Health Market Inquiry –

Oral Summary Submissions

SA Federation for Mental Health

9 February 2016

The SA Federation for Mental Health will be presenting on the following issues to the Health Market Inquiry on the 17th February 2016:

The SA Federation for Mental Health is a national, not for profit, non-governmental organisation that aims to co-ordinate, monitor and promote services for persons with Intellectual Disability (Mental Handicap), Psychiatric Disability (Mental Illness) as well as promoting mental health and well-being. Seventeen mental health societies and numerous member organisations, actively involved in the field of intellectual disability, psychiatric disability and mental well-being, constitute the Federation. Our four main programmes are: capacity building, human rights, social integration and mental health awareness.

For the most part, mental health is a neglected health issue and often, because of the nature of the condition, leaves patients who suffer from mental health problems in need of protection.

Private to Public Healthcare Referral Disconnect

- In the experience of many private health care users there is a disconnect between the private and public mental health services, for example it has been reported that patients accessing private services may require transfer to public services, often because their medical aid funds have been exhausted. In the public sector, these patients need to start over at primary health care level, despite having already been assessed and diagnosed by the private health service provider. In other words public healthcare service providers will not accept a diagnosis from the private health sector. This causes delays in treatment and is a waste of resources. These delays usually mean patients go without treatment while waiting to be assessed or re-diagnosed in the public sector. This needs to be addressed to ensure continuous access to health care.

  RECOMMENDATIONS: ensure that an effective referral structure is implemented between the public and private sectors in cases where clients need to be transferred between the two for access to adequate health care services.

Limited Hospitalisation

Most medical aids limit hospitalisation for mental disorders (e.g. bipolar mood disorder and schizophrenia) to 21 days, which is often not sufficient time for recovery – and when transfer is made from the private psychiatric hospital to then continue treatment at a public psychiatric hospital, the person is required to start at primary health care level and cannot go straight to a public psychiatric hospital (tertiary facility) – this interferes with the continuation of treatment and recovery process and is again a waste of resources. Regulation 8(1) states that *'any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit*

conditions.' However, besides Bipolar and Schizophrenia, which are listed as part of the 27 chronic illnesses on the PMB's list, other mental conditions carry a three week hospitalisation limit. This limitation on treatment of a PMB only applies to mental health conditions. The limitation placed on hospitalisation for mental health conditions is discriminatory and deprives patients of the right to full treatment and care cover for a PMB.

RECOMMENDATIONS: To review the hospitalisation limit placed on mental conditions in the PMB's list. Also, to allow for patient transfers from private psychiatric hospitals directly to public tertiary facilities – this will decrease the burden on the primary health care system.

Discriminatory Exclusion of Psychosocial Services

In the experience of many patients, medical aid does not cover psychosocial rehabilitation for persons with psychosocial disability, whilst rehabilitation is covered for physical disabilities. The distinction between mental and physical condition is unfair and discriminatory. Psychosocial rehabilitation is an important part of treatment and reintegration as it provides the patient with essential skills. Annexure A to the Regulations of the Medical Schemes Act recognises that medical practises are constantly changing and that the *'impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions*' should be reviewed accordingly. The regulations provide that '*a review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives'*. This mechanism for reviewing PMBs is incomplete as it does not make provision for reviewing the changes in medical care and precipitates the neglect of treatment options that have become available for diseases that have previously been side lined.

RECOMMENDATIONS: Psychosocial rehabilitation services is not offered by private or public hospitals, it is only by NGOs who run such facilities, which are in most cases funded by Department of Health. This service should start at hospital level to aid in social reintegration, prevent the revolving door syndrome and make rehabilitation services accessible. Medical aids should amend their policies to acknowledge psychosocial rehabilitation.

Function and Composition of Essential Drugs List Committees

The functioning and composition of the EDL committees is unclear, specifically on the criteria which is used when decisions are made on what medicines are to be listed on the EDL list and which to be removed. Persons with mental disorders respond differently to medications and often settle on one type that stabilises them – when it happens that that specific medication is no longer available, sometimes because it has been removed of the EDL list, it impacts severely on the service user's mental wellbeing and recovery. It is permissible for medical aid schemes to restrict patients' cover to medication which appears on its formulary drugs list. However Section 15I (a) of the Regulations asserts that '*such formulary or restricted list must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability'*. The effectiveness of a drug is a specified consideration when determining which drugs should be removed or substituted on the formulary drugs list, and the health care providers interacting with the patients are most knowledgeable on the effects of medication on patients. As such, there should be an evident representation of patients, personally or through healthcare providers in EDL committees, to ensure compliance with the regulations. Further Section 15I (c) states that '*provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause*

adverse reaction in a beneficiary, without penalty to that beneficiary'. Some mental health providers have observed that changing the medication of patients has detrimental effects, as it may destabilise or unsettle users in this vulnerable patient group. Constant changes in the medication of mental health patients is neglectful of the consequences and a breach of the regulations.

RECOMMENDATIONS: Mental health care users should be represented on the EDL committees by a person who would add value in terms of experiences with service users and how they relate to treatment options.