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**JOB NO. 05/10523**

**- PROJECT IMSA -  
INVESTIGATING THE IMPACT  
OF MANAGED CARE ON  
DOCTORS' PRACTICES  
& PATIENT CARE**

**PHASE II: QUANTIFICATION - PERSONAL INTERVIEWS  
SUMMARY REPORT**

**PREPARED FOR: THE MEMBERS OF IMSA**

**PREPARED BY: VBH HEALTH CARE RESEARCH CONSULTANCY  
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## 1 **RESEARCH MOTIVATORS**

2004 was a watershed for the healthcare industry with the Department of Health legislating changes with far reaching consequences to all spheres of this industry – from manufacturers, to wholesalers to pharmacists and doctors, as well as to the end-user / consumer.

Some examples of the changes legislated include:

- Pricing control – single exit prices, distribution and dispensing fees, prescribed mark-ups
- Generic substitution
- Dispensing and practice licences / certificates of need
- Restrictions on marketing activities – outlawing of bonusing, deals, incentives, sampling and the like.

Further impacting on the industry is the ever increasing role that the medical aids or funders are playing in terms of driving prescription on a cost-containment basis – the concern being that this is not in the interests of the total quality of care provided to the patient / consumer. Since the key focus of managed care appears to be that of cost-containment, providers of healthcare services may be wrongly incentivised in terms of cost outcomes, rather than benefit outcomes. The doctor – patient relationship is also threatened by this system.

Whilst the pharmaceutical industry does not dispute that it is important to pay attention to the above-mentioned issues, in the interest of providing affordable healthcare in South Africa, this cannot be to the detriment of viability of the players in this market, without whom there would be no healthcare system in the country.

It seems that several of the laws implemented by the Department of Health have not been based on sound research or sufficient investigation of the relevant markets, and more importantly, without the involvement of representation from the healthcare sectors to present their sides of the scenario. This has resulted in laws being passed that are not financially viable for some of the parties concerned.

A number of key multinational companies present in South Africa (MSD, Pfizer, Novartis, Roche, Sanofi-Aventis and Lilly) decided to act on this and formed a body called IMSA (Innovative Medicines of South Africa). Since these companies have the same interests at heart, the feeling is that a united force is more powerful in terms of addressing legislative issues of concern, and interfacing with the Department of Health.

One of the key issues that IMSA wishes to address is that of managed healthcare (MHC) and the effect that it has on:

- Doctors' practices in terms of their management and day-to-day administration
- Doctors' prescribing habits
- The level of care received by patients – both acute and chronic.

IMSA wished to benchmark the performance of MHC and the schemes involved, so that a strategy can be developed to reform the healthcare market in the best interest of all players concerned. Whilst it is known that managed care and medical schemes place limitations on the doctors' practices and can threaten the doctor – patient relationship, the magnitude of this is unknown. Hence, marketing research was identified as a tool to assist in measuring the impact of MHC and providing a solid base for future strategies.

VBH Health Care Research was approached to design a research survey to assist in obtaining answers to some of the issues under discussion, the results of which were presented in May 2005.

Following on from this research a second, quantitative phase of research was conducted amongst GPs and physicians exploring in greater depth some of the pertinent issues raised during the first phase.

Contained in this document are the findings emerging from the quantitative phase (Phase II) of the research project.

## **2 TARGET MARKETS**

The following target markets form the basis of this research:

- ❖ GPs
- ❖ Physicians

in active, full-time private practice.

## **3 RESEARCH AIM**

The overall aim of this research was summarised:

*“To quantify the effect of funders and managed healthcare on doctors’ practices and prescribing habits, as well as the care afforded to patients”.*

### **3.1 Specific Information Objectives**

The following information needs were addressed in this research project:

- Focus on PMBs
  - chronic conditions that should be added to the list of CDLs
- Focus on four conditions not included / not adequately covered in the CDL listing (namely hormone related menopausal disorders, chronic psychiatric illness, osteoporosis and bipolar mood disorder):
  - the need for treatment algorithms for these conditions
  - priority ranking
- Assessment of adequacy of CDL algorithms; shortfalls of current CDL treatment algorithms; suggestions as to which treatment algorithms are more appropriate to follow
- Discussion of commonly seen medical conditions:
  - percent of cases where medical aids are preventing doctors from doing what they feel is best for the patient
  - manner in which treatment is being curtailed

- Limited consultations per year – are doctors able to adequately treat patients?
- Impact of PMBs on:
  - quality of patient care
  - patient's access to care
  - outcome of disease management
- Focus on formularies:
  - extent to which doctors are referring to formularies
  - perceived level of script changing at pharmacies
- Time spent dealing with medical aid-related queries and tasks performed
  - the calibre of the contact person at the medical aid
- Medical aid intervention and doctors' reaction
- Cost containment / single exit pricing:
  - impact on the cost of medicines
  - percentage decrease in cost of generics and multinational medicines
- The need for one body / organisation to represent the needs of private medical practitioners:
  - who should be doing this?
  - what issues should be addressed?
- Awareness and knowledge of IMSA
- Extent to which doctors agree with a variety of topical issues (as identified during the qualitative phase of this project).

## **4 RESEARCH STRUCTURE**

### **4.1 Methodology**

The required information was obtained via personal, individual interviews. A semi-structured questionnaire was designed and used for this phase of the research. This type of questionnaire allows for all questions to be posed in the same way to each respondent whilst providing opportunity for the interviewer to probe on pertinent issues.

### **4.2 Sample Size and Coverage**

Client requested that a statistically representative sample of GPs and physicians in full time, active private practice in the main metropolitan centres of the country be interviewed. Figures obtained from Medpages indicated the following:

- A total of 4 429 GPs in active, full time private practice in the main metropolitan centres of South Africa (defined as 011, 012, 021, 031, 033, 041 and 051 dialling codes)
- A total of 239 physicians in active, full time private practice in the main metropolitan centres of South Africa.

Using a finite population adjusting formula, it was determined that statistically representative samples at 95% accuracy of GPs and physicians were as follows:

- GPs – statistically representative sample: 383
- Physicians – statistically representative sample: 147.

It was therefore decided that the following number of interviews would be conducted for this survey:

- 400 interviews with GPs
- 150 interviews with physicians
- **Total sample: 550.**

Ultimately only 532 interviews were conducted, including 400 GP and 132 physicians interviews. Section 5 of this document provides an in-depth account of respondent targeting and selection as well as reasons for the shortfall on the physician sample.

### **4.3 Fieldwork**

The timing of the fieldwork for this survey was not ideal as it was interrupted by the December holidays. Fieldwork was conducted during the period 1 December 2005 to 15 February 2006.

### **4.4 The Questionnaire**

A copy of the questionnaire used for this phase of the research has been appended to this document (Appendix I).

## 5 DEFINING THE SAMPLE

The universe for this survey was defined as GPs and physicians in full time, active private practice in the main metropolitan centres of South African including Johannesburg, Pretoria, Bloemfontein, Durban, Port Elizabeth and Cape Town.

### 5.1 GP Sample

A comprehensive list of GPs in active, full time private practice was given to VBH from which the sample was to be selected – this list being obtained by merging SAMA's and MSD's databases.

From this merged list containing 5 902 names, the names of all doctors practising in the relevant main metropolitan centres of South Africa in which interviews were to be conducted, were selected. Names of respondents obviously in provincial practice were then removed as were those without full contact details, resulting in a universe of 2 875 doctors from which respondents could be selected.

A geographic comparison of the sample achieved, compared to the target audience of 2 875 GPs, is as follows:

AREA	TARGET AUDIENCE 2 875		SAMPLE ACHIEVED 400	
	No.	%	No.	%
Johannesburg	1030	36%	145	36.25%
Pretoria	399	14%	55	14%
Bloemfontein	74	2.5%	10	2.5%
Durban	442	15.5%	60	15%
PE	181	6%	25	6%
Cape Town	749	26%	105	26.25%
<b>TOTAL</b>	<b>2 875</b>	<b>100%</b>	<b>400</b>	<b>100%</b>

The spread of interviews in each of the regions within these main metropolitan centres was proportionate to that of the target audience, thereby ensuring representation across a wide spread of areas.

## 5.2 Physician Sample

Identifying the physician sample was carried out in the same way as the GP sample was selected - a comprehensive list of physicians in active, full time private practice was given to VBH – this list being obtained by merging SAMA's and MSD's databases. VBH then merged this list with its list of physicians, yielding 257 potential contacts.

From this merged list, the names of physicians practising in the relevant main metropolitan centres of South Africa in which interviews were to be conducted were selected. Contacting these 257 doctors further reduced the target audience to 213 options, for the following reasons:

- 15 provincial practice / not in full time private practice
- 10 unknown / not located
- 8 different speciality
- 6 retired
- 3 emigrated
- 2 dead.

The outcome of contacts with this universe of 213 "qualifying" respondents was as follows:

- 132 successfully interviewed
- 53 refusals
- 11 no appointments available within the fieldwork period
- 7 couldn't pin down
- 6 on maternity leave / on leave
- 4 cancelled their appointment.

Thus the 132 physician interviews represent a contact rate of 62% (132 out 213).

A geographic comparison of the sample, compared to the universe of 213 physicians is as follows:

AREA	TARGET AUDIENCE 213		SAMPLE ACHIEVED 132	
	No.	%	No.	%
Johannesburg	63	30%	33	25%
Pretoria	42	20%	26	20%
Bloemfontein	7	3%	6	4.5%
Durban	38	18%	25	19%
PE	13	6%	9	6.5%
Cape Town	50	23%	33	25%
<b>TOTAL</b>	<b>213</b>	<b>100%</b>	<b>132</b>	<b>100%</b>

### **5.3 Recruiting Respondents and Incentive Payments**

In November 2005 SAMA sent out an electronic newsletter to all its members informing them of the upcoming survey and imploring members to donate their time and participate in this survey.

On contacting potential respondents (which included both members and non-members of SAMA) a copy of this letter was again sent (either by email, fax or in some cases via personal delivery).

VBH did not receive a very favourable response to the idea that doctors were to participate in this survey without (adequate) compensation for their time despite a R50 gift voucher being given as a token of appreciation of their time, comments such as:

*"Time is money"*

*"There is no such thing as a free lunch"*

*"I pay a lot of money to SAMA each year to be a member for which they do absolutely nothing. Why should I do this for free?"*

being received. This non-payment resulted in a very high refusal rate, especially amongst the physician sector of the sample. Indeed, in order to beef up the physician sample, doctors who had previously refused to grant an interview had to be recontacted and offered an incentive for their participation. This resulted in an additional 21 physician interviews being secured.

## **6 RESEARCH FINDINGS**

All research findings were computer analysed in great detail, with area, speciality, SAMA membership, population group and practice type (cash practice) being used as demographic breaks. A full set of analysis tables has been provided as a separate document to this report.

Contained in this section of the report is a summary of the main findings of the survey.

Findings within this document have been presented as % of the sample and have been broken down to represent GP versus specialist opinion. Should data be required on any of the other analysis breaks, this can be referenced in the computer analysis tables.

## 6.1 Sample Demographics

The demographics of this sample are as follows:

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>532</b>	<b>400</b>	<b>132</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>AREA</b>			
	<b>%</b>	<b>%</b>	<b>%</b>
Johannesburg	33	35	25
Pretoria	16	15	20
Bloemfontein	3	3	5
Durban	16	15	19
Port Elizabeth	6	6	7
Cape Town	26	26	25
<b>SAMA MEMBERSHIP</b>			
	<b>%</b>	<b>%</b>	<b>%</b>
SAMA member	73	73	73
SAMA non-member	27	27	27
<b>POPULATION GROUP</b>			
	<b>%</b>	<b>%</b>	<b>%</b>
Asian	16	15	18
Black	4	4	4
Coloured	5	5	5
White	75	76	73
<b>PRACTICE TYPE</b>			
	<b>%</b>	<b>%</b>	<b>%</b>
Cash practice	26	29	19
Non-cash practice	68	66	75
Private patients pay cash / both	6	6	6

### **6.1.1 Average Number of Patients Seen per Day and Medical Aid Membership**

Respondents gave an indication of the number of patients that they see per day and estimated the proportion of their patients that are medical aid beneficiaries – the range of estimates received in this regard has been summarised in the table opposite.

On average these doctors estimated that they see between 25 and 26 patients per day, with the GPs' average patient load at 27 – 28 patients per day being somewhat higher than the physicians' at 17 – 18 patients per day.

Interestingly, these doctors reported a fairly high level of medical aid membership – the GPs estimating that on average three quarters of their patients are medical aid beneficiaries whilst the physicians gave a somewhat higher average figure of 87 - 88%.

The average estimate in terms of medical aid membership differed somewhat between white (average estimate: 80 – 81% of patients) and \*black doctors (average estimate: 67 – 68%).

Please note: where the term "black" appears in this report, it has been used to collectively refer to black, Indian / Asian and coloured respondents.

**PATIENT DEMOGRAPHICS**

	TOT	SPECIALITY	
		GP	PHYS
	Base (No.) %	400 100% %	132 100% %
<b>AVERAGE NUMBER OF PATIENTS SEEN PER DAY</b>			
10 or less	7	3	19
11 – 15	12	5	31
16 - 20	19	14	34
21 - 25	20	25	7
26 - 30	23	29	3
31 - 35	11	14	2
36 - 40	5	5	3
41 - 50	2	3	-
More than 50 per day	1	2	1
<b>Ave. No. pts seen per Dr. per day</b>	<b>25 - 26</b>	<b>27 - 28</b>	<b>17 – 18</b>
<b>PROPORTION OF PATIENTS WHO ARE MEDICAL AID BENEFICIARIES</b>			
1 – 10%	-	1	-
11 – 20%	1	1	-
21 – 30%	1	2	-
31 – 40%	2	2	-
41 – 50%	6	8	2
51 – 60%	6	8	2
61 – 70%	12	15	2
71 – 80%	30	34	20
81 – 90%	30	24	45
91 – 99%	11	6	27
100%	-	-	1
<b>Ave % pts who are medical aid beneficiaries:</b>	<b>77-78%</b>	<b>74-75%</b>	<b>87-88%</b>

## 6.2 CDLs in the Spotlight

In the opening question of the interview respondents were given a sheet on which were listed the 25 CDLs / chronic conditions medical aids are obliged to cover and were asked what other chronic conditions, not included in this list, they believe should be incorporated into the CDL. Respondents were limited to mentioning a maximum of 5 conditions here and were asked to mention the conditions in order of importance.

Over 100 different conditions were mentioned at this time, those mentioned by 5% or more of the sample having been summarised in the table opposite.

Overall half the sample agrees that depression should be included in the CDL and just short of two fifths of the sample agrees that osteoporosis and osteoarthritis are two other important conditions to include in the CDL. Thereafter, menopausal disorders, allergic rhinitis and reflux disease were mentioned.

In an attempt to determine where the doctors are placing particular emphasis, respondents were asked to list the diseases in order of priority. A summary of the top four conditions mentioned in the top three positions is as follows (note this data has been shown separately for GPs and physicians). Figures shown = the percent of the sample mentioning the condition in each position:

<b>GPs (Base = 400)</b>					
<b>FIRST POSITION</b>		<b>SECOND POSITION</b>		<b>THIRD POSITION</b>	
Depression	39%	Depression	16%	Osteoporosis	9%
O-arthritis	14%	O-arthritis	15%	Depression	7%
Osteoporosis	11%	Osteoporosis	12%	O-arthritis	7%
HRT-related	5%	Allergic rhinitis	6%	Menopause	7%
<b>PHYSICIANS (Base = 132)</b>					
<b>FIRST POSITION</b>		<b>SECOND POSITION</b>		<b>THIRD POSITION</b>	
Osteoporosis	18%	Depression	8%	Osteoporosis	7%
Depression	13%	O-arthritis	8%	Depression	6%
O-arthritis	11%	Osteoporosis	8%	O-arthritis	5%
HIV-related	8%	HIV-related	6%	Gout	5%

This table shows that whilst the GPs are placing greater emphasis on depression, the physicians feel that the first priority should be osteoporosis.

**CHRONIC CONDITIONS DOCTORS FEEL SHOULD BE INCLUDED IN THE  
CDL**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>532</b>	<b>400</b>	<b>132</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	%	%	%
Depression / major / mild	55	64	30
Osteoporosis	39	37	44
Osteoarthritis / arthritis / all	39	42	29
Menopausal disorders	17	21	5
Allergic / chronic rhinitis	13	16	5
Reflux disease / GORD	11	11	14
HIV / HIV + related diseases	9	7	15
Gout	8	8	11
Anxiety / anxiety disorders	8	10	4
Hyperthyroidism	7	6	12
Eczema	5	7	-
Spastic colon	5	5	4
None	8	7	12

### **6.2.1 Focus on Hormone-related Menopausal Disorders, Psychiatric Illness, Osteoporosis and Bipolar Mood Disorder**

It was pointed out to the respondents that the Council of Medical Schemes Report for 2003 / 2004 included hormone-related menopausal disorder, psychiatric illness, osteoporosis and bipolar mood disorder in their top 10 list of treated conditions, yet the first three conditions are excluded from the current CDL list and there is no treatment algorithm for the fourth condition, bipolar mood disorder.

Against this backdrop, respondents indicated the extent to which they agree that treatment algorithms should be developed for these four conditions and then ranked the conditions in terms of priority – 1 representing the most important condition for algorithm development, 2 = the second most important condition, etc. Findings in this regard are summarised in the tables opposite and overleaf.

The top two box scores (the proportion of the sample that agree / strongly agree that algorithms should be developed) for each of these conditions is as follows:

<b>Top two box scores:</b>	<b>GPs</b>	<b>PHYSICIANS</b>
Hormone-related menopausal disorders	80%	68%
Chronic psychiatric illness	84%	61%
Osteoporosis	88%	88%
Bipolar mood disorder	82%	68%

and clearly show that these doctors (the GPs more so than the physicians) agree that algorithms should be developed for these four diseases. Indeed this finding reinforces spontaneous mention of osteoporosis as noted in the previous section.

**THE EXTENT TO WHICH DOCTORS AGREE THAT TREATMENT  
ALGORITHMS SHOULD BE DEVELOPED FOR FOUR CHRONIC  
CONDITIONS**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>400</b>	<b>132</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>HORMONE RELATED MENOPAUSAL DISORDERS</b>			
Strongly agree	47	52	30
Agree	31	28	38
Neither agree nor disagree	9	8	13
Disagree	8	8	11
Strongly disagree	5	4	8
<b>CHRONIC PSYCHIATRIC ILLNESS</b>			
Strongly agree	51	56	35
Agree	27	28	26
Neither agree nor disagree	10	7	20
Disagree	5	5	7
Strongly disagree	5	4	9
<b>OSTEOPOROSIS</b>			
Strongly agree	61	61	61
Agree	27	27	27
Neither agree nor disagree	4	5	2
Disagree	4	4	5
Strongly disagree	4	3	5
<b>BIPOLAR MOOD DISORDER</b>			
Strongly agree	49	52	38
Agree	30	30	30
Neither agree nor disagree	11	9	19
Disagree	5	5	5
Strongly disagree	5	4	8

## **Priority Ranking**

Based on the number of respondents ranking each condition in each position (1 to 4), one is able to calculate a weighting figure that shows the relative importance of one condition over the next. These weighting figures and the corresponding overall rank order have been summarised in the table opposite.

Overall these doctors feel that the priority of developing algorithms should be firstly with osteoporosis, followed by chronic psychiatric disorders, hormone-related menopausal disorders and then bipolar mood disorder. GP versus specialist opinion does differ slightly, with the GPs placing greater emphasis on the need for algorithms for chronic psychiatric illness before osteoporosis whilst the reverse is true for the physicians.

**PRIORITY RANKING – AVERAGE RANK POSITION**

<b>Base (No.) %</b>	<b>TOTAL</b>		<b>GPs</b>		<b>PHYSICIANS</b>	
	<b>532</b>		<b>400</b>		<b>132</b>	
	<b>100%</b>		<b>100%</b>		<b>100%</b>	
	<b>Weight</b>	<b>Rank order</b>	<b>Weight</b>	<b>Rank order</b>	<b>Weight</b>	<b>Rank order</b>
Osteoporosis	1369	<b>1</b>	1013	<b>2</b>	356	<b>1</b>
Chronic psychiatric illness	1314	<b>2</b>	1066	<b>1</b>	248	<b>2</b>
Hormone-related menopausal disorders	1169	<b>3</b>	927	<b>3</b>	242	<b>3</b>
Bipolar Mood Disorder	968	<b>4</b>	744	<b>4</b>	224	<b>4</b>

## 6.3 Discussion of CDL Treatment Algorithms

### 6.3.1 Appropriateness of CDL Treatment Algorithms

The interview focused on 11 of the more commonly seen CDL conditions with respondents initially indicating how appropriate / adequate they feel the CDL treatment algorithms are. Summarised in the table opposite are the findings in this regard.

Between a quarter and a third of the sample have no problem with / believe that the treatment CDL algorithms are more than adequate for:

- asthma
- diabetes mellitus
- hyperlipidaemia
- cardiac failure
- hypertension
- COPD
- coronary artery disease

Indeed, taking the proportion of the sample noting that treatment algorithms are just adequate or more than adequate, raises the proportion of the sample showing some degree of acceptance of the algorithms to between 52% of the sample (for hyperlipidaemia) and 70% of the sample (for asthma).

There are respondents, however, who believe that some of the algorithms are lacking, those receiving highest mention in this regard include:

- Hyperlipidaemia (36% marginally / seriously inadequate)
- Hypertension (26% marginally / seriously inadequate)
- Rheumatoid arthritis (24% marginally / seriously inadequate – the physicians being more dissatisfied than the GPs here).

A relatively large proportion of the sample also indicated dissatisfaction with the schizophrenia CDL algorithms but caution must be exercised when looking at this result since the number of doctors indicating that they see and treat this condition is fairly low (127) and a significant proportion of these 127 doctors (28%) indicated that they are unfamiliar with the CDL treatment algorithms for this condition.

Awareness of the CDL algorithms is also somewhat lacking for chronic kidney disease, epilepsy, rheumatoid arthritis and coronary artery disease.

Whilst less than a fifth of the sample indicated dissatisfaction with the diabetes mellitus CDL treatment algorithm it is important to point out that, as a group, the physicians are less satisfied with these treatment algorithms than the GPs.

### APPROPRIATENESS OF CDL TREATMENT ALGORITHMS

( ) = No. doctors indicating that they see and treat the condition	% of the sample agreeing that.....				
	More than adequate	Just adequate	Marginally inadequate	Seriously inadequate	Not familiar with CDL algorithm
<b>Hypertension (Tot = 530)</b>	<b>32</b>	<b>31</b>	<b>16</b>	<b>10</b>	<b>11</b>
GPs (399)	34	30	17	10	10
Physicians (131)	25	35	15	10	15
<b>Diabetes Mellitus (Tot = 521)</b>	<b>25</b>	<b>42</b>	<b>11</b>	<b>6</b>	<b>15</b>
GPs (392)	27	44	10	5	14
Physicians (129)	16	39	16	10	19
<b>Hyperlipidaemia (Tot = 520)</b>	<b>24</b>	<b>28</b>	<b>18</b>	<b>18</b>	<b>12</b>
GPs (390)	26	28	18	17	11
Physicians (130)	17	29	18	20	16
<b>Asthma (Tot = 518)</b>	<b>36</b>	<b>34</b>	<b>11</b>	<b>8</b>	<b>11</b>
GPs (396)	38	34	11	7	10
Physicians (122)	30	34	10	11	16
<b>COPD (Tot = 494)</b>	<b>25</b>	<b>39</b>	<b>14</b>	<b>8</b>	<b>14</b>
GPs (369)	25	41	14	7	13
Physicians (125)	26	34	14	10	17
<b>Cardiac failure (Tot = 484)</b>	<b>24</b>	<b>40</b>	<b>12</b>	<b>4</b>	<b>19</b>
GPs (358)	25	41	12	4	18
Physicians (126)	20	38	13	6	23
<b>Coronary artery dis. (Tot = 469)</b>	<b>23</b>	<b>38</b>	<b>12</b>	<b>6</b>	<b>22</b>
GPs (349)	24	38	11	6	21
Physicians (120)	19	39	13	5	23
<b>Rheumatoid arthritis (Tot = 413)</b>	<b>12</b>	<b>40</b>	<b>16</b>	<b>8</b>	<b>24</b>
GPs (315)	12	42	15	6	25
Physicians (98)	11	31	19	15	24
<b>Epilepsy (Tot = 328)</b>	<b>13</b>	<b>44</b>	<b>12</b>	<b>4</b>	<b>27</b>
GPs (249)	16	44	10	4	25
Physicians (79)	4	44	16	3	33
<b>Chronic kidney dis. (Tot = 231)</b>	<b>10</b>	<b>34</b>	<b>15</b>	<b>6</b>	<b>36</b>
GPs (133)	12	35	13	4	36
Physicians (98)	6	32	18	8	36
<b>Schizophrenia (Tot = 127)</b>	<b>9</b>	<b>35</b>	<b>16</b>	<b>13</b>	<b>28</b>
GPs (114)	10	34	18	11	27
Physicians (13)	-	38	-	23	38

In an attempt to get an overall feel for the level of dissatisfaction with the CDL treatment algorithms, the total number of doctors indicating that they feel one or more of the 11 treatment algorithms under discussion is marginally or seriously inadequate was determined.

In total, 56% of the sample fell into this category, as follows:

- ❖ Total sample: 297 / 56%
- ❖ GPs: 223 / 56%
- ❖ Physicians: 74 / 56%.

Having given an indication of their perceptions of the appropriateness of the CDL treatment algorithms the respondents discussed the 11 different disease areas focused on in terms of the manner in which the treatment algorithms fall short and which treatment algorithms they feel are perhaps more appropriate. Input was also obtained relating to the impact of medical aid restrictions, with respondents indicating the percent of cases where they feel medical aid restrictions are preventing them from treating patients appropriately and the nature of the restrictions being imposed by medical aids. The individual findings in this regard, for each of the 11 disease areas discussed, are shown in Appendix II of this report, whilst an overview of these findings is given here.

Please note that numerous comments carrying low or individual mention were received whilst the various treatment algorithms were being discussed – these have not been included in the body of this report and can be referenced in Table 6 of the computer analysis tables (separate document).

### **6.3.2 Manner in which CDL Treatment Algorithms Fall Short**

Considering the manner in which these doctors feel that treatment algorithms fall short (as laid out in the table opposite) it is important to note that many of the main categories of comments are inter-related but have been kept separate in an attempt to emphasise the nuances of the comments.

Those who are not entirely satisfied with the CDL treatment algorithms believe that they are restrictive in that certain drugs / therapies are not allowed (access to newer drugs is limited and use of generics is being enforced), treatment protocols and products that are to be used are outdated, they do not allow doctor flexibility nor do they allow for patient individuality and the standards of treatment are not up to scratch. In addition, some feel that the algorithms are not clear.

Discussion continued overleaf

**OVERVIEW OF THE MANNER IN WHICH THE CDL TREATMENT  
ALGORITHMS FALL SHORT**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No. of Drs noting that treatment algorithms are marginally or seriously inadequate)</b>	<b>297</b>	<b>223</b>	<b>74</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>%</b>	<b>%</b>	<b>%</b>
Certain drugs / therapies not allowed	39	38	43
Outdated protocols / treatment	29	26	38
Restrictive	22	22	19
Unclear / confusing	18	17	20
Criteria / scores too high	17	16	20
No patient individuality	14	12	22
Not up to standard	11	8	22
Difficult to use combination therapy	10	9	12
Need to commence with treatment earlier	9	8	12
More visits / tests / investigations needed	9	8	12
Must prove treatment failure	9	8	11

Examples of some of the comments backing up these opinions are as follows:

- *"Far too often we are forced to treat with generics"*
- *"The algorithms we deal with are pure rubbish. I don't know who made them up. They use cheap generic, old fashioned medicine"*
- *"The new medications that have more advantages and less side-effects are not provided for"*
- *"They do not take the latest data into account"*
- *"We are using stuff that was developed 25 years ago"*
- *"We are forced to work with products out of the ark"*
- *"We have to try old products first and prove failed treatment before we can give new generation products"*
- *"Certain patients need to be treated differently and to try and achieve this is a nightmare"*
- *"Not always easy to follow the criteria as patients are all different"*
- *"Some patients need more than just the basics and one can't modify treatment"*
- *"The design for chronic conditions seems to have been drawn up by people who are not experts in their field. They appear to be lacking in recent or current data and are outdated in many respects for conditions. There is room for improvement. I feel our algorithms have been drawn up for a third world country"*
- *"The best medication with the least side-effects is used last"*
- *"They don't make provision for all the ifs".*

Some of the comments passed in terms of how the CDL treatment algorithms fall short were very condition specific, the main issues being as follows (refer to Appendix II of this document for the full range of comments):

Hypertension:	ARB use limited; enforcing the first line use of beta blockers or diuretics
Diabetes Mellitus:	Don't allow for use of newer classes of insulin e.g. Lantus
Hyperlipidaemia:	Criteria / goals for treatment are too high ; limited / outdated risk criteria; forcing use of simvastatin generics in place of Lipitor; treatment based on old guidelines
Asthma:	Limited access to Singulair / LTRAs and Seretide; won't allow use of combination products
COPD:	Spiriva not included in guidelines
Cardiac failure:	Use of ARBs restricted
Coronary artery disease:	Enforcing the use of outdated products in general
Rheumatoid arthritis:	Restricting the use of COX II inhibitors / Celebrex; don't allow the (early) use of disease modifying agents / biologicals; disease management (e.g. chronic pain) not adequately covered
Epilepsy:	Outdated; don't allow for the use of the newer anti-epileptic agents
Chronic kidney disease:	Dialysis not supported / paid for
Schizophrenia:	Limited access to newer drugs.

### **6.3.3 More Appropriate Treatment Algorithms**

When commenting on the CDL treatment algorithms for the 11 specific conditions under consideration the respondents were asked to give suggestions as to which other algorithms could perhaps be more appropriate.

Generally speaking comments were very fragmented here with a large proportion of those commenting not able to give any suggestions or unaware of other algorithms. Where comments were received, the doctors generally broadly suggested the use of algorithms developed by local and / or international associations / societies relevant to the each specific disease area – e.g. the SA Rheumatology Association / Society or the International Asthma Association. There were also suggestions that South African leaders in their relevant fields could give assistance in this regard.

See Appendix II for specific comments relating to the 11 disease areas discussed.



#### **6.3.4 Percentage of Cases where Doctor Cannot do what he Feels is Best**

Still focusing on the 11 conditions, the respondents were asked to select the four conditions with which they have the most experience, and for each of these four conditions to indicate in approximately what proportion of cases seen medical aid pressure is preventing them from doing what they feel is best for the patients.

Then, using 5 predetermined categories, the respondents indicated the nature of medical aid restrictions preventing them from treating their patients in the best possible fashion.

An overview of the findings is presented in this section of the report, whilst the full details on a per indication basis is presented in Appendix II of this report.

The table opposite shows a summary (on a per indication basis) of the average proportion of cases where, as a result of medical aid pressure, the doctors feel they are unable to do what is best for their patients. Average estimates here show the opinion that treatment is compromised in anything between a fifth (chronic kidney disease) and half the patients seen (schizophrenia).

Whilst the highest percentages received related to schizophrenia, these should be regarded with caution as they are based on the estimates given by just four doctors.

Apart from schizophrenia, treatment appears to be most compromised in patients suffering from hyperlipidaemia, COPD, hypertension and asthma – where it is estimated that treatment is compromised in between two fifths and just under half of all such patients seen.

As a group, the GPs reported a higher level of restriction for hypertension, CAD, cardiac failure and rheumatoid arthritis than did the physicians.

## MEDICAL AID PRESSURE

% of cases where doctors are unable to do what is best for the patient

(Base = No. doctors discussing condition)

		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Hypertension</b>	<b>Base (No.)</b>	<b>513</b>	<b>390</b>	<b>123</b>
Ave % cases where Dr cannot do what is best		40 – 41%	42 – 43%	37%
<b>Hyperlipidaemia</b>	<b>Base (No.)</b>	<b>405</b>	<b>328</b>	<b>77</b>
Ave % cases where Dr cannot do what is best		47 – 48%	48 - 49%	45 – 46%
<b>Asthma</b>	<b>Base (No.)</b>	<b>379</b>	<b>333</b>	<b>46</b>
Ave % cases where Dr cannot do what is best		40 – 41%	40 – 41%	38 – 39%
<b>Diabetes Mellitus</b>	<b>Base (No.)</b>	<b>373</b>	<b>283</b>	<b>90</b>
Ave % cases where Dr cannot do what is best		30 – 31%	30 – 31%	30 – 31%
<b>COPD</b>	<b>Base (No.)</b>	<b>142</b>	<b>87</b>	<b>55</b>
Ave % cases where Dr cannot do what is best		46 – 47%	47 – 48%	45 – 46%
<b>CAD</b>	<b>Base (No.)</b>	<b>131</b>	<b>86</b>	<b>45</b>
Ave % cases where Dr cannot do what is best		33 – 34%	36 – 37%	28 – 29%
<b>Cardiac Failure</b>	<b>Base (No.)</b>	<b>102</b>	<b>38</b>	<b>64</b>
Ave % cases where Dr cannot do what is best		27 – 28%	30%	25 – 26%
<b>Rheumatoid Arthritis</b>	<b>Base (No.)</b>	<b>43</b>	<b>30</b>	<b>13</b>
Ave % cases where Dr cannot do what is best		46%	49 – 50%	37 – 38%
<b>Chronic Kidney Dis</b>	<b>Base (No.)</b>	<b>14</b>	<b>4</b>	<b>10</b>
Ave % cases where Dr cannot do what is best		22 - 23%	20%	24%
<b>Epilepsy</b>	<b>Base (No.)</b>	<b>7</b>	<b>7</b>	-
Ave % cases where Dr cannot do what is best		23 - 24%	23 - 24%	-
<b>Schizophrenia</b>	<b>Base (No.)</b>	<b>4</b>	<b>4</b>	-
Ave % cases where Dr cannot do what is best		52 - 53%	52 - 53%	-

### **6.3.5 Manner in Which Treatment is Compromised**

Respondents were given five different options outlining the manner in which treatment could be compromised as a result of medical aid pressure and were asked to indicate in what percent of cases each of these options applied. Once again, an overview of the findings is presented here, whilst the full range of responses on a per indication basis can be referenced in Appendix II of this report.

In total, 518 respondents (97% of the sample) indicated that their treatment is compromised in patients suffering from one or more of the four conditions discussed. The major issue here appears to be that doctors do not have the freedom to use the actual product that they believe is best coupled with the fact that access to the class that they believe is best is also restricted. Just under three quarters of the sample noted that there are times that they cannot see the patient often enough, with three fifths noting they cannot conduct the tests that they wish. A similar proportion of the sample indicated that they cannot continue treatment for as long as they wish.

An overview of the proportion of patients affected by these limitations is as follows:

- Treatment of coronary artery disease and cardiac failure appears to be most affected by doctors not being able to conduct the tests that they wish – this being especially highlighted by the GPs. The GPs estimate that in between a fifth and a quarter of patients treated for these conditions they cannot conduct the tests that they wish
- In terms of not being able to use the class thought best, greatest limitation is noted when treating hypertension – on average it is estimated that the best class cannot be used in half the hypertensive patients where medical aid limitations apply
- These respondents estimated that where medical aid limitations apply, the ideal product cannot be used in an average of 64 – 65% of hyperlipidaemia patients and in an average of 61 – 62% of COPD cases. These findings emphasise spontaneous comments where it was noted that limited access to Lipitor (hyperlipidaemia) and Spiriva (COPD) is an issue

Discussion continued opposite

## NATURE OF MEDICAL AID RESTRICTIONS

% of doctors indicating that they encounter each given type of restriction

Dr cannot.....	TOTAL	GPs	PHYSICIANS
Base (No.)	518	391	127
Conduct the tests he wishes	61%	61%	60%
Use the class thought best	93%	93%	94%
Use the product thought best	99%	98%	100%
See the patient often enough	72%	72%	73%
Continue therapy long enough	58%	59%	56%

- In terms of not being able to see the patients often enough, this seems to be an issue across the board, regardless of the condition for which the patient is being treated. On average, it is estimated that between a fifth and a quarter of patients cannot be seen as often as the doctor would like
- Not being able to continue therapy for as long as the doctor would like appears to affect between 13% and 22% of patients suffering from the chronic conditions being discussed.

## 6.4 The Issue of Limiting the Number of Consultations

Against the backdrop of the limitations medical aids are enforcing in terms of the number of consultations patients are allowed per annum, the respondents indicated whether or not they feel such limitations are compromising treatment, and if so the nature in which treatment is being compromised – see comments in table opposite.

Three quarters of the sample concurred that treatment is indeed being compromised by the fact that medical aids are limiting the number of consultations per annum. When asked to elaborate on ways in which treatment is compromised, a long list of comments was recorded, with fragmented weight of mention. In essence, the doctors feel that they are not able to adequately follow-up their patients and to monitor the drug therapy initiated, or the stability of their condition. With this being the case, the patient's condition has often worsened before they are due to see the doctor again, and treatment has to be altered or reassessed.

Several doctors made reference to the fact that the medical aids allow for patients to have one or two follow-up consultations per annum for a chronic condition, and they believe that this is far too infrequent. Many stipulated that 3 – 4 monthly visits are more realistic.

The specialists feel strongly that visits at their level should be more frequent because one is generally dealing with serious conditions, and these patients need more intensive monitoring.

When discussing the ways in which treatment is being compromised, the doctors in this sample made spontaneous reference to specific indications / conditions. An overcode of the weighting in this regard is as follows:

[Base = 394 (No. doctors mentioning treatment is compromised)]

- Diabetes [29%]
- Hypertension [25%]
- Asthma [11%]
- Hyperlipidaemia [4%].

**THE IMPACT OF LIMITING THE NUMBER OF CONSULTATIONS PER ANNUM**

	TOTAL	GPs	PHYS	
	Base (No.) %	532 100%	400 100%	132 100%
Generally able to adequately treat patients	25	26	22	
Treatment is being compromised	74	73	77	
Other	1	1	1	
<b>MANNER IN WHICH TREATMENT IS BEING COMPROMISED</b>				
	Base (No.) %	394 100%	293 100%	101 100%
Complications develop / condition worsens before next consultation	15	17	10	
No adequate follow-ups / not able to monitor sufficiently	11	12	9	
If you have initiated therapy, the patient needs to be stabilised / must check on therapy	10	12	6	
Patient can become uncontrolled if not seen often enough	10	10	11	
Patients don't come back for check-ups because funds run out	9	9	8	
Uncontrolled patients need more frequent visits (e.g. hypertension, diabetes)	9	7	13	
Need to see patients every 3 or 4 months (twice a year seems to be the limit)	8	6	13	
Specialist visits need to be more frequent	7	-	26	
Frequency of tests limited	7	6	7	
Difficult to see if medication is working / cannot change doses / medication easily	6	6	6	
Need to meet individual needs of patients	5	5	6	
Affects compliance / cannot monitor compliance well	5	6	3	
Patients resort to telephonic consultations	4	4	2	
Cannot deal adequately with co-morbidities	4	3	6	
Increases hospitalisation	4	4	3	
Ideal is to see patients monthly	4	4	3	

## **6.5 The Impact of PMBs**

Summarised in the table opposite is this sample's opinion of the impact that the introduction of PMBs has had on the quality of patient care, the patient's access to care and the outcome of disease management.

In all instances, the majority of the sample (over half) indicated that the impact has been negative, slightly more so for the outcome of disease management and the quality of patient care than for the patient's access to care.

Approximately one quarter of the sample believes that PMBs have had a positive impact on the outcome of disease management and close on a third feels the same for the quality of patient care and the patient's access to care.

### THE IMPACT OF PMBs

	TOTAL	GPs	PHYS
	Base (No.) %	532 100% %	400 100% %
<b>IMPACT ON THE QUALITY OF PATIENT CARE</b>			
Positive	29	27	33
Negative	56	59	45
No impact	13	11	17
Positive and negative / other	2	3	5
<b>IMPACT ON THE PATIENT'S ACCESS TO CARE</b>			
Positive	31	29	36
Negative	52	56	43
No impact	15	15	17
Positive and negative / other	2	-	4
<b>IMPACT ON THE OUTCOME OF DISEASE MANAGEMENT</b>			
Positive	24	23	27
Negative	57	60	49
No impact	16	15	20
Positive and negative / other	3	2	4

## **6.6 A Brief Focus on Formularies**

A brief discussion of formularies commenced with the respondents estimating in what percent of cases where they prescribe drug therapy they refer to the relevant formularies prior to writing the prescription. Following on from this, they gave an estimate as to the perceived extent to which scripts are altered at pharmacy level. Findings have been summarised in the table opposite.

The upper half of the table opposite details the percentage of cases where doctors prescribe according to formularies. A wide range of estimates was obtained, with over a quarter of the sample stating that they are not complying with formularies at all, up to a small proportion (4%) indicating that they use formularies all the time. The average figure shows that doctors are prescribing according to formularies in about two fifths of cases, although the median figure is lower than this at 21 – 30% of cases.

In the lower half of the table are the doctors' estimates as to the percentage of scripts that are changed at pharmacy level without doctor approval. Close on a tenth of the sample stated that they could not comment in this regard, whilst once again there is a wide range of estimates. On average, doctors in this sample estimate that over two fifths of scripts are changed at pharmacy level – the median figure also being in this region.

### FOCUS ON FORMULARIES

	TOTAL	GPs	PHYS
	Base (No.) %	532 100% %	400 100% %
<b>% OF CASES WHERE DOCTORS PRESCRIBE ACCORDING TO FORMULARIES</b>			
None / 0%	27	27	30
1 – 10%	16	16	14
11 – 20%	4	4	5
21 – 30%	4	4	2
31 – 40%	2	3	1
41 – 50%	9	8	10
51 – 60%	4	4	2
61 – 70%	5	6	5
71 – 80%	15	15	15
81 – 90%	8	8	8
91 – 99%	2	2	3
100%	4	4	5
<b>Average % cases prescribed according to formularies</b>	<b>39%</b>	<b>39%</b>	<b>40%</b>
<b>PERCEIVED EXTENT OF SWITCHING AT PHARMACY LEVEL</b>			
None / 0%	2	2	1
1 – 10%	9	7	14
11 – 20%	12	13	7
21 – 30%	16	15	19
31 – 40%	9	10	6
41 – 50%	17	17	18
51 – 60%	8	8	7
61 – 70%	7	8	5
71 – 80%	8	8	8
81 – 90%	3	3	4
91 – 99%	1	1	-
100%	1	1	2
Don't know / not informed	8	7	10
<b>Average % cases where scripts are changed at pharmacy level</b>	<b>44%</b>	<b>44%</b>	<b>42%</b>

## 6.7 Dealing with Medical Aids

The doctors were asked to reflect on an average week in their practice and estimate the number of hours that they **personally** spend dealing with medical aid related queries, be this liaison directly with medical aids or discussing medical aid reimbursement. Along the same line of thought, they estimated the amount of time in an average week other employees in their practice deal with medical aids on the doctor's / patient's behalf.

A wide range of estimates were received, as tabulated opposite, with the doctors estimating that they personally spend an average of 4 – 5 hours a week dealing with medical aid queries, and their employees spend an additional 9 – 10 hours per week in this regard.

This results in an average of at least 13 – 15 hours per week being spent per practice, on medical aid related issues or queries, depending on the number of doctors in the practice.

### DEALING WITH MEDICAL AIDS

	TOTAL	GPs	PHYS
	532	400	132
	100%	100%	100%
<b>Base (No.)</b>			
<b>%</b>			
	<b>%</b>	<b>%</b>	<b>%</b>
<b>No. hours Dr spends per week dealing with medical aid-related queries</b>			
None	5	6	4
Up to 1 hour	14	15	11
1 – 2 hours	18	19	14
2 – 3 hours	11	10	13
3 – 4 hours	6	7	4
4 – 5 hours	20	18	26
5 – 6 hours	8	8	7
6 – 8 hours	8	7	9
9 – 10 hours	8	7	11
11 – 15 hours	2	2	2
15 – 28 hours	1	1	-
<b>Average hours per week spent by doctor</b>	<b>4 – 5</b>	<b>4</b>	<b>4 - 5</b>
<b>No. hours other employees spend per week dealing with medical aid-related queries</b>			
None	9	12	2
Up to 1 hour	4	5	2
1 – 2 hours	6	7	4
2 – 3 hours	5	5	6
3 – 4 hours	6	6	4
4 – 5 hours	11	9	14
5 – 6 hours	5	6	2
6 – 8 hours	7	6	9
9 – 10 hours	13	10	22
11 – 15 hours	12	15	8
16 – 20 hours	9	8	15
20 – 40 hours	6	6	7
48 – 72 hours	1	1	-
Full time department / employ 2 ladies to deal with this / large part of the day	5	5	5
<b>Average hours per week spent by employees</b>	<b>9 – 10</b>	<b>9</b>	<b>10 - 11</b>

### **6.7.1 Medical Aid Related Activities**

The doctors were given a list of various activities or tasks that they or their employees may find themselves doing when dealing with medical aids and they were asked to apportion their time spent on medical aid issues according to these activities / tasks. The upper section of the table opposite shows the average percentages for each sector of the sample.

The doctors estimate that about a third of their time spent interacting with medical aids involves dealing with medical aid queries with their patients – this being more common amongst the GPs than the specialists. About a quarter of the time they spend writing letters of motivation (this being a more common practice for the specialists) and about a fifth of the time they spend making phone calls to the medical aids. When they are spending time with medical aid issues, the doctors estimate that about a tenth of this time involves chasing up reimbursements from medical aids and about a tenth of the time is taken up receiving phone calls from medical aids.

### **6.7.2 Calibre of Medical Aid Personnel**

Still focusing on their dealings with the medical aids, it was brought to the doctors' attention that doctors have often complained about the calibre of person with whom they have to deal when motivating at medical aid level, often noting that they are dealing with non- or under-qualified people. Doctors in this sample were asked to comment on the extent to which they feel the calibre of the medical aid personnel is an issue. Responses outlined in the lower section of the table opposite indicate that this is perceived as a very real problem, with close on three quarters of the sample (slightly biased towards the specialists) stating that it is a great issue. Most of the remainder said that it is somewhat of an issue.

## DEALING WITH MEDICAL AIDS CONTINUED

	TOTAL	GPs	PHYS
	532	400	132
	100%	100%	100%
	Base (No.)		
	%	%	%
<b>Nature of the doctor's interaction at medical aid level</b>			
<b>Ave % time spent:</b>			
Dealing with medical aid-related queries with patients	31	33	23
Writing letters of motivation	25	22	34
Making phone calls to medical aids	20	20	19
Chasing up reimbursement from medical aids	13	13	11
Taking phone calls from medical aids	9	9	9
Completing chronic medicines applications	1	1	2
Other	1	1	1
<b>The extent to which the calibre of the person dealt with at the medical aid is an issue</b>			
	%	%	%
Great extent	71	69	80
Somewhat	22	24	15
Not at all	5	5	4
Other	2	2	1

### **6.7.3 Rejection / Intervention by Medical Aids**

The doctors focused on the medical aid patients that they see in an average month and estimated the percentage in whom medical aids intervene and enforce changes to the treatment protocol, and where there is intervention, the doctors elaborated on the course of action that they generally take.

The upper section of the table opposite shows the estimates in terms of the percentage of patients where there is medical aid intervention. There was a wide variance in estimates, with the average figure in the region of two fifths of cases. The median figure is slightly lower with medical aid intervention happening in 21 – 30% of cases.

In reaction to the medical aid intervention, the doctors stated that in a third of cases they are unhappy with the alternative treatment stipulated by the medical aid, but would accept the changes without motivation. In close on half the cases the doctors indicated that they motivate for the original treatment protocol, but it was noted that this motivation is unsuccessful in about half these cases. The specialists appear slightly more successful than the GPs in terms of motivating for the original protocol. In just a fifth of cases the doctors indicated that they are happy with the changes suggested by the medical aids.

## DEALING WITH MEDICAL AIDS CONTINUED

	TOTAL	GPs	PHYS
	Base (No.) %	532 100% %	400 100% %
<b>Proportion of medical aid patients in whom medical aids have intervened and enforced changes to treatment protocol</b>			
None / 0%	4	3	8
1 – 10%	14	14	16
11 – 20%	19	18	21
21 – 30%	14	14	12
31 – 40%	12	13	8
41 – 50%	10	10	10
51 – 60%	6	7	4
61 – 70%	6	7	3
71 – 80%	9	8	14
81 – 90%	4	5	2
91 – 99%	1	1	-
100%	1	1	2
<b>Average % cases where there is MA intervention</b>	<b>39%</b>	<b>40%</b>	<b>36%</b>
<b>Doctors' reaction to medical aid intervention</b>			
<b>Ave % of cases where Dr:</b>			
Unhappy with the medical aid's alternative treatment protocol, but accepted the changes without motivation	32%	32%	30%
Unsuccessfully motivated for original treatment protocol	24%	25%	22%
Successfully motivated for original treatment protocol	23%	21%	30%
Accepts and is happy with the suggested changes	21%	22%	17%

## **6.8 Single Exit Pricing**

Respondents gave their impression of the impact that single exit pricing / SEP has had on the price of medicines in general and then estimated by what percentage they feel the price of generic and original / multinational medicines have dropped – see table opposite.

Over four fifths of the sample believes that SEP has had an impact on the price of medicines, half of whom claim that this impact has been substantial. Ten doctors, however, observed at this point that they believe the price of medicines has actually gone up.

Those who indicated that SEP has had an impact on prices, estimated that the price of generics has dropped by an average of 22% and the price of original medicines has dropped by an average of 30%.

## SINGLE EXIT PRICING

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No.)</b>	<b>532</b>	<b>400</b>	<b>132</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>IMPACT ON THE PRICE OF MEDICINES</b>			
Great impact	40	44	29
Some impact	43	43	45
No impact at all	14	11	22
Prices have gone up	2	2	2
<b>PERCENT BY WHICH THE PRICE OF GENERIC MEDICINES HAS DROPPED AS A RESULT OF SEP</b>			
<b>Base (No.)</b>	<b>445</b>	<b>348</b>	<b>97</b>
	<b>%</b>	<b>%</b>	<b>%</b>
Not sure / don't know	10	9	12
Some have started going up	2	2	3
Not much change	1	1	-
None / 0%	12	12	11
1 – 10%	21	19	29
11 – 20%	19	19	19
21 – 30%	15	16	10
31 – 40%	6	7	5
41 – 50%	9	10	7
51 – 80%	5	5	3
<b>Average % by which generic prices have dropped</b>	<b>22%</b>	<b>23%</b>	<b>20%</b>
<b>PERCENT BY WHICH THE PRICE OF ORIGINAL MEDICINES HAS DROPPED AS A RESULT OF SEP</b>			
<b>Base (No.)</b>	<b>445</b>	<b>348</b>	<b>97</b>
	<b>%</b>	<b>%</b>	<b>%</b>
Not sure / don't know	7	7	10
Some have increased	2	2	2
A lot / significantly	1	1	-
None / 0%	1	1	1
1 – 10%	12	10	19
11 – 20%	20	21	19
21 – 30%	28	29	27
31 – 40%	13	15	8
41 – 50%	11	11	8
51 – 80%	3	2	5
<b>Average % by which original prices have dropped</b>	<b>30%</b>	<b>30%</b>	<b>28%</b>

## **6.9 One Body Representing the Interests of Private Medical Practitioners**

It was pointed out to the doctors that the move towards managed health care seems to have largely curtailed the freedom that they enjoyed in the past in terms of deciding how best to treat their patients. Probing as to whether they believe there is a need for a single body / organisation to represent the interests of private medical practitioners revealed that all but 6% of the sample believes there to be a need for a representative body.

Commenting as to what organisation / body should be representing their interests (see table of comments listed overleaf), close on three quarters of the doctors spontaneously identified SAMA. At this point some doctors qualified their suggestion and it is recommended that individual comments are referenced in Table 16 of the analysis tables. It is noteworthy, however, that a fair proportion of the sample made negative comments about SAMA, the essence of which included:

*“SAMA – but they don’t do anything, they seem to have no clout”*

*“SAMA – but what do they do for us? Zilch!”*

*“There is a body – SAMA, but they are not representative of the people anymore because nobody trusts them. They are tigers with no teeth. They hold meetings and meetings and meetings but on our survival, they are useless”*

*“SAMA is an organisation for doctors but I feel that it is now an organisation that is self-centred and only wants to make a profit out of doctors”.*

A small number of doctors were more positive when making their suggestion for SAMA to represent the doctors’ interests:

*“SAMA has a good base – perhaps they should be the ones representing us”*

*“They try hard but I don’t think they get enough support from the doctors, also they don’t have enough legal power”.*

Approximately two fifths of the sample felt that the responsibility lies with the doctors themselves to form a united body and fight for their rights:

*“Yes! Yes! Yes! Let there be a body of doctors who can speak up and get through to the dictators”,*

although many doctors added that they simply do not have the time to do this.

The doctors who did not spontaneously mention SAMA as an option in terms of fighting for the rights of private medical practitioners were asked whether they feel SAMA could play a role in this regard – see comments tabulated overleaf. Just over a quarter of the sample did not mention SAMA spontaneously and, of these, three quarters reacted negatively to the suggestion of SAMA fighting for the doctors’ rights:

*“I’ve never had much faith in them – they seem to be a bit of a dead organisation that doesn’t do much”*

*“SAMA has done nothing for me in the 25 years that I have been in practice”*

*“SAMA needs a wake-up call – for too long now they have let medical aids walk all over us doctors”*

*“They are part of the problem – lots of talk and committees but no action”*

*“I see them mostly as a medical political organisation rather than being involved with the day to day grind of medical practice”*

*“I boycotted them on principle because they were pro-government and anti-black”.*

Adding these doctors with negative sentiment about SAMA to those who spontaneously noted SAMA in a negative light previously results in 37% (184) of the sample (evenly split between GPs and physicians) making negative comments about SAMA and the role it plays / could play in fighting for doctors’ rights.

An analysis of these 184 doctors who are negative about SAMA on a racial and SAMA membership basis revealed the following:

Population group: 40% white: 26% \*black

SAMA membership: 59% non members; 29% members

showing that the white doctors and SAMA non-members are more negative about this organisation than are their \*black counterparts and those who are SAMA members.

Close on a fifth of the doctors who were prompted about the likely involvement of SAMA in representing doctors felt that this is a possibility:

*“They’ve got the power to fight the medical aids”,*

with some suggesting that SAMA be the driving force behind electing an appropriate body:

*“It could be a SAMA-elected committee”.*

The remainder of the sample made comments of a more neutral flavour, although the nuance here was again that SAMA has the power but has not proven itself:

*“They could, but they have to prove that they are on our side”*

*“They could play a role but I’m not a member because you don’t get much benefit by being one”*

*“SAMA can play a role in fighting for GPs’ rights but their say is too small to really carry weight”*

*“They are trying, but the wheels are turning very slowly”.*

**ONE BODY REPRESENTING THE INTERESTS OF PRIVATE MEDICAL PRACTITIONERS**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No.)</b>	<b>532</b>	<b>400</b>	<b>132</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>IS THERE A NEED FOR SUCH A BODY?</b>			
Yes	94	94	92
No	6	6	8
<b>WHERE DOES THIS RESPONSIBILITY LIE?</b>			
<b>Base = Doctors stating that there is a need</b>	<b>498</b>	<b>377</b>	<b>121</b>
	<b>%</b>	<b>%</b>	<b>%</b>
SAMA	72	73	68
- should be SAMA but they are ineffective / have no power	(18)	(19)	(14)
- SAMA with others	(5)	(4)	(6)
The doctors themselves / doctor groups	42	41	45
- doctors must form an organisation	(11)	(11)	(8)
- IPAs	(9)	(11)	(1)
- unified approach – doctors and SAMA	(5)	(5)	(7)
- specialist organisations / spesnet	(5)	(-)	(19)
- GP associations	(3)	(5)	(-)
- health professions council	(3)	(4)	(2)
Other organisations	5	5	5
<b>WHAT ROLE COULD SAMA PLAY IN THIS REGARD?</b>			
<b>Base = doctors not mentioning SAMA spontaneously</b>	<b>139</b>	<b>100</b>	<b>39</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>Yes - they could be involved / could help appoint a body</b>	<b>18</b>	<b>17</b>	<b>21</b>
<b>Negative comments</b>	<b>68</b>	<b>67</b>	<b>69</b>
- not doing anything for doctors	(26)	(24)	(31)
- too weak / no teeth / puppets	(15)	(12)	(23)
- out of touch / become too political	(9)	(11)	(3)
- not representative of all doctors	(9)	(10)	(5)
<b>Mixed / neutral comments – maybe, but they haven't proven themselves</b>	<b>15</b>	<b>17</b>	<b>10</b>

### 6.9.1 What Issues Should be Addressed?

Following on from the question identifying who / which bodies should be fighting for the rights of private medical practitioners, the doctors were asked to outline the issues they should be addressing and who they should be lobbying in this regard.

The table overleaf presents an overview of the many different issues that the doctors in this sample believe should be addressed by the representative body. Please note that these are broad overcodes of an extensive list of very emotive comments and it is strongly recommended that these be referenced in Table 17 of the analysis tables. Contained in the commentary below are some examples of the nature of these comments.

The most burning issue for these doctors, noted by three quarters of the sample, is that of protecting or restoring their rights as doctors and their freedom to diagnose and treat as they are trained to do:

*“It is unacceptable that medical aids are allowed to tell me what drugs I may prescribe and what tests I can order”*

*“Fight for the doctor to treat patients as they were trained to do”*

*“Give us freedom to make choices in the best interests of our patients”*

*“I’m hating medicine so much I’m going to take the first opportunity to get out. Medical aids have too much power!”*

*“The doctor patient relationship is being eroded and this is due to a financial model”.*

About a third of the sample highlighted the fact that attention needs to be paid to the doctors’ fee structure and the charges for consultations:

*“Everyone else is deciding my fees except me”*

*“Adequate profit for the time and effort put in by the dispensing doctor”*

*“As private businesses we should not have to discuss the service that we provide with anybody other than the patient. No other profession has to justify their costs or action taken”.*

A quarter of the sample felt that the patients' rights and freedom of choice are being compromised and must be addressed:

*"We are being forced not to use our medical advice because things are being decided purely on a cost basis"*

*"Stop the medical aids exploiting the patients, making huge profits for themselves by only allowing generics".*

Within this category, several doctors complained that patient confidentiality is being compromised, particularly with the use of ICD 10 codes, which then disclose the nature of the patient's condition to the medical aid. Several doctors also noted that the ICD 10 codes should be abolished because they are time consuming to implement and are often not relevant.

Just under a quarter of the sample stated that the doctor should have more involvement in developing formularies and structuring the protocols by which they are dictated, and a similar proportion of the sample complained about the restrictions in terms of their prescribing power:

*"I am often forced to use a drug that I know is inferior"*

*"Often I have to give the patients generics when I know it is not the best treatment. It is an insult to the patient and I feel insulted by the medical aid schemes for having to do it"*

*"Pharmacies can give our patients what they want, but we can't prescribe what we want"*

*"More and more doctors will be summonsed in law for neglect of the patient and it is the medical aids' fault for not allowing prescription of the correct medication".*

A fifth of the sample highlighted issues when dealing with medical aids – reimbursements being slow, non-existent or incomplete as well as the calibre of the personnel dictating what the doctor should be doing:

*“They need to change the medical aid act so that patients are not allowed to be paid directly, because then they don’t pay the doctor”*

*“We shouldn’t be instructed by non-medical people on how to treat our patients”*

*“It is outrageous that an ill-trained, ill-qualified person at a medical aid can tell an expert how to treat his own patient”.*

**ONE BODY REPRESENTING THE INTERESTS OF PRIVATE MEDICAL  
PRACTITIONERS CONTINUED**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No.)</b>	<b>498</b>	<b>377</b>	<b>121</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>WHAT ISSUES SHOULD BE ADDRESSED?</b>			
<b>Protect / restore doctors' rights</b>	<b>75</b>	<b>75</b>	<b>77</b>
- restore autonomy	(54)	(52)	(62)
- protect the doctor – patient relationship	(5)	(5)	(5)
- doctors must unite	(5)	(5)	(6)
- stop government from intervening	(4)	(5)	(1)
- protect the GP as the gate-keeper	(4)	(5)	(-)
<b>Fees and related issues</b>	<b>32</b>	<b>31</b>	<b>32</b>
- ensure reasonable fee structure	(21)	(21)	(21)
<b>Patients' rights / freedom of choice</b>	<b>26</b>	<b>26</b>	<b>26</b>
- patients are entitled to quality care	(7)	(7)	(5)
- must not compromise care for cost	(6)	(6)	(6)
<b>Formularies / protocols</b>	<b>23</b>	<b>22</b>	<b>25</b>
- doctors should have more input	(7)	(6)	(10)
- more involvement in PMBs	(4)	(5)	(3)
- do away with limited visits	(4)	(3)	(4)
<b>Products / prescriptions</b>	<b>22</b>	<b>21</b>	<b>24</b>
- stop restrictions on scripts / freedom to prescribe	(12)	(12)	(11)
- use best drugs available	(6)	(4)	(11)
<b>Dealing with medical aids</b>	<b>18</b>	<b>17</b>	<b>21</b>
- reimbursements are a problem	(6)	(5)	(8)
- medical aid personnel	(6)	(4)	(11)
- medical aids are only interested in profits	(5)	(6)	(3)
<b>Administration issues</b>	<b>13</b>	<b>13</b>	<b>14</b>
- do away with ICD 10 coding	(7)	(7)	(9)
- medical aids cause huge administrative burden	(6)	(6)	(7)
<b>Prices / cost of drugs</b>	<b>5</b>	<b>6</b>	<b>4</b>

### **6.9.2 Who Should the Representative Body be Lobbying?**

Closing the section on having a representative body fighting for the rights of the private medical practitioner, the doctors outlined who they felt this body should be lobbying regarding all the issues previously discussed.

Comments, outlined in the table opposite, clearly indicate that the medical aids or medical funders are a key target, followed by the government or Ministry of Health.

**ONE BODY REPRESENTING THE INTERESTS OF PRIVATE MEDICAL  
PRACTITIONERS CONTINUED**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No.)</b>	<b>498</b>	<b>377</b>	<b>121</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>WHO SHOULD BE LOBBIED?</b>			
Medical aids / funders	78	75	88
State / Government / Ministry of Health	50	54	40
General public / patients / support through the media	4	5	3
HPCSA	4	4	3
Pharmaceutical companies	3	3	3
Doctors	3	3	-

## 6.10 Focus on IMSA

In the penultimate question of the interview awareness of IMSA was probed for – see comments obtained at this time in the table opposite. Just 16% (one sixth) of the sample indicated that they were aware of IMSA / Innovative Medicines of South Africa, with the remaining 84% having never heard of this organisation.

The 86 respondents who stated that they had heard of IMSA were asked to elaborate on what they know about this organisation. As outlined in the table opposite, over half these doctors had heard of IMSA but did not know any details. (Please note figures are reflected as number of mentions and not %). Some of those who gave details about IMSA merely stated that the organisation was formed by several multinational companies.

It is interesting to see the negative perception communicated by nine doctors (mainly GPs) relating to IMSA's involvement in legislation on single exit pricing and dispensing issues – comments illustrating this sentiment include:

*“I don't like them – they are five companies that are co-responsible with the government for single exit pricing, without consulting with the doctors”*

*“They interfered when they shouldn't have – they became a friend of the court in a dispensing case”*

*“They became a friend of the court and private dispensing doctors came to war with them in the dispensing court battles”*

*“They defend their turf at the expense of others”.*

Some doctors, however, observed that IMSA has been involved in the dissemination of information (sometimes through meetings) regarding managed care and topical legislative issues. A small number of doctors held the belief that IMSA is an organisation working for the doctors' rights.

Probing as to the companies belonging to IMSA revealed that over half the respondents aware of IMSA do not know which companies formed this body. Pfizer, Sanofi-Aventis, MSD and GSK received the highest mention in this regard (see lower section of table opposite).

### FOCUS ON IMSA

	TOTAL	GPs	PHYS
<b>Base (No.)</b>	<b>532</b>	<b>400</b>	<b>132</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
<b>PRIOR TO THIS INTERVIEW HAD YOU HEARD OF AN ORGANISATION CALLED IMSA?</b>			
Yes	16%	16%	15%
No	84%	84%	85%
<b>KNOWLEDGE ABOUT IMSA</b>			
<b>Base (No.)</b>	<b>86</b>	<b>66</b>	<b>20</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
Don't know much about them / know very little	46	38	8
Started by multinational companies / ethical companies	15	8	7
Perceived as being a "friend of the court" / working against the doctors	9	8	1
Held meetings / provided information on managed care	6	3	3
A body working for doctors' rights	4	4	-
<b>COMPANIES BELONGING TO IMSA</b>			
<b>Base (No.)</b>	<b>86</b>	<b>66</b>	<b>20</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
Pfizer	14	8	6
Sanofi-Aventis	11	5	6
GSK	9	8	1
MSD	9	4	5
Eli Lilly	6	3	3
Novartis	5	3	2
Major international companies	4	2	2
AstraZeneca	3	-	3
Boehringer Ingelheim	2	2	-
Not sure / cannot remember	44	38	6

## 6.11 Closing Statements

In closing the interview, respondents were handed a sheet of statements relating to managed care and were asked to indicate the extent to which they agreed with each statement. The outcome of this exercise is summarised in the tables overleaf.

For each statement the doctors indicated whether they strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. Reflected in the tables are two scores for each statement:

- ❖ Top two box scores: representing the % of the sample indicating “strongly agree” or “agree” with each statement
- ❖ Bottom (btm) two box scores: representing the % of the sample indicating “disagree” or “strongly disagree” with each statement.

From these figures it is apparent that there is agreement with **all** of the statements presented, and a very low level of disagreement. Aspects where over 90% of the total sample is in agreement include:

- Patients present with multiple complaints which they have "saved up" as a result of medical aid benefit limits
- I believe that I should not have to negotiate with medical aids
- I should not have to justify my treatment choice to someone who has not examined the patient
- The legislated prescribed minimum benefits (PMBs) are interpreted by medical aids as **maximum** benefits
- When medical aids insist on making changes to my treatment protocols, I hold them personally responsible for any problems that the patient may encounter as a result of these changes.

There were only two statements where the level of agreement is less than 70%:

- On average, at least a quarter of the time that I spend with a patient is spent discussing funding issues rather than the patient's condition
- The introduction of disease management algorithms has regressed medical care to standards established 10 to 15 years ago.

## LEVEL OF AGREEMENT WITH CLOSING STATEMENTS

**TOP 2 BOX = % indicating “strongly agree” and “agree”**

**BTM 2 BX = % indicating “disagree” and “strongly disagree”**

		<b>TOTAL [532]</b>	<b>GPs [400]</b>	<b>PHYS [132]</b>
Managed health care interventions have negatively impacted on the quality of the doctor – patient relationship	<b>TOP 2 BOX</b>	86%	88%	82%
	<b>BTM 2 BOX</b>	5%	5%	5%
The fees paid by medical aids for ordinary consultations has resulted in doctors limiting the time they spend with each patient	<b>TOP 2 BOX</b>	72%	73%	69%
	<b>BTM 2 BOX</b>	14%	15%	13%
Patients present with multiple complaints which they have "saved up" as a result of medical aid benefit limits	<b>TOP 2 BOX</b>	91%	93%	86%
	<b>BTM 2 BOX</b>	2%	2%	3%
On average, at least a quarter of the time that I spend with a patient is spent discussing funding issues rather than the patient's condition	<b>TOP 2 BOX</b>	66%	67%	61%
	<b>BTM 2 BOX</b>	16%	16%	17%
The introduction of disease management algorithms has regressed medical care to standards established 10 to 15 years ago	<b>TOP 2 BOX</b>	69%	69%	70%
	<b>BTM 2 BOX</b>	10%	10%	9%
Patients rely on me for knowledge about their medical aid option benefits	<b>TOP 2 BOX</b>	80%	83%	68%
	<b>BTM 2 BOX</b>	9%	7%	14%
Patients feel that it is my duty to negotiate my treatment choice with the medical aid, on their behalf	<b>TOP 2 BOX</b>	86%	88%	83%
	<b>BTM 2 BOX</b>	7%	7%	7%
I believe that I should not have to negotiate with medical aids	<b>TOP 2 BOX</b>	95%	95%	95%
	<b>BTM 2 BOX</b>	2%	2%	2%
It is unethical to discuss a patient's condition with his / her medical aid	<b>TOP 2 BOX</b>	82%	82%	83%
	<b>BTM 2 BOX</b>	6%	6%	8%
Advisors at medical aids are hard to reach	<b>TOP 2 BOX</b>	86%	83%	94%
	<b>BTM 2 BOX</b>	4%	5%	2%
I should not have to justify my treatment choice to someone who has not examined the patient	<b>TOP 2 BOX</b>	94%	94%	94%
	<b>BTM 2 BOX</b>	2%	2%	3%

**LEVEL OF AGREEMENT WITH CLOSING STATEMENTS (continued)**

		<b>TOTAL [532]</b>	<b>GPs [400]</b>	<b>PHYS [132]</b>
The legislated prescribed minimum benefits (PMBs) are interpreted by medical aids as <b>maximum</b> benefits	<b>TOP 2 BOX</b>	92%	93%	89%
	<b>BTM 2 BOX</b>	1%	1%	-
When medical aids insist on making changes to my treatment protocols, I hold them personally responsible for any problems that the patient may encounter as a result of these changes	<b>TOP 2 BOX</b>	91%	92%	88%
	<b>BTM 2 BOX</b>	2%	2%	4%
I believe that treatment algorithms prevent me from doing the best for my patients	<b>TOP 2 BOX</b>	78%	78%	76%
	<b>BTM 2 BOX</b>	5%	6%	5%
Medical aids are allowing patients too few consultations per annum	<b>TOP 2 BOX</b>	86%	87%	85%
	<b>BTM 2 BOX</b>	2%	2%	2%



## **7 EXECUTIVE SUMMARY**

Contained in this section of the report is a summary of the main findings emerging from the 532 personal individual interviews, during which opinions about the impact of managed care on doctors' practices and patient care were quantified.

When assessing the findings it is important to bear in mind that the sample was representative of GPs and physicians practicing in the main metropolitan centres of Johannesburg, Pretoria, Bloemfontein, Durban, Port Elizabeth and Cape Town.

### **SAMPLE COMPOSITION**

- ❖ Interviews were conducted amongst statistically significant samples of GPs and physicians in full time, active private practice in the main metropolitan centres of the country
- ❖ The spread of interviews in these areas was proportional to the geographic distribution of the universes identified for this survey
- ❖ The sample comprised:
  - 132 physicians
  - 400 GPs
  - 73% SAMA members
  - 25% non white doctors (16% Asian, 4% black, 5% coloured)
- ❖ 26% of the sample indicated that they run cash practices and a further 6% noted that private patients pay cash
- ❖ The average number of patients seen per day by the doctors in this sample is as follows:
  - GPs: 27 – 28 patients per day
  - Physicians: 17 – 18 patients per day
- ❖ Medical aid membership amongst these doctors' patients was pinned at:
  - GPs: 74 – 75% medical aid beneficiaries
  - Physicians: 87 – 88% medical aid beneficiaries

## FOCUS ON CDLS

- ❖ Probing as to which conditions doctors feel should be added to the list of 25 CDLS, identified the following conditions as important for inclusion:

✓ Depression	55%
✓ Osteoporosis	39%
✓ Osteoarthritis	39%
✓ Menopausal disorders	17%
✓ Allergic / chronic rhinitis	13%
✓ Reflux disease / GORD	11%.

The top three conditions in order of mention for inclusion in the GPs' opinion are: depression, osteoarthritis and osteoporosis, whilst the top three conditions in order of mention by the physicians are: osteoporosis, depression and osteoarthritis.

- ❖ Reacting to the fact that hormone-related menopausal disorder, psychiatric illness, osteoporosis and bipolar mood disorder were amongst the top 10 most treated conditions in 2003 / 2004 and are not included / adequately covered in the current CDLS, yielded the following in terms of the proportion of the sample agreeing / strongly agreeing that these conditions should be included in the current list of CDLS:

	<b>TOTAL (532)</b> %	<b>GPs (400)</b> %	<b>PHYS (132)</b> %
Hormone related menopausal disorder	78%	80%	68%
Chronic psychiatric illness	78%	84%	61%
Osteoporosis	88%	88%	88%
Bipolar mood disorder	79%	82%	68%

Ranking these conditions in terms of the priority for developing treatment algorithms yielded the following overall rank order (1 = highest priority):

	<b>TOTAL (532)</b> <b>Rank order</b>	<b>GPs (400)</b> <b>Rank order</b>	<b>PHYS (132)</b> <b>Rank order</b>
Osteoporosis	1	2	1
Chronic psychiatric illness	2	1	2
Hormone-related menopause disorder	3	3	3
Bipolar mood disorder	4	4	4

## TREATMENT ALGORITHMS

- ❖ The proportion of the sample holding the opinion that one or more of the 11 CDL treatment algorithms focused on is marginally or seriously inadequate is as follows:
  - Total sample: 297 / 56%
  - GPs 233 / 56%
  - Physicians 74 / 56%
  
- ❖ There was great variance in opinion as to the adequacy of the CDL treatment algorithms for 11 of the most commonly seen CDL conditions. Findings in this regard are summarised for the total sample in the table that follows, but it is important to note that GPs and physicians did differ in their opinions here (see body of the report):

( ) = No. doctors indicating that they see and treat the condition	Proportion of the sample agreeing that.....			
	More than adequate	Just adequate	Marginally inadequate	Seriously inadequate
Hypertension (Tot = 530)	32	31	16	10
Diabetes Mellitus (Tot = 521)	25	42	11	6
Hyperlipidaemia (Tot = 520)	24	28	18	18
Asthma (Tot = 518)	36	34	11	8
COPD (Tot = 494)	25	39	14	8
Cardiac failure (Tot = 484)	24	40	12	4
Coronary artery dis. (Tot = 469)	23	38	12	6
Rheumatoid arthritis (Tot = 413)	12	40	16	8
Epilepsy (Tot = 328)	13	44	12	4
Chronic kidney dis. (Tot = 231)	10	34	15	6
Schizophrenia (Tot = 127)	9	35	16	13

- ❖ Between a quarter and a third of the sample believes that the CDL treatment algorithms for asthma, hypertension and cardiac failure are more than adequate, whilst for these same conditions, between 28% and 42% believe that the algorithms are just adequate.
  
- ❖ Conditions receiving highest mention in terms of having CDL treatment algorithms that are marginally or seriously inadequate were identified as:
  - hyperlipidaemia (36% mention)
  - hypertension (26% mention)
  - rheumatoid arthritis (24% mentions, physician bias).

- ❖ Awareness of the CDL treatment algorithms is lacking for the following conditions – with between a quarter and a third of the sample noting that they are unfamiliar with these CDL treatment algorithms:
  - Chronic kidney disease
  - Schizophrenia
  - Epilepsy
  - Rheumatoid arthritis
  - Coronary artery disease
  
- ❖ Those who are not entirely satisfied with the CDL treatment algorithms believe that they are restrictive in that certain drugs / therapies are not allowed (access to new drugs is limited and use of generics is being enforced), treatment protocols and products that are to be used are outdated, they do not allow for doctor flexibility or patient individuality and the standards of treatment are not up to scratch. In addition, some feel that the algorithms are not clear / not easily understood. In specific cases, e.g. hyperlipidaemia, it is felt that criteria / scores for initiating therapy are too high
  
- ❖ Suggestions as to which specific treatment algorithms might be more appropriate than the CDL treatment algorithms used for the most commonly seen CDL conditions, yielded little useful information. A large proportion of those commenting were unaware of or did not mention any other treatment algorithms whilst those who did make specific comment often suggested the use of algorithms developed by local bodies / organisations relevant to the specific disease areas or to getting input from key opinion leaders in the relevant fields

## **TREATMENT RESTRICTIONS**

- ❖ In total, 518 respondents hold the opinion that their treatment of patients suffering from at least one of the 11 most commonly seen chronic conditions included in the CDLs is being restricted as a result of medical aid pressure. The average proportion of patients in whom treatment is being compromised was calculated for each of the 11 conditions discussed, as shown in the table that follows overleaf (caution must be exercised when assessing the findings for schizophrenia, epilepsy, chronic kidney disease and to a lesser extent rheumatoid arthritis as these figures are based on small samples):

		<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Hypertension</b>	<b>Base (No.)</b>	<b>513</b>	<b>390</b>	<b>123</b>
Ave % cases where Dr cannot do what is best		40 – 41%	42 – 43%	37%
<b>Hyperlipidaemia</b>	<b>Base (No.)</b>	<b>405</b>	<b>328</b>	<b>77</b>
Ave % cases where Dr cannot do what is best		47 – 48%	48 - 49%	45 – 46%
<b>Asthma</b>	<b>Base (No.)</b>	<b>379</b>	<b>333</b>	<b>46</b>
Ave % cases where Dr cannot do what is best		40 – 41%	40 – 41%	38 – 39%
<b>Diabetes Mellitus</b>	<b>Base (No.)</b>	<b>373</b>	<b>283</b>	<b>90</b>
Ave % cases where Dr cannot do what is best		30 – 31%	30 – 31%	30 – 31%
<b>COPD</b>	<b>Base (No.)</b>	<b>142</b>	<b>87</b>	<b>55</b>
Ave % cases where Dr cannot do what is best		46 – 47%	47 – 48%	45 – 46%
<b>CAD</b>	<b>Base (No.)</b>	<b>131</b>	<b>86</b>	<b>45</b>
Ave % cases where Dr cannot do what is best		33 – 34%	36 – 37%	28 – 29%
<b>Cardiac Failure</b>	<b>Base (No.)</b>	<b>102</b>	<b>38</b>	<b>64</b>
Ave % cases where Dr cannot do what is best		27 – 28%	30%	25 – 26%
<b>Rheumatoid Arthritis</b>	<b>Base (No.)</b>	<b>43</b>	<b>30</b>	<b>13</b>
Ave % cases where Dr cannot do what is best		46%	49 – 50%	37 – 38%
<b>Chronic Kidney Dis</b>	<b>Base (No.)</b>	<b>14</b>	<b>4</b>	<b>10</b>
Ave % cases where Dr cannot do what is best		22 - 23%	20%	24%
<b>Epilepsy</b>	<b>Base (No.)</b>	<b>7</b>	<b>7</b>	<b>-</b>
Ave % cases where Dr cannot do what is best		23 - 24%	23 - 24%	
<b>Schizophrenia</b>	<b>Base (No.)</b>	<b>4</b>	<b>4</b>	<b>-</b>
Ave % cases where Dr cannot do what is best		52 - 53%	52 - 53%	

- ❖ Using five different categories of restriction the respondents indicated the manner in which their treatment is being curtailed by medical aid restrictions. The proportion of the sample noting such limitations (regardless of whether this was for one or more of the 4 selected conditions being discussed) is as follows:

<b>Dr cannot.....</b>	<b>TOTAL (518)</b>	<b>GPs (391)</b>	<b>PHYS (127)</b>
Conduct the tests he wishes	61%	61%	60%
Use the class thought best	93%	93%	94%
Use the product thought best	99%	98%	100%
See the patient often enough	72%	72%	73%
Continue therapy long enough	58%	59%	56%

- ❖ A summary of the percentage of patients suffering from each of 7 of the 11 most commonly seen CDLs discussed, affected by the various medical aid restrictions is as follows (based on the total sample; figures shown in brackets after each condition = the number of doctors indicating that medical aid pressure is negatively affecting treatment):

CONDITIONS	% of patients affected by medical aid restrictions (total sample). Dr cannot.....				
	Conduct tests wanted	Use best class	Use best product	See pt often enough	Continue Tx long enough
Hypertension (490)	12 – 13%	49 – 50%	56 – 57%	23 – 24%	13 – 14%
Hyperlipidaemia (386)	11 – 12%	38 – 39%	64 – 65%	15 – 16%	18 – 19%
Asthma (357)	15 – 16%	41 – 42%	57 – 58%	23 – 24%	19 – 20%
Diabetes Mellitus (373)	16 – 17%	33 – 34%	47%	26 – 27%	13 – 14%
COPD (139)	13 – 14%	43 – 44%	61 – 62%	27 – 28%	21 – 22%
CAD (120)	21 - 22%	32 – 33%	50 – 51%	23%	19 – 20%
Cardiac failure (102)	20%	29 – 30%	42 – 43%	24 – 25%	16 – 17%

Four conditions have been excluded from this table, namely: rheumatoid arthritis, chronic kidney disease, epilepsy and schizophrenia because of the small number of doctors discussing each of these four conditions.

## LIMITED NUMBER OF CONSULTATIONS

- ❖ 74% of doctors (73% GPs; 77% physicians) agree that treatment is being compromised due to the fact that medical aids are limiting the number of consultations patients are allowed per annum
- ❖ Elaborating on the manner in which treatment is being compromised yielded a long list of rather fragmented comments, the main issues being:
  - Complications develop / the condition worsens
  - Unable to follow-up / monitor sufficiently
  - Need to check / stabilise patients on newly initiated therapy
  - Patients can become uncontrolled
  - Uncontrolled patients need more frequent visits
  - Patients don't present for check-ups as they should.

Spontaneous mention in terms of specific indications / conditions where treatment is being compromised included:

- Diabetes (29%)
- Hypertension (25%)
- Asthma (11%)
- Hyperlipidaemia (4%).

## THE IMPACT OF PMBs

- ❖ The majority of the sample (52 – 57%) concur that the impact of PMBs on the quality of patient care, the patients' access to care and the outcome of disease management has been negative. On the other side of the coin, between a quarter and just short of a third believe that there has been a positive impact (figures shown = opinion of the total sample):
  - **Impact on quality of patient care:** positive 29%  
negative 56%
  - **Impact on patient's access to care** positive 31%  
negative 52%
  - **Impact on outcome of disease management:** positive 24%  
negative 57%

## FORMULARIES

- ❖ The percent of cases where doctors prescribe according to formularies was calculated as:

	<b>TOTAL (532)</b>	<b>GPs (400)</b>	<b>PHYS (132)</b>
Ave % cases where doctors prescribe according to the relevant formulary	39%	39%	40%
Median	21 – 30%	21 – 30%	21 – 30%

## SUBSTITUTION AT PHARMACY LEVEL

- ❖ Perceptions as to the percentage of scripts that are changed at pharmacy level were calculated as:

	<b>TOTAL (532)</b>	<b>GPs (400)</b>	<b>PHYS (132)</b>
Ave % cases where scripts are changed at pharmacy level	44%	44%	42%

## DEALING WITH MEDICAL AIDS

- ❖ The average number of hours that doctors and their staff spend per week dealing with medical aids were calculated as follows:

	TOTAL (532)	GPs (400)	PHYS (132)
Ave No. hours / week spent by doctors dealing with medical aid related queries	4 - 5	4	4 - 5
Ave No. hours / week spent by employees dealing with medical aid related queries	9 - 10	9	10 - 11

- ❖ On average, 31% of the time these doctors spend dealing with medical aid-related queries is spent explaining issues to the patients; 25% of the time is spent writing letters of motivation; 20% of this time is spent making phone calls to medical aids; 13% is spent chasing up on reimbursement from medical aids and 9% taking phone calls from medical aids. The remaining 2% of this time is spent completing chronic medicines application forms.

The physicians appear to spend more time writing letters of motivation to the medical aids and less time discussing medical-aid related issues with their patients than do the GPs

- ❖ Close on three quarters of the sample (with a specialists bias – 80%) indicated that it is a big problem to them that the people that they have to deal with at medical aids are non- or under-qualified.
- ❖ 96% of the sample noted that medical aids have intervened in the treatment of their patients. On average, these doctors estimated that in 36 – 40% of the medical aid patients that they treat in an average month, medical aids intervene and enforce changes to their treatment protocols.

The doctors summarised their reaction to medical aid intervention as follows:

- ✓ Unhappy with medical aid alternative, but accept changes without motivation (30 – 32%)
- ✓ Unsuccessfully motivate for original treatment (22 – 25%)
- ✓ Successfully motivate for original Tx protocol (21 – 30% - physicians more successful than GPs)
- ✓ Accept and am happy with suggested change (17 – 22%)

## **SINGLE EXIT PRICING**

- ❖ 40% of the sample (with a GP bias – 44% GPs versus 29% physicians) believe that the introduction of SEP has had a great impact on the price of medicines whilst a similar proportion of the sample (43% - equal GP and specialist opinion) believe the SEP has had somewhat of an impact on the price of medicines
- ❖ A small proportion of the sample (2%) believes that SEP has resulting in an increase in the price of medicines
- ❖ On average it is thought that the price of generics has dropped by between 20 and 23% whilst the price of original medicines has dropped by 28 – 30%

## **ONE BODY REPRESENTING THE INTERESTS OF PRIVATE MEDICAL PRACTITIONERS**

- ❖ 92 – 94% of the doctors interviewed agree that there is a need for one body to represent the interests of private medical practitioners
- ❖ 68 – 73% of those who see a need for a single body to represent the needs of private practitioners believe that this duty lies with SAMA (spontaneous mention), but a quarter of those identifying SAMA added that, whilst it is SAMA's responsibility, this organisation is ineffective / lacks the power to do the job
- ❖ 41 – 45% of those who see a need for a single body to represent their needs, believe that the doctors themselves or doctor groups should be doing this representation
- ❖ Those 139 doctors not spontaneously mentioning SAMA as playing a role in representing the interests of private medical practitioners were probed in this regard – 18% of those probed feel that SAMA could play a role here whilst 68% don't feel that SAMA would be effective in this role
- ❖ In total, 37% of the sample (evenly split between GPs and physicians; with a white and non member bias) expressed negative comments about SAMA and the role it plays / could play fighting for doctors' rights

- ❖ Issues that should be addressed by the organisation that champions for the private medical practitioners' rights include:
  - Protecting and restoring doctors' rights (75%)
  - Addressing fees and related issues (32%)
  - Fighting for patients' rights and freedom of choice (26%)
  - Allow for greater doctor input in formularies and protocols (23%)
  - Addressing issues relating to product / prescription restrictions (22%)
  - Address medical aid-related issues (18%)
  - Address administration issues (13%)
- ❖ Those doctors seeing a need for a single body to fight for the rights of the private medical practitioner identified the medical aids (78%) and the government / department of health (50%) as the two primary organisations that should be lobbied

## **FOCUS ON IMSA**

- ❖ 84% of the doctors interviewed had never heard of IMSA
- ❖ Those 86 doctors (66 GPs and 20 physicians) indicating awareness of IMSA elaborated on what they know about this organisation – the level of knowledge being very scant:
  - Don't know much / know very little (46)
  - Started by multinational companies (15)
  - Friend of the court / working against doctors (9)
  - Held meetings / provided info on managed care (6)
  - A body working for doctors' rights (4)

- ❖ 44 of the 86 doctors claiming awareness of IMSA could not identify any of this organisation's member companies. The remaining respondents believe that the following companies are members:
  - Pfizer (14)
  - Sanofi-Aventis (11)
  - GSK (9)
  - MSD (9)
  - Eli Lilly (6)
  - Novartis (5)
  - Major international companies (4)
  - AstraZeneca (3)
  - Boehringer Ingelheim (2)

## CLOSING STATEMENTS

- ❖ Based on the findings emerging from the first phase of this research project, 15 statements summarising opinions expressed in the qualitative phase were developed in order to quantify opinion
- ❖ Top two box scores (the proportion of the sample indicating "strongly agree" and "agree" with each statement) show that there is a high level of agreement with all of the statements presented. Aspects where over 90% of the total sample is in agreement include:
  - Patients present with multiple complaints which they have "saved up" as a result of medical aid benefit limits
  - I believe that I should not have to negotiate with medical aids
  - I should not have to justify my treatment choice to someone who has not examined the patient
  - The legislated prescribed minimum benefits (PMBs) are interpreted by medical aids as **maximum** benefits
  - When medical aids insist on making changes to my treatment protocols, I hold them personally responsible for any problems that the patient may encounter as a result of these changes.

- ❖ There were only two statements where the level of agreement is less than 70%:
  - On average, at least a quarter of the time that I spend with a patient is spent discussing funding issues rather than the patient's condition
  - The introduction of disease management algorithms has regressed medical care to standards established 10 to 15 years ago.



## 8 **CONCLUSIONS**

The departure point for this survey was the need to quantify the impact of managed care on doctors' practices and the quality of patient care. The findings of this survey confirm GPs' and physicians' dissatisfaction with the current status quo – burning issues (80% or more agreement / weight of mention) being identified as follows:

- 92% of the sample believe that more than just 25 conditions should be included in the CDLs – depression, osteoporosis and osteoarthritis being key conditions that are currently excluded
- 97% of the sample noted that there are times when medical aid pressure prevents them from doing what they feel is best for their patients – the major issue here being that use of what the doctors perceive to be the best classes / products is restricted by the medical aids
- 98% of the sample are of the opinion that their scripts are changed at pharmacy level
- 95% of the sample are having to personally deal with medical aids – and on average, spend 4 – 5 hours per week of their time doing this task
- 93% of the sample have an issue with the calibre of person they must deal with at the medical aids and 86% hold the opinion that medical aid advisors are hard to reach
- 96% of doctors have had their treatment protocols changed by medical aids – 88% of whom reported that there are times that they are unhappy with the medical aid's alternative treatment but accept the changes without motivation. This finding implying that the doctors are giving up the fight and settling for what they believe is inferior treatment for their patients. Against the backdrop that 89% of the sample have at times motivated unsuccessfully for their original treatment protocol, it is no surprise that doctors are giving up this fight
- the quality of the doctor - patient relationship is thought to have declined (86% agreement) and 72% of the doctors admitted to spending less time with their patients as a result of the fees paid by medical aids for ordinary consultations

- 86% of the sample agree that medical aids are allowing patients too few consultations whilst 91% agree that patients are "saving up" ailments as a result of medical aid limitations – this in turn must be having a negative impact on the quality of patient care
- doctors feel they are being pressurised by their patients into being liaisons between patients and their medical aids (80% agreement that patients rely on doctors to explain the ins and outs of their medical aids to them; 86% agreement that patients rely on the doctors to deal with their medical aids). This in turn must be negatively impacting on the quality of the doctor - patient relationship since 95% of doctors agree that they should not have to deal with medical aids
- further creating strife for the doctor is the antagonism that they feel in having to justify their treatment to someone who has not examined the patient (94%) coupled with the opinion that it is unethical to actually have such a discussion with the medical aid (82% agreement)
- 94% of the sample see a need for a single body / organisation to represent the interests of private practitioners (restoring doctors' rights being the main issue that such a group needs to address). Whilst it was suggested that SAMA could play a role here, some doubt this organisation's ability to do so.

Other issues of concern to these doctors, although not to such a large extent as those noted above (50 – 79% weight of mention), include:

- 56% of the sample believe that one or more of the CDL treatment algorithms are marginally to seriously inadequate and 78% of the sample agree that treatment algorithms are preventing doctors from doing the best for their patients
- 74% of the sample agree that treatment is being compromised as a result of the limitations medical aids are placing on the number of consultations allowed per year
- Between 52 and 57% of the sample agree that PMBs have negatively impacted the quality of patient care, patient's access to care and the outcome of disease management
- Doctors are spending less time with their patients (72% agreement).

On the positive side:

- 83% of the sample believes that SEP has had a positive impact on the price of medicines.

It is vitally important that SAMA / IMSA disseminate the findings of this survey to GPs and physicians as promised in the letter used for respondent recruitment. Failure to do this could (further) alienate doctors.

**APPENDIX I**

**QUESTIONNAIRE**

**APPENDIX II**

**DISCUSSION OF 11 CDL TREATMENT  
ALGORITHMS**

## HYPERTENSION

### MANNER IN WHICH THE HYPERTENSION TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>530</b>	<b>399</b>	<b>131</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>137</b>	<b>105</b>	<b>32</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Certain drugs / therapies not allowed	46	31	15
- don't allow ARBs	(15)	(10)	(5)
- forced to treat with generics	(7)	(5)	(2)
- forced to use cheap old fashioned drugs that don't work	(6)	(4)	(2)
- don't acknowledge the importance of H2s	(3)	(3)	(-)
Outdated protocols / treatment	29	24	5
Too restrictive	21	18	3
Enforce first line use of beta blockers or diuretics	18	13	5
Allow no patient individuality	14	10	4
Not up to standard / lag behind	9	5	4
Not clear / understandable	5	4	1

### MORE APPROPRIATE TREATMENT ALGORITHMS - HYPERTENSION

	TOTAL	GPs	PHYS
<b>Base (No. Drs who feel algorithms are inadequate)</b>	<b>137</b>	<b>105</b>	<b>32</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
Should allow Dr freedom / own approach	11	6	5
JNC7	9	5	4
Cardiology society	4	3	1
American heart association / society	4	3	1
Don't know / no one really comes to mind	27	24	3
None stated	18	15	3

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**HYPERTENSION**

<b>HYPERTENSION</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>513</b>	<b>390</b>	<b>123</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
		<b>%</b>	<b>%</b>	<b>%</b>
None		4	4	6
1 – 10%		12	9	19
11 – 20%		15	15	16
21 – 30%		17	17	17
31 – 40%		10	11	7
41 – 50%		13	14	10
51 – 60%		8	9	6
61 – 70%		6	6	4
71 – 80%		9	10	7
81 – 90%		3	2	5
91 – 99%		1	1	-
100%		2	2	4
<b>Ave % pts where prevented from doing what I thought to be best</b>		<b>40 – 41%</b>	<b>42 – 43%</b>	<b>37%</b>

**NATURE OF THE RESTRICTIONS**

**HYPERTENSION**

<b>HYPERTENSION</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>490</b>	<b>374</b>	<b>116</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Ave % cases where cannot...</b>				
Conduct tests wanted		12 – 13%	12 – 13%	11 – 12%
Use class thought best		49 – 50%	51%	45 – 46%
Use drug thought best		56 – 57%	57%	55 – 56%
See pts often enough		23 – 24%	23 – 24%	22%
Continue therapy as long as desired		13 – 14%	14 – 15%	10 – 11%

**DIABETES MELLITUS**  
**MANNER IN WHICH THE DIABETES MELLITUS TREATMENT**  
**ALGORITHMS FALL SHORT**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No. of Drs seeing and treating condition)</b>	<b>521</b>	<b>392</b>	<b>129</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>91</b>	<b>57</b>	<b>34</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Outdated protocols / treatment	22	13	9
- don't allow for the use of newer classes	(6)	(4)	(2)
- other, newer more effective drugs available	(5)	(3)	(2)
Certain drugs / therapies not allowed	22	14	8
- won't allow newer medicines like Lantus	(9)	(6)	(3)
- enforce the use of generics	(4)	(2)	(2)
Choice of drugs is limited	12	8	4
- can't use the drugs I feel are best	(4)	(3)	(1)
Algorithms not clear / understandable	11	8	3
Do not allow for patient individuality	6	3	3
Treatment is not up to standard	5	2	3

**MORE APPROPRIATE TREATMENT ALGORITHMS - DIABETES MELLITUS**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No. Drs who feel algorithms are inadequate)</b>	<b>91</b>	<b>57</b>	<b>34</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
Diabetic Society	7	5	2
Diabetic Society of SA	5	3	2
Centre for endocrinology	4	3	1
American Guidelines	4	-	4
Must allow doctor freedom / flexibility	6	4	2
Must be allowed to use Lantus	4	1	3
Must follow international protocols	3	1	2
Don't know / one doesn't really come to mind	17	14	3
None that I know off / all useless	9	7	2
None stated	11	6	5

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**DIABETES MELLITUS**

<b>DIABETES MELLITUS</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>373</b>	<b>283</b>	<b>90</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
		%	%	%
None		9	9	8
1 – 10%		22	22	23
11 – 20%		19	18	21
21 – 30%		15	15	16
31 – 40%		8	8	7
41 – 50%		11	12	7
51 – 60%		6	7	4
61 – 70%		2	2	2
71 – 80%		5	5	7
81 – 90%		1	1	3
100%		2	2	2
	<b>Ave % pts where prevented from doing what I thought to be best</b>	<b>30 – 31%</b>	<b>30 – 31%</b>	<b>30 – 31%</b>

**NATURE OF THE RESTRICTIONS - DIABETES MELLITUS**

<b>DIABETES MELLITUS</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>373</b>	<b>283</b>	<b>90</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>Ave % cases where cannot...</b>			
Conduct tests wanted		16 – 17%	17 – 18%	13 – 14%
Use class thought best		33 – 34%	32%	36 – 37%
Use drug thought best		47%	45 – 46%	51 – 52%
See pts often enough		26 – 27%	25 – 26%	29%
Continue therapy as long as desired		13 – 14%	13 – 14%	11 – 12%

## HYPERLIPIDAEMIA

### MANNER IN WHICH THE HYPERLIPIDAEMIA TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>520</b>	<b>390</b>	<b>130</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>188</b>	<b>139</b>	<b>49</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Criteria / goals for treatment are too high	49	34	15
Certain drugs / therapies are not allowed	48	39	9
- force use of generics (which are not as effective 11)	(24)	(17)	(7)
- forcing generic use instead of Lipitor	(10)	(10)	(-)
Access to medication restricted	26	21	5
Don't include the use of newer drugs	17	12	5
Based on old guidelines / not in line with current evidence based medicine	14	7	7
- based on outdated Framingham data	(5)	(4)	(1)
Patients need medication earlier / late treatment recommendations	13	11	2
Don' t take into account patient individuality	12	7	5
Treatment not up to standard	11	7	4
Want 1st line Tx to be with older drugs / generics	8	5	3
Guidelines need to be more specific	5	3	2

**MORE APPROPRIATE TREATMENT ALGORITHMS – HYPERLIPIDAEMIA**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No. Drs who feel algorithms are inadequate)</b>	<b>188</b>	<b>139</b>	<b>49</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
European guidelines	6	2	4
NCEP guidelines	6	-	6
Cardiology Society / Association	5	3	2
American Heart Association / Foundation	4	3	1
American protocol / guidelines	4	3	1
SA Cardiac / Cardiology Society	4	3	1
SAMJ guidelines	4	2	2
Must allow Dr freedom / flexibility	8	5	3
Must be allowed to use Lipitor	4	4	-
Don't know / no one really comes to mind	37	31	6
None stated	27	22	5
None / all are shocking / don't like algorithms	15	13	2

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**HYPERLIPIDAEMIA**

<b>HYPERLIPIDAEMIA</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>405</b>	<b>328</b>	<b>77</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	%	%	%
None	4	4	6
1 – 10%	8	8	12
11 – 20%	11	11	10
21 – 30%	11	10	13
31 – 40%	11	10	13
41 – 50%	14	16	8
51 – 60%	13	13	10
61 – 70%	6	7	3
71 – 80%	13	13	12
81 – 90%	4	4	5
91 – 99%	1	2	-
100%	3	2	8
<b>Ave % pts where prevented from doing what I thought to be best</b>	<b>47 – 48%</b>	<b>48 – 49%</b>	<b>45 – 46%</b>

**NATURE OF THE RESTRICTIONS**

**HYPERLIPIDAEMIA**

<b>HYPERLIPIDAEMIA</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>386</b>	<b>314</b>	<b>72</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Ave % cases where cannot...</b>			
Conduct tests wanted	11 – 12%	11 – 12%	10 – 11%
Use class thought best	38 – 39%	39 – 40%	36 – 37%
Use drug thought best	64 – 65%	64 – 65%	63 – 64%
See pts often enough	15 – 16%	15 – 16%	16 – 17%
Continue therapy as long as desired	18 – 19%	18 – 19%	16 – 17%



## ASTHMA

### MANNER IN WHICH THE ASTHMA TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>518</b>	<b>396</b>	<b>122</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>95</b>	<b>70</b>	<b>25</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Certain drugs / therapies not allowed	30	21	9
- stipulate generic use	(9)	(6)	(3)
- don't allow for Singulair	(6)	(4)	(2)
- don't allow for Seretide	(5)	(5)	(-)
Don't allow for combination therapy	21	14	7
Outdated protocols / treatment	14	10	4
Restrict the use of certain medications	12	9	3
- limited products to choose from	(4)	(4)	(-)
Don't take into account patient individuality	7	5	2
Not clear / not understandable	7	5	2
Protocols not up to standard	7	3	4

### MORE APPROPRIATE TREATMENT ALGORITHMS – ASTHMA

	TOTAL	GPs	PHYS
<b>Base (No. Drs who feel algorithms are inadequate)</b>	<b>95</b>	<b>70</b>	<b>25</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
International asthma association	5	4	1
SA Pulmonology Society	5	4	1
GENA guidelines	3	1	2
Must allow Dr freedom and flexibility	5	3	2
Don't know / no one really comes to mind	16	15	1
None / each one as bad as the next / don't like algorithms	13	12	1
None stated	10	9	1

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**ASTHMA**

<b>ASTHMA</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>379</b>	<b>333</b>	<b>46</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
		%	%	%
None		5	5	4
1 – 10%		14	14	13
11 – 20%		13	12	26
21 – 30%		13	13	9
31 – 40%		8	8	13
41 – 50%		18	20	7
51 – 60%		8	8	4
61 – 70%		4	4	4
71 – 80%		11	10	15
81 – 90%		2	2	2
100%		3	3	2
	<b>Ave % pts where prevented from doing what I thought to be best</b>	<b>40 – 41%</b>	<b>40 – 41%</b>	<b>38 – 39%</b>

**NATURE OF THE RESTRICTIONS**

**ASTHMA**

<b>ASTHMA</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>357</b>	<b>313</b>	<b>44</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>Ave % cases where cannot...</b>			
Conduct tests wanted		15 – 16%	15 – 16%	12 – 13%
Use class thought best		41 – 42%	42%	36%
Use drug thought best		57 – 58%	57 – 58%	59 – 60%
See pts often enough		23 – 24%	23 – 24%	24 – 25%
Continue therapy as long as desired		19 – 20%	19%	26 – 27%

## COPD

## MANNER IN WHICH THE COPD TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>494</b>	<b>369</b>	<b>125</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>106</b>	<b>77</b>	<b>29</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Certain drugs / therapies not allowed	43	34	9
- won't allow the use of Spiriva	(26)	(22)	(4)
- forced to use generics	(9)	(6)	(3)
Outdated protocols / treatment	17	9	8
Restrictive	12	9	3
Protocols not up to standard	10	6	4
Does not allow for patient individuality	9	4	5
Not clear / understandable	5	5	-
Restriction on combination therapy	4	2	2
Need treatment earlier / to use options earlier	4	3	1

## MORE APPROPRIATE TREATMENT ALGORITHMS - COPD

	TOTAL	GPs	PHYS
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>106</b>	<b>77</b>	<b>29</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
SA Pulmonology Society	8	7	1
Pulmonary society	4	3	1
SAMJ guidelines	3	2	1
Need to include Spiriva	5	2	3
Don't know / no one really comes to mind	25	19	6
No specific one / all as bad as each other / don't like algorithms	13	12	1
None stated	8	8	-

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**COPD**

<b>COPD</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>142</b>	<b>87</b>	<b>55</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
		%	%	%
None		2	3	-
1 – 10%		13	11	15
11 – 20%		13	11	15
21 – 30%		12	10	15
31 – 40%		7	8	5
41 – 50%		18	20	15
51 – 60%		7	5	11
61 – 70%		6	7	5
71 – 80%		10	11	7
81 – 90%		6	6	7
91 – 99%		-	1	-
100%		6	6	5
	<b>Ave % pts where prevented from doing what I thought to be best</b>	<b>46 – 47%</b>	<b>47 – 48%</b>	<b>45 – 46%</b>

**NATURE OF THE RESTRICTIONS**

**COPD**

<b>COPD</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>139</b>	<b>84</b>	<b>55</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>Ave % cases where cannot...</b>			
Conduct tests wanted		13 – 14%	15 – 16%	11%
Use class thought best		43 – 44%	43 – 44%	42 – 43%
Use drug thought best		61 – 62%	63%	60 – 61%
See pts often enough		27 – 28%	27 – 28%	27 – 28%
Continue therapy as long as desired		21 – 22%	23 – 24%	17 – 18%

## CARDIAC FAILURE

### MANNER IN WHICH THE CARDIAC FAILURE TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>484</b>	<b>358</b>	<b>126</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>80</b>	<b>56</b>	<b>24</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Certain drugs / therapies not allowed	21	11	10
- generics must be used	(7)	(4)	(3)
- ARBs not freely accessible	(5)	(2)	(3)
Outdated protocols / treatment	15	11	4
Restrictive	10	7	3
Not clear / understandable	9	5	4
Protocols not up to standard	9	4	5
Does not allow for patient individuality	7	6	1

### MORE APPROPRIATE TREATMENT ALGORITHMS – CARDIAC FAILURE

	TOTAL	GPs	PHYS
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>80</b>	<b>56</b>	<b>24</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
European Guidelines	5	2	3
American Heart Association	4	3	1
Cardiology Society / association	3	2	1
SAMJ Guidelines	3	2	1
Must allow Dr freedom and flexibility	4	2	2
Need to be able to use ARBs	2	1	1
Don't know / no one really comes to mind	17	11	6
No specific one / all bad as each other / don't like algorithms	10	10	-
None stated	9	8	1

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**CARDIAC FAILURE**

<b>CARDIAC FAILURE</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>102</b>	<b>38</b>	<b>64</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
		%	%	%
None		10	8	11
1 – 10%		27	24	30
11 – 20%		19	13	22
21 – 30%		17	18	16
31 – 40%		5	8	3
41 – 50%		7	8	6
51 – 60%		3	5	2
61 – 70%		6	11	3
71 – 80%		3	3	3
81 – 90%		1	-	2
100%		2	-	2
	<b>Ave % pts where prevented from doing what Dr thought to be best</b>	<b>27 – 28%</b>	<b>30%</b>	<b>25 – 26%</b>

**NATURE OF THE RESTRICTIONS**

**CARDIAC FAILURE**

<b>CARDIAC FAILURE</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>102</b>	<b>38</b>	<b>64</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Ave % cases where cannot...</b>				
Conduct tests wanted		20%	24 – 25%	17 – 18%
Use class thought best		29 – 30%	32 – 33%	28 – 29%
Use drug thought best		42 – 43%	41 – 42%	42 – 43%
See pts often enough		24 – 25%	27 – 28%	22 – 23%
Continue therapy as long as desired		16 – 17%	19 – 20%	15 – 16%

**CORONARY ARTERY DISEASE**  
**MANNER IN WHICH THE CORONARY ARTERY DISEASE TREATMENT**  
**ALGORITHMS FALL SHORT**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>Base (No. of Drs seeing and treating condition)</b>	<b>469</b>	<b>349</b>	<b>120</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>82</b>	<b>60</b>	<b>22</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Certain drugs / therapies not allowed	21	13	8
- forced to use generics	(12)	(9)	(3)
Outdated protocols / treatment	15	9	6
Restrictive	12	10	2
Protocols not up to standard	7	2	5
Does not allow for patient individuality	6	5	1
Not clear / understandable	6	5	1
More tests / investigations needed	4	3	1

**MORE APPROPRIATE TREATMENT ALGORITHMS – CORONARY ARTERY**  
**DISEASE**

	<b>TOTAL</b>	<b>GPs</b>	<b>PHYS</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>82</b>	<b>60</b>	<b>22</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
American Heart Association	5	4	1
No one / all as bad as each other / don't like algorithms	14	12	2
Don't know / no one really comes to mind	14	11	3
None stated	11	7	4

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**CORONARY ARTERY DISEASE**

<b>CORONARY ARTERY DISEASE</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>131</b>	<b>86</b>	<b>45</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	%	%	%
None	7	6	9
1 – 10%	24	17	36
11 – 20%	17	19	13
21 – 30%	13	14	11
31 – 40%	6	6	7
41 – 50%	11	13	7
51 – 60%	7	9	2
61 – 70%	4	3	4
71 – 80%	4	3	4
81 – 90%	3	2	4
100%	4	5	2
<b>Ave % pts where prevented from doing what I thought to be best</b>	<b>33 – 34%</b>	<b>36 – 37%</b>	<b>28 – 29%</b>

**NATURE OF THE RESTRICTIONS**

**CORONARY ARTERY DISEASE**

<b>CORONARY ARTERY DISEASE</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>120</b>	<b>79</b>	<b>41</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Ave % cases where cannot...</b>			
Conduct tests wanted	21 – 22%	22 – 23%	18%
Use class thought best	32 – 33%	33 – 34%	30 – 31%
Use drug thought best	50 – 51%	48 – 49%	56%
See pts often enough	23%	24 – 25%	21%
Continue therapy as long as desired	19 – 20%	18 – 19%	21 – 22%

## RHEUMATOID ARTHRITIS

### MANNER IN WHICH THE RHEUMATOID ARTHRITIS TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>413</b>	<b>315</b>	<b>98</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>97</b>	<b>64</b>	<b>33</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Certain drugs / therapies not allowed	22	12	10
- enforcing the use of generics	(8)	(5)	(3)
- not allowing the use of COX II inhibitors	(6)	(4)	(2)
- won't pay for Celebrex	(3)	(3)	(-)
Outdated protocols / treatment	17	9	8
Restrictive	13	10	3
Not up to standard	10	4	6
Unclear / confusing	9	5	4
Disease management not adequately covered	7	7	-
- don't cover chronic pain	(4)	(4)	(-)
Need to commence with treatment earlier	6	3	3
Does not allow for patient individuality	5	3	2
No algorithms	4	4	-

### MORE APPROPRIATE TREATMENT ALGORITHMS – RHEUMATOID ARTHRITIS

	TOTAL	GPs	PHYS
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>97</b>	<b>64</b>	<b>33</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
SA Rheumatology Association / society	8	5	3
Rheumatology Association / society	8	5	3
Don't know / no one really comes to mind	28	18	10
No specific one / all as bad as each other	7	6	1
None stated	13	10	3

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**RHEUMATOID ARTHRITIS (Caution: small base)**

RHEUMATOID ARTHRITIS	TOTAL	GPs	PHYSICIANS
Base (No.)	43	30	13
%	100%	100%	100%
None	7	7	8
1 – 10%	19	10	38
11 – 20%	2	3	-
21 – 30%	7	7	8
31 – 40%	2	3	-
41 – 50%	26	27	23
51 – 60%	9	13	-
61 – 70%	2	3	-
71 – 80%	12	13	8
81 – 90%	9	10	8
100%	2	-	8
<b>Ave % pts where prevented from doing what Dr thought to be best</b>	<b>46%</b>	<b>49 – 50%</b>	<b>37 – 38%</b>

**NATURE OF THE RESTRICTIONS**

**RHEUMATOID ARTHRITIS (Caution: small base)**

RHEUMATOID ARTHRITIS	TOTAL	GPs	PHYSICIANS
Base (No.)	39	27	12
%	100%	100%	100%
<b>Ave % cases where cannot...</b>			
Conduct tests wanted	23 – 24%	25 – 26%	18 – 19%
Use class thought best	49 – 50%	55%	37 – 38%
Use drug thought best	55 – 56%	59 – 60%	45 – 46%
See pts often enough	24 – 25%	25 – 26%	21 – 22%
Continue therapy as long as desired	21 – 22%	26 – 27%	10%

## EPILEPSY

## MANNER IN WHICH THE EPILEPSY TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>328</b>	<b>249</b>	<b>79</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>51</b>	<b>36</b>	<b>15</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Outdated protocols / treatment	14	7	7
Unclear / confusing	13	11	2
Certain therapies not allowed	7	4	3
- Topamax excluded	(3)	(1)	(2)
- enforce use of generics	(3)	(2)	(1)
Restrictive	6	5	1
Not up to standard	4	1	3
Does not allow for patient individuality	3	3	-

## MORE APPROPRIATE TREATMENT ALGORITHMS – EPILEPSY

	TOTAL	GPs	PHYS
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>51</b>	<b>36</b>	<b>15</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
Must include newer therapies	3	2	1
Based on local specialists' (neurologists') opinion	3	3	-
Don't know / none really comes to mind	14	9	5
No specific one	6	5	1
None stated	10	7	3

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**EPILEPSY (Caution: small base)**

<b>EPILEPSY</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>7</b>	<b>7</b>	<b>-</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
		<b>%</b>	<b>%</b>	<b>%</b>
None		43	43	-
1 – 10%		14	14	-
21 – 30%		14	14	-
31 – 40%		14	14	-
81 – 90%		14	14	-
100%		-	-	-
<b>Ave % pts where prevented from doing what Dr thought to be best</b>		<b>23 – 24%</b>	<b>23 – 24%</b>	<b>-</b>

**NATURE OF THE RESTRICTIONS**

**EPILEPSY (Caution: small base)**

<b>EPILEPSY</b>		<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
	<b>Base (No.)</b>	<b>4</b>	<b>4</b>	<b>-</b>
	<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Ave % cases where cannot...</b>		<b>%</b>	<b>%</b>	<b>%</b>
Conduct tests wanted		23 – 24%	23 – 24%	-
Use class thought best		6 – 7%	6 – 7%	-
Use drug thought best		10%	10%	-
See pts often enough		6 – 7%	6 – 7%	-
Continue therapy as long as desired		6 – 7%	6 – 7%	-

## CHRONIC KIDNEY DISEASE

### MANNER IN WHICH THE CHRONIC KIDNEY DISEASE TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>231</b>	<b>133</b>	<b>98</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>48</b>	<b>22</b>	<b>26</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Reluctant to pay for treatment / dialysis	11	3	8
Must be more specific / criteria are vague	11	6	5
Not up to standard	8	1	7
Does not allow for patient individuality	4	-	4
Earlier treatment needed	4	1	3
Certain therapies not allowed	3	2	1
- restricted to generics	(3)	(2)	(1)

### MORE APPROPRIATE TREATMENT ALGORITHMS – CHRONIC KIDNEY DISEASE

	TOTAL	GPs	PHYS
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>48</b>	<b>22</b>	<b>26</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Must follow international guidelines	3	1	2
Don't know	10	6	4
None aware of	5	2	3
None stated	4	1	3

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**CHRONIC KIDNEY DISEASE (Caution: small base)**

<b>CHRONIC KIDNEY DISEASE</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>14</b>	<b>4</b>	<b>10</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
None	21	25	20
1 – 10%	29	25	30
11 – 20%	14	-	20
21 – 30%	7	25	-
31 – 40%	21	25	20
91 – 99%	7	-	10
100%	-	-	-
<b>Ave % pts where prevented from doing what Dr thought to be best</b>	<b>22 – 23%</b>	<b>20%</b>	<b>24%</b>

**NATURE OF THE RESTRICTIONS**

**CHRONIC KIDNEY DISEASE (Caution: small base)**

<b>CHRONIC KIDNEY DISEASE</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>11</b>	<b>3</b>	<b>8</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Ave % cases where cannot...</b>			
Conduct tests wanted	31 – 32%	36 – 37%	30%
Use class thought best	31 – 32%	20%	35 – 36%
Use drug thought best	36 – 37%	26 – 27%	40 – 41%
See pts often enough	35 – 36%	31 – 32%	36 – 37%
Continue therapy as long as desired	24 – 25%	25%	24 – 25%

## SCHIZOPHRENIA

### MANNER IN WHICH THE SCHIZOPHRENIA TREATMENT ALGORITHMS FALL SHORT

	TOTAL	GPs	PHYS
<b>Base (No. of Drs seeing and treating condition)</b>	<b>127</b>	<b>114</b>	<b>13</b>
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>36</b>	<b>33</b>	<b>3</b>
<b>MANNER IN WHICH ALGORITHMS FALL SHORT:</b>	<b>No.</b>	<b>No.</b>	<b>No.</b>
Outdated	8	7	1
Unclear / confusing	7	7	-
Limited / restrictive	5	5	-
Can't treat properly at GP level	5	5	-
Poor product choice	4	3	1
Not up to standard	3	2	1

### MORE APPROPRIATE TREATMENT ALGORITHMS - SCHIZOPHRENIA

	TOTAL	GPs	PHYS
<b>No. of Drs. treating condition who feel that CDL treatment algorithms are marginally / seriously inadequate</b>	<b>36</b>	<b>33</b>	<b>3</b>
	<b>No.</b>	<b>No.</b>	<b>No.</b>
SA Psychiatric Association	3	3	-
American Psychiatric Association			
Must allow more doctor flexibility	2	2	-
Don't know	13	12	1
None stated	5	5	-

**PERCENT OF CASES WHERE DOCTORS ARE BEING PREVENTED FROM  
DOING WHAT IS BEST FOR PATIENT**

**SCHIZOPHRENIA (Caution: small base)**

<b>SCHIZOPHRENIA</b>	<b>TOTAL</b>	<b>GPs</b>	<b>PHYSICIANS</b>
<b>Base (No.)</b>	<b>4</b>	<b>4</b>	<b>-</b>
<b>%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	<b>%</b>	<b>%</b>	<b>%</b>
1 – 10%	25	25	-
41 – 50%	25	25	-
61 – 70%	25	25	-
81 – 90%	25	25	-
<b>Ave % pts where prevented from doing what Dr thought to be best</b>	<b>52 – 53%</b>	<b>52 – 53%</b>	<b>-</b>

**NATURE OF THE RESTRICTIONS**

**SCHIZOPHRENIA**

See computer analysis tables – very small base

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