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**Title: The Ethical Tariff**

Author: Prof C A Joseph Honorary Associate Professor University of Limpopo (Medunsa) and the Witwatersrand.

The Ethical Tariff was introduced by the HPCSA in an attempt to set an upper limit to fees charged by doctors. This implied that fees above those proposed in the tariff would be unethical. This attempt to define an ethical tariff based on a particular fee level set in 2006 is incorrect.

The ethics of tariff is concerned with the doctors’ behaviour with respect to how fees are charged rather than the actual level of fees. Doctors may be unethical even when charging below the “Ethical Tariff” set by the HPCSA, conversely charges above the HPCSA tariff are not necessarily unethical.

Hippocrates 400BC recorded a code of behaviour (ethics) to be taken as an oath by doctors. It remains largely intact though rewritten by different institutions to suit the modern idiom.

Today medical ethics is essentially a code of moral behaviour that has developed through centuries of caring by a profession that is placed in a unique position of trust by their patients.

We can debate on an ethical dilemma or question based on:

1: Irrational approach

2: Rational approach

**Irrational approach**

This may be difficult to understand or explain, but it “just feels right”. Doctors develop this over years of work with colleagues and patients where trust is paramount. Ethical behaviour is essential to maintaining this trust, without which high standards of professional care are impossible. Working in this environment endows the “just feels right” ability.

**Rational approach**

The rational approach consists of:

1. Principlism
2. Consequencialism

Principlism is essentially an application of the Hippocratic Oath encompassing “non nocere (first do no harm)”, justice and autonomy.

Consequencialism is the consideration of the consequences of the behaviour on quality of care, the greater good (altruism) and cost effectiveness (fiduciary responsibility).

An ethical tariff, therefore is one that “feels right”, is just, cost effective and respects a patient’s autonomy. It is about moral behaviour regarding the tariff and not the actual fee level. The fee level may vary according to quality of service, outcomes and practice costs.

Practice costs vary from group to group, specialist to specialist and geographically, so attempting to set a “ceiling” would be arbitrary. It could also have a negative effect on the quality of care and would therefore be unethical.

An “Ethical Tariff” is about behaviour with respect to fees and coding rather than a set fee or “ceiling”.

A doctor may charge a “low” fee, but still act unethically with respect to tariffs by behaving in any of the following ways:

* Overservicing ie performing unnecessary services (tests or procedures) for a fee.
* Padding accounts ie adding charges for services that are not rendered.
* Scheduling repeat visits or hospital admissions that are not indicated.
* Entering into a payment arrangement with an administrator of a fund or funds.

Most doctors would agree with the first three comments, but some may have a problem with payment arrangements. Unfortunately these fail the ethical test on numerous levels, for example:

* Autonomy: both patient and doctor autonomy is negated or diminished.
* Quality care: compromised by time constraints and arguable protocols. Current payment arrangements completely ignore quality assessment and even fail to ensure all necessary services are reasonably available. Doctors are exposed to possible dual loyalty between what is best for the patient and what is best for the payment partner.
* Justice: this is not served by permitting 3rd party interference with patient management. These arrangements are aimed at benefitting 3rd parties and possibly doctors at the expense of the patient.
* Altruism: many plans lose money on payment arrangements resulting in patients usually on lower option plans cross subsidizing these losses (this is the poor paying for the rich). 50% of patients on the largest payment arrangement in SA are on losing plans. The greater good is not served, but the administrator of this largest payment arrangement profited by more than R1billion last year.
* Fiduciary responsibility: our ethical duty is to care for the patient and costs that they incur, not the profits of a 3rd party.
* Finally it just does not “feel right” to have a for profit administration partner in the doctor - patient relationship.

Charging set fees per procedure based on a patient’s funding plan (“payment arrangements”) rather than quality, experience and outcomes is unjust. Many, if not all of these payment arrangements are not cost effective (50% of members in the largest payment arrangement are in plans with operating losses), they are not altruistic (for the good of 3rd party profits rather than for the greater good) and do not measure quality or outcomes. Patient and doctor autonomy is ignored. Despite the quantum in these payment arrangements being below (up to 70% lower) the “ceiling” set by the HPCSA “ethical tariff” they are unethical.

An ethical tariff is less concerned with quantum than the application of codes and charges. However there could be situations where charging a higher quantum would be unethical.

Charging higher fees for PMB conditions based on the requirement that PMBs must be paid in full is unjust and therefore unethical. Fees should be based on experience, complexity and practice costs, not the patient’s medical plan or whether the fund must pay in full or not.

Generally doctors charge the same or less for PMB conditions (B Steenekamp, CMS research), which “feels right”. 67% charge NHRPL for non PMB conditions, but 70.3% charge NHRPL for PMBs.

**Percentage of doctors charging NHRPL, 1x - 3x NHRPL and >3x NHRPL (PMB vs non PMB conditions). B Steenekamp**

These findings contradict the BHF claims that doctors abuse PMBs and that the PMB legislation is a threat to the financial stability of medical schemes. Furthermore the following graph demonstrates that the payout to consulting and surgical specialists is relatively small.

**% MEDICAL AID PREMIUMS SPEND 2009/2010**

Only 10.59% (VAT incl) is spent on consulting/surgical specialists. Approximately half of this is on surgery. Take out the VAT and only 4% of every rand paid to medical aids by patients is spent on surgeons.

The NHRPL tariff was declared unreasonably low, irrational and set aside by Judge Ebersohn, July 2010. Furthermore, the judgement found the failure to introduce tiered consults and the distinction between specialist groups’ remuneration was unreasonable and irrational.

Whether it is ethical to charge fees according to an irrational and unreasonable NHRPL tariff is arguable. The NHRPL is certainly unjust in its differential payments to specialist groups and could therefore be unethical. However it may be impractical to charge otherwise under conditions where funders refuse to pay doctors unless the NHRPL (or similar so called fund tariff) is charged. As the NHRPL is unreasonably low (Ebersohn judgement), then Rule J (for disproportionately low fees) may be applied to all NHRPL rates. Indeed, this may be the ethical answer to such unfair and unjust circumstances.

Ethics and the law are not always good bedfellows (it may be legal to disclose confidential patient information, but unethical). A moral compass demonstrates where these may differ with reference to tariff. Behaviour should remain in the red segment. Though the yellow segment is legal, it is unethical and should be avoided.

With the promulgation of the Consumer Protection Act in April, doctors who charge different fees, based only on the particular medical plan that a patient belongs to, for the same procedure or consultation are in contravention of the Act. This shifts payment arrangements from the unethical/legal quadrant to the unethical/illegal quadrant.

Doctors who believed such payment arrangements were both ethical and legal are now faced with the possible shift of payment arrangements to the illegal quadrant.

**The Moral Compass**

ETHICAL

=

Overservicing Padding accounts Unnecessary procedures

UNETHICAL

ILLEGAL

LEGAL

Payment arrangements 3rd party profits Convenience admission

Managed care has created some confusion and misunderstanding. Legal processes are used to cloud ethics. The doctor’s leadership is undermined by the use of “service provider”, thereby weakening the doctor’s role in disease management and the “feels right” ability to assess 3rd party interference. Managed care attempts to place “case managers” in control of disease management. Interference in the doctor-patient relationship is inevitable.

Managed care sets tariff at differential rates according to plans (unjust!), selects doctors and medicines (autonomy!), and places cost before quality to ensure 3rd party profits and returns for shareholders. Unethical, yet it is a successful R2billion business in South Africa, all from patients’ premiums with little or no opposition from doctors. It surely contravenes the Consumer Protection Act and is currently under investigation. Hopefully the law will succeed where doctors have regrettably failed to protect their patients from this abuse.

Conclusion

The Ethical Tariff is not what you charge, but how you charge. It is a fair and just fee applied with regard to your patient’s right to autonomy, freedom of choice and quality medical care. It is a tariff that honours the doctor patient relationship without 3rd party interference. It takes cognisance of our fiduciary responsibility to cost effective care without sacrificing quality. The quantum is based on cost, experience and outcomes, respecting your patient’s right to time, respect and compassion.

References:

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