ISSUES IN MEDICINE

Health care discrimination against the mentally ill — a comparison of private health insurance benefits for major depressive disorder and ischaemic heart disease in South Africa

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Discrimination against the mentally ill dates back to antiquity. In classical Greece, people with mental illness were not allowed to walk the streets of the city, and their families were fined if they failed to control them.[1] In the Middle Ages, many of the mentally ill were branded as witches[2] or 'treated' by means of starving, flogging and chains.[1] In the first half of the previous century the mentally ill in Europe were persecuted and killed by the Nazi regime.[3,4] South Africa has been no different from the rest of the world in terms of discriminating against psychiatric illness, and in 1846 the prison colony on Robben Island was converted into a hospital for 'lepers, lunatics and other chronically ill patients'.[5] Although the situation seems to have improved over the last few decades, stigmatisation of mental illness remains extremely prevalent, even in so-called developed societies.[6,7]

Advocacy groups have become increasingly important role players in the field of mental health, although with mixed success. Media-supported educational campaigns have done a great deal to raise the level of public awareness, thereby dispelling old myths and misconceptions on which the discrimination was based. Also, as a result of governmental lobbying, some countries have moved to address the issue of dicriminatory practices against psychiatric patients. This includes discriminatory health care funding practices, where benefits for the treatment of psychiatric disorders are substantially less than those for other illnesses. In the USA, pressure by these groups led to the introduction of the Mental Health Parity Act of 1996, which went some way towards reducing discriminatory funding practices. At the present time, 35 states in the USA have passed mental health parity laws establishing standards for reimbursement coverage of mental illness.[8]

South Africa is a country with a past record of discrimination. However, while the apartheid era was universally condemned as one of the worst examples of human rights violations, the transition to democracy and the accompanying constitution stipulating equality for all before the law offers a message of hope. Unfortunately many South Africans can attest to the fact that a liberal constitution does not necessarily imply freedom from discrimination. Psychiatrists have long held that there is widespread discrimination against the mentally ill in South Africa. In the past few years, various support and advocacy groups, as well as the South African Society of Psychiatrists, have issued a plethora of press releases highlighting discriminatory practices against the mentally ill. However, there has been little research published on this subject, particularly in the South African context.

In order to investigate this issue empirically, we evaluated the benefits available for two common disorders in South Africa, one a so-called 'psychiatric disorder' and one a 'physical disorder'. We chose major depressive disorder (MDD) and ischaemic heart disease (IHD), as these are both common disorders in South Africa.[9-11] Further, a landmark World Health Report[12] identified both of these disorders as major contributors to the worldwide burden of disease in terms of death and disability-adjusted life years. In this report, MDD is identified as the fourth most important cause of disability in the world and IHD as the sixth most important. The purpose of this study was to compare benefits available for MDD and IHD to persons with private health insurance in South Africa.

What was done

This was a descriptive study of benefits offered by private medical funds open to all members of the public in South Africa. Only information available in the public domain was used and we limited our search to medical funds where information could be obtained from a website. Only options with a monthly premium above R450 were included. All information included refers to single members only. Medical fund options were excluded from the study if they did not have a website that was accessible without a password. Options that offer only a savings plan or hospital plan were also not included. The study protocol was approved by the institutional review board of the University of Stellenbosch.

One hundred and sixty-four South African medical funds were identified using the Internet search engine 'ananzi'. Each medical fund was then contacted telephonically to obtain a web address.

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Information obtained from the website concerning inpatient care, outpatient care, specialist consultations, psychotherapy and chronic medications was entered into a Statistica database. All information was gathered over a 5-month period stretching from November 2002 to March 2003.

Statistical analysis

Statistical analysis was performed using Statistica 6 software (StatSoft, Inc. 1999 - 2003). The majority of the analyses were discriptive in nature. Where means were calculated, standard deviations (in brackets) and ranges are presented. Correlations between numerical variables were calculated using Spearman's rank order correlation coefficients.

What was found

Of the 164 funds identified, 57 fulfilled the criteria for inclusion in this study. Funds excluded and reasons for doing so are listed in Table I. The remaining 57 funds offered 130 different options that were included in the analysis. The mean monthly premium for the 130 options was R994.80 (SD R370.80) per member per month. Benefits provided for inpatient and outpatient treatment for the two disorders are presented in Table II. These amounts only include options where limits had been placed on benefits. When we considered options with no limits placed on benefits, we found that there were 96 options (73.8% of the total) with no limits placed on inpatient benefits for the treatment of IHD, but only 11 options (8.5% of the total) with no limits placed on inpatient treatment for MDD. We did not find a statistically significant correlation between the monthly premium paid by members and inpatient benefits for either IHD ($r = 0.15$, $t = 0.79$, $p = 0.43$) or MDD ($r = 0.07$, $t = 0.80$, $p = 0.43$).

In terms of outpatient benefits, 10 options (7.7% of the total) offered unlimited benefits for the treatment of IHD whereas 3 options (2.3% of the total) offered unlimited benefits for MDD. When correlations were sought between monthly premiums and outpatient benefits, we found that although there was a trend towards such an association for IHD, this did not reach statistical significance ($r = 0.17$, $t = 1.90$, $p = 0.06$). In the case of outpatient treatment for MDD, a significant correlation was found between the monthly premium and benefits for psychiatry ($r = 0.20$, $t = 2.19$, $p = 0.03$) and psychology ($r = 0.26$, $t = 2.93$, $p = 0.004$).

Although our information on chronic benefits was somewhat limited, we found that in the majority of options (115/130, representing 88.5% of the total) chronic medication benefits for the two disorders were the same. The benefits for IHD were considered to be better than for MDD in 12 of the options. In 4 of these, limits were placed on the amounts available for psychiatric disorders that were not placed on the treatment of IHD; in 4 other options there were co-payments for prescriptions for psychiatric medications that did not apply to IHD; and in a further 4 options chronic medications for the treatment of psychiatric disorders required prior motivation by a specialist whereas chronic benefits for the treatment of IHD received automatic authorisation. Two options (1.5% of the total) offered no chronic benefits for either disorder. There were no instances where chronic benefits offered for MDD were considered more favourable than those for IHD. We did not find any significant differences in the premiums between options with greater benefits for IHD and those with equal benefits ($t = 0.12$, df = 119, $p = 0.91$).

Table I. Medical funds excluded from the analysis

Reason for exclusion	Number of funds
Closed schemes — not open to the public	59
No telephone number available	26
No website	7
Insufficient information on website	11
Only offering hospital plan	1
Only offering savings plan	1
No longer in existence	1
Fund liquidated	1
Total	107

Discussion

Notwithstanding the fact that the global disease burden of MDD is greater than that of IHD, there is, at our most conservative estimate, a 20-fold greater benefit availability for the inpatient treatment of IHD than for the treatment of MDD in private health care settings in South Africa. In fact, the vast majority of the options that we considered placed no limitations on the inpatient treatment of IHD whereas in most cases there were severe

Table II. Inpatient and outpatient benefits for IHD and MDD

	Mean (Rands)	Minimum (Rands)	Maximum (Rands)	Standard deviation (Rands)
Inpatient IHD*	411 509.09	10 000.00	2 000 000.00	440 091.29
Inpatient MDD*	20 283.19	0.00	300 000.00	35 196.32
Outpatient IHD	1 755.71	0.00	9 600.00	2 024.08
Outpatient MDD	850.17	0.00	7 500.00	1 365.60
Psychology	736.85	0.00	3 000.00	803.64

* These figures include only capped options (IHD = 33 and MDD = 118) and exclude options with no limits.
IHD = ischaemic heart disease; MDD = major depressive disorder.

restrictions placed on the treatment of MDD. Although this was the most prominent discrepancy, outpatient benefits and even chronic medication benefits showed discriminatory funding policies, albeit not to the same degree.

Another sobering finding was that the outpatient benefits for psychiatry or psychology do not cover more than three sessions per year with either of these professions — a visit frequency that is hopelessly inadequate to provide a reasonable standard of care. In fact, the data on outpatient benefits suggest that, in South Africa, most medical fund options offer little beyond a hospital plan. Although most people with mental illness can attest to discrimination on a variety of levels,[13] it is so much more disconcerting when this occurs within the health care industry.

There will no doubt be defenders of the current approach of differentiating psychiatric disorders from other medical illness in terms of service provision, possibly arguing that psychiatric patients are less ill, or less likely to benefit from treatment interventions. This is simply not true, however, as the disability caused by MDD in terms of impaired physical and role functioning, more days in bed due to illness, more work days lost, increased impairment at work, and high use of health services is greater than for most other diseases.[14,15] Furthermore, modern psychiatry is able to provide extensive evidence for effective intervention in MDD and other psychiatric disorders.[16] Ironically, depression is a co-morbid disorder in up to 25% of patients with IHD and has also been identified as an important independent risk factor for cardiac events after coronary artery bypass surgery.[17,18] Clearly, restricting funding for the treatment of MDD is not only discriminatory, but also shortsighted as effective intervention is likely to be cost saving when taking into account the total direct and indirect costs of treating MDD.[19]

Psychiatrists frequently encounter obstacles to the admission of their patients to private hospitals. While stigmatisation and negative stereotypes probably contribute to this, there may be another reason for this problem — the fee structure for inpatient treatment of psychiatric patients is different from that of patients with other disorders, with the daily tariff for a psychiatric bed often only about 50% of that of a general medical bed. Hospital financial managers, eager to balance budgets and maximise profits, may therefore be less eager to have psychiatric patients in their hospitals. Another risk of discriminating against psychiatric patients and reimbursement of psychiatrists and other health care workers is that working conditions become increasingly difficult, and rewards fewer. This is likely to be a substantial contributory factor to the current mass exodus of psychiatrists and other mental health care workers from South Africa. According to the South African Society of Psychiatrists, almost 40% of all practising psychiatrists in the country have left over the past 2 years!

The Bill of Rights of the Republic of South Africa[20] specifies people with disability as one of the groups that may not be discriminated against. It goes on to state that 'National legislation must be enacted to prevent or prohibit unfair discrimination.' Psychiatric disorders are included among these disabilities. Section 10(1) of the recently approved Mental Health Care Act of South Africa[21] states: 'A mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status.' Despite these legal safeguards, discriminatory practices continue unabated.

A limiting factor in interpreting the results of this study may be the fact that we did not present standardised cost models for the two disorders. Future studies should preferably incorporate some sense of the cost of 'standard practice' and 'best practice' to further ensure fairness in the comparison. However, the magnitude of the difference in benefits as well as the fact that there are time limits placed on psychiatric treatment only, should convince even the most jaded sceptic. Discrimination by the health industry against the mentally ill is a fact. Health professionals, in conjunction with consumer advocacy groups, should address this issue without delay.

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