CONFIDENTIAL

REPORT ON SASCI HMI SURVEY
September 2016

INTRODUCTION AND BACKGROUND

SASCI participated in the Health Market Inquiry hearings on 18 February 2016. Based on questions asked not only of SASCI, but of statements made by other stakeholders and pursuant to key issues identified by SASCI and others (e.g. who evaluates provider requests for patient care to be reimbursed), SASCI decided to obtain some further information from its members which could be helpful to the Inquiry.

SASCI's Executive Committee (ExCo) decided to undertake a survey for this purpose, and commissioned EKC to undertake this for them. EKC developed a draft survey, which was approved, with amendments, by the ExCo (Annexure "A"). The survey was done by means of EKC's Survey Monkey account, and no data or information were submitted to the SASCI office, any office bearer or any ExCo member. SASCI members were invited to provide real examples of their experiences, to supplement or support survey answers, directly to EKC. EKC gave an undertaking of confidentiality that no individual practitioner or patient details would be revealed.

It must be noted that there has been no verification of the information provided, and that it is based on the experiences of the participating respondents. The frequency with which certain responses where repeated, do indicate some level of consistency in experiences by interventional cardiologists.

RESPONDENTS

SASCI has around 120 members who are cardiologists in private practice. The survey was sent to all members, and 36 respondent. This amounts to a response rate of 30%.

RESULTS

Summary of results

The results of the survey can be summarised as follows (more details provided under each hearing below):

1. Practitioners that participated are, for the most part, experienced professionals.
2. Medical scheme reimbursement levels are used as a *de facto* price reference by practices.
3. DSP / preferred provider uptake is surprisingly high.
4. Contact with medical schemes rarely involve access to qualified medical practitioners and other healthcare professionals.
5. In difficult or complex cases, scheme approval processes mostly take longer than a week.
6. When their matters are referred by schemes or administrators for second opinions, the identify of those practitioners are, mostly, not known.
7. In interaction with a scheme, some respondents give up when they do not make headway, with others trying a couple of times before telling the patient that they were not successful.
8. Medicines deemed appropriate by the cardiologist appear to be declined in about half the cases.
9. For typical treatments used in interventional cardiology, the ease of obtaining reimbursement of such care appear inconsistent.

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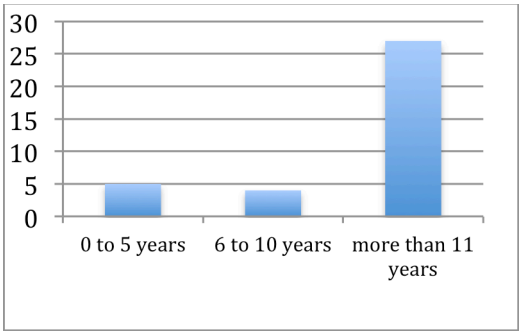
Analysis of survey results

1. Practitioner profile in terms of experience



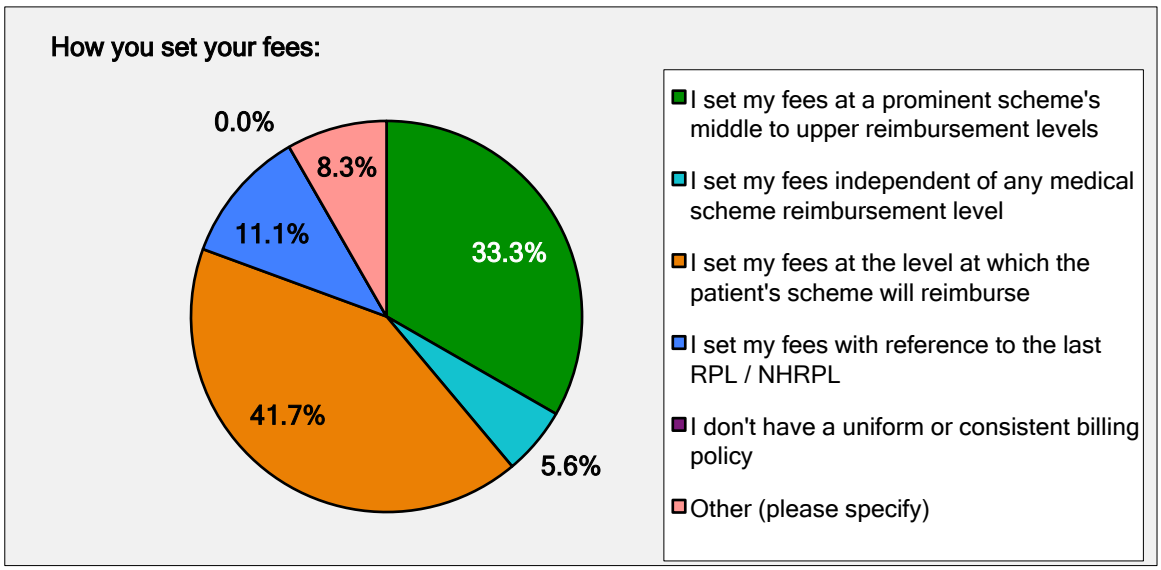
The bulk of the respondents (27 or 75%) had been in practice for longer than 11 years, with 4 being in practice six to 10 years, and 5 having been in practice 5 years or less.

The practitioners who completed the survey therefore are largely *experienced* professionals. **This is an important consideration when interaction with medical schemes or medical scheme administrators are concerned**. Not being able to interact with clinical peers, or even just with general practitioners, are therefore a great source of frustration to this group of professionals

2. Medical scheme reimbursement levels are used as a *de facto* price reference

The second question aimed to establish, in the absence of a reference price list or benchmark fee, on what basis or reference interventional cardiologist set their fees. It also attempted to show whether there is, as is often alleged, a general disregard for reimbursement levels of medical schemes, and that doctors, and in particular specialists, would grab the opportunity of the absence of a fee list and simply charge "what they want", in particular when they know the scheme would have to fund the care.

The results show that, for the respondents, 41.7% (15) set their fees in line with scheme reimbursement levels, with 33.3% (12) setting it with reference to prominent medical scheme rates' middle or upper levels. Therefore, for the vast majority of respondents, the reference for their prices, are those medical schemes are willing to reimburse. Two of the three respondents who stated "other" also indicated that they reference their fees to a prominent medical scheme (Discovery), of which one said he/she then always discounts down to the specific patient's medical scheme reimbursement levels. This means that 38.9% of respondents reference their fees to a prominent medical scheme, and in total more than 80% of respondents showed sensitivity to the market as determined by medical schemes. A further 4 respondents (11.1%) set their fees with reference to the old RPL – reference price list, which has been updated by third party entities such as those providing practice billing software. **Only *two* respondents stated that they set their fees independent of medical schemes reimbursement level considerations**.



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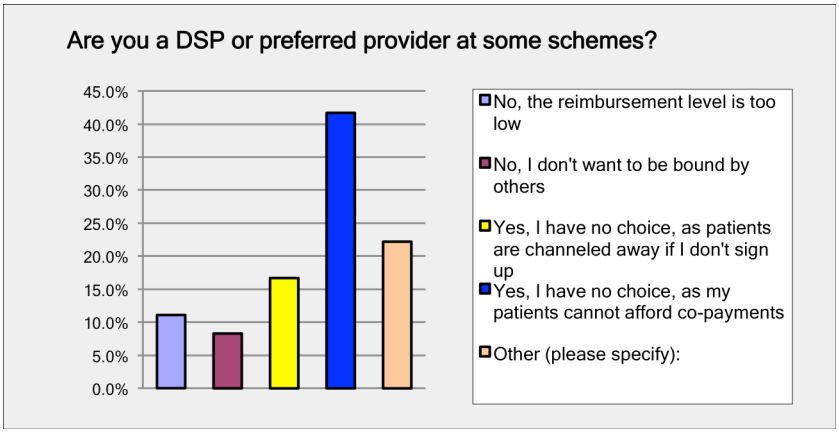
None of the respondents stated that they did not have a consistent or uniform billing policy – this is probably due to the HPCSA's rulings over the past three years relating to informed billing consent, and the effect of awareness-raising relating to the provisions of the Consumer Protection Act, requiring consistency and transparency in pricing and billing.

3. DSP / preferred provider uptake surprisingly high

To provide some insight into the allegation that professionals, and in particular specialists (including those in short supply, such as the interventional cardiologists), would be reluctant to enter into DSP arrangements, and thereby leaving schemes open to "open-ended" PMB claims, the question was asked whether the specific practitioner was part of a DSP or preferred provider arrangement or not.



The results show that the majority of respondents were in DSP arrangements (58,4% or 21 respondents). The reasons for signing up differed, some felt that they had no choice but to sign, either because their patients would not be able to afford co-payments, or because they were afraid of patients being channelled away from their practices.

When adding the respondents who indicated that they too have signed (under the option "other"), but for different reasons than the two set out in the question options, **the total percentage of respondents in DSP arrangements rose to 27 or 75%.** These 6 respondents were satisfied to sign up, and indicated that it was their choice. Only one of the respondents in the "other" category stated that the reimbursement rates were "not competitive", which aligns with the 4 respondents who stated that the reimbursement rates were too low. In total, therefore, 5 respondents (13.9%) were of the view that scheme DSP contracts offer inadequate reimbursement rates. Only 3 respondents cited the need for independence (not be bound by others) as a reason for noting signing DSP agreements.

In a related question, the implications of not being a DSP or preferred provider was canvassed. 12 respondents stated that the scheme then pays the member, and 14 stated that the scheme then pays the provider, but at the non-DSP rate (which would be lower than the DSP rate). In a minority of cases the patient had to pay the provider and claim back from the scheme (7 respondents, 19.4%). Of the three respondents that chose "other", one said the scheme paid the NHRPL rate, and another said s/he did not see patients for whom s/he was not the preferred provider.

4. Contact with medical schemes rarely involve access to qualified medical practitioners and other professionals

During the SASCI submission to the HMI hearings, medical schemes were referred to as "departments of silly questions". Based on this and other healthcare professional submissions to the HMI, the panel asked medical schemes whether they have qualified persons on hand who could respond to medical scheme queries. All scheme and administrators responded positively that they indeed employ persons who would be able to interact on a professional level with the doctor or other professional.

However, the survey showed that 16 respondents (44.4%) stated that they never accessed a qualified medical practitioner at a medical scheme, 15 (41.7%) had "rare" access to such a practitioner, meaning that **the bulk of practitioners in the survey had limited or no access to qualified medical practitioners at the scheme or its administrators**. Only one respondent had access "always" and 4 had "occasional" access to a medical practitioner. In total, the overwhelming majority of respondents (97%) did not have access to a medical practitioner when needed, in their interactions with the scheme or its administrator.

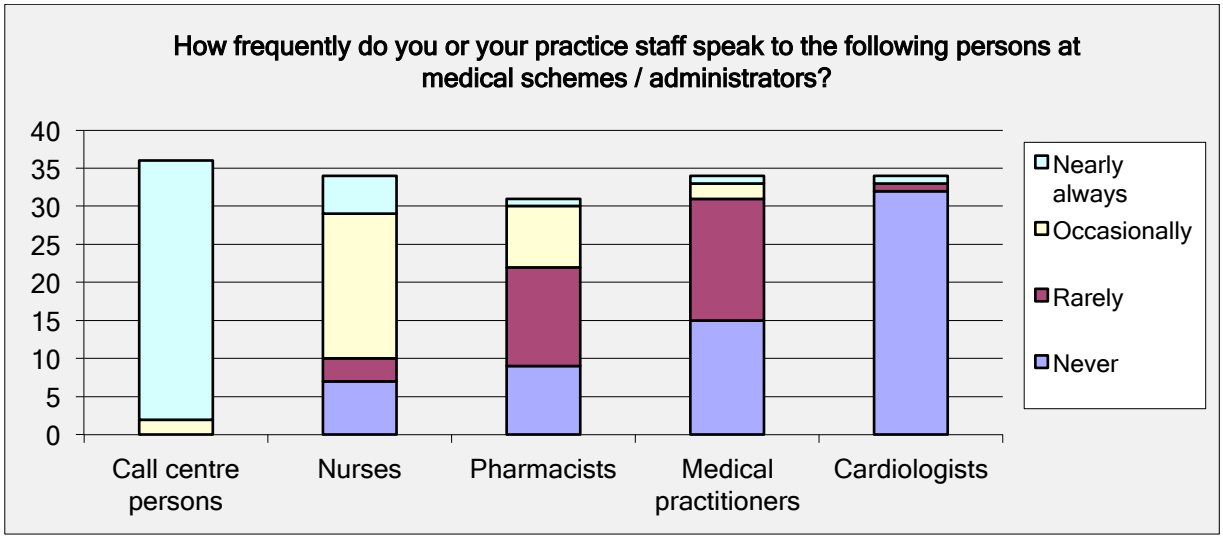
Only 3 respondents (8.3%) reported that had the direct contact details of schemes' medical advisors (who would be medical practitioners, i.e. qualified doctors). One respondent stated that the advisors are rarely available and "not keen to shoulder responsibility". In addition to these respondents, one respondent reported:

I insist on my rights to speak to a colleague and simply refuse to deal with call center supervisors or nurses. If the Dr doesn't call back within 6 hrs, I address a mail to the CMS and cc the CEO of the scheme.

Even when measured against other professionals that may be employed by medical schemes and their administrators, such as nurses and pharmacists, access for the respondent group of super-specialists are limited. **Contact is limited to call centre agents, and second most to nursing professionals. Speaking to a clinical peer, i.e. another cardiologist, appears to be extremely rare**.

It must be noted that nursing professionals are, by law, not allowed to diagnose or treat patients, except by special permit issued by the Director-General of Health in instances where no or limited medical practitioners are available. A nursing professional would therefore be acting outside of her scope of practice, her training and her skills, should she for example have to access or reply to a clinical query relating to the types of patients seen by interventional cardiologists. The same principle apply to pharmacists, who are only trained in the medicinal component of treatment, as already prescribed, and who are not empowered, trained or experienced in diagnoses, treatment and prescriptions. They are able to evaluate medicines interactions, or possible side-effects and adverse events, but would not be able to evaluate whether a specific treatment path would be appropriate or not.

The results of this part of the survey show the following in terms of frequency of access to various types of scheme or administrator staff:



Two respondents provided comments, which confirms the necessity to (a) reach and (b) be able to speak to clinical peers:

Medical advisers at medical schemes never return calls and are never available to discuss complex problems, nor are they remotely interested in our views to get the patient better at lower cost to schemes, esp with newer procedures/ interventional techniques.

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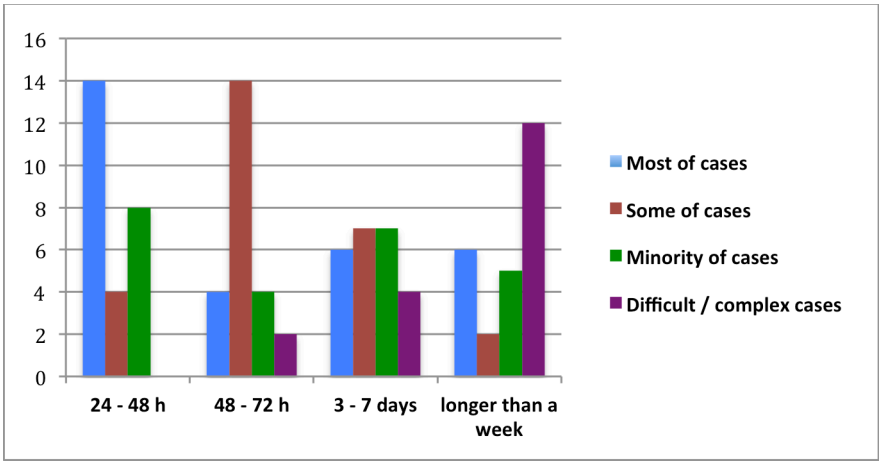
It is very difficult to discuss cases with the medical advisors who are mostly GPs with an interest in clinical research. They tend to apply guidelines rigidly and blindly and do not have the experience or insight into cardiology which is a complex field. It would be much better to discuss cases with another peer (interventional cardiologist).

5. In difficult or complex cases, scheme approval processes mostly take longer than a week

During replies at the HMI hearing set 1, medical schemes and administrators stated that medical scheme motivation processes takes about 48 hours. In the experience of most of the respondents (14), most of cases were resolved with the scheme within a day or two. However, 8 respondents felt that a minority of cases were resolved within 48 hours and 4 respondents that only some cases were resolved in that time. 14 reported that some cases where resolved within 2 to 3 days. 6 respondents reported that, for them, most of the cases were only resolved between 2 to 7 days. **Complex or difficult cases took for 12 respondents longer than a week**, and for a minority (2) it took two to three days. It must be noted that it would indeed be in complex and difficult cases where interventional cardiologists would require a speedy responses, and access to clinical peers. Those patients would, in health terms, be the most vulnerable and in need of speedy access to healthcare.



6. When their matters are referred by schemes or administrators for second opinions, the identify of those practitioners are, mostly, not known

Only two respondents indicated that they knew the identity of the persons to whom their cases, which they have taken up with a medical scheme (e.g. a so-called difficult or complex case, where the patient requires treatment that fall outside of stock-standard scheme-reimbursed care. **All other respondents stated that they either never know who the person is who is re-evaluating the case (20) or mostly do not know who that person is (14 respondents)**.

This is important from a regulatory perspective. The Health Professions Council[1] requires of professionals to –

- Adhere to their scope of practice, i.e. the person who evaluates a case must be "adequately educated, trained and sufficiently experienced" (ethical rule 21); and
- Professionals must always "maintain proper and effective communication with his or her patients and other professionals| (ethical rule 27A).

[1] GNR.717 of 4 August 2006: Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974 as amended.

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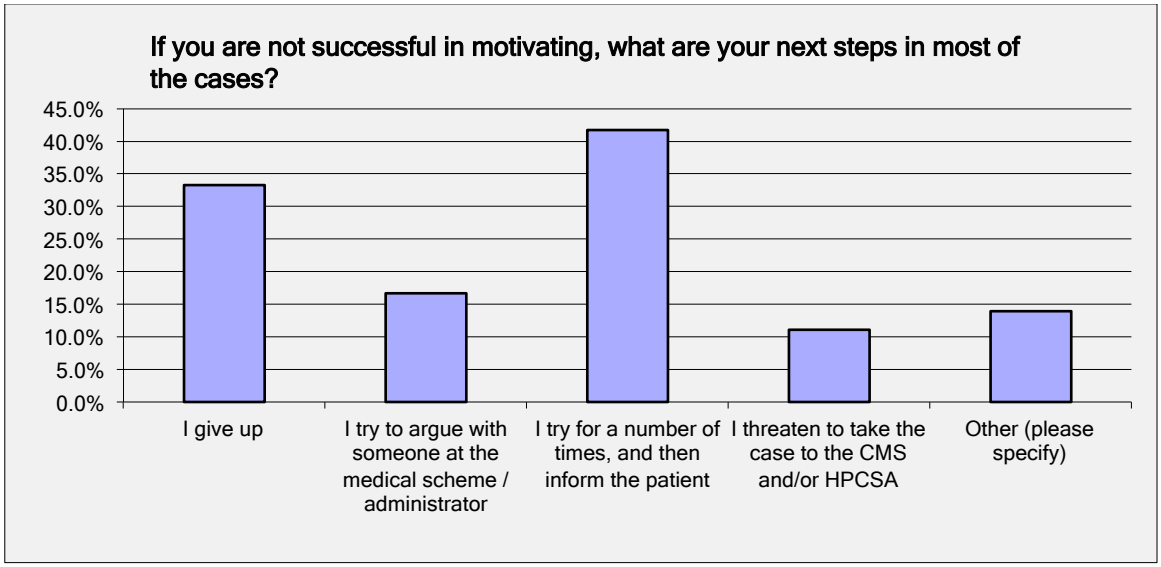
To ensure compliance with these criteria, the identity of the professional who re-evaluates the case must be known.

7. In interaction with a scheme, some give up when they do not make headway, with others trying a couple of times before telling the patient



The second most prevalent response from professionals are to give up (12), while **most (15) would try a couple of times and some (6) argue with the scheme and 4 reported that they threaten the scheme with the CMS or HPCSA**. Five respondents marked "other" and four of them reported that they took the following steps:

Usually I eventually persuade the scheme, but the problem arises when the patient is critically ill or urgent, in which case I do what is in the best interest of the patient, and negotiate payments for the procedure later.

If I believe medication is critical otherwise give up.

I inform the patient if he agrees we continue with procedure.

I suggest that the patient should report the case to the CMS. I have found that the CMS seems to usually rule in favour of the medical scheme though.

8. Medicines deemed appropriate by the cardiologist appear to be declined in about half the cases

No respondents appear to have a success rate of 100% where their patients need an appropriate medicine. **Only 4 respondents (11.1%) say they are mostly able to prescribe what is appropriate to the patient, and 6 (16.7%) obtain that in the majority of cases**. However, 16 respondents (72.2%) either seldom, or around half the time, get what they would deem the appropriate medicine for their patients.

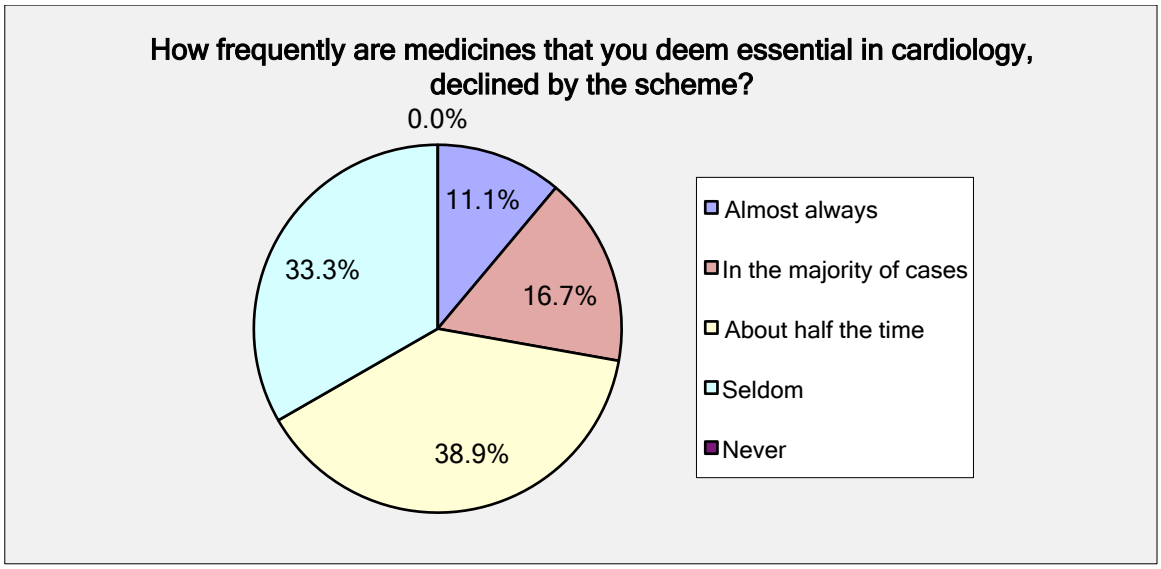
Three respondents commented that statins, medicines used in high cholesterol and its associated effect, i.e. cardiovascular disease (CVD), in particular as far as doses are concerned which was stated to not be according to the guidelines. Respondents also commented as follows:

Clopidogrel longterm in complex, multivessel and several long stented areas. basic lipophilic ACE -I eg PREXUM declined, because scheme only pays for enalapril - ineffective in proper secondary prevention.

Xarelto, Pradaxa, Ezetrol, Tambocor, Rhythmol are some examples.

Funders to follow a stepped care approach even though no data exists for that approach. Clopidogrel often declined.

Clopidogrel Ticagrelor (stent thrombosis on Plavix) Prasugrel(high risk PCI, stent thrombosis , DM) Eplerenone (in patients who fail spiractin), Antiarrhythmic agents - amiodarone, flecainide etc.



One responded stated “there is usually an acceptable alternative. The issues are marketing related!”. This is understood to mean that companies are successful in marketing these products to professionals, and that non-reimbursement may therefore not relate to inadequate or inappropriate reimbursement policies.

9. For typical treatments used in interventional cardiology, the reimbursement of such care appear inconsistent

The procedures on which this question are based, are, or should be, in most cases, indicated for PMB conditions. According to regulation 8 to the Medical Schemes Act, 1998, the “diagnosis, treatment and care costs” thereof, should be funded in full. In managing the costs of this, schemes may institute managed care interventions, which, in turn, should adhere to the various regulations (including those on procedural fairness entrenched in regulation 15D), and substantive criteria, set by regulation 15H (evidence-based medicine and exceptions in certain instances).

Most respondents (29) “seldom” or “never” experienced reimbursement issues with **drug-eluting stents**. The picture with pacemakers also appear to be better from a reimbursement perspective (purple and green on the chart). Overall, it seems that only for drug-eluting stents and pacemakers, reimbursement is not a major issue, whereas for key other interventions, practiced within the specific discipline within a super-speciality, reimbursement is difficult or problematic (indicated by red brackets).

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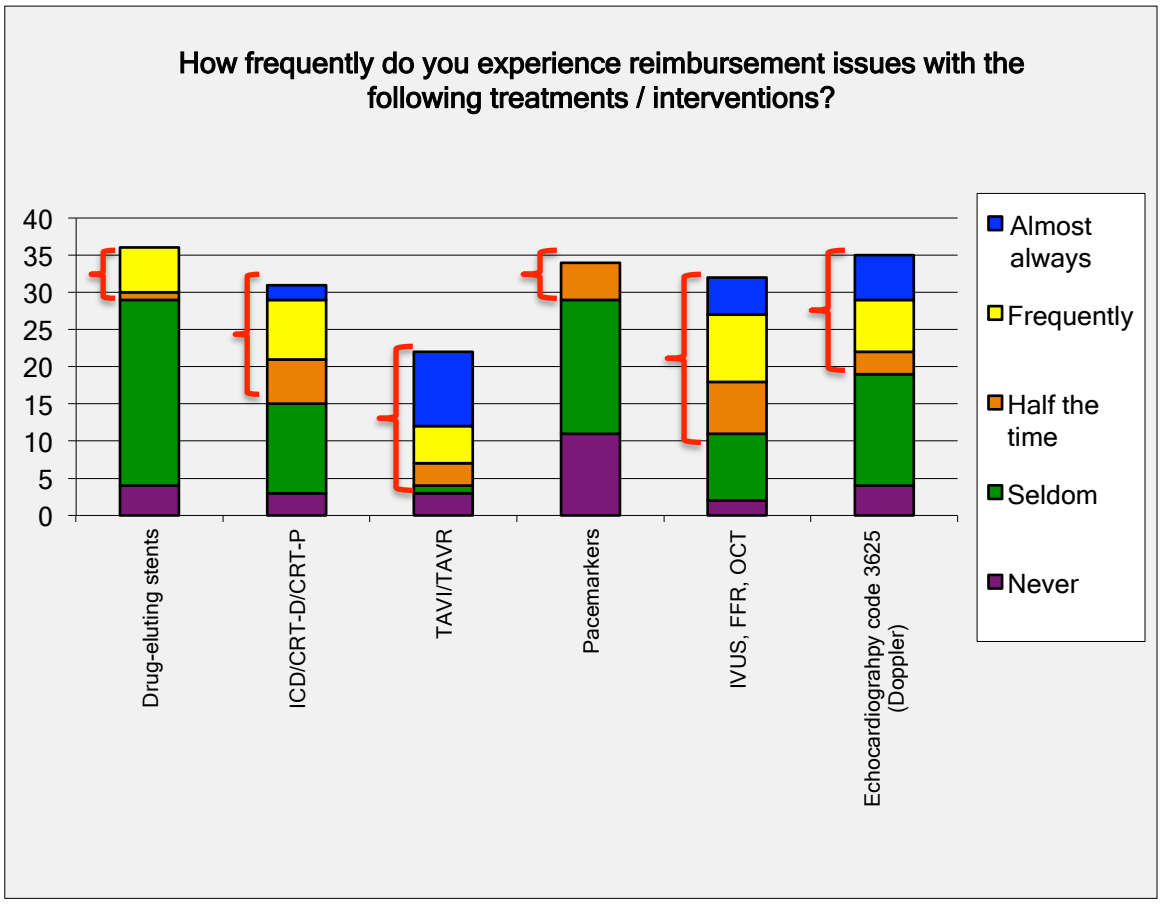
However, and in spite of a ruling by the Final Appeal Board of the CMS,[2] that **TAVI/TAVR**[3] (indicated for Aortic Valve Stenosis) should be funded at least up to the level of open heart surgery, 18 respondents reported experiencing reimbursement issues "almost always", frequently" or about "half the time" (indicated by the colours blue, yellow and orange on the chart). **IVUS,**[4] **FFR**[5] **and OCT**[6] (all of which allow for more appropriate cardiology interventions) also appear to be problematic from a reimbursement perspective, with more respondents (14 out of 32) undertaking this procedure reporting difficulties. 16 out of 35 respondents experienced difficulty in the reimbursement of **Doppler**,[7] with 19 who reported "never" or "seldom" experiencing reimbursement issues.



[2] *Medshield v Mabin and the Registrar, CMS*, ruling of 11 November 2013.
[3] Trans-aortic valve implantation / replacement.
[4] Intravascular ultrasound
[5] Fractional flow reserve.
[6] Optical coherence tomography.
[7] Heart imaging.

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