2000: 614, Williams 2009: 49). I think it is also fair to assume that society's commonly held beliefs or expectations of the character and conduct of medical professionals seem consistently aligned with what virtue ethics would consider as morally desirable.

In contrast to principlism (emphasising a patient's wishes and best interests), and consequentialism (preferential value of the aggregate outcome of actions independent of their intention), the virtue ethicist might evaluate the intrinsic moral worth of a payment model proportional to how effectively it promotes

expression of the virtues in both doctor and patient. Importantly, virtue ethics does not consider patient autonomy a moral priority, because the desire to do something does not in itself justify the moral worth of the action (Jackson 2013: 13).

The ethical theories just described commonly find application in actual health care scenarios. In order to prioritise ethical fundamentals in the practice of medicine, payment models should probably not deter their continued expression. In preference, such models would actively promote alignment with patient-centred moral principles, an appreciation of favourable clinical and social consequences and sustained encouragement of virtuous characteristics of medical professionals or medical professionalism. In chapter 7 the fee-for-service payment model is critically evaluated (amongst others) therefore with regard to compliance with the basic moral standards described in this chapter.

4. REVIEW OF PERTINENT SOUTH AFRICAN LEGISLATION, GUIDELINES AND REGULATIONS

In this chapter I do not propose a detailed or extensive review of the laws, regulations or professional guidelines which pertain to medical practitioners. Rather I have highlighted the most relevant of these to the extent that they potentially inform the payment debate. I first outline applicable core legislation, then briefly discuss the National Patients' Rights Charter and lastly illustrate how they have informed the ethical guidelines for good practice and conduct of medical practitioners.

4.1 Legislation

Chapter 2 of the Constitution of the Republic of South Africa (1996) affirms everyone's inherent dignity (s 10), their right to have their dignity respected and protected (*ibid*), the right to bodily and psychological integrity, including security in and control over their body (s 12(2)(b)) and the right to have access to health care services (s 27(1)(a)). The National Health Act 61 of 2003 by definition covers private health care (s 2(a)(1)), and is intended to provide uniformity with regard to progressive realisation of the constitutional right of access to health care services for all South Africans (s 2(c)(i)). The Minister of Health is responsible for promoting the alignment of health services with the country's socio-economic development plan (s 3(1)(b)), and determining the *policies and measures necessary to protect, promote, improve and maintain the health and well-being* for its citizens (s 3 (1)(b)).

As already mentioned in the principlism review above, medical practitioners are required on request to inform patients of the fee that they intend to charge before rendering a professional service (Health Professions Act 1974: s 53(1), National Health Act 2003: 6(1)(c)). They are also required to do so if their fee is higher than the usual fee levied for a similar service (*ibid*). The Health Professions Act governs the Health Professions Council of South Africa, which in turn is tasked with the following objectives according to the Act:

- ✓ Regulate and promote professional and ethical standards (s 3(m));
- ✓ Investigate complaints concerning medical practitioners[3] and discipline contraventions of the Act in order to protect the public (s 3(n));
- ✓ Ensure that medical practitioners respect a patient's constitutional rights to human dignity, bodily and psychological integrity and equality, and behave accordingly (s 3(o));
- ✓ Guide the profession and protect the public (s 15A(h)).

According to the Consumer Protection Act (no. 68 of 2008), a patient would be considered a 'consumer', and a medical practitioner a 'supplier' (Slabbert and

[3] While the Act is relevant to all health professionals, for clarity I refer here to the subset of medical practitioners.

Pepper 2011: 800).[4] Consumers also appear to be preferentially protected by the Act where conflict with other legislation arises (s 4(4)). The Act is intended to promote access to goods and services (s 3(1)(b)), fair business practices (s 3(1)(c)), and advance the social and economic welfare of consumers by encouraging a consumer market that is fair, accessible, efficient, sustainable and responsible (s 3(1)(a)). Section 8 of the Consumer Protection Act provides protection to consumers from discrimination or preferential provision of services.

While a detailed analysis of these protections is beyond the scope of this report, it is interesting to consider what specific implications this section of the Act potentially has on particularly capitation payment models, fee-for-service and to some extent pay-for-performance arrangements.[5] Health services

[4] I outlined in section 1.1 how equal reference to 'consumer' and 'patient' carries with it a potentially negative connotation of commodification in the health care context. This particular section refers specifically to the Act, and therefore to consumers in the more general interpretation.

[5] This is particularly relevant with regard to any variance in access to particular goods and services (s 8(1)(a)), fees for the same goods and services (s 8(1)(e)), and differences in the quality of goods or services provided (s 8(1)(d)). Legislation does, however, usually ring-fence such provisions thereby leaving many others open to legal interpretation. Discrimination on the basis of race, gender or disability for example is specifically provided for in section 9 of the Constitution, Chapter 2 of the Promotion of Equality and Prevention of Unfair Discrimination Act (No. 4 of 2000) and section 24 of the Medical Schemes Act (No. 131 of 1998: s 24(2)(e)). Relative access to the range of health care services in the private sector according to the financial means of the patient as consumer is probably less well provisioned.

rendered in the absence of appropriate consent are defined as 'unsolicited' by the Act (s 21(1)(e)), and a patient is not obliged to pay for such services (s 21(7)). Since its promulgation in 2010, the Consumer Protection Act has not actually featured prominently in the South African health care context. Part of the reason for this is that the Act makes provision for a consumer court - distinct from a court primarily in the limitation of its power (Dinnie 2009: 43). Notwithstanding the inclusion of the doctor-patient relationship in the Act, a consumer court is therefore relatively limited in its capacity to consider complaints which may arise (*ibid*). The Act provides that doctors are responsible for remedy of any defect incurred, or refunding of their portion of the incurred expense (s 54(2)). In practice, most consumers who suffer lasting damages as a result of this relationship are therefore necessarily required to seek assistance from common law courts (Dinnie 2009: 44). This would include the recovery of additional costs incurred by the patient in the process of such a remedy (*ibid*).

Finally, the Medical Schemes Act (no. 131 of 1998) represents an attempt to improve the public's access to private health care, and provide some protection to members of medical schemes. In order to prevent unfair discrimination, admission to a medical scheme and payment of contributions may be conditional upon income and/or number of dependents only, and no longer any other grounds such as age, sex or health status (s 29(1)(n)). The

Act gives rise to the Council for Medical Schemes – a juristic body which, amongst others, is designed to protect members of medical schemes (s 3(1), s 7(a)). The Council must also align the functioning of medical schemes with national health policy, recommend quality and outcomes measures for actual health provision by medical schemes, investigate complaints and settle disputes involving medical schemes and generally identify and distribute information about private health care (s 7(b-e), s 16).

As a member of the public, or of a medical scheme, it is difficult to confirm exactly how the Council is performing this specific mandate, or how adequately. Neither is relevant feedback regarding the performance of its function to protect members within a fee-for-service health care environment is easily accessible on the Council's official web site. More specifically, the official portal does not communicate how the body has "investigated complaints" or "settled disputes" involving medical schemes (s 7(d)). The only references are to proposed mandates, but not to *how* they are carried out, *what* has been achieved, and *how successful* the Council has been in protecting members of medical schemes as required by the Act. The following refers to member protection by the "Complaints Adjudication Unit" – no further links, information, resources or results are provided in support of these statements:

> This Unit serves the beneficiaries of medical schemes and the general public by investigating and resolving complaints and disputes lodged against medical schemes. Amongst other duties, the Unit is also responsible for the following: Monitoring the fair treatment of members and ensuring that members have access to the benefits provided for in the rules of medical schemes; Monitoring compliance with the Medical Schemes Act and the registered rules of medical schemes; Providing legal certainty and consistency on decisions issued on complaints.
>
> Council for Medical Schemes n.d.
>
> www.medicalschemes.com/Content.aspx?105

In support of this, an obvious but important problem is that prices of primary healthcare providers are simply not regulated (Halse *et al* 2012: 8). This, together with collapse of the National Reference Health Price List ("NHRPL"), contributed to the need for a market-inquiry into pricing of the South African private health care sector by the Competition Commission. One of the concerns is that the current standard of independent pricing could be coordinated anti-competitive (Halse *et al* 2012: 9). The failure by the Council for Medical Schemes to provide a regulatory framework for pricing in private

health care simultaneously represents a failure to the protect members as described above (Medical Schemes Act 131 of 1998: s 3(1), s 7(a)).

Regulation 8 of the Medical Schemes Act represents a further ethical and practical challenge to the fee-for-service environment (Act 131 of 1998: Reg. 8). According to s 8(1) of the Regulations, the diagnosis and treatment of the prescribed minimum benefit (PMB) conditions should be covered in full (no co-payments by members are provisioned) regardless of the benefit options being offered by the scheme. PMB conditions include for example diabetes mellitus, hypertension, asthma and a list of others outlined in Annexure A of the Regulations. Any emergency medical condition is also considered a PMB condition (Act 131 of 1998: Reg. 7). The loophole afforded by this Regulation provides temptation for health care providers operating in a fee-for-service environment to charge more for services rendered for PMB conditions in comparison to other conditions. Either way it seems that an ethical and legal conundrum exists, for if it were not mandatory for medical schemes to cover PMB claims in full, practitioners charging more than a scheme's re-imbursement rate would necessarily trigger a co-payment liability for the patient. While this scenario impacts negatively on patients in one respect, it represents a somewhat more financially predictable model for medical schemes, and savings could presumably be passed on to members in the form of reduced contribution premiums. Regulation 8 as it stands, however,

exposes medical schemes to over-servicing and over-charging for PMB conditions.

4.2 National Patients' Rights Charter

The Patients' Rights Charter recognises that as citizens we have the right to participate in our own health-decisions (autonomy principle), and in health care policy development (Department of Health 1999: s 2(2)). Our rights to access to health care include being treated with courtesy, patience, empathy and tolerance by a health care provider displaying a positive disposition consistent with respect for our human dignity (Department of Health 1999: s 2(3)(f)). We have a right to choose our health care provider or health facility (Department of Health 1999: s 2(5)), to complain about the health care service received and receive comprehensive feedback after such complaints have been investigated (Department of Health 1999: s 2(12)). Patients have a responsibility to investigate the cost of their health care and make appropriate arrangements for payment (Department of Health 1999: s 3(9)).

4.3 Guidelines for Good Practice

The Health Professions Council of South Africa (HPCSA) provides some general guidance on the payment debate. The guidelines emphasises many of the core ethical values and principles such as autonomy, beneficence, non-

maleficence and justice mentioned in chapter 3 above (HPCSA (2) 2008: s 2(3)). Very early on in the guidelines practitioners are advised to avoid over-servicing, declare relevant financial interests and prioritise the clinical need of a patient above other factors (HPCSA (2) 2008: s 5(8), HPCSA (3) 2008: s 1(1))). They are also required to avoid providing unnecessary services and to "refrain from…participating in improper financial arrangements, especially those that escalate costs and disadvantage individuals or institutions unfairly" (HPCSA (2) 2008: s 9(1)).

In general, a medical practitioner should avoid any form of remuneration or benefit which induces him to under-service, over-charge, over-service, act unprofessionally or perform acts which are not medically indicated. (Government Gazette 2006: s 7(3)). The clinical need of patients is the medical practitioner's priority. Any inducements or incentives which threaten professional autonomy, professional independence or compliance with a medical practitioner's ethical rules and policies are therefore not permitted (HPCSA (1) 2008: s 1(1), HPCSA (3) 2008: s 1(2)). "Over-servicing of any kind is unacceptable" (HPCSA (1) 2008: s 1(1)). In any capitation, prepayment or similar risk-sharing arrangement there should be peer review, practice profiling and a comprehensive utilisation review in order to avoid under-servicing (HPCSA (1) 2005: s 4(15)). In booklet 5 health care practitioners are disallowed from both the receipt and offering of commission

on goods, substances and materials (HPCSA (3) 2008: s 3(9)). Difficulty arises because health practitioners are entitled to charge a mark-up fee on many goods, substances and materials that they utilise in the rendering of health care. I would argue that this effectively represents commission in an alternative form – i.e. the more consumables invoiced, for example, the greater the income from such consumables. The additional "fee-for-goods" received may induce practitioners to purchase and utilise (effectively selling) such goods, substances and materials in excess of the reasonable need to do so in order to maximise profit. This is therefore not logically distinct from the ethical difficulties encountered with fee-for-service generally.[6]

[6] Receiving and sharing in fees from professional partners and associates is permitted in section 10(3) of booklet 5 (HPCSA (3) 2008). In a similar way to the commission example just outlined, practitioners could induce partners within a private practice to over-service in order to maximise both personal and shared profits. The author has observed this practice amongst medical associates on multiple occasions.

5. MORAL TENETS OF AN IDEAL PAYMENT MODEL

I have outlined some basic moral theories, which inform health care and more specifically some fundamental moral principles involved in private practitioner remuneration. I have also provided a brief overview of the pertinent regulatory environment in which South African doctors provide health care services. I will now sketch the background of medical professionalism and the social contract before proposing an integration of the basic moral tenets already discussed in a way that could inform moral evaluation of health care payment models. Later I specifically apply these consolidated principles to the formulation of a kind of moral blueprint against which payment models in general could be morally evaluated.

5.1 Background – the social contract

Health professionals have traditionally pursued their profession according to the terms of an unwritten, relatively unstructured yet commonly accepted understanding or contract with the societies in which they have lived and worked (Cruess *et al*. 2000: 1189). It has been characterised by a specific, but implicit relationship between the role of doctors and society where in return for personal sacrifice, service, altruism and the pursuit of medical knowledge health providers were given financial reward, status and privileges such as the right to self-regulation and professional autonomy (*ibid*).

The two parties in this traditional form of the social contract had relatively well defined roles: physicians devote time and effort towards gathering and furthering medical knowledge and skill, and use such attributes to assist with healing individuals within societies and the serving of society in general. In order to perform these functions effectively they are required to display a strong sense of morality, commitment to the public good and a developed sense of altruism (Williams 2009: 48).

Many have argued that the concept of a medical practitioner's autonomy and the patient's best interests are necessarily interdependent (Emanuel and Pearson 2012: 368). In order to encourage physician autonomy a move away from fee-for-service is necessary, and would almost certainly entail a modification in the way that they practice (*ibid*).[7] By operating relatively autonomously within privileged or less prescriptive occupational oversight it is necessary for doctors to develop a system of self-governance (Williams 2009: 48).

[7] Autonomy in the professional sense implies a certain freedom with which professions self-govern and professional decisions are made. The social contract assumes a significant degree of professional autonomy to be in the best interests of the patient. What Emanuel and Pearson are implying is that fee-for-service effectively erodes such autonomy by rendering service conditional upon a fee, rather than solely the product of professionalism.

Society in turn holds physicians in high regard – a position that is arguably deserved given the extent of their studies, privileged knowledge base and the high moral standards required of them (Schei and Cassell: 2012). A significant degree of trust characterises the unspoken contract (Anderson 1995: 413). This is particularly necessary given the vulnerability that patients often experience in health care (*ibid*). The characteristics and the moral obligations assumed of them mean that medical practitioners are subject to a code of accepted behaviour which embodies these elements (Cruess *et al*. 2000: 1189). Today we could equate this to the concept of professionalism (*ibid*). This is succinctly described in the following extract:

> … (Medical) professionalism consists of those behaviours by which we—as physicians—demonstrate that we are worthy of the trust bestowed upon us by our patients and the public, because we are working for the patients' and the public's good.
>
> (Swick 2000: 614)

The notion of professionalism has essentially been accepted as the basic foundation of the social contract (Cruess *et al*. 2000: 1190). Central to professionalism is that it implies a set of moral obligations to both patients and their communities (Swick 2000: 616). Furthermore, despite the dramatic

changes experienced by all professions in the modern era, the social contract and professionalism remain as pivotal today as they were thousands of years ago (Dhai and McQuoid-Mason 2008: 2).

Professionalism, however, is less obvious in health care today. The current trend towards technical- and knowledge-focused, transactional health provision has probably shifted some of the focus away from the physician's respected and central moral role in historical communities. Some argue that a new kind of independent 'health care entrepreneur' has emerged who values the commercial aspects of their profession over professionalism (Williams 2009: 49).

I would contend that this change represents a structurally flawed and logical disconnect between two necessarily interdependent concepts. The progressive changes we have observed in the health professional's thinking seem at odds with, and in relative isolation to the society which they are designed to serve. In a sense, professionals have tried to re-define themselves independently of the social contexts, which defined them in the first place (Cruess *et al*. 2000: 1190). If the very contract which professionals have always granted tacit consent to exists for the purposes of serving such societies, then a correction towards a more traditional contract seems likely or even inevitable. It follows that any such correction would necessarily entail a

strengthening of professionalism: a core principle from which the social contract derives its meaning.

5.2 The basic tenets

The payment debate in private practice is in many respects analogous to a balance of power. Too much control over a payment model by medical practitioners potentially weakens the realisation of patients' best interests. Too much in the hands of patients could potentially both discourage doctors and render health care unprofitable. Excess influence by health insurers exposes the industry to real risk of significant paternalism. Ideally, the locus of control for payment in health care should probably be as equally balanced as possible to provide for the interests of all concerned. In real terms, during a medical consultation the practitioner should (by whatever specific mechanism) have the patients' best interests in the forefront of his mind, and be discouraged or unable to manipulate expected remuneration at either the patient's or their health insurer's expense.

One of the main assumptions on which this research is based is that the best interests of a patient should be prioritised in some way during the health care delivery process. In application to payment model design, it should therefore be clear how central the role of principlism ought to be in the process. I have

shown how professionalism is critical to the provision of appropriate health care. It would therefore be desirable and beneficial for payment models in private practice to not only preserve, but *encourage* medical professionalism. This is arguably the most difficult tenet to successfully achieve. With the introduction of fee-for-service, the potential for over-servicing and therefore the interests of some medical practitioners – unlike in the social contract – are not always consistent with medical professionalism (see also footnote 5 above). Unless the interests of a practitioner could in some way be connected to or aligned with medical professionalism, both professional autonomy and the patient's best interests are potentially threatened. Concerns about autonomy have been raised with the introduction of a pay-for-performance arrangement (Saint-Lary *et al.* 2012: 487), as well as any transactional-based model, such as fee-for-service (Australia Productivity Commission 2008: 97). Lastly, (notwithstanding some ethical criticisms already raised) on a purely technical basis payment models are required by law to comply with pertinent regulations and professional guidelines.

In summary, the basic tenets that I have proposed are:

- ✓ Consider the best interests of the patient
- ✓ Encourage medical professionalism
- ✓ Comply with pertinent regulations and professional guidelines
- ✓ Balance locus of control between all parties

5.3 Sustainability

In order to meet its principle objectives, this research purposefully neglects rigorous examination of any payment model's specific application or actual consequences. Nevertheless, it is reasonable to assume that any proposed and viable payment model should probably be consistent with economic sustainability of the specific health context to which it applies. I have already indicated why a sustainable private health insurance industry is necessary. For its sustained acceptance and application, the proposed moral fundamentals of any payment model should also be robust and conceptually compatible. A definitive evaluation of the various economic considerations that a model should address are, however, beyond the scope of this report.

6. THE SOUTH AFRICAN PRIVATE PRACTICE ENVIRONMENT

This report has outlined the background, the moral context and regulatory environment of the payment debate in South Africa. In order to appropriately evaluate the fee-for-service model in South Africa, this chapter first highlights some of the basic features that characterise the local private practice environment. I have broken these down into general context, remuneration, the relevant parties' best interests and governance-related features.

6.1 General context

For the purposes of a properly contextualised discussion, I propose the following general assumptions:

Assumption 1

Medical practitioners in private practice invoice for particular medical goods (consumable items such as medicines and materials) and services (consultations and medical or surgical procedures). A specific service is generally assigned a monetary value dependent on (1) the medical practitioner's speciality, and (2) the average time an equivalently qualified specialist would spend on a similar service.

Assumption 2

Within a particular speciality, the monetary value of medical services is not meaningfully correlated with a practitioner's overall experience, effectiveness or any other intrinsic variable with regard to either the majority of cash-paying (or so-called 'private') patients, or many of their medical insurers;[8]

Assumption 3

The majority of medical practitioners' annual consultation fee increases are inflation-dependent. Medical inflation is more than double the rate of general inflation in most countries, averaging 7.9% in 2013 (Towers Watson 2014: 1). South Africa's medical costs increased by 8.4% and 8.1% on average in 2012 and 2013 respectively, compared to general inflation of 5.7% and 5.8% for the same periods (Towers Watson 2014: 5).

[8] Medical insurers are increasingly negotiating payment contracts with doctors which propose fees contingent upon compliance with a number of pre-determined management criteria (example), and less often upon clinical outcomes relative to a pre-determined benchmark. This increasingly applies to the management of patients who suffer from chronic medical conditions such as hypertension and diabetes.

6.2 Remuneration

A few important points follow from the above assumptions, and in turn inform a more detailed analysis of how medical practitioners in private practice characteristically earn their income. It is necessary to delineate and accurately conceptualise this process insofar as it provides necessary insight into the conditions best suited for the interests of private medical practitioners. This provides the basis for comparison to the best interests of both patients and health insurers, which is in turn fundamental for the moral evaluation of fee-for-service payment.

If we assume fees to be on average fairly standardised within a speciality, the relative variable most predictive of a doctor's turnover would simply be the *number of invoices raised* i.e. the number of patients seen.[9] Within the same private practice it would therefore be possible for a doctor in the first year of their career, for example, to generate a similar professional turnover to an equivalently qualified, but far more experienced doctor. This would be possible by simply by raising an equivalent number of invoices.

[9] There are obviously exceptions to this generalisation, but a comparison between doctors in similar specialities performing a similar range and mix of professional tasks has been assumed.

Now consider the medical practitioner who attempts to increase their relative earnings. It is clear that this could usually only be achieved by:

- ✓ Increasing the number of patients seen;[10]
- ✓ Increasing the consultation fee above general and medical inflation;
- ✓ Increasing the number of chargeable items (or the fees for such items) per consultation; or
- ✓ Reducing practice spend on fixed costs, consumable items and services.[11]

Some important corollaries also flow from the thread of this discussion. Firstly, in order for a medical practitioner to accommodate more bookings in a day he would need to:

- ✓ Shorten consultations;
- ✓ Over-book his diary; or
- ✓ Work longer hours.

[10] This should be understood in terms of a volume / time ratio, for example patients seen per day.

[11] Importantly, this could possibly have implications for the overall quality of the health service rendered.

Secondly, in order for any of these strategies to be productive, there would need to be sufficient demand to provide the required volume of patients: a variable that is not in the practitioner's immediate control. In South Africa a relative excess of patients exists since the overall demand for health care (including private practice) exceeds the relative supply of medical practitioners (Breier 2008:).[12] This is not therefore a limiting factor in South Africa.

6.3 Parties' best interests

I have reviewed some basic moral theories, which inform health care generally, and how they could theoretically apply to the moral fundamentals of an ideal payment model. While some of what follows may be considered self-evident, for clarity I will now describe what I would consider are broadly speaking the best interests of patients, medical practitioners and health insurers. This is instructive as it provides the much of the applied basis of the critical discussion of fee-for-service which follows in the next chapter.

[12] A recognised shortage of medical practitioners exists in South Africa: average of 7 medical practitioners per 10 000 population versus 28:10 000 in developed (high-income) countries (Breier 2008: 13).

Best interests of patients

Patients ideally require timeous and accurate diagnosis as well as effective and efficient care. This may entail the performance of special investigations, specialist intervention/s and the best available treatment – usually from a skilled medical practitioner. A number of ancillary conditions are important such as being treated appropriately and with the dignity and sensitivity which promotes comfort and confidence. This necessarily includes attention to the psychological and emotional needs of patients. Sufficient consultation time, health promotion and follow-up planning are also in the patient's best interests. I would collectively summarise the above as *effective care*.

While it may seem obvious that the best effective care is desired by most patients, it is not possible in my opinion to exclude the financial cost of health care for patients in private practice from an appreciation of what constitutes their best interests. Health insurers and public health care services are also necessarily subject to this cost variable. For this reason, the best effective care may not necessarily be accessible or available to either the patient, health insurer or health service. In summary, I would therefore propose that what is

reasonably in a patient's best interests is the *most effective, available care which the patient can afford.*[13]

Best interests of health insurers

Health insurers have a technically difficult task with regard to protecting their best interests. This is largely because their best interests entail simultaneous attention to four principal and equally powerful mandates.

Firstly, health insurers are required to provide an effective service to their members. Health insurers therefore share many of the same interests as those of the patients they insure. They are particularly cost-conscious to maintain the lowest effective average premium costs for their population of members in order that they remain competitive to rival insurers. Secondly, health insurers are under pressure to provide sufficient incentive (agreed remuneration) for medical practitioners to encourage their continued

[13] I concede that this is probably controversial, and potentially problematic. Ideally, a fair price is obviously a better option compared to an inferior service. The difficulty is that this line of argument threatens the concept of private practice entirely. Firstly, the price of a service is presumably the price at which such a service has been determined to be sustainable by the private provider. Secondly, it is difficult to imagine how concessions on the price of services on this basis could simultaneously avoid a slippery slope ending in health cover for all. This would effectively represent an abolishment of private practice altogether. Private practice is therefore by definition characterised by the relative affordability of health care services.

collaboration. Thirdly, compliance with a variety of stringent, and periodically changing industry regulations is mandatory. Lastly, the health insurer must successfully fulfil the above mandates while remaining an economically viable business concern.

Best interests of medical practitioners[14]

Professional decision-making assumes a degree of professional autonomy. To the degree that specific clinical decision-making and interventions are appropriate or indicated, medical practitioners would presumably benefit from maximum professional autonomy to arrive at such decisions. Unlike in a more traditional society influenced by the social contract, medical practitioners today have increasingly become sole proprietors, or health care entrepreneurs (Williams 2009: 49). In this situation, it would be in a medical practitioner's best interests to levy maximum professional fees for services in order to prosper financially.

In terms of contractual agreements with health insurers, practitioners would presumably once again benefit from a liberal degree of professional autonomy.

[14] I have avoided describing predictable extremes such as 'no accountability', or 'minimum time spent at work' etc. A realistic view given the prevailing professional medical environment has been assumed.

In addition, many professionals prefer to reserve the option to supersede contractual boundaries where it is deemed professionally or morally necessary. The interpretation or application of the terms of contracts would presumably be those best suited to maximise income.

Less obvious conditions which might be in the best interests of many medical practitioners could include:

- ✓ Adequate perceived income and perceived growth in future income;
- ✓ Adequate job satisfaction, perceived professional growth and future job satisfaction;
- ✓ Limited personal accountability for provision of poor quality health care;
- ✓ Limited administrative and regulatory burden.

In summary, while patients require effective, cost-effective care, the best interests of medical practitioners in private practice are not obviously similarly aligned. Health insurers have the technically challenging task of simultaneously providing for the interests of both patients and medical

practitioners. It is evident that unless alternative conditions exist[15], it is not unreasonable to conclude that in some circumstances fee-for-service payment could inherently promote under-servicing with respect to effective care, and over-servicing with respect to the relative cost of health care. I will attend to this argument in more detail after a brief review of governance in private practice.

6.4 Governance

Major political change in South Africa in the 1990s was followed by the promise of an actively reforming health system to provide necessary redress for the shortcomings of traditional apartheid health care (Coovadia *et al.* 2009: 817). Not only have specific health care-related goals failed, but there has also been relatively ineffective governance in the post-apartheid era (Coovadia *et al.* 2009: 820).

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[15] It is probably unfair to simply include all medical practitioners in this fairly generalised context. It is obviously true for example that many practitioners share interests which do align with those of their patients or health insurers. These may include the desire to help or support their patients above other considerations such as time or remuneration. Many practitioners are also sensitive to cost considerations, and attempt to assist their patients wherever they can. Rather than discount the possibility that many such practitioners exist, I've attempted to illustrate how the fee-for-service payment model – *as a model* – may not necessarily encourage these characteristics. Practitioners who provide health care from a more sensitive perspective therefore do so relatively *independently* of the influence of fee-for-service payment model. I will attend to this again in my critical evaluation of fee-for-service.

In the current private practice environment, in addition to relatively weak regulatory oversight there is, in addition, arguably a paucity of effective governance with respect to the *quality* of health care rendered by medical practitioners.[16] Medical practitioners in private practice do not, for example, usually undergo any form of regular 'performance appraisal', 'management review' or 'efficiency audit'. A relatively basic continuing professional development system administered by the HPCSA is the only proactive, regulatory program which addresses this issue – and only indirectly so. Compliance does not involve any kind of review of actual patient care.

In fact it does not seem to be the regulatory bodies which are primarily promoting good clinical practice, but the private health insurers. Interestingly, such encouragement is usually in the form of the inherent variable to which fee-for-service is most sensitive: differential medical practitioner remuneration. It is beyond the scope of this report to analyse why the quality of medical care has thus far not been effectively evaluated or constructively utilised to promote better care. Briefly, I would propose that health care is probably both difficult to quantify and the relative success of interventions not always easily evaluated. Secondly, an under-supply of medical practitioners probably simultaneously represents a relatively unbalanced negotiating advantage in

[16] Author's note from exposure to the private practice environment.

comparison to patients, health insurers and administrators for any kind of discussion on medical practitioner accountability.

While these assumptions might suggest that health care and therefore governance are difficult to evaluate, in itself this does not represent a convincing argument for why they should not be evaluated at all. Health care evaluation is simply necessary for health care governance and the promotion of good medical practice. In a society where patients' interests are important, a failure in good governance is therefore inevitably a failure to actively promote patients' best interests. The next chapter evaluates the fee-for-service payment model in the context of the private practice environment and the moral fundamentals of health care.

7. CRITICAL EVALUATION OF FEE-FOR-SERVICE

I will now critically evaluate the fee-for-service model against the criteria and principles thus far developed in order to defend the thesis that the fee-for-service payment model is morally unjustified. To do so I will rely on many of the assumptions outlined, including many of those pertaining to the South African private practice environment described in chapter 6. Later I consider some relevant difficulties with alternative payment models before proposing how this research could be constructively utilised in the design of more morally robust future payment models.

7.1 Moral weaknesses of the fee-for-service model

I have described some features of the private practice environment which inform the payment debate, and particularly those pertinent to the evaluation of fee-for-service. Earlier in the report I outlined some of the more influential moral principles and theories in health care, and applied them to what could be considered the desired fundamentals of any payment model. I will now highlight the weaknesses of the fee-for-service model by comparing its compliance with these moral fundamentals. In conclusion I will argue that the fee-for-service model for remuneration of medical practitioners in private practice is morally unjustified.

Principlism

It's critical to once again emphasise that the principle objective of this research is whether the fee-for-service model, as a model, inherently promotes or fails to promote a patients' best interests. It is not unreasonable to assume that fee-for-service could promote the best interests of patients under certain conditions. I will indicate in the next section however, that in such situations patients' interests are promoted as a function of both market conditions and the fee-for-service payment model, and not necessarily by virtue of the attributes of the payment model alone.

I think it is clear when considered independent of relative market conditions, there is probably little in the design of the fee-for-service model which inherently promotes either the best interests of patients (beneficence, non-maleficence and respect for autonomy), or justice. I think it is also clear that it neither discourages these basic health care principles. Besides possibly fulfilling the minimum criteria of enabling remuneration by a patient or health insurer *at all*, in the absence of other compelling arguments it is difficult to appreciate how the model inherently *promotes* medical professionalism, the best possible patient care, an active avoidance of harm or the consideration of a broader context and distributive justice.

Consequentialism

It could be argued that the motivation medical practitioners have to retain patients for repeat business makes the fee-for-service arrangement particularly effective in a competitive environment (generous supply of medical practitioners who compete for patients). The desire or need to retain patients could promote better quality health care, which in turn results in promotion of a patient's best interests (beneficial consequences).

While this is certainly difficult to dispute, the benefits just described are more the result of *the specific context* in which fee-for-service finds itself rather than a result of any specific benefits inherent to the model, *as a model*. In fact as I have already argued, the South African environment is one example of a context in which similar market factors are not always experienced. Contrary to the potential benefits that characterise fee-for-service in a generous "supply" market, the model is not inherently geared to promote beneficial consequences for patients in one which experiences an "under-supply" of medical practitioners. Rather, markets such as these rely on some form of oversight or regulation in order to monitor whether medical practitioners conduct their practices in alignment with promotion of beneficial consequences for their patients in preference to promotion of their own. In conclusion, fee-for-service does not inherently promote beneficial consequences for patients as a model

in a way that would morally comply with the basic requirements of consequentialism.

Virtue Theory

I proposed earlier how a modern understanding of what it means to be a 'virtuous' medical practitioner is probably most closely approximated by the concept of medical professionalism. I have also described the parallels of modern professionalism with the traditional social contract. In application to fee-for-service, in a manner similar to the arguments just outlined for consequentialism, I concede that in specific environments (for example relative over-supply of practitioners) the relative virtue of practitioners may appear to be encouraged.

Once again though I would argue that any apparent promotion of medical professionalism cannot be reliably separated from the accidental environmental context in which the model finds itself. This is again quite simply because the fee-for-service model does not promote medical professionalism in an under-supply environment, but rather it's opposite. In support of this I refer to the review of the best interests of the relevant parties where I showed how the interests of patients and practitioners are often poorly aligned. It is therefore difficult to justify the existence of a virtuous medical

practitioner - one who complies with the values of medical professionalism – in any fee-for-service environment on the basis of the attributes of the model. Rather, medical practitioners who embody a strong sense of professionalism probably do so on the basis of characteristics independent of the fee-for-service model and largely *inherent to themselves*.

I conclude, therefore, that there is little evidence that the fee-for-service model for private practitioner remuneration inherently promotes the basic features of three examples of ethical theories on which health care is grounded – namely principlism, consequentialism or virtue ethics.

7.2 Fee-for-service and the regulatory environment

In the absence of features which actively promote the best interests of patients, the fee-for-service model is heavily reliant on the prevailing regulatory context to ensure the protection of patients. Earlier I highlighted some basic regulations, legislation and good practice directives which are principally designed to protect patients' interests. It was also mentioned in chapter 4 that despite the Medical Schemes Act (no. 131 of 1998), gaps exist in the regulation of private health care in South Africa. A detailed review of how the regulatory framework protects or fails to protect the patient in this context is beyond the scope of this report. Even if it *could* be argued that the regulatory

framework was adequately adapted to providing for such protection, based on personal professional experience effective governance in South African health care is often, however, relatively weak. While such observations are not materially contributory for the main purpose of this study, I think they illustrate how in addition to being morally problematic, fee-for-service arguably operates in a weakly administered, and relatively reactive regulatory environment. This effectively represents a potential double blow for both promotion and protection of patients' best interests.

8. A PROPOSED MORAL CHECKLIST: PRE-CONDITIONS FOR PAYMENT MODEL DESIGN

It should be clear that what is being suggested in this research is not a substitution of existing criteria which define payment systems in private practice. Nor does the scope of this report address the question of 'what' or 'how much' doctors should be paid. Rather, I have attempted to describe the fundamental basis of 'how' practitioners are remunerated, and the ethical problems we face when examining 'why' they should be paid in this way at all.

It should also be clear why the research has purposefully not considered other contingent factors which are obviously relevant to payment model design. These might include for example public policy, budget and various clinical and practice-related technicalities. Insofar as none of these substantially inform a description of the desired and common *ethic* of an essential doctor-patient encounter, they therefore cannot similarly inform the ideal *moral standard* against which payment arrangements for such an encounter can be measured. It should not be understood though that such contingent factors are unimportant. Nor should it follow that the integration of these contingencies as practical necessities in payment model design necessarily jeopardises the moral worth of the model as a whole. What does follow though is that excluding contingent practicalities from the formation of a moral standard has the effect of independently highlighting whatever moral weaknesses there may be inherent to a payment model being evaluated.

What I have also attempted to show is how the fee-for-service payment model in particular, and payment models in general, can be morally evaluated based on how they influence the doctor-patient relationship. In some way an overview of the foregoing discussion reads not unlike a kind of moral checklist. It seems only intuitive therefore to now outline the main findings in the form of a proposed moral blueprint against which any current or future payment model can be tested.

8.1 A proposed moral checklist

Given the prevailing socio-economic and regulatory environment, does the structural design of a payment model:

- ✓ *Discourage over- or under-servicing?*
- ✓ *Promote the interests of patients, providers and the community?*
- ✓ *Promote medical professionalism by recognising effective and appropriate health care?*
- ✓ *Promote accountability by discouraging sub-optimal health care?* [17]
- ✓ *Comply with pertinent regulations?*

[17] I think of this as a 'skin in the game' or 'accountability' clause.

I would like to propose an additional, moderating standard similar to one often applied in law. Judgements often reflect not only on the facts of a matter and whether or not they comply with the law, but also on their compliance with what is *in the spirit of the law*. Similarly I would propose that the design of any payment model should ideally be *consistent with the spirit of health care.* Payment models which by and large comply with the conditions proposed here are unlikely to require the application of this last moral 'standard'. In such instances, though, there is little harm in subjecting them to an additional moral test. Models which cannot comply for whatever reasons or limitations might, however, be rationally sanctioned merely as a consequence of such reasons or limitations. Reflecting on whether such models are consistent with the spirit of health care elegantly and quickly illustrates any generally understood deviation from it. While I would agree that it is open to fairly wide interpretation, the simple, intuitive and overriding nature of this last condition is simultaneously difficult to ignore. I believe that discussion generated during reflection on this basic principle could have a morally grounding effect that is arguably more beneficial on balance for patients' best interests than it is likely to be restrictive to the same because of latitude with respect to its specific interpretation. The last check then:

- ✓ *Comply with the spirit of health care?*

8.2 Application and extensions

A moral checklist like the one proposed means little unless it can be both endorsed by the relevant parties and find practical application in informing policy design and implementation. I therefore encourage the assembly of an independent ethics body to continually evaluate and modify for endorsement both (1) the proposed moral checklist presented here, as well as (2) the moral basis of existing and planned payment models.

The role of such a group could be thought of as analogous to that of a standard research ethics committee. In both instances the body endeavours to maintain compliance with ethical standards while simultaneously protect the best interests of patients, medical practitioners and the community. Such an ethics body should be represented by independent practitioner associations (IPAs), Department of Health and/or the HPCSA, members of the general public, health insurers and ethicists.

8.3 Implications for communities

Robust public policies consider not only community outcomes, but also how individual community members can be affected by their widespread policy implementation. While I concede that payment policies cannot exclusively be modelled around the moral interests of patients, the converse notion that they

be modelled exclusively around clinical and economic outcomes seems equally untenable. The principal advantage of any model that prioritises the patient's best interest side-by-side with economic, clinical benefit and other practical and policy considerations is its degree of inherent moral control. I think it is clear from this report that our current payment policy in South Africa is not similarly ring-fenced by equivalent moral protections.

I acknowledge that in many countries or societies it may be impractical to adopt a payment model which fully complies with similar moral requirements to those proposed in this report. Similarly, it may be economically impractical for many to even properly scrutinize their existing models with a view to adopting change. The payment systems of such societies' health care services could therefore not always be informed by a similar moral influence and consequently enjoy a similar degree of inherent moral control.

In light of the foregoing, it would be incumbent upon and achievable for such policymakers to disclose to patients (1) why these adopted conditions cannot be adequately met, and (2) what specific weaknesses such omissions expose. They would then be required to (3) encourage awareness of what potential negative implications this could have during consultations with private practitioners, as well as (4) practical ways to recognise and manage these effectively. This would be morally required in order to enable citizens and

providers to utilise private health care services with the best possible degree of autonomy.

9. DISCUSSION AND CONCLUSION

The main limitation of the study is that it doesn't propose a comprehensive, viable alternative to the current remuneration model. The current report also gives relatively little attention to the other principal payment models – particularly pay-for-performance, which currently attracts favour in for example many developed countries. The patient-centred nature of the review means that applicability to actual processes, holistic public policies, populations and outcomes is not adequately discussed. Furthermore, the actual mechanics of how the moral principles outlined can be effectively and seamlessly applied to actual payment systems has also not been adequately examined. For these reasons, the study's general applicability to actual health models is not described, and the purpose or utility of the research might be questioned. Precisely because this research does not (extend to a description of or describe) any morally viable payment models in preference to the fee-for service system, the report is unclear on whether payment policies ought to do away with fee-for-service entirely.

In response I would argue however that the criticisms proposed above in fact simultaneously highlight the study's greatest strength: a purely ethical enquiry that is not influenced by the practicalities of actual systems, their economics, sustainability or specific valued outcomes. Rather than negate the utility of our existing payment model, this research effectively highlights how it might currently value economics, outcomes and the practitioner's interests above professionalism and the best

interests of the patient. This should have the positive effect of inviting constructive debate and discussion for informing more relevant and morally acceptable payment models in the future.

It could be argued that this research has not focused sufficiently on the role of the health insurer as an integral component of the payment debate. I have attempted, where relevant, to illustrate where consideration of health insurance is necessary as it informs the moral basis for a critique of fee-for-service. Extension beyond such applications is both beyond the scale of this report, and potentially inconsistent with its principal aims. I would argue that one of the weaknesses of existing systems is the apparent paucity of such constructive (particularly moral) discussion which informed their design. It is possible that their almost 'accidental' evolution and lack of robust moral rationale is probably correlated in some way to their degree of success or failure, and probably also their ultimate sustainability in the context of the communities in which they apply.

In highlighting the weaknesses of a payment model it should not be inferred that each component of the model is unusable. While I have argued fee-for-service is probably morally flawed, it is unreasonable to conclude that each component of the model must necessarily be similarly flawed. On the contrary, I would argue that many of the components of fee-for-service are actually very useful. For one, the concept of health care as a 'service' is well captured by the model. Service implies

that in some way patients are ‘consumers’ or ‘users’ of health care, and doctors are ‘providers’. This interpretation is relatively congruent with the Patients’ Rights Charter (Department of Health: 1999), the Constitution (1996), the National Health Act (61 of 2003) and the Consumer Protection Act (68 of 2008). In my opinion, neither the salary or capitation models capture quite this same focus. In a sense, the findings suggested in this research in some way represent a kind of ‘moral compass’ for health care. For this reason, such findings should probably be examined for validity independently of their actual application to payment models in private health care. If sound, they could be applied as one among many foundational guides for the design of such models. By reflection, any resulting model could then also be morally evaluated on the basis of its compliance / non-compliance with these moral guidelines. Furthermore, it probably follows that unless the need for a robust moral framework is rejected altogether, it would be incumbent on any alternative payment model to demonstrate either (1) how such a model happens to already comply with similar moral requirements, or alternatively (2) what equally compelling and ethically sound arguments are provided in support of an alternative moral framework.

This report represents an initial moral probe into a relatively controversial, but fundamental area of private health care. In addition, since many of the principles outlined here are morally fundamental to the provision of health care services generally they are in many respects applicable to both private and public health

sectors and their policy designs – locally and internationally. I have outlined and acknowledged the inherent limitations of this research. The vastly different contexts and practical realities to which the payment debate potentially applies simultaneously represents the unique challenges faced in any kind of attempt at serious payment model reform. Further discussion, criticism and constructive development of its central arguments is therefore encouraged to enable mature application of this and similar research to the payment debate, future payment models and consequently the promotion of patients' best interests. The explorative nature of this research (probably unsurprisingly) poses many more questions than it actually provides answers. To the extent that the payment debate seriously considers these questions, I would argue that the inevitable focus they bring on ordinary people in need of health care effectively *connects* them (both people and questions) to the solution in a way that is both necessary and elegantly difficult to ignore.

In this report I have described the various payment models for private practitioner remuneration, and evaluated the moral suitability of the adopted fee-for-service model in the South African context. I have reviewed the ethical fundamentals of caring for patients and promoting their best interests. The fee-for-service model as it is applied to private practice has been analysed and shown to be poorly-compliant with accepted moral fundamentals. In conclusion I have defended the thesis that the current remuneration model for private medical practitioners is not morally justifiable as it does not promote a paying patient's best interests. In the absence of

specific and viable alternatives to the current payment models I have proposed how a simple moral checklist could be generally applied in order to safeguard promotion of a patient's best interests.

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