Business Practices Policy

POLICY DETAILS	
Department	Core Operations
Division	Professional Practice
Policy	Business Practices Policy
Version	4
Date Approved	28 March 2024

Table of Contents

DEFINITIONS 1
1. INTRODUCTION 3
1.1 BACKGROUND 3
1.2 APPLICABILITY 3
1.3 NON-COMPLIANCE TO THE POLICY 3
1.4 POLICY STATEMENT 4
2. KEY ELEMENTS OF THE BUSINESS PRACTICE POLICY 4
2.1 BUSINESS STRUCTURES 4
2.1.1 ACCEPTABLE BUSINESS STRUCTURES 4
2.2 UNDESIRABLE CORPORATE INVOLVEMENT 5
2.3 CORPORATE INVOLVEMENT 5
2.4 EMPLOYMENT OF HEALTH PRACTITIONERS 6
2.5 CRITERIA TO GUIDE HEALTH PRACTITIONER ON MATTETRS RELATING TO EMPLOYMENT OR APPOINTMENT 6
3. APPENDICES 8
3.1 FRANCHISES 8
3.2 MANAGED CARE MODELS 8
3.3 GATEKEEPERS 8
3.4 CLINICAL ADVISORS 9
3.5 SPECIFIC PRACTICE ISSUES 9
3.6 GROUP PRACTICES 12
3.7 PREFERRED PROVIDERS NETWORKS 12
3.8 QUALITY OF CARE 12
3.9 RESTRICTION OF CHOICE 13
3.11 SHARING OF FEES 13
3.12 UTILISATION MANAGEMENT 14
3.13 PRE-AUTHORISATIONS 14
3.14 CASE MANAGEMENT 14
3.15 PROFILING 15

DEFINITIONS

Business practice means a business conduct of a registered health practitioner to achieve objectives of professional practice.

Business structure means a business category of an organisation or model that is legally defined and recognised.

Corporate entities mean entities not registered with the HPCSA who employ or appoint a registered health practitioner or provide health services on behalf of practitioner (whether of a financial, administration, legal, rental, or similar nature) in terms of an agreement.

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).

Corporate ownership means legal ownership of a professional practice by person not registered in terms of the Health Professions Act, 1974 (Act No. 56 of 1974).

Ethical rules mean the ethical rules of conduct for registered practitioners made in terms of the Health Professions Act, 1976 (Act No. 56 of 1974).

Franchise is defined as 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 for the Franchisor are 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.

Gatekeeping means a process by which healthcare practitioner determine a patient's appropriate level of care. In healthcare, primary care physicians or general practitioners ordinarily serve in the gatekeeper role, providing access to specialists and coordinating patient care. The gatekeeper model in healthcare refers to the use of primary care physicians as a

point of entry into the healthcare system. Gatekeeping has crucial influences on service utilisation, health outcomes, healthcare costs, and patient satisfaction.

Health Market Organisations (HMO) means organisations which provide health insurance services that usually limit coverage of care for health practitioner who work for, or contract with HMOs. They generally exclude cover for out-of-network providers.

Health Commercial Organisation (HCO) means an organisation which trades health or health related goods and services on the open market and includes but is not limited to hospital groups.

Health practitioner means a person registered as such under the Health Professions Act, 1974 (Act No. 56 of 1974) and, in the application also a juristic person exempted in terms of Section 54A of the Health Professions Act, 1974 (Act No. 56 of 1974).

The Act means the Health Professions Act, 1974 (Act No. 56 of 1974).

Private practice means the practice of a health practitioner who practises on his or her own account, either in solus practice, or as a partner in a partnership, or as an associate in an association with other practitioners, or as a director of a company approved in terms of section 54A of the Health Professions Act, 1974.

Professional Practice means a practice where registered health practitioner utilise specialised knowledge, critical inquiry, skills and evidence-informed decision making; continuous development of self and others, accountability, responsibility for insightful competent practice; demonstration of a spirit of collaboration and flexibility to optimise service and practice that reflects the commitment to caring relationships with patients and families and strong ethical values.

Public service means a service rendered by the state at the national, provincial or local level of government and includes organizations which function under its auspices or are largely subsidized by the state.

1. INTRODUCTION

1.1 BACKGROUND

1.1.1 As a result of the changing socio-economic environment in South Africa and its impact on the provision of healthcare 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 healthcare sector in order to guide health practitioners and to protect the public. This document is an exposition of some of the areas that continually beset the healthcare industry and affect the professional practice of the health practitioners registered with the Act.

1.1.2 This document forms part of the many policy directives on ethical conduct and professional practice and thus is an integral part of the regulations specifying acts/omissions in respect of which disciplinary measures may be instituted against health care practitioner registered with the HPCSA.

1.2 APPLICABILITY

This policy applies to all health practitioners registered with the Health Professions Council in terms of the Act.

1.3 NON-COMPLIANCE TO THE POLICY

1.3.1 Failure by a health practitioner to conduct herself/himself in line with the provisions of this policy shall constitute an act or omission in respect of which the professional board concerned may take disciplinary action in terms of Chapter IV of the Act, following an inquiry.

1.3.2 At an inquiry, the board concerned will be guided by the ethical rules, its annexures, ethical rulings or ethical guidelines and these policy provisions, or any statement or directive Council makes from time to time.

1.3.3 All health practitioners are required to comply with this policy.

1.4 POLICY STATEMENT

1.4.1 The Council is committed to providing support and guidance to health practitioners on matters relating to business practices.

1.4.2 This policy is developed to align with the Act, its rules, regulations and it is in line with the acceptable best practices aimed to guide the professions to ensure the protection of the public.

2. KEY ELEMENTS OF THE BUSINESS PRACTICE POLICY

2.1 BUSINESS STRUCTURES

2.1.1 Acceptable Business Structures

2.1.1.1 The following business structures are generally accepted by the HPCSA:

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

2.1.1.2 For professional practice, health practitioner is not permitted to embark on any other business formation or structure outside of the defined above. In this regard, the HPCSA may need to be approached for advice and guidance.

2.1.1.3 A health practitioner may outsource the administration or establish a company to manage the administration of her/his business provided that such arrangement is not in violation of the established ethical rules of the Council.

2.2 UNDESIRABLE CORPORATE INVOLVEMENT

2.2.1 A person (whether a natural person or a juristic person) who is not registered in terms of the Act 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.
ii) giving (directly or indirectly) shares or an interest similar to a share in the professional practice to such a person.
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.

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

2.3 CORPORATE INVOLVEMENT

2.3.1 An agreement for corporate involvement with professional practice should be negotiated on an arms-length basis in terms of which an objectively determined market related and fair remuneration is established.

2.3.2 All health practitioners must always act in the best interest of their patient/s and place the clinical needs of their patient/s as paramount. To this end, a health practitioner should always avoid potential conflict of interest and maintain professional autonomy, independence, and commitment to applicable professional and ethical norms. Any conflict of interest 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 priority to the clinical need of a patient, is unacceptable.

2.3.3 Corporate involvement is permissible under the following conditions:

i) ethical rules and policies of the Council to be complied with.
ii) health practitioner should take full responsibility for the compliance of the corporate unregistered party with the ethical rules and policies of the Council.
iii) health practitioner should not hide behind the corporate veil but should take individual responsibility for all business transactions and operations of the business.
iv) no hiving off of fees to a corporate entity.
v) no coercion by corporate entities on practitioners to enter arrangements that would violate the ethical rules.

2.4 EMPLOYMENT OF HEALTH PRACTITIONERS

2.4.1 Health practitioner registered with the Council may employ fellow registered health practitioner in accordance with the provisions of ethical rules.

2.4.2 Should a health practitioner wish to be employed or appointed by any unregistered entity, agency, agent, institution, or person, such employment or appointment should be aligned with the interests of the professions and the public.

2.4.3 It is the responsibility of the health practitioner to evaluate that the prospective contract of employment is suitable for conducive ethical and professional practices in accordance with ethical rule 18.

2.5 CRITERIA TO GUIDE HEALTH PRACTITIONER ON MATTETRS RELATING TO EMPLOYMENT OR APPOINTMENT

2.5.1 Registered health practitioner may use the following criteria as a guide to determine if the prospective employment or appointment offered is aligned with the interest of the profession and the public: -

a) Motive or Goal

The reason/s or motive for employment should not be about primarily extracting financial benefits to the detriment of the public.

b) Service to specific groups of people

The employment relationship or appointment should strive to serve the needs of citizens, for example, a non-profit, charitable and similar organisations.

c) Clinical independence of health practitioners

The health practitioner should be satisfied that the employer will place sufficient measures to mitigate business practices that would compromise patient care or promote the provision of services for the primary purpose of acquiring financial or material benefit. The health practitioner should also check that the employer mitigates against undue influence and exertion that may compromise his/her clinical independence.

d) Method of remuneration

A health practitioner should ensure that potential ethical transgressions, such as perverse incentive is avoided. Practices that enrich a health practitioner, or a private hospital either financially or in kind at the cost of a payer or patient with no scientific evidence or cost-effective considerations are not acceptable.

e) Clinical governance

A health practitioner should ensure that the employer’s offer includes sufficient measures of how the professional autonomy of the health practitioner will be maintained in order to make independent clinical decisions without undue interference.

f) Peer review mechanisms

Health practitioner should check how the internal peer review mechanisms are structured, constituted, governed and supported by evidence-based practices.

3. APPENDICES

3.1 FRANCHISES

3.2 A franchise implies the sale of exclusive rights to the franchisee and in general is also dependant on advertising of the franchise. Health practitioner engaging in franchise arrangements of healthcare services should guard against practising in any form of business which has inherent requirements that violate ethical rules. These include but are not limited to: Rule 3: Advertising, Rule 4: Professional Stationery, Rule 5: Naming of practice, Rule 6: Itinerant practice, Rule 7: Fees and commissions, Rule 8: Partnership, Rule 8A: Rooms, Rule 18: Professional appointments, Rule 19: Professional secrecy, Rule 21: Performance of professional acts, Rule 22: Exploitation, etc.

3.3 MANAGED CARE MODELS

3.3.1 Health practitioner 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.

3.3.2 Health practitioner involved in these models including those in clinical and non-clinical practice (even as clinical advisors) must at all-times act in the best interest of patients. In this regard, they should adhere to the following principles:

3.3.2.1 Non-violation of professional independence.

3.3.2.2 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 the Council.

3.3 GATEKEEPERS

3.31 It is acceptable (perhaps preferable) for medical schemes to require their members to select a general practitioner as a coordinator for their healthcare services. Members

should however be allowed on an ongoing basis to select a ‘gatekeeper’ from a panel of health practitioners and to appeal to the scheme in the event of dissatisfaction with services provided.

3.4 CLINICAL ADVISORS

3.4.1 The Council does not condone interventions from clinical advisors in the management of patients. Nevertheless, clinical advisors are required to be registered with Council or with any healthcare statutory body in South Africa.

3.5 SPECIFIC PRACTICE ISSUES

3.5.1 In addition to aspects covered by the regulations to the Medical Schemes Act, the Council regard its necessary to express an opinion on the following issues, which are pertinent to a system of managed health care.

3.5.1 Access to Clinical Information

3.5.1.1 Access to confidential healthcare information about a patient by a third party requires the informed consent of the patient, his/her parent/guardian (if the patient is a minor), executor of the estate/next-of-kin or curator as required by law.

3.5.1.2 Health practitioner must guard against the rights of individuals being eroded by the possibility of payment being withheld because of non-disclosure.

3.5.2 Accountability (Liability)

3.5.2.1 Health practitioner is required to treat their patients with reasonable skill and care. It is advisable that where a health practitioner’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.

3.5.2.2 In those instances where decisions of medical schemes or managed care organisations 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 involved.

3.5.3 Clinical Guidelines

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

3.5.3.2 These guidelines should not be dictated or influenced by managers of HMO.

3.5.4 Contracts

3.5.4.1 Health practitioner 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.

3.5.4.2 It is not permissible for health practitioner to enter contracts that transgress the ethical rules or affect the clinical independence and judgement of a health practitioner.

3.5.4.3 Contracts entered with registered health practitioner shall be produced when requested by the Council.

3.5.5 Cost Saving Benefits

3.5.5.1 It is acceptable for health practitioner to be rewarded for delivering quality cost-effective care and saving of costs 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.

3.5.5.2 Incentives can, for instance, be given for using evidence-based medicine and ensuring no under or over-servicing of patients. Cost saving rewards should be subject to independent audit.

3.5.6 Credentialing and Accreditation of Providers

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

3.5.7 Disclosures

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

3.5.8 Financial Incentives

3.5.8.1 Enriching a health practitioner either financially or in kind with no evidence based or scientific basis or cost-effective considerations is undesirable. Financial incentives should only be used to promote quality and cost-effective care and not encourage the withholding of medically necessary care. Health practitioner 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.

3.5.8.2 Incentive payments to health practitioner should 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 always be provided. Reference should be made to the policy statements ad guidelines pertaining to perverse incentives and related matters for health care professionals (that is Booklet 11).

3.5.9 Formularies

3.5.9.1 Formularies or restricted medicine lists should be based on best practice principles, that also consider cost-effectiveness.

3.5.9.2 Financial benefits to providers according to prescriptions based on volume and/or price of formulary medicines are not acceptable. Health practitioners are reminded of the Council's perverse incentive policy in this regard.

3.6 GROUP PRACTICES

3.6.1 With regards to group practices, health practitioner should have regard to the ethical rules of conduct for registered practitioners. For example, the general restriction for partnerships in ethical rule 8 does not apply to the following professions:

3.6.1.1 A Pathologist forming an incorporated practice (Personal Liability Company), partnership or association with a Medical Technologist.

3.6.1.2 A Radiologist forming an incorporated practice, partnership or association with a Nuclear Physician or Radiographer.

3.7 PREFERRED PROVIDER NETWORKS

3.7.1 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.

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

3.8 QUALITY OF CARE

3.8.1 In any healthcare 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.

3.9 RESTRICTION OF CHOICE

3.9.1 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. It is advisable that a ‘point of service’ option is offered to patients, even at additional cost to the patient.

3.10 RISK SHARING

3.10.1 Risk-sharing options between medical schemes and health practitioners, such as capitation, are slowly gaining popularity. This is inherent to managed care provision. Both health practitioner and patients should be thoroughly informed about the risk they assume and should ensure that adequate mechanisms are in place to manage the risk. Patients must be kept as healthy as possible i.e., through education and preventive measures. Inherent in prepayment arrangements is the risk of ‘under servicing’. Therefore, utilisation reviews, practice profiles and peer review methodologies are prerequisites.

3.10.2 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.

3.11 SHARING OF FEES

3.11.1 Corporate entities are gradually entering the healthcare arena not only as funders of care, but also to deliver health care. This will increasingly challenge the entrenched values of health care practice. Health practitioner 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.

3.11.2 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. Charges levied for these services should be based on a previously agreed to rate, and not based on a percentage of the income of the practitioner. The agreed rate may not be based on commission or income.

3.11.3 There is a difference between voluntary arrangements from which the health practitioner 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 model of practice.

3.12 UTILISATION MANAGEMENT

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

3.13 PRE-AUTHORISATIONS

3.13.1 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.

3.13.2 An appeals process should be available for any provider disagreeing with the medical scheme's/managed care organisation's decision.

3.14 CASE MANAGEMENT

3.14.1 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 other relevant health practitioners e.g., nurses to coordinate the financial arrangements of the patient, benefit management, high-cost care management, as well as helping with suitable alternative care arrangements on discharge is also acceptable.

3.15 PROFILING

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