

PRINCIPLES RELATING TO DOCTOR PROFILING¹

Managed care programmes often entail the application of mechanisms that profile, rank and/or measure the utilisation of drugs, frequency and cost of consultations, referral patterns etc. of medical practitioners. In South Africa this is regulated by, *inter alia* the policy documents of the Health Professions Council of SA (HPCSA) and the regulations to the Medical Schemes Act of 1998, as amended.

Section 59 of the Medical Schemes Act allows medical schemes to pay either the provider or the patient/member. However, this provision should not be used to penalise practitioners in a manner that does not conform to the rules and regulations set out below.

POLICY PROVISIONS RELATING TO DOCTOR PROFILING

Two policy documents are relevant in this context:

- The Perverse Incentives Policy of 2001 (PIP), that, in broad terms prohibit actions or omissions and the offering of any form of compensation or benefit in return for such (in)action where this is not in the interest of a patient; and
- The Undesirable Business Practice Policy of 2003 (UBPP), that addresses contemporary forms of business ventures in healthcare, including managed care strategies and whether these are permissible or not.

The UBPP lists a number of managed care strategies and addresses the parameters of acceptability as follows:

- It would not be permissible to enter into contracts that transgress the Ethical Rules or affect the clinical independence and judgment of practitioners.
- Providers may be rewarded for delivering quality cost-effective care, but-
 - Any cost saving benefits achieved should ultimately be passed on to the patient.
 - Incentives can for instance be given to using evidence-based medicine, whilst ensuring no under or over-servicing of patients.
 - Cost saving rewards should be subject to an independent audit.
 - Quality based on best practice may not be sacrificed in the interest of cost.
- 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.
- Financial incentives should –
 - Only be used to promote quality and cost-effective care and not to encourage the withholding of medically necessary care.
 - Rather be based on performance according to criteria that are founded in best practice and ethical behaviour of individuals.
 - Not be based on prescriptions volume and/or price.
- 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.

¹ This document is provided by Innovative Medicines SA in the interest of providers and patients. It does not constitute legal opinion and practitioners are advised to contact their professional associations or legal advisors in cases that may arise in this context.

- Providers must inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage.
- Preferred provider (DSP) networks should be selected on basis of professional qualifications, competence and quality of care.

From the above it is clear that the mechanisms used in peer review need to go beyond a mere exercise in costs and expenditure. Peer review should incorporate elements in which the clinical appropriateness of interventions is evaluated, so as to ensure that patient rights and interests are protected.

MEDICAL SCHEME REGULATIONS

The regulations permit the utilisation of various managed care interventions, including the utilisation of formularies, protocols and pre-authorisation in the context of the PMB's. Regulation 15D sets out the standards for managed care, which includes that -

- There should be procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of interventions.
- Documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost-effectiveness and affordability, should be used.
- Criteria for any decision-making factor should be transparent and verifiable.
- The appropriateness of managed care decisions should be evaluated periodically by clinical peers.

In terms of formularies, regulation 15I creates exceptions to the strict enforcement of formularies, and managed care organisations should have mechanisms to accommodate this provision, without penalty to the patient, or the provider. Formularies, whether explicit or implicit, must be based on evidence, defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research".

Regulation 15E entitles providers to inform patients of the care they require, even if they are part of a managed care agreement, without any disadvantage for doing so.

A change in consultation fees paid, especially in the case of prescribed minimum benefits (PMB's) may fall foul of the provisions of regulation 8 that compels the payment in full of the diagnosis, treatment and care costs of the PMB's, unless there is a DSP agreement and/or formularies, protocols or pre-authorisation, provided such are executed in line with relevant legislative provisions.

CONTACTS

COUNCIL FOR MEDICAL SCHEMES

Private Bag X34, Hatfield Pretoria 0028 Tel 012 431 0500 Fax 012 430 7644 <http://www.medicalschemes.com>

HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA (HPCSA)

P.O. Box 205, Pretoria 0001 Tel 012 338 9367 <http://www.hpcs.co.za>

INNOVATIVE MEDICINES SA

PO Box 2008, Houghton, Tel 011 880 4644 Fax 011 8805987 <http://www.innovativemedicines.co.za>