



Medical aid double standards

To the Editor: I am distressed by obvious discrepancies in clinical standards applied by medical aids.

A friend, due for delivery of her first baby, was under the care of a midwife. When she went into labour, the midwife was unable to find her a bed at the birthing unit because all the beds were occupied by women who had had elective caesarean sections (CS). Eventually she laboured and delivered in a suboptimal side-room, with poor facilities for monitoring and delivery. She was then moved into a regular room, but she was told that she could only use it until the morning of the next day because it had been booked for another woman having an elective CS.

There are only a few institutions to which a midwife can directly admit women, and seemingly these few places are oversubscribed by largely unnecessary cases.

Elective CSs at maternal request are more costly, with longer recovery periods than elective vaginal delivery, with no clear



benefit to either mother or infant. I cannot understand how medical aids support this practice by agreeing to fund them. Many private obstetric practices have CS rates of well over 70% – three times the World Health Organization recommended rate. Surely some form of justification is required for procedures that are of no medical or obstetric benefit to a patient?

Our medical aid publishes a detailed schedule of benefits every year. It interests me that the fund chooses to limit certain benefits for recognised and manageable conditions, which must place a significant number of people in financial problems. Psychiatric benefits (for our scheme) are capped at R20 000 per year per family; this includes all outpatient consultations and therapy sessions, as well as any cost of any admission required. If a member has a major depressive episode requiring admission (which is usually an extended admission, requiring at least a week), and then needs ongoing weekly therapy sessions (a vital part of mental health management), this capped amount would very soon be used up.

However, the fund is happy to pay for known 'lifestyle' diseases, with no cap on available funds at all. Conditions secondary to chronic smoking and alcohol consumption are not excluded, and the many and varied complications of obesity are happily paid for. Any attempt at improvement of health is excluded, or only minimally funded (e.g. dietician visits, therapy sessions), but the consequences of unhealthy living are supported.

There must be a way for medical aids to restructure the benefits they offer to promote healthy living and wise choices. At the moment, we can eat, drink and be merry because we'll all be bailed out when problems arise; but if we don't, and our mood slips, we'll be queuing up at the poorly staffed government mental health services because our funds will only last a week or so.

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