ANNEXURE 2 TO IPAF REPLY TO HEALTH OUTCOME MEASUREMENT AND REPORTING SUBMISSION

2. IMPLEMENTATION OF THE QUALITY MANAGEMENT SYSTEM

The health care industry is adequately regulated in South Africa by inter alia the National Health Act, The Health Professions Act and the Ethical guidelines of the Health Professions Council of South Africa ("HPCSA"). Save for the Continuous Professional Development ("CPD") program of the HPCSA, and possibly the algorithms linked to the Prescribed Minimum Benefits ("PMB’s"), there are no nationwide practical measurements or guidelines in place in South Africa to influence the clinical behaviour of medical professionals. It is important to link healthcare outcomes, clinical behaviour, quality of patient care and the reduction of healthcare costs in a transparent manner and this is done by way of actuarial analysis and comparison.

A well-structured quality management system improves healthcare outcomes to the patient while maintaining prudent health care expenditure. We believe that the IPAF quality management system achieves this through the use of Insight’s services.

3. HOW DOES THE IPAF/ INSIGHT QUALITY MANAGEMENT SYSTEM WORK

Data is received by Insight from the participating Funder in an anonymised format (patient specific information is encrypted). It is risk adjusted per practitioner depending on the doctor’s patient profile for age, sex, disease prevalence etc. and a profile is produced for that individual doctor using criteria related to quality outcomes, and related costs of achieving these outcomes.

A profiling “dashboard” is produced for each member doctor. This is essentially a pictorial and graphic “report card” for doctors taking into account key measurements which tell doctors how they compare to their peers (who are anonymised) in terms of quality and value.

Updated information is sent directly to the actuarial consultants (Insight) from the participating Funders. The report cards are updated and emailed to GPs every 3 months. We attach an example of a report card hereto marked IPAF 1.

The objective is to give GPs a quick and easy way to be aware of the quality, value and costs they are generating against a normalised sample of their peers.

IPAF also seeks to educate doctors so that they in turn can assist their patients in understanding and utilising what Primary Health Care benefits (for example through preventative healthcare measures like mammograms etc.) the participating schemes offer and what members may be expected to pay by way of self-payment. From this the

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doctor will ascertain the level of billing which is appropriate for them using the appropriate billing codes.

For example a GP can explain to a patient the benefit of registering their chronic conditions with the medical scheme and the benefits associated therewith. IPAF encourages patient centered care in a narrative where the patient is educated, informed, engaged and can participate in shared decision making with his or her GP. IPAF encourages patient activism in their health seeking behavior.

4. THE IMPORTANCE OF QUALITY AND COST MEASUREMENT SYSTEMS:

a) Preventative and Promotive healthcare

The IPAF quality measurement system encourages preventative care and therefore GP’s will receive a higher score on their report card if they regularly do preventative screening tests for their patients. Specifically the report card measures the GP on HIV tests, mammograms, pap smears, personal health assessments, flu vaccines and prostate antigen tests i.e. the GP scores well if he or she regularly orders the aforementioned screening tests (so in this case appropriate utilization is actively encouraged). Preventative care is absolutely in the best interest of the patient.

In this regard please see IPAF 2 which contains statistics from Medscheme which clearly show that Network doctors do more preventative screening tests than non-network doctors. There are various other benefits associated with network versus non-network doctors according to Medscheme. It is important to realise that IPAF does not have any contractual relationship with Medscheme, but the value of a network of contracted doctors (Designated Service Providers) is borne out here, as indeed it is in the IPAF network.

IPAF 3 is an example of a quarterly report compiled by Insight for a well-known medical scheme which clearly illustrates the reduction in cost to the scheme after introducing IPAF peer review and profiling. Not only were costs to the scheme reduced significantly but the patients’ healthcare outcomes were improved due to the encouragement of preventative screening tests.

b) Proxy measures for outcomes

The GP is further measured on the prevalence of diabetes, cardiac, respiratory and thyroid diseases in his or her practice and the extent of complications from these diseases which have generated admission days in hospital. The GP is therefore required through the practice of preventative medicine to influence hospitalisation of patients with chronic diseases. The lower the patients’ hospitalisation rate, the better the GP scores as most of these diseases have a strong preventative element which the GP can influence.

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c) Direct versus Indirect costs:

GP's are measured on direct costs which are defined as costs within the control of the GP, for example GP visits, acute medicines prescribed by the GP, pathology and radiology tests. Direct costs are measured per allocated patient per month. Indirect costs come from specialist visits and their decisions to investigate, operate, hospitalise the patient, etc.

d) Peer review:

If a GP does not score well over a 6 to 9 month period, he or she is contacted by a nominated IPAF member (GP) from a different geographical region which eliminates bias, who will act as mentor and record recommendations and suggest appropriate measures to improve healthcare outcomes which should translate into cost saving for the patient in the long run. An example of a peer review form is attached marked IPAF 4. The recommendations and outcomes for improvement by that GP is therefore made by a fellow GP who has been identified as a mentor and not the funder in any way. This ensures that the best interest of the patient is served at all times.

Review of professional practice by a peer is an internationally acceptable valuable and important part of maintenance and enhancement of a health practitioner's clinical and professional skill. It is also the tool used to address practice aberrations in cost and outcomes. Medical Peer Review is the process by which a committee of physicians examines the work of a peer and determines whether the physician under review has met acceptable standards of care in rendering medical services. The standards are established by physicians using evidence-based medicinal guidelines. A medical peer review may be initiated at the request of a patient, a physician or a funder.

The term "Peer Review" is sometimes used synonymously with performance appraisal. Due to the way information is gathered in South Africa, from claims submissions with ICD 10 codes, peer review is focused on diagnosis, process measurements and clinical outcomes (where the profiling team has the data to assess clinical outcomes). The entire process is dynamic and has changed over time with a greater emphasis on quality, and value process measurements and a decreased weighting on costs to medical schemes.

With the introduction of Peer Review committees, the emphasis is on mentoring the reviewed doctor. The statistical report is viewed against the clinical activity, the seriousness of the case and whether the costs are directly due to the physician being reviewed or emanate from referral costs to specialists and hospitals.

IPAF ensures that its peer reviewers are regularly trained to keep up to date with the latest literature on new modalities of care, medical care guidelines and ethics.

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The commitment by IPA’s to review colleagues is part of our philosophy of attaining the highest possible level of quality within limited resources.

With the limited disposable resources and the majority of patients cannot afford to purchase programs that are able to meet all his or her needs. It is therefore incumbent upon us to assist and review for appropriateness, necessity, the choices made in terms of laboratory and radiological investigations and the appropriate referral to secondary and tertiary care. Hence choices will be predicated not only on the basis of strict clinical considerations but also on medico-economic considerations.

The actual “Peer Review” is based on profiling data. As previously indicated various schemes use different profiling systems. The data is usually retrospective over 12 months and is risk adjusted for age, gender, co-morbidities and any relevant confounding variables. This allows us to compare any GP with the average benchmark of his peers on a like for like basis. Peer reviewers are empowered to readjust the doctors network category upwards after their interaction with the provider should there be good evidence presented at the interview.

Physicians who are reviewed have voluntarily signed a contract with the funders, as well as a Form of Accession agreeing to the terms and conditions of the contract between the Funder and IPAF, to be accessible to the patient at all times, to manage the clinical care appropriately and safely and to subject themselves to Peer Profiling, and resultant Peer Review if necessary.

The categorisation of practices is then relayed to the Funders to enable them to identify and reward doctors who work efficiently, honestly and cost effectively, and who implement the most appropriate evidence based care for their patients without compromising patient safety or care.

e) Self-Assessment on Quality

IPAF has developed a basic checklist which lists all the essential equipment a GP practice should have to ensure minimum levels of quality and care for the patient. GP’s can and do use this checklist to self-assess their quality and care performance levels

f) Appeals process

An appeals process is in place whereby a doctor, who disagrees with the outcome of peer review, is able to approach the peer review committee and have such report re-assessed.

g) Referral to higher authority

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Should the peer reviewer feel that the doctors' performance or behaviour is unacceptable, they are empowered to make various recommendations to the Funders or the HPCSA for example that the GP is not acting in the best interest of the patient. To date there is not a single case or complaint that has been lodged with the HPCSA against any IPAF member or the IPAF by a member of the public alleging that such person’s health has been compromised or that an IPAF member has acted unprofessionally by participating in the peer review and profiling system. Indeed, quite to the contrary, the evidence shows that the IPAF peer review and profiling system benefits patients’ health care outcomes.

Yours sincerely

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