HIV/AIDS TREATMENT FUNDING – DO WE WAIT FOR GOVERNMENT'S PROVISION OF HIV/AIDS TREATMENT?

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INTRODUCTION

The issue of providing treatment to HIV-infected employees and medical scheme beneficiaries is increasingly being discussed in boardrooms and medical scheme meetings around South Africa. There has been a tangible change in attitude on this issue – previously energy and resources were focused on increasing awareness and preventing new infections. A number of factors have caused this situation, including:

MATURING EPIDEMIC

The HIV epidemic is now over 20 years old and we are seeing the emergence of an AIDS epidemic with an increasing number of HIV-infected employees getting ill and having to leave work or dying of complications related to the virus. As a result, employers are starting to experience the financial effects of the epidemic by way of rising absenteeism, disability and staff turnover rates. In a study conducted by the Bureau for Economic Research on behalf of the South African Business Coalition on HIV/AIDS (SABCOHA) in 2003, nearly 40% of companies surveyed indicated that they had experienced lower labour productivity and increased absenteeism as a result of HIV/AIDS.

Medical schemes have also started to feel the effect of the epidemic by way of increased hospitalisation costs in the previously 'young and healthy' age groups and are identifying ways of managing this trend – treatment is clearly an option.

FALLING COSTS OF TREATMENT

The costs of medically managing the HIV-infected individual have fallen significantly in recent years. In 1998 an annual amount of R48 000 was necessary for this purpose. This has fallen to below R10 000 in most cases in 2004. This decrease has been the result of reductions in costs of antiretroviral (ARV) medication, as well as lower costs of investigations for monitoring the condition.

ACTIVIST PRESSURE

Increasingly companies and medical schemes are being placed under pressure by activist groups to provide for treatment of HIV-infected employees. This has been especially true for multinational organisations operating in South Africa. This pressure is set to increase as treatment is made more widely available.

GOVERNMENT TREATMENT PROGRAMME

The announcement of its treatment programme by the Department of Health during 2003 has prompted action from some organisations who feel that they should lead government in this field.

MEDICAL SCHEME LEGISLATION

The Medical Schemes Act has delineated a number of chronic illnesses for which medical schemes were obligated to fund management with effect from January 2004. While HIV/AIDS was not included on this list it is widely anticipated that it will be incorporated in this list of Prescribed Minimum Benefits for 2005.

As a result of the abovementioned factors, HIV treatment benefits are being provided by an increasing number of companies and medical schemes and the number of patients having access to treatment has increased significantly. This has raised a range of issues that need to be addressed in order to ensure sustainability of effective HIV/AIDS risk management programmes.

LOW TREATMENT ENROLMENT RATES

In almost all instances where HIV treatment benefits have been offered, the number of patients registering for treatment has been surprisingly low. This has caused some critics to question HIV/AIDS prevalence statistics. These low enrolment rates should be viewed rather as a reflection of the following:

- low personal awareness of HIV status
- personal denial of HIV infection

- lack of awareness of available benefit
- concerns about confidentiality.

These factors reinforce the message that treatment should only be offered within a well-structured HIV/AIDS risk management programme in an environment that empowers individuals with the relevant knowledge and skills to manage their own personal risks. Essential components of such a programme include awareness and prevention, an organisational HIV/AIDS policy (and strategy) and voluntary counselling and testing (VCT), as well as treatment. The ultimate objective of HIV/AIDS interventions is to prevent new infections from occurring. Fig. 1 demonstrates how VCT provides the empowering link between HIV prevention and treatment.

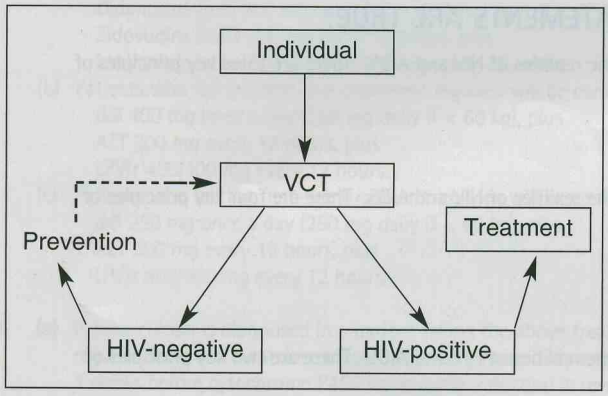

Fig. 1. Voluntary counselling and testing.

Unless all aspects of the programme are in place, diagnosis and enrolment rates will not reflect the actual quantum of HIV infection in the workplace.

PREVENTION OF NEW HIV INFECTIONS

While care and support of HIV-infected employees is imperative, prevention of new infections should always be a major focus of all HIV/AIDS programmes. This is especially true in light of trends experienced in other parts of the world where ARV therapy is widely available. Research conducted in a number of these places (including the UK, the USA and the Netherlands) has shown the emergence of 'treatment optimism'. It appears that if treatment is easily accessible, individuals change their perceptions of the condition, no longer seeing it as a terminal illness. The result of this is an unfavourable (regressive) change to risk-taking behaviour and an increase in the rate of new infections. The USA has seen the re-emergence of strains of sexually transmitted infections that were thought to have been almost completely eradicated.

This trend needs to be taken seriously in South Africa, where access to ARV therapy is increasing. Treatment and prevention programmes should be integrated in a structured manner to provide the appropriate prevention message while encouraging testing and treatment.

GOVERNMENT PROVISION OF ARV THERAPY

Provision of ARV therapy in the public sector has been announced and is currently being rolled out. An understanding of the complexities involved in this process as well as the comprehensive infrastructure that is required have cast some doubt over the timelines of this 'ARV roll-out' and its potential effectiveness. However, many employers are assessing whether they should be making provision for treatment of employees with HIV/AIDS or whether it would be prudent to wait for treatment to be made available by the Department of Health.

Given the uncertainties related to the government programme it would probably be prudent for organisations to continue with their plans for the implementation of treatment programmes. Management of HIV/AIDS is complex for both doctor and patient, so it is imperative that this process is tightly managed and closely monitored. This is best achieved by enrolling patients on an HIV/AIDS disease management programme. These ensure that patients are receiving the most appropriate medication, that they have access to support and counselling and that they understand the absolute necessity of adhering to prescribed treatment. Failure to do this results in an increased rate of treatment failure and promotes resistance to ARV medication.

Organisations providing treatment in a structured manner are able to reap the benefits of a healthy, more productive workforce in a return for their investment. They are then well positioned to make an objective assessment of the effectiveness of the government's programme and, should it be possible, transfer their participating employees to the public sector programme at an appropriate time. It is also possible that a hybrid of the public and privately funded initiatives may offer the best results, e.g. accessing services offered on the public sector while maintaining the supportive measures offered by the disease management programme. In summary, provision of treatment should not be delayed while clarity is being sought on this issue, but arrangements should be structured to allow for flexibility should circumstances change.

CONCLUSION

There are distinct benefits to treating patients living with HIV/AIDS. The decision to provide this benefit should however not be taken without consideration of the implications and only as part of a comprehensive HIV/AIDS risk management programme.

ARV therapy will be made available in the public sector, but until the extent and effectiveness of this initiative can be accurately assessed it would not be prudent to delay the implementation of treatment programmes.