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SADAG submission to the Competition Commission: Market Inquiry into the Private Healthcare Sector

Introduction

1. SADAG is a Non-Profit Organisation, a registered Section 21 Company which was established 21 years ago to serve as a voice for patient advocacy, education and de-stigmatisation of mental illness in the country.
2. SADAG manages a 16-line toll-free counselling and referral call-center which operates from 8am-8pm, seven days a week and fields over 400 calls per day from across the country.
3. SADAG maintains a network of over 250 support groups across all 9 provinces, where the community members lack access to resources or have no funds for treatment, medication or information, this is inclusive of public health care patients and/ or private health care patients.
4. For a full list of SADAG services please refer to the following website : www.sadag.org and to Exhibit A which provides a comprehensive profile of SADAG
5. SADAG welcomes the initiative by the Competition Commission to conduct a market inquiry into the private healthcare sector.

Key points to be addressed

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

In terms of the Medical Schemes Act of 1998 (Act number 131 of 1998) and its regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of:

- Any life-threatening emergency medical condition
- 27 chronic conditions – Exhibit B
- A defined set of 270 diagnostic and treatment pairs (DTPs) – Exhibit C

However there are certain requirements that a member must meet before he/she can benefit from the PMBs are the 3 requirements are:

- The condition must be part of the list of defined PMB conditions
- The treatment needed must match the treatments in the defined benefits on the PMB list
- Members must use the scheme's designated healthcare service providers

In terms of mental illnesses only Bipolar Mood Disorder and Schizophrenia are listed as conditions under the 27 chronic conditions.

Major Depression is covered under the 270 DTPs. Major Depression is only covered for hospitalization (3 weeks) or consultations (15 outpatient contacts), which is capped depending on the health plan selected. Special forms have to be submitted as the benefit is not automatically available. Consequently many members are unaware of their access to these benefits.

According to the World Health Organisation (WHO) - October 2015, "Depression is a common mental disorder with an estimated 350 million people worldwide being affected. It is the leading cause of disability worldwide, and is a major contributor to the overall burden of disease, especially when long-lasting and with moderate or severe intensity, Depression may become a serious chronic health condition. It can cause the affected person to suffer greatly and function poorly at school, work and in the family. At its worst Depression can lead to suicide and over 800 000 people die due to suicide every year." In South Africa, 31.5% of teenagers have attempted suicide that required medical treatment, and 9.5% of all teenage deaths are due to suicide. The statistics are shocking but it is the stark reality of the current situation. Please refer to Exhibits D and E.

7. Limited medical treatment for non-PMB conditions

A medical scheme is only required to provide cover for the treatments, procedures, investigations and consultations that are given for each specific condition on the DTP list. Members are not aware that they need to send additional information motivating for treatment that is needed. The medical scheme can review such information and may choose to approve the treatment, but information regarding this process is not made readily available.

More comprehensive benefit options provide a chronic medicine benefit package that covers more than the maximum 27 chronic conditions listed as PMB's. Therefore only patients on the top-end medical plans are able to access medication from their chronic medicine benefit for Major Depression, Generalised Anxiety Disorder, Obsessive Compulsive Disorder, and Post Traumatic Stress Disorder, for example.

8. Range of medication restricted to those listed on the formularies

The Council for Medical Schemes (CMS) publishes and periodically updates therapeutic algorithms or protocols for the treatment of PMBs, which acts as guides for Pharmacy and Therapeutics committees within medical schemes in compiling formularies (also referred to as approved medicine lists) of drugs to treat chronic conditions.

Patients are sometimes faced with stock-out situations whereby their prescribed medication is not available and they are forced to have their medication changed or receive no medication at all. Medication that is prescribed for mental illnesses has various side effects and sometimes it takes the patient 3-6 weeks to get used to the drug. The consequences of changing medication used to treat mental illnesses are thus more severe than for those patients who change their medication for other conditions.

9. Generic substitution

Mandatory generic substitution came into effect in 2003 with the implementation of the Medicines and Related Substances Control Amendment Act No. 90 of 1997. The Act states that pharmacies should inform all private patients about the availability and benefits of generic alternatives. Pharmacists must dispense the generic unless the generic is more expensive that the branded option, or when the prescribing practitioner has explicitly stated that the branded drug should not be substituted or when the brand is on the Medical Control Council list of Non-Substitutable Medicines (a list that contains approximately 50 drugs that have a narrow therapeutic range that are known to produce erratic intra- and inter-patient responses).

However patients are complaining that when they switch to a generic drug after becoming well controlled on a branded option, they don't derive the same benefits or they experience a relapse. Furthermore they are finding that their symptoms are lasting longer and this compromises their mental health, well-being and ability to function.

10. Co-payments made by patients on private medical schemes

Most medical schemes use reference pricing to encourage cost-effective prescribing. Reference price models used in the private sector help to determine a benchmark price for a group of chronic disease therapies above which there is limited or no reimbursement. The most common approach used in South Africa's private sector is generic reference pricing of generically similar drugs, using models such as Maximum Medical Aid Price (MMAP) or Medicine Price List (MPL).

Patients can choose a generic from a predefined list but they must pay out-of-pocket when choosing any product that exceeds the price of the benchmark generic (including a brand).
The problem that exists currently is that the price models vary in terms of the benchmarking methods in terms of which generic price is used (the lowest, the average or a selected generic price). Many medical schemes also use an exclusion list for drugs that are not cost-effective according to the scheme. This is not a patient-centered approach whatsoever but one that is primarily based on monetary / commercial gain.

Patients need to make out-of-pocket payments when they choose not to use a Designated Service Provider (DSP) for treatment, or when they choose not to use a formulary drug for a chronic condition or when the cost of the drug exceeds the maximum payment amount for non-formulary drugs or the generic reference price threshold.

The medical option plan chosen will determine the amount of co-payment that the patient needs to make. Higher end options providing more benefits. Nevertheless the costs for drugs to treat mental illnesses are very high and some patients have to stop using the drugs altogether, as they can't even afford the cheaper generic even if one is available. This impacts on the management of their illnesses and in their ability to function in their environment, home, work or school.

11. Limited hospitalisation benefit

A Diagnostic and Treatment Pair (DTP) links a specific diagnosis to a treatment and therefore broadly indicates how each of the 270 PMB conditions should be treated. The treatment and care of PMB conditions should be based on healthcare that has worked best, taking affordability into consideration. However should there be a disagreement about the treatment of a specific case, the standards (also known as practice and protocols) as found in the public sector will be applied. Exhibit C

Hospitalisation is capped at 3 weeks/year and this presents as a serious problem for patients. Some are not ready to be discharged but have to leave the private hospital due to them reaching their medical aid limits, others have had to go to public healthcare facilities where often the medication that they need is not readily available. They then have to change medications, psychiatrists, psychologists, and this can severely impact on their treatment regime and recovery.

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 assessed individually and a blanket generic approach should not be applied."

12. Specialist treatment is very expensive

Specialists commonly charge 200-300% above medical aid rates which means that patients have to make out-of-pocket payments or reduce the number of visits that they make to specialists such as pyschiatrists, neuropsychologists or clinical psychologists. Notwithstanding that the patient has no choice but to visit a psychiatrist as the chronic application form has to be completed by the psychiatrist especially with regards to the management of mental illnesses.

13. Mental Illnesses are not considered a serious as other physical conditions

The list as stipulated on the 27 CDL and the 270 DTP shows that mental illnesses are marginalized in terms of treatment, medication, hospitalisation cover and specialist consultations.

WHO provides information relating to the Mental Health profile of each country but the information that is provided for South Africa shows that no major importance is given to Mental Illnesses in this country. South Africa has a Mental Health policy but no reports were submitted on mental health financing, inpatient and outpatient care, human resources for mental health or data on the prevalence of mental disorders. Exhibit F

However many reports were tabled for HIV/AIDS, TB, Stroke, Hypertension and Diabetes. Research has shown that there is a high incidence of Depression amongst patients suffering from chronic illnesses.

14. Information is not readily available to patients about treatment options, medication 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 information is not readily made available to patients and even some doctors are unaware of this regulation.

When a patient's treatment is ineffective on formulary drugs which are fully funded and the patient supplies 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 that their members follow an appeals process in these instances. This process can be difficult and time-consuming for the patient and then the patient just gives up, and does not get the right medication or treatment option or pays for their medication in full.

Often patients are subject to a waiting period and they have to wait for their cover to come into effect (sometimes for 6 months or more) if they have newly joined a medical scheme, and especially if they had not been on a medical scheme within the past 2-3 years or more. Members don't often read the list of exclusions until they need to use the benefit. These waiting periods and exclusions are often not explained to members prior to joining. Members are expected to read and understand long complicated benefit booklets often only supplied after they have joined the scheme.

15. Recommendations

- Mental Illness as a burden of disease must be taken much more seriously and be given the requisite attention that it deserves.
- WHO has recognized that Depression is a priority condition and has been listed on their Mental Health Gap Action Programme (mhGAP). The programme aims to help countries increase their services for people with mental, neurological and substance use disorders.
- PMB conditions need to be urgently revised and updated regularly.
- Better treatment options, medications, hospital cover and consultations are needed for patients.
- Brokers and medical schemes must be upfront with their members in terms of what is covered fully, what the limitations are and when one should change their benefit options.
- In the United States of America mental and behavioural health services are listed as essential health benefits and all plans cover behavioural health treatment such as psychotherapy and counselling, mental and behavioural inpatient services and substance use disorder treatment.
- Medical schemes should not discriminate against a pre-existing condition including mental health and substance use disorder conditions if members disclose their condition up front.
- Coverage for pre-existing conditions should begin from the day that you start on your medical scheme.
- Medical Schemes should look at holistic approached to managing the care and well-being of patients with mental illnesses.

- Medical Aids should incentivize patients to get involved in exercise programmes, yoga and meditation programmes and other supplementary programmes to help decrease the incidence and severity of mental illnesses.
- Medical schemes should fund support group meetings that give the patient and their family members the much needed out-patient and after-care support that they need.
- Medical schemes should invest in the early diagnosis of mental illnesses especially in children that may have a higher predisposition to a disorder especially when their parents have been diagnosed with a mental illness.
- We need to reduce the stigma that is prevalent with mental illness by not categorizing mental disorders into pre-determined boxes, where the level of care and support by specialists and private hospitals are marginalized.
- We need the proper regulation of tariffs charged by medical schemes, specialists, hospitals, etc.
- We need to adopt a patient centered approach whereby the patient can competitively shop for the best possible benefit options without it being a financial burden to the patient.
- We need to be committed to Universal Health Coverage, which promotes the need for equitable access to quality healthcare without making demands for out-of-pocket payments that are high and not sustainable.
- Access to mental healthcare is not a privilege but a constitutional right and should be treated as such.
- Mental illness impacts on all aspects of a person's life, namely, social, physical, environmental and economical and should be treated in a holistic and comprehensive manner.