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Medical Aid Benefits for Mental Health

The article "Will my medical expenses be paid if I become suicidal" by Ina Skosana and Joan Van Dyk (Mail & Guardian Newspaper, 20 APR 2017) tells of the painful experience of Trish and Katlego who both suffer from chronic, severe mental illness.

The article refers to the Prescribed Minimum Benefits (PMB's) for mental health- the benefits that medical aid schemes will pay for out of 'risk' for people with mental disorders (in other words, what the medical schemes will pay outside of any savings plan). The debate about the benefits for mental illness is particularly relevant at this time. The prevalence of mental illness is increasing, and, according to the World Health Organisation, will soon be the biggest cause of disability globally. In South Africa, Neuropsychiatric Disorders are ranked 3rd in their contribution to the overall burden of disease, after HIV and AIDS and other infectious diseases. As Noluthando Nematswerani of Discovery confirms, more people are being treated for mental illness every year.

But, as we know, the economy isn't exactly booming, and the pile of money that the funders of healthcare (government or the medical schemes) have to spend every year isn't growing as quickly as is the burden of disease. So the minimum benefits have become the maximum benefits, as Dr Allers bemoans. In addition, as Rajesh Patel of the BHF has said, while we may all agree that the benefits for mental illness are not sufficient, there is no consensus on what a comprehensive benefit for mental health should look like.

So how come the schemes will pay for everything associated with Trish's asthma? Well, I think this is because the medical aid schemes have collected massive amounts of data about patients seeking treatment for common physical illnesses such as Asthma over the years, and so they can reasonably predict what Trish will need to recover from her asthma episode. But when it comes to mental illness, the schemes haven't collected as much information and so they can't predict what the treatment pathway or costs will be. So, until the providers and funders of care find better ways to classify and categorise the 'need for care' associated with an episode of mental illness, we are probably going to be stuck with the schemes sticking to the minimum benefits. I'm pleased to tell you that there is work going into this, but we're not yet at the point where anyone can confidently describe what the revised benefits should look like.

As Roseanne Murphy da Silva says: "Instead of blaming each other, we should all take a step back and say: 'How can we provide quality care to everyone in South Africa. How can we do better?'" This call to action, to 'do better' brings us to the search for what modern health economists refer to as 'value'. Value is- the sweet spot where quality of care meets efficiency- enabling people to get well and stay well with the minimum resources and inconvenience. There is much work to do as we try get to the point where mental illness is given parity with physical conditions.

To return to the PMB's: Katlego, with his diagnosis of Bipolar Mood Disorder, should qualify for chronic benefits paid for by his medical aid scheme, as BMD is one of the 25 or so chronic PMB conditions. He should not run out of benefits for medication, so long as he stays within the scheme rules, and he should be entitled to reasonable medical care - appointments with

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psychiatrists at reasonable periods, for instance, even after he's left hospital.

And finally, a suicide attempt is listed as an emergency (PMB) condition with associated minimum benefits, and a medical scheme member can access up to three days in hospital or 6 outpatient visits. If it's then determined that you are suffering from a Mood Disorder such as Depression or Bipolar Mood Disorder, your minimum benefits will include hospitalisation of up to 21 days per annum. So some of your medical expenses will be covered, but probably not all… I encourage everyone to visit the Council for Medical Schemes website to find out more about them (www.medicalschemes.com/medical_schemes_pmb/). MHM

Editor's note: The acquisition of Akeso by Netcare has not yet been finalised by the Competition authorities, and as such Akeso currently operates independently of Netcare.

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CODE	DIAGNOSIS	TREATMENT
182T	Abuse or dependence on psychoactive substance, Including alcohol	Hospital-based management up to 3 weeks/year
910T	Acute delusional mood, anxiety, personality, perception disorders and organic mental disorder caused by drugs	Hospital- based management up to 3 days
901T	Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse	Hospital admissions for psychotherapy/ counseling up to 3 days, or up to 12 out-patient psychotherapy/counseling contacts
910T	Alcohol withdrawal delirium; alcohol intoxication delirium	Hospital- based management up to 3 days leading to rehabilitation
908T	Anorexia Nervosa and Bulimia Nervosa	Hospital- based management up to 3 weeks/ year or minimum of 15 outpatient contacts per a year
903T	Attempted suicide, irrespective of cause	Hospital- based management up to 3 days or up to 6 outpatient contacts
184T	Brief reactive psychosis	Hospital-based management up to 3 weeks/ year
910T	Delirium: Amphetamine, Cocaine, or other psychoactive substance	Hospital- based management up to 3 days
902T	Major affective disorders, including unipolar and bipolar depression	Hospital-based management up to 3 weeks/ year (including inpatient electroconvulsive therapy and inpatient psychotherapy) or outpatient psychotherapy of up to 15 contacts
907T	Schizophrenia and paranoid delusional disorders	Hospital-based management up to 3 weeks /year
909T	Treatable dementia	Admissions for initial diagnosis; management of acute psychotic symptoms – up to 1 week