An analysis of the employment of medical practitioners in South Africa: keynote address presented by Ms Zeenat Dasoo at the MMPA 16th Annual Congress, August 2013

INTRODUCTION

It has been remarked that the wealth of a nation depends on the health of its population. If the health of a nation is a barometer of its political economy, then health care is the indicator of its national capital. In Africa, like everywhere else, the rich are healthy, the poor are not. The poor face profound systemic and structural obstacles to market access, severe disease burdens, economic and political instability, and severe stress on social networks, resulting in a perfect storm of persistent poverty.

According to the World Health Organization’s latest statistics, in South Africa, a person is approximately 4.5 times more likely to have tuberculosis and 22 times more likely to have HIV than the global average. In addition, in South Africa, life expectancy for both sexes is 58 years, compared to the global average of 70 years. The delivery of adequate and appropriate health care to all citizens of this country can thus not be overstated.

All health care systems, however, evolve in predictable ways. They start with providing the following fundamentals: good nutrition, clean water and sanitation, adequate housing, decent education, personal security, and opportunities for work. Inadequacies in any of these fundamentals create deterioration of health care measures and result in a slide in the stock of national health capital. African countries perform poorly on a wide range of these indicators. Health systems, such as they are, including those in South Africa (despite its relative wealth), are overwhelmed by the incredibly high burden of disease emanating from the failure to procure these fundamental conditions.

The public health care sector in South Africa (and which may be true for many other developing countries), is unfortunately characterised by a lack of systems, inept resource management, insufficient skills and resources, and poor financial administration. The private health care sector, in contrast, is well-resourced and delivers relatively good quality and efficient services. This disparity between the public and private health sectors, in particular swift access and care provided in decent surrounding, leads unsuspecting average users of the private sectors, in particular swift access and care provided in decent surrounding, leads unsuspecting average users of the private health care sector to believe that the health care outcome is superior, thereby justifying its costs. This is not necessarily true as the alternative for most people is not an option.

A health care system where the clinical needs of the majority of people are underserviced, or not serviced at all, is completely unsustainable. Access to a viable health care system by all of a country’s population should be the goal of any country that wants to prosper. The South African Constitution entrenches the principle that all citizens are entitled to a responsive health care system.* But faced with the maelstrom of inadequate access, what can be done to ensure that all of our population have access to adequate health care?

Recently, the issue of rising health care costs has taken the centre stage of the national debate, with various interested parties taking pot shots at each other as to the reasons for rising health care costs. The Competition Commission is soon to begin an inquiry into the private health sector. Also, the viability of the change to the national health system, to the proposed National Health Insurance (NHI) model, and its operation in the market with other funders, will hopefully also be subject to scrutiny. An issue that is central to the debate on both the competition enquiry and the NHI is the employment of medical practitioners.

EMPLOYMENT OF MEDICAL PRACTITIONERS

The Health Professions Council of South Africa (HPCSA) recognises that practitioners should at all times act in the best interests of their patients and regard the clinical needs of their patients as paramount. To this end, a medical practitioner should always avoid potential conflicts of interest and maintain professional autonomy, independence and a commitment to the relevant professional and ethical rules and policies. Any conflicts of interest, incentives or forms of inducement that threaten such autonomy, independence or commitment to the appropriate professional and ethical rules and policies, or that do not accord first priority to the clinical needs of patients, are unacceptable.

On 19 February 2009, the HPCSA issued a media statement, regarding the amendments made to the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 (HPA) in relation to the employment of medical practitioners. In essence, it stated that only a medical practitioner may employ a medical practitioner within the same professional category, or one who supplements or completes the employing medical practitioner’s health care of treatment.

The Employment of Medical Practitioners

1. The Constitutional right of access to health care services, and specifically the child’s right to basic health care services and the provision of medical treatment to detainees (found in sections 27(1)(a), 28(1)(c) and 35(2)(e) of the Constitution).
intervention. The media statement also highlighted the amendments relating to medical practitioners’ financial interests in hospitals and the prohibition on the sharing of rooms.†

On 6 August 2012, the HPCSA issued a media statement, requiring all employers of medical practitioners to review their current model of employment of medical practitioners, consequent to the amendment of the Ethical Rules of Conduct for Practitioners Registered under the HPA.

Notwithstanding the content of the media statements, it should be noted that the legislation does not prohibit the employment (selectively or otherwise) of medical practitioners by non-medical practitioners. However, the employment of medical practitioners by non-medical practitioners requires the approval of the HPCSA. Furthermore, the HPCSA also has at its disposal, the ability to impose harsh sanctions against those medical practitioners who choose to remain employed without its consent. The HPCSA has effectively been anointed judge, jury and executioner to determine whether or not a medical practitioner can be so employed.

The HPCSA appears to have the view that the selective prohibition of the employment of medical practitioners and the sharing of profits with non-medical practitioners is the panacea to the undesirable practices of under-servicing, over-servicing, self-referrals and the risk to the clinical independence of medical practitioners. The HPCSA is aware that there is a myriad of different schemes that medical practitioners can employ to circumvent the rules, and that disallowing the employment of medical practitioners by non-medical practitioners will not necessarily prevent such circumvention, neither will the employment of medical practitioners necessarily lead to such circumvention. However, removing the ability of non-medical practitioners to employ medical practitioners has the consequence of driving up costs. There does not appear to be any cogent justification for the blanket selective prohibition by the HPCSA for the employment of medical practitioners by non-medical practitioners. The amendment of legislation relating to the requirements for ownership by pharmacists, although not identical to the issue relating to the employment of medical practitioners, is nevertheless instructive. It was essentially claimed that the duty of care owed by pharmacists towards patients would not be compromised if the ownership of pharmacies vested solely with pharmacists. It was eventually determined that such a requirement of ownership was inimical to the interests of patients, through limiting access to pharmacies and driving up costs. As a consequence, ownership of pharmacies was de-regulated and non-pharmacists (mainly retail chains) were allowed to own pharmacies. As a result, access and the cost effectiveness of pharmaceuticals have improved significantly. It is noteworthy that, in the first four years after ownership deregulation, the total number of pharmacies in South Africa increased by 15%. The duty of care was ensured by employing only pharmacists to dispense medicines, thereby proving that ownership of pharmacies by pharmacists was not the sole means of ensuring that the duty of care was observed. Similarly, it can be argued that the employment of medical practitioners by non-medical practitioners will not necessarily lead to the contravention of the Ethical Rules.

The recent pronouncement by the chairperson of the South African Medical Association (SAMA) that it will not support the employment of doctors in the private sector by any (private) funder (of health care), as it does not serve the interests of their patients, echoes the sentiment of the HPCSA in this regard.5

The selective prohibition on the employment of medical practitioners can potentially shut down efforts to contain rising medical costs, prevent medical practitioners from competitively engaging in the economy by choosing to be employed, and threaten the ability of the most marginalised sections of our labour force (and, for that matter, some communities) to access decent health care.

Whilst the interests of the public need to be protected against self-serving and pernicious medical practitioners, it is submitted, with due respect, that a selective prohibition on the employment of medical practitioners to achieve this is myopic and unsustainable in the context of the social upheaval resulting from inadequate access to decent health care by the majority of our people.

HUMAN CAPITAL: HEALTH PROFESSIONALS VS HEALTH WORKERS

The largest public sector strike since 1994 occurred when nurses, among others, went on strike. This elicited an emotional comment by the then Minister of Public Service and Administration (the “Minister”), who castigated the nurses for striking because nursing was a “calling” and not a job.

Here is the tricky question: is the labour offered by all health workers divinely ordained, as suggested by the then Minister, or do professionals, like everyone else, follow the market? Professionals sell their labour for a commensurate value and, in the case of the health workers embarking on strike action, the strike was a consequence of an imbalance in this regard.

Important social and economic debates arise as a result of this divide in how the medical profession is perceived: as a spiritual injunction or is it no more or less like any other labour that is subject to the forces of the market? It is notable that other developing countries also struggle to understand the role of the medical profession as agents for social change. It is being questioned whether a critical comment made by one of India’s foremost sociologists almost three decades ago is still relevant: “An outstanding characteristic (of medical professionals in India) is their self-centredness, the overriding concern for their own ambitions and frustrations… Their involvement in community affairs is limited.” However, it is acknowledged that medical practitioners “are also powerless in many subtle and insidious ways. Remunerative career pathways in government service are hard to come by, and the private sector, driven by commercialisation of medicine, offers little by way of intellectual or ideological sustenance.” The frustrations faced in India in respect of its health care delivery models are similar to South Africa or, for that matter, any other developing nation.

† Rule 18 of the Ethical Rules provides that only an employer approved by the HPCSA may employ a practitioner, and that such employment must be in terms of a written contract of employment and made available to the HPCSA at its request.
It begs the question whether these comments are relevant to medical practitioners in South Africa today. To attract and retain medical practitioners, undoubtedly the bedrock of any health care delivery service, adequate financial and professional rewards must be provided. If these do not exist, the reality is that these professionals will either leave the profession or migrate to a jurisdiction where adequate rewards are provided. As Jeffery Sachs notes, “global science is directed by the rich countries and for the rich-country markets, even to the extent of mobilising much of the scientific potential of the poorer countries.”

If governments and, for that matter, private entities, wish to retain their medical practitioners they must offer adequate benefits. If they cannot, medical practitioners are obliged to seek better opportunities. The unfortunate reality is that dramatic appeals to patriotism and divine callings will always be trumped by cold hard cash.

So, if medical practitioners are expected to be subjected to the dynamics of employment, their strength at the bargaining table must also be appreciated by any prospective employer.

THE ECONOMICS OF HEALTH CARE

The economics of health care are influenced by mortal behaviour. The laws of supply and demand for health care do not conform to classical interpretation. The common rules of economics do not apply when an exchange occurs between a party with a monopoly of information, knowledge and skills, and a fearful human of fragile mortality. As a result of the scarcity of skills and knowledge, medical practitioners enjoy an inordinate level of social and cultural power, translating into the concentration of enormous economic power. Scarcity drives up costs and there is a natural predilection to hold onto such knowledge, which in turn creates distortions in the markets and, in particular, to costs. There is therefore an undeniable logic to maintain the status quo in order to preserve the elevated social, cultural and economic positions of medical practitioners. This maintenance, whether intentional or not, manifests in measures such as the illogical selective prohibition of the employment of medical practitioners by non-medical practitioners.

Some of the risks inherent in a restrictive approach to the health care market is the uneven distribution of benefits, regulatory incoherence, the goal of competitors to be uncompetitive, and the potential of rapacious profiteering by health care providers (including medical practitioners, administrators of medical schemes, pharmaceutical companies, brokers of medical insurance and hospital groups) in the face of scarce resources underpinned by the scourge of crony capitalism.

In order to balance the risks, it has been postulated that the success of the global capitalist system is dependent on the entrenchment of social justice and democracy. A market economy, therefore, needs institutions to serve such social goals as political freedom and social justice, otherwise, social upheaval will be the inevitable consequence as marginalised people are pushed to the wall when these risks materialise.

HEALTH CARE FINANCING

The central proposition on the financing of health care in Africa, or anywhere else for that matter, rests on the question: who pays? The answer must be found in the context of the global forces that shape local responses to health care.

The global health care market needs to serve roughly seven billion people, making it one of the most universal industries on the planet. Markets reduce everything, including human beings (labour) and nature (land and health) to commodities. In 2011/12 South Africa spent about R258.4 billion (8.6% of GDP) on health care services – with an almost equal split between public and private health care expenditure (albeit only approximately 20% of the population is privately insured).

Public and private funders

The divide between the public and the private health care sector also informs the manner in which health care is financed.

- There is currently no formal health care financing in the public sector; however, it is the intention of the Department of Health to introduce NHI.
- In contrast, there is health care financing in the private sector in the form of medical scheme insurance and health insurance policies. The conventional medical scheme financing model in the private sector has, however, come under fire as being prohibitively expensive for a large part of the country’s population, and accusations being made of rapacious profiteering at the expense of cutting costs of service providers such as medical practitioners.

A unique South African development as a funding alternative

- An interesting trend has developed over the decades, as a result of the inability of black people to access adequate public health care systems under the apartheid regime, and an overburdened and inadequate public health care system since 1994. The private sector (in particular, the large industrial and mining companies) have organically developed an autonomous and affordable health care delivery system for their workforces in the guise of the health maintenance organisation staff model (the “HMO staff model”). This model developed as a consequence of employers’ occupational health legal obligations towards their employees.
- Conventionally, employers only played a role in funding health care in the private health care sector by participating in medical schemes for their employees.
- In order to address the perceived inadequacies of both public and conventional private health care, employers have gradually taken on the role of both health care funder and provider. This phenomenon has, for various legal, political, social and historical reasons, been most pronounced in the mining and industrial sectors.
- Such employers need a healthy workforce, which translates into better production and greater profitability. Employers have responded by developing a unique system of health

‡ Notwithstanding the planned NHI initiative, the budget of the country provides for the allocation of funds to deliver health care services through various public health care facilities throughout the country.
The underlying principle of the HMO staff model is that adequate and appropriate health care can only be delivered through the scrupulous control of costs, of which the direct employment of medical practitioners and ownership of other essential suppliers of health services (such as hospitals, pharmacies and, in some instances, the formation of closed medical schemes and ownership of managed care organisations) plays an important role.

CONCLUSION

Health care reform must, as a central principle, decisively resolve the issue of the power of the HPCSA to selectively prohibit the right of a non-medical practitioner entity to employ medical practitioners. In light of the impending NHI, how can the HPCSA sustain any coherent argument for the selective prohibition of the employment of medical practitioners if, indeed, a NHI has to apply evenly across both the public sector, where doctors are employed, and the private sector, where doctors are not? This obvious disparity provides NHI with an unfair competitive advantage over the private sector funders. Hopefully, this issue will be fully ventilated at the impending Competition Commission Inquiry. The stance of SAM in this regard is also odd. On the one hand, it advocates the prohibition of the employment of doctors in the interests of their duty of care to patients, yet has no issue with any ethical dilemma faced in this regard by medical practitioners employed by public institutions. Furthermore, it also affiliates itself as a labour union to Cosatu. These contradictions are yet to be explained.

The HPCSA’s role to protect the public against pernicious behaviour of medical practitioners is important. However, the quick fix selective prohibition on employment by the HPCSA appears to be an antithesis to this role as it can be construed as coddling the very medical practitioners the HPCSA is charged with monitoring, from the dynamics of the market. The stance also has the following consequences: it distorts the market and creates unfair competition advantages for some role players, it does not necessarily prevent the harm that the HPCSA seeks to prevent, it frustrates the dire need to contain unsustainable rising health costs in this country, it hinders access to adequate and affordable health care by marginalised sectors of our society, it denudes medical practitioners of their rights to choose whether they want to be employed or not, and it hinders the development of alternative competitive (and potentially low cost) health care financing models.

The tried and tested HMO staff model, if implemented efficiently, has the potential to fill the gaps left by public and private health care, thus contributing to the health and, ultimately, the wealth of South Africa as it benefits one of the most disadvantaged parts of the labour force in this country. This cannot be over-emphasised. The health delivery systems in the mining and industrial sectors bear testament to the real possibility that health care costs can be contained and that access to superior health care, even by the most marginalised sectors of the South African community, can be achieved through the implementation of these models. The affordability of these models is, however, premised on the employment of medical practitioners. If left unchallenged the selective prohibition of employment of medical practitioners by the HPCSA and SAMA’s support thereof pose a significant threat to the HMO staff models adopted by the mining and industrial companies, especially post-Marikana, a blot on the country’s history that epitomised the need for decent benefits for disaffected workers. The HMO staff model should therefore be encouraged, allowed to evolve and not be stifled by short-sighted policies that are basically protectionist in their nature.

The fact is that global market forces will determine the evolution of the debate. Whether one agrees with it or not, the sooner we all realise that the health care industry is just a market and that human capital in health care is scarce, highly trained and utterly mobile, the sooner the debate will be elevated to another level.

Private sector employers, government, medical practitioners, medical schemes and health care insurers, hospital groups, the HPCSA, the Board of Health Care Funders, the Council for Medical Schemes, SAMA, other role-players in the health care industry, employees and the public in general, cannot afford to ponder this debate as the global economy is determining the trend. There are no compelling reasons as to why medical practitioners should not be employed and why their labour, like any other labour, should not be subject to market forces of supply, demand and competition.

Ms Zeenat Dasoo is a partner at Webber Wentzel in alliance with Linklaters. She practices in the Mergers and Acquisitions department and her focus areas include corporate work for health sector clients.

REFERENCES