ISSUES IN MEDICINE

AFFORDABLE MANAGEMENT OF HIV INFECTION IN THE PRIVATE SECTOR

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Current estimates suggest that the number of HIV-infected people in South Africa will soon reach approximately 3 million, with 1 600 new cases per day (90% of whom are unaware of their infection).[1]

Medical scheme cover is still unavailable to the majority of people in the private sector. Until recently, medical schemes have tackled the problem by studiously avoiding the issue. They have either excluded cover for HIV/AIDS-related diagnoses, or imposed inadequate benefits. These benefits are often not used, because of the lack of associated confidentiality and because they are insufficient to cover the cost of effective antiretroviral therapy.

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By excluding or restricting benefits, medical schemes have now created an untenable situation for themselves. Irrespective of this policy, they are paying for undisclosed HIV-related illnesses and hospitalisation. As the number of HIV-infected beneficiaries rises, schemes will be faced with massive unmanaged costs with potentially catastrophic implications for all their members. The situation is worsened by a lack of accurate data on the extent of the problem within individual schemes.

With these issues in mind, Pharmaceutical Benefit Management (Pty) Ltd (PBM) has developed a comprehensive programme ('Aid for AIDS') to allow for reimbursement of all aspects of treatment of HIV/AIDS. Its aim is to facilitate clinical and financial management of HIV infection and to reimburse the most cost-effective and appropriate therapy, within the available budget, for beneficiaries of client schemes.

The management of HIV infection/AIDS presents unique challenges. These include exciting new therapeutic approaches, newly extended life expectancy, difficulties in predicting the real costs of care, the wide variety of services which may be required during the course of the disease, and confidentiality. Dynamic consensus guidelines are essential for the informed decision making necessary to meet these challenges. The 'Aid for AIDS' (AfA) guidelines were developed following extensive discussions with local consultants as well as medical practitioners throughout the country. The first edition has been circulated as a discussion document to the majority of practising doctors in South Africa who are involved in treating people living with HIV/AIDS. As this document forms the basis of the AfA programme, it has to be scientifically and ethically sound. Every effort will be made to ensure that this continues in future.

There is no doubt that recent declines in morbidity and mortality due to HIV infection are attributable to the use of potent new antiretroviral regimens.[2] Internationally accepted guidelines recognise the optimal treatment of HIV infection as being a triple combination of two nucleoside reverse transcriptase inhibitors and a protease inhibitor (highly active antiretroviral therapy or HAART).[3] The combination is usually initiated when the CD4 count has dropped to below 500 cells/μl. However, judicious financial modelling indicated that medical schemes would not always be able to afford this ideal approach.

Currently, therefore, three levels of access to payment for antiretroviral therapy are provided for by the AfA programme: level 1 — prevention of vertical transmission; level 2 — dual nucleoside reverse transcriptase inhibitors; and level 3 — conventional triple therapy. It is anticipated that level 1 would always be combined with either level 2 or level 3. Currently, dual and triple therapy would only be approved for payment when the CD4 count falls to below 350 cells/μl. All patients have access to therapy for both minor HIV-related conditions and AIDS-defining conditions and hospitalisation, and funding is also provided for immunisation, prophylactic medication (e.g. co-trimoxazole) and appropriate investigations needed to monitor clinical progression. Regular consultations and counselling are covered.

Dr John Cowlin has pioneered benefit management in South Africa. He introduced the splitting of medical benefits into chronic and routine. He fought through uncharted territory in order to do this but emerged relatively unscathed! Under his leadership the first chronic medication programme in South Africa was introduced, followed by the Aid for AIDS programme. As Executive Chairman of PBM (Pty) Ltd and board member of Medscheme he plays an influential role in South African health care. Laubi Walters is growing old, but remains committed to translating the principles of clinical pharmacology into everyday practice. As Clinical Director, he is responsible for the clinical standards of PBM (Pty) Ltd's programmes and is the project leader for Aid for AIDS. In the role of senior medical advisor, Dr Leon Regensberg talks to the medical profession on a daily basis. His primary task is to balance the unforgiving evidence-based approach with pragmatism. Guy Ramsay is a young scientist who by means of sifting evidence delivers clear and succinct solutions which often astound the three clinicians.

The principle of 'event-driven benefits' underpins the AfA programme. This unique concept links defined biological and pathological events to specific treatment programmes. The occurrence of such an event in the patient's illness will make available the benefits to fund the approved treatment protocol. The AfA programme therefore depends on co-operation from the responsible medical practitioner to notify the programme once an event has occurred, otherwise the benefit cannot be made available. Pre-authorisation is only required for hospitalisation and certain very costly investigations and therapies, and this has been kept to a minimum to limit the administrative burden on providers of care.

The issue of confidentiality has been addressed by creating a restricted access administrative unit with a dedicated computer and communication system. Provided patients, doctors, pharmacists and hospitals deal directly with the unit, HIV-positive beneficiaries cannot be identified by the employer, the medical scheme or the administrator. Secure toll-free fax and phone lines are available for medical practitioners, and a dedicated nurseline is available for use by members enrolled on the programme to assist with queries and enhance compliance with prescribed treatment. This has been identified as a major factor in the effectiveness of antiretroviral therapy.

AfA has no interests in the buying, distribution or selling of medicines. It will, however, work closely with the pharmaceutical industry in order to reduce the cost of expensive antiretroviral therapy and other drugs used in the treatment of opportunistic infections. Encouraging developments have already occurred in this regard. These will benefit persons who are not members of medical schemes as well. Co-operation with academic institutions and professional organisations, as well as other interest groups, is being explored. The programme also offers opportunity for research and the development of an Afrocentric approach to the treatment of HIV/AIDS in South Africa.

While accepting certain financial realities, the AfA programme represents a significant advance in the provision of care and availability of benefits to the majority of previously disadvantaged medical scheme members and their dependants who are living with HIV infection and AIDS.

1. Palella FJJ, Delaney KM, Moorman AC, *et al.* Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. HIV Outpatient Study Investigators. *N Engl J Med* 1998; 338: 853-860.
2. Report of the NIH Panel to Define Principles of Therapy of HIV Infection. *MMWR* 1998; 47: (RR-5): 1-41.

CONFRONTING AIDS — A PLEA FOR A NATIONAL DRIED MILK FORMULA

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The threat of AIDS is rapidly spreading across South Africa, and few are at greater risk of infection than babies born to HIV-positive women. The risk of vertical transmission of HIV from mother to infant is approximately 35% in South African populations where breast-feeding is commonly practised. It has been estimated that up to half of perinatal transmission may occur via breast-milk. As a result, many HIV-infected mothers are advised not to breast-feed their infants. While this practice is widely accepted in affluent countries, it must be viewed with caution in poor communities where undernutrition and gastro-enteritis remain common causes of infant mortality.

The recent worldwide attempts to promote exclusive breast-feeding of newborn infants, especially in developing countries, have received much support in South Africa, with the implementation of the ten steps to successful breast-feeding and the baby-friendly hospital initiative. The slogan 'breast is best' is often heard, and posters promoting the many advantages of breast-feeding are prominently displayed in antenatal clinics. Will all that has been achieved by these programmes simply be swept away by the AIDS epidemic?

The argument for giving dried milk formulas to newborn infants at risk of HIV infection is convincing. Furthermore, many health care organisations, such as the World Health Organisation, suggest that HIV-infected women who can afford to buy milk formula should be discouraged from breast-feeding. Where does this approach leave the woman who is unable to afford milk formula, or the State, which may not be able to provide free or subsidised formula to these infants? An innovative scheme to bring the cost of milk formula within the reach of most HIV-infected mothers is needed.

A cheap national dried milk formula was introduced into the UK very successfully. A similar scheme could be launched in South Africa. Contracts could be issued on a competitive basis to the private sector for the manufacture of a suitable milk formula which should meet the basic nutritional needs of normal infants. A further reduction in cost could be achieved by packaging the formula in sachets rather than tins. The packaging would carry no commercial name or advertising, but simply give the contents as South African national infant

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