DOCTORS, ETHICISTS HIT OUT AT THIRD-PARTY FUNDERS

Doctors at the cutting edge of bio-ethics, medical politics and health care spending have voiced collective anger at the undermining of patient trust and goodwill by 'bloated' third-party funders.

Speaking about dual loyalties and ethics at SAMA's pilot conference on 'Strategies for the survival of doctors in South Africa', several protagonists condemned an environment which turned doctors into 'agents of a plan driven by cost-containment motors'.

Dr Ames Dhai, of the Department of Bio-Ethics at Wits University, said that what frightened her most was 'that, as doctors we have started to believe that we have other obligations competing with our obligation to our patients'.

Dr Jan Talma, chairman of SAMA's specialist private practice committee (SPPC) charged medical schemes with 'forcing doctors into becoming businessmen'.

He said a single set of ethical rules for doctors, funders and hospitals was urgently needed to replace existing double standards.

An unsustainable situation existed in which less health care was being delivered for more money, while practice costs and the consumer price index soared, leaving ethical doctors financially stranded and moving out of core health care delivery.

The vision for a career in medicine had been destroyed with SAMA suffering a net loss of 1 000 members per annum as doctors moved into the funding industry, administration, and overseas.

Echoing SAMA chairman, Dr Kgosi Letlape, Talma said much of the 'so-called (doctor) fraud issues' were inextricably linked to doctors, especially GPs, being unable to make a living in an increasingly hostile climate.

Letlape said third-party funders should assist patients, not enslave doctors, and vowed to fight for a patient reimbursement system where doctors ceased to be paid by medical aid schemes.

'I'm not a businessman, I'm a doctor — it took me 15 years to become a surgeon and I'll be damned if a 3-year graduate is going to tell me how to do my job,' he added.

SAMA chair, Dr Kgosi Letlape with his World Medical Association colleagues, Secretary General Dr Delon Human and Preident, Dr James Appleyard.

Dhai defined dual loyalty as a 'simultaneous experience of implied, real or perceived obligation to the patient and to a third party, be it an insurer, employer or the state'.

She said a socially and legally acceptable departure from the obligation to patients might sometimes be required, such as breaching confidentiality to protect a third party or notifying for health surveillance purposes.

However, what remained 'critical' was the moral acceptability of such departures and the fairness and transparency of balancing these conflicting interests in such a way that they remained consistent with human rights.

Dhai said nothing exposed health care professionals' true ethics more than the way in which their interests were balanced against those of their patients.

Examples included refusing to treat highly contagious diseases, fear of malpractice, and earning a gatekeeper's bonus by blocking access to health care.

In his keynote address, Dr Delon Human, a former Pretoria GP, now Secretary-General of the World Medical Association, put it differently: 'When physicians think private thoughts they know where the ethical framework lies'.

He said physicians were not business partners — they were the partners and advocates of their patients.

Dhai said arguments which accommodated self-interest were only cogent when the conception of medicine that underlay them was accepted.

This conception was that medical knowledge belonged to the health professional and was to be dispensed in the marketplace on terms set by its owner.

It also proposed that being ill and in need of care was no different from needing any other service or commodity.

She argued that three things set medicine apart from other occupations and therefore demanded a degree of altruism and an obligation of (self-) effacement.

Illness put individuals in a uniquely vulnerable and exploitable state in which they had to compromise their dignity and 'release intimacies of body and mind'.

'When we invite that trust we make an offering to put our knowledge at service — knowledge which society has sanctioned (through science)'. This knowledge did not belong to health care professionals.

Dhai said that doctors embraced third-party payers 'at their peril' and at

the risk of 'destroying almost overnight the ethics of their profession'. They were being forced to compromise their care to create savings for third parties and the profits went directly to shareholders.

Doctors achieved this by 'scrimping' on the care they delivered — a term more popularly known as 'the practice of cost-effective medicine'.

Lambasting executives in managed health care as 'trained for the moment when dual loyalties came to the fore', Dhai also called for a single code of conduct across all sectors of the health profession.

She observed, 'they (executives) say, "I'm not denying care, I'm denying payment!".'

No set of guidelines could be detailed enough to accommodate patients' vast variability or keep up with new technologies that emerged while the studies on which they were based were highly questionable.

Clinical discretion was crucial if health professionals were to negotiate with patients to reach mutually acceptable treatment regimens.

'If we don't have the authority to negotiate a solution, patient-doctor trust suffers.'

SAMA chairman, Dr Kgosi Letlape, made the point more forcefully. He said doctors had 'allowed the undertakers to come in where we have failed'.

Doctors had to fight for resources while their patients were disallowed benefits.

'We've put ourselves at the end of the food chain because we've abandoned the patients and have been following the money-bags for too long,' he said.

'Our oath is to put patients first and to do no harm — there's nothing in there which says how much we earn for putting mankind first.'

Dr Jan Talma said an unbearable situation lay ahead. 'There are so many changes on the horizon — changes of role players, capitation models, global fees, cost containments — we need contracts for all this and the funding industry, hospitals and doctors in business entities are busy with that.'

However, all this created ethical problems, such as withholding treatment.

Talma said only 30% of patients' money was assessed by medical ethical rules while 70% was assessed by very different criteria.

Judge Albie Sachs, one of the architects of the South African Constitution on which he now arbitrates together with 10 fellow judges, told delegates that it was not enough to just focus on the patient - doctor relationship.

Dhai said nothing exposed health care professionals' true ethics more than the way in which their interests were balanced against those of their patients.

'That's the starting point, but we have to look at it in a context of sustainability.'

He cited the tragic landmark 1998 Soobramoney v. the Minister of Health, KwaZulu-Natal case in which the court upheld a King Edward Hospital policy to limit dialysis for chronically ill patients only to those eligible for transplants.

Soobramoney died in his attempt to enforce what he claimed were his constitutional rights to health care (in his case, life-saving dialysis).

The 11 judges found that the hospital's policy was forced upon it by shortages of funding, equipment and staff and that its 17 dialysis machines were well managed, with priority given to patients who would benefit from renal transplants.

Because Soobramoney's condition was not an emergency as understood in the constitution, he had to go to the 'back of the queue'.

(The constitution demands only that 'reasonable measures' be taken to realise health care access.)

Judge Sachs said rationing of human resources was not 'anti-human rights'.

'If resources were co-existent with compassion, this would have been the easiest case in the world,' he stressed. He urged SAMA to look at the 'principal medical needs,' of access to clean water, safe electricity and housing.

When it came to moral sustainability, SAMA was crucial as an ethical community which fought for better work conditions, patient advocacy and the context in which healing took place.

Stephen Harrison, head of Research and Monitoring at the Council for Medical Schemes, blamed perversities in price setting for soaring costs and distortions in the health care spend.

He said this expenditure, particularly in the private sector, failed to reflect the primary health care led policy direction of the 1997 White Paper on health transformation.

Citing the latest report of the Registrar of Medical Schemes, he said GPs accounted for 8.5% of medical scheme expenditure, medicines for 24.3% and private hospitals for 32.2%.

He added that fraud and abuse were 'ripping the guts out' of the funding industry, causing financial suffering to both patients and 'providers' and costing R4 - R8 billion per annum.

The major key to long-term cost control, quality management and sustainable 'provider' income lay in the contracting between funders and 'providers', with appropriate risk sharing.

Penny Thlabi of the Board of Healthcare Funders (BHF) said deciding how finite health care resources would be allocated was not the exclusive preserve of doctors.

Funders and the private health care industry were facing major challenges, including mandatory coverage of 25

chronic conditions (from 1 January 2004).

At present all efforts were being directed at assisting schemes in managing the risks.

A second BHF challenge was the consolidation in the private hospital sector.

Thlabi, who had earlier come under verbal attack from several physicians, said doctors needed to be 'more honest' about their collusion in driving up private hospital costs.

Harrison, quoting an ancient Chinese proverb, added if 'we don't change direction, we'll end up where we're headed'.

Chris Bateman

A DOCTOR WITH A MODERN AIDS MISSION

Veteran US Congressman, AIDS activist and seasoned fund-raiser, Dr Jim McDermott, believes that South Africa will receive about R3.65 billion of the R105 billion promised by the US government to fight the global HIV/AIDS pandemic.

'That's the kind of figure our embassy is talking about,' he told the *SAMJ* during a visit to Cape Town in late August.

In South Africa to attend the Foundation for Professional Development's (FDP's) popular 3-day HIV/AIDS management course, McDermott, a Democrat with a long history of African involvement, said the 'moment of truth' for the US government had finally arrived.

'The USA's fiscal year start(ed) on October 1, so (President) Bush has to act soon or else he won't be able to have his AIDS funding signing ceremony,' he said.

Partly because the R105 billion global total ($14 billion) had not been budgeted for by the US 'in one chunk', South Africa would probably receive around R735 million ($100 million) annually for 5 years.

McDermott firmly believes the first instalment will be available 'early next year' — a timely financial boost if the much-trumpeted South African government roll-out of antiretroviral (ARV) drugs has begun by then.

'We'd like at least to get the ARV component started where feasible and then figure out such things as education for physicians and equipment for hospitals,' he said.

A pioneer of HIV/AIDS awareness in the US government, McDermott, who is a psychiatrist, founded the International HIV/AIDS caucus, organises AIDS seminars in the US Congress and has raised millions to help Third World countries fight the pandemic.

The architect of the African Growth and Opportunities Act which has opened up huge markets for African countries, McDermott is a former US government Foreign Service mental health officer.

He spent 9 months based in Lusaka, servicing 26 US embassies in sub-Saharan Africa.

'I couldn't help seeing the AIDS problem burgeoning around 1988. I especially remember the stigma, I just found myself drawn in,' he explained.

McDermott recalls the fear generated by the death of the cook for the American ambassador in Lusaka — and how some US staffers believed AIDS could be spread by mosquitoes.

However, his involvement in the AIDS field began much earlier (1984) when, as a physician and State legislator in his home town of Seattle, Washington, friends and associates of his began dying from the virus.

Washington and California were home to the biggest gay communities in what was then a homophobic environment; difficult in which to successfully budget funds to fight an incipient, largely homosexual epidemic.

'Wherever you turned somebody blocked it; but eventually in 1985 I got $300 000 passed for pure AIDS education,' McDermott said.

He was elected to Congress in 1988 and began developing a national health insurance plan for the USA (today 16% of US citizens have no health insurance, a fact McDermott deplores).

While his AIDS interest did little for him politically, he persevered.

A conversation in 1989 with the then Speaker of the US Congress, Tom Foley, in which McDermott emphasised how AIDS was a burgeoning heterosexual problem in Third World countries, proved pivotal and led to the US International AIDS caucus.

'I couldn't interest our politicians in travelling to see for themselves, so I decided that if you can't bring Mohamed to the mountain, you can at least bring the mountain to Mohamed.'

A series of African and other Third World leaders in the HIV/AIDS field began streaming into the US Congress for a series of HIV/AIDS seminars.

McDermott outlined to Foley how HIV/AIDS was a social, economic and security problem — 'for example I told him that 25% of the Zambian Air Force were HIV positive'.

Foley, who was a confidante and close friend, promptly authorised an ability for McDermott to travel anywhere in the world, gathering information on the pandemic.