Business Practice Policy

POLICY DETAILS	
Department	Core Operations
Division	Professional Practice
Policy	Business Practice Policy
Date of review	27 March 2025

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DEFINITIONS

Business structures means a business category of an organisation, or model that is legally recognised and characterised by the legal definition of that particular category.

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

Corporate ownership means legal ownership of an entity by persons not registered in terms of Health Professions Act, 1974 (Act No. 56 of 1974).

Corporate entities mean unregistered entities who employ registered health practitioners or provide health services on behalf of practitioners (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).

Ethical rules mean the ethical rules of conduct for registered practitioners made in terms of the Health Professions Act (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.

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

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

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

Professional Practice means a practice where registered health practitioners 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.

Private practice means the practice of a health practitioner who practises for 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 established in terms of section 54A of the Act.

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 or recognised by a board for the purposes of these rules.

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

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 (hereafter referred to as the HPCSA) to determine what may be regarded as acceptable business practices in the healthcare sector in order to guide the 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 practices of health practitioners registered with the HPCSA.

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 and omissions in respect of which disciplinary measures may be instituted against health 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 Health Professions Act, 1974 (Act No. 56 of 1974) (hereafter referred to as 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 a transgression in respect of which the professional board concerned may take disciplinary action in terms of the Act, following an inquiry.

1.3.2 At an inquiry, the professional board concerned shall be guided by the ethical rules, its annexures, ethical rulings or ethical guidelines and relevant policy statements which the board concerned, or any statement or directive Council or the professional board makes from time to time.

1.4 POLICY STATEMENT

1.4.1 Council is committed to providing support and guidance to health practitioners who conduct business in healthcare sector.

1.4.2 This policy is developed in terms of the relevant Acts and the ethical and professional rules in line with acceptable best practice 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 acceptable 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 Health practitioners are not permitted to embark on any other business formation or structure for professional practice outside of the ones 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 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:

a) transferring the income stream (or any part thereof) generated in respect of patients from the practice to such a person.
b) giving (directly or indirectly) shares or an interest similar to a share in the professional practice to such a person.
c) 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.
d) 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 registered health practitioner in terms of the Act is **not permissible.**

2.3 CORPORATE INVOLVEMENT

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

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

2.3.3 Corporate involvement is permissible under the following conditions:

a) ethical rules and policies of HPCSA to be complied with.
b) health practitioner takes full responsibility for the compliance of the ethical rules, regulations and policies of the HPCSA.
c) health practitioner should not be able to hide behind the corporate veil but should take individual responsibility for all business transactions and operations of the business.
d) no hiving off of fees to a corporate entity.
e) no coercion by corporate entities on practitioners to enter arrangements that would violate ethical rules.

2.4 EMPLOYMENT OF HEALTH PRACTITIONERS

2.4.1 Generally, the employment of health practitioners by a person or entity not registered in terms of the Act is not permissible. However, the following employment agencies are recognised for the purposes of employing health practitioners:

(i) The public service.
(ii) Universities / training institutions (only limited for purposes of training and research).
(iii) NPO's/NGO's (subject to approval of the relevant professional board).

2.4.2 All registered health practitioners may employ fellow health practitioners in accordance with the Ethical Rules.

2.4.3 Should the health practitioner wish to be employed by any unregistered entity (that is, an entity not registered in terms of the Act and not exempted in line with par 2.4.1 above), agency, agent, institution, or person, such entity shall be approved by the HPCSA prior to such employment to ensure that the interests of the professions and the public are upheld. Any other employment which falls beyond the scope of professional practice is not required to lodge an application.

2.4.4 It is the responsibility of the health practitioner to check that the prospective employer has been approved by the HPCSA in accordance with the provision of the Ethical Rules, if not approved, the employer can be requested to lodge or submit an application for approval addressing the criteria listed on par 2.5.

2.5 CRITERIA TO BE ADDRESSED BY THE NON-REGISTERED EMPLOYER WHO SEEK TO EMPLOY REGISTERED HEALTH PRACTITIONER

a) **Motive or goal.**

i) The reason/s or motive/s for employment shall be expressed adequately in line with the interest of the public and the professions.

ii) The health practitioner shall only accept an employment contract which has as its primary aim the enhancement of the quality of health-care services to patients, is structured to contain costs, enhance access to appropriate, high quality health-care services or products to patients, and is not designed to extract profit for the benefit of the practitioner or their employer to the detriment of patients.

b) **Service to specific groups of people.**

i) The employer shall express how the professional appointment or employment is intended to serve the citizens, such as non-profit, charitable and similar organisations.

b) **Clinical independence of practitioners**

i) The employer shall express how measures are going to be implemented (if not already available) to mitigate against unethical business practices that would compromise patient care or promote the provision of services for the primary purpose of acquiring financial or material benefit.

ii) Information must be provided on how the health practitioner will retain clinical independence at all times, and the employer must express measures to safeguard

against undue influence and/or exertion which may compromise her/his clinical independence.

c) **Method of remuneration**

i) The employer shall express how potential ethical transgressions, such as perverse incentives, will be avoided. Practices that unduly enrich a health practitioner, or a non-registered employer either financially or in kind at the cost of a payer with no evidence based scientific basis or cost-effective considerations are not acceptable.

d) **Clinical governance**

i) An employer shall ensure that their offer includes measures of how the professional autonomy of the health practitioner will be ensured in order to make independent clinical decisions without undue influence and interference.

ii) The administrative and governance structure of the employer shall also be provided for consideration.

e) **Peer review mechanisms**

i) The employer shall provide evidence of how the internal peer review mechanisms are structured, constituted, governed and supported. Where such evidence is not available, reasons shall be advanced.

2.6 A proposed contract of employment shall always accompany the application to employ or appoint a health practitioner.

2.7 CRITERIA TO BE ADDRESSED BY REGISTERED HEALTH PRACTITIONER WHO SEEK TO ACQUIRE FINANCIAL INTEREST OR SHARES IN A HOSPITAL OR ANY OTHER HEALTH CARE INSTITUTION

a) Registered health practitioner may possess direct and/or indirect financial interest or shares in a hospital or any other health care institution, provided that such

interest of shareholding is approved by the HPCSA in line with the Ethical Rules. The health practitioner shall address the following criteria on the application: -

i) Such interests or shares are purchased at market-related prices in arm's length transactions. The application shall address whether the purchasing is at market related price and at arm's length transaction.

ii) Rand value of each share is provided. Independent auditor's report to confirm share value, must be made available.

iii) Evidence of share market price determination and verifications must also be provided to the HPCSA.

iv) Indication whether the shares or financial interest are from a stock exchange listed entity.

v) List of shareholders of the entity in question.

b) The purchase transaction or ownership of such interest or shares does not impose conditions or terms upon the practitioner that will detract from the good, ethical and safe practice of his or her profession.

i) Evidence of share agreement shall be provided for consideration.

(c) The returns on investment or payment of dividends are not based on patient admissions or meeting particular targets in terms of servicing patients.

i) Evidence of share agreement shall be provided for consideration and a declaration shall be made on the application form.

d) Such a health practitioner does not over-service patients and to this end the established and appropriate peer review, admission policies and clinical governance procedures for the treatment and quality monitoring mechanisms, shall be provided.

i) Evidence of share agreement shall be provided for consideration and a declaration shall be made on the application form.

(e) Such practitioner does not participate in the advertising or promotion of the hospital or health care institution, or in any other activity that amounts to such advertising or promotion.

i) Evidence of share agreement shall be provided for consideration and a declaration shall be made on the application form.

(f) Such practitioner does not engage in or advocate the preferential use of such hospital or health care institution.

i) Evidence of share agreement shall be provided for consideration and a declaration shall be made on the application form.

(h) The health practitioner shall annually submit a report to the council accompanied by the updated (if any) peer review protocols, patient admission policy, quality monitoring mechanisms, and patient referral rates, between own and other entities.

3. APPENDICES

3.1 FRANCHISES

3.1.1 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 should guard against practising in any form of business which has inherent requirements that violate one or more of the following ethical rules of the HPCSA, particularly Rule 3: Advertising, Rule 5: Naming of practice, Rule 4: Information on professional stationary, Rule 7: Fees and commissions, Rule 8: Partnership, Rule 8A: Consulting rooms, Rule 18: Professional appointments, Rule 19: Professional secrecy, Rule 21: Performance of professional acts, and Rule 22: Exploitation.

3.2 MANAGED CARE MODEL

3.2.1 Health 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.

3.2.2 Health practitioners 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:

3.2.2.1 Professional independence should be inviolate;

3.2.2.2 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 HPCSA.

3.3 GATEKEEPERS

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

3.4 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.

3.5 SPECIFIC PRACTICE 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.

3.5.1 Access to Clinical Information

3.5.1.1 Access to confidential health care 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.

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

3.5.1.2 Accountability (Liability)

3.5.1.3 Service 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.

3.5.1.4 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.

3.5.2 Clinical Guidelines

3.5.2.1 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.

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

3.5.3 Contracts

3.5.3.1 Health practitioners 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.

3.5.3.2 It is not permissible for health practitioners to enter contracts that transgress the Ethical Rules or affect the clinical independence and judgement of practitioners.

3.5.3.3 Contracts entered with registered health practitioners shall be produced upon request by the Council.

3.5.4 Cost Saving Benefits

3.5.4.1 It is acceptable for service 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.

3.5.4.2 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 service providers 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

Service providers 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 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.

3.5.8.2 Incentive payments to the health practitioners 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 be always provided. Reference should be made

to the Policy Statement pertaining to Perverse Incentives and related matters for Health Care Professionals (Booklet 11).

3.5.9 Formularies

3.5.9.1 Formularies or restricted medicine lists should be based on best practice principles, also considering 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. Providers are reminded of the HPCSA's perverse incentive policy in this regard.

3.6 GROUP PRACTICES

3.6.1 With regards to group practices, health practitioners should have regard to Rule 8 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".

3.6.2 The restriction in Rule 8 does not apply to the following professions: -

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

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

3.7 PREFERRED PROVIDERS NETWORKS

3.7.1 Service 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 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 exists.

3.8 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.

3.9 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 if 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.

3.10 RISK SHARING

3.10.1 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.

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 health care arena not only as funders of care, but also to deliver health 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.

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. 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 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 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 model of practice.

3.12 UTILISATION MANAGEMENT

3.12.1 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.

3.13 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

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

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 BUSINESS PRACTICE MATTERS

The relevant Committee of Council considers any matter relating to business practices.