



Policy Document

On

Business Practices

As at 26 October 2016

TABLE OF CONTENTS

1	INTRODUCTION	4
2	PRINCIPLES OF BUSINESS MODELS	4
2.1	ACCEPTABLE BUSINESS MODELS.....	4
2.2	UNDESIRABLE CORPORATE OWNERSHIP	4
(I)	TRANSFERRING THE INCOME STREAM (OR ANY PART THEREOF) GENERATED IN RESPECT OF PATIENTS FROM THE PRACTICE TO SUCH A PERSON; OR.....	4
(II)	GIVING (DIRECTLY OR INDIRECTLY) SHARES OR AN INTEREST SIMILAR TO A SHARE IN THE PROFESSIONAL PRACTICE TO SUCH A PERSON; OR	4
(III)	TRANSFERRING INCOME OR PROFITS OF THE PROFESSIONAL PRACTICE TO A SERVICE PROVIDER THROUGH PAYMENT OF A FEE WHICH IS MORE THAN A MARKET RELATED FEE FOR THE SERVICES RENDERED BY THE SERVICE PROVIDER.....	5
(IV)	PAYING OR PROVIDING A SERVICE PROVIDER WITH SOME OR OTHER BENEFIT WHICH IS INTENDED OR HAS THE EFFECT OF ALLOWING THE SERVICE PROVIDER OR PERSONS HOLDING AN INTEREST IN SUCH A SERVICE PROVIDER TO SHARE, DIRECTLY OR INDIRECTLY, IN THE PROFITS OR INCOME OF SUCH A PROFESSIONAL PRACTICE OR TO HAVE AN INTEREST IN SUCH A PROFESSIONAL PRACTICE.....	5
2.3	CORPORATE INVOLVEMENT	5
2.4	EMPLOYMENT OF PRACTITIONERS	5
3	APPENDIXES	6
3.1	FRANCHISES	6
3.2	MANAGED CARE	7
3.2.1	GATEKEEPERS.....	7
3.3	CLINICAL ADVISORS	7
3.4	SPECIFIC ISSUES	7
3.4.1	ACCESS TO CONFIDENTIAL INFORMATION	8
3.4.2	ACCOUNTABILITY (LIABILITY)	8
3.4.3	CLINICAL GUIDELINES	8
3.4.4	CONTRACTS.....	8
3.4.5	COST-SAVING BENEFITS	8
3.4.6	CREDENTIALING AND ACCREDITATION OF PROVIDERS	9
3.4.7	DISCLOSURE	9
3.4.8	FINANCIAL INCENTIVES	9
3.4.9	FORMULARIES	9
3.5	GROUP PRACTICES	9
3.6	PREFERRED PROVIDER NETWORKS	10
3.7	QUALITY OF CARE	10
3.8	RESTRICTION OF CHOICE	10
3.9	RISK-SHARING	10

3.10	SHARING OF FEES	10
3.11	UTILISATION MANAGEMENT	11
3.11.1	PRE-AUTHORISATION	11
3.11.2	CASE MANAGEMENT	11
3.11.3	PROFILING	11
4	COMMITTEE TO CONSIDER UNDESIRABLE BUSINESS PRACTICE ISSUES	12
5	HOSPITAL REGULATION.....	ERROR! BOOKMARK NOT DEFINED.

1 INTRODUCTION

As a result of the changing socio-economic environment in South Africa and its impact on the provision of health care in the country, the need arose for the Health Professions Council of South Africa (HPCSA) to determine what may be regarded as acceptable business practices in the health-care sector in order to protect the public. This document is therefore an exposition of some of the areas that continually beset the health care industry and affect the professional practices of practitioners registered with Council.

This document forms part of the many policy directives on ethical conduct and professional practice and thus an integral part of the Regulations Specifying Acts/Omissions in Respect of Which Disciplinary Measures May be instituted against health care practitioners registered with the HPCSA.

2 PRINCIPLES OF BUSINESS MODELS

In terms of current legislation there are a number of desirable business models and some undesirable business models.

2.1 ACCEPTABLE BUSINESS MODELS

- Solo Practice
- Partnerships/Groups/Organisations
- Associations
- Personal liability companies (incorporated practices – Inc.)
- Franchises (subject to compliance with the ethical rules)

Any of the above who outsourced their administration or established a company to manage the administration provided that such arrangement is not in violation of the established ethical rules of Council.

Any other business model/formation or structure outside of these models must come to HPCSA for consideration or approval by the HPCSA

2.2 UNDESIRABLE CORPORATE OWNERSHIP

A person (whether a natural person or a juristic person) who is not registered in terms of the Act and in accordance with the Ethical Rules, does not qualify to directly or indirectly, in any manner whatsoever, share in the profits or income of such a professional practice and which, without limiting the generality of the foregoing, may take the form of:

- (i) transferring the income stream (or any part thereof) generated in respect of patients from the practice to such a person; or
- (ii) giving (directly or indirectly) shares or an interest similar to a share in the professional practice to such a person; or

- (iii) transferring income or profits of the professional practice to a service provider through payment of a fee which is not a market related fee for the services rendered by the service provider.
- (iv) paying or providing a service provider with some or other benefit which is intended or has the effect of allowing the service provider or persons holding an interest in such a service provider to share, directly or indirectly, in the profits or income of such a professional practice or to have an interest in such a professional practice.

Direct or indirect corporate ownership of a professional practice by a person other than a registered practitioner in terms of the Act is **not permissible**.

2.3 CORPORATE INVOLVEMENT

Corporate Involvement means the provision of services by corporate entities, (whether of a financial, administration, legal, rental or similar nature) to a professional practice in terms of an agreement (other than a simulated agreement) negotiated on an arms-length basis and in terms of which an objectively determined market related and fair remuneration or fee is payable by the professional practice to the entity or such other person for the services rendered.

All health care practitioners should at all times act in the best interest of the patient and place the clinical needs of the patient paramount. To this end, a health care professional should always try to avoid potential conflict of interests and maintain professional autonomy, independence and commitment to the appropriate professional and ethical norms. Any conflict of interests or incentive or form of inducement which threatens such autonomy, independence or commitment to the appropriate professional and ethical norms or which does not accord first priority to the clinical need of a patient, is unacceptable.

Corporate involvement is permissible on the following conditions:-

- (i) ethical rules and policies of HPCSA are complied with;
- (ii) practitioners take full responsibility for the compliance of the corporate unregistered party with the ethical rules and policies of Council;
- (iii) practitioners are not able to hide behind the corporate veil but are able to take individual responsibility for all business transactions and operations of the business;
- (iv) no provision is made for hiving off fees to a corporate entity;
- (v) no coercion by corporate entities on practitioners to enter into arrangements that would violate ethical rules.

2.4 EMPLOYMENT OF PRACTITIONERS

Generally the employment of practitioners by persons not registered in terms of the Act is not permissible; however the following employment agencies are recognised for the purposes of employing practitioners that are registered under the Health Professions Act:

- (i) The Public Service;
- (ii) Universities / Training Institutions (only limited for purposes of training and research);

- (iii) Mining companies & NPO's/NGO's (subject to approval of the relevant professional board);
- (iv) All registered persons within the HPCSA may also employ fellow registered practitioners in accordance with the Ethical rules.

Any other agent; institution; person may lodge an application with the HPCSA for the purposes of employment of a practitioner registered with the Health Professions Council save that any other employment which falls beyond the professional practice is not required to lodge an application with the HPCSA.

If employment of practitioners is approved, applications for employment should be carefully considered taking the following criteria into consideration:

1. **Motive or Goal:** This should indicate the reason for employment.
2. **Service to specific groups of people:** Such as non- profit, charitable and similar organisations. Private Hospitals should not be allowed to employ because of a profit motive.
3. **Training of students:** Such as at Universities set out above.
4. **Clinical independence of practitioner:** Practitioners should refrain from engaging in practices that would compromise patient care or in services not indicated in order to acquire financial or material benefit. No un-due influence should be exerted on practitioner to compromise his clinical independence.
5. **Method of remuneration:** There should be no Perverse Incentives. Undesirable practice enriching a practitioner either financially or in kind at the cost of a payer for professional practice with no evidence based scientific basis or cost effective considerations.

Furthermore, all employing institutions should be accredited by the HPCSA subject to the condition that the practitioner's clinical independence is not violated by the employing body and that the employing body also does not exploit the practitioner or make the practitioner to violate Council ethical rules.

3 APPENDIXES

3.1 FRANCHISES

The definition of a Franchise is as follows:

“A franchise is a system in which one organisation (“Franchisor”) grants the right to produce, sell or use a developed product, service or brand to another organisation or person or group of persons (“Franchisee”). Royalties based on either turnover or contractually agreed to be paid by the Franchisee. The Franchisee agrees to comply with the Franchisor’s policies in respect of buying, marketing, and management. The Franchisor may offer advertising and back-up services”.

A franchise implies the sale of exclusive rights to the franchisee and in general is also dependant on advertising of the franchise. Practitioners engaging in franchise arrangements of health care services may potentially transgress one or more or all of the following ethical rules:

- Rule 3: Advertising**
- Rule 3: Canvassing and touting**

Rule 4:	Naming of practice
Rule 8:	Information on professional stationary
Rules 7:	Fees and commissions
Rule 8:	Partnership
Rule 16:	Professional secrecy
Rule 18:	Professional appointments
Rule 20:	Consulting rooms
Rule 22:	Exploitation
Rule 30:	Performance of Professional Acts

Franchising per se is not prohibited; however, a practitioner shall not practise in any form of business which has inherent requirements that violates one or more ethical rules of HPCSA regard being had to the ethical rule on the naming of practices as recorded in the ethical rules of the Council.

3.2 MANAGED CARE

Practitioners may engage in managed care models, group practices, preferred provider networks or any other such models provided that their involvement does not result in them violating the Act, ethical rules and guidelines. Practitioners involved in these models including those in clinical and non-clinical practice (including clinical advisors) must at all-time act in the best interest of patients.

The following principles are resolved upon:

- (i) Professional independence should be inviolate;
- (ii) Harmonisation of regulatory frameworks amongst the different role-players in the managed health care field and professional conduct regulation so that no single party allows for violation of ethical rules of HPCSA;

3.2.1 GATEKEEPERS

It is acceptable (perhaps preferable) for medical schemes to require their members to select a general practitioner as gatekeeper to coordinate their health care needs. Members should however be allowed on an ongoing basis to select a new 'gatekeeper' from a panel of doctors and to appeal to the scheme in the event of dissatisfaction with services provided.

3.3 CLINICAL ADVISORS

The HPCSA does not condone intervention from clinical advisors in the management of patients. If there is such intervention, the advisors share the responsibility for the well-being of the patient;

3.4 SPECIFIC ISSUES

In addition to aspects covered by the Regulations to the Medical Schemes Act, the HPCSA regards it necessary to express an opinion on the following issues, which are pertinent to a system of managed health care.

3.4.1 ACCESS TO CONFIDENTIAL INFORMATION

Access to confidential health care information about a patient by a third party requires the informed consent of a patient, his/her parent/guardian, executor of the estate/next-of-kin or curator as required by law.

Practitioners must guard against the rights of individuals being eroded by the possibility of payment being withheld on the basis of non-disclosure.

3.4.2 ACCOUNTABILITY (LIABILITY)

Providers are required to treat their patients with reasonable skill and care. It is advisable that where a provider's recommendation regarding the treatment options of a patient differs from that of the medical scheme or managed care organisation, such recommendation(s) must be submitted to the patient in writing to enable the patient to make an informed decision as to the treatment path to be followed.

In those instances where decisions of medical schemes or managed care organisations acting on their behalf are not in the patient's best interest and the patient suffers harm as a result thereof, liability should also accrue to the medical scheme.

3.4.3 CLINICAL GUIDELINES

The medical protocols, clinical guidelines and review criteria used by medical schemes and managed care organisations must be developed by healthcare practitioners according to scientific criteria.

These guidelines should not be dictated or influenced by managers of HMO organisations whose primary objective is cost-saving.

3.4.4 CONTRACTS

Providers should ensure that legal, ethical and clinical norms are adhered to in managed care contracts. The aim should be to strive towards evidence based medicine and ethical behaviour for the benefit of the patient.

It would not be permissible to enter into contracts that transgress the Ethical Rules or affect the clinical independence and judgement of practitioners.

3.4.5 COST-SAVING BENEFITS

It is acceptable for providers to be rewarded for delivering quality cost-effective care and saving of cost by educating patients to live healthy lives. However, any cost saving benefits achieved should ultimately be passed on to the patient as the primary sponsor of his/her own care.

Incentives can for instance be given for using evidence based medicine and also ensuring no under or over-servicing of patients.

Cost saving rewards should be subject to independent audit.

3.4.6 CREDENTIALING AND ACCREDITATION OF PROVIDERS

Credentialing and accreditation of providers is acceptable provided that both processes are based on objective and transparent criteria such as professional competency, professional qualifications, experience, etc.

3.4.7 DISCLOSURE

Providers must inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage.

3.4.8 FINANCIAL INCENTIVES

Perverse Incentives

Enriching a practitioner either financially or in kind with no evidence based of scientific basis or cost effective considerations is undesirable.

Financial incentives should only be used to promote quality and cost-effective care and not to encourage the withholding of medically necessary care. Providers should not allow financial incentives to influence their judgements of appropriate therapeutic alternatives or deny their patients access to appropriate services based on such inducements. Their patients' interests must always come first.

Incentive payments to providers should rather be based on performance according to criteria that are founded in best practice and ethical behaviour of individuals.

Incentives may not be used to encourage either 'over' or 'under' servicing of patients. Appropriate care should be provided at all times.

Reference should be made to Item 3.7 of Policy Statement pertaining to Perverse Incentives and related matters for Health Care Professionals (Booklet 7).

3.4.9 FORMULARIES

Formularies or restricted medicine lists should be based on best practice principles, also taking account of cost-effectiveness. Financial benefits to providers according to prescriptions based on volume and/or price of formulary medicines are not acceptable. Providers are in particular reminded of the HPCSA's perverse incentive policy in this regard.

3.5 GROUP PRACTICES

With regards to group practices, Practitioners should have regard to Rule 8 (3) of the Ethical Rules which provides that:

“ A practitioner shall practise in partnership, association or as a juristic person only within the scope of the profession in respect of which he or she is registered under the Act”.

The restriction Rule 8(3) does not apply to the following professions:

- (i) A Pathologist forming an incorporated practice (Personal Liability Company) , partnership or association with a Medical Technologist
- (ii) A Radiologist forming an incorporated practice, partnership or association with a Nuclear Physician or Radiographer.

3.6 PREFERRED PROVIDER NETWORKS

Providers should have the right to participate in any preferred provider network if it meets the criteria of professional qualifications, competence and quality of care.

Council policy states that these networks should not be exclusive – that all providers must have the option of being included unless compelling reasons for exclusion exists.

3.7 QUALITY OF CARE

In any health care delivery system the emphasis should always be on providing quality care to patients in the most cost-effective way possible. Quality based on best practice may not be sacrificed in the interest of cost. However, quality must be seen in the context of affordability. Quality assurance measurements must be introduced.

3.8 RESTRICTION OF CHOICE

In an ideal health care system, choice should be maximised as it enhances competition. It is however acknowledged that restrictions on the choice of providers, treatment options and/or referrals may be necessary in the interest of access to health care services provided that quality of care is not sacrificed. It is advisable that a 'point of service' option is offered to patients, even at additional cost to the patient, to allow the patient to consult a provider of choice.

3.9 RISK-SHARING

Risk-sharing options between medical schemes and providers, such as capitation, are slowly gaining popularity. This is inherent to managed care provision. Both providers and patients should be thoroughly informed about the risk they assume and should ensure that adequate mechanisms are in place to manage the risk. Philosophically it means that patients must be kept as healthy as possible i.e. education and preventive measures.

Inherent in prepayment arrangements is the risk of 'under servicing'. Therefore utilisation review, practice profiles and peer review methodologies are prerequisites.

Thus the HPCSA needs to revisit its position on prepayment policies.

All managed care contracts providing for incentive withholds, i.e. payments for a certain percentage of generic prescriptions - and for payment of fees to providers, should include provisions for an independent audit to ensure timely reimbursement of withholds. The audit should also review whether the amount withheld is appropriate, reasonable and in keeping with the terms of the contract.

3.10 SHARING OF FEES

Corporate entities (big business) are gradually entering the health care arena not only as funders of care, but they are also becoming involved in the delivery of care. This will increasingly challenge the

entrenched values of health care practice. Providers should be sensitive to these developments and ensure that the values inherent to health care practice are not sacrificed and their clinical autonomy not affected by these developments.

These corporate entities typically provide certain management services and infrastructure to providers in return for financial reward, which often amounts to a percentage of turnovers. Examples exist where providers receive a percentage of fees billed in return for these services as well as paying a percentage of the debtors' book to debt collectors for the collection of professional fees. Such arrangements are regarded as transgressing the ethical rule prohibiting the sharing of fees between a practitioner and a person who did not render a commensurate part of the services (dichotomy). Charges levied for these services should be on a previously agreed rate and not based on a percentage of the income of the practitioner. That agreed rate may not be based on commission or income.

There is a difference between voluntary arrangements from which the provider can withdraw if he so wishes and one where his position is dependent on his continued compliance with the organisation's requirements. The latter is not acceptable.

3.11 UTILISATION MANAGEMENT

The medical protocols, clinical guidelines and review criteria used by medical schemes and managed care organisations must be developed by providers according to scientific criteria.

The following processes form part of utilisation management.

3.11.1 PRE-AUTHORISATION

Pre-authorisation procedures should be conducted according to scientifically developed protocols (clinical guidelines) and should include peer-to-peer communication prior to any denial of benefits. The pre-authorisation process should also be a prompt and efficient process. An appeals process should be available for any provider disagreeing with the medical scheme's/managed care organisation's decision.

3.11.2 CASE MANAGEMENT

It is acceptable that one person assumes the responsibility of the overall coordination of the patient care. The medical doctor is best suited to fulfil this role. The utilisation of nurses to coordinate the financial arrangements of the patient, benefit management, high cost care management, as well as providing assistance with suitable alternative care arrangements on discharge is also acceptable.

3.11.3 PROFILING

Profiling of providers is acceptable provided it is done in a transparent and scientific manner. Providers should be allowed to query their personal profiles and should have the right to understand the criteria used in determining the profile.

4 COMMITTEE TO CONSIDER UNDESIRABLE BUSINESS PRACTICE ISSUES

A Committee consisting of Council members must be appointed to consider applications for employment of practitioners in terms of the criteria as set out in Item 2.3 of this document, as well as applications for shareholding as specified under 4.8. Practitioners wishing to engage in a specific business venture or employ a model that involves corporate entities and/or unregistered persons must, prior to engaging with the respective parties, apply to the Committee for approval. It is recommended that the said Committee be constituted by the following persons:

A Lawyer

A member of the affected profession

A Chairperson who should be a member of the Council

Two additional members from the Council

It is further recommended that this be a standing Committee appointed to serve for the full term of the Council.