SASCI

South African Society of Cardiovascular Intervention

SASCI HMI

18 February 2016
10.20 – 11.10

Dr Dave Kettles
President

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Who are we?

Non profit registered section 21 company, formed 2003

Special interest group of the South African Heart Association

103 full members, cardiologists, and 119 allied professional members

Our members perform around 90% of all coronary interventions performed in South Africa

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Who are we?

Total: around 200 cardiologists to serve our population

Estimate: at annual incidence of 300/100 000 pa: 150 000 cases of myocardial infarction per annum expected in South Africa

ALL should ideally have access to an interventional cardiologist for contemporary care!

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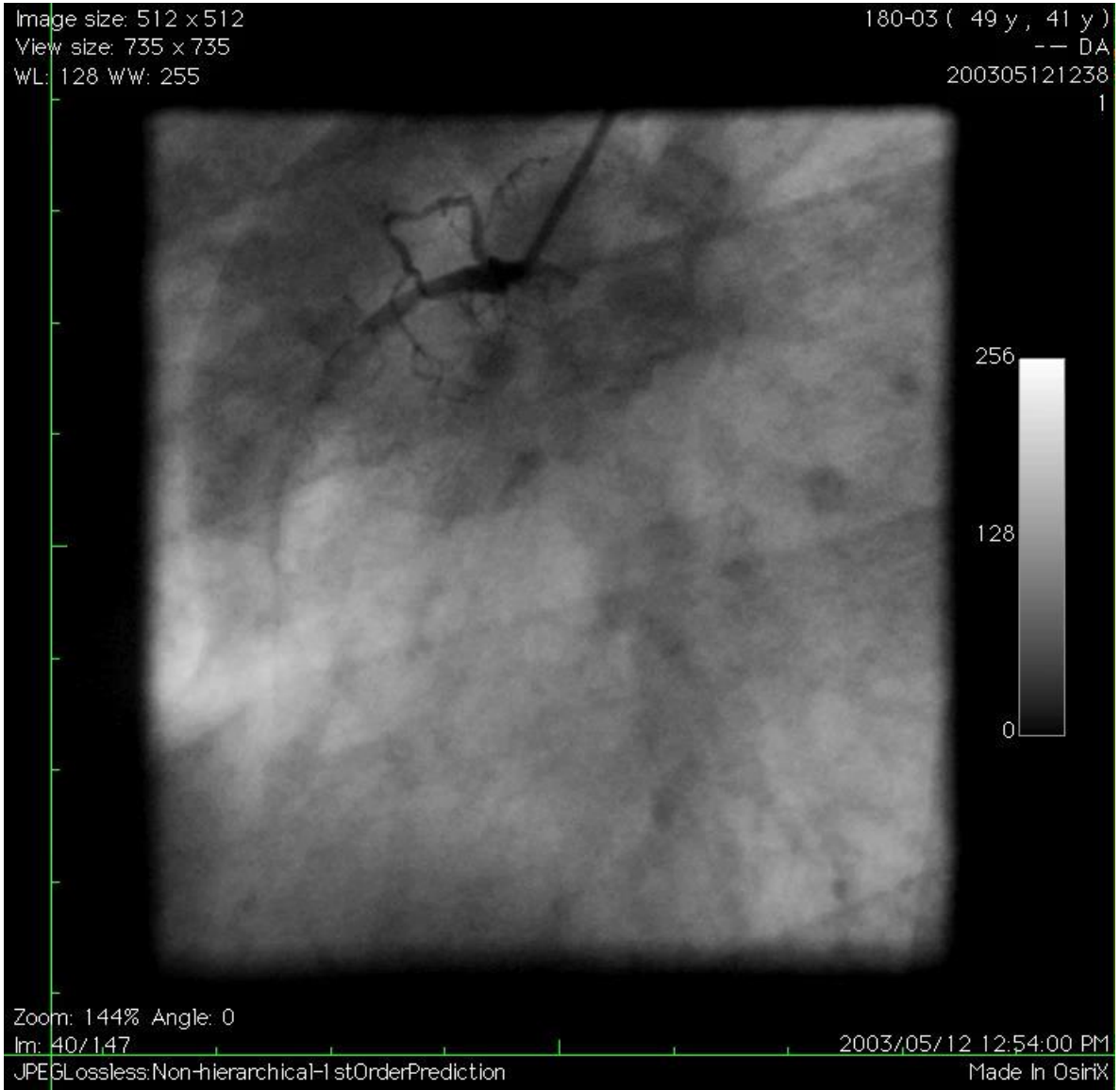
What do we do?



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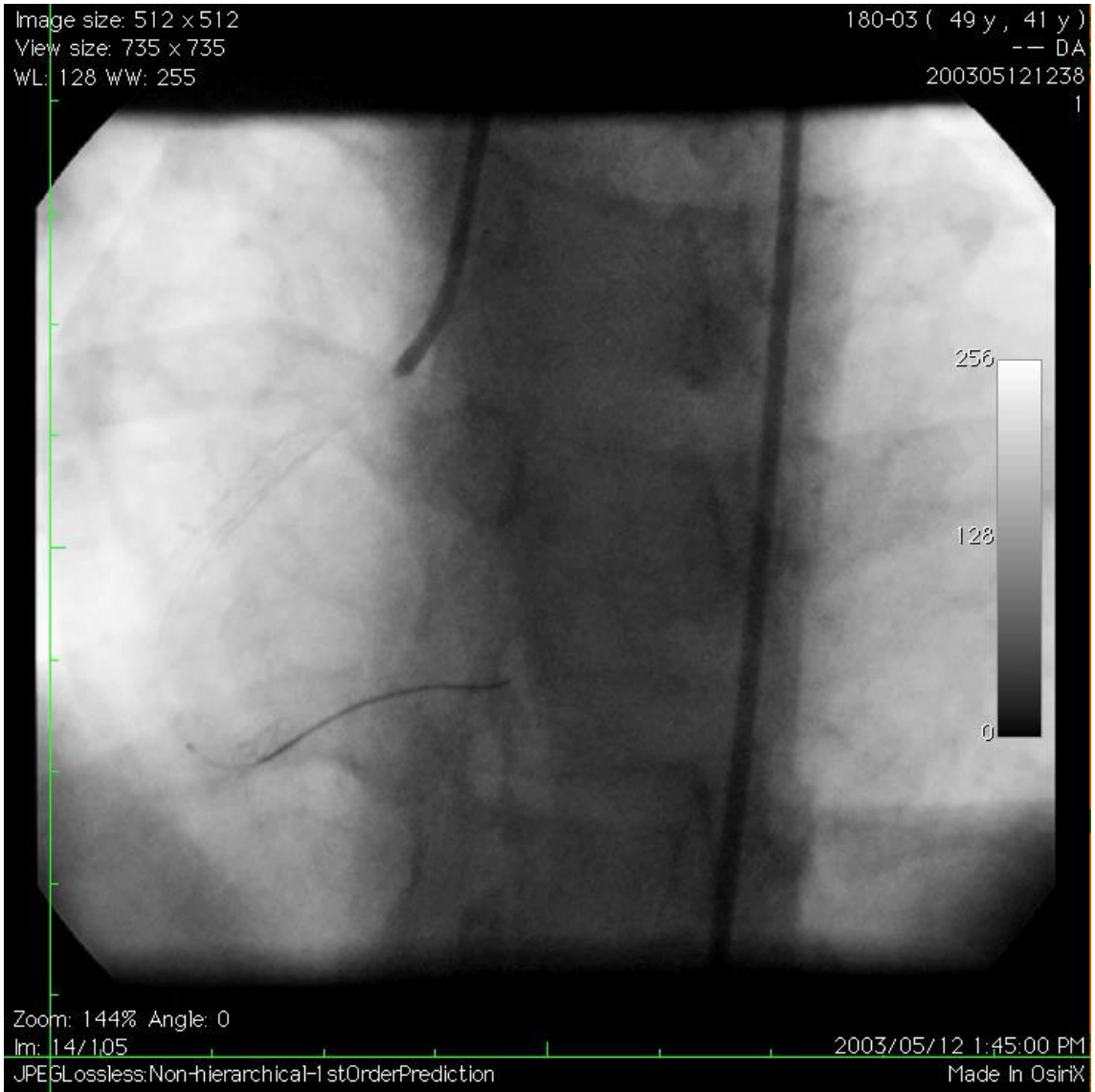

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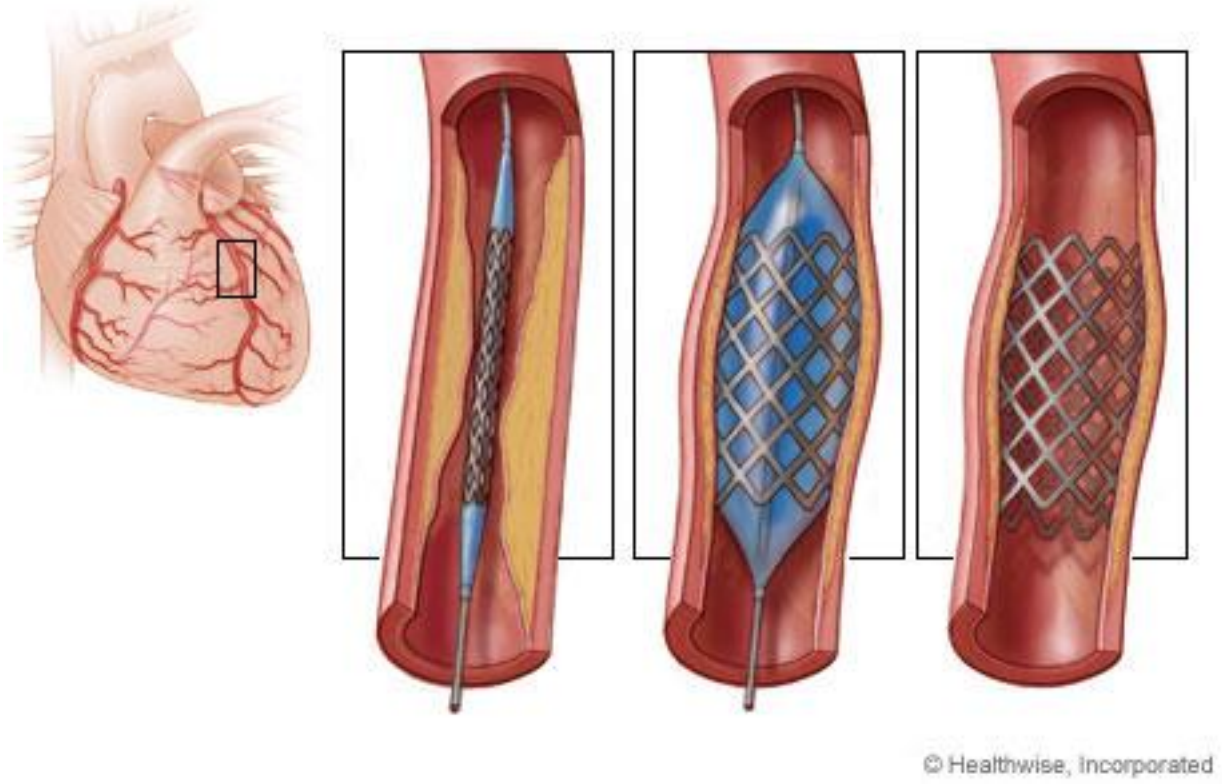

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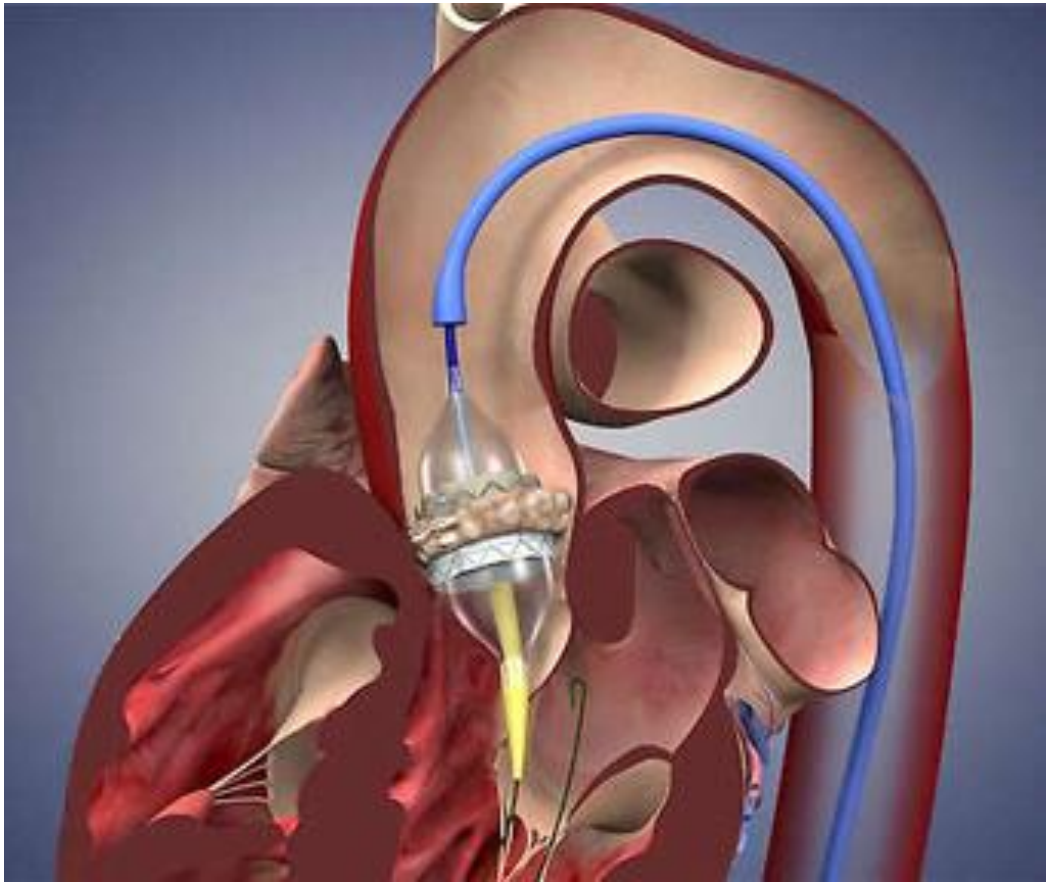

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How do we function in the private sector?

Referred patients

Often emergencies

PMB diagnoses, often life threatening illnesses that demand immediate action for best possible outcome

Also elective consultation work

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Why are we here?

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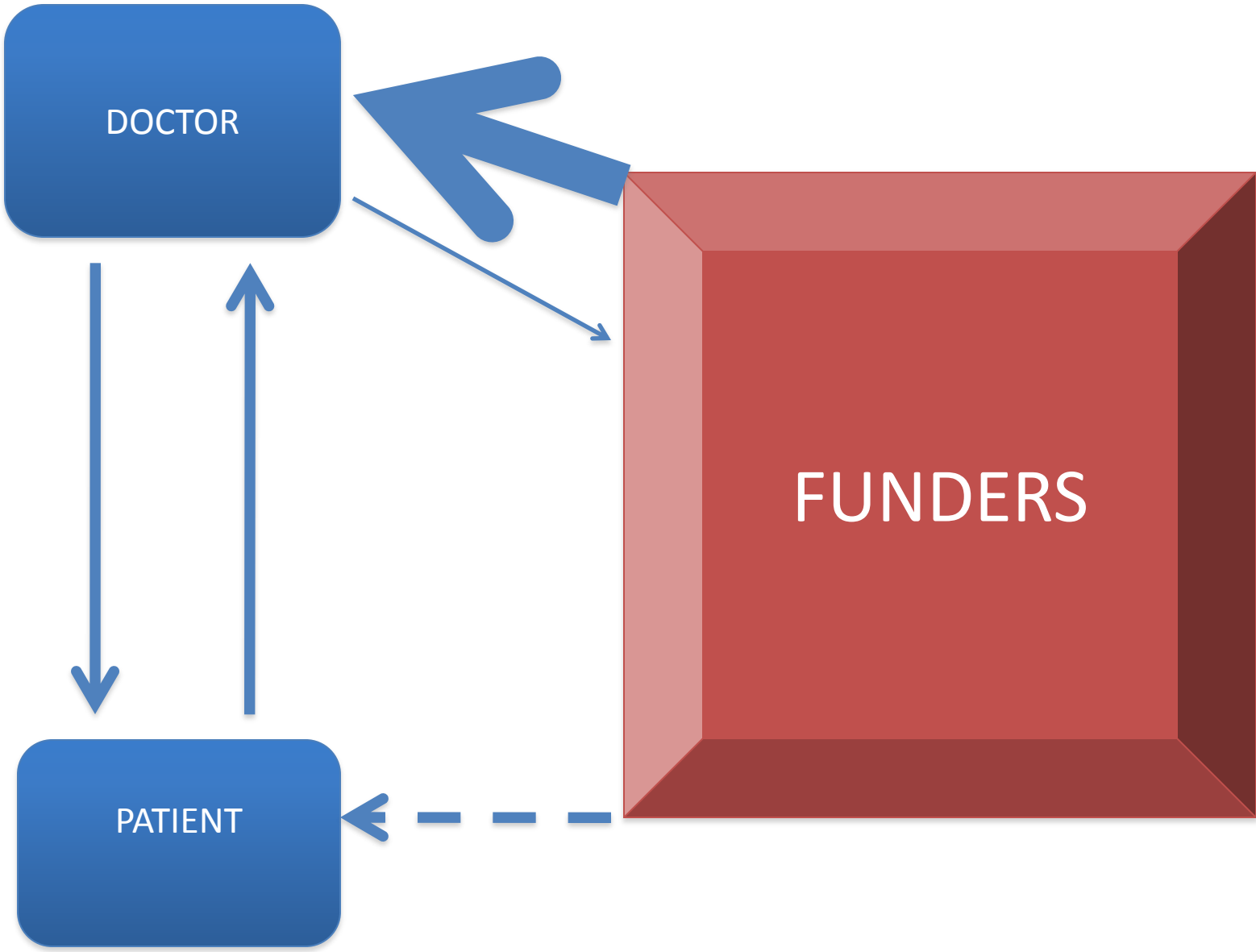

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Please sir, could I treat this high cholesterol?

Please sir, could I place a stent?

Please sir, I promise you a pacemaker really really really is necessary…

FUNDERS

Like I said, I needed to use that balloon…

It really was a heart attack, you cannot force the patient to pay for that!

You do need an anesthetist to do a bypass operation

This patient remains in hospital, because they are sick…

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There is a gross imbalance of power

1.Between funder and patient

Funder – patient problems

Patients do not know their rights and nobody is telling them

Simple messages need to be conveyed and understood:

- Chronic medicine should be provided without copayment
- Cardiac emergencies may not attract copayment for hospital-based interventions
- You may consult your cardiologist for an annual review under PMB care plan allocation and this cost should be born by the funder

Funder – patient problems

How difficult is it to get funding for important, but expensive items for life threatening illnesses?

For us: best example is TAVR

You can have your valve replaced, but only if you do it in the way that we say you should (open surgery).

Yes, the operation will kill you!

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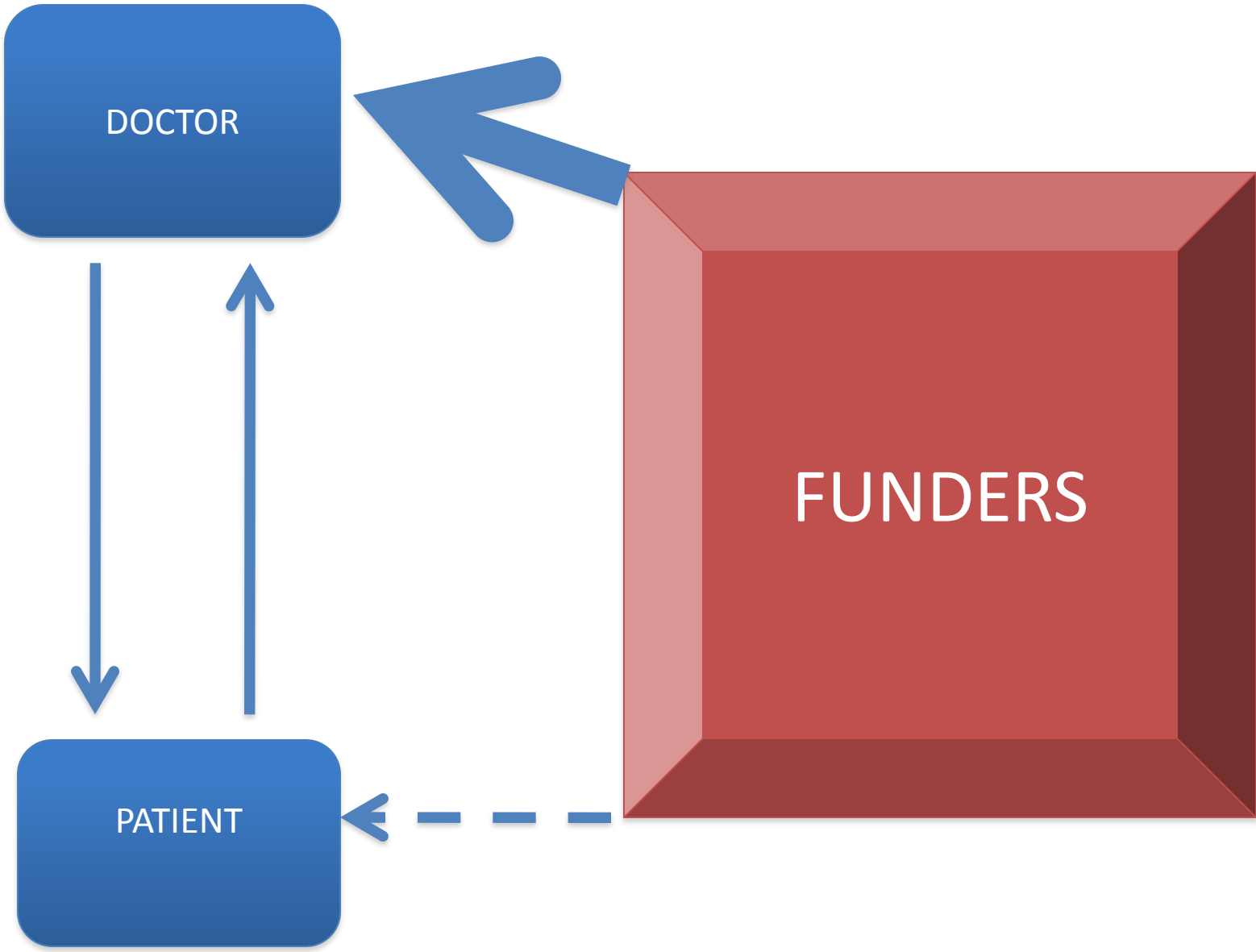

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There is a gross imbalance of power

2. Between funder and doctor

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FUNDERS

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Funder-doctor problems

What sort of treatment is best?
the funder decides (multivessel revasc)

What ancillary imaging modalities do you need in the catheterisation laboratory
the funder decides (IVUS in LMS stenting)

What drug should I use:
the funder decides (Warfarin vs NOAC for PE)

Funder-doctor problems

Deciding what to pay for, is the same as deciding how to treat!

None of my patients can afford to have an opinion different from the funder

SO, NOR CAN I

BUT THEN THEIR PROTOCOLS SHOULD BE CONTEMPORARY AND EVIDENCE BASED?

SADLY, NOTHING COULD BE FURTHER FROM THE TRUTH?

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Funder-doctor problems

Funder decides how much we should charge for our services

by coercion

Different specialists will get different fees for the same procedure

Coding rules : one cannot possibly get remunerated properly for ‘new’ procedures that we have been performing for ten years

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Funder-doctor problems

The request for motivation as a deliberate tactic to defer payment

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Funder-doctor problems

The department of stupid questions

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Funder-doctor problems

Why did you use FFR wire?

SA Heart

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5 December 2012

SASCI STATEMENT ON USE OF INTRA-VASCULAR ULTRA SOUND AND FRACTIONAL FLOW RESERVE IN IMPROVING OUTCOMES AND COST EFFICIENT MANAGEMENT IN PATIENTS UNDERGOING CORONARY ANGIOGRAPHY

The Executive Committee of the South African Society for Coronary Intervention has reviewed the data on the appropriate use of Intra-Vascular Ultrasound (IVUS) (aka ICUS) and Fractional Flow Reserve (FFR) and strongly recommends that the cost pertaining to the use of these devices is routinely covered by the medical aid fund, and that this payment is pre-authorized prior to the coronary angiogram being done.

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Funder-doctor problems

Why does the patient not have a drip?
Why did you use two angioplasty balloons?
Why did you need a second stent?
Why did you need to admit the patient to do a bypass operation?
Why did you use angiographic catheters to do an angiogram?

Implications of such power imbalances?

Doctor patient relationship is undermined at every turn?

Innovation grinds to a halt

New technology can never be introduced

Service providers eventually succumb, and desist from attempting to do what is best for their patient.

Dare I say it: patients may sustain irreversible harm, even resulting in death

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Implications of such power imbalances?

Patients are denied access, even to that for which they have already paid

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Clinicians perspective?

I have no desire to spend precious time fighting burdensome bureacracy in order to access the right to deliver old fashioned treatment to disempowered patients who, despite paying substantially to an insurance company are coerced into accepting second or third rate treatment options masquerading as ‘evidence based protocols’

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So why are we here?

We want to continue delivering a world class service, to as many patients as humanly possible

We believe that South Africans should have access to contemporary care

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So why are we here?

We believe that the environment in which we are forced to work is detrimental both to service delivery and the future of our discipline

Interventional cardiology is going to be ever more essential as we face an epidemic of cardiovascular disease which cannot be managed in any other way!

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So why are we here?

We must advocate on behalf of our patients and our population, who often are unaware of the treatment modalities they are being denied, the drugs and devices that are being ignored, and the loss that our nation would sustain were we to allow our pool of interventionists to continue to shrink, and such hard won expertise to be so diluted as to be irrelevant to the care of our nation.

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So why are we here?

We have no hope if we stand alone against funders in defending our discipline and our patients

We have no means, and no right to stand together, for such could be seen as collusion?

And so we appear before you to share a different perspective perhaps?

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So why are we here?

There are very very few of us

Those of us still here, are committed

We love what we do

We want to be able to continue serving, and are committed to ensure that the next generation is even better equipped than we have been to deal with the needs of our population

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Thank you for your kind attention