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A subsidiary of
MediKredit Integrated Healthcare Solutions (Pty) Ltd

Head Office
132 Jan Smuts Avenue
Parkwood, Jhb, 2193
P O Box/Posbus 692
Parklands, Jhb, 2121

Switchboard: *+27 (0) 11 770-6000*
Call Centre: *+27 (0) 11 770-6200*
Facsimile: *+27 (0) 11 770-6001*

Comments on Mental Health Issues in the PMB setting

Performance Health (PH), a subsidiary of MedKredit Integrated Healthcare Solutions (Pty) Ltd, would like to thank the Council for Medical Schemes (CMS) for affording us this opportunity to highlight several shortcomings in the PMB cover for the mental health disorders. Schizophrenia and Bipolar Mood Disorder (BMD) are catered for under the ***PMB CDL*** conditions, but Unipolar Depression, Obsessive Compulsive Disorder, Alzheimer's Disease, Anorexia Nervosa and other mental health disorders are excluded.

Introduction

- This disparity in psychiatric healthcare funding correlates with the trend of discriminatory funding practices in South Africa, where *benefits for mental health disorders are considerably less than for 'physical' disorders, such as cardiovascular disease.* Of the 25 PMB CDL conditions, 9 are cardiovascular related, whereas only 3 are psychiatry related (considering that Parkinson's disease also has a substantial mood disorder component, which is not addressed in the legislated algorithm).
- Hospitalisation benefits for physical and mental disorders also differ in the funding environment in South Africa. Due to lack of guidance in this regard and perhaps a lack of emphasis, a scheme may only reimburse *one* admission for Alcohol Abuse (DTP, Mental Illness, code 182T) in a private facility and thereafter would only reimburse treatment if the patient is admitted to a State facility. This limitation certainly does not apply to numerous admissions for cardiovascular conditions, which are often lifestyle and diet related.
- Furthermore, in an analysis by Oosthuizen and co-workers, it was concluded that there is a *20-fold greater benefit availability for the inpatient treatment of Ischaemic Heart Disease (IHD), than for Major Depressive Disorder (MDD)* in private healthcare settings in SA. Outpatient and chronic medication benefits also showed differentiated funding, although not to the same degree.

The current PMBs

1. While Unipolar Depression is listed as one of the 272 DTP conditions (code 902T), and thus is in fact a PMB condition, there is still discrimination and a lack of guidance as to the treatment thereof. For example, hospital-based medical management and outpatient psychotherapy are limited to 3 weeks/year and 15 contacts, respectively, and *no mention is made of any pharmacotherapy*. Although in State, a psychotherapy session could possibly also include receiving an envelope of medicine, in private practice psychotherapy and pharmacotherapy services are supplied and claimed by separate health professionals.
2. This limitation in terms of contact sessions does not apply to the cardiovascular conditions such as Hypertension, IHD, etc, although Funders are entitled to monitor and control both the number and interval of physician visits and related tests on an annual basis.
3. Clear treatment algorithms are also available for the most common cardiovascular diseases, but not for Major Depressive Disorder (MDD), which is the predominant mood disorder.

The Impact on Society and Healthcare Resources

1. Mood disorders rank among the *top 10 causes of worldwide disability* and according to a WHO report, Depression will be the number 2 cause of disability worldwide by the year 2020.
2. Furthermore, MDD also impacts the lives of family and friends of the depressed person and carries a high risk of suicide. In addition, Depression has a deleterious impact on the economy in terms of absenteeism, reduced productivity and *inappropriate use of healthcare resources*.
3. Modern psychiatry can provide extensive proof of *effective (and cost-effective) treatment in MDD*, resulting in improved quality of life and ultimately more appropriate expenditure of healthcare resources.
4. Interestingly, Depression is a co-morbid condition in up to *25% of patients with IHD* and has been identified as *an independent risk factor for cardiac events after CABG*. Furthermore, *myocardial infarction and stroke may trigger changes in neurotransmitters of the brain, resulting in Depression.*
5. Untreated Depression may in fact cause/aggravate certain physical symptoms, such as chronic pain.
6. The negative impact of MDD on an individual and on the healthcare industry as a whole, is therefore probably *no less* than that of BMD, which is recognised as one of the 25 PMB CDL conditions by Funders of Private Healthcare and forms part of the Risk Equalisation Fund (REF) structure.
7. Depression, not being a CDL condition, is generally only covered by Schemes from the Chronic benefit pool on the middle and/or highest plan option, and mostly subject to yearly Chronic limits. This inevitably results in at least 2 key problems:
    a. Increased hospital admissions for untreated/poorly treated Depression (where medication for Depression is not covered on the particular plan option of the patient, or where the Chronic limit is exceeded)
    b. *'Buy down' and/or incorrect ICD-10 coding (or up-coding)* in order for the patient to gain access to antidepressants under the banner of BMD and therefore the PMB risk pool of benefits.
8. In view of the worldwide 'explosion' of BMD (i.e. expanding awareness of the disorder and subsequent over-diagnosis), physicians may categorise a patient as 'bipolar' in order to ensure Scheme reimbursement of medication, even if the diagnosis of BMD in the particular patient is not clear in terms of DSM-IV criteria. This has been *admitted* in a public forum by a respected South African psychiatrist.

9. According to PH reports, there has been a continuous growth in the number of patient registrations for BMD over the past 3 years (e.g. a 24% increase from Feb 2007 to Feb 2008 for a particular PH client with an informed membership base.

Treatment of Mental Health Conditions

1. There is a significant overlap in the treatment of unipolar and bipolar depression – both may require antidepressants, 'mood stabilisers' and antipsychotics at various time points of treatment, depending on subtype and clinical manifestation of the disorder. Antidepressants are however *not recommended as monotherapy for BMD*, due to the risk of switching the patient into mania. Mood stabilisers are the mainstay of treatment of BMD.
2. Lack of a published, legislated algorithm for the treatment of BMD complicates the matter further, as Medical Schemes *do not have the backup of protocols based on recognised guidelines and cost-effectiveness.* The 2006 Hospital Adult EDL from the Department of Health does not seem to be adequate, as it only lists Lithium, Sodium Valproate and Carbamazepine as possible maintenance treatment options. According to the EDL, *Lithium is the treatment of choice for both mania and depressive episodes and for maintenance*, and this is supported by international guidelines (e.g. NICE, CANMAT and American Psychiatric Association). **However**, in SA clinical practice Lithium is not commonly used as first-line treatment anymore. This may be due to the side effect profile (or perceived side effect profile) and requirements for blood drug level monitoring. Lamotrigine does not even feature in the DoH EDL, despite the fact that effectiveness in bipolar depression is well proven, the drug is registered for use in BMD in SA and features prominently in international guidelines, and there are several generic equivalents available - making this a cost-effective option, especially in BMD type II patients.
3. The so-called 'tertiary EDL' may perhaps list other appropriate medication for BMD, but this EDL is not available in the public domain, and numerous attempts from PH to obtain it have been unsuccessful.
4. Lack of published, legislated guidance on the treatment of BMD has therefore left Schemes having to consider *whatever treatment is prescribed* and often this includes 'off label'-use of drugs, such as the atypical antipsychotics and newer anticonvulsants.
5. Of the atypical antipsychotics, only Olanzapine is currently registered for BMD in SA, but there is also good evidence of efficacy available for Aripiprazole, Quetiapine and Ziprasidone and some of these are registered as maintenance treatment for BMD by the FDA. **However**, the efficacy studies were mostly conducted against placebo, and therefore do *not* prove that the atypical antipsychotic is *as cost-effective as Lithium or Lamotrigine* when used as first-line mood stabilisers.
6. Psychiatrists in private practice nevertheless place a huge emphasis on the long-term use of the atypical antipsychotics in the treatment of BMD and are generally not open for negotiations about it. SASOP has in fact drafted and implemented their own BMD treatment algorithm where the atypicals feature quite prominently as long-term treatment.
7. The atypicals are perceived to have a better side effect profile than conventional mood stabilisers, such as Lithium, Sodium Valproate and Carbamazepine, but the FDA has issued warnings with regards to the cardiovascular side effects (dislipidaemia, increased blood glucose, weight gain, etc.) of the atypical drug class.

Uncontrolled costs and non sustainability

1. In clinical practice, the atypicals are widely prescribed for BMD and they are much more expensive than conventional mood stabilisers. The concern is that Managed Healthcare is not in the position to deny approval of these drugs, as patients are often 'already stabilised' on this treatment by the time that the authorisation is requested.
2. Apart from growth in BMD patient numbers, there has been a constant increase in medicine costs related to BMD over the past 3 years – e.g. In the same Scheme above, we have seen an increase of nearly 29% in the number of reimbursable items claimed, as well as a 32% increase in the total medicine costs, *despite* a low increase in individual drug Single Exit Price in the period Feb 2007 to Feb 2008.
3. PH is currently conducting an investigation as to the specific reasons for the increased costs and it is hypothesised that it may be due to increased use of atypical antipsychotics, as well as 'overdiagnosis' of BMD. We are currently analysing claims reports to establish how many patients with 'BMD' are using antidepressants as monotherapy, as this group of patients may in fact rather have unipolar depression. Even if they truly have BMD, their treatment would need to be reviewed, as antidepressant monotherapy is inappropriate in BMD and could lead to relapse and hospitalisation.
4. We would ideally have liked to present these findings along with this submission, but unfortunately due to the short time frame for comment we are limited to assumptions at this stage.
5. Once our investigation is completed, we may be able to provide updated comments on the mental health issues in the PMB setting.

Summary

- The current disparity between the various mental health conditions in terms of direction offered through algorithms and guidelines (or lack thereof in some cases), has resulted in misinterpretation and an 'open check book' scenario in many instances.
- The lack of provision of a legislated algorithm for the treatment of BMD has resulted in the professional organisation defining their own treatment algorithm - which may not equate to *minimum benefits*, but best practice, and in many cases with a lack of head to head studies.
- There is a perceived practice of 'up-coding' to ensure patients receive benefits from the insured pool, and therefore downgrading to the lower option may occur, as the treatment benefits are guaranteed.
- A clear revision is required of all the mental health benefits as part of the PMB review, with greater guidance to funders to prevent any ambiguity and disparity.

Compiled by:

Elsabé van der Merwe
Protocol Pharmacist, Medikredit

Matthew Dijkstra
Clinical Operations Director, Medikredit

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References available on request.