



SPECIAL ARTICLE

Prescribed minimum benefits – quagmire or foundation for social health reform?

B Taylor, A Taylor, D Burns, J D Rust, P Grobler

The concept of a minimum level of care is central to the facilitation and achievement of a more equitable and efficient quality health care system in South Africa. The National Health Act¹ mandates that 'the Minister must, within the limits of available resources ensure the provision of such essential health services, which must at least include primary health care services and equitably prioritise the health services that the State can provide'. The Department of Health inquiry into a system of social security for South Africa concluded that government policy needs to provide a framework that 'results in cover for a minimum level of essential health benefits irrespective of whether it is provided in the public or the private sectors'.² This need for a basic package of care is further endorsed by the draft Health Charter.³ Although various government initiatives have defined essential services, the Prescribed Minimum Benefits (PMBs) as provided for by the Medical Schemes Act have had the greatest prominence.⁴ Not only are they legislated, but they are the envisaged platform for the social health insurance package which is to be pre-funded by all earning above a given threshold, and which will define the entitlement for any person contributing towards such insurance. The aim of this article is to elucidate the core package approach in South Africa and to focus more specifically on the appropriateness of pursuing the current PMBs as the platform for social health reform.

Defining essential care

The concept of minimum or essential care is only important because of resource limitations. Ideally, everybody should have access to all the health care they need. However, because funds are limited, care must be prioritised to ensure access to at least the most important services.

The ambit and level of care so prioritised are critically dependent on the monetary amounts available – the greater

the resources, the more generous the interpretation of what is indeed regarded as indispensable. Where there are only limited financial constraints, as in various First-World countries, the predominant challenges for policymakers in this regard are limited to delineating what in fact constitutes a health care need (e.g. to what extent should a health care system ensure the availability of cosmetic surgery or advanced dentistry) and to defining 'best clinical practice' based on available evidence. However, as financial limitations become starker, the challenge of prioritisation grows exponentially, with social objectives of health, cost efficiency of different health care interventions, local priorities, and moral considerations of distributive justice becoming critical determinants of decision making.

Essential care packages in South Africa

Other than prioritising health care services to ensure fair allocation of limited resources, core packages (interchangeably referred to as essential health, basic benefit or minimum care packages) are also intended to effect particular aspects of health care reform or policy.⁵ Different packages therefore have different purposes and implications, and for this reason it is important not to use these terms generically, but rather indicate which specific package is referred to. To date the following core packages have been defined by the South African government.

*The Primary Health Care Package (PHCP)*⁶ is expressed in terms of norms and standards and is aimed at strengthening primary care services in the public sector. It provides goals that all clinics delivering primary care services should achieve. Standards tend to reflect infrastructural requirements, including staff training and availability of medicines, whereas norms tend to identify care targets. Community participation to plan services and identify priorities is actively encouraged. The main focus is on the management of prevalent conditions.

*The Essential Drugs List (EDL)*⁷ is not only central to the PHCP, but also guides service delivery at secondary and tertiary care institutions. It identifies which drugs should be procured for common conditions at the various levels of the health care system and describes how these drugs should be used.

The PHCP and EDL are therefore aimed primarily at improving access to quality care within State-funded facilities. Both are guidelines and act as a support base towards planning public services. By adhering to the Batho Pele principle of 'people first', the PHCP specifically encourages public

Health Policy Unit, Medscheme Health Risk Solutions, Cape Town

B Taylor, MB ChB, Int Dip Res Eth

D Burns, MB ChB, FRCP, PhD

J D Rust, BA, LLB

P Grobler, BCom, FIA, FASSA

Neurovascular Unit, Department of Neurosurgery, University of Cape Town

A Taylor, MB ChB, FCS, MMed

Corresponding author: B Taylor (bettinat@medscheme.co.za)



participation in the design of local health care services, as well as accountability on the part of the managers responsible for those services. It is a flexible package, provides no legal basis for entitlement by patients and guides allocation of a fixed budget with an emphasis on improving access to care for common diseases.

This contrasts with the PMBs which define the minimum level of care that has to be funded by all private medical insurers. They are aimed at increasing access to predominantly private services by promoting risk cross-subsidisation among medical scheme beneficiaries and by facilitating the future roll-out of mandatory, income-related medical scheme contributions. They are regulated, rigid and define a legal entitlement to care. Any change to their ambit directly impacts budget allocation, as well as the total budget. They are the proposed basis for an eventual social health insurance package (SHIP (personal acronym)), also referred to as the basic benefit package (BBP) by the Ministerial Task Team on Social Health Insurance.

From PMBs to the BBP

Historic overview of the PMBs

To assess the feasibility of using PMBs as the platform for social health insurance (or indeed as the benchmark for the development of other core packages), a review of their development is necessary. Originally they were collated by Soederlund and Peprah⁸ with the key objective of preventing free use of public services by those who could afford to pre-fund their medical care, thus protecting public hospitals from having to fulfil the role of 'minimum insurer'. Such an approach was aligned with the Department of Health's social health insurance strategy applicable at the time.⁹ To this end hospital-based care was ranked within proposed budgetary constraints to include first and foremost care that was regarded as non-discretionary (or urgent). Cost-effectiveness of care was considered as a secondary factor. Resulting from this was a proposal for a list of diagnosis-treatment pairs (DTPs) that included most emergency care, as well as hospital-based care for life-threatening conditions, some urgent care of non-life-threatening conditions, maternity care and palliative care for the terminally ill. Specifically excluded from the recommended package were very high-cost or ineffective treatments, and those for non-urgent, non-life-threatening conditions (e.g. cataract surgery, elective arthroplasty), as well as primary care services and out-of-hospital medicines relating to the DTPs.

Regulations and subsequent amendments in terms of the Medical Schemes Act (Act No. 131 of 1998) in chronological order

20 October 1999¹⁰

The original PMB recommendations were eventually legislated in terms of 271 DTPs which were defined in broad diagnostic

and therapeutic categories (e.g. epilepsy – status epilepticus, initial diagnosis, candidate for neurosurgery: medical management, ventilation, neurosurgery). However, there were some noteworthy, yet unexplained, differences between the seminal work and the final regulations. Despite broad adaptation of the principle that minimum care was limited to urgent, cost-effective hospital-based care in public facilities, some isolated highly discretionary services, as well as primary care interventions, had been added to the minimum benefits package (e.g. screening for breast cancer and cervical cancer, hormone replacement therapy, and infertility treatment). Of note is also that the key objectives of the PMBs were expanded to encourage improved efficiency in the allocation of private and public health care resources, and to protect medical scheme members against loss of insurance cover during time of greatest need.

4 November 2002¹¹

Other than limited expansion of some primary care services relating to HIV infection and the inclusion of all emergency services, the most relevant early development of the PMBs was the apparent de-linking of the 271 DTPs from the concept of a hospital-based package, thus including primary care services for these diagnoses as well. It is postulated that such a shift resulted from the concern that limitation of the PMBs to hospital-based care would exacerbate inefficiencies in the allocation of private resources as members seek specialised care that could equally be delivered in a primary care setting. The expansion of PMBs to include delivery of services in the private sector where these are not reasonably accessible in the public sector is also noteworthy.

6 October 2003¹²

In line with government's updated strategy on the implementation of social health reform, PMBs were expanded further to include the care of chronic conditions. Such reform was aimed at removing residual risk selection by schemes and increasing medical scheme coverage.¹³ To this end, therapeutic algorithms for 25 chronic diseases previously identified (also referred to as the Chronic Disease List or CDL) were published. Diagnosis descriptions for these particular conditions were based on the *International Classification of Diseases (ICD-10)* coding, and treatment was described as a stepwise approach to pharmacological management. The rationale for propagating a disease-based approach (as for example opposed to a drug-based approach) with regard to the management of chronic conditions is unknown. Furthermore, although prevalence, disease burden, cost efficiency and disease severity were mentioned as criteria that contributed to disease selection, the rationale for selection of one disease over another remains obscure. It is also unclear why the standard of care reflected within therapeutic algorithms was not consistently benchmarked against public sector practices, but instead included treatments not readily available at State facilities (e.g.



angiotensin-2-receptor blockers for hypertension, and more liberal use of statin therapy).

3 December 2004¹⁴

Following the public sector's commitment to the roll-out of antiretroviral therapy for the management of HIV infection, such care as outlined in national treatment guidelines was added to the PMB package.

11 February 2005¹⁵

Despite poor efficacy and high cost of treatment, as well as non-availability in the State sector, beta-interferon was added to the therapeutic algorithm for multiple sclerosis for patients with frequently relapsing and progressive disease. The rationale for such a decision is not publicly available.

In summary, the current 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. There are also some 26 chronic conditions requiring comprehensive cover for care; however the reason for inclusion of such diseases is not explicit and the standard of care is not benchmarked consistently against what is reasonably available in the State. Furthermore, there are some *ad hoc* services that cannot be explained readily.

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 (where individual members cannot reasonably access such care in State facilities). These changes are likely to reflect 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.

Proposed future of PMBs

Further expansion of PMBs is now in the offing. The report to the South African Risk Equalisation Fund Task Group by the International Review Panel recommends inclusion of 'all care that is usually delivered by primary care physicians'.¹⁶ Reasons cited for such expansion include *inter alia* that primary care plays a pivotal role in the realisation of efficiency gains within a framework of social health insurance, and that the current package is not marketable as a stand-alone product. Such expanded PMBs are commonly referred to as the basic benefit package by policymakers and refer to the social health insurance package (SHIP) to which all persons earning above a certain threshold will be mandated to contribute on an income-related basis.

Another parallel *de facto* expansion of PMBs that has been proposed by the regulator involves the so-called 'common benefits' for individual medical schemes.¹⁷ The minimum level of care for individual medical schemes as per Circular 8¹⁷ is an

attempt by the Council for Medical Schemes to broaden risk cross-subsidisation within individual medical schemes, and thus ensure that there is no risk-selection activity in respect of essential health care. Such a minimum package is proposed to include PMBs plus all benefits common to all members of the particular scheme, which must include all hospital care covered by that scheme. This contrasts with the recommendation by the International Review panel where expansion would affect all schemes and where in the event of a risk-equalisation fund risk cross-subsidisation could be expanded across the industry.

Against such a background, a basic package (BP) has also been proposed by the draft Health Charter. It is argued that such a core package is necessary to facilitate equity in health care which refers to equal access to equal care for equal need. The care so identified should reflect the 'health safety net for all'. Although more recent versions of the Health Charter differentiate this package from the PMBs (drafts on file), the BP must by definition be a subset of the PMBs if the former is interpreted as entitlement to predefined health care services funded by a third party. However, given South Africa's heterogeneous health care delivery system, fragmented funding thereof, as well as the country's highly diverse population, the value and feasibility of a single care-based package is questioned. Reasons for such a stance include the following:

1. The concept of a rigid health safety net for all undermines the principle that every citizen has the right to participate in the development of health policies¹⁸ and as such undermines the existing PHCP which encourages engagement of the population in the design of local health care services. As funds are increasingly channelled towards mandated services, non-mandated services are likely to be neglected.

2. It has already been identified that essential health care packages are aimed at facilitating particular aspects of health care reform. Given the different priorities identified for reform of the public and private delivery systems, it is unrealistic to expect a single package to achieve highly contrasting objectives.

3. As the definition of essential care is also an exercise in the prioritisation of limited funds, there must be a system of transparent budgeting. Although a central equity fund to pay for essential services has been proposed as part of a national health insurance system, this is not only a very long-term goal, but the feasibility thereof has been questioned.¹⁶

4. Given that prioritisation is influenced by the cost-efficiency of health care services, the proposed variability of both costs and outcomes between different delivery systems and locations is problematic. Not only do acquisition prices of services differ (e.g. the State purchases medicines at State tender prices), but outcomes depend on local infrastructure and expertise.

The social health insurance package (SHIP)

Having argued against a single basic package for the country, the question then remains whether the PMBs are the



appropriate foundation for social health reform. For various reasons, it is proposed that they are in fact unsuitable. From perspectives of prioritising care in a just manner, there are perceived problems relating to the decision-making process to date. From perspectives of engineering health system and financing reform, there is a concern that the PMBs are failing in their key objective of promoting efficiencies in the allocation of private resources, plus they have been identified as being too expensive to promote medical scheme growth.

Fair allocation of scarce resources

Accountability for reasonableness (A4R)

As suggested previously, there are unfortunately no simple technical solutions that decide how best to allocate scarce resources in an equitable manner. Instead, such decisions are rooted in diverse (and often conflicting) values and value systems that range from scientific and economic to social and moral ones. For this reason it has been suggested that the process whereby decisions are taken is of critical importance. In this regard a conceptual framework, also known as 'accountability for reasonableness' or A4R, has been developed.¹⁹ According to this model, a process that underpins fair decision-making must *inter alia* adhere to the following two criteria: (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.

Although the original definition of PMBs followed such a process, their subsequent development did not abide by such principles.

Undue abandonment

Non-inclusion of care within an explicitly defined regulated minimum package predisposes to such care becoming increasingly inaccessible. This is supported by the observation that in an attempt to keep medical scheme contributions affordable and competitive, private funds are discriminating against those with non-statutory diseases in their benefit design. With the introduction of the CDL, 29.1% of open medical scheme options stopped providing chronic medication cover for patients with non-statutory diseases.²⁰ In essence this means 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.

Although it may be argued that a minimum package will always be discriminatory, i.e. someone who needs care will lose out, exclusion of care should not be done haphazardly.

For example, how can it be justified that in a system of social health insurance an individual with a debilitating arthritide other than rheumatoid arthritis should be mandated to pre-fund health care on an income-related basis, yet purchase no care whatsoever for a disease that they have acquired by mere chance? To the contrary it could be argued that if this was instead a lifestyle-propagated disease such as hyperlipidaemia, a severe restriction on mandatory funding of related care may be justified more readily (assuming that treatment does not achieve an overall cost-saving to the health care system). By not funding pharmacotherapy as per practice guidelines, individuals would still have the choice of intense lifestyle modification. Furthermore, many patients would suffer no negative consequences from non-treatment, while others would continue to suffer future vascular events even if they had access to pharmacological interventions, i.e. the beneficiaries of active treatment would always remain incognito.

Health system management, reform and financing

Efficiency of service delivery

There is also no convincing evidence to date that PMBs have achieved meaningful efficiencies in the allocation of private resources. Despite there having been some increased use of formularies and protocols to promote more cost-effective use of medicines,²⁰ hospital, specialist and administration costs have continued to increase.²¹ There are theoretical reasons to believe that PMBs could be positive contributors, and before further reform it is important to establish a better understanding of their potential role in this regard.

Affordability

Furthermore, the recent enquiry to identify barriers to the expansion of medical schemes concluded that the PMBs in their current format are too expensive and for this reason it has been suggested that an alternative set of minimum benefits should be considered for low-income medical schemes (LIMS).²² It is noteworthy that the benefits proposed in this regard have been specified in terms of services rather than diseases as occurred with the current minimum package.

Although the intentions of the PMBs have always been good, 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 benefiting from health services. Furthermore, it has been recognised that PMBs are too expensive for meaningful expansion of medical scheme membership. For this reason an alternative core package has been proposed for the low-income market (LIMS). However, given that the latter is at the heart of social health reform, it is argued that the eventual benefits of LIMS would more aptly be regarded as the SHIP going forward. If accepted, the ongoing purpose of PMBs necessitates clarification as they would no longer provide the platform on



which income cross-subsidisation in support of low-income earners could occur. Before introducing further PMB-based risk cross-subsidisation in the industry (e.g. risk-equalisation fund, PMB expansion, benefit design changes as per Circular 8), these issues should be addressed.

Conclusion

Core packages are at the crux of health reform in South Africa. Strategically, they have two key functions. The one is to prioritise health care services within budgetary constraints in order to ensure that available resources are allocated most judiciously. The other is to prioritise health care services in order to effect a particular aspect of health care reform that is ultimately aimed at building a more equitable health care system. Although the notion of a basic set of health care benefits for all is appealing, the single core package approach is by no means the panacea for achieving equity in health care financing and access. For some interventions there is likely to be agreement that everyone should have access to these, irrespective of their ability to pay (e.g. simple analgesia for acute pain or palliation, assistance during childbirth), yet the scope of services decided by such consensus is likely to be very limited. From the perspective of guiding reform of the health care delivery system, the goals of change between the private and public delivery systems are simply too different to be accommodated under one umbrella. Furthermore, the extent to which government and medical administrators can prioritise care fairly and efficiently via the explicit definition of benefits is limited. In many instances such prioritisation is best performed by practitioners. However, the current structure of the health care delivery system and its legislative framework, including PMBs, is not conducive to bedside rationing where care is funded through medical schemes. It is argued that particularly for specialised services, a 'queueing' system would lead to significantly fairer and better health outcomes than an all-or-nothing funding approach. A queueing system in this instance refers to a mechanism whereby treating practitioners have a direct responsibility for allocating limited resources judiciously (e.g. by means of accountability for a fixed budget or a fixed number of beds). Above all, core packages cannot be developed and implemented within a budgetary vacuum (given that they are a product of resource limitations). Particularly where minimum benefits are mandated in legal terms, there must be consideration of their potential financial impact and the implications thereof. For example, as the scope and level of care of PMBs is increased, the funding of non-statutory services is likely to decrease even further and medical scheme membership may be impacted negatively as the cost of the core package escalates (unless of course significant efficiencies are achieved in the delivery of legislated care or the

core package is subsidised in a meaningful manner, neither of which is envisaged in the South African context in the short to medium term). Or, as PMB-based risk cross-subsidisation is further enforced through scheme-specific common benefits and the REF, young and healthy members may increasingly opt out of medical schemes, unless membership is compulsory.

At this point in time the core package approach in South Africa is a quagmire on which no equitable or sustainable health care system can be built. To be successful, different initiatives must be clearly delineated, their objectives defined and prioritised, their contents developed in a fair manner and their impact monitored. Most of all, there must be a common (and realistic) vision for health care financing and delivery in South Africa. Blinkered pursuit of solidarity through forced risk cross-subsidisation may result in more harm than good, unless synchronised with financing reform – for this there must be engagement of organised labour, business representatives, and those in government who hold the purse strings.

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