SASES

The South African Society of Endoscopic Surgeons

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Update on the Medscheme – SASES Laparoscopic Appendectomy Pilot Study

Aim: To make MAS affordable

Role Players: Medscheme and the Medical Aids they manage
SASES members who join the pilot study

Essentials of the Study:
No Letters of Motivation (LOM) for Laparoscopic Appendectomies
Surgeon to stay within financial parameters placed on the basket for disposables
The choice of disposables within that basket as per the Surgeon
The supplier of the disposables as per the Surgeon

Timelines: First SASES Medscheme meeting 6 June 2014
Presentation to SASES members – 8 August 2015
Press release 10 August 2015

Commencement date:
Hopefully to be started April 2016

To do: Get the Medscheme Medical Aids on board individually
Get the major hospital groups on board

Review: 6 months after commencement

Goal: If successful to then take on the Laparoscopic Inguinal Hernia

Attached: 1) Press release 10 August
2) Response to questions raised by a SASES member on the viability of this Pilot Study

PRESS RELEASE

Medscheme and South African Society of Endoscopic Surgeons (SASES) reveal plans to pilot a new funding model for laparoscopic surgery.

In a joint presentation between Medscheme and SASES a new plan was revealed to address the challenges associated with funding laparoscopic (keyhole) surgery. The concept and a proposed pilot project which will address the high cost of consumables was presented at the prestigious ASSA SAGES congress held at the Durban International convention centre over the weekend. It was attended by surgeons and gastroenterologists in the public and private sector. Mr Simon Dreyer, a senior actuary at Medscheme and Dr Dick Brombacher, Vice-President of SASES outlined the project in a joint presentation.

Dreyer outlined the longstanding challenges of funding laparoscopic surgery in an environment where financial resources are limited. He went on to indicate that as an example a laparoscopic appendectomy can cost nearly 50% more than an open appendectomy. "It is because of this that we currently have interventions in place to restrict the funding of a number of endoscopic procedures, these include protocols allowing funding when certain criteria are met, letters of motivation from surgeons and co-payments" Dreyer indicated.

One of the key issues driving the price of laparoscopic surgery was the cost of the additional consumables that are used by surgeons to perform laparoscopic surgery. Dreyer illustrated this using laparoscopic appendectomy as an example. The average cost of the consumables was just over R4600 per case, but there was a large range in the cost of the consumables used in this procedure. Dreyer illustrated examples where in some cases the cost of consumables used by surgeons approached R20 000 and in other cases surgeons were able to do the same procedure using consumables costing less R2000.

Dr Brombacher indicated that the current funding interventions in laparoscopic surgery, especially where surgeons were expected to write a motivation was not only an additional administrative burden but also intrusive on clinical autonomy. "As a society we wanted to work with Medscheme to understand what was driving the costs and then work together to find new solutions to address the funding and clinical outcomes of laparoscopic surgery. We chose to start with laparoscopic appendectomy as a pilot with the intention of expanding the learnings to other procedures" stated Brombacher. Brombacher went on to state that the large variation in the use of and cost of laparoscopic consumables came as a surprise "and I wanted to share this information with all laparoscopic surgeons".

Dr Brombacher went on to propose a solution to the members of SASES whereby a network of interested surgeons will be contracted who agree to keep the cost of laparoscopic consumables within a determined price. In addition consideration would be given to one tariff for appendectomy irrespective of whether it is done laparoscopically or open removing any financial incentive to do the procedure laparoscopically. "Surgeons who participate in this pilot will not be required to motivate to do a laparoscopic appendectomy. Their clinical outcomes and costs would be monitored and where indicated, outliers will be subject to peer management from SASES. Surgeons will be completely free to use whatever consumables they want as long as they keep within the determined cost for consumables and their clinical outcomes where good. SASES will support them and we have already had some discussions with the device companies." stated Brombacher.

Dreyer went on to indicate that this initiative will reduce the cost of current laparoscopic appendectomies, allow for more of these procedures and still be cost neutral for medical schemes. Dreyer stated that "it is critical that the hospital groups and device companies also review their pricing and there have already been discussions with some of the major hospital groups and device companies". Ultimately the member will benefit and this initiative could be expanded to other procedures going forward.

"We wanted to test this proposal with our surgeons before Medscheme engaged their client medical schemes on this. The ASSA SAGES conference was the ideal platform and I am delighted that there was an overwhelming positive response from surgeons on this joint initiative" stated Brombacher.

Kevin Aron, the Chief Executive Officer of Medscheme states "Ongoing confrontation and litigation are unlikely to solve the current healthcare challenges we are facing as an industry. This is a great example illustrating how funders and healthcare professionals can work together to find solutions. By engaging and sharing information we were able to understand their challenges as surgeons and they were able to understand ours as funders. It is when common ground is found that new and innovative solutions can be formulated jointly. We can now take a mutually agreed solution to our client medical schemes for the benefit of their members."

QUESTIONS AND ANSWERS

<www.sases.org.png>

From: *SASES MEMBER*
Sent: 27 August 2015 10:30
To: info@sases.org
Subject: Laparoscopic Appendectomy

Attention Dr D Brombacher

Whilst I applaud your attempts to work with medical aids to reduce the administrative burden I wish to remind you of the following:

Back in the day Surgicom had a similar agreement with Discovery for surgeons to reduce the costs of consumables. It turned out that in fact most surgeons do not have much say in the final hospital costs, and it is the hospital that drives up the cost of each operation. Certainly, working at a Life Hospital, there is very strong pressure to use certain sutures, ports etc. as they have cost agreements in place with various companies, and obviously they are intent on maximising profits. As you know medical doctors have no executive power in the private hospitals, and

management will thwart any “interference” in their financial affairs. The end result of the Discovery / Surgicom initiative was that no savings were evident after 1 year, so the scheme was terminated.

When it comes to global fees for certain operations, as in DRG’s (diagnosis related group) there has to be **complete** co-operation between hospital management and the doctors doing the operations, and **both** must reap benefits from the resultant savings. To date the private hospitals have totally excluded medical doctors from these discussions as they wish to keep any additional profit to themselves, and studiously exclude doctors. So what is the underlying motivation for us to help save the medical aids money??

I still do not understand the need for a “motivation letter”? The information is clearly contained in the codes that are submitted – these give the type of doctor (practice number), the diagnosis (reason for operation), and the actual operation to be done. If the medical aids wish to be informed in writing, why the need for coding??

Regards

SASES MEMBER FRCS

Dear *SASES MEMBER*

Many thanks for your email and constructive points

I together with many others remember only too well previous projects / undertakings partnered with Medical Aids and the setbacks these undertakings had

The Discovery CPT4 Coding agreement of 1998 comes to mind.

Despite this the SASES Exco took the line of re opening channels of communication with Medscheme to find common ground

I am not sure whether you attended the detailed resume' of all this work which Simon Dreyer (Senior Actuary Medscheme) and I presented at the ASSA/SAGES meeting in Durban on Saturday 8 August

At this talk I walked you through the SASES website (**sases**.org)
We looked at

1) **Position Statement on the use of Equipment and Medical Devices in surgical settings**

Published 1 July 2014
Elsabe Klink was tasked with addressing the issue of the Surgeons autonomy re choice of devices and the suppliers of the same
It is a fantastic legal document which at the time we advised our membership to use as the 'trump card" for if and when Private Hospital Groups or their Pharmacists dictate the Surgeons choice in equipment selection
Regular and more frequent use of this position statement should alleviate the situation you allude to with Life and their dictatorial style

2) **Consensus Document on Appendectomies**

This document together with supporting letter from Prof. Eugenio Panieri-Dept of Surgery Groote Schuur Hospital; Prof. Alp Numanoglu - Dept of Paediatric Surgery Red Cross Children's Hospital; Prof. Zach Koto - University of Limpopo Medunsa campus Dr George Mukhari Academic Hospital - support Laparoscopic Appendectomy as

- the Standard of care both in the Private and Public Sector.

Despite all this work having been done and being downloadable from the SASES Website - to use in correspondence with funders - the membership still needed constant Letters of Motivation (LOM's) to justify/ defend / get payment for the aforementioned operation

The initial meetings with Medscheme were to try and get around the members perception of unreasonable demands of LOM's and from these meetings we developed a mutual understanding of each other's needs and concerns. Very early on it was evident that the :
- Laparoscopic Cholecystectomy
- Laparoscopic Hiatus Hernia repair and
- Laparoscopic Colectomy were agreed on as Laparoscopic procedures.

The debate was the Laparoscopic Inguinal Hernia repair and the Laparoscopic Appendectomy

As Simon Dreyer shared with the attendees at the talk is the old truth that there are 2 sides to every story. We the SASES members feel aggrieved that our autonomy is compromised however the schemes do have to balance the books and as long as there are surgeons using up to R20 000 in disposables - routinely for a Lap Appendix - there was and is no way they would ever role out a blanket ruling of allowing all appendectomies to be done laparoscopically without T's and C's. These T's and C's sadly currently are and will remain LOM's and lots of very frustrating paperwork

One could argue that the code we supply is enough - the need for LOM's then falls away. Sadly that is not going to happen while the differential on costs is so large and varied. There is a surgeon whose total cost of "disposables" is R795 per case. He /she is the lowest dot on the scattergram. The scattergram is however very wide

and varied for the same procedure done by different surgeons.

Simon Dreyer and SASES then sat down and teased out all the statistics. We looked at reasonable disposable needs. The model of 3 Trocars/ Haemolocks or Endoloops et al was used. Quotes from Covidien / Purple Surgical and Ethicon Endo Surgery were procured by SASES. The average price was just under R3000 for the aforementioned.

Medscheme then looked at what they could afford for disposables per case to make it work. Their number independently worked out was R3870. This leaves space for that extra Trocar if needed / that Endo bag where a No 8 glove's thumb just is not big enough etc.

This "basket price" for disposables (R3870) will then be what the surgeon may use per case. The disposables chosen and the supplier used remain wholly and solely the choice of the attending surgeon (hence the reference to the Elsabe Klink document).

The pilot study will be for a limited 6 months period.
The surgeons taking part will have to be SASES members
After 6 months both SASES and or Medscheme have the right to cancel the agreement

Bob like any working group we accept:
- this pilot study may not be perfect
- there will be stumbling blocks along the way

But we as the SASES Exco who have worked hard and long on this with Mike Marshall's team at Medscheme hope that it may be a step in the right direction

I hope this explains it all a bit better and hopefully answers some of your very justified concerns

Kind Regards

Dick Brombacher

Vice President
SASES Exco