Innovative Medicines South Africa

Executive Summary of NHI Policy Brief 10

Defining the Benefit Package

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.

The minimum package of health benefits is governed by the National Health Act and section 27 of the Constitution. The right to access healthcare may be subject to limitations. Government must take sensible legislative and other measures within available resources to progressively fulfil these rights.

Minimum benefit entitlements are defined differently in the public and private sectors. The public sector establishes services which provide comprehensive cover for an undefined range of conditions which may be qualified through the use of protocols, or norms and standards. Medical schemes must provide cover for at least the Prescribed Minimum Benefits (PMBs) in terms of the Medical Schemes Act No. 131 of 1998. The Taylor Committee of 2002 argued that there must be convergence between the two approaches and that Government must define what it regards as basic essential services which everyone must be covered for. The PMBs for HIV are one of the clearest examples where the private sector entitlement has closely followed the public sector minimum package of care.

At present, the PMB package is a list of some 270 diagnosis-treatment pairs primarily offered in hospital; all emergency medical conditions; and diagnosis, treatment and medicine according to therapeutic algorithms for 25 defined chronic conditions on the Chronic Disease List (CDL). It accounted for 52.7% of total healthcare expenditure in a 2008 study of medical schemes. The extent of PMBs differs by age and gender, with Under 1's, pregnant women and the elderly having higher proportions of healthcare expenditure covered as PMBs. Ideally, the minimum package should cover more of health expenditure but this counters the affordability of the package for low-income workers.

In the technical work on PMBs by Söderlund & Peprah, primary care was excluded at the outset due to "a strong government commitment to the provision of free primary care to all citizens." This did not occur and the medical schemes package was not altered for the changed position on primary care. Many stakeholders now argue primary care be included in the PMBs. The International Review Panel in 2004 "strongly recommends including primary care, i.e. 'all the care that is usually delivered by primary care physicians'". This is to "ensure that the PMB becomes a marketable package".

The current cost of funding the PMBs is a significant affordability obstacle to the extension of scheme coverage to low-income households. The Low Income Medical Schemes (LIMS) process considered possible changes to the scope of benefits. A LIMS minimum package (LMP) was proposed that focused on out-of-hospital primary care with in-hospital events being covered in the public sector.

A complete review of PMBs was begun by the Council for Medical Schemes in 2008 but there have been no further public developments since a third draft of the report dated March 2009. The proposed PMB package in the draft has not yet been costed.

The first of the two figures overleaf illustrates the classic cycle of benefit design, which starts with defining the package, costing it and finally pricing[a] it. Affordability is then assessed and may often lead to the need to redesign and constrain the package. If implemented, the providers are engaged and funders typically focus on monitoring provider behaviour and volume of services. But another way to define benefits is from a more provider-driven perspective, shown in Figure 2. This cycle starts by assessing affordability and considers the income cross-subsidies feasible amongst those earning an income. This amount of money is then discussed with providers who consider the feasibility of what can be provided given that budget, leading to a definition of the package. In this approach it is important for funders to monitor quality. A future NHI should begin with what income cross-subsidies are feasible between low- and high-income workers to determine the affordable amount.

[a] Costing involves determining the total amount needed to fund the benefits for a defined package for a defined group of people. Pricing involves spreading the cost across those who can contribute.

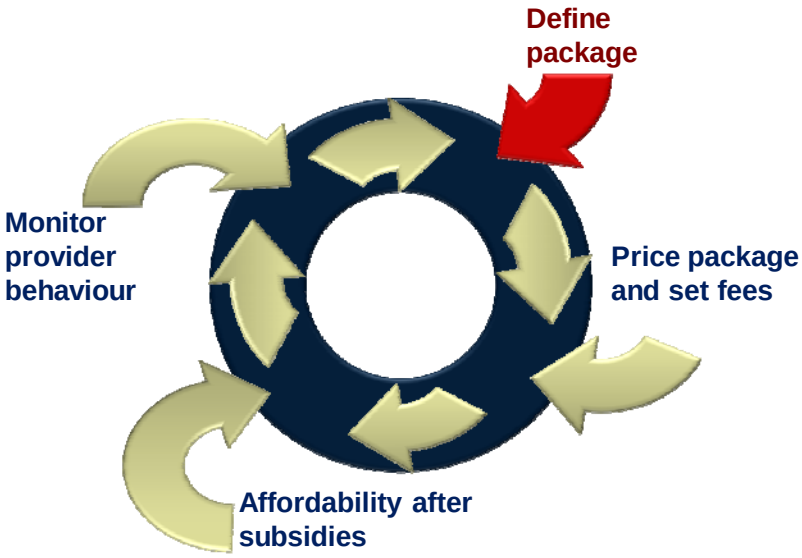

Figure 1: Classic Funder-Driven Benefit Design

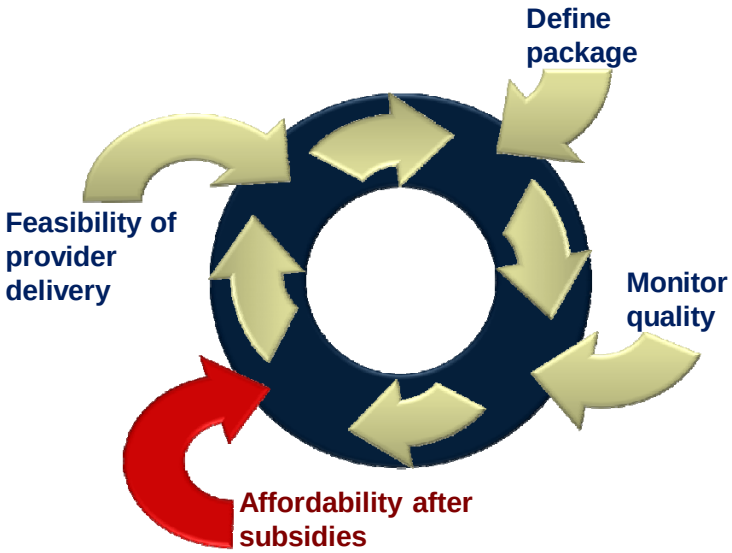

Figure 2: Alternative Provider-Driven Benefit Design

Summarised for IMSA by **Jessica Nurick and Shivani Ramjee**

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Further resources on the IMSA NHI web-site:
http://www.innovativemedicines.co.za/national_health_insurance.html

- The full policy brief, as well as the slides and tables used.
- A glossary of healthcare terms.