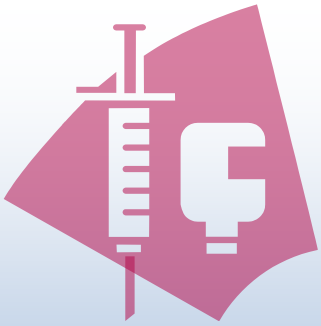
CMScript

Diagnosis



Treatment

Care

Issue 11 of 2009

HIV/AIDS and PMBs

This month's edition of CMScript covers PMBs and HIV/AIDS, and PMBs and medical emergencies. This is the time of year when most of us are travelling, and when most emergencies happen; 1 December is the day that the world commemorates World AIDS Day.

The theme chosen to commemorate this year's World AIDS Day in South Africa was 'I am responsible. We are responsible. South Africa is taking responsibility '. The emphasis lay on everyone getting tested to know their status.

All care for any exposure to HIV and AIDS is covered under the prescribed minimum benefits (PMBs) enshrined in the Medical Schemes Act. In April 2010 the PMB guidelines with regards to HIV and AIDS will alter significantly to combat some of the concerns that have arisen over time. CMScript asked Ronelle Smit, Clinical Analyst at the Council for Medical Schemes (CMS), to describe the extent to which PMBs cover HIV infection and the changes that will take effect in 2010.

'PMBs allow for the testing, prevention, and treatment of HIV to be covered by medical schemes. The regulation also covers the treatment of complications arising from HIV infection.'

HIV is also an overriding factor by law. Overriding factors are indicated in the Act with a # sign. This means that if you have HIV and another PMB condition, for example pneumonia, the entitlements guaranteed under pneumonia are overridden by the HIV entitlements.

Below is a list of the benefits that medical scheme members are entitled to when they have HIV or AIDS:

- HIV voluntary counselling and testing
- As of April 2010, all patients with both TB and HIV will get treatment with anti-retrovirals if their CD4 count is 350 or less. At present treatment is available when the CD4 count is less than 200.
- Screening and preventative therapy for TB – this includes immunisation for TB
- Diagnosis and treatment of sexually transmitted infections
- Pain management in palliative care – palliative care is the medical or comfort care that decreases the severity of a disease or slows its progress rather than providing a cure
- Treatment of opportunistic infections – for example pneumonia and Kaposi Sarcoma, a type of cancer
- Prevention of mother-to-child transmission of HIV – this prevention includes ARV treatment for the mother, caesarean sections instead of normal births, and baby milk formula instead of breast feeding Post-exposure prophylaxis following occupational exposure or sexual assault – dual therapy (the use of two different types of ARVs) is indicated if a low risk of infection is present but triple therapy (the use of three different types of ARVs) is indicated if a high risk of infection is present
- Complications of treatment is also part of PMB coverage

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- Medical management and medication, including the provision of ARVs and ongoing monitoring which will be bolstered by the Department of Health's National Strategy Plan for HIV and AIDS and STIs 2007-2011 which will see 80% of patients of ARVs being covered by 2011and a strengthening of research and development.

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Ronelle continued: "Many schemes have designated service providers or DSPs who are appointed to treat their HIV-positive members. Know who your DPS is so that you don't incur co-payments for using a non-DSP. DSPs may include general practitioners and pharmacies or courier pharmacies. Always ensure that you have enough medication so that you don't run out."

Most schemes run HIV management programmes and require their members to take part in them. These programmes focus on education and ensuring that your treatment and management is effective and efficient.

Don't forget your PMBs in an emergency

The festive season is supposed to be a time of happiness but so often it is marred by road accidents as many people travel long distances to be with family and friends. It is important to be well-versed in what the Medical Schemes Act says about PMBs with regards to emergencies. To better illustrate the rights that a medical scheme member has in an emergency situation, CMScript put the hypothetical situation below to CMS Clinical Analyst, Ronelle Smit.

An emergency medical condition is described in the Act as the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide such treatment would result in the serious impairment of bodily functions or a serious dysfunction of a bodily organ or its part, or would place the person's life in serious jeopardy.

Carole Ntanda* and her friend Zolile Oliphant* are travelling home to enjoy the Christmas break with their families in Rustenburg. On the way their vehicle is involved in a car accident. When the emergency services get to the scene they find Zolile conscious but badly hurt and Carole unconscious. Zolile confirms that she is not a member of a medical scheme but Carole is.

In a situation like this the emergency services need to take both women to the closest emergency room, regardless of whether or not it is a private or public hospital or whether the facility is a designated service provider (DSP) for the patient who is a medical scheme member. It's also important to note that emergency conditions are not limited to the setting where the cover is rendered, like a hospital. "Treatment at the scene of the accident is also covered by PMBs," says Ronelle.

Once Carole has been stabilised, her medical scheme may opt to move her to one of its designated service providers (DSPs); it is the responsibility of the scheme to find her a bed in the DSP they intend moving her to. The treating doctor at the current facility must confirm that Carole is medically stable and that she will not suffer any risk in being transferred. The treating doctor must also refer Carole to another doctor in the DSP facility and provide a complete medical history. If Carole is not stable enough to be transported to a DSP facility, she may stay in the non-DSP hospital and the scheme should still fund this as a PMB. Because Zolile is not a medical scheme member, she will have to incur the cost of staying at the hospital that stabilised her if it happened to be a private hospital or she could arrange that she be moved to a public hospital where she will be looked after for free if she falls within a certain income group.

Prevention of mother-to-child transmission of HIV includes ARV treatment for the mother, caesarean sections instead of normal births, and baby milk formula instead of breast feeding.

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Pictures: courtesy of Microsoft Clip Art online

Policy changes as from April 2010

All children under one year of age will get treatment if they test positive. Initiating treatment will therefore not be determined by the level of CD cells.

TB and HIV/Aids will now be treated under one roof. This policy change will address early reported deaths arising from undetected TB infection among those who are infected with HIV. This step was taken on learning that approximately 1% of our population has TB and that the co-infection between TB and HIV is 73%.

All pregnant HIV positive women with a CD4 count of 350 or with symptoms regardless of CD4 count will have access to treatment. At present HIV positive pregnant women are eligible for treatment if their CD4 count is less than 200.

All other pregnant women not falling into this category, but who are HIV positive, will be put on treatment at fourteen weeks of pregnancy to protect the baby. In the past this was only started during the last term of pregnancy.

In order to meet the need for testing and treatment, all the health institutions in the country are working to ensure they are ready to receive and assist patients and not just a few accredited ARV centres. Any citizen should be able to move into any health centre and ask for counselling, testing and even treatment if needed.

The implementation of all these announcements is effective from April 2010. Institutions

*Names are fictional

Side bar:

1 Designated service providers or DSPs are contracted by your medical scheme to provide a member with certain healthcare services.

2 Medical schemes may never renege on their responsibilities towards a member should contractual discrepancies arise between the scheme and its DSP.

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