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# ETHICAL IMPLICATIONS OF ADOPTING VALUE-BASED HEALTHCARE IN AFRICA

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Submitted to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree Master of Science in Medicine (Bioethics and Health Law).

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(Student number: **1534278**)
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## ABSTRACT

Value-based healthcare (VBHC) is purported to be the solution to address the issues that are present within fee-for-service (FFS) healthcare reimbursement. As the global discourse around adopting VBHC gains momentum, the body of knowledge on the topic is growing. Conversely, the literature on VBHC's ethical implications is still sparse. Nonetheless, a few ethical issues have emerged from existing literature and will be detailed below.

Civil society and the healthcare fraternity ought to be concerned about the ethical implications of the shift in reimbursement models. This is particularly important in Africa, where economic disparities are glaring and extend into the healthcare sector.

Some literature highlights issues of justice, equity, and solidarity as requiring attention with adopting VBHC. They are concerned with how VBHC disproportionately benefits certain populations at the expense of vulnerable populations.

Secondly, concerns about the VBHC's impact on patient autonomy are also emphasised as posing a risk of incentivizing providers to under-treat as a means of maximising revenue.

Also, the extensive IT system integration required to underpin VBHC means that patient medical records and treatment history will be stored in a centralised location, accessible to a wider team of providers to monitor population-based patient outcomes statistics. This raises a critical issue of how patient confidentiality will be preserved within VBHC.

The concept of “value” in healthcare is unclear and thus poses the real risk of measurement metrics being skewed towards cost containment vs patient outcomes and quality. Thus, providers would potentially use patients for financial gain. Additionally, the lack of cost transparency by providers also makes it challenging for patients to understand how their treatment is priced, how their care is evaluated and how treatment decisions are being made, ultimately potentially resulting in a mistrust of the healthcare system.

Finally, VBHC does not make provisions for traditional or alternative medicine providers, who are an essential component of the healthcare system in most LMIC countries (especially in Africa). The oversight of this cultural nuance risks alienating large segments of populations, thus posing a real threat to patient dignity.

This paper seeks to consolidate and describe the emerging ethical issues based on globally available literature. In light of the ethical issues raised in the previous chapter, I will argue that adopting VBHC in Africa is morally justified. I hinge my thesis on the Afro-communitarian tenets of shared identity, solidarity and goodwill. However, South Africa’s NHI (which is the most explicit national VBHC in Africa) as spelt out in the National Health Insurance (NHI) Bill of 2019, omits to include Traditional African Healers as part of the care team, thus potentially alienating a significant portion of the population. Secondly, the NHI Bill of 2019 does not provide clarity on how confidentiality will be maintained under the NHI. Until these two issues have been satisfied, I argue that VBHC in Africa is conditionally morally justified. My argument is supported by the Utilitarian ideological basis that actions provide the greatest benefit ought to be pursued. Kantian ethics adds that limiting the citizen’s choices under the NHI is an assault to their autonomy and therefore also deems adopting VBHC in Africa as being conditionally morally justifiable.

Dad, you still inspire me.

Zimi, thank you for extending me grace

# CHAPTER 1

# INTRODUCTION

*“Anything that just costs money is cheap” - John Steinbeck*

## BACKGROUND & CONTEXT

The global move towards universal healthcare coverage (UHC) has sparked an overhaul of the healthcare sector, which aspires not merely to amend the current dominant fee-for-service (FFS) reimbursement model but to disrupt it completely by introducing the concept of value into healthcare. In the FFS reimbursement model, healthcare providers (providers) are paid based on the volume of services they provide. For example, patients are billed for each service they receive within their treatment journey, including consultations with their treating doctor, lab tests, scans, hospitalisation, and any post-operative treatment required. As such, the quantity of services dispensed is positively correlated to the provider’s revenue. Therefore, healthcare providers are rewarded for the volume of services meted out. Quality of the service, cost, and treatment outcomes metrics are not considered. Provider reimbursement is not tied to the quality of care given, patient outcomes and experience of the care received, or the total cost of care (Healthbridge, 2018, p1).

On the other hand, the value-based healthcare (VBHC) reimbursement model channels significant changes to reimbursement in the healthcare industry. At its core, VBHC proposes that healthcare providers ought to be reimbursed for contributing to positive patient outcomes while minimising the

total cost of care dispensed throughout the treatment journey and simultaneously providing quality care (WEF, 2017, p1). Thus, providers will not be financially disadvantaged if the level of healthcare value provided, meets the minimum clinical outcomes, cost, and quality standards.

In the 2017 *Value in Healthcare: Laying the Foundation for Health System Transformation* report, the World Economic Forum cited that although progress has been made towards a value-based healthcare system, no country has fully transitioned. The progress towards full VBHC integration has been hampered by systemic "obstacles to change that are built into how traditional health systems are organized, financed, and regulated, and how financial and non-financial incentives are structured" (p6).

As the global VBHC agenda continues to spread, the ethical issues surrounding the adopting VBHC in Africa remain to be thoroughly investigated.

## 1.1 BACKGROUND

The transition from a volume-based care model poses some challenges, not least of which is a fundamental cultural shift in how the healthcare business is conducted (which is notoriously slow in adopting change and innovations). Therefore, the swiftness with which the transition from volume- to value-based healthcare models is unfolding creates uncertainty for healthcare providers (Prada, 2022, p1).

According to the Harvard Business School's Institute for Strategy and Competitiveness series on VBHC, six criteria define a true VBHC system, namely:

1. Healthcare should be structured around medical conditions. Care plans consisting of medically relevant integrated services must be developed based on the “full cycle of care and delivered in integrated practice units (IPUs)” (Organize Care Around Medical Conditions, p1).
2. Individual patient outcomes and the relative cost of care must be monitored, and evaluated on a per-patient basis to ensure that real value is being created. Traditional healthcare measurements “fail to collect outcomes that matter to patients and the costs to achieve them” (Systems Integration, p1).
3. Value-based contracts must be based on both creating patient value by measuring the outcomes that matter the most to them, and creating treatment efficiencies that bring down the total cost of care (Aligning Reimbursement with Value, p1).
4. Provider integration at all levels of care is essential to provide real value to patients. “When providers integrate care across a network of facilities, and in conjunction with community resources, they add value for patients, providers, and the system as a whole” (Systems Integration, p1).
5. Outlines geography of care. “By expanding strategically and integrating with community providers, those already renowned for innovation and excellence and patient care can widen access, improve treatments, and help reduce fragmentation and geographic ‘gaps’ in services” (Geography of Care, p1).
6. Central to achieving a VBHC efficiency is information technology interoperability. Currently, IT architecture must meet the standards

> required to fully support VBHC. They reflect the existing healthcare system, systemically fragmented and lacks transparency among healthcare stakeholders (Information Technology, p1).

Michael Porter (2016) illustrates his definition of value in healthcare using the following formula (p5):

$$\text{Value} = \frac{\text{Set of outcomes that matter to patients for the condition}}{\text{Total costs of delivering them over the full care cycle}}$$

Porter (2010) describes 'value' in healthcare as achieving healthcare outcomes that matter to patients and "unites the interests of all actors in the system" (p2477). He postulates that health providers exclusively focus on improving healthcare outcomes that do not matter to patients cannot be defined as adding 'value'. "Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all actors in the system" (Porter, p2477). Douglas A. Conrad (2016) elaborates that value in healthcare can only be achieved by obtaining "maximum health benefit at minimum cost, and—operationally" (p2058).

To expand on his definition of value in healthcare, Porter (2010) further explains that a singular focus on cost reduction will undermine patient outcomes as process efficiencies do not equal improved healthcare quality as measured by patient outcomes. What the VBHC model aims to achieve, according to Porter (2010), is not just a reduction in the individual cost of healthcare services but rather the "total costs of the full cycle of care for the patient's medical condition" (p2477).

Where VBHC has been implemented, four distinct areas have shown the greatest impact: at a provider level, product innovation, procurement and at a payer level.

***Product VBHC***

An example of product VBHC includes solving the rare but life-threatening problem of site infections following the implantation of cardiac devices (i.e., pacemakers). Treatment is often costly (estimated at $50 000 per case in the US) as it requires additional surgery and the replacement of the often-costly device (BCG, 2017, p2).

An example of this is Medtronic's innovative an antibiotic sheath that covers their defibrillators and pacemakers, and has been shown to reduce postoperative infections by up to 50% (BCG, 2017, p2)

This example illustrates how medical technology manufacturers play a pivotal role in achieving VBHC by shifting their innovation strategy from developing stand-alone products but rather value-based solutions.

***Payer/ funder VBHC***

Payers/ funders play an integral role in the success of VBHC initiatives, primarily because they have "visibility across health systems and, therefore, are well positioned to monitor outcomes and costs for full cycles of care" (Horner *et al*, 2019, p3).

The Swiss national health system has recently moved away from the FFS model, by introducing managed care options. Ben Horner *et al.* (2019, p10) showcases how "one such managed-care model brings primary care

providers… together in networks that manage the total cost and quality of the care delivered to their aggregate patient population. GPs receive a base compensation that is a combination of a per-patient subscription fee and fee-for-service payments. But GPs have the potential to earn a bonus when their network's quality-of-care score is above a predefined threshold and the total cost of care for the pooled patient population is below risk-adjusted expectations".

***Healthcare provider VBHC***

The healthcare provider is where patients interface with the overall healthcare system. As such, providers play a critical role in implementing VBHC principles.

The Boston Consulting Group (BCG, 2018, p3) highlights an example of how, within 18 months, Santeon, a conglomeration of seven of the Netherland's leading academic hospitals, has realised a 30% reduction "in unnecessary inpatient stays and up to 74% in the rate of reoperation due to complications in breast cancer patients.

These results were achieved using a VBHC-focused approach to managing five medical condition groups, with implementation focusing on VBHC four stages. These included (i) the creation of multidisciplinary teams whose role was to establish the medical condition groups and their respective outcomes metrics, (ii) detailed internal review of data and immediate initiation of any required amendments to the care plan and treatment efficiencies, (iii) leveraging external expertise for system enhancing inputs, and (iv)

community and payer engagement to on transitioning toward VBHC contracting (BCG, 2018, p3).

***Procurement VBHC***

Since 2015, value-based procurement (VBP) has become increasingly popular within European health systems. It allows providers to make procurement decisions based not merely on the unit price of a healthcare product, but instead to investigate the "overall value of the solution it can create, in terms of improved outcomes for patients, reduced total cost of care, and benefits to stakeholder such as health care workers" (p3). The net benefit is an improvement in the cost of healthcare procured by providers and, simultaneously, improved quality of the care that is dispensed to patients (p3).

Patients (and by extension communities) being the ultimate beneficiaries of healthcare services and products are directly impacted by the issues that may arise during the transition to VBHC and once it is implemented. It is, therefore, important that the ethical implications of adopting VBHC be understood, especially in the planning phase of implementing VBHC in health systems across the world. With the awareness of the ethical issues that may arise, funders, providers, suppliers, and policymakers can relook the policies and processes that govern how VBHC will be implemented through the eyes of the patient.

Reimbursement models impact how healthcare is costed and delivered to patients. More critically, it affects how providers (especially doctors) relate to patients. Of concern is how this change in doctors' key performance

indicators may cause undertreatment and undermine patient autonomy. These changes may be most remarkable in LMICs where healthcare staff shortages, poor healthcare infrastructure, and rampant poverty are a reality.

### 1.2 RESEARCH QUESTION

What are the ethical implications of adopting VBHC in Africa?

### 1.3 RATIONALE FOR THE STUDY

In South Africa (SA), with the imminent roll-out of National Health Insurance (NHI), designed as a solution to addressing UHC, discussions on how the NHI will "ensure that health care service providers, health establishments and suppliers are paid per the quality and value of the service provided at every level of care" (NHI Bill of 2019, s10(1)(k)) are at the fore. Governments worldwide and other healthcare stakeholders are investigating how VBHC "can guide investments and reform of health systems to enhance their resilience and to support Universal Healthcare Coverage" (Prada, 2022, p1).

Critical stakeholders in the healthcare industry are now under pressure to understand how the shift from volume-based to value-based healthcare models will be implemented in the African context and what processes ought to be in place for the transition to take place with minimal disruption to service provision and quality.

Civil society ought to be concerned about the ethical implications of the shift in reimbursement models. This is particularly important in Africa where economic disparities are glaring and extend into the healthcare sector.

## 1.4 RESEARCH AIM

To describe and critically discuss the most pertinent ethical issues related to the adoption of VBHC, namely (i) the selection bias that may be introduced in the healthcare system, (ii) under-treatment resulting from cost-containment initiatives, (iii) risk to patient confidentiality posed by extensive IT system integration, (iv) the erosion of the caring aspect of healthcare, (v) an unclear definition of 'value' in healthcare resulting in unclear health measures, and (vi) VBHC perpetuating the Western concept of healthcare in Africa.

## 1.5 RESEARCH OBJECTIVES

1. To provide a critical, in-depth overview of the literature related to the ethical implications of adopting VBHC in Africa.
2. To describe and critically discuss the ethical issues related to adopting VBHC in Africa.
3. To provide a summative analytical and normative evaluation of the ethical issues uncovered in adopting VBHC in Africa (and make some recommendations).
4. Defend a thesis or some claims arising out of the analysis. It is my opinion that, in Africa, VBHC is conditionally morally justified . To prove this, I will draw on Afro-communitarianism's concepts of social cohesion, goodwill and solidarity, supported by the Kantian Categorical Imperative and the Utilitarian notion that acts that provide the greatest benefit to the majority are morally justified .

## 1.6 RESEARCH DESIGN

This project was normative in scope and entails a descriptive and analytical critique of the most pertinent ethical issues related to the ethical implications of the adopting VBHC in Africa.

## 1.7 RESEARCH METHODS

The research was based on desktop and library-based research; no new data was collected or analysed; and the research did not involve human participants. The typical research methods and standards applicable to philosophical research were used including interpreting and critically analysing the most critical texts, postings, and relevant government legislation to answer the research questions. The analysis of the relevant texts involved defining and clarifying concepts, the identification and criticisms of assumptions, analysis and evaluation of theoretical frameworks, and the articulation of the most reasonable interpretation of significant concepts found in the sources of literature retrieved from but not limited to research articles, books, computer accessible databases, Government legislation, and other academic search engines for gathering my research data (Steve Biko Centre for Bioethics, p9-10).

## CHAPTER 2

## AN IN-DEPTH REVIEW OF EXISTING LITERATURE

*"Outcomes that matter most to patients are the true North Star of achieving high value care" - Dr Christina Åkerman*

The novelty of VBHC as a reimbursement model, especially in Africa, dictates that I must first detail both FFS and VBHC and then provide a comparative analysis. To achieve this, I will present the literature that defines and describes FFS and highlight its shortcomings that have triggered the global pursuit of an alternative reimbursement model. Having done so, I will then outline the development of VBHC and its proposed implementation framework. Finally, I will give an overview of some barriers to the VBHC roll-out highlighted in the existing literature. As I expand on VBHC, I will highlight some ethical issues requiring further interrogation.

### A broken healthcare system

The fee-for-service reimbursement model can be traced back to the 1930s when Blue Cross Blue Shield insurance set lucrative reimbursement rates for hospitalisation and surgery. However, even at that time, Michael K. Magill (2016) claims that physician reimbursement rates for "cognitive services" were "lower per minute of physician time" and have persisted, as seen in the reimbursement rates set by US CMS (p400).

Globally, fee-for-service (FFS) is the most commonly used reimbursement model in healthcare. It "establishes set rates for each specific service

provided based on time, complexity, and the skill needed to deliver the service" (ASHA, p1). Miller (2012) outlines that the volume-based nature of healthcare provider payment presents a problem in that using this model, little to no consideration is given to the quality of healthcare provided and how it improves patient outcomes (p5).

Healthbridge (2018) adds that in the FFS model, the patient is billed individually for each check-up, laboratory test, scan, hospital stay, etc., and that provider income is maximised by increasing patient volumes. Simply put, the more patients a provider services, the higher their income. Healthbridge further explains that the FFS model is scalable irrespective of organisational size and structure. As such, patients have options in terms of "doctors, specialists, hospitals and other healthcare providers available" (Healthbridge, 2018, p1). This presents "virtually unlimited scope for providers to provide services to patients" and simultaneously increase their earnings (Healthbridge, 2018, p1).

Despite the ubiquity of FFS, it has created unintended systemic problems, resulting in escalating healthcare costs with little to no improvement in patient outcomes. Harold D. Miller (2012) describes four key issues endemic to the FFS model,.The first is the volume-based nature of provider reimbursement, with little to no consideration of the quality or effectiveness of the services it provides to patients. Therefore, volume is the primary driver of provider income and not value. He states that "research has shown that more services and higher spending may not cause better outcomes; indeed, it is often exactly the opposite" (p5).

Similarly, healthcare providers are financially compromised by “providing better quality services” that make their patients remain healthy. The crux of Miller’s (2012) argument is that in the noble pursuit of improved care quality, the total cost of care is lowered. However, so are the provider’s revenues (p5).

Miller (2012) also cites issues with the fragmented nature of payment of healthcare by providers involved in a patient’s care. During a course of treatment, each provider involved in the patient’s care is paid separately. This “can result in paying for duplicative tests and services for the same patient, and it provides no incentive for separate providers to coordinate their services” and therefore save the patient money throughout their treatment course (in addition to ensuring an effective and well-coordinated treatment plan) (p5).

Individualised provider payments lead to an increase in provider treatment and cost variability in addition to placing more pressure on internal provider systems and processes (RevCycle Intelligence, 2020, p1).

The final challenge that Miller (2012) raises is that of primary care physician shortages in some areas due to low reimbursement of “preventative care and care coordination services” whose aim is to prevent “unnecessary illnesses and treatment” (p5). Magill (2016) echoes this by adding that one of the possible causes of the perpetuation of the rate disparity for physicians is due to “[treating] total payment for physicians as a zero-sum game in which decision making is dominated by non–primary care physicians…” (p400).

These issues together, Miller (2012) says, make the FFS model undesirable

and have precipitated the transition to a new reimbursement model that reduces costs and, at the same time, improves the overall quality of healthcare (p5).

Healthbridge (2018) asserts that one of the disadvantages of FFS is that it offers little in the form of cost reduction incentives. The model does not reward (or penalise) providers for reducing patient healthcare costs. Similarly, it neither incentivises improvements in or on-target quality nor efficacy in the delivery of healthcare services. There exists no means for such standards to be collected across providers, who each use their own patient management and billing systems, to aggregate these and accurately report the results. Finally, like Miller (2012), Healthbridge highlights the wastage caused by duplication of services dispensed to patients during a cycle of care as being another FFS drawback.

The momentum gained in the discourse related to alternative reimbursement models (especially VBHC) may be a result of the covid-19 pandemic which put a spotlight on healthcare systems around the world, especially related to healthcare quality and their disproportionate costs. Goldis Mitra (2021) affirms that the sudden global urgency in healthcare reformation is driven by the efficiencies highlighted during the covid 2019 pandemic, specifically “income instability and the need for rapid practice change that often outpaces fee schedule cycles” (p805).

The challenges of the prevalent FFS model are extensive and the global motivation towards the migration away from volume-based healthcare to alternative reimbursement models (specifically VBHC) is strong. Healthcare

requires transformation to arrest skyrocketing healthcare costs that do not add to improved patient outcomes. The next section looks at the VBHC model to understand what changes in the healthcare sector are required to create more efficiencies for both providers and patients.

**Value in healthcare and the evolution of the concept**

The concept of value in healthcare can be traced as far back as 1853 -1856 when Florence Nightingale, while serving in the Crimean War, developed a system of recording and measuring the "outcomes of care and instituted robust clinical changes based on these data" (Wallang, 2020, p205).

In 2006, in their book *Redefining Health Care*, Michael Porter and Elizabeth Tiesberg introduced a more comprehensive concept of value in healthcare, called VBHC. They propose that "the right objective for health care is to increase value for patients, which is the quality of patient outcomes relative to the dollars expended. Minimizing costs is simply the wrong goal, and will lead to counterproductive results… Every policy and practice in health care must be tested against the objective of patient value". In January 2015, the US Department of Health and Human Services (HHS) announced that it planned to fully transition to a value-based reimbursement model, by the end of 2018 (LaPointe, 2016, p1).

In a later work, Tiesburg and colleagues (2020) further explain the concept of VBHC as a means of overhauling current ineffective and inefficient system while simultaneously "improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care - as well as improving clinician experience, a fourth aim that others have

proposed” (p3)

Paul Wallang (2020) avows VBHC’s scalability to all global markets regardless of their economic strength or health system sophistication. “‘Volumising value’ by creating better outcomes for the same or reduced resources has the potential to save and improve many lives across the globe. Low- and middle-income countries (LMICs) have made admirable strides in improving healthcare on the basis of increasing the volume and access of services delivered” (p207).

The scalability, and more importantly, the applicability of VBHC in LMICs, especially in Africa, through a bioethical lens, is what this paper aims to address. The next section of this chapter will outline the VBHC strategic framework to implement VBHC globally.

**A strategic framework for implementing value-based healthcare in all settings**

Based on over a decade of research, Tiesberg and colleagues (2020) developed a strategic framework for implementing VBCH as a guiding framework to assist providers design and implement their value-focused programmes (p3). The framework covers five areas that are essential for successfully implementing VBHC in any setting.

First is the requirement for a deep understanding of the population's healthcare needs, and subsequently segmenting patients according to their individual needs based on their medical condition. Thereafter, designing relevant care plans for each medical condition is required. Creating

Integrated Learning Teams is then essential to regularly review patient outcomes based on the care plans created and reconfigure these plans where required to ensure improvement in the quality of care provided. An essential component of VBHC is the measurement of health outcomes and costs, and ensuring that these are within the defined parameters. Finally, establishing expanded networks aids the integrated treatment team to leverage new and innovative technologies and expertise available in different organisations.

*Understanding the shared health needs of patients*

In healthcare, similar medical specialties (e.g. neurologists) form group practices offering patients the same services. However, patient needs do not fit this structure. Providers miss the mark by not structuring a treatment plan to include other specialities and available community services that work together to form integrated services that efficiently support patient needs (Tiesburg *et al.*, 2020, p4).

Organising healthcare services around patient segments with similar medical needs (e.g. diabetes, cancer, pregnant women, HIV in teenage girls, elderly with no chronic conditions, etc.) allows clinical teams to anticipate consistent patient needs and provide frequently needed services efficiently, doing common things well. The efficiency afforded by structuring care around patient segments frees clinicians from scrambling to coordinate services that are routinely required (Tiesburg *et al.*, 2020, p4).

Grouping patients by medical needs is intuitive as doing so allows for efficient use of limited resources available for the healthcare services specific to each patient group.

For example, the optimal diabetes treatment team would consist of an endocrinologist, podiatrist, dietitian, cardiologist, neurologist, urologist, psychologist and pathology lab. This mix of health professionals would provide the support a typical diabetes patient (without complications) would require throughout their cycle of care.

On a practical level, this requires more healthcare providers (specifically hospitals and practices), each offering services for a select group of medical conditions. This is already the case where the number of specialty hospitals and clinics (i.e. eye clinics, pain clinics, back clinics, urology clinics, surgical hospitals, etc.) is growing in Africa. Under VBHC, general hospitals would need to (i) reduce the number of medical conditions they treat, or (ii) create 'hospitals-in-hospitals' to cater for specific medical conditions (Porter & Tiesberg, 2006).

This focused approach enables providers to deepen their understanding of the details and nuances of the care cycle and the associated costs of achieving desired patient outcomes, of a given medical condition. The narrow focus also results in increased provider efficiency and effectiveness and improved patient value (Porter & Tiesberg, 2006).

*Design a comprehensive solution to improve health outcomes*

Once patients are grouped according to their medical needs, the next step is for the integrated treatment team to establish a suitable and cost-effective care or treatment plan for each medical condition. An essential aspect of the design of a care or treatment plan is placing the patient's clinical and non-clinical needs at the centre plan. "For example, a clinic for patients with migraine headaches might provide not only drug therapy but also psychological counseling, physical therapy, and relaxation training. Similarly, a clinic for patients with cancer might include transportation assistance as a service for those who have difficulty getting to their regular chemotherapy appointments" (Tiesberg *et al.*, 2020, p5).

In this step, care teams must design medical and non-medical solutions that address potential medical and non-medical impediments to improving patient outcomes (Tiesberg *et al.*, 2020, p5).

*Integrated learning teams*

A multidisciplinary team, in some cases including non-medical members, ought to be established to oversee the management of patient groups. Ideally, this team should be co-located to facilitate easy and frequent communication to drive efficiency and effectiveness of care. This team works together to regularly review patient outcomes based on the care plans created and reconfigure these plans where required to ensure improvement in the quality of care provided. The process provides learning opportunities for the team and opportunities to teach other teams outside of their network

so as to expand knowledge and experience all with the aim of improving the quality of care (Tiesberg *et al.*, 2020, p5).

*Measure health outcomes and costs*

Tiesberg and colleagues (2020) explain that integrated teams, once they have defined the condition-specific solutions for improved patient outcomes, ought to define the most important measures of health. This should not solely be looked at through a clinical lens, but rather from the patient's perspective of what outcomes matter most to them (i.e. how they would define a state of health and wellbeing).

To align with the VBHC's basic premise, the costs of services provided per patient need to also be impeccably measured. Not doing so, would most likely cause escalating healthcare costs, even where patient outcomes are improved, which would in essence perpetuate the current situation (and a negation of the concept of value creation). Healthcare organisations ought to consider using "cost-grouping methodologies" to source the data that is required to establish and monitor the value of the care provided and finally to determine efficiency gaps and improve on these (Tiesberg *et al.*, 2020, p6).

The above is easily implementable at an organisational level. However, when the network of VBHC-enabled organisations increases across organisational and regional lines, therein begins the issue of IT system interoperability. There are a vast number of patient management systems (PMS) and electronic health record (EHR) and electronic medical record (EMR) systems and each practice utilises one that meets its unique patient

needs. If VBHC works as it has been described, patients will have specialists elsewhere in the country as part of their integrated treatment team. As such, the issue of how patient data will be securely and efficiently shared between organisations. Powerful IT systems that can integrate with organisational and practise PMSs, EMRs or EHRs will need to be developed.

*Expand(ed) partnerships*

Partnerships outside of the integrated care team's healthcare organisation may be necessary to leverage new and innovative technologies and expertise available in different organisations. These expanded partnerships may be between healthcare organisations or across geographies. Expansions may also benefit doctors located outside of metropolitan areas where expertise is limited.

**Barriers to implementation of VBHC:**

Although there is a global emphasis on a transition to VBHC models, no one government has fully implemented it. In Europe and the US, a few organisations have started to implement portions of VBHC. The sluggishness with which the implementation is happening may be due in part to the systemic challenges of transitioning from FFS. Another consideration for the delay could be due to the complexity of VBHC, particularly its implementation.

This section will outline the barriers to implementing VBHC as reflected in the literature. I will address each barrier individually and highlight any ethical issues that arise.

*How other markets are doing with implementing value-based healthcare*

Globally, VBHC is topical, as most health systems plan for its implementation. However, as much as the literature covering the topic is growing, the experience of fully implementing VBHC does not exist. As such, the US CMS is constantly reviewing and enhancing its existing VBHC policies and procedures (Watson, 2022, p1).

Governments and organisations must stay abreast of the developments in VBHC before, during, and after implementation. Ideally, providers ought to have a VBHC champion on staff whose role is to stay abreast of global research and emerging trends in, and organisational implementation of VBHC. At a national level, a combined VBHC policy-making and implementation task team that oversees the implementation of existing and development of new policies that foster an environment for VBHC to succeed at all levels of healthcare delivery. It is important that the task team is held accountable to both policy development and implementation to ensure that implementation is done effectively and efficiently and that there is clear accountability.

It is concerning that discussions on VBHC planning and implementation are progressing in many markets, despite the variations in understanding of its implementation. This lack of clarity raises concerns about how patient rights and autonomy may be impacted under such uncertainty.

*Social determinants of health*

Even if VBHC were to be impeccably implemented, social factors remain a

threat to achieving VBHC's primary objective, which is to improve patient outcomes. "Social determinants of health (SDoH) are factors that influence a person's ability to lead a healthy lifestyle. These include things like poverty, education level, access to healthcare, housing conditions, and food security" (Watson, 2022, p1). Poverty and other social issues stand in the way of improving patient outcomes.

The SDoHs outline that poor nutrition is a consequence of poor access to healthy foods, the lack of financial resources of low-income households to afford basics needs like food and healthcare, mental health issues, low levels of healthcare education and language barriers that prevent people from effectively articulating their healthcare needs (Watson, 2020, p1).

These SDoHs are a reality in most African countries, where much of the population lives below the poverty line. Unless providers incorporate SDoH screening (and routinely analyse the data to uncover gaps and risks) as part of designing their condition-specific care plans and localise these by municipality, area, or region, VBHC is likely to miss at-risk groups and fail at meeting the outcomes that are most important to patients, namely capability, comfort, and calm (Waston, 2020 and Tiesburg, 2020, p2).

*Generating patient engagement*

There is sufficient literature covering the challenge of getting healthcare professionals' buy-in of VBHC. However, little has been said about doing the same for patients. Without patient buy-in, care plans are unlikely to have the desired impact. This is not unique to VBHC because it applies to FFS. However, it bears mentioning as a potential barrier to the successful

implementation of VBHC in any setting.

Morgan Watson (2020) highlights that “patient engagement is essential in value-based care since the results of patient engagement align directly with the goals of value-based care. If providers can effectively empower patients to participate in their healthcare routines, they can improve the quality of care, increase patient satisfaction, and reduce costs. Patients want to be able to manage their own care, understand the costs involved in their treatment, and make better decisions about their healthcare” (p1).

She proposes that “digital patient engagement tools” should be designed to enable patients to become stakeholders in their health. These include telehealth platforms, digital appointment booking and appointment reminders, electronic delivery of lab test results, digitised treatment information, web-based medical expense tracking tools and digital claim-submission platforms for patients (Watson, 2020, p1).

As VBHC is hinged on achieving patient outcomes that matter to patients, then it is self-evident that patients play an essential role in its success. Without their engagement and personal investment in their health, very little can be done by healthcare providers to achieve optimal health as measured by patient outcomes. The patients’ inability to access healthy food and information regarding health maintenance practices, will nullify the treatment given. As a result, the cost of care will escalate as patient health deteriorates.

*Analysing data for audits and incentive payments*

In South Africa (SA), the National Health Insurance (NHI) Bill (passed by the

upper house of parliament - the National Council of Provinces in December 2023), presents a clear VBHC bent, namely to “ensure that health care service providers, health establishments and suppliers are paid in accordance with the quality and value of the service provided at every level of care” (NHI Bill B11B of 2019, s10(1)(k)). The Bill proposes a capitation reimbursement model for primary healthcare providers and an “all-inclusive [fee] and based on the performance” for specialists and hospitals (NHI Bill B11B of 2019, s41(3)(b)).

Like the US CMS, the NHI Bill (2019) outlines a one-payer system for contracting all healthcare providers. The CMS uses a Merit-based Incentive Payment System (MIPS) to determine an organisation’s eligibility for payment of services rendered, which is based on a performance-based scoring mechanism. The scoring mechanism details whether providers are due for a bonus, a penalty or no payment based on their performance against “quality, improvement activities, promoting interoperability, and cost” criteria (AAPMR, 2023 and CMS, 2022).

Watson (2020, p1) highlights that although this scoring mechanism is useful, the data analysis required is complex and requires a unique skill set that is not readily available.

What stands to be understood is whether African governments and implementing organisations have (or can locally source) the skills required. If not, the data used to monitor patient outcomes against cost will be inaccurate and therefore compromise the core objectives of transitioning to VBHC, that is, to improve the quality of healthcare and reduce costs.

Without quality healthcare outcomes and cost of care data, healthcare providers (and governments) can not determine the value of the care they are providing. They will not be able to review and amend healthcare services that are dispensed. In addition to this, they will not be able to track whether the total cost of care is declining or not. Without all this information, the pain of transition to VBHC will be for naught.

*Collecting data from disparate electronic health (EHR) and medical (EMR) record systems*

Interoperability poses a significant barrier to VBHC implementation for the reasons mentioned above. Without the ability to collect, analyse and share patient data across multiple institutions, VBHC's scalability is in question. And without scalability, there is a real chance of healthcare inequality's persistence (or exacerbation).

An interoperability strategy must be developed, presumably by governments that provide a framework or platform against which providers can integrate (Watson, 2020, p1).

Linked to this is the issue of insufficient resources and inefficient workflows. Agilon Health (2020) explains that the shortage of skilled personnel required to establish such a complex platform is a major barrier to VBHC adoption. Ideally, the required platform must be able to generate unique patient identifiers that eliminate duplications, and seamlessly integrate with the EHRs and EMRs utilised by all healthcare providers in the market. Similarly, the platform must effectively provide multiple layers of access to patient data

based on the cadre and type of provider. It must also allow easy access to patient data across multiple providers if it is to support the establishment and functioning of integrated (or multidisciplinary) treatment teams.

*Unpredictable revenue streams and financial risk*

The premise on which the VBHC reimbursement model is built is financial risk reallocation. Historically, funders have carried all the financial risk associated with healthcare provision. VBHC shifts the risk to providers as a means of incentivising improvements in quality healthcare. This has a direct impact on provider revenues and thus is cause for major concern and the genesis of much of provider resistance to the adoption of VBHC (Agilon Health, 2022). Notably, it raises concerns about how salaried healthcare professionals (especially doctors) will be compensated under the VBHC model. In SA, much is still unclear how this will be resolved. However, RevCycle Intelligence (2020, p1) advises that incentive models similar to those used by the US CMS ought to be considered, namely accountable care organisations (ACOs), bundled payments, and patient-centred medical homes, discussed below.

The primary challenge placed on VBHC is in the area of provider incentives. The largest shift within the VBHC model, is the shift of financial risk away from funders, to providers. Providers now carry the responsibility of ensuring that their clinical practices are in line with local, regional or international treatment protocols, and fall within a budget set for each medical condition group. Any deviation away from standard treatment protocols could mean a loss in revenue for providers. This risk shift is applied to all VBHC

reimbursement and incentive models, including those listed below.

*Accountable care organisations*

Doctors, hospitals, and other providers voluntarily elect to join an accountable care organisation (ACO), which establishes a network of healthcare providers to exclusively service a predetermined subset of the population (i.e. Medicare beneficiaries). Designed by the US CMS, ACOs goals are to improve the quality of care provided by eliminating overservicing "while reducing medical errors" (RevCycle Intelligence, 2020, p1).

In an ACO contract, providers within the network accept some financial risk as the savings (and losses) are shared. The financial upside is generous depending on the programme joined, and when high-quality care at reduced costs is achieved. However, there may be financial losses when these objectives are not met, and the providers are required to recompense the funder for not meeting the agreed objectives" (RevCycle Intelligence, 2020, p1).

*Bundled payments*

Bundled payments (also called episode-based payment) reflect a single payment made to all providers involved for a single "episode of [patient] care" and are based on predetermined treatment costs for a specific condition (RevCycle Intelligence (2020, p1).

As with all value-based incentive programmes, there is a financial risk to providers. Using the bundled-payment model, healthcare providers share

savings (as well as losses) made on the delivery of appropriate patient care below the allocated amount.

*Patient-centred medical homes*

The patient-centred medical home (PCMH) is a care delivery model where each patient is allocated a PCMH-accredited primary healthcare doctor whose role is to coordinate all healthcare services and care for the patient (RevCycle Intelligence, 2020, p1).

To date, this care model has shown a lot of promise in its ability to cut costs and materially reduce emergency room visits and hospital admissions. RevCycle Intelligence (2020) highlighting “a 15 percent decrease in emergency department visits, an 18 percent reduction in inpatient admissions, and a return on investment of $4.50 for every dollar spent. Another Maryland-based PCMH stated that it saved $98 million and increased its quality scores by 10 percent in one year” (p1).

This value-based care model appears to be the most feasible for the African context. The creation of a community-based care model aligns with how healthcare is currently organised on the African continent. However, there is concern about how PCMHs will be resourced given the existing healthcare professional shortage in many African countries.

**Conclusion**

In this chapter, I have detailed how the FFS reimbursement model has been embedded in the healthcare sector globally for almost a century. But with it has risen the issue of escalating health care costs with limited or no

improvement in the quality of care meted out, as measured by patient outcomes.

Value-based Health care has been identified as a viable alternative reimbursement model to replace the broken FFS model. However, given the limited real-world experience of its full implementation, especially at a national level, it may just be a utopian ideal

Also outlined in this chapter is the evolution of VBHC globally and explained why the concept of “value” in healthcare originated. Also covered in this chapter was Tiesburg’s strategic framework for the developing a VBHC programme. Finally, a major aspect of the transition to VBHC is the shift in financial risk from funders to providers. This has raised numerous challenges hampered by the endemic FFS model where providers care little to no financial risk for the dispensing of their services. The most common VBHC contracts were also discussed to highlight that under VBHC, and the challenges with each were also mentioned.

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# CHAPTER 3

## DESCRIPTION AND CRITICAL DISCUSSION OF KEY ETHICAL ISSUES

*"Ethics is knowing the difference between what you have a right to do and what is right to do." - Potter Stewart*

Despite the swift uptake of VBHC in most Western countries there remains some scepticism on whether it is globally applicable and scalable. Groenewald and colleagues (2019) are dubious of the results it promises to deliver based on its limited implementation globally. They also question whether value in healthcare can be created given healthcare's uniqueness and inherent complexity (p1).

The lack of extensive real-world application of the VBHC reimbursement model is cause for concern. The full extent of ethical issues is still unknown, even in developed markets where some aspects of VBHC have been implemented.

In this chapter, I will present and discuss the ethical issues that arise in adopting VBHC, especially in an African context. I will begin by examining the risk of over - and under-treatment in VBHC precipitated by provider greed. Subsequently, I will discuss healthcare providers' potential to use patients to drive profits. Thirdly, I will present currently available literature on how the adoption of VBHC could cause patient discrimination and a widening

of healthcare inequality in Africa. The fourth ethical issue to be discussed is how adopting VBHC in Africa risks eroding the caring aspect of medicine and, in turn, patient dignity and personhood. Finally, I will expound on how the very definition of 'value' in healthcare is ambiguous and may cause more harm than good.

### 3.1 Potential for Over-/undertreatment

As discussed in the previous chapter, VBHC is centred on improving patient outcomes for every dollar spent on a given population group exhibiting the same care needs. For example, patients diagnosed with insulin resistance will have similar care needs versus elderly patients with multiple comorbidities. As such, the care dispensed to the pre-diabetic will be similar and can be streamlined to ensure optimising existing healthcare resources and reducing the per-patient cost of care (and similarly, the care plan created for elderly patients with multiple comorbidities).

The initial stage of implementing VBHC is for care teams to evaluate shared patient health needs per medical condition and to create systems and processes that align with these. What follows is for care teams to create care plans that address not only the clinical needs of each established medical condition but also the non-clinical needs to maximise the patient outcomes and eliminate any issues that may impede the attainment of these. Alongside this last step is determining the per-patient cost of care for a given medical condition group.

This involves establishing the baseline costs of care using historical treatment cost data. Existing literature is consistent in that one of the impediments to VBHC is the lack of accurate and aggregated historical data on the cost of care as measured against patient outcomes. . As such, healthcare organisations planning to implement VBHC are in a precarious position knowing that historical data offers little guidance in creating a baseline against which to establish care programmes for medical condition groups. At the same time, they are required to use historical data to determine the appropriate level of care and the cost of this care.

The Economist Intelligence Unit‘s (EIU) 2016 report on VBHC’s global implementation status in 25 countries (including LMICs) stresses that “in many healthcare systems today, information about the overall costs of care for an individual patient, and how those costs relate to the outcomes achieved, is very difficult to find… For example, data in disease registries that track a particular patient population's clinical care and outcomes are often inaccessible, lack standardisation and/or are not linked to each other, if they exist at all” (p8).

This is especially true in developing countries where cost non-transparency is endemic. The EIU (2016) goes on to highlight that developing countries such as Brazil, South Africa and the UAE are some countries that lack national disease registries (p13 -14). They highlight that the lack of patient outcomes and cost of treatment data can be resolved with the increased usage of electronic health records (EHRs) and electronic medical records

(EMRs), which would aid in tracking treatment accounts and their respective costs (p14).

Maxwell O. Akanbi and colleagues (2011, p1) cite that although African countries still lag behind developed nations, there has been a significant rise in the adoption of EHRs in African healthcare organisations. This is mostly due to low internet penetration on the continent, which stands at 10% of the continent's (mostly urban) populations versus the 30% global average. Secondly, EHR set-up has historically been costly and requires skills and manpower.

Akanbi and colleagues (2011, p1) go on to stress some limitations to existing EHRs on the continent, namely that most of these are paid for via donor funding, and their sustainability is, therefore, uncertain. Alongside this is the unreliable power supply in most African countries, which has precipitated "the need for parallel data entry", thus adding to the administrative burden of already overstretched healthcare professionals (p4). However, the care coordination that undergirds the VBHC model is hinged on the availability of digital outcomes and cost data, which is still lagging in many countries (EIU, 2016, p14).

This lack (or fragmented nature) of EHRs, EMRs, and available population health and healthcare cost data reveals a noteworthy ethical dilemma for African nations planning to implement VBHC. It opens up questions on how care programmes (and their relative costs) will be established to not compromise patients. There is a real risk of overtreatment or undertreatment based on the (non)available historical data's quality (and accuracy).

As mentioned in the previous chapter, studies have determined a direct and positive correlation between specialist compensation methods and increased surgical rates. In Jason Shafrin (2009, p1) study on how compensation methods affect surgical rates in specialists and primary care providers, he established that “when specialists are paid through a [fee-for-service] scheme rather than on a capitation basis, surgery rates increase 78%”. Corbett (2016, p1) elaborates that the Shafrin (2009, p1) study also unearthed that FFS had a direct and positive impact on the out-patient surgical rates which increased by 84 per cent.

Ben Horner's and colleagues (2019, p1) *Paying for Value in Health Care* report states that some US hospitals conducted “in-patient procedures” on patients with multiple complications, earning profit margins of over 300%. He summarised by saying that “... the reimbursement system made it economically irrational to improve health care value by minimizing complications" (p1).

Given that so little exists in the way of historical population healthcare cost data, undertreatment is a reality in the African context. This poses a serious problem for African health systems already burdened with some of the world’s largest pandemics, such as tuberculosis, HIV, and malaria. If VBHC is implemented and care programmes are established using the existing national healthcare data, then new medical burdens could be created. Non-communicable diseases (NCDs) such as cardiovascular disease, diabetes, mental health conditions, and cancer are skyrocketing, particularly in people classified as having low socio-economic status. The burden of

NCDs is expected to grow, and these “are estimated to cause more premature deaths on the continent than all other conditions combined by 2030 and, by far, most death and disability by 2063” (Africa CDC, 2022).

This presents a bleak picture for Africa and the adoption of VBHC could exacerbate the situation if African healthcare stakeholders utilise the substandard historical healthcare data as a baseline to establish care programmes for their citizens. Therefore, African nations must coordinate their discussions on alternative methods (e.g. global benchmarking) of designing care programmes that will not further compromise an already besieged population.

The next ethical issue that comes to the fore is how patient autonomy will be compromised by profiteering healthcare providers.

### 3.2 Using Patients to Drive Profits

VBHC promises to coordinate care to ensure its effectiveness and efficiency. It focuses on transparency via sharing patient medical information. As such, the ambition is to eliminate duplications and overtreatment, thereby reducing the total patient cost of care. However, it can not be ignored that the potential for providers to undertreat and underservice patients exists as providers attempt to maximise on profits (Corbett, 2016).

As mentioned in the previous chapter, a drawback of VBHC is the unpredictable revenue streams and financial risk that providers are expected to shoulder. It, therefore, makes sense that any business in a similar position would take the necessary steps to mitigate these risks and ensure their

sustainability. This creates fertile ground for provider profiteering. Even where provider revenue streams are not under pressure post-adoption of VBHC, the risk still exists, driven by greed. Thus, adopting VBHC opens up opportunities for patient exploitation, which may become embedded in the organisation's culture, systems, and processes to maximise profits.

When care teams design care solutions for medical conditions, those who are shrewd may identify opportunities to maximise organisational profits. They may develop care solutions which under-service patients. In bundled (or episode-based) payments and accountable care organisations (ACOs), the sharp-witted providers pocket the difference between the actual cost of their care and what funders reimburse to the detriment of their patients' health.

Healthcare product and drug manufacturers (including pharmaceuticals, diagnostics, and medical devices) remain tight-lipped about their pricing models, citing patent protection. If VBHC is to lead to more cost transparency across the entire healthcare value chain, manufacturers need to disclose their cost structures and how these are set across the globe. Without this, patient mistrust will persist, and possibly worsen under VBHC. The effort to reduce the overall cost of care will be undermined should manufacturers remain opaque about their pricing. For VBHC to work, manufacturers must work to remove their reputation of being opportunists who profit off patients' physical distress and vulnerability (Garattini & Padula, 2018, p1035-6).

In Africa, many pharmaceutical drugs cost significantly more than in Global North markets (i.e. US and those in Europe); reaching up to 30 times the

“minimum international reference price for basic generic medicines” (Silverman, 2019, p5). These high drug prices negatively impact patient outcomes in that they make some necessary drugs unaffordable and therefore inaccessible to economically challenged countries and patients (Tsou *et al.*,2021, p685).

Of primary concern is the recent increase in innovative pharmaceuticals for rare diseases that carry a hefty price tag, even for patients in wealthy nations. Given the already high prices of healthcare products, especially in Africa, VBHC presents an additional opportunity for manufacturers to maximise profits by increasing the prices of existing products or developing new and expensive solutions for niche disease areas.

In Chapter 1, I presented how funders can play a crucial role in VBHC by ensuring that meaningful quality metrics are set against provider incentives. To safeguard against provider profiteering, funders ought to be rigorous in ensuring that they incentivise appropriate patient care and outcomes instead of focussing on cost-saving and financial gain. The BCG (2019, p12) states that "measuring and reporting health outcomes is a prerequisite for payment reform".

However, funders themselves can be perpetrators of patient exploitation if their reimbursement criteria are primarily focused on reducing costs versus making care more efficient (as measured by the cost of the full cycle of care) and effective (based on patient outcomes).

Procurement teams within national and institutional healthcare organisations are pivotal in ensuring that they procure solutions that provide overall value in terms of patient outcomes and reduced total cost of care (Horner *et al.*, 2019, p3). With stories of corruption within the healthcare sector rife across the continent, measures ought to be in place to verify the validity of procurement decisions against VBHC objectives. The opportunity for procurement teams to quote for low-value solutions at high-value prices and pocket the difference is one that should not be ignored.

Rowe & Moodley (2013) expand on the possible impact of the adoption of VBHC may compromise patient health under the NHI. They postulate that capitation, a reimbursement model that pays the provider a specified amount of money for each enrolled patient over a "set period of time… incentivises under-provision of services by doctors because the more services they actually provide, the more a patient is costing them".

> *"In the system of managed care,…a specific amount is paid to the doctor per enrolled person for a set period of time. This incentivises under-provision of services by doctors because the more services they actually provide, the more a patient is costing them. Capitation is the method of payment that will be adopted in the new NHI in South Africa. Currently, public sector doctors are paid a set salary per month, regardless of number of patients seen or services provided. A system of managed care may encourage doctors to be motivated by financial rewards…"* (p4).

What is clear is that there exists potential for patient exploitation within VBHC at various levels of the healthcare ecosystem. African governments, already riddled with systemic corruption in healthcare, ought to safeguard against this by establishing (or sourcing existing) independent auditing and verification systems that curtail profiteering at the expense of patients.

The next section will outline how adopting VBHC may lead to a degeneration of social cohesion and exacerbate discrimination and healthcare inequality.

## 3.3 VBHC as a potential threat to distributive justice, unfair patient discrimination, and disruptor of solidarity

### *3.3.1 VBHC as a threat to distributive justice*

Oliver M. Fisher and colleagues (2020) describe distributive justice as "the fair and appropriate distribution of benefits, risks and costs within a society. In a medical context, this requires patients with similar cases to be treated in a similar manner, and for there to be overarching equality of access to finite health resources" (p291).

The current African healthcare situation is fraught with socioeconomic inequalities, typified by under-staffed and over-crowded public healthcare facilities with ageing infrastructure servicing the masses. This is contrasted by the few privately run state-of-the-art facilities available to those who have financial means. It is, therefore, essential to interrogate what impact VBHC will have on the status quo. It is my opinion that should African countries adopt VBHC before they have fully determined their readiness to do so, taking into consideration the prevailing ethical issues listed above, the

existing healthcare inequalities may worsen. Poor implementation of VBHC could negatively impact patient outcomes as healthcare quality deteriorates and is intensified by healthcare professional despondency due to increased workload due to increased patient load resulting from poorly structured and ineffective care programmes.

Those with the financial means could leave the public healthcare system and opt for better-managed private healthcare facilities, a situation which already exists in Africa. High-earning patients opt to travel to other countries (or regions within the country) for better quality care. From a continental perspective, poorly implemented VBHC may cause regional healthcare disparities which will drive regional (or international) medical travel from areas of poor quality healthcare to regions with better quality healthcare.

Increases in medical travel raise a series of legal and clinical concerns. There is the question of which legal jurisdiction medico-legal liabilities lie in the event that a patient suffers injury due to treatment received in a foreign country and how redresses will be handled (Lunt *et al.*, p26).

The continuum of care is broken when treatment is received in one health system and continued in another (Lunt *et al.*, p24). The differences in the quality of healthcare between the foreign country and the country of origin add another layer of complexity and risk to medical travel (Lunt *et al.*, p26).

Another important consideration for medical tourism is its impact on patient confidentiality, as the referring home-based doctor would be required to share patient information with the treating foreign-based doctor (Lunt *et al.*, p27). The legal question here would be which patient confidentiality laws

ought to govern shared patient information in foreign health markets; the country in which treatment is undertaken or the patient's country of origin?

Furthermore, the travel of ill patients may spread contagions that may pose a population health risk similar to that seen with the COVID-19 pandemic (Lunt *et al.,* p27).

Increases in regional medical travel create a potential for causing regional tensions, where (especially) public healthcare facilities (with their existing limitations) have to distribute these to a wider patient base (including foreign nationals), at the expense of local patients. A similar scenario may unfold even in the private healthcare sector, where local patients could wait longer for consultations and surgeries.

### 3.3.2 *VBHC may lead to unfair patient discrimination*

South Africa's Medical Schemes Act of 1998 was established to protect patients by regulating member selection (UCT & Rhodes University, 2010, p22).James Corbett (2016) outlines that incentivizing healthcare provision may inadvertently lead to the unethical practice of "cherry picking of healthy patients" and the "lemon dropping" of patients with suboptimal healthcare status as they may require more costly treatment (p4).

Cherry picking is not a new practice that may be introduced with VBHC. It exists under the FFS model and has been documented in various settings. The practice exists where doctors do not take on patients with complications and extensive comorbidities as a means to preserve their professional reputations and potential future earnings. As such, it becomes even more

important that risk-adjustments are incorporated in inventive models within VBHC to eliminate ‘cherry picking’ (MedScape, 2013 and Smith & Marshall, 2021, p e229-230).

This practice of cherry-picking and lemon-dropping of patients, although the data predominantly focus on Canadian and US-based physicians, may be an unspoken global phenomenon. Research ought to be done in Africa to establish doctors' use of this practice and how it impacts patient health. The ethical issues surrounding this are significant, including denying patients their right to health. This right is enshrined in the Constitution of the Republic of South Africa of 1996 s27(1)(a), mandating that “everyone has the right to have access to health care services, including reproductive health care”. Unjustifiably discriminating against patients solely based on their health profile impedes their access to healthcare services. This is a clear violation of their human rights.

Although patient selection by doctors is not illegal in many countries, it presents an ethical conundrum that places the doctor’s right to select which patients they treat against the patient’s right to unbiased and quality healthcare. Funders, therefore, play a pivotal role in ensuring that patient discrimination does not occur at a doctor level with the adoption of VBHC. Funders must institute measures to eliminate unfair discrimination against patients with poorer health outcomes for the purpose of maximising their income.

### 3.3.3 *VBHC as a disruptor of solidarity*

Mirjam Pot (2022) summarises solidarity as " [acknowledging that people are dependent on each other in many respects, and it captures those support practices that people engage in out of concern for others in whom they recognise a relevant similarity" (p681).

In the context of healthcare, solidarity in its descriptive form outlines that all beneficiaries of a healthcare system are united in their reliance on that system's services for their health and general well-being. By extension, health system beneficiaries share their efficiency and challenges. However, in its prescriptive form, solidarity in healthcare may refer to a moral requirement for a unified healthcare system that services all its beneficiaries. The latter is the foundational objective of universal healthcare coverage.

Groenewoud and colleagues (2019) assert that "in Anglo-Saxon countries, solidarity is often used synonymously with the concept of 'justice'. Solidarity means: equal freedom and equal opportunities for all persons in a society. Inequalities are acceptable as long as they work out for the good of the least well off (p4)*".* This said, they highlight the risk that these 'freedoms' invoke, namely that patient "voting with your feet" in favour of better quality healthcare services, is a privilege afforded to the educated and wealthy. The options of better quality healthcare services may not be known or accessible to less-educated and less-wealthy patients (p4).

They illustrate how a patient's economic status may impact solidarity in an example where a wealthy widow has a bad experience with an orthopaedic surgeon and opts to post a bad review online. She then researches and

selects another orthopaedic surgeon as a replacement. Her less financially secure brother-in-law wasn't aware that one could replace their doctor if they were not happy with their services. His natural feeling is that of being stuck in a substandard healthcare system, with little knowledge of how to escape it (p5).

The above example is a reality in many countries where significant socio-economic disparities exist. In Africa, these disparities are such that the "average incomes of the top 10% are about 30 times higher than those of the bottom 50%, well above the value found in other extreme inequality regions" (Chancel *et al.*, 2019, p2).

Chance and colleagues also go on to state that despite the African inequality gap being predominantly driven by "within-country" inequality, "between-country" inequality is also a contributor. Between-country inequality refers to economic disparities between countries in the same region (i.e. SADC, ECOWAS and EAC) (p2).

Thérèse Eriksson's and colleagues (2020) review of patient-reported outcome measures in Stockholm, Sweden, where a VBHC programme has been implemented, found that there were noticeable variances in the incomes of patients who were given surgical treatment vs those who were not. Those with higher incomes received more surgeries under VBHC, thus highlighting VBHC's role in perpetuating healthcare inequalities. This is especially concerning in African markets where healthcare inequalities exist (p1).Groenewoud and colleagues (2019) raise concerns that patients opting

out of a healthcare system to force healthcare improvement is potentially degrading. He explains that

> "*shared values are dependent on people collectively enjoying them… We are all familiar with this from for example cultural heritage or National Parks, but why should we not cherish our health care systems in the same way? Shared enjoyment of health care also encompasses a shared responsibility for the improvement of the good, whenever a member of the group experiences problems or dissatisfaction in using it. Where VBHC's focus on choice and exit potentially degrades the value of healthcare… calling on people's responsibility to defend the shared good of healthcare*" (p5).

In some countries in Africa, the option to opt out of the publicly provided healthcare system exists. In Tanzania, 30% of health facilities are privately owned versus Ghana's private healthcare sector, contributing 42% to the country's health service delivery (TDR, 2022, p1). In South Africa, the public sector services 71% of the country's population, with 27% making up the private sector, which is funded by a combination of government and member contributions (Rensburg, 2021).

The NHI Bill of 2019 emphasises that social solidarity is essential for its success. It defines social solidarity as "providing financial risk pooling to enable cross-subsidisation between the young and the old, the rich and the poor and the healthy and the sick".

Social solidarity is an underpinning principle of the NHI Bill;

> *(s5) "National Health Insurance will be based on the following overarching principles: (b) Social solidarity — all regardless of their socio-economic status will benefit from a national system of health care, which is based on income cross-subsidies between the affluent and the impoverished and risk cross-subsidies between the healthy and the sick".*

Finally, social solidarity is considered a chief income source for the NHI Fund in that the funds required to sustain the NHI will be sourced from tax revenue collected, employee and employer payroll tax, personal income tax collections and the reallocation of provincial funds and grants, and medical scheme tax credits back into the fund (NHI Bill, 2019, s49(1)).

The option to opt out of a healthcare system establishes a basis on which healthcare inequalities would persist, if not worsen. Reinvestment in public facilities is required to ensure that they meet basic standards of care and service provision, and focus on improving patient outcomes.

Healthcare systems looking to implement VBHC ought to ensure that it does not threaten solidarity (in its descriptive form), and promotes its prescriptive form by improving and standardising the quality of healthcare services provided. In doing so, more patients will remain within the system thus concentrating the investments made for improved infrastructure, more doctors and better overall quality of care. Each patient will be a custodian of the healthcare system and strive to ensure that it holds the providers accountable for the quality of services dispensed, thus improving the healthcare system overall.

### 3.4 An erosion of the caring and trust aspect of medicine

This section examines the potential for VBHC to erode the caring and trust aspect of medicine. Notably, the South African Consumer Protection Act 68 of 2008 classifies patients as consumers of healthcare products and services. To this, Kirsten Rowe and Keymanthri Moodley (2013) highlight that

> "*From a sociological perspective, the choice of labelling patients as health care consumers is highly significant… A person's sense of identity and behaviour can be influenced by the titles assigned to him or her… The ethical implications of patients being viewed as consumers are potentially problematic. If health care is treated as a commodity, this may cause the replacement of professional ethics with business ethics"* (p2).

Rowe & Moodley (2013) go on to outline that the commodification of healthcare is the end point of classifying patients as consumers and this may cause an erosion of the caring aspect of healthcare (p1). To add to this argument, Doran and colleagues (2017) offer that "A more fundamental concern is that altruism, trust, and compassion—indispensable virtues in the field of health care —will inevitably be degraded by pecuniary incentives" (Doran *et al.*, 2017, p460).

Groenewoud and colleagues (2019) casts a similar perspective on VBHC in that VBHC's singular view on care plans neglects the "'patient values' [which] are a patient's unique preferences, concerns and expectations he or she brings to a clinical encounter. We believe the patients' unique values in life should be prescriptive and action guiding; not standard sets of indicators" (p2).

The dilemma of medical condition grouping and establishing outcome measures against these is such that these measures provide for data standardisation, which facilitates analysis and auditing. However, in doing so, it precipitates a risk of introducing business ethics into healthcare. As such, patients may be viewed as "profit or loss centres" and the caring aspect of healthcare, which undergirds it, will therefore disintegrate (Groenewoud *et al*., 2019, p4).

The next issue that may instigate further trust disintegration between patients and providers is whether providers will adequately inform patients about incentive structures utilised by all key healthcare stakeholders involved in their care plan, including their treating doctor. If nondisclosure persists, this will be a direct assault on patient autonomy. "The American Medical Association Council on Ethical and Judicial Affairs has charged that health care entities and physicians have an ethical responsibility to disclose financial incentives that may lead to underusing services. However, there are concerns about whether such disclosure will enhance the trust and ability of patients to make informed choices about their care" (Levinson, 2005, p625).

However, should healthcare providers opt for full disclosure of their incentive structures, it must be done for all providers throughout the healthcare value chain and at a level (and in the use of language) that ensures that patients fully understand these. Patients ought to know how each provider with whom they interact is incentivized given the risk of cost containment and underservicing that exists in VBHC incentive models. Voluntary provider disclosure may still cause patient distrust of their doctors and the entire healthcare system (Levinson, 2005, p628).

Doctor morale is also at stake, especially in ACO and managed care organisations, where they may feel as though the treatment restrictions compromise their professional autonomy. J.J.Stoddard and colleagues (2001) cite that higher managed care organisation participation was a key indicator of physician dissatisfaction due to a perceived lack of professional autonomy (p675).

Further to this, doctor morale in VBHC settings may be further compromised by standardised incentive schemes which may have a negative impact on their earnings. This is especially important for doctors serving patients in low income and economically marginalised areas. As mentioned in Chapter 2, Social determinants of health (SoDH) play a significant role in patient outcomes and are outside of the doctor's control. Therefore VBHC inventive models must incorporate risk-adjustments to offset the potential revenue losses based on poor patient outcomes. (Putera, 2017, p7).

The consequence of poor doctor morale is poor patient care. The consequences of this on a large scale is worrisome. Necessary measures

must be taken to ensure that patients do not remain blind to how their providers are incentivised and doctor incentives must be risk-adjusted so as not to compromise doctor earnings.

### 3.5 An obscure definition of "value" in healthcare

This section explains why the definition of “value’ in healthcare is problematic and why it poses a potential risk to how VBHC is understood and implemented. Wallang (2020) acknowledges that ‘value’ has proven difficult to define and this remains the case today (p205).

Susan N. Landon *et al.* (2021) elaborate that

> “*At a basic level, value is commonly thought of as a ratio of outcomes to cost. Yet, this can be interpreted variably in practice. Outcomes can be defined in terms of quality, harms or benefits. They can be limited to health outcomes or extended to the quality of life. Similarly, definitions of cost can vary by perspective (cost to whom?), time frame (over what period?) or scope (e.g. cost of supplies or services). Given this variability, coming up with a precise, operationalizable definition of value to drive health system change has been challenging… definitions of value collected may seem similar given frequent usage of terms such as quality, outcomes and cost. Yet, the specifics of these terms varied significantly, generating markedly different definitions of value” (p2 & 5)*.”.

Gijs Steinmann and colleagues' (2020) analysis of the "ambiguity surrounding VBHC" found in academic literature reveals the depth of divergent opinions on the topic.

> *"To some scholars, VBHC is primarily a 'management concept' or a 'management innovation'; to others, it is basically a business 'strategy' for both providers and payers; others see it as a 'governance regime', or a 'health policy framework to integrated care'. Additionally, while the importance of outcome measurements for VBHC is generally well established, the range of its utility remains debated. Whereas some argue that outcome measurements seem less valuable regarding chronic diseases, others argue that such measurements are actually particularly applicable to chronic conditions" (p2).*

The ambiguity of the definition of 'value' in healthcare is problematic. Foremost, its definition determines how VBHC is implemented. Given the divergent opinions of the definition, the risk is that misinterpretation may lead to the development of unclear and profit-focused healthcare measures which directly and potentially negatively impact patient care.

**Conclusion**

Value-based healthcare offers the hope of significant and positive changes within healthcare, especially for LMICs where governments have an opportunity to build strong healthcare systems and processes to support it. Its emphasis on positive patient outcomes as the primary measure of

success presents a meaningful shift from the current volume-based and fragmented healthcare sector.

However, some ethical issues have arisen based on the limited implementation of VBHC in the few governments and healthcare providers globally that have implemented aspects of VBHC. These include its potential for under- or over-treating patients, provider profiteering, concerns of patient confidentiality and consent, the infringement on patient autonomy and dignity, a threat to solidarity and how it may erode the caring and trusting aspect of medicine.

These ethical issues ought to be addressed by African policy-makers and governments in the planning stages of the adoption of VBHC. There need to be plans in place to preserve patient rights and eliminate abuses of power and profiteering to already vulnerable patient populations.

VBHC should be considered a continental strategy for improving healthcare in Africa. Planning should be done at this level, with more detailed planning and implementation executed at a regional level to safeguard against islands of healthcare excellence which could cause increased regional and continental medical travel.

Having reviewed existing literature on the concept of VBHC globally, and highlighted the existing (and potential) ethical issues that may manifest from its adoption, I will present why the adoption of VBHC is ethical. In the same vein, I will explore some objections to adopting VBHC in patient care. In the next chapter, I will make recommendations for addressing the ethical issues raised by the implementation of VBHC to protect African patient populations.

# CHAPTER 4

## THE MORAL JUSTIFIABILITY OF ADOPTING VBHC IN AFRICA

*“To cure sometimes, to treat often, to comfort always” - Hippocrates*

Being a descriptive project, I have highlighted the key ethical issues relating to the implementation of VBHC globally that arise in existing. Having done so , I now present an normative thesis on the moral justifiability of adopting VBHC in Africa. This will give the world an opportunity to learn new insights into the ethical implications of VBHC in an African context.

In this chapter, I will argue that the adoption of VBHC in Africa is conditionally morally justified. To do this, I will draw on key values, particularly social cohesion (or solidarity), goodwill and shared identity grounded in Afro-communitarianism. I will supplement this with the Kantian Categorical Imperative and the principle of utility grounded in Utilitarianism.

Finally, to establish my argument, I will utilise the imminent roll-out of South Africa’s National Health Insurance (NHI) as a case study of how one African government plans to transition to VBHC. The SA National Health Insurance (NHI) Bill of 2019, has been adopted by both houses of South Africa’s parliament and at the time of writing this is awaiting the President’s signature to be passed into law.

What is beyond the purpose of this discussion is the ethical justifiability of UHC or the NHI as a whole. What is also not included is an epistemological overview of the moral theories listed above. I will use ethical and moral interchangeably to mean the same thing.

**An overview of South Africa's National Health Insurance (NHI)**

The NHI emphasises a unified health system for all South Africans, irrespective of economic status. The mandate of the NHI is to eliminate the two-tiered system which reinforces that only those with financial means deserve access to the best healthcare and therefore optimal well-being. The NHI further underscores solidarity as a cornerstone of its implementation and success. The *NHI Bill* ,outlines the objectives of the overhaul the SA healthcare system , namely to:

- *"achieve the progressive realisation of the right of access to quality personal health care services;*
- *make progress towards achieving Universal Health Coverage;*
- *ensure financial protection from the costs of health care and provide access to quality health care services by pooling public revenue in order to actively and strategically purchase health care services based on the principles of universality and social solidarity;*
- *create a single framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate the fragmentation of health care funding in the Republic;*

- *promote sustainable, equitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system; and*
- *ensure continuity and portability of financing and services throughout the Republic*" (p3)

The SA Department of Health's *Some Key Messages on the National Health Insurance (NHI)* (2020) document elaborates that the annual R46,7 billion medical aid scheme subsidy (which includes tax credits paid out to medical members annually) will be discontinued and that the money will be added to the NHI Fund for the benefit of all South Africans (p3).

The NHI will directly contract with all healthcare providers (i.e. hospitals and health professionals) and allocate them effectively so that everyone has equal access to healthcare resources (vs. the private sector having the lion's share of specialists) (NHI Bill , 2019, s13.2). Primary Health Care will be strengthened to ensure efficient use of limited resources.

In an attempt to migrate away from the problematic FFS model, a major change to how health providers will be reimbursed has been outlined by the NHI Bill (2019), namely:

- 41(1): "The Fund, in consultation with the Minister, must determine the nature of provider payment mechanisms and adopt additional mechanisms". .

- 41(2): “The Fund must ensure that health care service providers, health establishments and suppliers are properly accredited before they are reimbursed”. .
- 41(3)(a): “An accredited primary health care service provider or health establishment providing primary health care services must be reimbursed by the Fund in accordance with the prescribed capitation strategy”. .
- 41(3)(b): “In the case of specialist and hospital services, payments must be all-inclusive and based on the performance of the health care service provider, health establishment or supplier of health goods, as the case may be”. .
- 41(3)(c): “Emergency medical services must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary”. .
- 41(4): “ Without limiting the powers of the Minister to make regulations in terms of section 55, the Minister may make regulations to— .
- 41(4)(a) provide that payments may be made on condition that there has been compliance with quality standards of care or the achievement of specified levels of performance; ”.
- 41(4)(b): determine mechanisms for the payment of an individual health worker and health care provider; and
- 41(4)(c): provide that the whole or any part of a payment is subject to the conditions outlined in a contract and that payments must only be affected by the Fund if the conditions have been met.

Having summarised the changes that the NHI will introduce to SA's healthcare system, I will now present the Afro-communitarian perspective of the adoption of VBHC in Africa. I do this by describing the tenets of the theory and then proceed to apply them to the adoption of VBHC in Africa.

**An Afro-communitarian perspective of the adoption of VBHC in Africa**

Given the geographical context of this paper, the Afro-communitarian ideology is the most applicable as the primary moral theory against which I hinge my argument that VBHC is conditionally morally justified in the African context. Notwithstanding, Kantianism and Utilitarianism also offer unique and correlating perspectives of the conditional moral justification of VBHC in Africa.

Luís Cordeiro-Rodrigues and Thaddeus Metz (2021, p3) offer that "Afro-Communitarianism is the view that harmonious communal relationships merit pursuit either as ends in themselves or at least as an essential means to some other end such as vitality or wellbeing. For Afro-communitarians, the way one communally relates to others is the moral standard by which to evaluate one's actions and character and thus formulate moral principles" (p3). Therefore, one's morality is positively correlated to the degree to which one relates to others. Similarly, one is considered as being immoral when one's actions create a negative relational experience.

The end result of pervasive "harmonious communal relationships" is social cohesion (or harmony) is held together by two values; a shared identity and goodwill as shown towards others. "As an Afro-communal ethic, identity and

solidarity cultivates and promotes the virtues of love, care, complementarity, justice, equity, fairness and patriotism in governance practices" (Obioha, 2021). Identity, the level to which one identifies with others, is a precursor for one's sense of belonging and ultimately interdependence with others (p20). This sense of belonging and interdependence results in a virtuous cycle of social cohesion and then solidarity, leading back to reinforcing identity.

How one relates to (or identifies with) others is a consequence of the degree of goodwill they extend to others. Goodwill is "acting and feeling in ways that enhance the well-being and excellence of others. It implies that one not only behaves so that others' good improves, but also desires this to be the case" (Cordeiro-Rodrigues & Metz, 2021, p3). Social cohesion is premised on goodwill. When one needs other members of their community to flourish, they will extend goodwill to others in exchange. A deep sense of social cohesion, based on goodwill, fosters an environment where solidarity can exist.

Metz (2018) introduces solidarity ("caring for others [or] acting for others' good) as an additional foundational value in Afro-communitarian ethics. He describes solidarity as "the combination of exhibiting certain psychological attitudes and engaging in helpful behavior. Here, the attitudes are ones positively oriented towards the other's good and include an empathetic awareness of the other's condition and a sympathetic emotional reaction to this awareness. The actions are not merely those likely to be beneficial, that is, to improve the other's state, but also are ones done consequent to certain motives, say, for the sake of making the other better off or even a better

person" (p52). This implies that moral status is also based on one's intentions towards others. Friendly or positive intentions (i.e. those that confer positive results to the recipient) are viewed as morally upright. "an action is right just insofar as it promotes shared identity among people grounded on good-will; an act is wrong to the extent that it fails to do so and tends to encourage the opposites, relationships of division and ill-will" (p115).

VBHC as a concept, reinforces solidarity. If the intentions are noble, the providers designing and implementing a VBHC-based system display friendliness and solidarity towards the population they serve. They do this by intentionally eliminating (or reducing) the negative aspects (or unfriendliness) of FFS, namely a lack of focus on whether the services dispensed provide patient value (Metz, 2014, p310).

Under the FFS model, little to no attention is paid to whether the patient perceives the services received to be of personal value (i.e. enabling them to flourish in their daily lives). Also, due to the volume-based nature of FFS, the cost of care is not considered, and therefore the patient carries the responsibility of inflated medical costs. In addition to this, provider payments are based on their performance against these established metrics and not purely on services rendered, despite their perceived and clinical impact on the patient's wellbeing.

This is a clear indication of how providers intent on implementing VBHC show friendliness and solidarity in that they display "caring for others [or] acting for others' good" (Metz, 2018, p52).

Under VBHC, the creation of medical condition groups establishes a framework for shared identity for patients within the group. Patients are grouped based on their similar healthcare needs (i.e. newly diagnosed diabetic patients under 50 years of age, with no existing chronic conditions). As such, their treatment would be similar, as would be the cost of care.

As such, patients, regardless of socio-economic status, race, gender etc. will receive the same treatment, and their providers will be measured against the same outcomes and treatment costs. This aspect of VBHC supports Afro-communitarianism's requirement for shared identity as a foundational requirement for moral rightness.

Looking at the current two-tiered healthcare system in South Africa (SA), supported by the FFS reimbursement model, what is clear is that this system has created and perpetuated 'separateness' within the country. The SA NDoH (2020) describes this healthcare inequality as "a number of problems including inequity, hospicentric care, high cost, poor outcomes and inefficient". The private sector caters to a small and wealthy minority, providing world-class healthcare to its patrons. On the other hand, the public sector typifies a third-world experience for the majority of the country's population. According to the Afro-Communitarian theory of right action, this state of affairs is morally unjustifiable. It (the existing healthcare system in South Africa) destroys social cohesion and distinctly fails to prioritise shared identity, goodwill or solidarity. By reinforcing "separateness", the SA healthcare system creates a division in the country's population, predominantly based on affordability. Those with means can access

world-class medical treatment in pristine settings and those without means are relegated to the impoverished, under-resourced and decaying public health system. The unintended consequence is an erosion of social cohesion and shared identity (especially where healthcare is concerned), and goodwill by the government, policymakers and the providers that benefit from a divided healthcare system.

The FFS model has also failed to correlate the cost of care dispensed with the clinical outcomes thus compromising the population's financial and physical well-being.

Each of the proposed changes to SA's health system under NHI reinforces solidarity. Together, they work to eliminate the distinction of South Africans by (historically allocated) racial groups and socio-economic class, as there is to be equity where health access is concerned.

South Africans already share a common identity through their nationality. The transition to the NHI will enhance this as it provides an additional source of shared identity (i.e. as patrons of a unified healthcare system), which they all contribute to (according to social solidarity standards laid out in the policy), and enjoy.

The value-based component of the NHI, outlined in section 41 (listed above), also enhances Afro-communitarian principles. The changes to provider reimbursement methods aim "to ensure effective cost-containment and future sustainability of the National Health Insurance" (NHI Bill Green Paper, 2011, s13[101]). African ethics suggests there is a moral obligation towards future

generations. Currently, the NHI aims to create an efficient healthcare system that does not compromise healthcare provision for future generations.

Kevin Behrens (2012) accounts that:

> "... ancestors who have died – but continue to have a presence – are entitled to respect… [indicate] that we do have moral obligations to future generations. These conceptions are that the environment is a communal resource, shared across generations, and that the present generation should express gratitude to its predecessors for preserving the environment on its behalf, by emulating its predecessors and preserving the environment for future generations" (p179).

Like the environment, healthcare is a shared resource that ought to benefit current and future generations. Therefore, according to Afro-communitarian ethics, there exists a moral obligation for current generations to ensure that they create and bequeath a fully functional, efficient, and patient-focused healthcare system for future generations. As such, African ethics proposes that shared identity, solidarity, and goodwill are not only applicable to present beneficiaries but ought to also be extended to future beneficiaries.

Additionally, the proposed provider reimbursement structure removes volume-based incentives. Instead, it utilises "performance-based mechanisms" which are linked to "controlling the expenditure through recommended formula, and adherence to treatment protocols for all conditions covered under the defined package of care" (NHI Bill Green Paper , 2011, s13). This reintroduces goodwill into healthcare and should aid in preventing the erosion of the caring aspect of medicine, as providers will now

be incentivized to ensure that those outcomes that matter most to patients are delivered.

The disease-related groups (also referred to as medical condition groups in VBHC literature) )under the NHI groups  patients with similar healthcare needs together and around which care programmes are designed to meet their unique needs.  With this in mind, the identified risk of 'lemon-dropping' and 'cherry-picking' is theoretically eliminated as there is no financial incentive for the government to exclude (or discriminate against) those with poorer health status. This is another show of how solidarity is upheld within the NHI's VBHC.

In the disease-related groups, treatment is  standardised and incentivised according to "adherence to treatment protocols for all conditions covered under the defined package of care. This  ensures the appropriate level of service provision and avoids underservicing, which is a common characteristic of many capitation-based systems" (SA NDoH, 2011, s13.1[109]). This exemplifies the  government's goodwill towards its citizens in that it has put processes in place to prevent shrewd providers from profiteering by skimping on services offered to patients.

Finally, an important aspect of improving patient outcomes within VBC is the focus on preventative care and the strengthening of primary healthcare services. Preventative care works to prevent ill from occurring (vs treating it once it has occurred)  and catching chronic and life threatening conditions as early as possible. Together, these improve patient outcomes and overall well being, thus enabling them to thrive.

A mature and organised primary health care ensures that patients are educated on and encouraged to practise good healthcare maintenance strategies. This works to prevent minor ailments needlessly escalating into more expensive and hard to manage complications. It provides structured management of patients with chronic diseases to reduce disease-related morbidity and mortality.

Where a country's labour force is healthy, its economy will inevitably be strengthened by its productivity. A strong economy can provide more services to its citizens, who continue to thrive in this congenial environment. The middle class will grow, and the indigent population will shrink due to the growing demand for labour.

In a study done by Fredj Jawadi and colleagues (2021) on the correlation between employment rates and crime levels, they found that in the 24 countries included in the study, there was a positive correlation between high unemployment rates and non-violent crimes (p448).

With a growing demand for labour, unemployment rates will drop and ultimately, the country's crime rates will also be reduced as citizens begin to experience an improved sense of confidence in the political structures and economy and therefore national pride will be enhanced.

The above typifies solidarity and shared identity. The socio-economic benefits of VBC are far reaching, especially in LMICs. As such, VBC establishes itself as, according to Afro-communitarian ethics, a morally justified healthcare model for Africa.

However, in some ways, the proposed NHI does not adequately meet the moral requirements of this theory. I will point these ways out now, because one of my conditions for the full moral justification of NHI VBHC is that these shortcomings be addressed. This is important because the NHI represents the only definitive national VBHC strategy outlined on the African continent and is likely to form the basis of other African nation's VBC strategies.

A conspicuous omission in the VBHC literature and policy documents globally, is the Traditional African Healers' role in the implementation of VBHC (especially in the Global South). It is unclear whether the NHI considers traditional healers as healthcare providers and, therefore, to be included within the proposed contracting and reimbursement structure. Cordeiro-Rodrigues & Metz (2021, p2) contend that "Traditional African Healers' practice consists, to a great extent, of giving moral advice to cure illness… Traditional African Healers are important cultural leaders of the communities who have the power to influence behaviour in desirable ways… a policy that involves Traditional African Healers is justified not only because they, when it comes to the African context, could bring a positive contribution, but also because the Afro-communitarian philosophy that informs their practices offers positive moral reasons to follow the Healers' prescriptions".

The importance of Traditional African Healers can not be underestimated if any African government is to achieve its intended UHC outcomes, namely, the improved health and welfare of the country's citizens. Traditional African Healers play a pivotal role in educating patients on basic health-promoting measures. In their paper on the role of Traditional African Healers in the

COVID-19 pandemic, Cordeiro-Rodrigues & Metz (2021) posit that Traditional African Healers' role in African societies is that of bastions of morality. It is off these moral guidelines that they base their cures for illnesses. In most cases, the prescribed treatment often follows conventional Western medicine (p2).

Therefore, it is intuitive that including Traditional African Healers as part of the healthcare provider ecosystem would be integral in health promotion and treatment adherence. Including Traditional African Healers into integrated care teams would cause better adoption of care programmes and improved health outcomes.

As key roleplayers in traditional African communities, Traditional African Healers are the bastions of cultural wisdom and community values. By sidelining them, solidarity is at stake as a significant aspect of the population's health ecosystem would be sidelined (therefore perpetuating a Western perspective of medicine).

Another area of concern is how patient confidentiality will be maintained and how patient consent will be obtained on the VBHC information system. In the NHI green paper (2011), the proposed information system is required for the "determination of the population's health needs and outcomes. The information system will also be essential for portability of services to the population. The National Health Insurance information system will be based on an electronic platform, with linkages between the National Health Insurance membership database (with updated contribution status) and accredited and contracted healthcare providers" (SA NDoH, 2011, s19 ).

In a continent with one of the highest rates of HIV/AIDS and associated stigma, there needs to be means by which governments intend to ensure patient confidentiality. Any breach of confidentiality within the proposed system risks significantly violating patient dignity and violating s14 of the National Health Act 61 of 2003 (NHA). Section 14 of the NHA states that "(1) All information concerning a user, including information relating to his or her status, treatment or stay in a health establishment, is confidential. (2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless (a) the user consents to that disclosure in writing; (b) a court order or any law requires that disclosure; or (c) non-disclosure of the information represents a serious threat to public health".

Preserving dignity is an important tenet of African ethics. If this indignity has violated another's dignity then the perpetrator will not have displayed solidarity and goodwill and would therefore be deemed an immoral person. Similarly, if their dignity is violated a person can not be kind and generous to others, and consequently , the community can not fully enjoy goodwill, kindness, and trust if others compromise its member's dignity.

However, section 15 of the NHA goes on to further explain instances where confidentiality and consent may be overlooked: "(1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user".

The lack of guidance on extenuating circumstances is worrying. With the roll-out of UHC across Africa, and its strong VBHC focus, there is an increased risk of breaches in confidentiality, which would erode the goodwill between patients and healthcare providers. The government ought to outline how it intends to obtain and maintain patient consent as patients move through the health system.

Given the above, the adoption of the NHI's VBHC is conditionally morally justified as it reinforces Afro-communitarian values (solidarity, goodwill and shared identity) but overlooks other key aspects of maintaining African patient dignity (i.e. inclusion of Traditional African Healers and is ambiguous on how patient confidentiality will be guaranteed).

Some may argue that Afro-communitarian ethics is exclusionary and does not consider the value systems of citizens of European descent residing on the continent (Obioha, 2021). I argue that African ethics transcends race and ethnicity, as it relates to the moral status of the individual first and then how they relate to their community.

An individual's rights are not subservient to those of the community. Individuals make up a community and therefore their dignity and well-being are essential to the moral structure within the community (p22).

Rights-based ethicists may also argue that VBHC is an infringement of the patient's right to access health services of their choosing. This claim is established on a misinterpretation of an individual's right to health. The World Health Organization's Constitution of 1946 stresses that "governments

have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures" (p1).

According to the WHO (2022), the right to health is limited to "the following: (i) "Freedoms include the right to control one's health and body (for example, sexual and reproductive rights) and to be free from interference (for example, free from torture and non-consensual medical treatment and experimentation). (ii) Entitlements [that] include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health" (p1).

The right to health does not extend to the individual's right to choose the type of healthcare and services that meet their preferences. Rather, the state, being the custodian of health in any country, determines what health system is implemented based on the population's needs, ensuring that there is "the highest attainable standard of health… through the allocation of maximum available resources" (WHO, 2022, p1). In South Africa, the government established a two-tier health system. Thus, the government has given its citizens the option of accessing health services either via the public sector (which provides these free of charge) or the private sector (which is paid for by individual members). The government's duty ends at providing a health system that is accessible to everyone and does not extend to meeting the individual preferences of its citizens.

With the migration to the NHI, the SA government is implementing a new health system that significantly reduces the services that are offered through the private sector. Membership in the NHI is mandatory for all citizens, but

individuals have the right to access services not provided for by the state through the private medical schemes funders that will reimburse providers for these additional services. Rights-based ethicists would have to prove that the services offered by the state are deficient to the extent that they compromise the population's ability to “attain the highest level of health” (WHO, 2022).

Afro-communitarian ethics, as spelt out above, supports the adoption of VBHC in Africa given that it supports its fundamental tenets. However, there are aspects of NHI VBHC that need to be strengthened before it can be adopted in South Africa. Including Traditional African Healers as healthcare providers with reimbursement rights under the NHI is an essential display of the government’s appreciation of its citizens' cultural beliefs and practices. Similarly, more discourse is required on how patient consent will be obtained and maintained and how patient confidentiality will be guaranteed.

In the next section, I will discuss how Deontological ethics' protection of autonomy supports the Afro-communitarian view that VBHC adoption in Africa is conditionally justifiable.

### 4.2 A deontological perspective

Deontological ethics is a duty-based ethics. This duty is hinged on the intrinsic value and dignity of all human beings based on their ability to reason and that they have desires. Henry Adobor’s (2022) summation of Kantian deontology is succinct:

> *"Kant's core focus on human dignity, driven by goodwill, is consistent with care for the vulnerable. Resting on three key principles of autonomy, dignity, and duty, Kant's moral philosophy addresses issues at the nexus of moral agency and duty to the vulnerable. First, individual autonomy holds that we make moral decisions based on our moral judgement of what we think is right, unclouded by any external influence, unless necessary. Kant's second focus is on dignity, the intrinsic worth of every human being…. Kant's concept of dignity [is that] 'the root idea of dignity is simply that virtually everyone, regardless of social station, talents, accomplishments, or moral record, should be regarded with respect as a human being.' Kant is emphatic that the dignity of a person cannot be traded for another source of dignity. Finally, is the idea of duty. Kant is emphatic about an individual's moral obligation to be beneficent towards those in need. To Kant 'the happiness of others is, therefore, an end that is also a duty'"* (p339).

Some may insist that Kantian ethics emphasises individualism and that the moral agent has no moral obligation to others beyond what moral duty requires (Adobor, 2022, p340). Adobor (2022) calls this a misinterpretation of autonomy: "Kant's focus on individual autonomy does not negate his concern for the welfare of groups or society… Although the moral agent is individualistic under Kantian ethics, this does not mean that people should be

selfish or self-centered in making moral decisions, a position Kant himself rejects" (p340).

VBHC's promise of improving patient outcomes without increasing (but ideally lowering) healthcare costs presents an opportunity to restore patient dignity. Until now, due to their vulnerable status (caused by ill health and limited medical knowledge), patients were at the mercy of a healthcare system that maximises profits with little quantifiable interest in the outcomes of such treatment as measured by what matters most to patients. The indignity in the current FFS stems from patients being subjected to health systems that value money above patient outcomes and profiteering from their vulnerability, which, according to Kantianism, is immoral. This position rests on the Kantian principle that people should never be used as a means to an end.

Health providers have a duty to care for the vulnerable. Their duty ought to arise from their "obligations or moral duty to act in a way that reflects goodwill towards others" (Adobor, 2022, p339). This summarises the basis of Kant's Categorical Imperative which states that one ought to act in a manner that assumes that that behaviour becomes a universally accepted standard. For example, if one believes that stealing is morally justifiable, then that person ought to assume stealing as a universally acceptable behaviour.

The NHI's VBHC component supports the restoration of human dignity by clearly presenting means by which provider profiteering will be reduced (if not eliminated altogether).

Patient participation is another salient feature of VBHC that aims to achieve the overarching objectives of the model: improving patient outcomes while

lowering costs. This places patients at the centre of the healthcare ecosystems for which they are the ultimate beneficiaries. As such, Patient Reported Outcomes Measures (PROMs) form an important measure for the success of VBHC. Nowhere is this more important than in Africa, where the patient-provider relationship is primarily paternalistic and uni-directional. Unfortunately, the NHI is silent on how it intends to measure, analyse and utilise patient-reported outcomes as part of the outcomes and cost data used to inform system improvements.

It should be noted that the NHI will provide healthcare services to all South Africans, legal permanent residents, refugees and inmates" (NHI Bill, 2019, s4). The role of medical schemes will be diminished to only cover those services covered under the NHI. This therefore removes citizens' ability to select their healthcare funder and the services they receive (NHI Bill, 2019, s6). This limitation of citizen choice, through a Kantian lens, is a challenge to patient autonomy.

As such, Kantian ethics would deem the adoption of VBHC in Africa as conditionally morally justifiable as some tenets of the moral theory are not satisfied in the context of the NHI. However, it must be noted that in another VBHC context on the continent, these may be sufficiently addressed. Therefore to conclude that VBHC is morally dubious based on one context is unreasonable.

Next, I will outline how Utilitarian ethics support Afro-communitarianism's determination of the conditional moral justification of adopting VBHC in Africa to argue for why my thesis is valid.

### 4.3 A Utilitarian perspective

The Utilitarian theory of right action rests on “the rightness of an act depending solely on its ability to confer the greatest good to the greatest number of people… Utilitarianism argues that acts that produce the best outcomes for the majority (act-utilitarianism) and rules that produce the best consequences (rule utilitarianism) are the correct moral choices to make” (Adobor, 2022, p340). Our moral obligations are to prevent and abstain from inflicting harm, pain or any type of suffering on all persons. It is clear why public policy decisions tend to be made using these utility-maximising principles. Policy decisions should benefit the majority.

To understand the Utilitarian perspective on VBHC, one must first unpack the utility-maximising aspects of the model. Firstly, and perhaps most importantly, VBHC is premised on improving the patient health outcomes that matter most to the patient. Tiesberg (2020) defines these as capability, comfort and calm.

> *“Capability is the ability of patients to do the things that define them as individuals and enable them to be themselves... Comfort is relief from physical and emotional suffering… Calm is the ability to live normally while getting care. Care that improves outcomes in all 3 of these dimensions creates a better experience for patients. Moreover, capability, comfort, and calm describe outcomes that result from the efficacy and empathy of health care, rather than its hospitality” (*, p682).

Each of the three dimensions outlined above, when met, results in improved quality of life. An improved quality of life allows the individual to thrive in all aspects of their lives. When individuals thrive, families and communities and eventually entire nations thrive. Achieving this utility maximising is morally obligatory as per Utilitarian ethics.

Over and above the patient benefits, “value-based health care connects clinicians to their purpose as healers, supports their professionalism, and can be a powerful mechanism to counter clinician burnout” (Tiesberg, 2020, p683). The universal benefits of happier and motivated clinicians are self-evident in how they benefit society at large.

In his study on healthcare price changes and expenditures in SA, Logan Rangasamy (2021) cites four important findings that have a significant impact on healthcare access in the country:

> *“Firstly, South Africa’s healthcare expenditures compare quite favourably with countries at similar levels of development. However, the efficiency of these expenditures lags behind those in comparable countries. Secondly, it was found that South Africa’s healthcare price rises have exceeded those in advanced countries even though healthcare demand and expenditures in these countries are much higher than is the case in South Africa. Thirdly, healthcare rises exceed those in other sectors of the South African economy. Finally, healthcare price changes adversely impact healthcare expenditures in South Africa. These*

*results indicate that price considerations are critical to improving healthcare access in South Africa"* (p607).

Another utility-maximising aspect of VBHC is its focus on reducing healthcare costs. This move stands to improve access to health care and health-seeking behaviours; the ultimate end of which is a healthier and more economically productive population.

As with the Afro-communitarian perspective of why adopting VBHC in Africa partially fulfils its requirements, Utilitarian ethics require additional clarity on how the SA government intends to preserve patient confidentiality within the NHI. Breaches of confidentiality would cause personal harm to patients and must be avoided at all costs.

Within the NHI, concern for Utilitarians is whether the proposed risk-adjusted capitation, compensation within the which measures "prescribed specific performance criteria,", will fairly reimburse General Practitioners (NHI Bill , 2019, s8(c) and s 39(b)).

Under the NHI, the SA government will be the sole purchaser and buyer of health services in the country. Health providers (hospitals, health professionals and emergency medical services) will be contracted to the government to dispense their services to the population. With the government being the sole contractor, there is only one legitimate source of reimbursement for providers. If the performance based system is not determined correctly, health professionals will be significantly negatively financially impacted. More practices will close and an unprecedented number of experienced health professionals may leave the country. The

medical profession may become undesirable for the youth, and fewer medicine graduates will be produced therefore exacerbating the already critical shortage of human resources in the SA health system. As such, the harm would extend to the entire population as the quality of care declines.

The Utilitarian conclusion to the question of whether VBHC is morally justified in Africa is that it is conditionally morally justifiable as there remains uncertainty regarding the utility impact of the proposed performance-based incentives set out for healthcare providers within the NHI Bill (2019). In its most basic form, VBHC is utility maximising and eliminates the harms caused by the FFS model and is therefore justified pending some clarifications on the concerns highlighted above.

# CHAPTER 5

# CONCLUSION

*“Things that matter most must never be at the mercy of things that matter least” - Goethe*

As the global discourse around the adoption of VBHC gains momentum and some governments start to implement aspects of VBHC, the body of knowledge on the topic is growing. Conversely, the literature on VBHC's ethical implications is still sparse. In this paper, I have consolidated the ethical issues raised in existing literature and contributed additional issues that are specific to the African context. Therefore this paper plays an important role in providing a view of the ethical implications of the adoption of value-based healthcare globally, and especially in Africa.

Chapter 1 provides details of the importance of VBHC, particularly in light of the global impetus to transition to this reimbursement model.

A thorough delineation between the FFS and VBHC models was done in Chapter 2. This chapter analyses the key differences between the models , and outlines some ethical issues that arise in both models.

Chapter 3 further expounds the outlined ethical issues (Chapter 2), drawing on the limited literature available on the topic to describe additional ethical issues specific to LMICs (especially in Africa).

Chapter 4 defends a conditional moral justification to implement VBHC grounded in Afro-communitarian ethics supported by Kantian and Utilitarian ethics.

This concluding section consolidates the salient points from this paper and recommends future studies.

**Salient points on the ethical implications of the adoption of VBHC in Africa**

VBHC is purported to be the solution to address the issues that are present within the FFS healthcare reimbursement model. The literature claims that VBHC will stave off the skyrocketing healthcare costs seen globally, and simultaneously improve patient health outcomes, a focus missing from the FFS model.

However, the definition of 'value' in healthcare is ambiguous. As such, how 'value' is defined has a direct impact on how VBHC is implemented. African government and policy makers ought to establish a singular definition of 'value' in healthcare as determined by the African context.

Porter and Tiesberg, the founders of this model, propose a detailed framework to guide VBHC implementation. However, to date, there have been pockets of VBHC implementation across (mainly) US and European health facilities, and only on aspects of the VBHC framework. Horner and colleagues (2019) raise an important challenge of implementing VBHC; "When it comes to value-based payment, perhaps the greatest challenge that health systems face today is how to implement value-based payment models

at the level of an entire health system. Even when individual payment initiatives demonstrate improved health care value, it is not immediately obvious how to knit them together into a comprehensive and coherent system-wide payment regime" (p1).

With this in mind, the South African government, in its imminent implementation of the NHI (which is established on VBHC), ought to take heed of the ethical implications of doing so. The limited literature focusing on the ethical issues in VBHC highlight several important issues that ought to be considered and addressed in its adoption. One of these issues raised is that of VBHC's impact on solidarity, equity and justice. There exists the risk that some shrewd providers will see the risk-adjusted capitation incentive model, as an opportunity to maximise profits by limiting the care given to patients which will ultimately have detrimental consequences to patient health.

The problem of under-treatment may not be limited to provider greed. It can extend to the inaccurate historical treatment cost data (endemic in Africa) used to determine care plans. This inaccurate data may stem from under reporting in historical data. It is on the care plans that provider incentives will be created. The knock-on effect of inaccurate benchmark data used, is significant and potentially detrimental to population health.

The regional and continental impact of having islands of healthcare excellence must also be considered by policy makers and governments, ahead of VBHC implementation. If this is not done, additional issues related to an influx of foreign patients in search of better health services, may cause

overstretching the VBHC-based health system. Continental and regional solidarity should be prioritised to avoid these.

‘Lemon-dropping’ and ‘cherry-picking’ are often seen in practice even when VBHC is not involved. This practice has been particularly seen “under the budget-based care that exemplifies the value-based model” (Corbett, 2016, p4). Measures ought to be established by funders to ensure that provider incentives are focused on patient outcomes and not skewed to cost-containment.

In addition, providers must intentionally and effectively communicate their inventive structure to patients as a means of maintaining the trust between providers and patients. HCP morale must also be assessed to ensure that it is not eroded by reduced incentive payouts due to factors outside of their control.

Finally, a healthcare system that desires to significantly improve population health, must incorporate alternative medicine and African Traditional Healers. Traditional African Healers play an important role in the health ecosystem of a large segment of Africa’s population. Their participation in public health initiatives may be beneficial in driving the health promoting behaviours required to ensure improved population health. Sidelining this group of health providers will perpetuate the “separateness” of mainstream, alternative and traditional healthcare which will cause this population to feel torn between the two conflicting systems. Where “separateness” exists, there too exists violations of personal dignity.

Additional research is required to investigate how Traditional African Healers and alternative medicine practitioners can be incorporated in the integrated treatment teams that consist of clinical and non-clinical members to enhance the achievement of patient outcomes.

The ideologies of Afro-communitarian ethics demand that VBHC be adopted in Africa to radically change the state of healthcare on the continent. VBHC offers an opportunity for strengthening solidarity within a country (and between countries where health services are included in free trade agreements). The model's promise to improve patient outcomes while reducing costs is a strong show of how VBHC promotes goodwill between providers and patients.

In a continent where the economic inequality is stark, VBHC bolsters a shared identity between the patrons of the healthcare system. The patrons are all equal beneficiaries and ought to work together to hold the government, policy makers and healthcare providers accountable for the quality that is dispensed and the associated costs.

Research on the ethical, social and legal implications of VBHC in Africa is at its infancy. Further research in all aspects of the model is required to ensure a complete understanding of the true impact of its adoption in the already complex African context. Work especially needs to be done to address whether existing Patient Reported Outcomes Measures (PROMS) are applicable to the African context and if not, what amendments are required. Another question that begs asking is whether VBHC should be a continental strategy vs that of individual countries to mitigate against islands of

healthcare excellence and to leverage the healthcare resources (including Doctors and specialists) available on the African continent. Finally, more research is required to determine whether VBHC reimbursement contracts that force providers to repay funders where specific metrics have not been met, is ethically justifiable given the myriad socio-economic issues African nations face that compromise the patient outcomes (and are beyond the control of any provider).

**References:**

Adobor H. 2022. Vulnerability, Moral responsibility, and Moral Obligations: the case of Industrial Action in the Medical and Allied Professions. *Medicine, Health Care and Philosophy;* 25:333–349.

Africa Centre for Disease Control and Prevention (CDC). 27 May 2022. Africa CDC Non Communicable Diseases, Injuries Prevention and Control and Mental Health Promotion Strategy (2022-26). African Union. https://africacdc.org/download/africa-cdc-non-communicable-diseases-injuries-prevention-and-control-and-mental-health-promotion-strategy-2022-26/ (Accessed on 17 July 2023).

African Union. About the African Union. https://au.int/en/overview (Accessed on 18 September 2023).

Agilon Health. 02 Dec 2022. How to overcome barriers to value-based care. https://www.agilonhealth.com/news/blog/value-based-care-barriers/ (Accessed on 04 July 2023).

Akanbi MO, Ocheke AN, Agaba PA, Daniyam CA, Agaba EI, Okeke EN & Ukoli CO. (2011). Use of Electronic Health Records in sub-Saharan Africa: Progress and challenges. *Journal of Medicine in the tropics*; Vol 14: 1-6.

American Academy of Physical Medicine and Rehabilitation (AAPMR). 2023. Merit-Based Incentive Payment System (MIPS). https://www.aapmr.org/quality-practice/quality-reporting/merit-incentive-payment-system (Accessed on 04 July 2023).

American Speech-Language-Hearing Association (ASHA). Value-Based Care: Alternative Payment Models. https://www.asha.org/advocacy/Value-Based-Care/ (Accessed 21 June 2023).

Behrens K. 2012. Moral obligations towards future generations in African thought. *Journal of Global Ethics;* 8. 179-191.

Boston Consulting Group (BCG). 13 June 2018. How Dutch Hospitals Make Value-Based Health Care Work. https://www.bcg.com/publications/2018/how-dutch-hospitals-make-value-based-health-care-work (Accessed 06 May 2023).

Chancel L, Cogneau D, Gethin A & Myczkowski A. 2019. Income inequality in Africa, 1990-2017. World Inequality Lab. World Issue Brief: September. https://wid.world/document/income-inequality-in-africa-1990-2017-wid-world-issue-brief-2019-06/#:~:text=Africa%20has%20the%20highest%20gap,inequality%20regions%20such%20as%20the (Accessed on 25 July 2023).

Conrad DA. 2016. The Theory of Value-Based Payment Incentives and Their Application to Health Care. *BMC Health Services Research;* 50:S2, Part II (December): 2057-2089.

Constitution of the Republic of South Africa, Act 108 of 1996.

Consumer Protection Act of South Africa No. 68 of 2008.

Corbett J. 2016. Ensuring the Values in Value-Based Payments. *Journal of the Catholic Health Association of the United States: Health Prog*ress; Mar-Apr;97(2):44-9.

Cordeiro-Rodrigues L & Metz T. 2021. Afro-Communitarianism and the Role of Traditional African Healers in the COVID-19 Pandemic. *Public Health Ethics*; Mar 20:phab006.

Doran T, Maurer KA & Ryan AM. 2017. Impact of Provider Incentives on Quality and Value of Health Care. *Annual Review of Public Health;* 38:1, 449-465.

Economist Intelligence Unit (EIU). 2016. Value-based healthcare: A global assessment. https://impact.economist.com/perspectives/sites/default/files/EIU_Medtronic_Findings-and-Methodology_1.pdf (Accessed on 15 July 2023).

Eriksson T, Tropp H, Wiréhn AB & Levin L. 2020. A pain relieving reimbursement program? Effects of a value-based reimbursement program on patient reported outcome measures. *BMC Health Services Research;* 20, 805.

Fisher OM, Brown KGM, Coker DJ, Mcbride KE, Steffens D, Koh CE, Sandroussi C. 2020. Distributive justice during the coronavirus disease 2019 pandemic in Australia. *ANZ Journal of Surgery;* 90: 961–962.

Garattini L & Padula A. 2018. Pharmaceutical pricing conundrum: time to get rid of it? *The European Journal of Health Economics;* 19, 1035–1038.

Groenewoud, AS, Westert, GP & Kremer, JAM. 2019. Value based competition in health care's ethical drawbacks and the need for a values-driven approach. *BMC Health Services Research;* 19, 256.

Harvard Business School: Institute for Strategy & Competitiveness. Organize Care Around Medical Conditions. https://www.isc.hbs.edu/health-care/value-based-health-care/key-concepts/Pages/organize-care-around-condition.aspx (Accessed on 19 February 2024).

Harvard Business School: Institute for Strategy & Competitiveness. Systems Integration. https://www.isc.hbs.edu/health-care/value-based-health-care/key-concepts/Pages/systems-integration.aspx#:~:text=When%20providers%20integrate%20care%20across,value%2Dbased%20health%20care%20system. (Accessed on 19 February 2024).

Harvard Business School: Institute for Strategy & Competitiveness. Geography of Care. https://www.isc.hbs.edu/health-care/value-based-health-care/key-concepts/Pages/geography-of-care.aspx. (Accessed on 19 February 2024).

Health Economics Unit, University of Cape Town & Institute for Social and Economic Research, Rhodes University. July 2010. Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care Regional Network for Equity in Health in East and Southern Africa (EQUINET): Discussion Paper 84.

https://www.equinetafrica.org/sites/default/files/uploads/documents/DIS84privfin%20mcintyre.pdf (Accessed on 07 August 2023).

Healthbridge. 27 August 2018. Fee-for-service (FFS) vs Value-based reimbursement model. https://healthbridge.co.za/blog/fee-for-service-vs-value-based-reimbursement-model/ (Accessed 22 June 2023).

Healthy People 2020. Disparities. Office of Disease Prevention and Health Promotion: Healthy People 2020.gov. https://wayback.archive-it.org/5774/20190703195956/https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (Accessed on 06 August 2023).

Horner B, van Leeuwen W, Larkin M, Baker J & Larsson S. 03 September 2019. The Boston Consulting Group. Paying for Value in Health Care. https://www.bcg.com/publications/2019/paying-value-health-care (Accessed 06 May 2023).

Jawadi F, Mallick SK, Cheffou AI, Augustine A. 2021. Does higher unemployment lead to greater criminality? Revisiting the debate over the business cycle. *Journal of Economic Behavior & Organization*; 182: 448-471.

Landon SN, Padikkala J, Horwitz LI. 2021. Defining value in health care: a scoping review of the literature. *The International Journal for Quality in Health Care* Nov 12;33(4):mzab140.

LaPointe J. 09 September 2016. Understanding the Value-based Reimbursement Model Landscape. RevCycle Intelligence. https://revcycleintelligence.com/features/understanding-the-value-based-reimbursement-model-landscape (Accessed on 22 July 2023).

Levinson W, Kao A, Kuby AM & Thisted RA. The Effect of Physician Disclosure of Financial Incentives on Trust. *The Archives Of Internal Medicine* 2005;165(6):625–630.

Lunt N, Smith R, Exworthy M, Green ST, Horsfall D & Russell Mannion. Medical Tourism: Treatments, Markets and Health System Implications: A scoping review. OECD: Directorate for Employment, Labour and Social Affairs. https://www.oecd.org/els/health-systems/48723982.pdf (Accessed on 01 August 2023).

Magill MK. 2016. Time to Do the Right Thing: End Fee-for-Service for Primary Care. *Annals of Family Medicine*; Sep; 14(5): 400–401.

Metz, T. 2014. African values and human rights as two sides of the same coin: A reply to Oyowe. *African Human Rights Law Journal*; 14: 306-321.

Metz, T. 2007. Toward an African Moral Theory. *Journal of Political Philosophy;* 15: 321-341.

Metz T. 2018. A Bioethic of Communion: Beyond Care and the Four Principles with Regard to Reproduction. In Marta Soniewicka (ed.), The Ethics of Reproductive Genetics - Between Utility, Principles, and Virtues. Springer, Cham, Switzerland. p49-66.

Miller HD. 2012. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality and Payment Reform. https://chqpr.org/downloads/Overcoming_Barriers_to_Payment_Reform.pdf (Accessed 20 June 2023).

Mitra G, Grudniewicz A, Lavergne MR, Fernandez R & Scott I. 2021. Alternative payment models: A path forward. *Canadian Family Physician*; vol. 67 (Nov): 805-807.

National Health Insurance Bill of South Africa of 2019.

Obioha UP. (2021). An Afro-communal ethic for good governance: Array. Acta Universitatis Danubius. Administratio, 13(1). https://dj.univ-danubius.ro/index.php/AUDA/article/view/990 (Accessed on 07 September 2023).

Porter ME & Tiesberg EO. 2006. Redefining Health Care: Creating Value-based Competition on Results. Harvard University Press. Boston, Massachusetts.

Pot M. 2022. Epistemic solidarity in medicine and healthcare. *Medicine, Health Care and Philosophy*; 25, 681–692.

Prada G. Value-Based Healthcare Models to Improve Patient Outcomes, Create Resilience and Advance Universal Health Coverage in Developing Countries. Global Solutions; The World Policy Forum (G20 Insights). November 3, 2022. https://www.global-solutions-initiative.org/policy_brief/value-based-healthcare

-models-to-improve-patient-outcomes-create-resilience-and-advance-universal-health-coverage-in-developing-countries/ (Accessed: 02 March 2023).

Putera I. 2017. Redefining Health: Implication for Value-Based Healthcare Reform. *Cureus Journal of Medical Science*; Mar 2;9(3): e1067.

Rangasamy L. 2021. Healthcare price changes and expenditures in South Africa: Some implications for economic policy. *Development Southern Africa*; vol 38(4): 607-621.

RevCycle Intelligence. 02 March 2020. What Is Value-Based Care, What It Means for Providers? https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers (Accessed 21 June 2023).

Rowe K & Moodley K. 2013. Patients as consumers of health care in South Africa: the ethical and legal implications. *BMC Medical Ethic;*. Mar 21;14:15.

Shafrin J. 27 April 2009. Operating on commission: analyzing how physician financial incentives affect surgery rates. *Journal of Health Economics*; https://onlinelibrary.wiley.com/doi/epdf/10.1002/hec.1495 (Accessed on 17 July 2023).

Silverman R, Keller JM, Glassman A & Kalipso C. 2019. Tackling the Triple Transition in Global Health Procurement. Centre for Global Development. https://www.cgdev.org/sites/default/files/better-health-procurement-tackling-triple-transition.pdf (Accessed on 19 August 2023).

Smith V & Marshall EG. 2021. "Meet and greets" in family practice: Who, why, and to what end? *Canadian Family Physician;* Aug;67(8):e227-e234.

South African National Department of Health (SA NDoH). 2019. National Health Insurance in South Africa: B 11. .

South African National Department of Health (SA NDoH). 2011. National Health Insurance in South Africa: Policy Paper. https://www.gov.za/sites/default/files/nationalhealthinsurance.pdf (Accessed on 26 August 2023).

South African National Department of Health (SA NDoH). 2020. Some Key Messages on National Health Insurance (NHI). https://www.health.gov.za/wp-content/uploads/2020/11/some-key-messages-on-nhi.pdf (Accessed 26 August 2023).

South African National Health Act 61 of 2003.

Steinmann G, van de Bovenkamp H, de Bont A & Delnoij D. 2020. Redefining value: a discourse analysis on value-based health care. BMC Health Services Research; 20, 862.

Steve Biko Centre for Bioethics. 2023. Guide for Developing and Submitting a Research Proposal. Faculty of Health Sciences. School of Clinical Medicine. University of the Witwatersrand. Johannesburg, South Africa.

Stoddard JJ, Hargraves JL, Reed M & Vratil A. 2001. Managed care, professional autonomy, and income: effects on physician career satisfaction. *Journal of General Internal Medicine*; Oct;16(10):675-84.

WHO Special Programme for Research and Training in Tropical Diseases (TDR). 13 December 2022. Role of the private health sector in providing healthcare for women and children in United Republic of Tanzania and Ghana. https://tdr.who.int/newsroom/news/item/13-12-2022-role-of-the-private-health-sector-in-providing-healthcare-for-women-and-children-in-Tanzania-and-Ghana (Accessed on 04 August 2023).

The Economist Intelligence Unit. 2016. Value-based healthcare: A global assessment. https://impact.economist.com/perspectives/sites/default/files/EIU_Medtronic_Findings-and-Methodology_1.pdf (Accessed 05 May 2023).

The Harvard Business School: Institute for Strategy and Competitiveness. Value-Based Health Care. https://www.isc.hbs.edu/health-care/value-based-health-care/Pages/default.aspx (Accessed: 01 March 2023).

The Lancet. 2021. Reinstating universal health coverage on the global agenda. *The Lancet* (Editoral); December 04. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02742-2/fulltext (Accessed: 02 March 2023).

Tiesberg E, Wallace S & O'Hara S. 2020. Defining and Implementing Value-Based Health Care: A Strategic Framework. *Academic Medicine*; 95(5): 682–685.

Tsou AY, Graf WD, Russell JA, Epstein LG. Oct 2021. Ethical Perspectives on Costly Drugs and Health Care AAN Position Statement. *Neurology*, 97(14): 685-692.

U.S Centers for Medicare & Medicaid Services (CMS). 31 March 2022. What are the value-based programs? Value-Based Purchasing Program. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs (Accessed on 04 July 2023).

U.S Centers for Medicare & Medicaid Services (CMS). Participation Options Overview. Quality Payment Program. https://qpp.cms.gov/mips/overview (Accessed on 04 July 2023).

Wallang P. 2020. Volumising value: value-based healthcare and its coming of age. *British Journal of Psychiatry Advances;* 26: 205–207.

Watson M. 2022. Healthjump. Top 5 Challenges in Value-Based Care (and How to Solve Them). 09 Nov. https://www.healthjump.com/blog/top-5-challenges-in-value-based-care-and-how-to-solve-them. (Accessed on 04 July).

World Economic Forum & The Boston Consulting Group (BCG). April 2017. Value in Healthcare: Laying the Foundation for Health System

Transformation Insight Report. https://www3.weforum.org/docs/WEF_Insight_Report_Value_Healthcare_Laying_Foundation.pdf (Accessed 05 May 2023).

World Health Organization. 10 December 2022. Human rights. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health (Accessed on 10 September 2023).

World Health Organization's Constitution of 1946