How medical practitioners perceive the impact of managed care on their practices and on patient care

August 2006
The objectives of this research were to:

1. understand the position and views of a representative sample of healthcare providers on the impact of managed care on their practices

2. use the results in a constructive way in order to effect changes and better co-operation in the interest of good patient outcomes, in view of new developments in, for example, CMS Circular 8.
WMA did global research project on Doctor Clinical Independence (Jan 2005).

WMA Research identified factors that make practice of medicine difficult for doctors.

There was need to verify, broaden and contextualise results for SA setting.
Why is this research important?

This research does not show any earth-shattering “new” issues, however:

It (to the best of our knowledge for the first time) quantifies the extent to which medical practitioners hold certain views on- & how they experience managed care activities.

The research results can be used successfully as a tool to engage these issues.
The results – a logical flow

1. What are the perceptions of doctors on statements that are associated with MC?
2. MC implies administration and time-issues: how are doctors experiencing these?
3. These administration and time-issues relate to specific managed care activities that may pose challenges: how are doctors experiencing these?
   3.1 Tests, treatment / therapy
   3.2 Number of consultations
   3.3 Algorithms/protocols & formularies
   3.4 Overall impact on selected CDL conditions
4. A solution-driven approach to the research: putting quality of care first

Perception ➔ Time & Activities ➔ Solutions
(a) Research structure

Methodology

- Personal individual interviews
- Fairly structured questionnaire

Target audience

- GPs
- Physicians in full time, active private practice

The sample

- Statistically representative of GPs and physicians in full time, active private practice in main metropolitan centres (defined by dialing code) of Jhb, Pta, Bloem, Dbn, PE, Cape Town:
  - 400 GPs
  - 132 physicians
- Selected from merged MSD & SAMA databases of GPs and physicians
- Geographically, sample distribution mirrors geographic distribution of lists

Statistically representative sample, personal interviews
### Sample demographics

<table>
<thead>
<tr>
<th></th>
<th>TOTAL (532)</th>
<th>GP (400)</th>
<th>PHYS (132)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAMA MEMBERSHIP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAMA membership</td>
<td>73%</td>
<td>73%</td>
<td>73%</td>
</tr>
<tr>
<td>SAMA non-membership</td>
<td>27%</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td><strong>POPULATION GROUP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>16%</td>
<td>15%</td>
<td>18%</td>
</tr>
<tr>
<td>Black</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Coloured</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>75%</td>
<td>76%</td>
<td>73%</td>
</tr>
<tr>
<td><strong>PRACTICE TYPE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash practice</td>
<td>26%</td>
<td>29%</td>
<td>19%</td>
</tr>
<tr>
<td>Non-cash practice</td>
<td>68%</td>
<td>66%</td>
<td>75%</td>
</tr>
<tr>
<td>Both</td>
<td>6%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>AVE NO. PTS SEEN PER DAY / MEDICAL AID STATUS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ave no. pts / day</td>
<td>25 – 26</td>
<td>27 – 28</td>
<td>17 – 18</td>
</tr>
<tr>
<td>Ave % m/aid beneficiaries</td>
<td>77 – 78%</td>
<td>74 – 75%</td>
<td>87 – 88%</td>
</tr>
</tbody>
</table>

More doctors moving to cash practices?
1. LEVEL OF DOCTOR AGREEMENT WITH STATEMENTS GENERALLY ASSOCIATED WITH THE MANAGED CARE CONTEXT
1. Level of agreement with general statements – total sample

| Statement                                                                 | Percentage
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed health care interventions: -ve impact quality of Dr-pt relationship</td>
<td>88%</td>
</tr>
<tr>
<td>Pts “save up” multiple complaints due to m/aid benefit limits</td>
<td>93%</td>
</tr>
<tr>
<td>Medical aids are allowing pts too few consultations per annum</td>
<td>87%</td>
</tr>
<tr>
<td>Pts feel it is Drs’ duty to negotiate with their m/aid on their behalf</td>
<td>88%</td>
</tr>
<tr>
<td>Pts rely on Dr for knowledge about their m/aids</td>
<td>83%</td>
</tr>
<tr>
<td>I should not have to negotiate with medical aids</td>
<td>95%</td>
</tr>
<tr>
<td>Unethical to discuss a pt’s condition with his / her medical aid</td>
<td>82%</td>
</tr>
</tbody>
</table>

Pt “saving up” complaints – less consultations / Drs seen as “intermediaries” to schemes?
1. Level of agreement with general statements – total sample

Top two box = % indicating “strongly agree” and “agree”

- **Should not have to justify Tx choice to someone who hasn’t examined pt (94%)**
- **PMBs are interpreted by m/aids as maximum benefits (92%)**
- **Advisors at medical aids are hard to reach (86%)**
- **Tx algorithms prevent me from doing the best for my pts (78%)**
- **Disease management algorithms have regressed medical care 10-15 yrs (69%)**
- **Medical aids insist on changes to my Tx protocols = they are personally responsible for resulting problems (91%)**

*GPs (Base = 400)*

*Physicians (Base = 132)*

Need to talk to peers / negative views on algorithms
Managed care by its very nature entails some measure of time spent on administration and/or justification of clinical routes recommended by providers.

During the research it became clear that this is a great source of frustration, but we are convinced that most of these issues can be addressed constructively.

Time + justification = frustration!
In the following section we unpack:

2. **Time spent** in terms of -:
   - Admin and medical scheme issues - numbers of hours
   - Types of issues addressed
   - Who doctors interact with

3. **Types of interventions** that practitioners experience:
   3.1 Tests, treatment / therapy
   3.2 No. of consultations
   3.3 Algorithms and formularies

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Unpacking time and managed care issues
### 2. The administrative burden

#### Ave no. hours spent per week dealing with medical aids – total sample

<table>
<thead>
<tr>
<th></th>
<th>TOTAL (532)</th>
<th>GPs (400)</th>
<th>PHYSICIANS (132)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personally: Ave</td>
<td>4 – 5 hrs</td>
<td>4 hrs</td>
<td>4 – 5 hrs</td>
</tr>
<tr>
<td>Staff: Ave</td>
<td>9 – 10 hrs</td>
<td>9 hrs</td>
<td>10 – 11 hrs</td>
</tr>
</tbody>
</table>

#### Nature of doctors’ dealings – total sample

- **Total (532)**
  - Pts don’t know their benefits: 31%
  - Motivation processes take time: 25%

- **GPs (400)**
  - Pts don’t know their benefits: 25%
  - Motivation processes take time: 20%

- **Physicians (132)**
  - Pts don’t know their benefits: 28%
  - Motivation processes take time: 34%

Doctors and their staff spend significant portions of their time on medical scheme issues.
2. The administrative burden: managed care / scheme interventions

### % cases where medical aids intervene – total sample

<table>
<thead>
<tr>
<th></th>
<th>TOTAL (532)</th>
<th>GPs (400)</th>
<th>PHYSICIANS (132)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ave %</td>
<td>39%</td>
<td>40%</td>
<td>36%</td>
</tr>
<tr>
<td>Median</td>
<td>21 – 30%</td>
<td>21 – 30%</td>
<td>21 – 30%</td>
</tr>
</tbody>
</table>

### IN NON-CASH PRACT (MED SCHEME)

<table>
<thead>
<tr>
<th></th>
<th>TOTAL (361)</th>
<th>GPs (262)</th>
<th>PHYSICIANS (99)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ave %</td>
<td>41 – 42%</td>
<td>42 – 43%</td>
<td>38 – 39%</td>
</tr>
<tr>
<td>Median</td>
<td>31 – 40%</td>
<td>31 – 40%</td>
<td>21 – 30%</td>
</tr>
</tbody>
</table>

### Reaction to intervention – total sample

- **Total (532)**
  - Accept but unhappy: 32%
  - Unsuccessfully motivate: 24%
  - Successfully motivate: 23%
  - Accept & happy: 21%
- **GPs (400)**
  - Accept but unhappy: 32%
  - Unsuccessfully motivate: 25%
  - Successfully motivate: 21%
  - Accept & happy: 22%
- **Physicians (132)**
  - Accept but unhappy: 30%
  - Unsuccessfully motivate: 22%
  - Successfully motivate: 30%
  - Accept & happy: 17%

**Interventions in approx a third of cases**
2. The administrative burden: staff at schemes

Extent to which calibre of contact person is an issue – total sample

Doctors find the calibre of the contact person at schemes an issue
3. Prevalence & types of managed care interventions:

3.1 Tests and Treatment
(general and per selected CDL conditions)
3.1 Types of pressures / restrictions

Nature of restrictions – Summary

<table>
<thead>
<tr>
<th>Cannot...</th>
<th>GPs (Base = 391)</th>
<th>Physicians (Base = 127)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use best product (99%)</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Use best class (93%)</td>
<td>93%</td>
<td>94%</td>
</tr>
<tr>
<td>See pt often enough (72%)</td>
<td>72%</td>
<td>73%</td>
</tr>
<tr>
<td>Continue therapy long enough (58%)</td>
<td>59%</td>
<td>60%</td>
</tr>
<tr>
<td>Conduct tests (61%)</td>
<td>61%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Tests ➔ Treatment options ➔ Continued care
### 3.1 Patients affected per selected CDL conditions

#### % of patients affected by restrictions (total sample)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>490</td>
</tr>
<tr>
<td>Hyperlipidaemia</td>
<td>386</td>
</tr>
<tr>
<td>Asthma</td>
<td>357</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>341</td>
</tr>
<tr>
<td>COPD</td>
<td>139</td>
</tr>
</tbody>
</table>

#### % of cases where doctor cannot...

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of cases where doctor cannot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperlipidaemia</td>
<td>64 – 65%</td>
</tr>
<tr>
<td>COPD</td>
<td>61 – 62%</td>
</tr>
<tr>
<td>Asthma</td>
<td>57 – 58%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>56 – 57%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>47%</td>
</tr>
<tr>
<td>Hyperlipidaemia</td>
<td>49 – 50%</td>
</tr>
<tr>
<td>COPD</td>
<td>43 – 44%</td>
</tr>
<tr>
<td>Asthma</td>
<td>41 – 42%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>38 – 39%</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>33 – 34%</td>
</tr>
</tbody>
</table>

**Use best product**

- **Hyperlipidaemia**: 64 – 65%
- **COPD**: 61 – 62%
- **Asthma**: 57 – 58%
- **Hypertension**: 56 – 57%
- **Diabetes M**: 47%

**Use best class**

- **Hyperlipidaemia**: 49 – 50%
- **COPD**: 43 – 44%
- **Asthma**: 41 – 42%
- **Hypertension**: 38 – 39%
- **Diabetes M**: 33 – 34%

**See pt often enough**

- **COPD**: 27 – 28%
- **Diabetes M**: 26 – 27%
- **Asthma**: 23 – 24%
- **Hypertension**: 23 – 24%
- **Hyperlipidaemia**: 15 – 16%

**Conduct tests**

- **COPD**: 16 – 17%
- **Asthma**: 15 – 16%
- **Diabetes M**: 13 – 14%
- **Hypertension**: 12 – 13%
- **Hyperlipidaemia**: 11 – 12%

**Continue Tx long enough**

- **COPD**: 21 – 22%
- **Asthma**: 19 – 20%
- **Hyperlipidaemia**: 18 – 19%
- **Hypertension**: 13 – 14%
- **Diabetes M**: 13 – 14%
3. Prevalence & types of managed care interventions:

3.2 Number of consultations
3.2 Ability to adequately treat & Limited number of consultations per year

**Impact – total sample**

- Generally able to adequately Tx patients (25%)
  - GPs (Base = 400)
  - Physicians (Base = 132)
  - 26%
  - 22%

**Manner in which Tx is being compromised – spontaneous – total sample**

- Can’t monitor sufficiently (11%)
  - GPs (Base = 293)
  - Physicians (Base = 101)
  - 12%
- Initial therapy needs to be checked (10%)
  - GPs (Base = 293)
  - Physicians (Base = 101)
  - 12%
- Complications develop / worsen before next visit (15%)
  - GPs (Base = 293)
  - Physicians (Base = 101)
  - 17%
- Can become uncontrolled (10%)
  - GPs (Base = 293)
  - Physicians (Base = 101)
  - 10%
- Uncontrolled need more frequent visits (9%)
  - GPs (Base = 293)
  - Physicians (Base = 101)
  - 10%
- Don’t come back for check-ups (9%)
  - GPs (Base = 293)
  - Physicians (Base = 101)
  - 9%
3. Prevalence & types of managed care interventions:

3.3 Treatment algorithms & formularies
3.3 Treatment algorithms

Overall problems with CDL treatment algorithms – spontaneous – total sample

- Certain drugs / therapies not allowed (39%)
- Outdated / no newer drugs (29%) 43%
- Limited / restrictive (22%)
- Not up to standard (11%)
- Confusing / not understandable (18%)
- Criteria too high (17%)
- No pt individuality (14%)

GPs (Base = 223)

- Certain drugs / therapies not allowed (38%)
- Outdated / no newer drugs (26%)
- Limited / restrictive (22%)
- Confusing / not understandable (16%)
- Criteria too high (12%)
- No pt individuality (17%)

Physicians (Base = 74)

- Certain drugs / therapies not allowed (38%)
- Outdated / no newer drugs (38%)
- Limited / restrictive (19%)
- Confusing / not understandable (22%)
- Criteria too high (20%)
- No pt individuality (20%)

TOTAL SAMPLE

GPs = 223 (56%)
Physicians = 74 (56%)
297 (56%)
4. A solution - oriented approach?

This is the current reality – but how do we move forward?
Vision:
An “NCQA” for South Africa:
A Comprehensive Performance Measurement System

Purpose: To reduce the burden of illness and to improve health and functioning

- Establish Goals/Aims
- Promulgate standardized measures
- Data collection and Aggregation

Public reporting
Accountability, Improvement, Population Health

Were the Aims Achieved?
Impact Assessment

What is quality?

Current quality initiatives focus on this aspect:

**Structure**
- “The way a health system is set up”
  - Material resources
  - Human resources
  - Organizational characteristics

**Process**
- What is done: dx, Rx
- rehab, prevention, pt. education?
- How it is done?

**Outcome**
- Results of intervention
- Physiology, health status, satisfaction, behavior

How do we make sure outcomes are measured & met?
How do we make sure outcomes are measured & met?

- Discussions from the floor...

- How do you see the future?

- What should SAMA’s role be?