PRESCRIBED MINIMUM BENEFITS

LOOKING BACK TO LOOK FORWARD

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ABSTRACT

Prescribed Minimum Benefits are a critical feature of the South African private healthcare environment. Current healthcare reform, regulation, system failures and abuse by service providers have brought into question the sustainability of PMBs in its current form. With the imminent move to universal healthcare coverage in the form of a National Health Insurance (NHI) system, the question raised is whether PMBs in its current form are a viable mechanism for a healthy South Africa?

The purpose of this paper is to understand the evolution of PMBs over time and evaluate its impact on key national health system objectives such as access and coverage, costs and efficiency, quality of care and sustainability with the aim to create a constructive debate around the provision of minimum benefit in the future.

KEYWORDS

Prescribed Minimum Benefits, NHI

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1. INTRODUCTION

The South African Healthcare system is a complex sector moulded by the inequities of the apartheid regime as well as the attempted justices post democracy. As such, the current and future South African government find themselves in a unique situation of reforming the system to achieve the goals as set out in the many documents framing the objectives of the healthcare system whilst constrained by significant resource and management weaknesses.

These weaknesses span inefficiencies in all parts of the public health sector from the mismanagement of financial resources and poor provincial administration, to the absence of a strong accountability framework for the health system. In both the public and private sectors, there are justifiable concerns around the efficiency of coverage, the cost effectiveness of current benefit packages and the absence of provider competition. Furthermore, medical schemes are faced with the challenge of providing cost-effective healthcare cover for their members in an environment of numerous complexities stemming from regulatory requirements, health reform objectives and initiatives, a relatively stagnant membership pool, high levels of medical inflation, as well as intense scrutiny from the public on the management of member funds. Nonetheless, the system is entrenched with numerous strengths including a relatively large and well-trained workforce with well-defined public and private institutions.

Although South Africa spends a significant amount of money on healthcare, health outcomes are poor and challenges are further exacerbated by the disconnection between the public and private sectors. Currently, top of the agenda is the reform of the South African healthcare system in the form of National Health Insurance (NHI) system. Critical to this reform is the establishment and provision of core minimum benefit packages. Given the perception of inequity and inaccessibility of healthcare services within both the public and private sector, establishing a core minimum benefit package and the principles around deciding what the benefit package should offer is an important step forward. Strategically, one would require a benefit package that prioritises health care services within budgetary constraints in order to ensure that available resources are allocated most judiciously, with the ultimate aim of building a more equitable health care system.

Prescribed Minimum Benefits (PMBs) in the private sector are one of the regulatory requirements that has come under the spotlight and become the focal point of numerous discussions concerning the affordability of medical scheme contributions as well as the appropriateness of the package in meeting healthcare objectives. The purpose of this paper explores the historic evolution of minimum healthcare policy design and developments in the context of both the public and private sector with the aim to understand the journey of healthcare provision in South Africa from the early policy objectives of establishing Social Health Insurance (SHI) system to the introduction of PMB’s in its current form. The timeline below provides a roadmap that details the journey of the most critical developments in the context of establishing PMB’s and is the foundation of Section 2 Looking Back. Section 3: Looking Forward aims to explore the applicability of a minimum package in the pending NHI environment.
The evolution of PMBs in South Africa

**ANC National Health Plan**
“...recommended that a Commission of Inquiry be appointed by the Government of National Unity as a matter of urgency, to examine the current crisis in the medical aid sector and to consider alternatives such as a compulsory National Health Insurance (NHI) system.” (ANC Health Plan, 1994)

**Medical Schemes Act No 131 of 1998**
This Act re-introduced the requirement for PMBs in medical schemes along with open enrolment and community rating. The PMBs were defined as of 270 diagnosis and treatment pairs as suggested in Soderlund and Peprah (1998).

**Medical Schemes Act amendments: emergency conditions and DSP**
These amendments were made to the Act in order to include emergency medical conditions as part of PMBs. They also introduced the concept of designated service providers.

**Medical Schemes Act amendments: CDLs**
These amendments were made to extend PMBs to cover the costs of diagnosis, treatment and medication for 25 chronic disease list (CDL) conditions.

**Medical Schemes Act amendments: HIV**
HIV was added to the CDL list following the public sector introduction of ARV guidelines.

**“An Essential Hospital Package for South Africa: Selection Criteria, Costs and Affordability”**
This paper by Soderlund and Peprah paper took the lead in defining PMBs in South Africa. Their recommendations were gazetted shortly thereafter with little alteration.

**Commission of Inquiry into a National Health Insurance System**
Proposed that coverage for a core benefit package be implemented in the medical schemes and health insurance industry (Broomberg & Shisana, 1995)
2. LOOKING BACK

This section of the paper is aimed at understanding healthcare objectives of the South African government post democracy, unpacking the policies shaping the current healthcare system and identifying the driving forces of the current PMB package. Post 1994 elections, the South African government committed itself to a number of specific goals in the area of social policy, including:

- The provision of affordable, decent and effective healthcare for all (2002, Taylor et al)
- Healing the injustices of the past, ensuring social justice and improving the quality of life for all South African citizens (inter alia by alleviating poverty and suffering), and freeing the potential of each citizen (South African Constitution)

From the above it can be seen that healthcare provision is an integral component of a minimum package of goods and services that is required for the development and advancement of people. (2002, Taylor et al). Section 27 of the Constitution states:

“….27. Health care, food, water and social security.-

(1) Everyone has the right to have access to –
   (a) health care services, including reproductive health care;
   (b) sufficient food and water; and
   (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment....”

However, in accordance with section 36 of the Constitution, limitations are placed on these rights to the extent that the limitation is reasonable and justifiable in an open democratic society based on human dignity, equality, and freedom. In the context of a developing country with limited resources, the progressive realisation of these rights to healthcare services requires an effective and equitable process and the development of a minimum package should reflect this need. (McLeod, National Health Insurance Policy Brief 10)

The ANC National Health Plan of 1994 laid the foundation for the developments that have been seen over the past 18 years. This document affirmed plans for a health system focused on Primary Health Care (PHC), with Community Health Centres (CHCs) providing comprehensive services including promotive, preventive, rehabilitative and curative care which would be managed under a District Health System to the public (ANC Health Plan, 1994).

The National Health Plan also provided the platform for the expected minimum benefits to be provided in the public sector by specifying intentions to provide the following benefits to the population:

- 24-hour casualty and maternity services
- Free health care in the public sector for children under six, pregnant and nursing mothers, the elderly, the disabled and certain categories of the chronically ill.

Preventive and promotive activities, school health services, antenatal and delivery services, contraceptive services, nutrition support, curative care for public health problems and community based care would be provided free of charge in the public sector (ANC Health Plan, 1994). Free health services for pregnant women and children under 6 years of age was swiftly instituted with Notice 657 of 1994, followed by free primary health care services for all in 1996 (Notice 1514 of 1996). These services were to be rendered in state facilities only and covered all applicable with the exception of medical scheme members & non-South African citizens.
The ANC Health Plan also stated that “it is recommended that a Commission of Inquiry be appointed by the Government of National Unity as a matter of urgency, to examine the current crisis in the medical aid sector and to consider alternatives such as a compulsory National Health Insurance (NHI) system.”

It is important to note that NHI was proposed as an alternative for the medical schemes sector. It was never envisaged as a replacement for the entire National Health Service (NHS) as in its current form (Mcleod, National Health Insurance Policy Brief 10). The ANC Health Plan further states that under the NHI, should it prove feasible, “the basic package of care to be covered by the NHI should be statutorily defined.” This inquiry would set the course of sail for the establishment of PMBs in the private health sector.

The work performed by Soderlund and Peprah (1997) in defining an essential package of hospital care “off-the-back” of the recommendations of the South African Committee of Inquiry into National Health Insurance (SACINHI, 1995), sets into motion the concept of establishing a mandatory Core Package of Hospital Benefits (CPHB). This CPHB would be provided for families and their dependants in the formal sector with the aim to address the pertinent issues of the healthcare system at that time i.e.

- Dwindling public resources would make it difficult to continue funding healthcare through tax for such a large population.
- The introduction of CPHB (low form of insurance) was an affordable and acceptable substitute for the uninsured formal sector (Soderlund and Peprah, 1997).

Soderlund and Peprah explained that the aims of establishing the CPHB for the formally employed were to:

- “Eliminate free riders/ dumping in the public sector”:

  With the introduction of a core hospital package, the minimum benefit package would explicitly exclude primary care services as this would be funded and provided via the public funded PHC. Thus implicitly, the CPHB would require all employed individuals and their families to cover at a minimum the costs of their use of the public hospital system. The exact definition of whether this would be indemnity cover or have a specified maximum per beneficiary per year was not explicitly defined (SACINHI, 1995).

In South Africa, the majority of the population have access to hospital care through a tax-financed, public hospital system, which is theoretically means-tested at point of entry. In practice, however, the means test is rarely applied, and most citizens receive care free of charge (Soderlund and Peprah, 1997). Thus the introduction of CPHB, would improve cost recovery within the public health system objective of the Department of Health and Provincial health administrations and would ensure that those who could afford to pay for public hospital care actually do (SACINHI, 1995).
Control anti-selection, cost escalation and ultimately improve efficiencies in the delivery of healthcare.

As a result of the state being seen as the insurer/provider of last resort, the window of opportunity for anti-selective behaviour by individuals who could afford private healthcare but opted for “free” public hospital care was too great. This was a main driver of the inefficient allocation of resources in the healthcare system. This provided a primary justification for the introduction of minimum insurance regulation (Soderlund and Peprah, 1997).

In addition, implicit in the ‘anti-dumping’ regulation above was the intention that low-risk members should cross-subsidise high risk members, rather than require the state to meet these costs which served the dual function of controlling cost escalation through subsidisation effects of a larger risk pool as well as to reduce the financial burden on the state (Soderlund and Peprah, 1997). Secondly, the introduction of a minimum package, whether in the form of Social Health Insurance (SHI) or through medical schemes reduced the potential to fragment the market into income and risk groups on the basis of size and cost of package (SACINHI, 1995). Simply put, even if insurers were forced to take all applicants and offer ‘community rated’ premiums, in the absence of a minimum level of benefits they could effectively distinguish high from low risk members and place them into different risk pools with differentiated premiums by designing policies that appeal specifically to different risk groups rendering healthcare unaffordable to the elderly and sick. Enforcement of a minimum level of benefits protects members and depending on the design of the package and legislation regarding membership, risk pooling could either occur on a medical scheme level or across the formally employed population (Soderlund and Peprah, 1997). Thirdly the introduction of a minimum benefit package would allow for easier comparison between medical schemes and encourage competition and subsequently drive innovation in the management of healthcare costs and control escalation.

In terms of improving efficiencies, the ability of public hospitals to generate and retain income through a new source i.e. funds from the introduction of CPHB would have significant positive effects on operations, governance and management. This would be realised through several related mechanisms. If public hospitals were allowed to retain a proportion of user fees charged, they would be encouraged to attract fee-paying patients and enter into service agreements with medical schemes to attract additional customers. Such trends and innovation would encourage competition between the public and private sector as well as improvements in infrastructure, managerial efficiencies and health outcomes. (SACINHI, 1995).

Following the inquiry into the establishment of a National Health Insurance system for the formally employed, the case of Soobramoney versus Minister of Health (Kwazulu-Natal) was an important development that moulded the perception of the provision of healthcare in South Africa. Mr Soobramoney, a diabetic who suffered from ischaemic heart disease and cerebro-vascular disease, kidneys failed in 1996 and applied to the Durban High Court based on the premise that he had a right to receive renal dialysis treatment from the hospital in terms of Section 27(3) (which provides that no-one may be refused emergency medical treatment) and Section 11 (the right to life) of the 1996 Constitution. The application was dismissed by the Constitutional Court on the basis that this was not an emergency which called for immediate remedial treatment. (Soobramoney, 1997).
This above decision by Constitutional Court was of considerable importance for health service provision and delivery in South Africa. Firstly, it limited the Constitutional guarantee against refusal of emergency medical treatment to that which was immediately necessary and to available remedial treatment on non-discretionary, dramatic, sudden events which are of a passing nature in terms of time. Secondly, the Court accepted that due to limited resources, the rationing of resources is integral to health service delivery in the public sector, notwithstanding the fact that this would perpetuate inequities between the private and public sector. Finally, this decision expressed the Court’s deference to executive authority by declaring itself slow to interfere with decisions taken by competent health authorities regarding allocation of resources. Allowing for these considerations, the appeal was dismissed, notwithstanding the Court’s recognition of the “hard and unpalatable fact that if the appellant were a wealthy man he would be able to procure such treatment from private sources.” (McLeod, National Health Insurance Policy Brief 10)

Hence, the need for a core package that would avoid/limit incidents where individuals would be refused cover for serious illness either through the public or private sector was required.

In establishing or designing a benefit package, the uncertainty regarding healthcare needs and costs of healthcare make it extremely difficult to prescribe benefits which ensure adequate access to care when needed but protect against abuse and prevent unjustified claims to ensure the most efficient allocation of resources. (Soderlund and Peprah, 1997). In 1998, Soderlund and Peprah detailed the selection criteria for an essential hospital package and were of the opinion that the approaches to defining the essential package may be categorised on two axes i.e.

- whether entitlements are explicitly or implicitly defined, and
- in the case of explicitly defined packages, whether the package is defined in terms of its cost or the actual services available.

Under this approach, an implicit approach to defining a core package for the private sector would define a package that consists of all the healthcare services currently available at public hospitals (Department of Health, 1997). However, this would add significant uncertainty as to what entitlements would be included under such an arrangement due to the differing levels of access to care between urban areas and the townships/rural areas. The implicit approach thus entrenches system inequity. In addition, the implicit approach would potentially expose the funders of such a package to considerably more cost-escalation risk as one only has to demonstrate that a public hospital somewhere in the country offers a particular service to secure “in principle” an entitlement to such services. The explicit approach to defining benefit levels is not without flaw as prescribing the level of benefit may impinge on individual and societal value systems, as well as professional domains and responsibilities in terms of the range of care that can be provided. Notwithstanding these limitations, Soderlund and Peprah believed that the only desirable and pragmatic approach to defining the minimum package in South Africa is to specify which services are necessary to treat and/or which specific illnesses are covered. (Soderlund and Peprah, 1998).

Furthermore, Soderlund and Peprah were of the opinion that in order to design the package of core minimum benefits for the private sector, the main objectives of the mandatory core package needed to be identified. This is explored in more detail below.
The initial work on the design of a minimum core package of benefits that would be offered in the private sector was done by Neil Söderlund, Solani Khosa and Enoch Peprah of the Centre for Health Policy at the University of the Witwatersrand. As a point of departure, Khosa, Söderlund & Peprah considered the then international experience with regard to minimum benefit design (McLeod, National Health Insurance Policy Brief 10).

Relevant international experience with respect to a “core-package” concept, whether public or private sector is found to be more limited in developing countries. However, in 1993 the World Bank released a report that strongly advocated that countries define essential health care services and give these priority in terms of public funding. In defining the package the World Bank recommended prioritising treatment of diseases where the total burden of disease, which was measured in terms of disability adjusted life-years lost, is high, and where any cost-effective interventions against the disease exist. Due to limited resources, the most cost-effective interventions for these common diseases in the developing world tend to be preventive or promotive (Soderlund and Peprah, 1997). In addition, prioritising based on burden of disease and costs effectiveness of treatment presents an interesting situation of how to handle two people having diseases with equally amenable cost-effective treatment. Would this result in the one with the more common disease being admitted to hospital, and the other turned away and hence seek treatment in the public sector? This approach contradicts one of the primary aims of eliminating free riders/dumping in the public sector.

Allowing for the strong government commitment to the provision of free primary care services to all citizens as well as economic theory which simply states that goods which benefit society at large, rather than simply an individual immediately, should not be left to the market affected as there will be a tendency to under-consume such goods. This provided a strong justification for the provision of primary care services as well as hospital care for mental illness and chronic infectious diseases to be funded through tax rather than through an insurance mechanism. This is because individuals, for example, may be unwilling to pay for coverage or not see the need for tuberculosis as an essential health care priority, whereas society as a whole, recognizing the risk of infection spreading, is likely to agree to pay for such care for those who need it and as such should be funded through tax revenue. (Soderlund and Peprah, 1997). As such the stated World Bank objectives in defining essential healthcare services were not applicable to South Africa when defining the core benefit package for the private sector.

Attention was then turned to developed country experiences in designing core benefit packages. Majority of the research available was aimed at priority-setting for public healthcare spending and the overriding point of view was that it was a complex exercise requiring compromises and strong political commitment for success. In addition, in most developed countries explicit lists of included and excluded interventions were avoided (Soderlund and Peprah, 1997).

However, an exercise performed by the State of Oregon in the United States of America proved to be integral in defining PMBs for the South African private sector in its current form. In the late 1980s, Oregon policy-makers were concerned by the fact that approximately 17% of the population were not covered by any form of medical insurance. A Commission was appointed and expected to come up with “a list of health services ranked in priority from the most important to the least important, according to the comparative benefits of each service to the entire population being served and judged by a consideration of clinical effectiveness and social values” (Kitzhaber, 1993).

The Commission produced a list of 750 diagnosis-treatment pairs (DTPs) describing almost all possible health care interventions. The first approach adopted to priority setting was to rank the 709 DTP’s according to cost effectiveness where effectiveness was assessed in terms of the quality adjusted life years saved. Given this criteria, the initial published list was heavily criticised as many life threatening conditions were ranked lower on the list than less serious diseases. The second phase of prioritisation grouped the 709 diagnosis-treatment pairs into 17 clusters, based on effectiveness, urgency of required care and whether or not the condition was life threatening and costs of care were ignored in developing these DTP’s (Soderlund and Peprah, 1997).
In determining a core package for South Africa, the Oregon example above and other studies differed in two key respects. Firstly, the NHI inquiry envisaged a package that would cover only hospital care and primary care would be funded through tax finance. Secondly, the South African ‘core package’ referred to cover that should be provided by individuals or companies and not what the state providers or public funds would provide. These differences had conflicting consequences as individuals would be paying themselves for everything within the package, and would thus have incentives to exclude nonessential care which would reduce some of the controversy around the package. However on the other hand if people were guaranteed access to some form of hospital care, but not primary care, they would be incentivised to overuse hospital services driving inflation whereas primary care might have been more appropriate and cost-effective. (Soderlund and Peprah, 1998).

There were other limited attempts at defining healthcare priorities in South Africa including the “Needs Norms Project for Primary Health Care Services” undertaken by the Centre for Health Policy which attempted to identify priorities and planning standards for primary health care services i.e. to “determine the need for and the type and range of primary health services to be provided for communities in South Africa”, but explicitly excluded the definition of a core package of such services. (Soderlund and Peprah, 1998) and (McLeod, National Health Insurance Policy Brief 10).

Furthermore, the Medical Association of South Africa had made recommendations on a multiple core benefit package in its submission to the 1995 NHI committee. This aimed to determine what the important areas of health research were in South Africa with a disease driven focus rather than defining an accompanying spectrum of interventions, or service aspects for diseases that were considered to be of high priority. (McLeod, National Health Insurance Policy Brief 10).

In defining the essential core package of benefits for the private sector, Soderlund and Peprah took the lead. Leveraging off the work performed for the State of Oregon, Soderlund and Peprah excluded primary care and chronic psychiatric/infectious disease treatments at the outset owing to the public good nature of these interventions. As such, the remaining DTP’s were allocated to urgency, effectiveness and cost categories in order to facilitate the prioritisation process. Interventions were then ranked according to various mixes of these three criteria and the final “core package” adopted had excluded all DTP’s that were either very high cost, ineffective, or for non-urgent, non-life-threatening conditions. This process resulted in the reduction from the 709 DTPs to 271 DTPs. Soderlund and Peprah noted that the results of this exercise was intended to inform reform of private medical scheme cover in South Africa as well as serve as the basis for the design of a future state health insurance product. They also noted that significant additional work was required particularly to assess the appropriateness of the prioritisation approach. However, following this there was no work performed in the refining of the core hospital package and the list of DTP’s that would form the core essential benefit package in the private sector was gazetted shortly without alteration. (McLeod, National Health Insurance Policy Brief 10).
In 2009 the first edition of the PMBs were published. This covered the 271 DTPs. The second edition of the regulations pertaining to PMBs were published in 2000. Since 1 January 2000, the gazetted DTP’s were officially referred to as the Prescribed Minimum Benefits (PMBs) that each registered medical scheme was legislated to offer as part of each benefit option. The PMBs are defined in Annexure A of the Regulations to the Medical Schemes Act (Act 131 of 1998), hereafter referred to as the ‘Act’. The primary objective of the Act was the expansion of coverage in terms of both the number of members and the benefits they enjoy. This objective was explicitly achieved by the combination of mandatory open enrolment, community rating and the PMB’s. While PMB’s and open enrolment would raise the costs of cover for younger individuals, the designers of the Act hoped that the collective efforts of opening up schemes to a large low-income market, creating larger risk pools and applying pressure to compete on the basis of efficiency, would bring down the costs of cover for most members (Doherty and McLeod, 2002).

Despite the advantageous intentions of the Act in terms of initiating an environment of social solidarity, equity and expanded benefit coverage, major concerns of the new legislation was equity of access to medical scheme membership and cross-subsidisation between the elderly and young and between low and high earners (Permain, 2000). One of the major changes to the Act affecting the cost structure of medical schemes was cited as the fact that schemes must pay for a wider range of treatments (PMB’s) and ailments including AIDS (Permain, 2000). This concern was, however, raised before the introduction of the Prescribed Minimum Benefits.

Nonetheless, the prescribed minimum benefits were legislated and refer to the benefits in section 29 (1) (o) of the Act. These benefits consist of the provision of the diagnosis, treatment and care costs of 270 diagnostic treatment pairs, including any emergency medical condition. The Act also cites the objectives of specifying a set of Prescribed Minimum Benefits within these regulations are two-fold (Medical Scheme Act, 1998):

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of private and public health care resources.

In addition, in terms of Regulation 8, every medical scheme is required to provide certain minimum benefits. This means that any benefit option which is offered by a medical scheme must reimburse in full, without co-payments or the use of deductibles, the diagnostic, treatment and care costs of the PMB conditions specified in Annexure A to the Regulations in at least one provider or provider network which must at all times include the public hospital system. The Act also enabled medical schemes and public hospitals to have an agreement for the provision of the minimum benefits to its members with payment for public hospitalisation as well as other tools to manage the costs in respect of PMBs, such as the use of designated service providers and formularies. Despite these measures, curbing the high costs of medical scheme cover in South Africa is still an important issue for the Council of Medical Schemes (Report of the Registrar of Medical Schemes, 2003).
Following the implementation of the core benefit package, in a possible attempt to contain claim costs and “cream-skim” the young and healthy lives, medical schemes significantly slashed the coverage of medicine for chronic conditions. (Mcleod, National Health Insurance Policy Brief 10). This contradicted the aim of reducing “dumping” by the private sector.

Consequently, in 2003 the Department of Health legislated changes to the PMB’s extending cover to include the cost of diagnosis, treatment and medication for conditions specified on the Chronic Disease List (CDL) further specifying that the cost must be covered in full by medical schemes. The CDL list defines 25 chronic conditions considered to be life-threatening, which are explicitly regulated in order to prevent late treatment and complications. (Mcleod, National Health Insurance Policy Brief 10).

As expected, the immediate and continuing fear of the healthcare industry is that the PMB legislation for these chronic conditions results in an increase in costs to the schemes. In addition, as the PMBs are funded by scheme members, such cost escalation ultimately creates hardship for those it is trying to benefit. Thus it is imperative that the costs relating to the PMBs are carefully managed and effective mechanisms for cross subsidization developed. (Taylor et al, 2007)

As a result, the concept of a Risk Equalisation Fund (REF) was considered where all medical schemes should participate in a fund that receives money from schemes and redistributes according to the risk profile of each scheme relative to the industry average. The REF would cover only the costs of the PMBs and was earmarked for implementation in January 2007. This fund would essential allow cross-subsidization to be effective across the industry rather than on a scheme or even option level and reduce the risk of high risk schemes/options being unable to provide the same minimum benefits as low risk schemes/options at an affordable level (SACINHI, 1995).

In addition, in order to ensure equity of access to treatment the Council for Medical Schemes developed algorithms for each PMB condition with a foundation of evidence based medicine and affordability. The intentions of these algorithms are to specify the minimum management criteria for each PMB condition. The algorithms address medication in full, but there is limited detail on consultations, investigations and procedures for diagnosis and medical management. (Taylor et al, 2007)

3. LOOKING FORWARD

Looking back there are many possible objectives for defining an essential minimum benefit package. These objectives span the obvious micro objectives of improving individual health outcomes as well as preventing catastrophic losses due to serious illness events to the macro outcomes of reducing reliance on public health services, controlling cost-escalation, ensuring adequate risk pooling and facilitating participatory democracy in health care spending. (Soderlund and Peprah, 1998)

Review of the developments in South Africa’s healthcare system to date indicate that the reform direction and approach developed and proposed in the 1995 National Health Insurance (NHI) Paper remains a valid point of departure for ongoing reform of the healthcare sector. Based on government objectives and the ruling party’s intentions, this requires that South Africa ultimately move toward a NHI system over time that integrates the public sector and private medical schemes within the context of a universal contributory system. (Taylor, 2002)

The National Health Insurance Policy Paper released by the South African government in August 2011 defines National Health Insurance as an innovative system of healthcare financing with far reaching consequences on the health of South Africans. The NHI is intended to bring about reform that will improve service provision. It will promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status.
However, the implementation of National Health Insurance will be done in a phased and systematic manner at both the national and sub-national levels. The migration period will occur in three phases over the fourteen years of implementation. (*NHI Green Paper, 2011*)

Post democracy, the SHI proposals made in 1997 went hand-in-hand with regulatory changes for the medical schemes industry through the Medical Schemes Act of 1998. This dual approach was considered necessary by the Department of Health as officials anticipated that the time taken to implement a SHI system would be considerable and it was judged feasible to improve regulation of medical schemes in the short-term. (*Taylor, 2002*) Taking into account the significant time horizon until NHI is implemented, begs the questions of whether the current industry concerns around PMBs and sustainability will be addressed in the short term whilst still addressing the feasibility of the long term migration of PMBs into a National Health Insurance system. Thus, in the spirit of looking forward, the section to follow details some of the concerns with the current PMB package as well as the measures implemented to control these concerns in the short term followed by the long term considerations of PMBs as a minimum package for the NHI system.

During 2006, the Board of Healthcare Funders (BHF) noted numerous concerns regarding the current PMB package.

- Questions regarding the applicability of using the State of Oregon DTPs as the template for PMBs in the private SA health sector. It is argued that the original principles and methodology were based on the State of Oregon priorities, burden of disease and demographics whilst the South African demographic, burden of disease and health priorities are evidently different to that of the State of Oregon and the benefits should reflect this.

- A significant driving factor for the introduction of PMBs was the provision of “catastrophic” health cover. This raises two concerns, firstly whether the definition of catastrophic is consistent across the private sector. Secondly, it could be argued that catastrophic healthcare cover has its origin in the commercial insurance as the cover is based on high cost items, usually less frequent conditions and health events. The inclusion of non-catastrophic events i.e. frequent high cost events nullifies this objective and as such can be seen as a driving factor for uncontrolled cost escalation.

- In the public sector, the Primary Health Care Package (PHCP) is expressed in terms of norms and standards and is aimed at strengthening primary care services whilst PMB is predominantly referred care (catastrophic cover) focused i.e. curative care. This represents a dichotomy in policy recommendation that needs to be resolved in the light of the health reform developments.

- The current PMBs are disease and severity based. In addition, although prevalence rates, disease burden, cost efficiency and disease severity were mentioned as criteria that contributed to disease selection, the rationale for the selection of one disease over another remains obscure. Non-inclusion of care within an explicitly defined regulated minimum package implies that patients with such conditions must either self-fund chronic care for these diseases or pre-fund it by joining more comprehensive, and therefore expensive, medical scheme options. Only few patients can afford either and hence many are excluded altogether from receiving necessary ambulatory care for non-statutory chronic conditions. They are thus discriminated against simply on the basis of their underlying disease (*Taylor et al, 2007*). As a result, this benefit cannot be considered equitable, nor can healthcare provision be considered to be accessible.

- The DTPs are not explicit i.e. there are no inclusion and exclusion criteria, no definition for “life threatening”, and no minimum non medicinal benefit entitlement for the CDLs implying that each scheme will compile its own detailed treatment protocols, based on affordability and evidence-based medicine for consultations, procedures and investigations in full (*Taylor et al, 2007*). As such these structural inadequacies lead to different interpretations of entitlement, conflict, and application of benefit which cannot be considered equitable, nor can healthcare provision be considered to be accessible.
• In addition, except for the CDLs, the provision of an ICD10 list by the Regulator, merely acts as a trigger for a potential DTP benefit, severity must be confirmed where applicable by the medical scheme. In addition, the onus is on providers to submit accurate and specific ICD10 codes to facilitate the identification of PMB benefits. (Code of PMB Conduct, 2008). According to Regulation 8, which requires PMBs to be paid in full, the current disconnect between DTPs and ICD10 codes creates a significant opportunity for providers to upcode claims.

• The National Health Act of 2003 provided a framework for our health system in line with the Constitution and other applicable health laws that were published, with the aim of achieving uniformity in respect of health services across the country with specific focus placed on the promotion and protection of the rights of vulnerable groups such as woman, children, the elderly and those with disabilities. The current PMB is inadequate for childhood illnesses and health needs with benefits that are heavily weighted towards adult health problems which to some extent defeats the objective of eliminating “dumping” in the public sector.

Recently, a contentious issue in the private sector has been the interpretation of Regulation 8 of the Act, which states that “any benefit option offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the Prescribed Minimum Benefits”. A legal battle ensued between the Council of Medical Scheme and the Board of Healthcare Funders, a representative body for medical schemes and administrators, who proposed that Regulation 8 be interpreted to mean that schemes are actually required to pay for PMBs at scheme tariffs. However the court finalised this matter and all PMB benefits are legally payable at cost or invoice price and it is unacceptable or unlawful for beneficiaries to incur and be held liable for co-payments in respect of such treatment.

Many are still of the opinion that, the provision for payment in full will continue to prove to be a dilemma for many medical schemes and threatens their sustainability, as in the absence of a National Health Reference Price List (NHRPL), providers will continue to interpret this Regulation as a blank cheque and, in some instances, to charge exorbitant rates for PMB treatment. The uncertainty of PMB treatment may potentially result in medical schemes having to consider huge contribution increases or limits to certain benefits in order to make provision for the potential high financial risks that PMB claims pose.

Pharmaceuticals and healthcare technologies continue to prove to be an integral component of any health care delivery system. Based on the expense of drugs as well as the need for prolonged use, the costs associated with various drugs can vary considerable. As such, to control costs a medical scheme can implement a formulary for the relevant PMB condition if the formulary contains a drug that can successfully treat the patient's condition. However, it is required that such formulary or restricted list must be developed on the basis of evidence-based medicine taking into account considerations of cost effectiveness and affordability, and must make provision for appropriate substitution of drugs where a formulary drug has been ineffective. This raises several questions to the application of PMBs around the responsibility in the designing of guidelines and determination of appropriate formularies and whether importantly it is in accordance with current clinical guidelines and the most important aspect to consider is it the best available treatment for the individual. (Rayner, 2004)

To this extent, the Department of Health recognised that there is constant change in medical practice and available medical technology. Consequently, the Department proposed to monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. As per the Act, this would include a review at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, provincial health departments and consumer representatives. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of—

(i) inconsistencies or flaws in the current regulations;
(ii) the cost-effectiveness of health technologies or interventions;  
(iii) consistency with developments in health policy; and  
(iv) the impact on medical scheme viability and its affordability to Members.

Overall, the current PMB package is disease-based with an emphasis on the diagnosis and treatment of conditions whose severity may necessitate hospitalisation and where treatment is regarded as non-discretionary. In addition, from the original package that was confined to delivery of hospital-based care in public hospitals, the current package has been expanded to make substantial provision for associated and additional ambulatory and primary care, as well as for service delivery in private facilities. These changes are most likely a function of the changing goalposts of health care reform, evolving objectives of the PMBs, different interpretation and prioritisation of such objectives, as well as efforts by the regulator to counter negative responses by the industry to PMBs. (Taylor et al, 2007).

In addition, there is also very little convincing evidence to date that PMBs have achieved meaningful efficiencies in the allocation of private resources. Despite their having been some increased use of formularies and protocols to promote more cost-effective use of medicines both claims and administration costs have continued to increase. From the above, there are theoretical reasons to believe that PMBs could be positive contributors, and despite the theoretical good intentions of the PMBs, their subsequent development has resulted in a package that is deemed to be inequitable and as such contrary to the key objective of social health reform which is aimed at enhancing fairness in the provision of health services. (Taylor et al, 2007).

Given the uncertainty surrounding the role of medical scheme in the future, the short term sustainability of the provision of PMB’s relies on the clear definition of these PMBs and their associated algorithms. The benefit entitlements should be comprehensive, with standardised entry and verification criteria together with defined baskets of services and goods associated with this entitlement, formularies, as well as treatment protocols. In developing these entitlements, evidence-based medicine, cost effectiveness, administrative simplicity and common conditions as well as conditions which are subject to high member abuse should be prioritized. Such protocol driven benefit definitions will ensure certainty concerning member entitlements, the ability of schemes to fairly and reasonably manage their liabilities in respect of members, the elimination of inefficient provider or patient conduct and ensure that PMB regulations do not result in the unfair exclusion of defined vulnerable groups. (RETAP, 2009)

There are many conflicting arguments as to the appropriateness of a minimum package of benefits. Some argue that the notion of a basic set of health care benefits for all is appealing; however the single core package approach is by no means the solution to all healthcare problems. It is understood that for some interventions there is likely to be agreement that everyone should have access to these, irrespective of their ability to pay but the scope of services decided is likely to be very limited. Where minimum benefits are mandated in legal terms, consideration must be given to their potential financial impact and the implications thereof. For example, as the scope and level of care of minimum benefits are increased, the funding of non-core services is likely to decrease even further (Taylor et al, 2007). Is this a suitable model to achieve equity and accessibility allowing for the myriad of challenges faced by the national health system, among these being the worsening quadruple burden of disease and shortage of key human resources? The counter argument advocates that apart from serving as a priority-setting tool from the point of view of management and financial allocation, the notion of a package of minimum interventions is a means of empowering people by making entitlements explicit. In addition, defining the package and linking it to the certification of providers generates the conditions for the system to actually deliver the specific interventions necessary to produce the maximum health gains for a given level of resources (Frenk et al, 2006). Notwithstanding the above arguments, the burning question is whether PMBs in its current form would be an appropriate minimum benefit package or platform for such social health reform.
Based on the NHI Green Paper issued in August 2011, the NHI is envisaged to achieve the following key objectives:

- To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not
- To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund
- To procure services on behalf of the entire population and efficiently mobilize and control key financial resources
- To strengthen the under-resourced and strained public sector so as to improve health systems performance

The NHI Green paper does not explicitly define what benefits will be available under the National Health Insurance; however it does mention that the provision of a comprehensive benefit package of care under National Health Insurance will be fair and rational. Furthermore, it states that a comprehensive healthcare package will include benefits aimed at prevention of diseases, promotion of health, treatment of diseases when prevention has failed as well as rehabilitative services. The section below provides a brief explanation of the minimum packages and the benefit entitlement in various countries.

The Dutch health system makes use of an individual mandate whereby every citizen is required by law to purchase basic health insurance from a private insurer. The insurers are then required to offer an essential benefit package using a community rating approach where premiums are income rated. This benefit package is comprehensive and includes primary care by general practitioners as well as specialised in- and out-hospital care. Furthermore pharmaceuticals included in the package are subject to a list of approved pharmaceuticals. Insurers are allowed to make use of selected providers (similar to South African DSP’s) however in practice almost all providers are accessible. It is envisioned that insurers will make more use of selected provider networks as more negotiation over service providers’ prices for different treatment is permitted. The resultant system of private providers with regulatory oversight system has worked well in the Netherlands with the establishment of a risk equalisation fund forcing insurers to compete on an efficiency and quality of service basis as opposed to a risk selection basis. (Rutten et al, 2009)

Switzerland has a health system with concomitant minimum benefits which are very similar to the Netherlands. The benefits package includes general practitioner services and specialist hospital care with exclusions for dental care and restricted long term care. There is also an individual mandate system with individuals compelled to purchase basic health insurance from insurers, however the insurers providing the basic insurance products are required to be non-profit legal entities. Furthermore the Swiss minimum benefit package includes far larger co-payment requirements than under the Dutch system where cost sharing is kept low. Another major difference is that the Swiss minimum benefit packages premiums are set at a geographical level (where the geographical regions are referred to as “cantons”) which leads to marked variability in premium sizes between “cantons”. A criticism of the Swiss model is that the formula defining the contributions to the risk equalisation fund empowers insurers to compete on risk selection (instead of just efficiency and quality of service), which contributes to wide premium variability. The Swiss case demonstrates the importance of a well-functioning risk equalisation fund in focussing competition on efficiency and quality of service. (Rutten et al, 2009)

Mexico achieved universal coverage upon introduction of its System of Social Protection in Health (SSPH) in 2004 which extended coverage to 50% of the population which were previously not covered under the social security system. The insurance element of the system, the “Seguro Popular”, established a minimum benefit package which included both primary and secondary health interventions. These secondary interventions were restricted to ambulatory and hospital care for basic specialities (basic specialities are defined as “internal medicine, general surgery, obstetrics and gynaecology, paediatrics, and geriatrics” (Frenk et al, 2006). 249 interventions are explicitly defined which cover an estimated 95% of causes hospital admissions. A further 17 tertiary interventions are defined which cover more complex and costly health benefits. The benefits are provided mostly by public providers. (Frenk et al, 2006).
In 2001 Thailand embarked on an ambitious health reform through the Universal Coverage Scheme (UCS) which extended the insured population from 40% of the population to 95% of the population over the period 2001 – 2004. (Hughes and Leethongdee, 2012). The basic benefit package underlying the UCS is comprehensive covering “outpatient, inpatient and accident and emergency services; dental and other high-cost care; and diagnostics, special investigations, medicines (no fewer than are included in the National List of Essential Medicines) and medical supplies”. (HISRO, 2012). The package also includes elements of clinically based preventative care and health promotion activities. The initial package was chosen to be consistent with existing health insurance scheme basic benefit packages, however over time a health technology assessment informed subsequent additions or removals of interventions from the benefit package. (HISRO, 2012)

Based on international experience, it is evident that the design of essential health care packages is aimed at facilitating particular aspects of health care reform. Given the different priorities identified for the public and private delivery systems as well as the different objectives of NHI compared to that of the PMB package, it is unrealistic to expect the PMB package to achieve these contrasting objectives. Many argue that in the long term, the key components to ensure the sustainability of a minimum benefit package, whether it be provided through a NHI system or whether PMBs continue to exist in its current form relies on achieving:

- **Sufficient Risk Pooling:**
  The South African risk pool is highly fragmented. The public sector is faced with an increasing population, both low-income and indigent, while the private sector population is not increasing. In addition, the public sector is facing a deteriorating burden of disease as a result of HIV/AIDS as well as increasing levels of diseases of poverty whilst the private sector is an aging population suffering from non-communicable lifestyle diseases. To provide a successful insurance mechanism meeting the essential needs of a diverse population relies on extensive risk pooling through the use of a combination of instruments. These would include the tax system, the creation of risk equalisation mechanisms Government mandates, and the reinforcement of community rating. (Department of Health, 2002)

- **Consistent Benefit Definitions:**
  Defining essential/minimum care is effectively an exercise in the prioritisation of limited funds. As mentioned earlier, there are no simple technical solutions that decide how best to allocate scarce resources in an equitable manner and such decisions are often rooted in diverse (and often conflicting) values and value systems that range from scientific and economic to social and moral ones.

In defining core benefits, a process that underpins fair decision-making must be adhered to. This would need to balance (i) relevance – rationales for priority-setting decisions must be based on principles that ‘fair-minded’ people can agree to be relevant in the context; and (ii) publicity – priority-setting decisions and their rationales must be publicly accessible with the overarching objective of maximising cost-efficiency of health care services (Taylor et al, 2007). In addition, the benefit definitions should pay careful attention to the incentives generated for providers and remove the possibility of perverse provider abuse through balancing healthcare objectives with the need for operational efficiency.

4. **CONCLUSION:**

Despite the immense challenges faced by many low-income South Africans in accessing quality care, it is reassuring to see the urgency with which the South African government is addressing the many problems facing the sector through the intended implementation of an NHI system. Although the finer details of the proposed NHI framework are not publicly available, the principles of solidarity and equity are central to achieving the objectives as set out in the NHI green paper of August 2011. These principles ensure that no individual is unfairly discriminated against based on their ability to pay or state of health which in short encompasses ‘fairness’. However, the NHI green paper still leaves an important question unanswered as
to how the funding and benefits of healthcare will be distributed within the confines of the available “resource wallet” and whether a minimum benefit package will be the vehicle in which equity is achieved.

5. FURTHER WORK:

We propose that the following research be performed to supplement the work performed above. This includes:

- Analysis of current cost of PMB’s per disease and as a proportion of total medical scheme expenditure.
- Analysis and research to understand the impact of the revised PMB definitions and compare these costs to the current existing standards of care. This is with reference to the circular dated 07 March 2012, “Methodology to assess the cost impact of PMB definitions”.
- Review and assessment of international best practice and global developments.
- Current government and regulatory developments, particularly with reference to health reform (e.g. NHI) and the role of a minimum benefit package within the guidelines and objectives of the system.
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