Medical Aid Scheme

Administered by Discovery Health

Newsletter

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Everyday medicines can damage your kidneys: Here's what you need to know

Kidney health is crucial for overall wellbeing, yet many people are unaware of the potential risks posed by everyday medicines. Understanding these risks and taking proactive steps can help you protect your kidneys from damage.

THE FACTS

- Kidneys are bean-shaped organs that filter waste and extra water from the blood, releasing them in urine. They filter about half a cup of blood every minute.
- All drugs can negatively affect kidney health (prescribed or over-the-counter (OTC) medicines, illegal drugs or alcohol). Even some hospital administered medicines can cause kidney disease.
- A study by the American Academy of Family Physicians found that up to 20% of kidney damage in a population could be caused by prescription and OTC medicines. Among the elderly, this can be as high as 66%.

COMMON MEDICINES THAT CAN HARM THE KIDNEYS

- Non-steroidal anti-inflammatory medicines, used to treat headaches and pain
- Diuretics (water tablets), used to remove excess water and salt from the body
- Certain antibiotics prescribed to treat bacterial infections
- Traditional medicines, including those used in enemas
- Herbal supplements
- Chronic intake of alcohol and illegal drugs like heroin, cocaine and ecstasy

SOME ARE AT HIGHER RISK OF KIDNEY DAMAGE

- Young children
- People over 60 years
- People receiving chronic treatment for cancer or autoimmune conditions
- People with comorbid conditions such as kidney disease, heart disease, hypertension, diabetes and liver dysfunction.

Professor Errol Gottlich, a paediatric nephrologist and the head of Discovery Health's Kidney Care programme, says the degree to which a medicine can harm us, and how fast this can happen, depends on our underlying kidney health and other personal health parameters.

WHAT IS KIDNEY DISEASE AND WHAT HAPPENS ONCE A PERSON DEVELOPS IT?

- Chronic kidney disease is an irreversible illness that causes the gradual loss of kidney function, leading to a build-up of fluids, electrolytes and waste in the body. Late-stage kidney disease requires dialysis (treatment which replicates the kidney's filtering function) or a kidney transplant, says Professor Gottlich.
- It affects over 850 million people globally and is currently ranked as the eighth leading cause of death globally. Sub-Saharan Africa has a prevalence rate of 6.4 to 8.7%.
- In 2023, the TFGMAS Administrator, Discovery Health noted a 9.5% increase (from 2022) in members diagnosed with chronic kidney disease, with an average age of 60 years.
- Common causes of the disease in Africa are closely associated with increased rates of HIV, hypertension and diabetes. Other causes include living with other infectious diseases, autoimmune diseases and structural abnormalities.

THE ACTIONS

Raise awareness: World Kidney Day was observed on March 14th this year. In line with this national health day, members of TFGMAS are encouraged to raise awareness about the risks to kidney health posed by various medicines.

Know your kidney health status: If you're at high risk, talk to your doctor about testing your kidney function before taking any medicines. Kidney function is checked with a urine test and, if needed, blood tests to examine the glomerular filtration rate (GFR).

Follow medical advice: Use prescribed or OTC medicines as instructed by your doctor or pharmacist. Take medicines for the right reason, at the right dose, and for the right duration. If you're concerned about the effects on your kidneys, consult your doctor.

By understanding these risks and taking proactive steps, you can help protect your kidneys from damage.

Get the right support and cover with our care programmes

What if you could access exactly the right support and cover for your health condition? That's exactly what TFGMAS's specialised care programmes are there for. They offer enhanced support and extra benefits to members living with diabetes, heart disease, kidney disease, depression and HIV. In this article, we will focus on our programmes for diabetes, mental health and HIV.

THE FACTS

- Health conditions like hypertension and diabetes are increasing in South Africa and globally.
- At TFGMAS, we understand that the right support improves your ability to manage a health condition. That is why our specialised care programmes help you and your doctors actively manage and monitor these conditions by giving you more support and benefits.
- Proper management of these conditions is crucial to maintaining quality of life.

DIABETES CARE PROGRAMME

The Diabetes Care Programme is based on established clinical and lifestyle guidelines. The programme will help you and your Premier Plus GP actively manage your diabetes. It includes:

- **A personalised dashboard** with your unique diabetes management score. You and your GP can agree on goals and track your progress on the dashboard. This will help to identify areas that need attention and identify steps you must take to manage your condition and stay healthy over time.
- **A diabetes educator** to guide you on key areas that include daily glucose monitoring and timing of medicine.
- **Extra blood glucose test strips each year.**
- **A biokineticist consultation**, as monitoring your daily glucose is important to tailoring your nutrition, activity and medicine.
- **An extra dietitian consultation** to help you with nutrition.
- **Funding for continuous glucose monitors (CGM).** These devices can help you monitor your glucose levels and TFGMAS will pay for these monitors and consumables up to the agreed and preferred negotiated rates, depending on your benefit plan's available benefits and clinical prerequisites, ensuring adequate cover while helping you monitor your condition.

MENTAL HEALTH CARE PROGRAMME

The Mental Health Care Programme is for members who've been diagnosed with episodic depression. The programme runs over a period of six to twelve months and it unlocks the following extra benefits to monitor and manage your condition:

- Up to three additional consultations with your Premier Plus GP
- A basket of antidepressant medicine
- Up to three additional psychotherapy consultations or nine group therapy sessions
- Digital mental healthcare, using internet-based cognitive behavioural therapy (ICBT) in an innovative way.

HIV CARE PROGRAMME

The HIV Care Programme gives comprehensive support to members living with HIV and AIDS to help them better manage their condition. When you join the HIV Care Programme, you and your Premier Plus GP can agree on key goals and track your progress on a personalised dashboard. You will also receive an additional consult with a social worker over and above your available day-to-day benefits per your chosen benefit plan.

THE ACTIONS

HOW TO JOIN THE DIABETES CARE PROGRAMME?

01 | You and your nominated Premier Plus GP must complete and submit a **Chronic Illness Benefit application form** to register you on the Chronic Illness Benefit for type 1 or type 2 diabetes.

02 | Your GP can then enrol you in the Diabetes Care Programme using HealthID, a convenient platform that doctors use to access your health records. You will need to grant your doctor access to your health records before your health records will be accessible.

For more information and benefit plan-specific details, visit the Diabetes Care Programme benefit page, as well as the 2025 **TFG Health or TFG Health Plus** benefit guide available on the website (www.tfgmedicalaidscheme.co.za and navigate to Find a Document > Guides, applications and newsletters > Benefit Brochures).

HOW TO JOIN THE MENTAL HEALTH CARE PROGRAMME

01 | Your nominated Premier Plus GP or a psychologist in our network can enrol you in the Mental Health Care Programme.

For more information and benefit plan-specific details, see the Mental Health Care Programme benefit guide and access your 2025 **TFG Health** or **TFG Health Plus** benefit guide by visiting the website (www.tfgmedicalaidscheme.co.za and navigate to Find a Document > Guides, applications and newsletters > Benefit Brochures).

HOW TO JOIN THE HIV CARE PROGRAMME

01 | Your nominated Premier Plus GP must register you for the condition by completing an HIV Care Programme application form first.

02 | Give your Premier Plus GP consent on HealthID to enrol you in the HIV Care Programme.

03 | Your Premier Plus GP can then enrol you in the HIV Care Programme.

For more information and benefit plan-specific details, see the HIV Care Programme benefit guide and access your 2025 **TFG Health** or **TFG Health Plus** benefit guide by visiting the website (www.tfgmedicalaidscheme.co.za and navigate to Find a Document > Guides, applications and newsletters > Benefit Brochures).

Your Cover for Emergency Hospital Admissions

Emergencies can happen unexpectedly, and knowing what to do when you need sudden emergency treatment at a hospital is crucial. This article outlines the steps you should take in an emergency, how you are covered for Prescribed Minimum Benefit (PMB) treatment when admitted to a hospital, and the differences in coverage across the two TFGMAS benefit plans.

UNDERSTANDING EMERGENCY HOSPITAL ADMISSIONS AND PMB COVERAGE

In the event of an emergency, it's important to understand your coverage and the actions you need to take. TFG Medical Aid Scheme (TFGMAS) offers two benefit plans: **TFG Health** and **TFG Health Plus**. Each benefit plan provides different levels of coverage for emergency hospital admissions and PMB treatment. PMBs are a set of defined benefits that ensure all medical scheme members have access to certain minimum health services, regardless of the benefit plan they have chosen.

THE FACTS

Emergency Medical Conditions: An emergency does not necessarily require a hospital admission, and not all urgent medical treatment falls within the definition of Prescribed Minimum Benefits (PMB). An emergency medical condition is defined as the sudden and unexpected onset of a health condition that requires immediate medical or surgical treatment. Without this treatment, there would be serious impairment to bodily functions, serious dysfunction of a bodily organ, or life-threatening consequences.

Prescribed Minimum Benefit (PMB) Hospital Network: TFGMAS has contracted with the KeyCare Hospital Network to give members access and cover for PMB level of care within a PMB Hospital Network. This network aims to limit your out-of-pocket costs. Here's how it works:

- You choose a primary provider who has a Direct Payment Arrangement (DPA) with the Scheme to facilitate the admission to hospital;
- You receive treatment for PMB conditions and level of care at a hospital within the PMB Hospital Network.
- This will ensure that all related accounts during the admission are covered at the contracted rates where the healthcare provider is contracted with TFGMAS.
- If you **voluntarily** choose to make use of a healthcare provider we are not contracted with (the TFGMAS Designated Service Providers), we may limit the payment and payment, which will depend on your chosen benefit plan's PMB benefit rules and you will be liable for any amount the provider charges in excess. In the case of the **involuntary** use of a non-Designated Service Provider, the costs of PMB treatment will be paid in full.

Coverage: In an emergency, you can go to any hospital, and TFGMAS will cover the cost for the first 24 hours or until you are stabilised. If further treatment is needed, you may be moved to a hospital within the PMB Hospital Network. If you choose to stay at the initial hospital, you may be liable for costs above the agreed and Scheme Rates, if registered on the **TFG Health Plus benefit plan**. **You will not be covered for funding outside of the network arrangement if you are registered on the TFG Health benefit plan.**

Hospital admissions and related accounts: Hospital admissions are funded from your chosen benefit plans's hospital benefit, covering hospital costs and related accounts (e.g., admitting doctor, anaesthetist, radiology, pathology). **Any account other than the hospital account** for in-hospital care are referred to as "related accounts". This could include the accounts for the admitting doctor, anaesthetist and any approved healthcare expenses like radiology or pathology.

See the tables below for more information at benefit plan level:

	TFG Health	TFG Health Plus
Hospital Networks and In-Hospital GP Network	If you are registered on the **TFG Health benefit plan**, you have chosen a benefit plan with a hospital network and need to make sure you use a hospital in that network to get full cover. The **TFG Health benefit plan** uses the KeyCare Hospital Network. We also established an In-Hospital GP Network and pharmacies that are designated service providers (DSP).	If you are registered on the **TFG Health Plus benefit plan**, you have access to designated service providers (DSP) at agreed and contracted Scheme Rates. The **TFG Health Plus benefit plan** uses the KeyCare Hospital and In-Hospital GP networks for **full cover of PMB treatment**. TFG Health Plus members can be admitted to any hospital for any procedure, but **in the case of PMBs, you may have co-payments for specialists if treated at a non-network hospital.** This means no deductible can apply where the admitting service provider is either on the Scheme's DSP or In-Hospital GP Network or In-Hospital Specialist Network, and you get these services from a hospital in the KeyCare Hospital Network.

WHEN YOU ARE ADMITTED TO HOSPITAL FROM CASUALTY FOR A MEDICAL EMERGENCY:

TFG Health	TFG Health Plus
The first R500 of the casualty unit's account is payable by you.	If you are admitted to hospital from casualty, we will cover the costs of the casualty visit in full from your Hospital Benefit, as long as we have preauthorised your hospital admission. We must be notified within 24 hours to preauthorise the claim, or claims, for payment.

THE ACTIONS

01 | UNDERSTAND YOUR BENEFITS:

- Familiarise yourself with the benefits available under your chosen TFGMAS benefit plan.

02 | NOTIFY TFGMAS:

- In case of an emergency or after-hours admission, notify TFGMAS within 24 hours or on the next working day.
- Call **0860 123 077** to speak to a consultant and obtain an authorisation number.

03 | CHOOSE THE RIGHT PROVIDER AND MAKE USE OF DSPs:

- Use the Discovery App or the TFGMAS website (https://www.tfgmedicalaidscheme.co.za) to find designated service providers (DSPs) and ensure your chosen providers are part of the PMB Hospital Network.

04 | KEEP YOUR INFORMATION HANDY:

- Always carry your medical scheme registration details.
- Download your electronic membership card from the Discovery App and keep a copy in your wallet.

05 | ALLOCATE A PRIMARY GP:

- If you are on the **TFG Health benefit plan**, ensure you have allocated a primary GP as your chosen and preferred healthcare provider.

06 | PREAUTHORISE CASUALTY ADMISSIONS:

- If admitted to hospital from casualty, ensure preauthorisation within 24 hours to avoid penalty charges. If incapacitated, your family members may call us to obtain authorisation.

By following these steps, you can ensure that you receive the necessary care in an emergency and that your PMB-related claims are paid correctly.

For a comprehensive list of the TFGMAS Hospital Network, visit www.tfgmedicalaidscheme.co.za and navigate to Find a Document > Information Guides > TFGMAS Hospital Network.

Importance of regular preventive screenings

How well do you know your health numbers? When last did you do your cholesterol, blood sugar, blood pressure or HIV tests? And what about cancer screenings and other such checks? These tests are the easiest way to identify potentially serious diseases early and deal with them as soon as possible for better outcomes.

THE FACTS

"Going for regular preventive screening checks is an investment in your own health," says Dr Noluthando Nematswerani, Head of Discovery Health's Centre for Clinical Excellence.

"Keeping up with these checks is the only way to catch potentially devastating illnesses like diabetes, hypertension, heart disease, cancer and others early on. The health checks that detect the early onset of these conditions are the simplest, fastest way to screen for common conditions that can cause serious healthcare complications if they're not diagnosed."

The following tests are done during your Health Check (which takes about 30 minutes to complete):

- HIV testing
- Body mass index (or BMI – the ratio of your weight to your height), to check if your weight is higher than what it should be
- Blood glucose testing (for diabetes)
- Blood pressure testing (for hypertension)
- Cholesterol testing (for hypercholesterolemia, or high cholesterol)

WHICH REGULAR PREVENTIVE SCREENING TESTS SHOULD YOU HAVE?

TFG Medical Aid Scheme members have access to essential screening and prevention benefits for a range of life-saving checks. These include:

- Mammograms, to screen for breast cancer
- Pap smears, to screen for cervical cancer
- Bowel cancer screening.

You can learn more about these tests in the next section of this article.

MORE ABOUT CANCER-SCREENING CHECKS

Screening for breast cancer

- If you have no family history of breast cancer, you should start having mammograms or breast ultrasounds from the age of 40 and have them every two years. **TFG Health Plus** members have access to mammogram screening every year.
- If you have a family history of breast cancer, start your screening tests when you are 10 years younger than the person who had cancer in your family was when they were diagnosed. A screening test once a year is recommended in such instances.
- Breast MRIs and genetic screening are also appropriate in certain cases. Your healthcare provider can advise you about this.

Screening for cervical cancer

This test finds abnormal cells so that they can be treated before they have a chance to turn into cervical cancer.

- For those who don't have a high risk of cervical cancer, screening should start from age 25. It's recommended they have either:
  - A Pap smear every three years; or
  - Human papillomavirus (HPV) screening every five years.

  Keep in mind that a Pap smear looks for precancerous cells that might become cervical cancer if not treated. An HPV test checks for the type of HPV that can lead to cervical cancer. **TFG Health Plus** members have access to mammogram screening every year.
- For those who have a high risk of cervical cancer (such as people living with HIV), a Pap smear once a year and HPV screening every three years is recommended.

Screening for colorectal cancer

- Stool-based tests are recommended every two years from age 45.
- A colonoscopy is recommended for those at high risk of developing this cancer, such as people with a family history of colorectal cancer or those living with medical conditions that increase the risk of colorectal cancer.

Screening checks for seniors

Members who are 65 years or older also have cover for a group of age-appropriate screening tests. These can be done by a general practitioner (GP) in the Premier Plus network or at a pharmacy in our defined pharmacy network. We cover hearing and visual screenings and a falls-risk assessment. These members may have cover for an extra GP falls-risk assessment, if they're referred by a Premier Plus GP, and depending on their screening test results and if they meet the Scheme's clinical-entry criteria.

THE ACTIONS

- **Book your health check today:** Find out your blood pressure, blood glucose levels, cholesterol and BMI by doing your health check at one of our wellness providers, like Clicks or Dis-Chem.
- **Learn more about your screening and prevention benefits:** Read the benefit guide (www.tfgmedicalaidscheme.co.za and navigate to Find a Document > Guides, applications and newsletters > Information Guides) to find out more about your screening and prevention benefits. We pay for the health check from your Screening and Prevention Benefit. This means it won't affect your day-to-day benefits.

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