



The South African Depression and Anxiety Group (SADAG)

Competition Commission:
Market Inquiry into the Private
Healthcare Sector



Introduction

- ▶ SADAG is registered NGO since 1994
- ▶ Leading Mental Health Advocacy Group
- ▶ Focuses on destigmatising mental illness & psychoeducation
- ▶ Manages 15 helpline call center offering free telephonic counselling, info & referrals to resources nationwide
- ▶ Receives over 400 calls per day into the call center
- ▶ Operates 7 days a week, 365 days a year
- ▶ Over 250 Support Groups nationwide
- ▶ Rural outreach projects
- ▶ School talk programmes including Teen Suicide Prevention
- ▶ Corporate Wellness and EAP



Background

- ▶ Worked with SASOP on advocating for Bipolar Algorithm to become PMB Chronic Condition
- ▶ Host various Patient Awareness Workshops about Understanding Medical Schemes
- ▶ Discovery Mental Health Benefit
 - ▶ Psychology Review Panel
 - ▶ Treatment Guidelines for Anxiety Disorders



1. Inadequate Prescribed Minimum Benefits (PMBs) cover for Mental Illness

- ▶ As per the Medical Schemes Act of 1998, all medical schemes have to cover all costs related to diagnosis, treatment and care of:
 1. Life threatening emergency medical conditions
 2. 27 chronic conditions
 3. Defined set of 270 diagnostic and treatment pairs (DTPs)

- ▶ However, there are certain requirements that the member must meet before they can benefit from PMBs:
 1. Their condition must be part of the list of defined PMB conditions
 2. The treatment needed must match the treatments in the defined benefits on the PMB list
 3. Members must use the schemes designated healthcare service providers



1. Inadequate Prescribed Minimum Benefits (PMBs) cover for Mental Illness

- ▶ Only Bipolar Mood Disorder & Schizophrenia are listed as Chronic Conditions
- ▶ Major Depressive Disorder is covered under the 270 DTPs
- ▶ Depression is only covered for hospitalisation (21 days) or 15 consultations depending on the health plan selected
- ▶ Special forms need to be submitted as the benefit is not automatically available
- ▶ According to the World Health Organisation (WHO) – Depression is a common mental disorder with an estimated 350 million people affected worldwide
- ▶ Depression is the leading cause of Suicide worldwide



2. Limited Medical Treatment for non-PMB conditions

- ▶ Medical Scheme is only required to provide cover for treatments, procedures, investigations and consultations that is listed for each specific conditions on the DTP list
- ▶ Members are not aware that they have to submit additional motivation documents to motivate for treatment that is needed
- ▶ The medical scheme can review such information and may choose to approve the treatment
- ▶ But the info about the process is not made readily available or explained to patients
- ▶ Some medical aids offer comprehensive benefit options through chronic medicine benefit packages that cover more than the 27 PMB conditions
- ▶ Only patients on top-end medical plans are able to access medication from their chronic medicine benefit for MDD, Generalised Anxiety Disorder, OCD and PTSD



3. Range of Meds restricted to those listed on formularies

- ▶ Council of Medical Schemes (CMS)s regularly updates therapeutic algorithms or protocols for treatment of PMBs
- ▶ This then acts as guidelines for P & T committees within medical schemes in compiling formularies (medicine lists) of drugs to treat chronic conditions
- ▶ Often patients experience stock-out situations – therefore forced to change their medications or receive no meds at all
- ▶ This doesn't give patients a chance to stabilise on treatment and puts them at a higher risk of relapse
- ▶ Psychiatric medications often have serious side effects or take 4-6 weeks to start working optimally
- ▶ Consequences of changing meds are higher than other conditions



4. Generic Substitution

- ▶ Mandatory substitution came into effect in 2003 with promulgation of Act no.90 in 1997
- ▶ All pharmacies have to notify private patients about availability and benefits of generic alternatives
- ▶ Pharmacists must dispense the generic unless:
 - ▶ Generic is more expensive than the branded option
 - ▶ Or when the prescriber has explicitly stated that the branded drug must not be substituted
 - ▶ Or when the brand is on the MCC list of Non-Substitutable Medications (-+ 50 drugs that have narrow therapeutic range known to produce erratic intra- and inter- patient responses)

Challenge



- ▶ Patients complain that when they have to switch to a generic after being well-controlled on a branded option – they don't derive the same treatment benefits and are at higher risk of relapse
- ▶ Due to this, they experience negative side effects or symptoms last longer
- ▶ Therefore compromising their mental health, well being and ability to function
- ▶ Often bad experiences or negative side effects are mentioned as reasons patients stop taking medication for their mental health issue therefore reducing compliance



5. Co-Payments made by patients on private medical schemes

- ▶ Most medical schemes use reference pricing as cost-effective prescribing
- ▶ Most common one used is generic reference pricing using models such as Maximum Medical Aid Price (MMAP) or Medicine Price List (MPL)
- ▶ Patients can choose generic from predefined list
- ▶ BUT may pay out-of-pocket when choosing a product exceeding the price of the benchmark generic
- ▶ Problem is that the price model vary in terms of benchmarking methods (no standard such as lowest, average or selected generic)
- ▶ Many medical schemes have an exclusion list of medications that are not cost effective according to that scheme
- ▶ This is not patient-centered approach but rather what is more cost effective or cheapest (cost vs. treatment)



5. Co-Payments made by patients on private medical schemes

- ▶ If a patient chooses a mental health professional not part of the Designated Service Provider (DSP) – they would have to pay out-of-pocket
- ▶ If a patient is prescribed a non-formulary drug and chooses to use that specific medication – they risk out-of-pocket payment when the drug exceeds the maximum payment amount for non-formulary or generic reference price threshold
- ▶ The medical aid option plan determines what co-payment that patient needs to make (e.g. higher end options provide more benefits – therefore less co-payment)



Challenge

- ▶ Cost of drugs to treat mental illnesses are very expensive
- ▶ Resulting in some patients stopping medication or not taking medication due to high costs and not being able to afford medication for the treatment period
- ▶ Often not being able to even afford the generic option if that is available
- ▶ Impacts severely on the management of their illness & ability to function in their home, environment, work or school



6. Limited hospitalisation benefit

- ▶ Diagnostic Treatment Pairs (DTP) determines how 270 PMB conditions should be treated
- ▶ Should be based on healthcare and affordability (in the best interests of the patient)
- ▶ If there is a disagreement between medical scheme & treating professional – then apply the public sector standard, best practice and protocols
- ▶ Hospitalisation is capped at 21 days (3 weeks)
- ▶ Simply not enough for patients to be stabilised and ready to go home
- ▶ Offers no long term treatment or maintenance plan after hospitalisation because the benefit is maxed out after 21 days



Case Study

- ▶ 16 year old boy attempted suicide twice in 1 week
- ▶ Was hospitalised for 3 days for the 1st attempt (PMB – hospital based management up to 3 days)
- ▶ After discharge, he attempted suicide 24 hours later
- ▶ Went back to the same hospital who turned him away due to no more benefits
- ▶ Teen was sent to state hospital and placed in a adult ward and was assaulted by fellow patients
- ▶ It was safer to go home without professional treatment rather than stay in the state hospital



6. Limited hospitalisation benefit

- ▶ After running out of the PMB benefits for the year, patients are forced to go to state facilities for treatment (or pay out-of-pocket for treatment)
 - ▶ They have to be reassessed by psychiatrists and psychologists
 - ▶ Have to change their meds due to availability of meds at state hospitals or clinics
 - ▶ Often experience stock-out problems with meds
 - ▶ Therefore negatively impacting their treatment, wellness and functionality

According to one of our callers...



“Medical Schemes are completely non-negotiable on this time limit which is entirely discriminatory as capped limits do not apply to most other health conditions. Furthermore each case should be assess individually and a blanket generic approach should not be applied.”



7. Specialist treatment is very expensive

- ▶ Specialists charge 200-300% above medical aid rates
- ▶ Which often means patients have to make out-of-pocket payments or reduce the number of visits they can make to the specialists which include psychiatrist, neuropsychiatrist or clinical psychologist
- ▶ Patients often have to visit the specialist face-to-face to fill in the chronic application form which costs them money
- ▶ Many specialists charge the patient upfront and it is the patients responsibility to claim back from medical schemes (which is difficult when mentally ill patients are already more vulnerable group due to the nature of the illness)
- ▶ Many specialists refuse to fill in the chronic application forms or motivation letters which makes it even more difficult for patients to access benefits
- ▶ Often specialists aren't trained with how to fill in the chronic application forms or don't explain to patients what the process is to access the benefits



8. Mental Illnesses isn't considered serious as other physical conditions

- ▶ The 27 Chronic Disease List (CDL) & the 270 Designated Treatment Pairs (DTPs) show that mental illness are marginalised in terms of treatment, hospitalisation cover & specialist consultations
- ▶ Mental Illness is not taken as seriously in South Africa as other chronic illnesses
- ▶ SA has a Mental Health Policy – but it lacks the info on financing, demographics analysis, prevalence data, etc.
- ▶ High incidence of Depression amongst patients suffering from chronic illness
- ▶ According to WHO, by 2030 Depression will be the leading burden of disease in the world
- ▶ With 1 in 3 South Africans that will or do experience a mental illness in their lifetime – it affects more people than what we believe



9. Info is not readily available to patients about treatment options, medications and DSPs

- ▶ According to Regulation 151 of the Medical Schemes Act, a medical scheme is obliged to provide an appropriate substitution drug to a patient, without any financial penalty to the beneficiary, when formulary drugs have been ineffective
- ▶ However, this is never explained or made available to the patient
- ▶ AND many doctors don't know about this regulation either, or how to pursue this avenue for their patient



9. Info is not readily available to patients about treatment options, medications and DSPs

- ▶ If a patient's treatment is ineffective on a formulary drug which is fully funded
- ▶ And the patient supplies all the necessary documentation to support such a claim
- ▶ The scheme is obliged to fund an alternative and proven drug in full
- ▶ However, most medical schemes require patients to follow an appeals process which is difficult and time-consuming
- ▶ Most of the time results in patients giving up and don't get the treatment or medication...or if they are able to, pay for their medication in full until they run out of money



9. Info is not readily available to patients about treatment options, medications and DSPs

- ▶ Often new medical scheme members are subject to a waiting period
- ▶ Sometimes waiting 6 months or more before their cover comes into effect when joining a new medical scheme
- ▶ Especially if they haven't been on a medical scheme for the last 2 or 3 years
- ▶ Members often don't read the list of exclusions until they need the benefit
- ▶ The waiting periods and exclusions are not explained to new members prior to joining
- ▶ Members are expected to read long complicated benefit booklets often supplied only after they have joined a medical scheme



Recommendations

- ▶ Mental Illness needs to be taken seriously as a real medical illness that needs real treatment
- ▶ PMB conditions needs to be urgently reviewed and updated
- ▶ Brokers and medical schemes need to be upfront and educate their members about benefits, processes, cover limitations, etc.
- ▶ According to International Guidelines and best practice – mental health is listed as an essential health benefit that includes both inpatient hospital based care as well as psychotherapy and counselling
- ▶ Medical schemes should not discriminate pre-existing conditions including mental health if a patient presents their condition upfront
- ▶ Coverage should start the day that a member joins a medical scheme



Recommendations

- ▶ We need proper regulation of tariffs charged by specialists, medical schemes and hospitals – not at the cost of the patient
- ▶ Need to adopt patient-centered approach to mental health benefits and treatment guidelines which would yield better success rates and prevent relapse and resistance
- ▶ Access to mental health care is not a commodity but is a human right and should be treated as such
- ▶ Medical schemes should build better working relationships with mental health NGOs to provide additional support and services to patients with mental illness including access to support groups, information and resources
- ▶ Provide access to information regarding medical scheme benefits and processes that is both user friendly and easy to understand
- ▶ Train call center staff at medical schemes how to better inform their members of various processes, benefits and treatment options

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