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A critical analysis of private practice billing guidelines for health professionals in South Africa

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Title: A critical analysis of private practice billing guidelines for health professionals in South 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 (MSc Med) in Bioethics and Health Law.

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29 April 2022

DECLARATION

Plagiarism Declaration

I Nicole Hudson- Lamb (Student number: 458642) am a student registered for MSc Med (Bioethics & Health Law) in the year 2021.

I hereby declare the following:

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Signature: Nicole Hudson-Lamb 

Date: 29/04/2022

DEDICATION

To my wonderful husband, Brendon Hamer.

He is my pillar of support and has encouraged me every step of the way.

ABSTRACT

South Africa`s private healthcare sector and the fees charged by private health professionals has become a major challenge and concern. The rising costs in the private healthcare sector are unsustainable and urgently need to be addressed. There have been several failed attempts by various role-players to establish a credible pricing benchmark. There are a number of short-comings and obstacles faced with the current guidelines provided to the private healthcare sector. The current Health Professions Council`s guidelines fail to define and advise what constitutes as overcharging with no booklets addressing this legal and ethical issue. I consider the legal and ethical implications where a health professional overcharges for their services. Rampant commercialisation in healthcare will destroy the traditional respect for the healthcare profession which has been carefully earned and deserved over the centuries. This forms the basis of my argument, that the current guidelines which govern billing practices of South African health professionals are ethically and legally inadequate. I claim that there is a compelling need for the regulating bodies to set and implement an "ethical billing range" for South Africa`s private healthcare sector. This "ethical billing range" would support and assist to better protect health professionals, medical schemes, and patients alike. The "ethical billing range" will also assist to curb the rate of private healthcare spending and promote sustainability in the private healthcare sector. This will further lead to improved access to healthcare services. I conclude that complete and comprehensive billing guidelines will address the ethical and legal inadequacies that exist in the current billing guidelines. This will not only benefit private healthcare, but healthcare in its entirety within South Africa.

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TABLE OF CONTENTS

Contents

DECLARATION ii

DEDICATION iii

ABSTRACT iv

ACKNOWLEDGEMENTS v

TABLE OF CONTENTS vi

LIST OF ABBREVIATIONS viii

Chapter 1: Overview of the research 1

1.1 Introduction 1

1.2. Research Question 3

1.3 Rationale for the Study 3

1.4 Thesis Statement 3

1.5 Research Aim 3

1.6 Research Objectives 4

1.7 Research Design 4

1.8 Research Methods 4

1.9 Ethics 4

1.10 Research Outcomes 5

1.11 Limitations 5

Chapter 2: Review of the current laws and guidelines governing South Africa's health professionals billing practices. 6

2.1 Introduction 6

2.2 An overview of the current private healthcare system in South Africa 6

2.3 The history of private healthcare in South Africa 7

2.4 Historical billing practices in healthcare and their impact in a South African context 8

2.5 The role of medical schemes, administrators and the Council for Medical Schemes 11

2.6 The relevant laws pertaining to billing practices in South Africa`s private healthcare sector 13

2.7 The current billing regulatory conundrum in the private healthcare sector and what is being done to resolve it 17

2.8 Conclusion 19

Chapter 3: Critical analysis of the principles of medical ethics associated with health professionals' billing practices. 20

3.1 Introduction 20

3.2 Ethics pertaining to billing practices in healthcare 21

3.3 Moral theories related to health professionals overcharging and why price setting is required 22

3.4 The ethical concern with commercialism in healthcare 27

3.5 Conclusion 29

Chapter 4: Recommendations to relevant industry bodies to revise their guidelines. 30

4.1 Introduction 30

4.2 Why setting of prices in the private healthcare sector is required 30

4.3 Legal cases related to overcharging 33

4.4 Why an ethical limit is required 36

4.5 Recommendations to the HPCSA 37

4.6 Conclusion 40

Chapter 5: Conclusion 42

REFERENCES 44

APPENDICES 53

LIST OF ABBREVIATIONS

BHF	Board of Healthcare Funders
CA	Competition Act
CC	Competition Commission
CMS	Council for Medical Schemes
CPA	Consumer Protection Act
CPI	Consumer Price Index
DBM	Doctors Billing Manual
DoH	Department of Health
EPL	Ethical Price List
FWA	Fraud, Waste and Abuse
GEMS	Government Employees Medical Scheme
GP	General Practitioner
HPA	Health Professionals Act
HPCSA	Health Professionals Council of South Africa
HASA	Hospital Association of South Africa
HMC	Health Monitor Company
HMI	Health Market Inquiry
ICU	Intensive Care Unit
MSA	Medical Schemes Act
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NHRPL	National Health Reference Price List
NPO	Non-Profit Organisation

OECD	Organisation for Economic Co-operation and Development
PMB	Prescribed Minimum Benefit
SAMA	South African Medical Association
SAPPF	South African Private Practice Forum
SMC	Singapore Medical Council
SSRH	Supply-Side Regulator for Health
RAMS	Representative Association of Medical Schemes
RPL	Reference Price List
TB	Tuberculosis
USA	United States of America
WHO	World Health Organization

Chapter 1: Overview of the research

1.1 Introduction

As an introduction to my topic, I will reflect on a known case involving Genesis Medical Scheme. In this case the health professional sutured a patient's eyebrow together and billed Genesis Medical Scheme ZAR 26 000 for the 23-minute procedure[1]. If we convert that into an hourly rate, it works out to roughly ZAR 67 826 an hour. This example of excessive billing by a health professional, leads to many unanswered questions. Some of the questions that come to mind are:

1. What are the current laws and guidelines in South Africa regarding the billing practices for private health professionals?
2. What are the ethical concerns when a health professional charges excessive fees?
3. How does the regulating body monitor excessive billing by health professionals?
4. What can be done to improve the current guidelines to limit cases of excessive billing in order to protect the various role players?

The above questions need to be examined and will be critically evaluated in my research report.

The South African private healthcare sector offers health services that are becoming increasingly unaffordable for most South Africans. This is evident in the recent Council for Medical Schemes (CMS) annual report which indicates a year-on-year decline in membership[2]. Private healthcare costs have consistently risen above inflation over the last decade and will continue to do so if the status quo is not challenged[3]. I will demonstrate that the escalating costs and dramatic price increases in private healthcare are unsustainable and will ultimately lead to serious implications for the private healthcare market. Some of these implications include increased out-of-pocket expenses for patients, reduced access to healthcare services due to unaffordability, the increased risk of debt for patients to name a few.

I will discuss the gaps in the current legislation regarding the billing guidelines for health professionals in South Africa. In this report, I will highlight the fact that there is lack of appropriate regulation with no set guidelines in place related to tariff determination or price limits. There has been no list of tariff guidelines published in South Africa since 2009. I will discuss how the 2004 Competition Commissions (CC) decision to stop collective bargaining, had in my view, far reaching consequences in the health sector[3]. This has contributed to the increase in tariff prices, particularly Prescribed Minimum Benefit (PMB) conditions. There is currently no reference framework for fees charged in South Africa`s private healthcare sector.

This allows the health professionals to charge whatever fee they feel is appropriate for their services rendered. With no price cap enforced, this is contributing towards the high cost of care. There is much uncertainty and a lack of protection for patients when they seek private healthcare services.

There has been poor implementation of existing legislation with a lack of regulatory co-ordination[3]. These are important aspects within South Africa`s private healthcare sector which need to be addressed. The private healthcare sector has regulatory measures in place, however, there have been many challenges related with these and, in my view, there has been an overall insufficient stewardship of this sector. I will discuss how the current laws and regulations are in my view, legally inadequate.

The current guidelines are opening the door to the unethical practice of overcharging. The practice of overcharging will be discussed in light of the ethical concerns it presents in healthcare. Medical professionalism allows health professionals the independence to perform their duties with integrity, and in South Africa this includes the setting of their own prices[4]. The Health Professions Council of South Africa (HPCSA) prohibits 'over-servicing or overcharging' in their Ethical Rules[4], however, no guidelines are provided relating specifically to this. The medical schemes as the funders similarly refer to 'over-servicing or overcharging' as 'waste and abuse'. Despite the HPCSA prohibiting 'over-servicing or overcharging', there were alarming statistics from the CMS` Fraud, Waste and Abuse (FWA) summit in 2019. It was found that FWA was increasing and costing the industry ZAR 22 billion a year[5]. I will use relevant moral theories to argue that the current guidelines which govern billing practices of South African health professionals are in my view, ethically inadequate.

The increasing cost of private healthcare is a major concern as South Africa has one of the highest, most persistent inequality trends in the world[6]. Recent statistics indicate that 13.5 million people live below the extreme poverty line with "approximately half the adult population were living below the upper-bound poverty line"[7]. I will demonstrate that the incomplete guidelines and increasing cost of private healthcare is leading to a widening disparity in access to healthcare services. The current private healthcare sector has multiple market failures and systemic issues which are threatening the healthcare of all South Africans. These need to be resolved for the sector to grow in a sustainable way which will improve accessibility of healthcare for all South Africans[3]. I will further argue that an "ethical billing range" should be promulgated to assist health professionals to act with integrity in their financial interactions with patients and medical schemes. Finally, I will provide formal

recommendations to the relevant industry bodies for a complete and comprehensive billing guideline.

1.2. Research Question

Should an "ethical billing range" be promulgated to address the ethical and legal inadequacies that exist in the billing guidelines for South African health professionals?

1.3 Rationale for the Study

There is a lack of adequate billing guidelines to support health professionals in their billing practices in the South African private healthcare sector. South Africa as a developing country, faces a major challenge with regards to access to healthcare. I will clarify the ethical and legal shortcomings identified in the private healthcare industries regulations and how they have become a major challenge to broadening access to health services. This study will provide recommendations for the regulatory bodies concerned. This study will emphasize the ethical concerns that a health professional in private practice ought to be cognizant of in their billing practices. The intended outcome for this study is for better protections of both the patient and the health professional as well as to re-establish the trust between all parties involved. This study is novel as it is unique in the South African context and seeks to deal with an ever-expanding unequal healthcare environment to improve overall access to healthcare.

1.4 Thesis Statement

I will argue that the guidelines which govern billing practices of South African health professionals are ethically and legally inadequate and therefore there ought to be an "ethical billing range".

1.5 Research Aim

To argue that the guidelines which govern billing practices of South African health professionals are ethically and legally inadequate and therefore there ought to be an "ethical billing range".

1.6 Research Objectives

- To critically analyse the current regulatory guidelines which govern South African private practice health professionals and show that they are legally inadequate.
- To use ethical theories to argue that the current regulatory pricing guidelines and laws are not ethically adequate.
- To provide recommendations to the HPCSA regarding health professionals` billing practices that would be ethically and legally adequate.

1.7 Research Design

This will be a normative study that will be using ethico-legal research methodology. I will review the relevant applicable laws and guidelines related to health professional billing practices and critically analyse their strengths and shortcomings. I will describe the ethical and legal implications regarding overcharging by health professionals. Recommendations to amend the current guidelines pertaining to ethical billing practices will then be presented.

1.8 Research Methods

As this is a purely normative study it will be based on library- and desktop-based research. No study participants will be involved in this study. No new data will be collected or analyzed. Bioethical and philosophical research methods will be used. Important texts, relevant legislation and available guidelines will be interpreted and ethically analyzed to answer the research question. In evaluating the available literature, I will clarify definitions and key concepts, identify and critique current circumstances and practices pertaining to the study. I will analyse, interpret, and apply relevant legal and ethical frameworks in the analytical process. In reviewing the relevant literature counter arguments will be considered and these will be refuted. In gathering the research data, sources of literature will primarily include books, International and South African legislation, case law and journal articles from leading databases.

1.9 Ethics

As this research report is a normative study, ethical clearance is not required as no research participants will be involved.

1.10 Research Outcomes

This report will provide information to the relevant industry bodies for use when drafting billing guidelines for South African health professionals. This report may offer opportunities to be published in a local peer-reviewed journal such as the South African Journal of Bioethics and Law.

1.11 Limitations

There is limited existing literature available related to this topic and as a normative study relies solely on existing empirical evidence the limitations of this study are subject to the typical limitations of normative work and the availability of current research.

Chapter 2: Review of the current laws and guidelines governing South Africa's health professionals billing practices.

2.1 Introduction

In this chapter I will review the current laws and guidelines governing South Africa`s health professionals billing practices and make a case to demonstrate that they are legally inadequate. Price setting and regulation within the healthcare sector can be utilized to advance more prominent incentives for all role-players, especially with finite resources in healthcare[3]. The numerous failures in attempting to establish a credible price benchmark in South Africa`s private healthcare sector has left the sector unregulated[3]. This has caused the inflation of medical treatment costs to be greater than the Consumer Price Index (CPI) with private healthcare becoming increasingly more unaffordable[8].

In order for this sector to operate efficiently, the pitfalls in establishing a credible price benchmark need to be considered and addressed. With no pricing benchmark, private healthcare prices are opaque with patients and health professionals equally uncertain. In my view, the private healthcare sector requires careful pricing regulation and enforcement by the relevant regulatory bodies with improved transparency.

There are numerous role players within the private healthcare sector which adds to the complexity of this sector[9]. These roles players include health professionals, private hospitals, pharmaceutical companies, emergency services, medical schemes, medical scheme administrators, insurance companies and medical consumable companies[9]. I will further discuss the roles of medical schemes and administrators and the function they perform in the reimbursement for healthcare services within the sector. Due to the considerable number of role players involved and the limited resources within this private healthcare sector, my suggestion is that an "ethical billing range" is promulgated to provide guidance and transparency to the industry.

2.2 An overview of the current private healthcare system in South Africa

South Africa currently has a two-tier healthcare system with both private and public healthcare sectors[3]. The public healthcare sector is financed by general tax with the emphasis placed on primary healthcare[10]. 84% of the South African population are reliant upon this under-resourced public sector[3]. The private healthcare sector on the other hand services the remaining 16% of the population, yet this sector accounts for 43% of the national healthcare expenditure[3,11]. When

comparing this percentage of current healthcare expenditure by South Africa`s private healthcare sector, it is found to be the highest percentage globally[3]. From these above statistics, it can be noted that there is a distortion of the private versus public percentage healthcare expenditure.

In South Africa, belonging to a medical scheme is voluntary and members pay a monthly contribution to access private hospitals and medical specialists[3]. There are also those who do not belong to medical schemes and pay on an ad-hoc basis for the access to the private healthcare network. There is no obligation for individuals to belong to medical schemes in South Africa, although in some instances private employers contribute towards medical insurance[12]. A concerning statistic as reported by the Department of Health (DoH) is that approximately 80% of South Africa`s medical specialists service this small population in the private sector[13]. It is clear from these statistics that the two-tiered healthcare system is divided along socioeconomic lines with a service bias towards upper income groups. As a comparison, the only other country which reflects this level of private healthcare spending is the United States of America (USA)[3].

South Africa is a third world country and has visible inequities between the public and private healthcare sectors. Over the past few decades South Africa`s private healthcare sector has garnered both political and economic importance as it is aiding the government to carry out its constitutional mandate of delivering quality healthcare to all South African citizens.[14] As health is not merely a market commodity, but an essential human need and social right, the government has a commitment and responsibility to provide healthcare services as well as to regulate the private healthcare sector[15]. In the study by McCartney et al.[16], it was found that countries "with social democratic regimes, higher public spending, and lower income inequalities have populations with better health". Therefore, there needs to be a move towards lowering the private spending and increasing the public spending in South Africa.

2.3 The history of private healthcare in South Africa

South Africa's unique healthcare situation has its roots within the country's history[3]. Until 1889, private medical services in South Africa were financed by out-of-pocket payments. The inception of today's medical schemes was established in 1889 to make provision for the healthcare requirements of white mine workers where membership to these medical schemes was limited to white individuals[3,17]. Healthcare services and facilities were racially isolated, and resources were apportioned at various levels.

By 1960, 169 medical schemes provided cover to more than 368,000 members and their dependents, which represented around 80% of the qualified population of whites, which was about 19% of the overall population at that time[3]. In the 1970s, the race restrictions were eventually removed leading to an increase in the number of medical schemes and racial diversity broadened. The promulgation of the Medical Schemes Act (MSA) in 1967 lead to a rise in the regulation of medical schemes. At this point, elements of social health insurance were instituted[17].

By the early 1980s, an estimate of 40% of General Practitioners (GPs) practiced in the private healthcare sector which by 1990 increased to over 60%[18]. The number of private hospitals tripled between 1986 and 2014. Medical specialists started working in both private and public hospitals and began investing as shareholders in the expanding for-profit private hospital networks, diagnostic companies, and related support services. It was, and still is commonplace for medical specialists to position their consultation rooms within private hospitals and then if required admit patients within these same hospitals[18]. In my view, this can blur the lines of perverse incentives.

Statistics available from 2010, indicated that there was a similar distribution of GPs between the private and public sectors[19]. Health professionals, particularly medical specialists, are highly skilled, are in demand and hold a large share of the market power. As of 2010, 56.2% of medical specialists worked in the private healthcare sector[19]. Medical specialists hold a large share of market power as their skill set is difficult to attain and the number of qualified medical specialists in a specific field are limited[14]. In my opinion, it is a concern that with no price limit enforced, health professionals, particularly medical specialists can charge very high rates and potentially overcharge for their services.

2.4 Historical billing practices in healthcare and their impact in a South African context

Dating back to 2000 B.C., the code of Hammurabi is the oldest surviving primary source related to medical fees. The code is a set of laws dictated by the Babylonian King, King Hammurabi. In this code it is laid out to physicians how they ought to be reimbursed for their services[20]. Sections 215-217 of the code reads as follows:

> "If a physician has treated a man with a metal knife for a severe wound, and has cured the man, or has opened a man's tumour with a metal knife and cured a man's eye; then he shall receive ten shekels of silver. If the son of a plebeian, he shall receive five shekels of silver. If a man's slave, the owner of the slave shall give two shekels of silver to the physician".

Many ancient authors, such as Aristotle, Aristophanes, Galen, Hippocrates, Plato and Sophocles, discussed whether doctors ought to be paid by any means. The Hippocratic writings refer to fees in some sections and even advises to practice medicine without payment[20]. In the past, health professionals were paid 'in kind' with whatever payment the patient could afford or produce and services or goods they had to offer[21]. Then, on the other hand, there are cases in history where affluent patients paid large sums of money to see their health professional, particularly if he was widely acclaimed. An example is Sir William Osler (1849-1919) who is supposed to have billed affluent patients a thousand guineas per consultation, also conducted free medical services for the poor[22]. Thus, the debate of medicine and fees has been around for centuries.

I will now look at how the billing guidelines were established for health professionals in South Africa. The first coding or billing booklet in South Africa was published in 1944 by the South African Medical Association (SAMA). SAMA is a non-profit organisation (NPO) representing GPs and medical specialists however membership with SAMA is not obligatory[23]. This coding booklet was called the Doctors Billing Manual (DBM) which contained tariff codes for procedures performed that applied to GPs and medical specialists. This DBM was updated annually and was acknowledged by many as an industry standard[24].

The Representative Association of Medical Schemes (RAMS) also negotiated a set of statutory tariffs which were published in the Government Gazette each year. The SAMA and RAMS rates had been on par until about 1978. Subsequent to the Board of Healthcare Funders (BHF) taking over, the rates that medical schemes were willing to pay and the rates that health professionals charged, started diverging. The BHF then published the scale of benefits in the Government Gazette each year[24].

Upon the introduction of the National Health Act (NHA) (Act 61 of 2003)[15] and together with the MSA[25], these two Acts covered the numerous aspects of the healthcare industry. These Acts included the tariffs charged by health professionals and the reimbursement rates for medical schemes. The legislation "allowed for and promoted collective bargaining and co-operation between the medical schemes and various healthcare providers under the auspices of their respective industry bodies", namely BHF, SAMA and the Hospital Association of South Africa (HASA)[26].

The use of collective bargaining and the publication of co-operatively negotiated tariffs remained unchecked until January 2004. After which the CC decided to prohibit all collective bargaining and tariff negotiations[3,27]. The setting of tariffs by HASA, BHF, SAMA and the

various industry bodies was found to be an act of collusion[28]. The CC found that there was an "effect of fixing a selling price"[28]. The BHF paid a R500,000 settlement and agreed to stop publishing its scale of benefits[29]. The BHF`s last published scale of benefits for health professionals was in 2003. In my opinion, the intervention by the competition authorities set in motion the countervailing power struggle between medical schemes, health professionals and prices charged in general.

The National Health Reference Price List (NHRPL) was then introduced by the CMS in 2004 on behalf of the DoH[30]. No negotiation was undertaken when compiling the NHRPL list. It was merely a guideline to the industry and aimed to be the outcome of the examination into costs in the private healthcare sector. The CMS was able to create this list as it derived no financial gain from establishing the tariff schedule. SAMA continued to publish a DBM between 2005 to 2009 which included the NHRPL tariffs[30]. There were health professionals with market power who deviated from the NHRPL without any market penalty[30].

The SAMA private tariff list then became the HPCSA Ethical Price List (EPL) in 2006[31]. The ethical tariff was then set at a limit of 300% of the NHRPL. The 300% included the reference rate plus up to 300% of the NHRPL rate[31]. The ethical limit implied the upper limit of fees and provided an indication of cost levels. In 2008, the HPCSA declared it was discontinuing its negotiated EPL in favour of the NHRPL rate, in order to comply with the CC standards[31].

In 2007, the DoH took over from the CMS to develop the NHRPL which eventually was referred to as the Reference Price List (RPL)[30]. In September 2009, Judge Piet Ebersohn set aside the RPL in a North Gauteng High Court ruling, where the RPL was declared unreasonably low and irrational[32]. The South African Private Practice Forum (SAPPF) along with a further 22 associations of healthcare professionals disputed the method in which the Director-General of Health had determined the RPL which was published on 24 December 2008[30]. The judgement found the "failure to put in place tiered, time-based consultations" and the distinction between specialist groups' remuneration to be "unlawful, invalid and null and void"[33]. It was also mentioned that: "The fact that the 2009 RPL reflected rates that were unreasonably low meant that private healthcare providers would continue to struggle to cover their cost …. a burden many of them have already carried for a number of years"[33]. The Judge also highlighted that the process in which the rates were determined would likely lead to the departure of health professionals from South Africa[32]. It is my opinion, that it was not the fact that a RPL was provided to the private healthcare sector, but rather the way in which and how the tariff amounts were determined, which was the issue.

In 2012, the HPCSA developed guideline tariffs as a response to complaints received from the public related to overcharging by health professionals[34]. The HPCSA retracted the guideline rates when medical associations again threatened legal action[29]. I believe that the constant challenging and threat of legal action by the healthcare professional fraternity has been partially or fully liable for the setting aside of all healthcare pricing guidelines. It could be seen to be undermining the coding structure and essentially increasing costs within the private healthcare sector[33]. The health professionals, as gatekeepers of healthcare, are seldom identified as the cause of the problem. However, in terms of pricing and billing, in the end, it is the health professionals who are setting their own fees[35]. There has been no pricing regulation since the judgment in 2009 which in my opinion has created a huge vacuum in the private healthcare sector.

2.5 The role of medical schemes, administrators and the Council for Medical Schemes

I will now highlight the role that medical schemes and administrators play in reimbursement for healthcare services in South Africa`s private healthcare sector. Recent statistics indicate that from 2019, there are 78 registered medical schemes which comprises of 20 open schemes and 58 restricted schemes[36]. Medical schemes are by law, NPO`s whose main aim is to assist members with their medical expenses[37]. However, even if you belong to a medical scheme your financial obligations do not necessarily end there. The purpose of the CMS is to regulate medical schemes and was founded to protect the interests of beneficiaries of various medical schemes[2]. Medical schemes` administrators are third parties who are in competition to deliver administrative services to open as well as restricted medical schemes[2]. In return, the medical schemes` administrators are remunerated from the contributions paid to the respective medical schemes[38]. Medical schemes and medical schemes` administrators are two separate legal entities with separate distinct functions and responsibilities.

Medical schemes are also notorious for their complexity of offerings and plans which makes it difficult for members and potential members to compare and make informed choices regarding what cover they require[39]. Medical schemes compete on various factors to enhance affordability and value for money cover. These factors attempt to attract younger, healthier members in order to offset potential risk factors such as the older sicklier member[39]. In my opinion, there is a need for greater competition, simplicity, greater transparency and consistency with the medical scheme offerings and reimbursement practices.

As the private healthcare sector has not had a RPL since 2009, medical schemes cannot rely on a RPL in their benefit structures. They are thus left to formulate their own reimbursement levels

or scheme tariff rates[3]. Each medical scheme has a different tariff rate based on their assessment of risk[40]. These tariffs are calculated by actuaries with the solvency ratio in mind. With each medical scheme reimbursing health professionals at a multiple of their own set tariff, it leads to inconsistent tariff rates across the sector[41]. Most medical schemes reimburse health professionals on a fee-for-services basis[42]. Typically, entry-level hospital plans will have a medical scheme rate of around 100 percent of the tariff rate, whereas more comprehensive full plans may pay up to 300 percent of the tariff rate[39]. There has been no standardisation of these tariffs across the different medical schemes, to the members detriment. There is an ever-increasing gap between what each medical scheme will pay and the rates which health professionals charge. This leaves patients to carry the burden of additional costs. This is supported by the 2019/2020 CMS annual report that indicates that the amount claimed and not paid per patient increased by 1.27% from 2018 to 2019[36].

The rising costs of private healthcare and lack of regulation has opened the door for a number of gap cover providers within the industry. This is noticeable as from 2018 there were 20 registered gap cover providers offering 84 different plans in South Africa[43]. The market for gap cover providers is being fuelled by the rising costs of private healthcare and the increase in out-of-pocket expenses for patients. The presence of gap cover providers is in a way an acceptance that the system is flawed, and that exceptionally high fees are charged by some health professionals. I believe there should be no need for these service offerings. If the private healthcare sector had a pricing benchmark or "ethical billing range" and regulation thereof, the medical schemes could set their rates accordingly. There are numerous market failures within the private healthcare sector and no single solution will work in isolation. I believe that a pricing benchmark would be a step in the right direction. Medical schemes ought to be calling for a reference price list to refer to as this would improve pricing transparency. This would then lead to improved relationships between medical scheme members, medical schemes and health professionals.

PMB`s ensure that all medical scheme members, irrespective of their chosen option, have access to certain minimum healthcare services[44]. The legislation governing the provision of PMBs is included in the regulations enacted under the MSA[25]. Medical schemes are obligated to pay the costs in full for the "diagnosis, treatment and care" of PMB conditions[44]. The mandatory cover of PMBs creates an opportunity for health professionals to determine their own extent of intervention and rates which ultimately must be paid in full by the medical schemes[45]. The concern which has arisen regarding PMBs is that medical schemes must fund these claims in full, irrespective of what the health professional charges.

2.6 The relevant laws pertaining to billing practices in South Africa`s private healthcare sector

South Africa`s current legislation reflects the era of human rights and liberal individualism[10]. Section 27 (1)(a) of the South African Constitution[46] assures the right of access to public healthcare services with little to no cost to the patient. The Constitution contains the Bill of Rights which imposes a duty on the government to take reasonable legislative and other measures, inside its means, to accomplish the right to healthcare services[47]. The right to access healthcare, if limited, also affects other aspects of life such as the ability to earn a living, provide for one`s family and the enjoyment of civil and political rights.

In terms of the NHA[15] section 90 (1)(v), the Minister of Health is tasked with a directive to regulate the price of health products and services. The last part of section 90 paragraph (v) makes any enforcement of a reference list difficult as it states these reference price lists for medical schemes and health professions, if provided, "are not mandatory"[15]. According to the function of the NHA it "intends to provide a framework for a structured uniform health system within the Republic"[15]. However, I believe that the function of this Act is not attainable with the current incomplete pricing framework.

The intervention by the CC in private healthcare in 2004 further complicated matters where any health tariff negotiation and collective bargaining was banned[27]. The Competition Commission is a legal body engaged by the public authority to research, manage, and evaluate restrictive business practices[48]. In terms of the Competition Act (CA) (Act 89 of 1998)[49], health professionals charging patients different fees for the same procedure based only on the patient's particular medical plan may be in contravention of the Act[33]. This is seen as collusion in section 4 of CA and any payment arrangements may therefore be construed as unlawful. The same holds true for any collective negotiations within the private practice sector[49]. Section 3 (1) of the CA declares that the "Act applies to all economic activity within or having an effect within the Republic" which ultimately places all economic activity in the healthcare industry within the domain of competition scrutiny.

As stated by Barber et al., it is unique to South Africa that price negotiation for industry regulatory purposes can be viewed as collusion from a legal perspective[3]. The precedent established by the CC due to their interpretation of the CA has thus halted the advancement of successful and enforceable guidelines and standards of pricing norms[3,45]. With collective bargaining banned, there is a lack of dialogue and co-ordination on agreed upon billing practices between medical schemes, health professionals and the medical scheme members[9]. I am of the

view that the private healthcare sector should be exempted from the principles of competition law and policy and that health professionals and medical schemes should be allowed to collectively negotiate tariffs in order to curb the rising costs. The interpretation of the CA should be set aside in order to promulgate an "ethical billing range" in the healthcare sector.

This is supported by Goga et al.[50] who state that due to the very nature of healthcare itself, it cannot be treated as a competitive economic market. In my view the Minister of Health should work with the CC to set up structures that will allow for collective bargaining in the healthcare sector. In addition to co-operation between the Minister of Health and the CC, the legislature can also amend provisions of the CA which will promote price negotiations in the private healthcare sector.

Along with advancements in western medicine, as well as the influence of political and economic factors, healthcare is said to be transforming from a profession into a business[51]. The implication of this is that healthcare is being treated more as a commodity rather than a right and patients are now being viewed as the consumers. This is reinforced by the Consumer Protection Act (Act 68 of 2008)[52] which refers to patients being viewed as consumers from a legal perspective. Section 27 of the Constitution[46] states that healthcare is a basic human right, yet the commercialisation of healthcare is leading to it being commoditised. This in turn puts healthcare at loggerheads with patients. The high exchange rates and reliance on international markets also contributes to the high prices in the private sector. In my view, a principal concern of commercialism in medicine is entrepreneurship by the healthcare professional, especially in an unregulated system[53]. Where patients are referred to as consumers, this viewpoint has short comings as patients cannot be viewed solely as consumers as they are still considered vulnerable and require additional protections to prevent exploitation[54]. There is an asymmetry of information with patients having limited medical knowledge and playing a more passive role. This is supported by Goga et al.[50], who state that there are significant differences between healthcare and other products or commodities and as such, pricing regulation is necessary.

Dating back to 1990, Africa[55] found that healthcare market failures can be defined as "asymmetry of information, the lack of a natural limit on costs, adverse selection, and moral hazard". This is still the case today. The CPA does attempt to create protection in this context with listing the rights of the consumer but still requires a level of government intercession to ensure equity[10]. A concern with Government's involvement in the private healthcare sector is strong viewpoints like that of Blade Nzimande, the Minister of Higher Education, Science and Innovation, who when referring to the private healthcare sector stated: "capitalist vultures, which thrive on peoples' illness to make huge profits".[14]

The Health Professions Act (Act 56 of 1974)[56] establishes the HPCSA. The HPCSA is mandated in terms of the Act to regulate the activities of health professionals in the private and public sectors[56]. Similarly, the NHA provides the Minister of Health with a directive to regulate the price of health products and services, the HPCSA is empowered to provide a billing framework by publishing ethical tariffs in terms of section 3 of the Health Professions Act (HPA)[56]. However, neither of these are being implemented. There are currently no reference price lists available for private practice health professionals supplied by the HPCSA. However, according to the HPCSA, healthcare professionals have an ethical responsibility to charge fair and reasonable fees and avoid overcharging[57]. The ethical rules of conduct for health professionals under the HPA, were updated on 1 March 2013 with annexure 7(3) stating that "A practitioner shall not... over-charge patients"[56]. With no RPL available, it is virtually impossible for patients and health professionals alike to ascertain what constitutes as overcharging or a reasonable fee[58]. A fair and reasonable fee for healthcare services rendered is dependent upon the relevant realities as well as expert opinions in that specific discipline. Who then decides what the best medical specialist in a specific discipline can charge? This is a challenging question to decide upon particularly when no billing guidelines or baseline is provided. In my opinion it does not help updating ethical rules if there are incomplete guidelines which are open to exploitation. The HPCSA need to define what is meant by 'overcharging'.

Patients are currently left without any guideline about whether they are being overcharged by health professionals despite the HPCSA having a statutory duty to fill this void. With patients being 'buyers' of healthcare, they generally know considerably less than the 'seller' or health professional who advises on the best options in terms of medicines or treatments, while the 'buyer' concurrently has a financial interest in the ultimate decision. With no billing guidelines, any claims by a patient that a healthcare professional is overcharging are based on a personal assumption by the patient as to what fee they feel the health professionals` services were worth or a past frame of reference. Even if patients ask what the fees are upfront and accepts this, only after the health professional has assessed them can the real fees be determined as each treatment can vary so greatly from one individual to the next. There is a further contention that patients are often blindsided with enormous accounts after treatment.

The HPCSA states that "excessive fees charged/overcharging" is included under "unprofessional conduct against which we may take disciplinary steps"[4]. However, none of their 16 booklets available to health professionals address what is meant by overcharging[57]. There is also a need to protect the health professional from the temptation of overcharging for financial gain. A complete and comprehensive framework would minimize the risk of a health

professional being found guilty of unprofessional conduct by overcharging. Unprofessional conduct is defined by the HPA as "improper or disgraceful or dishonourable or unworthy conduct"[59]. In terms of section 42, health professionals found guilty of such conduct are subject to penalties such as censure, caution, suspension for a while, expulsion from the register, compulsory service or a fine[56].

It is the responsibility of the HPCSA to deal with matters relating to professional conduct but since the RPL had been set aside in 2009, the HPCSA is presently confronted with an issue when managing complaints related to overcharging[50]. In the HPCSA annual report for 2019/2020, 0.6% of the complaints received were for health professionals overcharging[60]. However, my observation was that in the 2020/2021 report overcharging complaints were left out in the 'sources of complaints' figure with no further reference made by the HPCSA as to the reason[61]. In all the recent reports, 'overcharging' is later grouped with 'charging for services not rendered' which was the third highest group for 2021[61]. I believe that these two offences need to be reported separately as they are separate issues.

As there are no legally determined tariffs at present, it is virtually impossible for the HPCSA to adjudicate on complaints of overcharging. Dr Meshack Mbokota, chairperson of SAMA's Specialist Private Practice Committee, supports this by stating "The notion that doctors are overcharging is therefore preposterous since there is no reference structure to measure their rates against"[62]. If the HPCSA does not have a billing guideline, they must make that determination on a case-by-case basis. However, the uncertainty over where that line is drawn, is likely to make disciplinary proceedings more complex. This is supported by reviewing the number of rulings that were made by the HPCSA in the last 10 years, where only 7 cases related strictly to overcharging were finalized[63-67].

Section 53(1) of the HPA requires a health professional, prior to providing healthcare services, to inform the patient of the medical costs involved as requested by the patient[56]. It is the duty of the health professional to inform the patient if their fees are higher than the typical charge[56]. Subsection 3(a) mentions that when the patient questions the amount charged, the patient ought to follow the following process:

> "The patient may, within three months after receipt of the account referred to in subsection (2), apply in writing to the professional board to determine the amount which in the opinion of the professional board should have been charged in respect of the services to which the account relates, and the professional board shall, as soon as possible after receipt of the application, determine the said amount and notify the

practitioner and the patient in writing of the amount so determined: Provided that before the professional board determines the said amount, it shall afford the practitioner concerned an opportunity to submit to it in writing his or her case in support of the amount charged".

This arduous process prescribed in the HPA is not patient nor health professional friendly and from my viewpoint seeks to put off the patient from querying the fees. There is still no transparency with regards to the actual fees that can be used as a reference. I feel that patients also know little about their rights and have little bargaining power when it comes to the provision of healthcare[68]. Patients' concerns ought to be facilitated by clarifying payment commitments early, although doing this is difficult and patients rarely negotiate the healthcare professionals' costs successfully[69]. Barber et al.[70], also state that "given that accurate comparable information about prices and technical quality are frequently unavailable, the value of health services is difficult to assess".

There is a need for a pricing benchmark which will highlight when a price is unethical. A cap would need to be set at a level that does not include the bulk of health professionals but highlights those that are charging excessively. In addition, there is far too much room for debate and neither healthcare professionals nor patients are provided with clear and understandable guidelines[50]. At present, there is insufficient regulation to safeguard all the role-players in the private healthcare sector in terms of pricing.

2.7 The current billing regulatory conundrum in the private healthcare sector and what is being done to resolve it

Despite the private healthcare sector facilitating significant economic activity and providing employment to many people the National Health Insurance (NHI) Green Paper states: "The amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity"[71]. This is a noteworthy incentive to provide an improved regulatory framework on pricing and potentially curtail the amount spent in the private healthcare sector.

Based on the 2019/2020 CMS annual report the out-of-pocket payments from 2014 to 2019 have been on an increasing upward trend across the industry[36]. Rates in private healthcare have risen consistently above inflation over the last 10 years[3]. The Health Market Inquiry (HMI) was initiated to "investigate and provide explanations for these increases in price and expenditure" in the private healthcare sector[72]. The CC initiated the inquiry and thus the HMI was done

primarily through a competitive lens[72]. There was a concern regarding the functionality of the private healthcare markets in South Africa with the concern being that there are factors that might subvert rivalry in the private medical care area[45]. The HMI took seven years to complete and was a "systematic and comprehensive investigation… into the SA private healthcare sector"[71]. The final HMI report was distributed in September 2019[72].

As found in the HMI there is currently a need for regulatory unity between the CMS and the HPCSA[45]. The HMI details that the current circumstances of regulatory failures after deregulation in the 1980s which was trailed by partial and insufficient re-regulation[72]. At this stage there is still an inability to effectively monitor and ensure regulatory compliance in the private healthcare sector[72]. The HMI analysis further concluded that medical schemes and members` interests were misaligned and that there were definite competitive issues identified in the private healthcare sector[45]. In general, the HMI concluded that "the private SA healthcare market suffers from multiple market failures from both provider and funder perspectives, with structural, behavioural and regulatory problems that harm competition and undermine access to healthcare"[45].

In support of my claim, the HMI also recognised "the need to improve the regulatory environment governing suppliers and recommended the establishment of a dedicated supply-side regulator of health (SSRH)" with pricing being one of the four main functions[72]. However, since its publication and recommendations in 2019, there has been no change in the industry guidelines and no reference price provided to the industry.

Another notable point was that the HMI also found the medical scheme market to be highly condensed[45]. Currently in South Africa, 70% of insured members belong to two medical schemes: Government Employees Medical Scheme (GEMS) and Discovery Health[72,45]. This lack of competition amongst the open medical schemes means that they have a strong influence over the market with the "buying power to monopsony price"[42]. It could also be argued that the medical scheme market power is greater than the health professionals`. Medical schemes, for instance, used the 2009 RPL list, though a non-binding guideline at the time, to determine levels of reimbursement[73]. Thus, any price list that is provided to the private healthcare sector needs to be negotiated and adequate for all role-players involved. The private healthcare sector must demonstrate clear indications of close co-operation for patient interests and improved expense control.

2.8 Conclusion

From the above review, I have highlighted factors which suggest that the laws and guidelines which regulate the South African private healthcare sector are inadequate. The lack of a RPL and regulation in the private healthcare sector is leading to an ever-increasing level of tension between health professionals and medical schemes due to the increasing disproportion in rates charged and benefits paid. I believe there needs to be stricter regulation and more accurate parameters for competition from the medical schemes` side. The removal of collective bargaining and price negotiation was not the only market failure. Though it had unintended consequences in the market, such as the inflation of medical treatment costs rising steeply, the way in which the prices were determined was not necessarily an appropriate marker from a competition policy perspective.

There are important externalities that exist in healthcare compared to other markets. This suggests that investments have expansive advantages for the individual, communities, and the public alike. Prices ought to mirror the value of healthcare services to individuals and society. Controlling healthcare spending while at the same time keeping up with or expanding access is a major policy prerogative for many governments. These policies in South Africa appear to be lacking which has allowed the private healthcare sector costs to rise above inflation, becoming increasingly expensive and unaffordable for most[3]. Establishing complete and comprehensive guidelines and providing a price schedule, this will enable the public healthcare sector to draw on private sector facilities in order to improve access to care and resources. The benefits could include and are not limited to, a greater number of beds available, a wider network of facilities and providers, greater collaboration and drawing on improved optimisation of the strengths of each sector.

Chapter 3: Critical analysis of the principles of medical ethics associated with health professionals' billing practices.

3.1 Introduction

In this chapter I will review the ethical issues related to South Africa`s health professionals billing practices. I will demonstrate that the current laws and guidelines provided to the health professionals pertaining to billing are ethically inadequate. I believe that the current guidelines or lack thereof falls short of discouraging the practice of overcharging by health professionals. Health professionals are free to charge what they feel their services are worth, with no cap on prices. Despite the lack of guidelines, there is an obligation and inherent ethical responsibility by health professionals to avoid overcharging[74]. However, altruistic actions are not sufficient to ensure healthcare costs are controlled which is why complete and comprehensive guidelines are required.

In the General Prologue of the Canterbury Tales, Geoffrey Chaucer expresses that health professionals have a "special love for gold"[20]. This statement can ring true for any persons irrespective of their profession. With advancements in medicine, as well as the influence of political and economic factors, healthcare is said to be transforming from a profession into a business[51]. I will further explore the relationship between professionalism and commercialism and see if the ideal balance can be struck. With the lack of complete and comprehensive guidelines, health professionals in private practice face a moral dilemma in their billing practices. On the one hand there is the element of altruism, and on the other hand is the element of self-interest[75]. This moral dilemma leads to a clash in values between business and medicine[71].

The term *overcharging* is vague, yet the consequences of overcharging are wide ranging particularly in healthcare. The Oxford Dictionary definition for *overcharging* is: "to make somebody pay too much for something"[76]. In South Africa`s private healthcare sector the current incomplete regulatory guidelines make it virtually impossible for patients to gauge when a health professional has overcharged them or not. However, in a survey conducted in 2013 by the Mail & Guardian, as many as 63% of respondents said they felt they had been overcharged by a private doctor or dentist[77]. In this chapter I use the word *overcharging* where a health professional charges significantly above the standard average rates. The standard average rates I will refer to are the upper limit rates at which the medical schemes reimburse for a service.

As stated by Freckelton[74], overcharging by health professionals is a challenging issue with few solutions on offer. The ethical concerns and challenges which arise due to the inadequate guidelines and laws governing South African health professionals` billing practices will be debated further in this chapter using ethical principles and theories.

3.2 Ethics pertaining to billing practices in healthcare

All health professionals have a responsibility to protect and promote health. These responsibilities lie at the heart of medicine and provide its moral foundation[78]. The healthcare professional-patient relationship is central to healthcare practice. There is a social and moral contract between the profession and the public. Within this lies professionalism and professional integrity[79].

Medical Professionalism can be defined as "a set of values, behaviours, and relationships that underpins the trust the public has in doctors"[80]. Classical professionalism essentially emphasizes altruism with its sense of service and self-sacrifice[80]. French philosopher Auguste Comte introduced the term *altruism* as an opposite to *egoism* with reference to working for the benefit of others[81]. Psychological egoism is where the health professional would be pursuing his/her own financial interest or welfare. It is based on the idea that we do not have duties to other people and endorses selfishness[82]. However, in healthcare, health professionals do have ethical duties towards their patients and society because of the Hippocratic Oath[83] that they have sworn. This is in direct conflict with psychological egoism.

Historically health professionals could not legally bill for their services and patients paid 'honoraria' which were given voluntarily[69]. This honorarium principle was said to have distanced professionalism from commercialism[69]. The set of ethical and social responsibilities as sworn for example in the Hippocratic Oath carried more weight than pursuing one`s own economic ambitions[10]. However, these ethical and social responsibilities are now being threatened by the corporatization of medicine[74]. Even in the era of consumerism, the bonds of trust and care which link patients to healthcare professionals ought to still be honoured[84].

Medical ethics speaks to the issue of fees primarily as a matter of professional etiquette and efficient business[84]. Dhai and McQuoid-Mason[79] state that financial pursuit is a failure of professionalism by healthcare professionals which leads to a breakdown in trust. I take the same viewpoint as Heath[85] who states that health professionals ought to expand on their notion of professional responsibility to acknowledge that their ethical duty toward patients includes an obligation to honest billing practices. The reason for this is because of the very nature of the

profession and the obligations that a health professional has in promoting and protecting the health of their patients in accordance with the Hippocratic Oath[83].

3.3 Moral theories related to health professionals overcharging and why price setting is required

I will now review the relevant moral theories related to ethical billing practices. According to Beauchamp and Childress's principles of medical ethics, the principles of beneficence and non-maleficence are founded in Utilitarianism that speaks to the greater good for the greatest number[86]. The principle of beneficence places an obligation on one to contribute towards the positive well-being of persons[87]. It is therefore intrinsic to the role performed by a health professional. Avoiding harm is simply insufficient. There needs to be positive steps taken to assist others[87].

From a billing point of view, private practice health professionals under the principle of beneficence, ought to not be overcharging based on the prima facie rule of obligation to protect and defend the rights of others and be altruistic[86]. In overcharging, the positive steps to assist others is not undertaken. Overcharging patients is not benefiting others, rather only benefiting the health professionals themselves. The principle of beneficence does not place an obligation for extreme sacrifice and altruism; thus, it does not call for health professionals to run their practices at a loss or give of their services for free but rather places an obligation to act for the benefit of others[86]. Thus, there is a call for a complete and comprehensive billing guideline which will assist health professionals to know where this line is, in order to meet their moral obligation of beneficence.

The principle of non-maleficence places an obligation to not intentionally inflict harm[87]. There is a duty on anyone who cares for patients to not harm the patient. Non-maleficence ensures that the health professional has a higher moral obligation to abstain from causing harm to others[69]. In terms of billing practices, where a health professional is overcharging and causing the patient significant out-of-pocket expenses, there are numerous potential harms to the patient. These include placing a financial burden on the patient as well as additional emotional and financial stress.

Where the current billing guidelines are incomplete, health professionals still need to act with due care so as to not violate the principle of non-maleficence. *Due care* implies that a health professional ought to act with a certain level of care and responsibility in a reasonable manner under a particular set of circumstances[88]. Acting with due care can be difficult to standardise as

each health professional is operating from a different set of moral codes and values. Therefore, the call for complete and comprehensive billing guidelines will assist the health professional to bill with due care in order to avoid violating the principle of non-maleficence.

The principle of justice and its derivative, distributive justice refers to the fair distribution of burdens and benefits[86]. John Rawls, an American Philosopher developed the theory of *Justice as Fairness* which has two main principles: liberty and equality[89]. Rawls explains that society is comprised of free agents each holding basic rights and co-operating within an egalitarian economic system[89]. Another important aspect is that no one should be exploited as this is neither fair nor legitimate. In our case, overcharging can be seen as exploitation of the patient and in order to limit this exploitation, pricing in the private healthcare sector needs to be better regulated.

In my opinion, South Africa`s two-tiered healthcare sector has unequal distributions of burdens and benefits. While section 27 of the South Africa Constitution incorporates the right of every person to "have access to healthcare services", this however, is not always practically implementable[46]. Where a health professional is overcharging in the private healthcare sector, this is further hampering this expectation and distributive justice, as now, an even larger number of patients are unable to access healthcare services. Rachels and Rachels[90] also state that: "Public life requires justice and beneficence" and in my view overcharging by health professionals goes against these principles and leads to abuse of one`s position and society as a whole.

The principle of autonomy, which is founded in Kantian Deontology, would allow for health professionals being free to charge what they feel their services are worth[90]. German Philosopher, Immanuel Kant, had high regard for autonomy and self-determination. As free rational agents, people possess the ability to make their own decisions and guide their conduct in order to achieve their goals[91]. Kant, however, proposes that this guidance be performed through reasoning and rationality and should not infringe upon the liberties of others[92]. With regards to billing practices, Kant would regard health professionals as free rational agents who are able to determine their own fees. However, according to Kant we ought to take others into consideration[91]. According to Kant, one can simply appeal to one`s own reasoning and intellect to determine what is right from wrong[91]. In the context of billing practices, a health professional ought to use their own reasoning and intellect to determine ethical fees. In my view, overcharging by health professionals shows little consideration for others and would therefore be considered as immoral from Kant`s perspective. Thus, the principle of autonomy can be outweighed by the other moral duties.

Kant further characterized morality as the principle and standard of rationality known as the *Categorical Imperative*[91]. In overcharging, a health professional would be going against Kant's categorical imperative and treating the patient not as an end, but rather as a means to an end[93]. In other words, if patients are viewed as a means of making money, then they are being instrumentalized. Overcharging could be viewed as disrespect to the patient by the health professional and the treatment of the patient as a means to financial gain. This is supported by Biller-Andorno[94] who states that "Rather than the healthcare institution serving the patient, the patient serves the healthcare institution's purpose of making profit". If a health professional knowingly approves of the maxim of overcharging, then they are universalizing that action and saying that everyone can overcharge for their services. This leads to a contradiction. According to Kant, moral actions cannot bring about contradictions and therefore overcharging is not universalizable[91].

Virtue ethics is a philosophy developed by Aristotle, as well as other ancient Greeks. It emphasises the behaviour and motivations reflected in the moral character of the decision-maker, with less emphasis on the decision being made. Virtue ethics describes the traits of character that can serve as traits that either attract (virtues) or repel others (vices)[90]. A profit motive reflects as a vice in that it can be associated with greed and selfishness. There is also another association between a profit motive and the loss of moral principles[95]. Given the nature of a health professional's relationship with society, it will also be to the benefit of the profession as a whole to be perceived with virtues such as trustworthiness, fairness, compassion, charity and benevolence[90]. Health professionals should be mindful that their actions, particularly those actions which are acted upon habitually, should be virtuous[90]. The virtues displayed by the individual health professional or as perceived by the patient can serve as a reason for preference towards, or the avoidance of, the health professional.

According to virtue ethics, even if kindness is acted upon only to advance the social esteem of the individual, it will not be viewed as virtuous but rather as ethical egoism. Mutual respect is also a cornerstone of virtue ethics. It is very rare for someone to possess full or perfect virtue and it is hard to achieve this ideal[96]. Greed and self-centeredness may be blind spots for even a fairly virtuous person. There can be a slippery slope from ambition to greed to fraud.

Aristotle argued that "we should treat objects in ways that are befitting to their fundamental nature, and since money is not meant to be a good in itself but only a medium of exchange"[95]. Thus, according to Aristotle, it is "unnatural to desire money as an end in itself"[95]. A health professional should be mindful of the contrary desires with regards to their billing practices, to strive to act with *phronesis* and with the patient's best interest at heart[96].

A healthcare professionals' actions can and do reflect broadly on their profession. Health professionals ought to remember that the context in which the virtue is performed is of significance. As stated by Grobler[33], it has more to do with the health professionals' moral behaviour with respect to how fees are charged rather than the actual level of fees. If the health professional is looking to charge high prices based on greed or the perceived justification that they are entitled to charge the high prices, then these are vices and are opposed to virtues.

Care ethics is based on the foundation that we are all essentially dependent on one another and that we have a sense of responsibility and moral obligation towards others[90]. In caring, there is a sensitivity to the needs of others. As stated by Rachels and Rachels[90]: "In public life our decisions might affect large numbers of people we do not know". Care ethics sees living well as caring for people within specific networks, attending to their needs, while at the same time maintaining their trust. This is crucial in the doctor-patient relationship[79]. Relationships are the primary inspiration for the ethics of care[90]. Caring and empathy may guide and enhance morality and as such, having an awareness of care ethics can enhance virtue ethics[90]. By being aware of the patient's needs, not just their physical needs but also their emotional needs, the health professional's behaviour towards a patient can be both virtuous and caring. In order for a health professional to fulfil his/her moral obligation it is important to maintain care and empathy towards these doctor-patient relationships.

Obligations and duties are not fundamental to care ethics[90]. Impartiality is not required to promote the interests of everyone alike. However, many will benefit through the promotion of care ethics as each health professional seeks to enhance and promote the welfare of their own networks. Healthcare is deeply personal and necessitates a relationship to some degree, which grants health professionals an opportunity to gain a deep appreciation and understanding for their patients and their typical challenges and expectations.

If there is no relationship, then caring cannot take place[90]. A caring relationship cannot take place if the cared-for cannot interact with the carer. As such, the responsibility is placed on the health professional to act morally toward the patients. The health professional and patient interact on a more personal basis whereas the industry regulatory bodies and the patients do not[90].

Thus, related to billing practices, a health professional overcharging can be viewed as causing a ripple effect of harms and reducing access to healthcare of others. Ethical billing practices would be an important element for health professionals to be mindful of. If the billing is deemed

to be too high, unfair or unclear, it may lead to a breakdown in trust within the doctor-patient relationship and the loss of care.

Consequentialism looks at the consequences and the idea that the right action always has the best consequences or outcomes. "The decisive factor in determining whether an act is right is if and only if the act is reasonably expected to produce the greatest good or the least harm when compared to alternative choices of action"[87]. Jeremy Bentham, an English Philosopher, developed the theory of utilitarianism as a type of consequentialism which is based on those actions which make people happy and that positive values (pleasure) must always override the negative values (pain)[97]. John Stuart Mill was a student of Bentham and later expanded on and made happiness the ultimate goal of utilitarianism[98]. Mill said that the main consideration when determining the consequences of an action, was the amount of happiness or unhappiness it created. Mill considered both quantity and quality of pleasure when considering the moral value of an act[97].

Mill`s *Greatest Happiness Principle* establishes that "actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the revers of happiness"[98]. I will be applying this principle of utility with regards to billing practices. In treating, helping, and curing patients, health professionals ultimately should receive fulfilment and intellectual happiness. They also derive financial gains from this interaction which could also be seen as increasing their overall happiness. The current system may allow for the happiness of the health professional to be further increased as it allows them freedom and liberty to set their own fees. If a complete and comprehensive billing guideline was in place and enforced, the health professionals may be displeased by having to lower their fees in accordance with the guideline rates. Their happiness may also be reduced as they may feel that their liberty has in effect, been compromised. However, according to Mill`s happiness principle, the maximization of happiness is not individual happiness but rather the happiness of everyone. Everyone's happiness counts equally[98].

Therefore, the happiness of the health professional is only one consideration, and the happiness of the patient also needs to be accounted for as well. For instance, when a patient in the private healthcare sector who belongs to a medical scheme, seeks medical treatment, is overcharged, and is left with significant out-of-pocket expenses, their overall happiness can be assumed to have decreased. If on the other hand their health professional did not overcharge for the service and the treatment they received was covered in full, their overall happiness could be assumed to have increased.

When health professional fees are increasing, medical schemes will ultimately tighten up on benefits or increase members contributions to protect the scheme reserves. This will leave the patients with more out-of-pocket expenses or higher monthly contributions which will likely reduce their happiness. High medical costs could potentially leave some patients in debt, further negatively affecting their health and decreasing their overall happiness. Some patients may be forced to discontinue treatment due to the lack of funds which is in contravention of the Hippocratic Oath[83]. Additionally, there will be an increase in mistrust between the patient, the health professional, and the medical schemes and an overall unhappiness of all role players concerned. Therefore, in my view the current, lightly regulated system is not leading to the sum total of happiness for everyone and therefore the current system is immoral and unethical.

In addition, Mill also states that: "As soon as any part of a person's conduct affects prejudicially the interests of others, society has jurisdiction over it, and the question whether the general welfare will or will not be promoted by interfering with it, becomes open to discussion"[99]. Therefore, with regards to private practice billing and the overcharging by health professionals, their conduct is affecting the interests of others, as well as the wider society. According to Mill, society then has the power to make decisions over it[99].

Mill goes on to say that "unfair or ungenerous use of advantages over others" is morally unprincipled and with regards to overcharging, this can be seen as an unfair use of the patient by the health professionals[99]. Health professionals have a high standing in society and a patient is generally not going to question the word of a health professional or the fees they charge. There is no protection for the patient with the current incomplete billing guidelines. This allows for this unfair advantage and abuse of health professionals over patients and according to Mill this is an object of moral reprobation[99].

From the above, we can see that when the moral theories are applied to the current state of South Africa`s private practice healthcare sector, the current system is ethically inadequate and immoral.

3.4 The ethical concern with commercialism in healthcare

The current lack of a billing framework means that health professionals are entitled to set their own fees and therefore are not breaking any set laws or regulations when exorbitant fees are charged. However, there are additional ethical concerns relating to the practice of overcharging. Bioethics literature "associates vulnerability with risk of harm and exploitation, and limited capacity for autonomy"[100]. Human vulnerability is not only associated with bioethical discourse

but is fundamental to bioethics[100]. The essence of responding to vulnerability is in providing care, satisfying needs and safeguarding against harm and exploitation.

In a healthcare system driven by profits, the opportunities for patient exploitation and manipulation are boundless. Another consequence is that perverse incentives are inherent in an unregulated system. With no benchmark in place, health professionals have the potential to blur the lines between altruism and personal financial gain. For example, a health professional could potentially be tempted to treat a patient long after they have received the benefits of the care in order to maximize their financial gain which is unethical.

By allowing the pursuit of economic gain to become commonplace in the practice of medicine, the well-being of patients is placed in serious jeopardy and exploitation of the patients and medical schemes is made possible. For example, during normal commercial activity, consumers should question the claims and motives of the service providers. However, in the doctor-patient relationship where trust is needed to improve the health prospects of the patient such conduct is detrimental[100].

A heightened focus on commercialism gives rise to a heightened focus on profitability. For example, a commercial environment can inhibit the health professional from making decisions in the best interest of the patient or the greater community. These decisions may be conflicted with monetary gains and profitability for the health professional. Therefore, in healthcare there are several negative aspects related to commercialism. These include conflicts of interest, de-professionalization, compromise in equity and quality of care, loss of patient centeredness and a breakdown in patient trust. I am therefore of the opinion that professionalism and unregulated commercialism in healthcare are mutually exclusive and cannot occur simultaneously.

On the other hand, it can be argued that the pursuit of profit in healthcare as well as the increased role for competition and entrepreneurship in the delivery of healthcare can potentially result in a more effective and efficient healthcare system. But, at what cost? The drive for profits in healthcare compounds the growing problem of access to care[101]. In a third-world country such as South Africa, the reality is that most of the population are living below the poverty line, and this can have dire consequences to society as a whole[7].

To uphold professionalism, complete and comprehensive guidelines are required which will attempt to remove or moderate the ethical concern of commercialism from the healthcare environment. The main driver for the health professional will not be in making money but rather in the moral foundation of protecting and promoting health and improving access to care. Being

aware of the pitfalls of commercialism in healthcare can assist market forces to a degree and in a way that is suitable for the healthcare sector[94].

3.5 Conclusion

The issue of setting and collecting of fees accentuates the professionalism problem as few other issues do[69]. Ethical standards impose that a patient's welfare ought to be a healthcare professionals' top priority, but the healthcare professional still needs to earn a living. Despite health professionals having the freedom to set their own fees, other important values and needs such as a concern for justice, professionalism, the dignity of persons and community-centred ethics, should be placed above profits[101]. The profit driven motive is morally problematic and creates a conundrum which is in contravention of the Hippocratic Oath[83].

In my opinion, the pursuit of profits should not jeopardise the morals of the profession and the values central to medicine. A complete and comprehensive billing framework that is enforced will assist health professionals in striking the correct balance and remaining professional without the ethical conflict of commercialism. I believe that unregulated commercialisation in medicine leads to the relinquishment of certain virtues and ideals that are vital to a moral community. The ideal of altruism has been perpetuated by health professionals whose primary concern has been the reduction of human suffering and the return to health. The current unregulated pricing free-for-all has blurred the lines between altruism and self-interest. Society must prevent important virtues and values from being extinguished by the self-driven interest of for-profit enterprise[101].

The moral theories of principalism, care ethics, virtue ethics, Kantian Deontology and Consequentialism all support that overcharging in healthcare is unethical. Complete and comprehensive billing guidelines will therefore promote ethical billing practices by health professionals. The current guidelines available to health professionals in South Africa are ethically inadequate in that they open the door to overcharging by health professionals.

I believe that health professionals should lead the call for a complete and comprehensive billing framework in order to protect themselves and their patients, and thus ensure just and fair treatment for all. The cost of private healthcare requires tighter regulation in order to improve distributive justice and access to healthcare. With healthcare as a basic human right, the pricing of healthcare should not be left entirely to market factors such as supply and demand to determine fees. The ethical practices of the past ought to be reflected upon in order to understand why the current billing practices are problematic, and how they can be improved upon in an ever-growing commercial world.

Chapter 4: Recommendations to relevant industry bodies to revise their guidelines.

4.1 Introduction

In this chapter I will support my argument that the current regulatory guidelines are legally and ethically inadequate and that new legislation ought to be promulgated to better protect patients and health professionals alike.

I believe that price setting and having complete and comprehensive billing guidelines is required as it will curb healthcare costs, improve access to healthcare in South Africa as well as improve the relationships between the various stakeholders[102]. I will recommend that there is a need for improved regulation and enforcement in this resource limited sector. Currently there is no unified pricing model for private healthcare in South Africa, due to the fragmentation of health professional organisations as well as the restrictions levied by the CA[49].

Further to this, recommendations will be provided to the relevant industry bodies. I will be reflecting on legal cases related to overcharging by health professionals to demonstrate the inconsistency in the application of incomplete guidelines. As part of my recommendation and in order to better monitor cases of overcharging in the private healthcare sector, an "ethical billing range" should be introduced. This will allow for an acceptable fair pricing model which health professionals in different categories could charge.

The "ethical billing range" would also increase transparency and assist health professionals operating in different geographical regions, with different skill sets, experience, expertise, and overheads to be adequately compensated. There is a need for the "ethical billing range" to be formulated and regulated by an objective independent regulatory body. Thereafter I will recommend that the CMS and the HPCSA need to participate in the development of complete and comprehensive billing guidelines without being restricted by the CA[49] and also assist in price setting and regulation for private health professionals.

4.2 Why setting of prices in the private healthcare sector is required

The World Health Organization (WHO) states that the duty of a healthcare system is to "provide quality services to all people, when and where they need them"[103]. This implies that an adequate healthcare system strives to provide the optimum care to the individual patient while concurrently being responsive to the greater healthcare needs of the population. This would be the case for both South Africa`s private and public healthcare sectors. In the study by Barber et al.[3], it is indicated that the current lack of regulation in South Africa`s private health sector has

caused price levels to be multiples higher when bench-marked against average incomes, than those seen across countries with high-incomes. This is a big concern as South Africa has very challenging economic circumstances and different priorities to high-income countries[7]. Only a small percentage of South African citizens have access to private healthcare. This number is likely to decrease as the official unemployment rate was reported at "34.4% in the second quarter of 2021"[104]. The HMI also supports the notion that the continued increase of private health costs would have an adverse effect on access to healthcare[72].

If we consider the economic rationale for price setting in the private healthcare sector, several advantages would be the control of costs, fostering competition on quality and mitigating against excessive financial claims[105]. These will each be discussed below.

Commercialism in healthcare can be characterized as "an application of the operating and managing principles typically found in business and commerce (financial incentivizing, profit-making, competition, marketing/advertising, and focus on the bottom line) to healthcare delivery"[106]. I believe that profit orientation and commercialism by health professionals are important cost drivers which conflict with the basic principles of medicine as discussed in chapter 3.

It can be expected, therefore, that the term *commercialism* in the context of healthcare is frequently used with a negative connotation[94]. It is not that healthcare should not have economic regard but rather that in some cases priorities are being reversed. As stated by Kumar et al.[105], the setting of prices can proactively prevent increases in prices of healthcare services especially in highly concentrated markets.

If we look at the rand spent per capita in 2019, the total expenditure in the private healthcare sector amounted to ZAR 169.07 billion with 8.95 million beneficiaries which is an average of ZAR 18 882 per beneficiary[36]. By contrast in 2019, the total expenditure in the public healthcare sector amounted to ZAR 206.6 billion with 49.61 million beneficiaries which is an average of ZAR 4164 per person[107]. These statistics alone indicate that prices in the private healthcare sector are inflated, unaffordable, unsustainable and ought to be restricted. The higher level of spending is not likely to reflect a higher burden of disease as the burden of diseases such as HIV and Tuberculosis (TB) fall predominantly on the public sector[108].

The HMI found that financial incentives in the private sector promoted overutilization[44]. In the HMI, it was also established that South Africa`s private sector admitted more patients to the Intensive Care Unit (ICU) than other countries with comparable data[45]. This is a major concern

considering the cost implications of an ICU admission. Setting of prices would help mitigate against excessive financial claims and perverse incentives.

From the above statistics, we can see that private healthcare users face increased vulnerability to increasing healthcare costs which necessitates an essential need for transparent and meaningful pricing guidelines. The lack of regulation and enforcement in my view is contributing to the unsustainable increase in healthcare spending. This is supported by Selesho[109] who stated that after the CC ruled that unified pricing in the private healthcare sector is anti-competitive, medical schemes began to determine their own prices. This has in turn negatively affected the sustainability of private healthcare. Thus, it is the sector as a whole which requires price setting for control of costs.

South Africa belongs to the Organisation for Economic Co-operation and Development (OECD) and as stated by Kumar et al.[105]: "Regulation in OECD countries generally enables collective bargaining". However, South Africa is an exception and does not allow for collective bargaining of healthcare tariffs. At present collective bargaining is hampered by the CC through section 3 of the CA[49]. In my opinion, we should allow for collective bargaining in healthcare. However, the stakeholders involved in the negotiation need to represent all participants within the value chain to ensure the agreed upon tariffs are not anti-competitive. This negotiation would need to be in the interest of the consumers. The OECD principle of collective bargaining can be used as a reference to South Africa. This will allow for collective bargaining to form a unified pricing model to control costs in the private sector and should not be classified as anti-competitive in the healthcare sector.

Competition is important in healthcare and should be encouraged as more healthcare participants will drive down the pricing and increase the quality of healthcare services. Competition should therefore be encouraged[110]. When prices are fixed health professionals must compete on parameters other than pricing which can stimulate efficiency, innovation and improved quality[94]. The high-priced health professionals would be forced to lower their prices in order to retain their market share[3]. Some may argue that price setting and regulation in healthcare may, in fact, reduce innovation and drive for latest technology. If prices are restricted to an upper limit, a health professional may not be sufficiently motivated to explore new technologies or treatments options. The question we have to ask then is: What good is the innovation and advancements in technology, if only a limited number of people can benefit from it?[111] In my opinion, innovation that excludes the majority of the population is not beneficial.

There are major political obstacles to installing price regulations and the setting of fees which may be heavily challenged by health professionals. Inevitably, healthcare professionals will resist any type of price controls, in part by appealing to a broad aversion to price setting and a deference to markets. However, the private healthcare market has clearly failed in many instances, and all role players should recognize the need for some intervention. It is thus in many health professionals` interest to not only support price setting but to also help shape and contribute to the price setting parameters. This will allow them to continue serving their mission while being effective at eliminating some of the extreme abuses they are now experiencing in the industry. In this spirit, health professionals should support policies that provide transparency and improve trust between all the parties involved[110].

Genuine patient care is compromised when rampant commercialism enters healthcare. It categorizes patients as primary consumers and as sources of revenue[94]. Christoff Raath, a CEO and actuary of the Health Monitor Company (HMC), examined data from an array of health professionals. Raath scrutinized accounts sent to medical schemes by general surgeons between the period of January 2010 and July 2013 and established that "the costs for services which fell under PMBs increased at an alarming rate over the same time"[112]. However, during this same time period other claims remained linear. Raath further concluded that "four of the ten largest anaesthetist practices in South Africa are explicitly charging more for their services when the surgery happened to be classified as a PMB"[112]. This type of abuse is inherent in a lightly regulated system. From the above examples, it is clear that setting of prices in the private healthcare sector is required and supported from an economic rationale.

4.3 Legal cases related to overcharging

Since 2010, the HPCSA have reported that they have finalised 330 matters related to 'overcharging/charging for services not rendered'. However, when the finalized cases are scrutinized, only seven cases have been finalized that relate directly to overcharging. The HPCSA currently group 'overcharging' with 'charging for services not rendered' in their annual reports[60,61]. However, I am of the opinion that these are two separate offences. They are two separate ethical concerns, and while they are grouped together, we cannot establish the severity of the one specific problem. Cases of overcharging are not being recognised for the serious offences that they are. Thus, the grouping is misleading. The finalized HPCSA cases related to overcharging and their penalties for the last 10 years are discussed below.

In August 2012, a health professional had a complaint laid against them for overcharging their patient for the delivery of her baby. "The respondent was found not guilty and discharged"[63]. It

is unclear as to what pricing benchmark was used by the HPCSA to determine that the health professional was not guilty. Details of this case were requested from the HPCSA. However, to date nothing has been received.

In May 2013, a health professional had a complaint laid against them that he/she charged the patient a fee which was excessive in the extreme. “The Respondent was discharged on all charges on the basis that there was no evidence to substantiate the charges”[64]. Again, it is not clear what pricing benchmark was used by the HPCSA and why there was no evidence in the form of an account to determine that the health professional was not guilty. Details of this case were requested from the HPCSA. However, to date nothing has been received.

In April 2014, a health professional had a complaint laid against them and their practice for overcharging for services rendered. “The Respondent paid an amount of ZAR 15 000, admission of guilt fine without appearing at the inquiry”[65]. Details of this case were requested from the HPCSA. However, to date nothing has been received.

In June 2016, a health professional had a complaint laid against them for overcharging their patient and using the wrong code. “The Respondent was found guilty in terms of Regulations 4(9) of the applicable regulations”. Additionally, “The Respondent elected to pay a fine of ZAR 15 000”[66]. It is unclear whether this was a simple mistake on the part of the health professional or an actual case of overcharging. These details too were requested from the HPCSA. However, to date nothing has been received.

In June 2016, a health professional had a complaint laid against them for 10 counts of overcharging the patient and/or the Medical Aid in 2009. “The Respondent was found guilty of unprofessional conduct on all 10 counts and sentenced as follows: ZAR 15 000 on each of the 10 counts, half of which was wholly suspended for 5 years”. “In total ZAR 150 000 of which half (ZAR 75 000) was payable to the HPCSA within 90 days from date of sentence and was wholly suspended for five years on condition that the Respondent was not convicted of unprofessional conduct involving billing errors or billing irregularities committed during the period of suspension”[66].

In September 2016, a health professional had a complaint laid against them for overcharging in respect of purported repairs done on the patient`s hearing aids. “The Respondent was found guilty of this count and was given a ZAR 10 000 fine”[66].

In May 2020, a health professional had a complaint laid against them for overcharging their patient and claiming more for the value of a hearing aid. “The Respondent was found guilty

and a penalty of a fine of ZAR 30 000, the operation thereof wholly suspended for three years on condition that she is not found guilty of a similar offence during the period of suspension"[67].

From the above seven cases, it is unclear on what benchmark was used by the HPCSA during the investigation and how the HPCSA determined the penalties. Details of each of the above cases were requested from the HPCSA however, to date nothing has been received. The penalties handed down by the HPCSA were far ranging which suggests a lack of complete disciplinary guidelines with regards to overcharging. For example, in one case the health professional was fined ZAR 15 000 and in another the health professional was fined ZAR 30 000 and was suspended for three years. The HMI final findings and recommendations report found that the "penalties levied by the HPCSA were inadequate"[45]. I believe that the problem is far deeper than what these few cases indicate. This is supported by the HMI final findings and recommendations report which states that there "was a large backlog in responding to complaints"[45].

If we refer to section 39 (1)(c) of the Constitution, it can be noted that "When interpreting the Bill of Rights, a court, tribunal or forum may consider foreign law"[46]. As reference to this, there is a case by Singapore's Medical Council (SMC) against Dr Susan Lim which provides a backdrop when reviewing the issue of health professionals being overly motivated by financial incentives. In the Susan Lim Mey Lee v Singapore Medical Council ruling, the healthcare professional was "liable for professional misconduct" in respect of the overcharging.

Dr Lim was given "the maximum financial penalty of $10,000 and the maximum suspension period of 3 years". The Court carefully examined all 94 charges against Dr Lim, and it was determined that the fees she had charged were "grossly excessive and vastly disproportionate to the services actually provided"[113]. Despite there being no fee guidelines for health professionals in Singapore, the Court still found Dr Lim guilty of overcharging[113]. The Singapore Ministry of Health has since published "percentiles of bill sizes for each procedure" for both their private and public hospitals[113].

The South African DoH, like the Singapore Ministry of Health, should adopt and publish a percentile of billing ranges for each procedure, as reference to both the public and private healthcare sectors. From the above case it can be noted that the Singapore Ministry of Health took a proactive step to improve the management of price regulation and South Africa could learn from this example in taking their own action.

The Singapore Ministry of Health has since also appointed a Fee Benchmarks Advisory Committee to assist in devising a benchmark of reasonable fees for health professionals[113].

Again, South Africa could turn to this example and note the need for an independent fee benchmark advisory committee. Singapore, however, are in the position to adjust swiftly and be proactive because of their political responsiveness and economic strength as compared to the challenges faced in South Africa[114].

4.4 Why an ethical limit is required

Prior to the distribution of medical insurance which drove a standardisation of fees, health professionals frequently billed patients in accordance with what they thought each patient could afford[69]. If standardised pricing is established, it reduces the need for healthcare users to scout around comparing prices which would potentially remove co-payments for patients and reduce healthcare prices overall[108]. There are however numerous factors which influence healthcare pricing. It was noted in the CC ruling back in 2004 that "the development of a system of tariffs was therefore a response to a substantive need for a code of ethics"[28]. Therefore, in my opinion an "ethical billing range" (sliding scale of fees) would assist in containing costs and minimizing the serious implications of dramatic prices increases in the private healthcare market.

The concept of an "ethical billing range" is also supported in part by Goga et al[50]. who suggest the best way forward would be for an independent mediator to create a basket that is representative of medical costs. This "ethical billing range" would act as a guide to the acceptable and fair level of prices for all parties involved, namely health professionals, patients and medical schemes. This "ethical billing range" would combine finance and philosophy. There needs to be a major shift in the current culture if the commercialisation of healthcare is to be adequately addressed with a need for ethics at the heart of the healthcare billing.

My recommendation for an "ethical billing range" would be that it should have a price ceiling or cap to provide certainty on the part of the health professional and patient. This is especially necessary with regard to PMBs, as in my view, there needs to be a maximum price set in order to prevent abuse by health professionals. This limit can then be used to determine what level of pricing is too high and at what point disciplinary action for overcharging may be a concern for the health professional. An ethical limit, if properly structured, "can address the most flagrant failures of the market without interfering with it, when it is working well"[109]. There is always a risk that the medical associations may once again threaten legal action, however if the tariff negotiations are done fairly with prior consultation, it would limit this potential. Specifically, if the ethical range is wide enough, it will provide sufficient room for billing appropriate to a specific discipline while also highlighting clear cases of overcharging.

Policy makers will face a trade-off about how stringent to set the range, as more stringent limitations produce bigger savings but are more disruptive of market interactions. The "ethical billing range" will typically consist of two parts: a base price and a multiple of the base price. The multiplier can be set at varying levels of stringency, but different base price choices influence market dynamics in ways that must be taken into account.

Specifically, once the base price is set, economic and political forces will act to push it higher. As stated by Chernew[109], it is important for policy makers to choose a base price to resist such forces. The ranges would vary based on the health professionals' years of experience, additional training, or qualifications and should be subject to peer review. I am of the opinion that setting of prices and the establishment of an "ethical billing range" will cut into the steep prices of healthcare services and improve overall affordability and access to healthcare.

4.5 Recommendations to the HPCSA

The HPCSA ought to fully utilise its powers to determine a cap on prices. I support basing the percentile on prices in the local market, as opposed to allowing insurer-specific prices. In high-income countries today, the development of credible prices in healthcare has been commonplace[3]. If prices are controlled in the private sector, it potentially allows the public sector to draw on private facilities and health professionals, expanding overall access to health services[3]. South African policy makers can use the economic rationale examples provided to see that credible prices in private healthcare are of great importance and are vitally necessary. I believe that the HPCSA should approach the Minister of Health and he/she should lead the call for the CC to grant an exemption for the healthcare sector. This would be in terms of subsection 2(a) only if (3)(b)(iv), in order for price negotiations to occur legally[49]. An independent and fair third-party arbitrator such as the CMS can be used where parties may differ.

There have been many failed attempts to establish a price schedule. These failed attempts have all lacked credibility and integrity in the past; thus, these two elements need to be in place as a foundation for the development of an "ethical billing range" for the private healthcare sector[32]. All parties should submit their proposals for tariffs and their reasonable ranges, and these should then be negotiated and agreed upon as an "ethical billing range". Once agreed upon, the "ethical billing range" should be published for everyone to comment on. This would improve transparency and improvements can then be made. I believe that simply improving price transparency would assist in reducing healthcare spending.

There is a need for government and related authorities to be proactive in advancing the setting of healthcare prices in order to attain policy objectives. To avoid making the same mistakes as in the years prior to 2010, the Minister needs to first deliberate with the National Health Council (NHC) as is required in section 90(10) of the NHA[15]. The setting of a price list requires thorough consultation and procedural fairness with all parties involved. The "ethical billing range" needs to be rational and set at a reasonable level. The perspectives of the Advisory Committee of the DoH need to be taken into account.

The 2009 RPL can be used as a reference with adequate consideration for inflation and adjustments. The proposed "ethical billing range" needs to accurately reflect the costs of running a private healthcare practice. Accurate statistics need to be collected, analysed, and interpreted by independent actuaries in order to identify the most feasible "ethical billing range". The "ethical billing range" data will need to be updated regularly to refine existing tariff codes and keep up to date with new coding structures as well as inflation. Learning from errors made with the 2009 RPL, the new "ethical billing range" needs to have tiered, time-based consultations and the relevant tariff codes as set out by the different health profession boards. Only once this "ethical billing range" has been agreed upon should it be published and used by the medical schemes to reimburse for healthcare services. This would prevent it from becoming the *de facto* determined level of remuneration in the healthcare industry prior to it being agreed upon.

We need to be mindful that if the fees are unreasonably low then there is a risk that health professionals may leave the country or focus on quick patient turnover to the detriment of quality healthcare. This would ultimately negatively disadvantage patients who may face the declining number of health professionals within the country[32]. Thus, the "ethical billing range" needs to be fair and reasonable.

Further to the risk that skilled medical specialists may flee the country if price setting is implemented, my recommendation would be that when it comes to medical specialists, the issue of supply and demand can be utilized to refute this claim. If we want to reduce the medical specialist costs, then there needs to be a concerted effort in incentivising and supporting the education of additional medical specialists[3]. This will then lead to a drop in prices as there would be an oversupply of skills. It is further recommended for Government to scale down the acceptance of students based on racial quotas at universities in order to train more health professionals, no matter their race[115].

An additional measure would be to include increasing the number of students existing Universities could take in or creating new institutions for the training of healthcare professionals. There is a pressing need for health professionals in South Africa and therefore the pool of candidates should not be limited. Instead, if there is a capacity issue with training facilities then that infrastructure should be addressed and developed to meet the demand. There can also be greater incentives to train GPs to be medical specialists. It is also essential to instil professionalism and ethical billing during medical students' impressionable and formative years. Financial ethics should be introduced to healthcare students while at studying at university.

SAMA has supported the HMI in relation to price setting, regulation and other interventions in the private healthcare sector[102]. SAMA makes mention of what is representative of a reasonable and fair value[27]:

> "We can conclude that a fair value is not below the cost to deliver the service and where tariffs are offered to healthcare professionals that result in a loss, additional fees should be recovered from the patient to support a sustainable business. We also know that a fair value should not be charging exorbitant mark-ups that do not represent a true reflection of the level of skill and risk of the procedure. As with most professional occupations, discretion should be applied when billing for services rendered".

What complicates the costs of healthcare services is that a healthcare professional's services should be provided at a fee that ensures it is viable for patients within their region to have cost-effective access to their services. Thus, the "ethical billing range" can include geographical variations. However, this is a delicate balance. There is a risk that health professionals may flood from rural to urban areas. As a result, the cost variations based on geographical ranges should not vary considerably.

There have been many calls for regulation to address the current situation, the most recent being the HMI. However, to date, and despite the recommendations nothing has been implemented and the private healthcare sector remains as lightly regulated as it was. The HMI recommended the SSRH to improve regulation related to pricing[45]. The regulator will assist to ensure that pricing is determined legally with sufficient value assessments. The regulator would be responsible for all the tariff negotiations.

In my view, despite the complexity of establishing a regulator there is an urgent need for a timeline to be in place to work towards. In the HMI final findings and recommendations report, it was also found that the "HPCSA lacks the capacity to enforce sanctions that have been

ordered by its disciplinary committees"[45]. This area needs to be addressed by the HPCSA. A possibility is the outsourcing of the enforcement of the sanctions or the improvement of their own ability to impose the sanctions ordered by their disciplinary committees[45].

There may be additional arguments against price setting that it may introduce distortions and eliminate the incentive to innovate for better quality of care. However, with the impending move towards NHI, the price controls will potentially be looming. If it is done prior to the NHI, the health professionals can use the "ethical billing range" to see how they can manage their practices and still run them at a profit. The "ethical billing range" developed can potentially be used by the NHI to serve as a pricing model from which to build. There is a need to move towards one set of codes for medicines, products and services which would also assist in the transition to the impending NHI[71.]

4.6 Conclusion

Without complete and comprehensive billing guidelines, it is near impossible to determine what would be considered a fair and reasonable fee. The current lightly regulated system allows for profit orientation which has driven up the healthcare costs in an unsustainable way. A profit motive in healthcare causes a conflict of interest that ultimately undermines patient care.

I am of the view that unregulated commercialism in healthcare will eventually taint a health professionals' patient trust and commitment, which are the very foundation of medicine. Patients are vulnerable and therefore setting of prices would be an approach to reduce patient harms[50]. If complete and comprehensive billing guidelines for healthcare professionals are provided it would address commercialism and its likely negative consequences and harms. The Minister of Health should in consultation with the CC allow for collective bargaining in the healthcare sector. The cost of private healthcare needs to be curtailed as it is increasing faster than South Africa`s economy is growing. These increasing healthcare costs are therefore becoming unsustainable.

Complete and comprehensive billing guidelines will assist in the delivery of quality care at a reasonable cost to those who require it. It will also require a well-organised co-operation of all role-players and transparent governance. In reviewing the legal cases related to overcharging, the HPCSA need to separate the grouping of 'overcharging' and 'charging for services not rendered' as they are two separate offences. The current grouping does not indicate the severity of overcharging alone. As overcharging for healthcare services can lead to legal action against the health professional, guidelines need to be clear for health professionals to be better protected.

The penalties for overcharging need to be consistent and the HPCSA needs to concentrate on improving their responses to complaints. They could potentially set up a task team to focus and improve on this important function. The HPCSA needs to at the very least, set a possible range of fees that are fair and reasonable in certain circumstances.

South Africa can look at and learn from international cases and law for reference as they are implored to do so in terms of section 39 of the Constitution[46]. Although the circumstances are different there can be opportunities to learn valuable lessons from these historic cases. The formation of an independent regulatory body would be a positive step for the sector as it will need an objective party to oversee the formation of an "ethical billing range" and its application thereafter. It will not be an easy process to set an "ethical billing range" and establish an independent regulator but that does not mean is should not be done.

Chapter 5: Conclusion

If we refer back to the original example where the health professional charged ZAR 26 000 for a 23-minute procedure, it is clear that the current lack of guidelines enables health professionals in South Africa to potentially abuse the system.

There have been no guidelines governing the billing practices for private health professionals since they were set aside in 2009. It is evident from my discussion and argument, that this has been the root cause of the abuse by overcharging and the widening of the gap in accessibility to healthcare. A lack of complete and comprehensive billing guidelines in South Africa's private healthcare sector contributes to the challenging task of keeping the costs manageable. This is evident by costs in the private healthcare sector increasing at a rate above inflation for the past decade[3]. Such price increases are unsustainable and the serious implications for the industry were demonstrated. Commercial forces have bored deep into the private healthcare system and drastic changes are required to address the multiple market failures.

No single solution will work in isolation; however, we need to keep on asking questions to challenge the status quo. Past government and CC decisions and the implications thereof need to be reflected upon to avoid repeating past mistakes.

There is a need for collective tariff negotiations to curb the rising costs in the healthcare sector. South Africa is deserving of a legally approved process whereby all role-players can take part in a clear bargaining chamber through which billing guidelines for healthcare services can be established.

The ethical price limits a health professional can charge remains arbitrary where there is no limit on prices. Price setting is one of the only ways to curb the high prices in healthcare as there is a perception that high prices mean a higher level or quality of care. Due to this perception health professionals will be able to justify their pricing as there is always a market and someone that would be willing to pay the prices, however high they may be.

Overcharging by a health professional is unethical behaviour as it goes against professionalism, the doctor-patient relationship, patient trust as well as community-centred ethics. The moral theories of principalism, care ethics, virtue ethics, Kantian Deontology and Consequentialism all support that overcharging in healthcare is unethical. Overcharging has the potential to leave patients in debt, stop patients` treatments prematurely due to lack of funds and cause more emotional and mental stress for patients. This is in direct conflict with the Hippocratic Oath.

Health professionals have an ethical duty towards their patients and that includes a commitment to honest billing practices. Therefore, a complete and comprehensive billing framework that is correctly enforced will assist health professionals in striking the correct balance between remaining ethical and professional as well as being commercially strong but not exploitative.

There is no clear evidence from any of the finalized HPCSA cases related to overcharging, as to how the final verdict was obtained nor what benchmark was used to determine the penalties. 'Overcharging' and 'charging for services not rendered' need to be separated by the HPCSA and not grouped together. This will allow for more accurate monitoring of excessive billing by health professionals. The HPCSA should provide a clear framework of what constitutes as overcharging in their Ethical Rules. This will enable the HPCSA to carry out their mandate in prohibiting 'overcharging'. Thus, it is imperative that the HPCSA assist in initiating, negotiating, and developing an "ethical billing range" with an independent regulator. The HPCSA can then determine standardised penalties for specific offences based on a complete disciplinary guideline.

Complete and comprehensive billing guidelines are required to limit cases of excessive billing. This will address commercialism in healthcare and the negative consequences of overcharging. To finalize the billing guidelines, a negotiation forum needs to be formed. The negotiation forum needs to be free of political involvement. The HMI was concluded, and recommendations were provided in September 2019. However, to date nothing has been implemented. There is an urgent need for the HMI recommendations to be put into a specific timeline for their implementation.

The current unruly nature of billing practices by health professionals is undermining the reforms proposed by government to make healthcare more accessible[32]. If the costs in the private healthcare sector are curtailed and healthcare services become more affordable, access to healthcare will improve.

Improved regulation and price setting in the private healthcare sector would result in increased access to care for a greater number of South Africans. This will assist to relieve the over-burdened public healthcare system. A healthcare system should not aggravate unfairness; however, this is the case with the current state of South Africa`s private healthcare system and needs to be addressed as a matter of urgency.

The continued growth and very survival of the entire South African healthcare system depends on this expeditious implementation of improved regulation and price setting.

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APPENDICES

Appendix 1: Human Research Ethics Committee waiver

Appendix 2: Report from “Turnitin”