



## **Policy Document**

**on**

## **Undesirable Business Practices**

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## **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 undesirable 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.

In order to establish a clear and unambiguous policy framework, it became necessary to constitute a Multi-Disciplinary Task Team to investigate and advise on a series of business practices in the health care industry. A workshop consisting of a wide range of stakeholders was then convened by the HPCSA to canvass as broad a view on these issues as possible.

### **STATUS OF THE DOCUMENT**

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 acceptable business models and some undesirable business models.

### **2.1 ACCEPTABLE BUSINESS MODELS**

- Solo Practice
- Partnerships
- Associations
- Incorporated Practices
- Any of the above who outsourced their administration or established a closed corporation to manage the administration provided that the practitioner does not permit or allow the Administrators to operate in violation of the established ethical rules of Council.

NB: Any other business model/formation or structure outside of these models is therefore unacceptable and would lead to prosecution by the HPCSA.

### **2.2 UNDESIRABLE BUSINESS MODELS**

A distinction needs to be made between corporate ownership and corporate involvement. While corporate ownership refers to transfer or acquiring of or an actual interest in a professional practice business, corporate involvement would refer to instances where a corporate entity through some equity exchange provides capital or infrastructure to the professional practice business in return for material benefit, share in profits and/or control over the manner in which the business is run.

## 2.2.1 CORPORATE OWNERSHIP / INVOLVEMENT

### a) Corporate Ownership

Direct or indirect corporate ownership of a professional practice by a person other than a registered practitioner under the HPCSA is not permissible. However, practitioners may own a professional practice business under the business models stipulated above.

### b) Corporate Involvement

Corporate involvement is permissible on the following conditions:-

- (i) ethical rules and policies of HPCSA are complied with;
- (ii) practitioners take responsibility for the compliance of the corporate unregistered partner 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.

## CORPORATE OWNERSHIP

“Corporate ownership means allowing a person (whether a natural person or a juristic person) who does not otherwise qualify as a partner or shareholder of a professional practice in terms of the Act or the Ethical Rules, 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 –

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

## CORPORATE INVOLVEMENT

“Corporate Involvement means allowing corporate entities or other persons to provide services, (whether of a financial, investment, administration, 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.”

The HPCSA holds the view that all health care professionals 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.

The ownership and use of high technology equipment creates a special problem, not only because of inappropriate use by health care professionals not duly qualified, but also due to over-servicing by appropriately qualified health care professionals. In general, problems related to the usage of high technology equipment are already covered by the relevant stipulations of this policy.

These forms of over-servicing and inappropriate care are dealt with in the Policy document on Perverse Incentives.

## **2.2.2 EMPLOYMENT OF PRACTITIONERS**

The first question should be whether it must be permissible for any person or body to employ a health care practitioner. If the answer is yes, the matter must be considered on the following basis.

In general the employment of practitioners is a complex issue which in some instances may be beneficial to patients and in others may expose patients to the same risks as referred to under corporate involvement. It is therefore suggested that employment of practitioners be decided on an *ad-hoc* basis by a committee to which reference will be made later in the document.

As a basis for considering these applications, the motive for the proposed employment should be carefully considered. If the motive is to generate income to the employer, or remunerate the employee on a fee-sharing basis, it should not be approved. A profit motive may also lead to the employee being required to reduce spending and as a result benefit from the savings, which is also not consistent with good practice.

It should however be possible for, i.e., Universities to employ practitioners to render a service to students. Also, in some instances, patients who can afford to pay for treatment received at such institutions as part of the student training programme. In such instances, where treatment is part and parcel of the clinical training of students, funds so generated should be available to the institution.

These aspects should be considered carefully in the case of managed care organisations wishing to employ practitioners.

The following employment agencies would be recognised for the purposes of employing practitioners that are registered under the Health Professions Act:

- (a) The Public Service;
- (b) Universities / Training Institutions (only limited for purposes of training and research);
- (c) All registered persons within the HPCSA may also employ fellow registered practitioners.

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.**

### 2.2.3 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 either based on turnover are usually or contractually 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. Franchises of health care services transgress one or more or all of the following ethical rules:

- |                     |  |
|---------------------|--|
| <b>Rule 1:</b>      | Advertising                            |
| <b>Rule 2:</b>      | Canvassing and touting                 |
| <b>Rule 4:</b>      | Naming of practice                     |
| <b>Rule 5:</b>      | Information on professional stationary |
| <b>Rules 6 – 9:</b> | Fees and commissions                   |
| <b>Rule 10:</b>     | Partnership                            |
| <b>Rule 16:</b>     | Professional secrecy                   |
| <b>Rule 20:</b>     | Consulting rooms                       |
| <b>Rule 23:</b>     | Exploitation                           |
| <b>Rule 30:</b>     | Performance of Professional Acts       |

**Franchising is thus not permissible at all**

### 3 MANAGED CARE

An evaluation of the South African health care environment predicts a growing focus on managed care initiatives in the future. Tools such as formularies, disease management programmes, contracts, utilisation review programmes, clinical guidelines and quality assurance programmes appear to be receiving increased attention.

Most medical schemes offer managed care options, which are restricting the choice of patients and providers to varying degrees and which are less expensive than the traditional fee-for-service options. These options are destined to grow in popularity as health care costs increase and economic realities force patients to look for more affordable health care cover.

With patients choosing managed care medical scheme options on an increasing basis, providers will have to become informed of the implications of managed care on their practices. Similarly patients will require education as to the implications of managed health care cover, especially in the event of capitation schemes.

The introduction of managed care programmes will increase the responsibility of the Health Professions Council of South Africa (HPCSA) with regard to the protection of the public interest and in guarding professional and clinical standards. This requires a review of existing ethical rules and rulings and the formulation of a policy to ensure that this responsibility is exercised. The HPCSA strongly believes that patients' needs should at all times be paramount in any system of health care delivery. **Therefore 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;**
- (iii) The HPCSA does not condone intervention from advisors and clinical management of patients, if there is such intervention, the advisors share the responsibility for the well being of the patient;**
- (iv) Scheme protocols should be harmonised with the ethical dispensation of the HPCSA.**

## **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.

### **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.

One should guard against the rights of individuals being eroded by the possibility of payment being withheld on the basis of non-disclosure. Also blanket permission for disclosure by the member on behalf of dependants is questionable. The Medical Schemes Act currently only requires schemes to take "reasonable" steps to protect confidentiality – this is considered to be inadequate protection for patients.

#### **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.

#### **4.3 CLINICAL GUIDELINES**

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

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

#### **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.

#### **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.

#### **4.6 CREDENTIALING AND AC CREDITATION 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.

#### **4.7 DISCLOSURE**

Medical schemes should at all times be required to clearly communicate to all members or prospective members of the scheme:

- Services to be covered
- Services not covered
- Extent of the coverage
- Any utilisation review requirements
- Financial arrangements/other restrictions that may limit services, referrals or treatment options

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

#### **4.8 FINANCIAL INCENTIVES**

##### **Perverse Incentives**

Undesirable practice enriching a practitioner either financially or in kind at the cost of a payer of professional practice with no evidence based of scientific basis or cost effective considerations.

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).

#### **4.9 FORMULARIES**

Formularies or restricted medicine lists should be based on best practice principles taking also 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.

#### **4.10 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.

#### 4.11 GROUP PRACTICES

Group practices between practitioners registered with the HPCSA, with the exception of radiologists and pathologists, are supported. **The issue of Group practices across Statutory Health Councils needs careful consideration due to the possible abuse and/or ethical considerations that go with Group Practices. Accordingly, it is submitted that Group Practices across Statutory Health Councils not be approved as a blanket principle but rather that individuals wishing to engage in a Group Practice across the Councils, lodge an application with a Committee consisting of/or representatives of the Councils that are affected by the proposed Group Practice in order for them to evaluate the need, circumstances, benefits, conditions and any other relevant factors before an application for a Group Practice may be approved. This would mean that the rationale behind the formation of the Group Practice needs to be explained and motivated to a Multi Disciplinary Committee that would consist of all the affected Councils / Professional Boards.**

#### 4.12 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.

#### 4.13 QUALITY OF CARE

In any health care delivery system the emphasis should always be to provide 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.

#### 4.14 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.

#### 4.15 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.

Inherently 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, 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.

#### **4.16 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 on an increasing basis challenge the entrenched values of medicine. Providers should be sensitive to these developments and ensure that the values inherent to medicine 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 dependant on his continued compliance with the organisation's requirements. The latter is not acceptable.

#### **4.17 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.

##### **4.17.1 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.

##### **4.17.2 CASE MANAGEMENT**

It is acceptable that one person accepts 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 providing assistance with suitable alternative care arrangements on discharge is also acceptable.

#### **4.17.3 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.

#### **5 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. It is recommended that the said Committee be constituted by the following persons:

1. An Auditor
2. A Lawyer
3. A member of the affected profession
4. A Chairperson who should be a member of the Council
5. 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.

#### **6 HOSPITAL REGULATION**

**Some form of regulation of private hospitals is required urgently. It is recommended that a body be set up or an existing body be tasked to regulate private hospitals. As a bare minimum, private hospitals should also be bound by the same ethical rules that bind health care practitioners to the extent that this may be practicable and appropriate in relation to juristic persons.**

**It is also recommended that the establishment of a private hospital be purely on the basis of need—certificate of need.**

#### **7 SUMMARY OF RECOMMENDATIONS**

**The Multi Disciplinary Task Team therefore recommends the following:**

- i. Business models for the purposes of conducting a professional practice are limited to those identified under paragraph 2.1.
- ii. All practitioners who have had corporate entities involved in the running of their professional practices in a manner that is inconsistent and/or contradictory to the ethical rules of the Council will be granted a once off indemnity period of six months from the date of the Council meeting (7 October 2003) to rectify all their contractual arrangements and/or agreements in order to

ensure that their professional practices are aligned with the acceptable business models and practices as determined by Council. Further that the practitioners who have been given that grace period to rectify their business or practice arrangements with the corporate entities will be required to submit proof that they have rectified the situation in relation to their contractual arrangements. Council will conduct Ad-hoc inspections to the practices of such practitioners who have had corporate involvement in the running of their businesses after the grace period has lapsed.

- iii. The employment of practitioners is limited to the categories as listed under paragraph 2.2.2., namely, Public Service, Universities and Training Institutions for purposes of training and research; and all persons registered under the Health Professions Act.
- iv. Franchises be disallowed and that all practitioners who have involved themselves in franchise agreements will be granted a probationary period of six months from the date of the Council meeting to rectify their business models and provide proof to the Council of their rectification of such arrangements in order for their professional practices to be conducted in line with the acceptable business models and further that Council conduct Ad-hoc inspections in such practices to determine the correctness of their practices and models.
- v. That Council appoints a Committee on Undesirable Business Practices and Professional Practice, the composition of which should be -
  - a. An Auditor
  - b. A Lawyer
  - c. Member from the affected profession
  - d. Chairperson who should be a member of the Council
  - e. Two additional members from Council
- vi. FURTHER that this Committee be appointed to serve for the full term of Council.
- vii. That all private hospitals be regulated through some form of legislation so that such hospitals are subject to the ethical codes of the Council.
- viii. That a Press Conference be convened to announce to the public and to the profession at large the findings of the Council in relation to Undesirable Business Practices.