Innovative Medicines South Africa

National Health Insurance Policy Brief 10

Defining the Benefit Package

The purpose of this series of policy briefs on National Health Insurance (NHI) and the related IMSA web-site is to put in the public domain material and evidence that will progress the technical work of developing a National Health Insurance system in South Africa. This includes tools for costing NHI and evidence on where savings could be achieved in moving to a future mandatory system with universal coverage.

This policy brief deals with defining the package of health benefits for a mandatory insurance system. It reviews the history of work done in South Africa since 1994 on this issue and suggests a model for thinking about the interaction between benefit design, affordability and delivery efficiency.

1. Legal and Constitutional Imperatives

In a document prepared by the Council for Medical Schemes for the Prescribed Minimum Benefit (PMB) review process[1], the relationship of the minimum package to legislation and the Constitution is outlined. "Section 3(1) of the National Health Act places the responsibility on the Minister of Health to, within the limits of available resources, develop the policies and measures which will protect, promote, improve, and maintain the health of the population. The Act specifically requires the Minister to ensure the provision of essential health services, which must include at least primary healthcare services, to the population."

"Section 27 of the Constitution states that everyone has the right to access healthcare services, inclusive of reproductive healthcare, and that no one may be refused emergency medical treatment. The section requires of the State to take reasonable legislative and other measures within the grasp of its resources to progressively realise these rights. In addition, section 28 of the Constitution specifies that children have the right to access basic healthcare services."

"In accordance with section 36, these rights may be limited in terms of law of general application 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. It is therefore required that this PMB review must be aligned with the progressive realisation of the right to healthcare of the population."

In the South African Health Review of 1998[2] a detailed account is given of a significant Constitutional Court decision in the matter of Soobramoney v Minister of Health, KwaZulu-Natal. "The appellant was a 41-year-old diabetic suffering from ischaemic heart disease, cerebrovascular disease and irreversible chronic renal failure. It was common knowledge that his life could be prolonged by regular renal dialysis. He did not have sufficient resources to continue renal dialysis in a private health facility, and so he sought dialysis treatment from Addington State Hospital in Durban."

"However, due to a shortage of resources, the hospital could only provide dialysis to a limited number of patients. The hospital therefore developed a set of guidelines to determine eligibility for the dialysis programme. The appellant, who suffered from other cardiac and cerebrovascular complications, was not eligible for the dialysis programme in terms of these criteria and so was denied treatment by the hospital. In July 1997, the appellant made an urgent application to the Durban and Coast Local Division of the High Court for an order directing Addington Hospital to provide him with ongoing dialysis treatment. The application was dismissed, and the matter was brought on appeal to the Constitutional Court."....

"Sachs J ... held the opinion that "the rationing of access to life-prolonging resources is . . . integral to, rather than incompatible with, a human rights approach to health care." As a consequence, 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."

"This decision of the Constitutional Court is of considerable importance for health service delivery in South Africa for a number of reasons. First, it limits the Constitutional guarantee against refusal of emergency medical treatment to immediately necessary and available remedial treatment in respect of dramatic, sudden events which are of a passing nature in terms of time. Secondly, the Court accepted that 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. Thirdly, the Court expressed its deference to executive authority by declaring itself slow to interfere with rational decisions taken by competent health authorities regarding allocation of resources. The Court implied, however, that there might be grounds for challenge of executive policies if such policies were unreasonable or if they were not applied fairly and rationally."

Mark Heywood, the Executive Director of the AIDS Law Project, has in more recent years written extensively on the issue of the relationship between human rights and health[3]. The interested reader is referred to his concise and very helpful work.

2. Public Sector Standards and Private Sector Minimum Benefits

The ANC Health Plan of 1994[4] said: "Resources will be rationally and effectively used, and priority will be given to the most vulnerable groups, and to the eradication, prevention and control of major diseases. Mechanisms that will integrate traditional and other complementary health practitioners will be investigated."

"Priorities for the National Health Service were outlined as follows: "Free health care will be provided 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 will also be provided free of charge in the public sector." ...

"The principal priorities are maternal and child health, nutrition, the control of communicable diseases, and violence. Special attention will be given to vulnerable groups and this will include the development of programmes for women's health, occupational health, rural areas, mental health, chronic illness, rehabilitation, and the elderly. In addition, the health priorities will also include health promotion, drugs policy, emergency care, substance abuse, environmental health and oral health. A special emphasis in all health programmes and activities at all levels in the system will be given to health promotion."...

"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." [Note that NHI was proposed as an alternative for the medical schemes sector and was never envisaged as a replacement for the entire National Health Service (NHS). Discussion of NHI occupies one page out of 77 pages of outlining the NHS]. Under the NHI, should it prove feasible, "The basic package of care to be covered by the NHI should be statutorily defined."

The Taylor Committee of 2002[5] reported on minimum benefits and there was a substantial submission by the Department of Health[6] that dealt with the relationship between minimum benefits under NHI and the norms and standards of the NHS. Taylor concluded "It is the recommendation of this Report that in the medium- to long-term South Africa move toward a National Health Insurance system compatible with multiple funds and a public sector contributory environment as defined in the

1995 NHI Committee Report. Initially the environment should continue to be strictly differentiated between a private contributory environment and a general tax funded public sector environment. Over time this strict differentiation can diminish with a broader contributory environment emerging, replacing general taxes as a revenue source. The ultimate elimination of general taxes as a key revenue source is unlikely for a fairly long time, and may in fact not even be desirable"…

"The public and private sectors define their benefit entitlements differently. The public sector establishes services which provide comprehensive cover for an undefined range of conditions. The conditions covered may be qualified through the use of protocols. The regulatory environment for private sector has moved toward the creation of positive lists of services for which cover is provided. The Medical Schemes Act No. 131 of 1998 now specifies a positive list of conditions and treatments which must be covered by schemes [the PMBs[a]].

"Government has to move toward defining what it regards as basic essential services which everyone must be covered for. Although these may be defined differently between the public and private sectors, there must be convergence on the approaches adopted in the two environments. Ultimately both the public and private sectors need to provide a *minimum core set of services*. Within medical schemes these would be regulated as *prescribed minimum benefits*. Within the public sector a similar process would occur and be framed as *minimum norms and standards*."

While the envisaged formal process of defining the minimum core set of services has not happened, the benefits provided for HIV/AIDS give the clearest examples of the congruency between PMBs and norms and standards. In a paper in 2003 arguing for PMBs in medical schemes to include anti-retroviral treatment, McLeod, Achmat & Stein[7] described the history of minimum benefits in South Africa and provided details of the evolving coverage for HIV/AIDS.

"The PMBs for HIV/AIDS in force from 1 January 2000 included only the treatment and management of opportunistic infections and localised malignancies." In November 2002 the Minister of Health called for "comment on the formulation of the PMBs and on the politically difficult issue of the inclusion of ARV therapy in the PMB definition. Given the need to ensure that minimum services are aligned in the public and private sectors, this raised politically sensitive issues."

While "a number of organisations lobbied for the inclusion of ARV therapy in the definition of PMBs" the regulations promulgated only added cover for "voluntary counselling and testing; treatment for tuberculosis, sexually transmitted infections and opportunistic infections, as well as pain management in palliative care. Significantly, the PMBs are extended to include the prevention of mother-to-child transmission (MTCT) of HIV and post-exposure prophylaxis following sexual assault." These had recently been adopted for public sector treatment following a successful campaign by the Treatment Action Campaign (TAC)[8].

"TAC had from the outset campaigned for a national ARV treatment programme for adults and children. Until August 2003, this met with fierce resistance from the South African Government – a resistance which only buckled because of the pressure of TAC". "But after 2004, South Africa established the fastest growing ARV treatment programme in the world."

It was not until Government accepted the need for ARV therapy in the public sector that PMBs were also extended to include ARVs. This was done in regulations published on 3 December 2004 that came into effect from 1 January 2005. The addition to the wording for HIV was: "Medical management and medication, including the provision of anti-retroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector". In subsequent years the preferred protocols for ARV therapy in the private sector[9] have often been ahead of those in the public sector. The minimum requirement for medical scheme members remains treatment as allowed for in the national guidelines applicable in the public sector.

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[a] The Prescribed Minimum Benefit package is a list of some 270 diagnosis-treatment pairs (PMB-DTP) primarily offered in hospital (introduced 1 January 2000); all emergency medical conditions (clarified from 1 January 2003); diagnosis, treatment and medicine according to therapeutic algorithms for 25 defined chronic conditions on the Chronic Disease List (PMB-CDL) (introduced 1 January 2004).

3. Prescribed Minimum Benefits in Medical Schemes

The graphs below illustrate that PMBs account for 52.7% of total benefits. In-Hospital benefits account for 54.2% of total benefits. However the mix is very different by age band and gender, with Under 1, women in the maternity years and the elderly having the highest proportion of PMBs in their total healthcare expenditure.

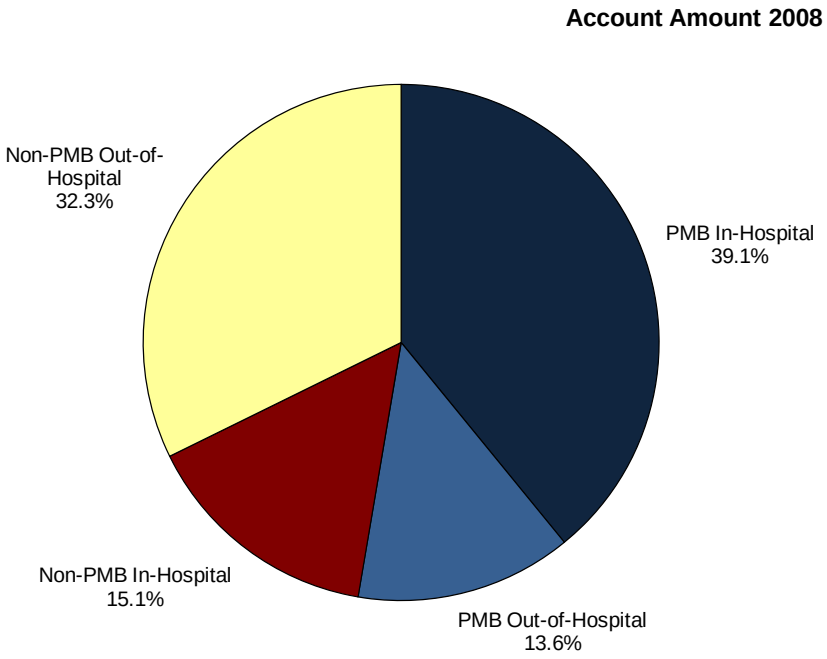

Figure 1: PMB and Hospital Status of Benefits in Medscheme in 2008

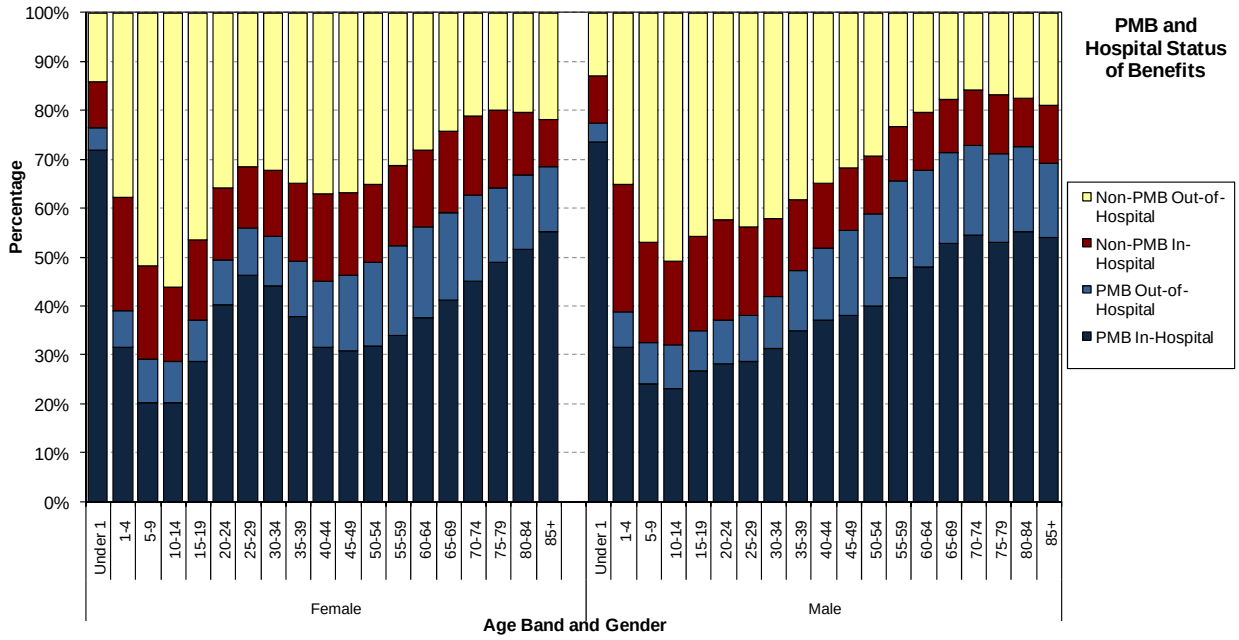

Figure 2: PMB and Hospital Status of Benefits by Age and Gender in Medscheme in 2008

The graphs above illustrate one of the fundamental dilemmas in PMB design in South Africa. At present PMBs cover only 52.7% of total health expenditure. The balance is left to each medical scheme to design, include or exclude as the trustees determine. Ideally, the minimum package should cover more of health expenditure but this runs up against the affordability of the package for low income workers. This interplay between design and affordability is taken up in the sections that follow.

4. Minimum Benefits in Other Countries

The initial work on the design of PMBs for medical schemes was done by Neil Söderlund, Solani Khosa and Enoch Peprah[10,11] of the Centre for Health Policy at the University of the Witwatersrand. The 1995 Committee of Inquiry into NHI[12] had recommended that there be mandatory insurance cover for a core package of hospital benefits for formally employed workers and their families.

Khosa, Söderlund & Peprah[10] considered the international experience with regard to minimum benefit design, considering the experience in the following settings in the 1980s and 1990s:

- **The State of Oregon in the United States of America**: in the late 1980s Oregon policy-makers were concerned that about 17 % of the population were not covered by any form of medical insurance and the intention was to extend Medicaid cover to this group. "The prioritisation task was entrusted to the Health Service Commission, which categorised benefits into "709 condition treatment pairs", and ranked them in terms of importance using cost-effectiveness analysis, information on the urgency of care, and public preference. Importantly, the priorities assigned had to be modified to exclude reference to whether or not full recovery was likely, since this was deemed to break laws protecting the disabled from discrimination." The final list was approved by the legislature became the basis for allocation of Medicaid resources in Oregon.

Oregon Rank	Oregon Category	Examples	Effectiveness Rank	Discretion Rank
1	Acute fatal—full recovery	Appendicectomy for acute appendicitis	1	1
2	Maternity care	Delivery and newborn care	1	1
3	Acute fatal—partial recovery	Surgery for intra-cerebral bleeding	2	1
4	*Preventive care for children*			
5	Non-urgent fatal—treatment improves life span or QoL	Hysterectomy for uterine cancer	2	2
6	Fertility control	Sterilization and contraception	1	4
7	Comfort care for terminally ill		3	1
8	*Preventive dental care*			
9	*Proven effective preventive care—adults*	*BP screening, cervical cancer screening*		
10	Acute non-fatal—treatment effective	Treatment of dental caries	1	3
11	Chronic non-fatal—one off treatment improves QoL	Hip replacement, cataract surgery	2	4
12	Acute non-fatal—treatment causes partial improvement	Surgery to repair knee ligaments	2	3
13	Chronic non-fatal—ongoing treatment improves QoL	Medication for sinusitis, migraine	3	4
14	Acute non-fatal—treatment symptomatic only	Treatment for acute viral infections	3	3
15	Infertility services	IVF, tubal microsurgery, Clomid	2	4
16	*Less effective preventive care—adults*	*Sigmoidoscopy for under 40s.*		
17	Treatment for conditions with minimal symptoms	Cosmetic surgery	4	4

Figure 3: The Oregon Categories with Effectiveness and Discretion[13]

- **The National Health Care System of the United Kingdom (NHS)**: "has offered tax-funded care free of charge to all residents since 1948. Due to resource constraints, some rationing of hospital care occurs, though not explicitly. The responsibility for prioritising and rationing the level of hospital care is devolved to local health authorities. Most health authorities have not developed explicit lists of included and excluded services, and instead tend to review requests for certain types of care on a case by case basis. Long queues for non-urgent treatment have become the main method of implicitly prioritising emergency care. This decentralised approach to prioritising implies that residents of different health districts might be entitled to different hospital benefits"[b].
- **Sweden**: "priority-setting revolves around guidelines and principles set by national and county health committees to inform decision-making. Treatment of life-threatening diseases is ranked the highest, with self-care disorders being at the bottom of the list".
- **The Netherlands**: a "core" package of health care services was identified "covering about 90% of pre-existing health care benefits. Based on the Dunning Committee's recommendations, interventions were included if it could be demonstrated that they were necessary, effective, efficient and primarily a state, rather than an individual, responsibility."
- **New Zealand**: "the government task team charged with the responsibility of defining a core benefit package of hospital services found the process more politically fraught than they had originally envisaged. They consequently opted for a set of guidelines for health authorities around prioritising certain types of care. These have been revised annually since the first report in 1992 and, with time, have come to more closely resemble a true core package."
- **Developing countries**: "In the 1993 World Development Report, the World Bank strongly advocated that countries define essential health care services and give these priority in terms of public funding. The approach recommends prioritising treatment of diseases where the total burden of disease, measured in terms of disability-adjusted life-years lost, is high, and where cost-effective interventions against the disease exist. [These interventions] tend to be preventive or promotive, and [this] approach consequently does not deal much with hospital interventions. Some twelve developing countries have attempted to define an essential package of health services using [this] approach, although most are at an early stage".
- **Mexico**: "the most noteworthy attempt is that of prioritising government health services for the poor in Mexico. The design of Mexico's health package was guided by the relative importance of health problems, efficacy and cost of prevention, and availability of resources. Interventions selected for inclusion were mainly of a public health nature, and relatively little attention was paid to what type of services hospitals should deliver."

The authors found that "Developed country experiences indicate that priority-setting for public health care spending is a complex exercise, requiring compromises and strong political commitment for success. In most developed countries, explicit lists of included and excluded interventions have been avoided. There has also been extensive public and professional consultation in all cases. The few developing country attempts at developing essential health care packages have tended to be more technocratic, rarely involving extensive consultation and, no doubt because of more limited resources, have produced lists of primarily public health and basic primary care interventions."

A review of minimum benefit design in other countries was produced by Discovery Health in 2005[13], using the Monitor Group Company's Global Review of Health Systems database. "This review looked at a selected group of countries, Argentina, Brazil, Chile, Mexico and Netherlands with [a Basic Benefit Package (BBP)], that were similarly ranked to South Africa using 5 categories[c] and more than 150 variables[d]. "In addition four other countries, Australia, Switzerland, USA and Taiwan were included as examples of Health systems with Basic Benefit Packages."

[b] This difference in entitlement by place of residence has become known in the UK as the "post-code lottery" and the issue continues to cause public concern.
[c] Categories were demand; supply; funding; regulation and outcomes.
[d] Variables included population, morbidity and level of wealth; medical workforce and facilities; public and private health system; life expectance, mortality and prevention.

In recent years there has been significant work on the question of designing packages and setting priorities in health. In the Health Policy journal[e] alone, there are 155 papers with the keywords "priority setting" and 135 on "rationing". An example is a March 2010 paper by Baltussen, Youngkonga, Paolucci & Niessenon using multi-criteria decision analysis to prioritize interventions[14]. The paper covers seven low- and middle-income settings and concludes that methodologies like this "can have far-reaching and constructive influences on policy formulation". The authors have offered to replicate their study in South Africa during 2010.

5. The Initial Design of PMBs for Medical Schemes

Khosa, Söderlund & Peprah[10] argued that the South African problem was different in two key respects. Firstly, only a package covering hospital care was envisaged. Importantly, "Preventive and promotive interventions, and primary care would be funded through tax finance, and be free to all residents. In this sense, the highest priority interventions have already been defined and made accessible to all."

"Secondly, the South African 'core package' differs in that it refers to the nature of insurance cover that should be taken out by individuals or companies, and not to what state providers or public funds should cover. ... under the ambit of an employer/employee mandate the core benefit package will cover less than half of the population."

Other limited attempts at setting healthcare priorities in South Africa were considered. These included 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, but explicitly excluded the definition of a core package of such services. Instead, normative target utilisation rates were set for all services currently offered." The **Medical Association of South Africa**[f] had made recommendations on multiple core benefit package in its submission to the 1995 NHI committee. A final example was the "**Essential National Health Research** (ENHR) prioritisation exercise. This aimed to determine what the important areas of health research were in South Africa. It took a particularly disease-focussed approach, ..., but did not look particularly at the intervention, or service aspect of diseases considered to be of high priority."

Söderlund & Peprah[11] proceeded to do the empirical work on the design of an essential package of hospital benefits for medical schemes.

"There may be many possible objectives for defining an essential benefit package. These include improving health service efficiency, preventing catastrophic losses due to illness events, reducing reliance on public health services, harnessing cost-escalation, ensuring risk pooling and facilitating participatory democracy in health care spending. ... the main objective of the proposed employee/employer mandate for a minimum package appears to be to prevent free use of public services by those who could afford low cost health insurance, but not necessarily the costs of care at point of use. There is thus, by implication, an assumption of market failure in the low-cost health insurance market. The main reason for this is that low cost care is unintentionally provided as a free good because public hospitals cannot turn away those in urgent need of care. Collecting fees after the event from those who can afford to pay has proven extremely difficult. We thus assumed that the main objective of the core package was a "minimum insurance" one, designed to prevent public hospitals from having to fulfil this role."

"The criteria used to define the essential package were, in order of priority:

- the extent to which there was another responsible party who should pay for treatment;
- the urgency (or degree of discretion) of required treatment; and
- the cost-effectiveness of treatment."

[e] http://www.journals.elsevierhealth.com/periodicals/heap/home

[f] SAMA, the **South African Medical Association**, was established on 21 May 1998 from a merger between the MASA and the Progressive Doctors Group.

"In order to define the essential package, a list of approximately 750 diagnosis-treatment pairs, describing almost all possible health care interventions, was adapted from the Oregon Health Plan Administration benefit descriptions. Primary care and chronic psychiatric/infectious disease treatments were excluded at the outset because the public good nature of these interventions suggested that they would be more appropriately funded from tax revenue, rather than insurance." Importantly, looking back at the Oregon categories of Figure 1, the following categories of interventions were not considered for inclusion:

"Primary care and chronic psychiatric/infectious disease treatments were excluded at the outset because the public good nature of these interventions suggested that they would be more appropriately funded from tax revenue, rather than insurance."

- Oregon rank 4: Preventive care for children
- Oregon rank 8: Preventive dental care
- Oregon rank 9: Proven effective preventive care – adults
- Oregon rank 16: Less effective preventive care – adults.

"The remaining 598 diagnosis-treatment pairs were allocated to discretion (or urgency), effectiveness and cost categories in order to facilitate the prioritisation process. Interventions were then ranked according to various mixes of these three criteria, as well as a 17 point priority scale developed by the Oregon Health Services Commission. The final "core package" adopted excluded all interventions that were either very high cost, ineffective, or for non-urgent, non-life-threatening conditions. It included all non-elective surgical procedures, elective surgical admissions for life-threatening conditions, maternity care, comfort care for the terminally ill, and virtually all medical admissions."

"In order to cost the essential benefit package(s) defined, hospital inpatient utilisation data were drawn from mine hospitals and private medical schemes (health insurers) in South Africa, and National Health Service (NHS) hospitals in the United Kingdom. Data were age-sex standardised to represent formally employed South Africans without current medical scheme cover." The technical work by Söderlund & Peprah remains a model of how to combine multiple datasets and researchers are urged to read the original paper[11] carefully before embarking on any pricing of PMBs.

The authors said: "The results presented in this paper are intended to inform both the regulatory reform of private medical scheme cover in South Africa, as well as the design of a future state health insurance product. Significant additional work is required, firstly at a technical level to assess the appropriateness of the prioritisation approach used here, and secondly, to take the debate around essential hospital benefits to broader political and public forums."

However there was little public debate at the time and the list of diagnosis-treatment pairs was gazetted almost without alteration in 1999. Of greatest concern for clarity of definition, while the original work by Söderlund & Peprah had contained both ICD-10 diagnosis codes and CPT-4 procedure codes, in the process of gazetting the list, all the codes were inexplicably left out.

The pricing of PMBs in 2002[15] argued for the clarification of coding of the PMB diagnosis-treatment pairs, saying: "'All stakeholders need an unambiguous definition of the PMB package. The Council for Medical Schemes is requested to reconsider the definition of PMBs in the Regulations and to include clear diagnosis and procedure codes in an amendment as soon as possible." This was done and a document was released in December 2004 containing ICD-10 codes for the PMB diagnosis-treatment pairs which was followed up by further iterations and improvements[16].

6. Subsequent Changes to PMBs for Medical Schemes

The PMBs gazetted in October 1999 came into effect for all medical scheme options from 1 January 2000. The early years of the re-implementation of minimum benefits[g] saw major changes to the way in which chronic medicine benefits were covered. Some schemes, in their haste to attempt to cream-skim only the young and healthy slashed coverage of medicine for chronic conditions.

[g] Minimum benefits had applied in medical schemes from the first Medical Schemes Act, No. 62 of 1967 until the Medical Schemes Amendment Act, No. 23 of 1993.

As a result, the Department of Health legislated changes to the definition of PMBs in late 2002, which became effective from 1 January 2004 when the PMBs were extended with the introduction of the Chronic Disease List (CDL). McLeod[17] described the development, saying: "This defines 25 chronic conditions considered to be life-threatening, which are explicitly regulated in order to prevent late sequelae and complications. The cost of diagnosis, treatment and medication for these conditions must be covered in full by medical schemes, subject to published treatment algorithms. The treatment algorithms were developed by practitioners and are specified in regulations."

Fish, Ramjee, Richards, Hongoro & Hoffman[18] studied and reported on the impact of the designated service provider and Chronic Disease List legislation on schemes and members. Their critical report has however not been publicly released. They found that although all options now covered at least the statutory diseases, coverage of chronic medicine had generally declined with beneficiaries being worse off than before, for example:

- "In 2003 12.6% of open scheme options and 21.6% of restricted scheme options did not provide any cover for chronic medication. In 2004 all options provided cover for at least some chronic medication."
- However this occurred at the expense of other chronic conditions, particularly in open schemes. In 2004, 42.5% of open scheme options provided cover only for the statutory CDL conditions. … coverage of a large number of chronic diseases (40 or more diseases) more than halved from 53.1% of options in 2003 to only 22.4% in 2004."
- "In 2003, 86.2% of beneficiaries had cover for more than 40 diseases (46.2% had a specified list with more than 40 diseases and 40.0% had an open list.) This has fallen to only 16.8% of beneficiaries in 2004. Beneficiaries have therefore lost access to coverage for a wide range of chronic conditions that are not in the legislation."
- "The percentage of options which covered no non-CDL conditions increased significantly from 10.2% in 2003 to 34.7% in 2004. This means that the proportion of beneficiaries with no cover above the CDL diseases has increased from 13.5% to 53.0%."
- "This shows that schemes tightened the list of diseases that were covered for chronic benefits from pooled funds to compensate for the removal of financial limits. The sharp reduction in medical scheme coverage of non-CDL conditions was a direct result of the legislative changes and will impact negatively on beneficiaries with these conditions."
- There were also benefit changes that impacted on members. "A significant change was the increased use of shared benefits for chronic medicine within schemes: in 2004, 41.7% of open scheme options paid chronic medicine from a shared benefit as compared to only 3.4% in 2003. In restricted schemes, the figures were 39.5% in 2004 compared to 5.7% in 2003. This means that a joint benefit limit is used for CDL conditions, acute medicine, GP visits and sometimes other out-of-hospital care. While the CDL conditions have to be funded after this benefit is exhausted, there is more competition for resources under this limit and the effect is less cover for the rest of the benefits in the pool."
- "A much greater use of formularies and protocols to manage the delivery of chronic benefits was noted. In 2004, 79.2% of open scheme options used a formulary and/or protocol for the provision of chronic medication as compared to only 33.6% in 2003. Within the restricted scheme environment, this has increased from 34.2% to 64.5%."

The International Review Panel that reported on the formula for risk equalisation in 2004[19] were adamant that the existing PMBs were inadequate. "The CMS, together with the industry, must ensure that the PMB becomes a marketable package. This requires developing a standardized Basic Benefits Package (BBP), composed of the PMB and the minimum additional benefits to make it a marketable package. The Panel strongly recommends including primary care, i.e. 'all the care that is usually delivered by primary care physicians'."

"The role of primary care in the medical schemes environment may currently be undervalued. Currently, it represents less than 10% of spending through the medical schemes risk pool, and only 14% of the costs through MSA. However 77% of all South African GPs work in the private sector, so there is a strong case for inclusion of primary care in the BBP, and its importance will likely grow with more managed care, and in the realization of efficiency gains in the framework of SHI. The inclusion of primary health care into the BBP serves two purposes: Firstly, it bridges the divide between the

range of services considered essential in the public sector and the current medical schemes setting. When primary care is included, the open medical schemes will be able to attract a broader range of the population. Secondly, it introduces new efficiency tools in terms of managed care into the medical schemes logic, and another important step towards SHI." ...

"In addition to the BBP, the medical schemes should be allowed to offer a few (say 3 to 5) supplementary benefits packages (SBP). Standardization will reduce product competition based on the design of numerous benefits packages (which hardly benefits the consumer) and increase price competition among the medical schemes."

7. The PMB Review Process in 2008

The initial regulations covering PMBs in 1999 had said there would be regular reviews[20]: "The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. A review shall be conducted at least every two years [emphasis added] by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. .... 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."

A complete review of PMBs was begun by the Council for Medical Schemes in 2008 (the PMB Review)[h]. The third draft of the report in that process was dated March 2009[1] and there have been no further public developments in the last 12 months. The earlier documents in the process had extensive material on the different ways in which a minimum package could be designed but this material is no longer in the most recent draft.

"Due to the differences in the private and public sectors, the mandating of a minimum set of benefits plays distinctively different roles. In the medical schemes environment, PMBs predominantly represent regulatory interventions to address market failure, while a mandated minimum set of benefits in the public sector chiefly represents rationing of scarce resources".

The PMB review steering committee proposed a PMB construct providing first-Rand cover as follows:

- **"In-hospital services**: subject to –
  - a general definition of hospital services
  - step-down services, including home-based nursing care
  - a categorical list of conditions and treatments (DTPs and the CDL)
  - a negative list (which serves to exclude inter alia, specific types of treatment, or treatment(s) provided under specific conditions)
  - NOTE: All hospitalisation is covered in this framework.

- **Out-of-hospital services**: subject to –
  - a general definition of out-of-hospital service
  - a categorical list of conditions and treatments (DTPs and the CDL)
  - specified primary care services inclusive of:
    - a basket of defined preventative care
    - a basket of defined basic dentistry
    - a basket of defined basic optometry

[h] See multiple submissions at the PMB Review web-site: http://www.medicalschemes.com/publications/publications.aspx?catid=33

- a basket of essential drugs
- a negative list."

"Note that the construct suggested here might not be affordable to lower-income groups, and the regulations should prescribe exemptions from these PMBs for low-income earners."

A key issue is that the proposed PMB construct has not yet been costed.

8. The Design of LIMS Minimum Benefits

The Low Income Medical Schemes (LIMS) process reported in 2006[21] under the leadership of Dr Jonny Broomberg: "The LIMS process has examined three broad sets of interventions that could be used to materially reduce the net medical scheme premium costs to low income households. These are:

- Direct subsidies, either from employers, or the State, or both [see Policy Brief 9 on Affordability[22]].
- Changes to the scope of benefits offered by medical schemes.
- Reductions in the costs of healthcare goods and services."

The LIMS process investigated the possible "establishment of separate medical schemes, or separate options within medical schemes, open only to low income households, which could be subject to a different regulatory environment, including a lower cost prescribed minimum package". "The Benefit Design, Governance and Regulation Task Group was tasked with focusing on various aspects of these ... LIMS schemes ... including issues such as the nature of a revised approach to a prescribed minimum package", the LIMS minimum package, or LMP. A sub-group, focusing on Benefit Design and Demarcation issues was led by Dr Brian Ruff and Dr Silvia Cornejo[i].

The final LIMS report deals with the perceived expense of the existing PMB package, saying: "After extensive debate, there was a clear consensus in the group that the current PMB scope, and the cost of funding these benefits, does pose a significant affordability obstacle to the extension of scheme coverage to low income households." "The strong consensus (but not unanimous) view of the group was in favour of proposing a modified approach to prescribed minimum benefits for schemes aimed at low income households."

The approach of reconsidering the Oregon categories but with a lower Rand limit was considered and ultimately rejected in favour of a simpler approach. "After extensive discussion and detailed research, the following LMP is proposed. Note that LIMS schemes would be free to offer additional benefits above the LMP, subject to some restrictions ... .

A. **GP consultations**: A minimum of:

- 3 GP visits for Principal Member (M); 6 GP visits for M + 1 dependent; ranging up to 12 GP visits for M + 4 dependents.
- A Max of 12 GP visits per family per annum.
- A formulary comprising a limited set of procedures to be performed in GPs rooms.
- An additional minimum of 3 GP visits per annum per beneficiary who has one or more LIMS PMB conditions.
- It is assumed that most LIMS options will contract with Designated Service Provider (DSP) GP networks, and are likely to offer unlimited GP consultation benefits.

[i] The final report says: "It should be noted, however, that the pharmaceutical industry is of the view that it did not manage to participate adequately in the work of the Benefit Design technical working group, and that its views on benefit design were therefore not adequately taken into account in the formulation of proposals by this group." See submissions on the final LIMS report at http://www.medicalschemes.com/publications/publications.aspx?catid=29

- GP networks may utilise nurses and other service providers, but the package must provide access to GPs where this is required.

B. **Pathology and radiology** investigations ordered by GP, subject to a defined formulary

C. **Dental consultations**: A minimum of:
- 2 dental visits per beneficiary per annum for basic conservative and restorative dentistry.
- No cover mandated for advanced dentistry or dentures.

D. **Optometry**: A minimum of:
- One eye test per 24 months.
- One pair of spectacles every 24 months, subject to clinical criteria and a formulary.
- LIMS schemes may elect to impose reasonable financial limits, as well as protocols related to lens prescriptions.
- A basic frame should however be covered in full.

E. **Medicines**: A minimum of a defined formulary for acute and chronic medications, based on the DoH Essential Drug List, with suitable modification where this list is considered to have gaps. Unless otherwise specified or defined as chronic medication, reimbursement of individual medicines may be limited to four courses per annum[j k].

F. **Emergency transport** to a public hospital (or private hospital in cases of life threatening emergency).

G. **Maternity Care Services**: Not mandated as part of minimum package.

H: **Specialist Benefits**: Not mandated as part of minimum package."

"LIMS members will have the protection of the current PMBs, except that only some of this would be funded by LIMS schemes themselves, with the balance of this entitlement funded and provided by the public sector. It was noted that some of this entitlement within the public sector may be limited to the extent that such members are still required to pay user fees in the public hospital system."

"The LMP proposed is intended to provide a minimum of a reasonably comprehensive package of out-of-hospital, primary healthcare. This is consistent with the preferences expressed by low income households in the LIMS [Household] survey for comprehensive primary care benefits in preference to private hospital cover." " ... the current estimate of the cost of the LMP in 2006 is approximately R108 per beneficiary per month. It is essential to note that these costs should be regarded as indicative only. Actual LIMS packages offered in the market are likely to cost somewhat more than this, due the inclusion of additional services beyond those mandated in the proposed LMP, and due to variance between the assumptions utilised here and actual experience in the market. In particular, it is very likely that most schemes will offer much more comprehensive GP cover, which in many cases may well include unlimited access to GP consultations. This is currently the practice in most low income medical scheme options utilising GP networks. The costing provided here does not take this benefit into account, and is based explicitly on the assumed utilisation in the LMP."

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[j] In relation to the particular medicines to be provided as part of the LMP formulary, representatives of the pharmaceutical industry have noted that they believe that they did not have adequate participation in the Benefit Design Task Group which worked on these issues, and that their arguments – for coverage in the LMP of all medicines required by the CDL PMB clinical algorithms – were not adequately taken into account in the final recommendations. The key debate here, on which the LIMS process therefore did not reach clear consensus, is whether all medicines currently funded as part of PMB CDL clinical algorithms should be funded as part of the LMP, or whether this funding obligation can be constrained to some extent in the LMP, and if so, whether the constraint of a formulary based on a modified version of the State primary care and hospital EDLs is an acceptable one.

[k] IMSA has recorded a strong objection to the use of a formulary approach in general, and to the use of a formulary based on the State EDLs in particular.

The PMB Review process by the Council for Medical Schemes agreed that there should be a separate LIMS package, saying "A separate dispensation must be established for low-income earners." The graph below conceptualises essential healthcare coverage in South Africa.

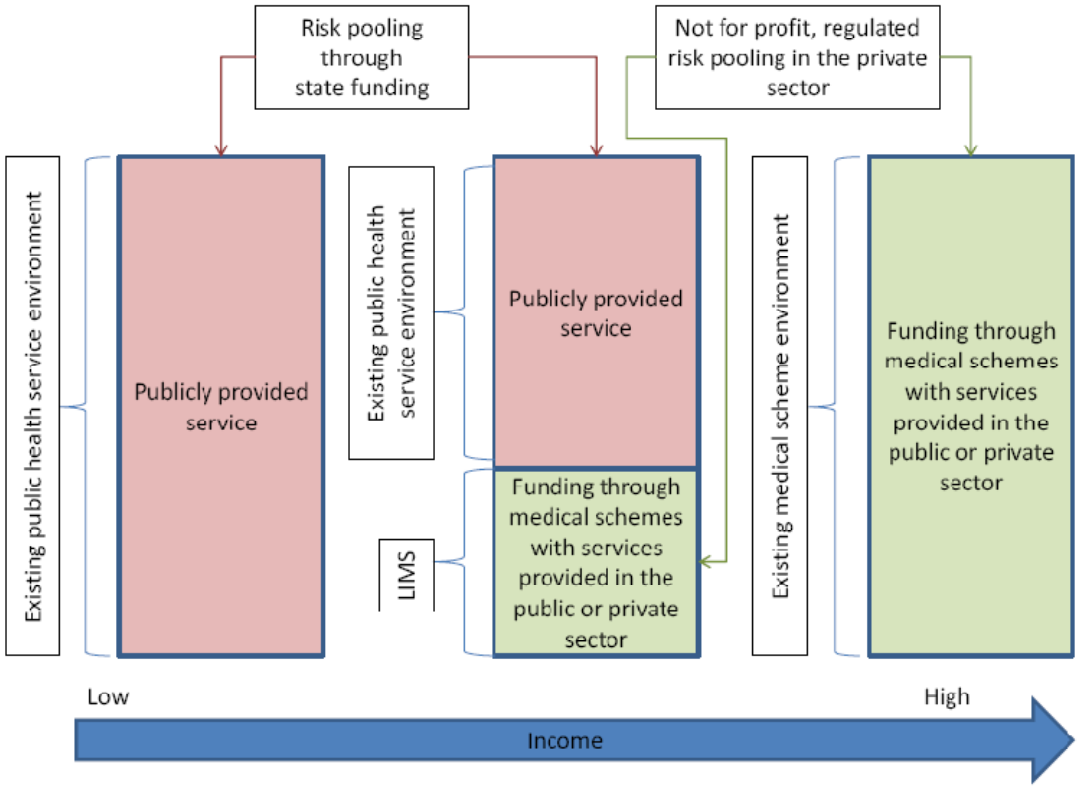

Figure 4: Access to Essential Healthcare.
Source: Council for Medical Schemes PMB Review Process[1]

9. Package Design and Affordability

Policy Brief 2[23] showed the predictable changes in price of PMBs if there is a move away from voluntary medical schemes through various phases of mandatory cover. If all those employed (at whatever income level) and their families were to be covered, the price of PMBs is expected to fall to 82% of the current level, simply through the difference in the age and gender profile. It was also reported that if the effect of anti-selection by pregnant woman and those with chronic disease were estimated, that the price of PMBs might be as low as 77% of the current level. These decreases are relatively predictable but are not enough to resolve the affordability problem for the lowest income earners.

Khosa, Söderlund & Peprah[10] wrote in 1997 about the desired process for developing minimum benefits, saying: "Assuming consensus on the basic objectives three technical issues need to be addressed:

- what should be included in the package of essential hospital benefits?;
- the cost of providing the benefits to the target group; and
- the contribution of beneficiaries and their employers."

Following this technical process, results need to be presented to a broad forum of stakeholders at which stage a package could be adopted, more technical work commissioned, or a wider process of public consultation entered into."

The first of the two figures below illustrates the classic cycle of design, costing and pricing which starts with the definition of the package, costing and pricing (see section 1 of Policy Brief 6[24] for the difference between costing and pricing). The question of affordability is then assessed and may often lead to the need to redesign and constrain the package. If implemented, the providers are then engaged and funders typically focus on monitoring provider behaviour and volume of services.

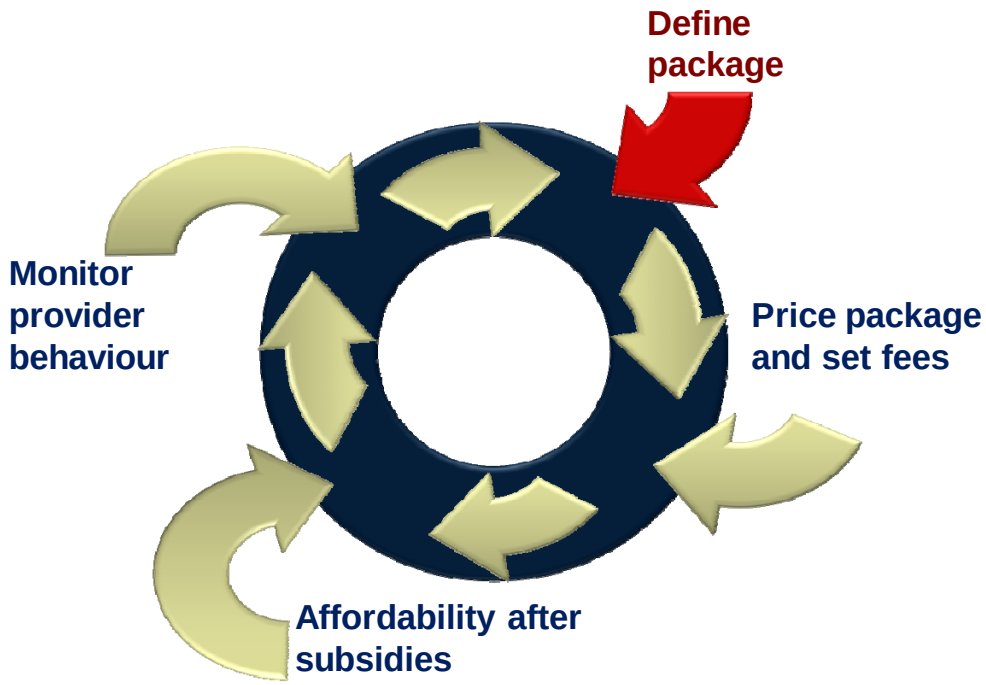

Figure 5: Classic Funder-Driven Benefit Design

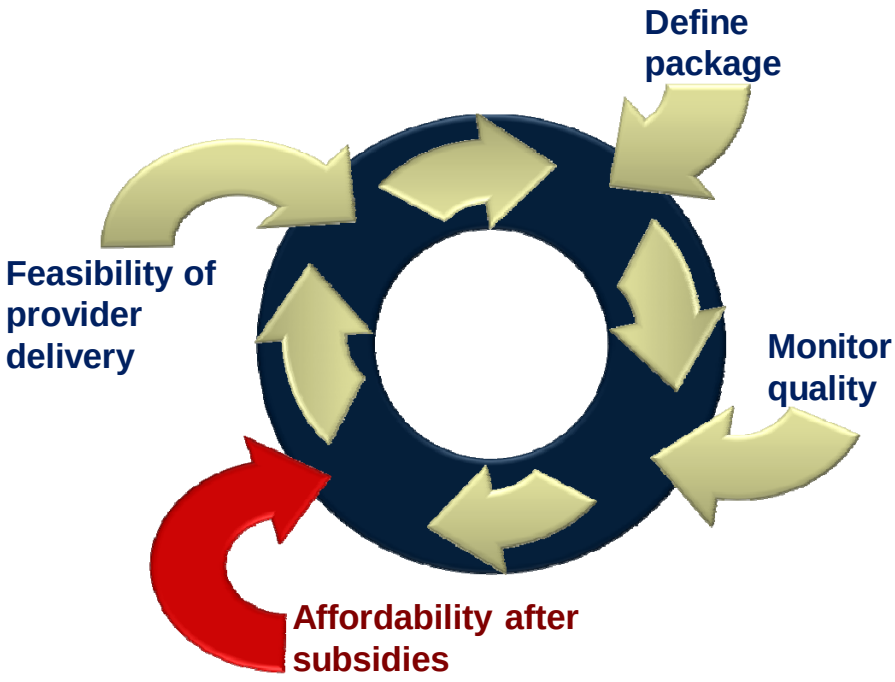

Figure 6: Alternative Provider-Driven Benefit Design

But there is another way. Figure 6 shows the same cycle from a more provider-driven perspective. This cycle starts with assessing affordability and would include considerations of income cross-subsidies that are feasible amongst those earning. This amount of money is then discussed with providers who consider the feasibility of what they think can be provided within that budget. This leads to a definition of the package to explain to the members. As payment to providers is in the form of budgets for each service (or capitation for primary care), the need for trustees of the funds to monitor quality is important.

10.The Implications for a National System

This Policy Brief has outlined the history of minimum benefits in medical schemes since 1994 and described the need for a linkage to public sector norms and standards. As advocated by the Taylor Committee in 2002[5], there needs to be process of defining the minimum core set of services applicable to both the National Health System (NHS) and a future mandatory system of National Health Insurance (NHI) for those able to contribute.

In re-designing and expanding the PMBs it is critical to remember that Söderlund & Peprah[11] specifically excluded primary care: "This was excluded, in the first instance, because of a strong government commitment to the provision of free primary care to all citizens." This did not materialize and the package defined for medical schemes was not altered to account for the changed circumstances on primary care. This is one of the reasons that many stakeholders argue for primary care to be included in the PMBs.

In considering the phasing of membership in a mandatory system, it may initially be necessary to design a package that can be offered to low income workers to improve affordability while membership is still voluntary for this group. However another solution is to ensure that there are significant income cross-subsidies between low and high income workers. This returns us to the affordability issue and work on this aspect of reform is needed to clarify exactly what degree of income cross-subsidy could be feasible in South Africa.

Produced for IMSA by
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Resources on the IMSA Web-site

The following is available on the NHI section of the IMSA web-site: www.imsa.org.za

- The slides used in this policy brief [PowerPoint slides].

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