



## LOSING THE LIFE BLOOD OF OUR PRIVATE HEALTHCARE MARKET

**W**hatever our perspective or political persuasion there are several facts that cannot be wished away by the private health sector. If we don't find an immediate sustainable solution to reining in the continual escalating cost of private insurance and to protecting the members buying this care, this continued abuse will compel government to enforce alternative payment options for this sector or face millions more who, because of the prohibitive cost of purchasing private cover, will once again become reliant on the state for their healthcare needs.

### The lifeblood of the private healthcare market

Of our total population of approximately 50 million:

- 19 million people are economically active.
- 13 million are employed.
- 4.3 million are in the informal sector but are in a precarious employment position and do not have access to basic benefits e.g. pension, medical aid cover and no formal written employment contracts.
- 8.3 million are employed in the formal sector and have access to basic employment benefits.
- 5 million contributing to and paying tax.
- About 78% of these 5 million taxpaying individuals earn on average R12 500 per month. This before tax. After tax and where both partners are working, the average net disposable income is in the range of R18 000 per month per middle income family household.

### How the economic recession hurts private healthcare purchasing decisions

Taking advantage of easy credit during the boom years, these middle class income earners splurged on homes, cars, cell phones and did not save. They have driven themselves into a massive debt pothole and now face staggering interest payments.

In 2010, the middle income earner family spent on average R19 000 per month in order to maintain their current standard of living. This is more than what they currently earn and with the continuing spiralling costs of grocery bills, a 25% hike in electricity, rising petrol prices, school fees and the escalating costs on medical insurance contributions, it comes as no surprise that these middle income earners are being forced to drastically cut back on their spending.

There are nearly 3 million people who are over three months in arrears on their monthly living bills.

Court judgments against debtors – 2.3 million last year, an increase of 410 000 over the year before with nearly 150 000 seeking debt counselling.

Of an estimated 1.2 million jobs lost this year alone, about one-fifth of them were held by middle-class tax paying South Africans.

### How the private medical insurance market has contributed to this predicament

For five straight years, private healthcare buyers continue to be burdened by double-digit increases in health insurance premiums, bringing the price for a typical middle

**LOSING THE LIFE BLOOD** continued

income family of four to nearly R2 200 per month. This after their employers have cross subsidised contributions of approximately 25% of the total medical insurance plan purchased.

As a percentage of total income after tax, this equates to about 24% of a middle income earner's total monthly income. Less than four years ago, their medical aid contributions were only about 12% of their total monthly income.

In our current economic climate there are many employer companies out there that are financially struggling to stay afloat and can no longer contribute towards their employees' health cover. Where this is the case, the burden now falls on the employee to cover the full cost of his family's private healthcare cover. The average contributions then go up to R2 933 per month, a staggering 33% of the individual's total disposable income.

Today the cost of a middle income family's health insurance option is rapidly approaching the gross earnings of a full-time minimum-wage worker. That is the total wage income of the other 4.3 million people who are informally employed but cannot afford the exorbitant costs for private cover.

The average middle income buyer of medical insurance cover is predominantly adults who are young and healthy. With the average age being 31, these buyers are seriously questioning the financial contributions they make towards these very expensive healthcare insurance plans which they do not necessarily need or use. They perceive it to be a grudge buy in comparison to their cars, groceries, cell phones etc.

The result is that they are now picking and choosing the healthcare cover they can afford, looking at what to keep, what to drop, and even considering taking the risk and opting out from medical cover completely.

**Worrying private insurance market trends**

There are approximately 3 488 million insured paying members with an additional 4 580 million non-paying dependents.

Of these 3 488 million members who buy cover, the trend in their buying decisions is now being made on affordability, and not on healthcare needs.

This is seen in the continued growth of the low cost insurance plan options being sold by the private medical insurance market. These affordable insurance plan options currently make up about 65% of all medical plans bought by these 3 488 million paying members.

Less than five years ago, this figure was only around 23% of all insurance plans offered and purchased in the market.

"Penny wise but pound foolish." There is an ever increasing trend in cost-shifting through co-pays in these low cost plans and due to the current financial burden these middle income purchases are already experiencing, with very little disposable income left over at the end of each month. These cost containment strategies are backfiring on medical insurance companies. Co-pay's increase fewer visits to doctors, but eventually more visits to hospitals and specialised care.

Private healthcare has become very expensive. The industry is under siege for doing a lot of useless things and charging a lot for it and the people paying the bill are asking a lot of questions and want prices to come down.

**Medical professionalism in a commercialised healthcare market**

These profound changes in our healthcare industry is leading to increasing anger, frustration, and a general unhappiness amongst many of our medical specialists. It is important that we take cognisance of what is causing this general unhappiness.

## LOSING THE LIFE BLOOD continued

The cynical in our healthcare market tend to say it's all about the money. Yes, it's about money. But it's not only about the money. To a large degree it's also about the fear of loss of control.

Being a doctor in today's environment isn't exactly what it used to be. The number of adverse external influences to treat patients are increasing by the day. Let's face it, being second guessed by call centre clerks or medical administration advisors, being forced to "play games" to obtain patient care, spending inordinate amounts of time attesting, with original signatures, and the inane amount of paperwork and billing submission requirements in order to get remunerated – it's both demeaning to the medical profession and it comes at a cost to the livelihood of the practice.

### **The service of patients and the honest reward from one's labour are not incompatible**

Doctors' after-expense incomes are a fairly small percentage of the total medical costs. Attempting to control the health budgets by restricting doctors' fees or by not taking into consideration the costs associated with managing a changing practice environment, we will not be able to control total cost expenditures.

The reason: in healthcare it is the demand, volume, and intensity of medical services, not the doctors' fees, that are the main factors driving up costs.

Whether we like to agree or not, doctors are the "key decision makers" in the delivery of healthcare and approximately 80% of all healthcare expenditures relating to the diagnosis and treatment of disease are tied to decisions made by them. How well these services are reimbursed inevitably affects how lavishly they are dispensed.

Additional distortions in remuneration will further create the incentive for doctors to increase the volume of their own services and shift the costs to the patient with

distortions of demand and supply, shortages of services, cost-shifting to uncontrolled healthcare markets, and continuous political pressures to extend and adjust the controls. This is where income becomes politics.

‘Of course money, on its own, may not solve all the problems.’

### **Let's face it, demoralised and frustrated healthcare professionals are not in anyone's best interest.**

Of course money, on its own, may not solve all the problems. But without it, only little gains are likely to be achieved with non-monetary initiatives. And what are those initiatives that are not going to need money?

The financing of healthcare and how it is distributed in our country is at a crossroads. Much of what will be the nature of future healthcare management depends on how each role player relates to money. This relationship has the potential to propel healthcare to provide greater good to society, or be subsumed by personal interests, even greed, profiteering and a potentially suicidal self-interest.

**Maybe it's time we rethink our approach?**

**Gary Patrick**  
**CEO SpesNet**

## POPULAR CONGRESSES FOR 2011

CONGRESS	DATE	CITY	COUNTRY
ACC 2011 ANNUAL SCIENTIFIC SESSIONS	2-5 April 2011	New Orleans	USA
M & M MEETING	6-8 May 2011		
EUROPREVENT 2011	14-16 May 2011	Geneva	Switzerland
ICNC (NUCLEAR CARDIOLOGY AND CARDIAC CT)	15-18 May 2011	Amsterdam	Netherlands
EUROPCR 2011	17-20 May 2011	Paris	France
HEART FAILURE 2010	21-24 May 2011	Gothenburg	Sweden
HAMMERSMITH ECHOCARDIOGRAPHY 2011	23-27 May 2011	London	UK
PASCAR CONFERENCE 2011	27-30 May 2011	Kampala	Uganda
CSI 2011 CONGRESS	23-25 June 2011	Frankfurt	Germany
EHRA EUROPACE 2011	26-29 June 2011	Madrid	Spain
EUROPEAN ATHEROSCLEROTIC SOCIETY	26-29 June 2011	Gothenburg	Sweden
ESH ANNUAL SCIENTIFIC MEETING 2011	17-21 July 2011	Milan	Italy
ESC 2011	27-31 August 2011	Paris	France
ECCR (EUROPEAN CARDIOVASCULAR RESEARCH)	29 September - 2 October 2011	Nice	France
EACTS (EUROPEAN ASSOCIATION FOR CARDIOTHORACIC SURGERY) 2011	1-5 October 2011	Lisbon	Portugal
VENICE ARRHYTHMIAS 2011	9-12 October 2011	Venice	Italy
CHEST 2011	10-15 October 2011	San diego	USA
<b>SA HEART 2011</b>	<b>23-26 October 2011</b>	<b>East London</b>	<b>South Africa</b>
TCT 2011	7-11 November 2011	San Francisco, CA	USA
FRSA (FRENCH-REUNION SOUTH AFRICA MEETING)	27-30 November 2011	Cape Town	South Africa

## MERGING MEDICAL AND MECHANICAL MANAGEMENT AT MOUNT GRACE

Supported by MSD & MEDTRONIC. During the MONTH of November 2010

**D**uring the weekend 5 to 7 November 2010, cardiologists attended an exceptionally well organised academic cardiology meeting discussing a textbook-full of conditions. This meeting confirmed that we still have world-class speakers amongst SA's cardiologists. MSD and Medtronic joined forces to make this highlight meeting possible. For MSD it was also a launch of Inegy and relaunch of Integrilin and a step towards regaining a leader role in the industry. For Medtronic it was confirmation of their leader role in providing for their customers a "something more" added value. A special congratulation to the organisers for the programme presented. We are looking forward to the next meeting in 2011.

We had the honour of listening to two excellent international speakers. Prof. J. Puma is Associate Director, Research at Lenox Hill Heart & Vascular Institute of New York and Lenox Hill Hospital. His research focused on anti-platelet therapy, adjunctive pharmacotherapy and novel devices in the treatment of coronary artery disease, acute coronary syndromes and PCI. Dr José de Ribamar Costa Junior is Director, Intravascular Imaging (IVUS & OCT) Core laboratory at the Cardiovascular Research Centre, São Paulo, Brazil. His hospital employs 300 cardiologists, which is nearly twice as many as in the whole of South Africa. He has a wealth of cathlab experience and knowledge of international guidelines.

At Friday night's dinner the humoristic motivational speaker Gavin Sharps, invited all to be someone who influences people, to make this world a better place for all, to make a difference, to be or mean something for somebody, to complain less and to do more, to be a dad and not merely a father or to be a wife and mom and not merely the woman in the house. Concentrating only on making money has a definite down side. The Bedouin Dinner on Saturday night was complemented by a wide variety of music to suit everybody's taste.

With Mike How-Ealy and Colin Schamroth in the lead, cyclists negotiated 50 to 70km along Hekpoort Neck and the beauti-

ful countryside each morning. We experienced the high quality organisational skills of Scatterlings.

The central message from the academic presentations was:

**GUIDELINES: Know them – use them – apply them. Below follow a few snippets.**

### ACS/PCI & Anti Platelet Therapy

- Changing from IV to oral therapy.
- Protocol driven strategies are superior.
- Not all patients are the same.
- Low risk patients do not warrant high risk therapy.
- MI pre-PCI implies a 5 x 6 months higher risk.
- Early invasive strategy leads to a MACE reduction of 19.4 → 15.9% at 6 months.
- Guidelines are followed in approximately only 50% of cases.
- Beware of ReoPro pre-PCI.
- We still need a clinical trial to prove benefit for Plavix pre-PCI, while we have evidence of benefit for Plavix in medical treatment strategy.
- Plavix at PCI gives only 60% Platelet aggregation inhibition whilst this figure ups to 90% if IV Gp2b3a were given.
- Estimate up to 30% non responders to Plavix.
- We need easier ways to assess/predict who may not respond to Plavix.
- TIMMI risk score of >3 implies significant increased risk.
- A 10% increase in guideline followers may lead to a 10% decrease in mortality.
- Bleeding significantly adds risk to ACS and PCI event.

### Sex/Gender Differences with ACS

- 40% of patients with ACS/MI die before reaching the hospital.
- If adjusted for risk, there is no difference in mortality between men and women.
- Younger women <65 years present more often with aberrant symptoms.

## MERGING MEDICAL AND MECHANICAL MANAGEMENT continued

- Older women often have more and worse risk factors than men.
- Women have more non obstructive CAD.
- In women there is a clear advantage of Primary PCI compared to Thrombolysis particularly with positive biomarkers.
- Women have more bleeding and vascular complications.
- Beware of thrombolytic overdosing in women.
- Despite less severe CAD women end up with the same mortality as men.

### Statins & PCI

- Beware not to stop statin pre-PCI; even if you have to give it via NG tube.
- Initiate statin pre-PCI with high dose.
- Statins make a difference if the event associated with raised hs-CRP.

### Reperfusion

- Primary PCI showed a clear advantage if done within 120 minutes after the event particularly in high risk patients.
- Facilitated PCI has a Class III indication = more likely to be detrimental.

### Update on Clinical Trials at PCR and TCT

- The Syntax Score; TIMMI Score and Euroscore are still underused.
- Syntax 0 – 22 = Low score = Favourable for PCI.
- Syntax Score 23 – 32 = Intermediate score = Probably for PCI.
- Syntax Score >33 is a clear indication for CABG as treatment option.
- Will the use of second generation DES have a better outcome?
- Is there still place for first generation DES like Taxus and Cypher?

- In resolute All Comers, most thrombosis in the resolute arm occurred within the first month and is considered to be procedure related and not DES related.
- Less deaths with Resolute but the study was not powered to indicate the significance of this finding.
- Cypher = first generation DES and restenosis may be due to fracture.
- Whilst working in a Cardiology Centre in Brazil with 300 fellow cardiologist Dr Cola certainly is qualified to have an opinion on these matters.

### Mechanic therapy for Hypertension – Renal Artery Ablation

- This procedure is maybe indicated if GFR >45ml/min with systolic BP still >160mmHg on three drugs at effective dosage.
- May need 3 – 4 ablations.
- Ablation time 40 minutes.
- Renal Artery Ablation cannot yet be included in any guidelines.

### Statins for Primary Prevention?

- Statins have no proven beneficial effect for heart failure.
- Statins have proven effect for FH.
- 80% of the population is at low risk for MI but still contribute 1/3 of all MI's.
- The evaluation of Short Term vs Lifetime risk as documented in JACC 2010;56:630-636 may motivate for easier starting on statins for primary prevention.
- It is still not proven that hs-CRP and Lp(a) implies higher risk to warrant statin for primary prevention.
- But then again, can we motivate Aspirin for primary prevention? Maybe not necessarily always.

### PCI: Gp2b3a Risk Assessment

- Does using Gp2b3a with PCI only make the doctor feel better or does it prolong the patient's life?

*Continued on page 72*

## MERGING MEDICAL AND MECHANICAL MANAGEMENT continued

- Always assess Efficacy vs Safety.
- And consider "Do no harm" vs "Net clinical benefit".
- Does any drug in Cath Lab have proven mortality benefit?

### Rhythm Management

- MRI with Pacemaker is not impossible but patient needs to not be pacemaker dependant with pace rate set to minimum with maximum output and to no rate response or similar facilities activated. This Sure Scan Technique however still only for optimal pacemakers.

### EPS for AF

- Patient selection and methods used effect outcome.
- Keep in mind mayor complication rate of up to 4.5%.

### Cardiac Protection in DM

- Orlistat 60mg tds must lead to 5% weight reduction by 3 months to be useful.
- Apo B should be <80mg/l and hCRP <2mg/l.
- Statin metabolism is influenced by Verapamil, Diltiazem and Amiodarone.
- IMT is an unnecessary examination unless the patient is symptomatic.
- Inegy is safer and more effective than high doses Simvasatatin.
- Simvastatin alone should probably only be used up to 40mg.
- Ecotrin actually only delivers 60mg of aspirin effectively – too low.
- Aspirin certainly for secondary prevention but questionable value for primary prevention in low risk patients.
- Consider Holter monitor for Obstructive Sleep Apnoea.

### ACS & PCI

- Plavix 300mg on admission and 300mg in cath lab with then 75mg bd 7 days and 75mg/day for one year.
- Prasugrel should be considered in future but beware of more bleeding.

- Ticagrelor 180mg bolus then 90mg bd as alternative but beware of more Bradicardia and Dyspnoea.
- Plavix prevents 2/100 MI's & CVA's per year.
- Integrelin similar efficacy as Aggrastat.
- Maybe only Double Bolus Gp2b3a at PCI without further infusion?

### Mechanical Therapy for Intra Coronary Thrombus

- Distal Protection Device in native coronaries confers to benefit as it has to pass the thrombus.
- Distal Protection Device useful in venous grafts.
- Proximal Protection Device and Aspiration in Coronaries a "yes" but the trials are small.
- AngioJet: No.
- X-cizer: Yes but .....
- Watch out for the M-guard Stent.

### ICD: Inappropriate Shocks

- No inappropriate shocks might mean too few shocks.
- The more shocks needed, the poorer the prognosis.
- Inappropriate therapies also leads to poorer prognosis.
- AF/SVT inappropriate sensing the main cause for inappropriate shocks.
- Inappropriate shocks occur in 10% of patients with 30% of shocks inappropriate.
- More shocks lead to progressive heart failure and death – due to more severe disease?
- RA Auricle lies next to LVOT and easy to wrongly sense R-Waves.
- Lead fracture is a function of time.
- We are looking forward to new programming guidelines.
- Always seek a secondary cause like infection, heart failure or thyrotoxicosis.
- Consider ablating VT if shocks are inappropriate.
- Keep your eyes open for CASSA ICD courses.

## MERGING MEDICAL AND MECHANICAL MANAGEMENT continued

### TAVI

- Consider if Euroscore 20; NYHA III and EF <50%.
- Bad EF do badly.
- Present success high due to effective training.
- 80% of patients improved at two years.
- One year survival 80% (as for normal octogenarians) with 70% at two years and no valve failure so far.
- 30 day mortality 5 – 7% = but may be up to 15% with stroke rate of <5%.
- Pacemaker needed.
- Ratio 2:1 for transfemoral: Trans-Apical.
- Pacemaker needed in 25%.
- Perivalvular AR minimal only in 5%.
- Vascular complication in 10%.
- Edward's Balloon expandable valve with shorter cage than the valve from Medtronic.
- Euroscore of 40 gives 60% one year survival.
- The results are improving.

### Multivessel Disease

- BM of DES?
- Consider FFR and IVUS for more appropriate therapy to assess culprit lesion.
- Clopidogrel is still imperfect – will Prasugrel be better?
- Your decision often depends on your experience.
- We should learn from real world cases.

### Atrial Fibrillation

- This is an age related disease affecting 25% of people >40 years and 1 – 2% of the population with 1/3 of cases "silent".
- Increase mortality x 2 and CVA x 5.
- Mortality of AF has not improved over the years.
- The risk for paroxysmal AF is higher than that for chronic AF.

- LV Dysfunction is the only independent echo risk finding of note.
- CHADS2 of "0" needs only Aspirin and score of 1 either Aspirin or Warfarin depending on the association of other vascular co-morbidities.
- Aspirin and Clopidogrel are inferior to Warfarin but better than Aspirin alone.
- Pradaxa 110mg bd is as effective as Warfarin with 150mg bd even better with even less haemorrhagic infarctions.
- Abixaban 5mg bd better than Aspirin but not yet compared to Warfarin.
- Only 50% of those who need Warfarin get it.
- Therapeutic range successful in only 65% in studies – and in RSA 45% = dismal!
- A Normogram exists to evaluate bleeding score – another guideline to use.
- In PCI use triple therapy but consider avoiding DES.
- Bridging with Clexane during intervention should be avoided at all cost.
- INR <2 may be useless but it's difficult to convince dentists of this fact.

### AF Ablation

- 50% 5 year cure.
- Indicated if rate and/or symptoms not controlled and earlier in younger patients and those with heart failure.
- Read the 2010 guidelines of drug therapy – although this guideline is still not without problems.
- We certainly should consider to ablate more!

Until next time

**Adriaan Snyders**

*Continued on page 74*



MERGING MEDICAL AND MECHANICAL MANAGEMENT continued



## CARDIOVASCULAR EMERGENCY CARE

It can still take between one and four hours for a patient to be transferred from an emergency room to a cardiac ICU within a city! This may be due to lack of ambulances; sometimes due to getting authorisation from medical aids for the transfer; but unfortunately also due to lack of awareness of the risks of delay. It is also still possible to find an emergency room without thrombolytic or Gp2bb3a medication or an emergency doctor not knowledgeable in how to use these drugs. Fortunately there are also centres of real excellence and even qualified ambulance staff who are prepared to administer thrombolytic medication, obviously with the cardiologist's consent. Trauma doctors should realise that in the presence of a clear clinical diagnosis, a chest x-ray and blood tests should never delay immediate therapy. We now have clear guidelines on how to treat cardiovascular and neurovascular emergencies.

It may be time for you to get involved in training at referral centres. Try and establish a good relationship with the ambulance services in your environment and maybe get involved in their training. The ambulance service is an extension of your emergency care. It has been shown long ago that with appropriate training, ambulance staff should be allowed to administer Clexane, Clopidogrel, Disprins and even thrombolytics. You could shrug your shoulders and not care – but this is not appropriate for a clinician. Phone your local ambulance service and trauma unit now!

It is maybe appropriate for the Heart and Stroke Foundation to be involved with educational and training programmes. Please assist should they ask you to help. This is also a magic opportunity for industry to become involved with educational programmes similar to the ESC's "Stent for Life" programme in Europe.

All hospitals, and particularly intensive care units, have an uphill battle to have trained staff available but this is no

reason to give up. It is possible to train permanent staff even if they are not yet qualified. Unfortunately hospital managers often prefer to allow an unfavourable nurse/patient ratio in intensive care to continue, rather than having extra staff available for emergencies – all to save money; sometimes hiding behind "lack of available staff"

‘ We need to educate and motivate ourselves on these matters. ’

Hospitals caring for cardiac emergencies should have facilities like a CVP set and temporary pacemaker available on the emergency trolley. It is not rare to wait for basic resuscitation equipment like this, even in large private hospitals. I have no idea how effective systems in the public hospitals are but from reports have no reason to believe that the situation is better.

The value/advantage of Primary PCI in certain emergency ACS cases is well established, but not always widely practised. Studies show clearly that managing emergencies according to guidelines leads to a better outcome. We need to educate and motivate ourselves on these matters.

**Adriaan Snyders**

## SOUTH AFRICAN SOCIETY OF CARDIOVASCULAR INTERVENTION

When reading this, 2011 will already be well underway and I hope that it will be a great year, both for you personally and for your patients. It is my privilege to report on SASCI's activity over the past number of months and for the rest of 2011.

As always I would like to thank my Executive Committee for their contribution to the society and our objectives. After almost 8 years at the helm of SASCI my contribution as President will conclude at the SASCI AGM to be held at the SA Heart Congress (October 2011). The "handover" of SASCI to a new leadership team creates the opportunity to rejuvenate and redefine ("tweak") our contribution to interventional cardiology as a whole. As Ex-Officio President I will still be actively involved, but more in a supportive role.

A society is only as strong as its members and is highly dependent on individuals willing to get involved to influence the macro environment we operate in (to the ultimate benefit of our patients). Getting new blood (not always necessarily young blood) involved is essential AND one area I would say the current Exco has not been very successful in (unfortunately not uncommon in non-profit organisations). At this point in time (some 6 months prior to the AGM), I will ask you to reflect on your contribution to the broader interventional cardiology (through the Society or individually). Members may contact me or our Executive Officer George Nel at 083 458 5954 if you wish to discuss your possible involvement in person.

The following are individuals who have been the cornerstone of our society for the past number of years.

President	Dr Graham Cassel
President (ex-officio)	Dr Tom Mabin
Vice-President	Dr Farrel Hellig
Secretary	Dr Adie Horak
Treasurer	Dr Clive Corbett
Members	Dr Cobus Badenhorst
	Dr Jacques du Toit
	Dr Jai Patel
	Dr Mpiko Ntsekhe
	Dr Sajidah Khan

Dr Chris Zambakides
Rob Millar (Industry, term end 2012)
Salome Snyders (Industry, term end 2012)
Mariska Fouche (Industry, term end 2012)
George Nel (assisted by Sanette Zietsman)

Executive Officer

The following major activities/programmes took place since the previous report:

### Council for Medical Schemes PMB

SASCI's commitment and involvement with the CMS PMB process has been noted and applauded within the health-care environment, not the least by CMS itself. SASCI obtained legal expertise through Elsabe Klinck and I believe this guided us in a professional, effective and legally sound manner. I thank Farrel Hellig (as Vice-President) whom, with George Nel, attended the important all-day CMS PMB meeting on 25 November 2010. From this meeting it is clear that SASCI will need to play a pivotal role in recommendations to CMS (including vetting clinical evidence but also potentially cost-effectiveness analysis). The ESC guideline(s) was submitted to CMS as best available "evidence base" and has been accepted by CMS as appropriate. It is envisaged that SASCI will actively engage CMS on appropriate "cases" to develop a functional working relationship in 2011. It is important to note that the CMS is a statutory body with the mandate to specifically "protect the interest of medical aid members".

### SCAI

The global Society for Cardiac Angiography and Intervention (SCAI) Congress took place in October 2011 in Istanbul. SASCI was invited to participate and I officially represented our society at this prestigious congress. Our relationship with SCAI is crucial to ensure that SA interventional cardiology remains relevant in the international arena.

Four South African Registrars did attend the annual Society for Cardiac Angiography and Intervention (SCAI) Fellows Programme in Las Vegas in December 2010. This was made

**SASCI** continued

possible through support from SCAI and SASCI, as well as Boston Scientific. The SA delegation for 2010 was Drs Riaz Dawood; Jens Hitzeroth; Aine Mugabi and Norman Lester. Feedback received from them was extremely positive and they indicated that this is a world-class programme. SASCI will continue with the programme in 2011. In addition to our local Fellows, Dr Jugessur Sanjiv's (a young cardiologist from Mauritius) attendance at the SCAI congress was also facilitated by SASCI.

**Cath Lab Registry**

The SHARE (SA Heart Association Registry) received a new financial lease of life through generous support from Netcare and Discovery Health. Data capturing remains a substantial hurdle in getting the programme operational at all sites. SASCI is actively engaging major role players (such as hospital networks) to address this specific stumbling block at unit level. Members such as Cobus Badenhorst (Exco member and our representative on SHARE), Adriaan Snyders, Tom Mabin and Mark Abelson remain shining lights that the programme can be implemented with success if there is real commitment.

George Nel (our executive officer) now oversees management and fundraising for SHARE (on behalf of SA Heart). I ask that members contact either George or Elizabeth Schaafsma at 083 603 7700 if they are interested in getting involved. This programme remains a cornerstone of the society objectives, which we have NOT delivered on as yet.

**MELISA**

Unfortunately MELISA (the online Medical Library of South Africa) is no longer commercially available in South Africa and, as part of a broader strategy, SASCI is re-evaluating our website ([www.sasci.co.za](http://www.sasci.co.za)) in general and access to medical journals specifically. I would like to thank Pharma Dynamics for their continued willingness to support these endeavours. SASCI members with an interest in electronic communication should contact George Nel if they wish to get involved or to make suggestions in this regard. We need to identify compelling reason(s) for our society website!

The following activities are planned for the foreseeable future (at time of writing):

- The 7th Annual SASCI Fellows Workshop will be held on 26 February at Netcare Sunninghill. The faculty will consist of Dr's Farrel Hellig (programme director), Graham Cassel, Cobus Badenhorst, and Chris Zambakides. We have 21 Fellows confirmed (more than 80% of those studying in South Africa) and it promises to be an exciting and informative day of learning for our young colleagues. This workshop is only possible through the substantial support we receive from all our corporate industry members (see company list below). In addition, Netcare has committed to sponsor "participation" of two indigent (public sector) patients as live cases for 2011. Thank you to the faculty, industry and the hospital group!
- During the Fellows Workshop, SASCI will also announce the recipient of the 2011 Boston Scientific RC Fraser International Fellowship Award in Interventional Cardiology. This award allows the recipient to travel internationally and spend four weeks at a renowned interventional centre.
- The highly popular EuroPCR 2011 will once again be held in Paris this year (17 to 20 May 2011). SASCI will again participate with another international society in a joint session. This meeting remains a must do on our annual calendar and ensures that the South African Interventional community maintains a high international profile. I would like to encourage colleagues to submit cases, abstracts and original work to the PCR meeting and contribute to the SASCI joint session.
- It is a challenge to ensure that the 2nd Annual SASCI Visiting Professor (VP) Programme achieves the high standards set by our first VP Prof. Jean-Pierre Bassand in 2010, but SASCI is confident that in Dr Spencer King we have a person who can achieve this. Dr King will spend October and November 2011 in South Africa as a visiting professor at several of our Medical Schools. I would like to thank Medtronic for their substantial and unconditional support of this valuable extension of SASCI's long-standing commitment to enhance cardiology sub-specialty training in South Africa.

*Continued on page 78*

## SASCI continued

- The South African Heart Association Congress 2011 will take place in East London from 23 to 26 October 2011. I am personally representing SASCI on the Congress Organising Committee and have confirmed that Dr Spencer King (visiting professor 2011) will be our key note international speaker at the congress. The programme will offer the interventional cardiologist worthy content and, in addition, our important AGM will also be held during the congress. PLEASE make sure that you attend.
- SASCI in collaboration with the France-Reunion Cardiology Group, and the South African Cardiac Surgery Group, will host the French-Reunion-South African (FRSA) Meeting in Cape Town from 27 to 30 November 2011 at the BOE convention centre in Cape Town. A big thank you should go to Tom Mabin for continuing to put us on the map and for his tireless effort to drive educational opportunities in South Africa. The FRSA meeting will feature a substantial international faculty and SASCI has already secured attendance of Drs Spencer King from Atlanta and Bernard

Gersh from the Mayo Clinic. This meeting has received international accreditation and Mayo Clinic endorsement.

I would like to thank our industry partners for their continued and unwavering support of SASCI and the society's constitutional objectives. Without these close and professional relationships few of SASCI's objectives would be achieved. I have never in the past specifically listed our corporate members and would like to do so in this Newsletter – Aspen, AstraZeneca, Baroque, B Braun, Boston, Cordis, Disa Vascular, Edwards, Lilly, Medtronic, MSD, Paragmed, Pharma Dynamics, Viking and Volcano. These companies are truly committed to our society and education in South Africa.

Please contact your Executive Officer George Nel at 083 458 5954 or [sasci@sasci.co.za](mailto:sasci@sasci.co.za) if you need any assistance or need to formally communicate with the executive.



**SASCI**

**South African  
Society of  
cardiovascular  
intervention**

**Dr Graham Cassel  
President, SASCI**

## ROMAN CATHOLIC HOSPITAL, WINDHOEK, NAMIBIA

### Cardiologist for the Windhoek Heart Centre

The Windhoek Heart Centre is located at the private, independent Roman Catholic Hospital in Namibia. The Hospital has just opened a purpose built, state-of-the-art Cardiothoracic Operating Room and Intensive Care Unit. Construction has also started on the Cardiac Catheterisation Laboratory, which is due to be commissioned at the end of June 2011. A Cardiothoracic Surgeon and a Paediatric Cardiologist have already opened Consulting Rooms in the Windhoek Heart Centre.

We are looking for Cardiologists willing to relocate to Windhoek to run their practice at the Roman Catholic Hospital. The prospective candidate should be a registered Cardiologist and will have to obtain registration with the Medical and Dental Council of Namibia. The successful candidate will also be encouraged to work for the Ministry of Health and Social Services at the Cardiac Unit at the Windhoek Central Hospital.

**Interested applicants should contact the Hospital Administrator, Sr. Amadea.**

Email: [admin@rchna.org](mailto:admin@rchna.org) | Tel: + 264 61 270 2004 | Mail: PO Box 157, Windhoek, Namibia



## CARDIAC ARRHYTHMIA SOCIETY OF SOUTHERN AFRICA (CASSA)

### SA Heart Association 2011

CASSA has the honour of hosting the annual South African Heart Association Congress in 2011. The congress will take place from 23 to 26 October at the new, ultra modern East London International Convention Centre. Please diarise this prestigious event.

Topics which delegates can look forward to include, atrial fibrillation, ethics, sudden-death, interventional cardiology, valve disease and intervention, and pulmonary hypertension.

### Accreditation of ICD practitioners

#### Introduction

These guidelines form the basis on which cardiologists (non-electrophysiologists) intent on doing ICD implantation would be accredited by CASSA, in terms of their proficiency in a blinded way. These guidelines would apply equally to cardiologists who have not as yet started ICD implantation, as well as to those who may have performed this procedure. They apply to cardiologists who are not electrophysiologists. People who have received accreditation from a reputable organisation such as HRS or ESC, will be exempt from the theoretical part of the accreditation process.

CASSA accredited electrophysiologists are accredited ICD implanters.

This accreditation would apply to ICD implantation for primary prevention only. In cases where sustained or haemodynamically important ventricular tachyarrhythmias have occurred, implantation should be performed by electrophysiologists only.

#### Basic requirements

- Proficiency in cardiac pacing.
- Attendance at a CASSA accredited course and passing of a CASSA accredited test.
- CASSA review of cases and mentoring:
  - For novice implanters,
  - For Cardiologists already implanting.

The complete accreditation guideline document can be perused on the CASSA website [www.cassa.co.za](http://www.cassa.co.za) or obtained from Franciska Rossouw at [franciska@cassa.co.za](mailto:franciska@cassa.co.za) or 082 806 1599. Applications to be accredited as an ICD practitioner are now open and candidates who are interested can contact the CASSA Executive Officer on the contact details above.

### Council of Medical Schemes (CMS) PMB benefit design

The CASSA EXCO took part in the Prescribed Minimum Benefit (PMB) guideline meetings at the Council of Medical Schemes toward the end of 2010. Here is a short summary of the main discussion points:

#### Background

The mandate of the CMS is to oversee that the PMB benefit of patients is applied correctly and fairly across schemes and options. They invited all Special Interest Groups in Cardiology to submit guidelines pertaining to their specific field of interest. CASSA prepared the necessary documents and submitted these to Council. During the meetings specific individual PMB codes were not discussed, but the principles of what constituted "desired care" which should be funded by all options of all schemes were defined. These are:

- **Evidence Based Medicine (EBM):** This is the conscientious, explicit and judicious use of current best evidence whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research. PMB guidelines should therefore cover the "average" case as well as the "complicated".
- **Cost-effectiveness:** Health economic analysis should accompany best clinical outcomes as set out in the EBM definition above. Some of the parameters that are used when a HTA is done are re-admission to hospital, downstream costs etc. The CMS does not have a HTA division and none of their staff is trained in doing Health Economic studies which could prove to be a barrier in getting new medicines or devices accepted as part of the PMB guidelines in future.

*Continued on page 81*

## HeFSSA NEWS

Please allow us the opportunity to report on HeFSSA's programmes since the last SA Heart Journal publication and also to give you a preview of what is planned for the near future.

We would like to use this opportunity to thank the dedicated HeFSSA Exco, under the leadership of the President, Prof. Karen Sliwa. Without her contribution and the dedication of Drs Eric Klug (Vice President), Martin Mpe (please check name) (Treasurer), Cristina Radulescu, Darryl Smith, Prof. Obel, Jean Vorster, Tony Lachman and Dave Gilmer, Prof. Sandrine Lecour and the industry Exco representatives, William Stranix and Patricia Magagula, the society would not be able to meet its numerous goals.

Global Survey of medical specialist management of chronic Heart Failure (GAPS-HF): Servier under the guidance of the HeFSSA Exco designed an awareness campaign in the form of a leaflet to inform General Practitioners about this valuable programme and in general about HeFSSA. Representatives from Servier are currently in the field actively distributing this information.

HeFSSA urges all medical practitioners (specialist and general practitioners alike) to complete this online questionnaire and in doing so contribute to our knowledge of Heart Failure in the developing world. The GAPS-HF questionnaire can be accessed through the WHFS website ([www.whfs.org](http://www.whfs.org)) or directly by using <http://gaps-hf.whfs.org>.

Council for Medical Schemes PMB – HeFSSA has been involved with the CMS PMB process and contributed to the positive outcome of the meeting held on 25 November 2010. The CMS is a statutory body with a mandate to specifically “protect the interests of medical aid members”. CMS's objective is to standardise “desired care” medical aid members receive for PMB conditions. Drs Martin Mpe and George Nel represented HeFSSA at the meeting and the society put forward the ESC guidelines as most appropriate evidence base from a clinical perspective. The

ESC guidelines were accepted as such at the meeting. It is obvious that HeFSSA, as well as the other societies, will play an essential role to guide the CMS in the PMB process.

The Joint UK/SA Cardiovascular Research Workshop – was held on 6 December 2010 at the Hatter Cardiovascular Institute at the University College in London.

Cardiovascular disease is the leading cause of death in the UK and is on the rise in South Africa. The main purpose of this first joint UK/SA Cardiovascular Research Workshop was to highlight the work of our young researchers and to promote fruitful cardiovascular research collaborations between the UK and South Africa. Institutions involved in this work are our respective Basic Science Cardiovascular Research Societies, the British Society for Cardiovascular Research (BSCR) and the South African Society for Cardiovascular Research (SASCAR). Dr Kemi Tabazarwa, a PhD student from the academic sector in South Africa, attended this workshop. Attendance by the SA delegation was financially supported by HeFSSA and one of our corporate members, Servier.

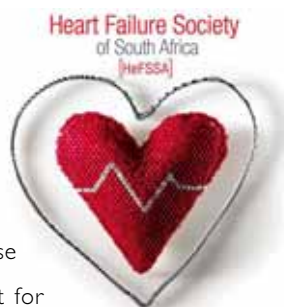
As communicated before, the Heart Failure Society of South Africa has an existing website that is now due for redesign and an upgrade. The Exco are currently in the process of doing this. Dr Tony Lachman and Prof. Karen Sliwa are at the helm of this. Industry has shown interest in supporting this endeavour. Please visit our website at [www.hefssa.org](http://www.hefssa.org) and send through your opinion/contributions to [info@hefssa.org](mailto:info@hefssa.org)

The Pan African Society of Cardiology (PASCAR) and the Ugandan Heart Association are convening the third multi-disciplinary conference on heart disease, diabetes, and stroke in Africa in Kampala, Uganda from 27 to 30 May 2011. Prof. Karen Sliwa will attend this meeting as one of the faculty members.

After the success of the GP Heart Failure Programme in 2010, the HeFSSA Exco has decided to extend these

## HeFSSA NEWS continued

meetings in 2011. This year we have expanded the areas where the meetings will be held from 6 to 18 areas. The GP's gave such positive feedback that we decided to use last year's programme content for



the new areas. For those areas which were already covered last year, the content has been updated to include more practical information (such as case studies). HeFSSA would like to thank all faculty members who are willing to allocate valuable time to the education of General Practitioners in Heart Failure.

These programmes are only possible through the dedication and shared expertise of the HeFSSA Exco, as well as unconditional educational grants and other support from HeFSSA corporate members Astra-Zeneca, Servier, Pharma Dynamics and Medtronic. Thank you for ensuring that HeFSSA's vision becomes a reality.

SA Heart Congress 2011 will be held from 23 to 26 October in East London. HeFSSA will contribute with both Prof. Karen Sliwa and Prof. Sandrine Lecour's expert input. They are developing a joint HeFSSA and SASCAR symposium on heart failure and a second, more clinical workshop on preventing heart failure in pregnancies.

HeFSSA aims to intensify the drive to increase membership of both the specialist and general practitioner's fraternity. Contact the HeFSSA office if you want to learn more about these events or if you want to participate in any of the programmes.

### Contact details

George Nel: info@hefssa.org or 083 458 5954  
Sanette Zietsman: zietsmans@vodamail.co.za or 083 253 5212

## CASSA continued

- **Affordability:** The issue of affordability remains a tricky one. Affordability of a certain treatment will be assessed by looking at the financial impact of such a treatment on the population of a specific option in a specific scheme. The state sector, as it has limited resources and huge numbers, will be used as benchmark when affordability assessments are done.

### The Result of the Meetings

CASSA proposed the European Society of Cardiology guidelines (Aug 2010) as "desired care" and this was accepted by the CMS. The process going forward is that any procedure that is currently being funded will automatically be required to be funded under PMB, any new procedure that is currently not funded but is in the guidelines, and where health economic evaluation indicates that it is either more efficacious at the same cost or equally efficacious at a lower cost, or both, will automatically become funded under PMB. The more difficult area is one where cost effectiveness is not demonstrated and a decision needs to be taken on a threshold for affordability in such circumstances. It was agreed that there would be regular review of the clinical data and cost effectiveness data for new devices. For new procedures which are not yet in the guidelines, it was agreed that companies need to bring the products to the respective professional body, which will evaluate the validity of the product and procedure and then recommend to the CMS a cost effectiveness evaluation after which the device/procedure will be evaluated for its potential to become a PMB.

### Annual CASSA travel grant

As part of its vision of education and training, CASSA will award an annual travel grant of R20 000 to individuals who would like to attend international arrhythmia-related conferences and/or courses.

Contact Franciska Rossouw at 082 806 1599 or email franciska@cassa.co.za for more information on CASSA and its events.



## SA HEART MEMBERSHIP

**T**he SA Heart Association is now clearly established and recognised internationally. SA Heart is an affiliate member of the ESC and this also gives you full access to ESC information pages. SA Heart is recognised by the ACC with some members also being international members of ACC and even FACC's. We host different specialist interest groups and contact with our neighbouring countries is increasing. Doctors from Africa attend our annual congress and you are also invited to the bi-annual PASCAR – Pan African Society of Cardiology Congress, which will be held in Kampala, Uganda, this year. Our members get more out of SA Heart than out of SAMA with your SAMA Membership fee far in excess of that of SA Heart. Escalating costs put a huge strain on our resources making raising our fees inevitable, although we try to contain this to a reasonable increase.

Some of you may be an unrecognised paid up member of SA Heart. We received a number of payments from members without knowing who they are from. Is this mystery payment from you? Perhaps you are wondering why you keep getting reminder letters for SA Heart Fees 2010?

We received the following payments with insufficient reference to reconcile them with any member's outstanding fees. Kindly double check and inform Erika at the SA Heart Office

erika@saheart.org immediately if this payment originated from you. Unfortunately we have to remove members whose account shows to be outstanding from the membership list.

Please remember to use your SA Heart Member number (not your South African ID number) as reference in future. You can expect your invoice for 2011 in March.

**23 March 2010 – reference:** Stancom R570237438 Univ van – presumably somebody from University of Stellenbosch? Amount R85.50.

**24 March 2010 – reference:** Investec Pb 6611115181081 – so if your birthday is on 11 November, you might be the one? Amount R1 080.00.

**26 March 2010 – reference:** Investec Pb Saha Acb 6917/135265 – none of these are SA Heart Member numbers – maybe it's your bank account number? Amount R650.00.

**4 May 2010 – reference:** Investec Pb 62013538874 – your account number? Amount R750.00.

**24 June 2010 – reference:** South African Heart – seems you got the references crossed. Amount R195.50.

**Adriaan Snyders & Erika Dau**

## CANADA-HOPE SCHOLARSHIP PROGRAMME – FELLOWSHIP AWARDS (2011-2012)

**Programme launch date:** 15 December 2010

**Application deadline:** 31 March 2011

CANADA-HOPE Scholarship Programme's primary goal is to further develop international collaborative efforts between researchers. The short term goal is to enable promising individuals to be mentored by prominent Canadian researchers. The long term objective of the program is to enable promising scientists and clinicians from Low and Middle Income Countries (LMIC), as identified by the Canadian International Development Agency (CIDA) and the United Nations (UN), to be exposed to some of the best science, laboratories and training environments in Canada. This round will focus on sub continental South Asia and sub-Saharan Africa.

### Value and term

The maximum amount awarded for a single award is \$174 000 for up to four years:

- Trainee stipend: \$40 000 or \$50 000 per annum. The stipend level is related to the major degree, licensure (where applicable) and experience of the applicant. Stipends are valued in Canadian dollars and are taxable.
- This award is non-renewable.

**Funding start date:** 1st July 2011

<http://www.researchnetrecherchenet.ca/rnr/6/vwOpprntnyDtls.do?prog=1197&view=currentOpps&org=CIHR&type=AND&resultCount=25&sort=program&all=1&masterList=true>

## TRAVEL SCHOLARSHIPS OF THE SOUTH AFRICAN HEART ASSOCIATION

The travel scholarship is available to all members and associate members living in South Africa and primarily aims to assist junior colleagues. In doing so, continued future participation in local or international scientific meetings/workshops is encouraged.

### REQUIREMENTS

- ▶ Applicants must be fully paid-up members/associate members in good standing for at least one year.
- ▶ Applications need to include:
  - ▶ Full details of the meeting/workshop;
  - ▶ The applicant's abbreviated CV; and
  - ▶ A breakdown of the anticipated expenses.
- ▶ Applications must reach the Association a minimum of 3 months before the event.

### RECOMMENDATIONS

- ▶ Acceptance of an abstract submitted by the applicant at the scientific meeting/workshop. (Should acceptance be pending, the application need still be submitted 3 months prior with a note stating expected time of approval.) In such a case the scholarship might be granted conditionally: that proof of the abstract being accepted is submitted afterwards);
- ▶ An invitation to participate as an invited speaker at the meeting;
- ▶ Publications in a peer reviewed journal/s in the preceding year;
- ▶ An applicant from a member of a previously disadvantaged community; and
- ▶ An application from a member younger than 35-years-of-age.

### ADDRESS APPLICATIONS TO:

The President  
South African Heart Association  
PO Box 19062  
Tygerberg  
7505

**A MAXIMUM OF FOUR SCHOLARSHIPS WILL BE AWARDED ANNUALLY.  
GRANTS FOR INTERNATIONAL MEETINGS WILL BE A MAXIMUM OF R20 000  
AND FOR LOCAL MEETINGS A MAXIMUM OF R7 500.**

## SOUTH AFRICAN SOCIETY FOR CARDIOVASCULAR RESEARCH (SASCAR)

SASCAR's main event over the last few months has been the organisation of the first joint United Kingdom/South Africa Cardiovascular Research Workshop that was held at the University College London in December 2010.

‘ The workshop’s aim is to promote young researchers. ’

The main research themes of the workshop were chosen to represent the major overlapping research interests in the UK and South Africa, and included: myocardial ischaemia reperfusion injury, signalling in cardio protection,

hypertrophic cardiomyopathy and heart failure and cardiovascular risk factors. With the aim of promoting the work of young researchers, each themed session was opened by a senior scientist from the UK or South Africa, and was followed by short presentations by PhD students from both countries. Dr Carola Niesler (University of KwaZulu-Natal), started this exceptional workshop with a talk that provided an update on her research on stem cell and ischaemia reperfusion injury. Later in the morning, Prof. Sandrine Lecour (University of Cape Town) gave an overview on the novel pro-survival SAFE pathway to protect against reperfusion injuries. The last session of the day ended with an exciting talk by Prof. Barbara Huisamen (University of Stellenbosch) on diabetes signalling and the heart. The six PhD students representing South Africa were:

NAME	INSTITUTION	TITLE OF PRESENTATION
Ms Sishi Balindiwe	University of Stellenbosch	Anthracycline-induced cardiotoxicity: the role of proteolytic pathways
Ms Nadia Carstens	University of Stellenbosch	Variants in rennin and rennin-binding protein genes modify cardiac hypertrophy in HCM patients independent of blood pressure
Ms Kim Lamont	University of Cape Town	Is drinking red wine a SAFE sip away from cardio protection?
Mr Wayne Smith	University of Potchefstroom	The effect of PPAR agonist on myocardial metabolism and infarct size in a rodent model of diet-induced obesity and insulin resistance
Dr Kemi Tibazarwa	University of Witwatersrand	Peripartum cardiomyopathy: challenges in diagnosis, prognosis and therapy
Mr Derick Van Vuuren	University of Stellenbosch	Protein phosphatase 2A: a dark horse in cardiac ischaemia/reperfusion

**(SASCAR)** continued



From left to right: Back: Sishi Balindiwe (SA), Kim Lamont (SA), Kemi Tibazarwa (SA), Derick Van Vuuren (SA), Wayne Smith (SA) and Nadia Carstens (SA). Front: Derek Hasuenloy (UK), Derek Yellon (UK), Sandrine Lecour (SA), Carola Niesler (SA) and Barbara Huisamen (SA)

The PhD student presentations were an outstanding feature of the workshop and certainly reflected the workshop's success in its aim to promote young researchers.

Following what was a long and fruitful day of presentations and discussions, the organisers hosted a dinner in the Wilkins Building at UCL, where Kim Lamont received the award for "Best South African PhD Student Presentation" for her presentation on the delineation of the cardio-protective components found in red wine.



Kim Lamont received the prize for best oral presentation

For the remainder of the week, the five visiting PhD students were kindly hosted by Prof. Michael Marber (King's College London), Prof. Ajay Shah (King's College London) and Prof. Derek Yellon (University College London) in their respective laboratories, which afforded the students an insight into cardiovascular research in the UK.

Following on from this successful event, we are planning to host the second workshop in South Africa in 2011.

The organisers were extremely grateful for the support of HeffSA and CASSA, who each sponsored the participation of a South African student. Our thanks also go to the SA Heart Association and the Medical Research Council in South Africa, the British Heart Foundation and the British Society for Cardiovascular Research, who all supported this initiative.



From Left to right: Wayne Smith (University of Stellenbosch), Shaun Davidson (UK), Kim Lamont (University of Cape Town), Derick Van Vuuren (University of Stellenbosch), Nadia Carstens (University of Stellenbosch) and Kemi Tibazarwa (University of Witwatersrand).



## INVITATION TO ALL CARDIOLOGISTS IN PRIVATE PRACTICE



Dear Colleague

Anthony Stanley has asked me to write a short letter to you inviting you to join the South African Private Practitioners Forum (SAPPF). Most specialist societies or groups have made the decision to affiliate to SAPPF and the forum's membership is growing constantly and currently stands at about 2 400 members.

Although the forum boasts a number of cardiologists as members, SAPPF would like many more cardiologists to join the organisation and we hereby invite you, as a responsible member of the private specialist body politic, to join our organisation. As a special gesture we are offering you the same terms of membership currently only offered groups that choose to affiliate to SAPPF.

Membership fees for individuals who join outside of their groups are R1 500 per annum, while groups are offered a membership rate of R1 000 per member – provided the group or society join as a group.

If you decide to join SAPPF on the basis of this appeal and apply on the application form attached to this letter, you will be offered membership on the same terms as all affiliated groups. In other words, we will accept your membership at a cost of only R1 000 per annum. This is a once-off invitation to join the SAPPF at a considerable discount and I urge you to accept it and join the one organisation that is truly striving to ensure a better deal for its members.

Two looming issues need the support of all doctors in practice and they are firstly the request that is about to be brought before the courts by BHF, who have requested the court to declare on the meaning of "payment in full" with respect to PMB conditions. I am sure you do not need to be reminded of the implications for all of us should the court rule in favour of the BHF interpretation, which is that payment in full should be limited by the rules of medical schemes. The second issue is the establishment of a pricing commission to replace the now defunct RPL process. Following the demise of the RPL process, there is an urgent need to find a new mechanism to establish an appropriate billing system that is fair and reflects a providers input costs.

The task before us is immense, so please take this opportunity to join forces with your colleagues in the quest for a fairer and more equitable deal for doctors working in the private sector.

Yours truly

**Dr Chris Archer**  
**CEO, SAPPF**



Unit 16 Northcliff Office Park  
203 Beyers Naude Drive, Northcliff 2115  
PO Box 2127, Cresta 2118

Tel: 011 340 9000  
Fax: 011 782 0270

### MEMBERSHIP APPLICATION

The SAPPF has been established in response to the extraordinary times we are living through and the enormous competing challenges facing the medical profession. The ethos of the SAPPF is to focus on meeting the challenges faced by private specialists, to create the best possible environment for them in which to serve their patients. This is a brand new venture and we are all pioneers. Together we will make a difference.

I, the undersigned hereby apply to take up membership in SAPPF (the Company). I acknowledge that the Articles of Association of the Company are available for my inspection.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 2011.

**Note:** Membership information, to be completed by the applicant (or each partner in the event of a group practice). The information below is necessary in order to prepare a complete members database. Please complete in full and retain a copy for your records. The majority of communications is by email and sms notifications.

Title \_\_\_\_\_ Surname \_\_\_\_\_

First names \_\_\_\_\_

Postal address \_\_\_\_\_ Code \_\_\_\_\_

Practice / physical address \_\_\_\_\_

\_\_\_\_\_ Province \_\_\_\_\_ Code \_\_\_\_\_

Identity number \_\_\_\_\_

Practice number (BHF), (PCNS) \_\_\_\_\_ HPCSA registration number \_\_\_\_\_

Vat registration number \_\_\_\_\_ Email address \_\_\_\_\_

Practice telephone no. \_\_\_\_\_ Practice fax no. \_\_\_\_\_ Cellular no. \_\_\_\_\_

Membership type      Fulltime private practice       Limited private practice

Public service & very limited private practice

Discipline (e.g. Cardiologist) \_\_\_\_\_

Sub-specialty (e.g. Paediatric cardiology) \_\_\_\_\_

**Please Fax Back to 011 782 0270**

**Banking Details:**

Account Name: South African Private Practitioners Forum  
Bank: ABSA Northcliff  
Account Number: 40-7290-8323

**2011 Annual Membership Fee – R1 140 (Incl. VAT) (This offer only)**

## THE SOUTH AFRICAN HEART ASSOCIATION RESEARCH SCHOLARSHIP

This scholarship is available to all full and associate members of SA Heart residing in South Africa. It is primarily intended to assist colleagues involved in outstanding research with their research programmes.

### REQUIREMENTS

- ▶ Applicants must be fully paid-up members or associate members in good standing for at least one year.
- ▶ Applications must include
  - ▶ the applicant's abbreviated CV;
  - ▶ a breakdown of the anticipated expenses; and
  - ▶ full details of the research.

### RECOMMENDATIONS

- ▶ Publications of related work in a peer-reviewed journal in the preceding year.
- ▶ Applicants from a previously disadvantaged community.
- ▶ Applicants younger than 35-years-of-age.

### ADDRESS APPLICATIONS TO:

Education Standing Committee  
South African Heart Association  
PO Box 19062  
Tygerberg  
7505

**APPLICATIONS WILL BE REVIEWED ANNUALLY BY THE SELECTION PANEL.  
THE CLOSING DATE IS SEPTEMBER 30.**

One scholarship to the maximum amount of R50 000 will be awarded annually.

**APPLICATIONS WILL BE ASSESSED ACCORDING TO THE RESEARCH PROTOCOL ACCOMPANYING  
THE APPLICATION AND SHOULD INCLUDE:**

- ▶ Abstract (maximum 200 words);
- ▶ Brief review of the literature (maximum 200 words);
- ▶ Brief description of the hypothesis to be investigated (maximum 100 words);
- ▶ Detailed methodology (maximum 500 words); and
- ▶ References.