Media Release - Innovative Pharmaceutical Association of SA (IPASA)

Will changes to the Prescribed Minimum Benefits (PMBs) Translate to Compromised Care?

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The National Department of Health recently gazetted proposed changes to regulations governing the payment of Prescribed Minimum Benefits (PMBs) by medical schemes, prompting a national debate. While the need for changes is acknowledged, it is important that this change does not compromise quality of care for medical scheme members.

Regulation 8 currently requires medical schemes to pay for the diagnosis, treatment and care of 270 conditions and 25 chronic illnesses, at provider cost in full, regardless to which benefit option the member belongs.

This means that if a medical scheme member has one of the listed medical conditions and chronic diseases, the medical scheme not only has to cover medication, but also doctors' consultations and tests related to the particular condition. The scheme may make use of protocols, formularies (lists of specified medicines) and Designated Service Providers (DSPs) to manage this benefit.

The amended regulation proposes that schemes be allowed to limit what they pay for prescribed minimum benefits to the rates set out in the 2006 national health reference price list (NHRPL). These costs would be adjusted to the Consumer Price Index (CPI), or at a rate agreed with the service provider.

It is important at this stage to outline the reasons why PMBs exist…. Primarily to ensure that medical scheme beneficiaries have continuous healthcare. This means that even if a member's benefits for a year have run out, the medical scheme has to pay for the treatment of PMB conditions. (CMS website: http://www.medicalschemes.com/consumer/Rights.aspx)

In short, "to provide minimum healthcare to everybody who needs it, regardless of their age, state of health or the medical scheme cover option they belong to." According to the Council of Medical Schemes (CMS) the aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable: (CMS website: http://www.medicalschemes.com/medical_schemes_pmb/).

However, in addition to this, PMBs also exist to "ensure that medical schemes remain financially healthy. When beneficiaries receive good care on an ongoing basis, their general wellness improves, resulting in fewer serious conditions that are expensive to treat."

Health Minister Dr Aaron Motsoaledi has been widely reported in several platforms where he has emphasised his main concern with the PMB's amounting to a "blank cheque" for healthcare service providers, based on the abuse of the legislated "paid in full and at cost" clause in the current regulation 8 by service providers. For their part, critics of the NDoH's proposed changes argue that medical scheme members will be left out of pocket and needing to pay more if schemes are allowed to limit what they pay for PMBs.

What is clear is that there needs to be some change to curb the abuses and "blank cheque" scenario that the minister and medical schemes have raised concerns about. Service provider representatives need to acknowledge the fact that the current system is open to abuse, and that there are those who can abuse the system as it is today. As always, the few bad ones spoil for everyone. Also, while not being conclusive, the evidence presented by medical schemes to the effect that some practitioners abuse the PMB system is a cause for concern.

But this may also be an opportunity for broader engagement around what might constitute a PMB and the practical tariffs that medical schemes should be obliged to pay. There can be no doubt about the need for a system of minimum benefits to ensure greater access to healthcare. However it should be noted by all parties that this system exists primarily for the benefit of medical scheme members and it is their interests that must be considered foremost, and their access to the best care should not be compromised by any legislative changes.