

## **BOARD OF HEALTH CARE FUNDERS** **BENEFIT DESIGN: A POLICY RESPONSE TO CIRCULAR 8**

### **1. Introduction**

The Council for Medical Schemes has proposed certain policies for a new benefit framework in Circular 8 entitled 'Consultation on a Revised Benefit Structure for Medical Schemes. In the Circular it is proposed that in addition to prescribed minimum benefits, schemes must offer to all of their members benefits that are common across all options within the scheme. This is to increase community rating within the scheme so that all members pay the same contribution for the same benefits and to eliminate practices that amount to risk rating through the use of options within medical schemes.

There has been no further comment or communication from the Council for Medical Schemes on the subject matter of Circular 8. A policy document has not been issued reflecting the revised views of the Council in light of the stakeholder comments received. For this reason the Board of Healthcare Funders deemed it necessary to develop a policy document which discusses in some depth the proposals of Circular 8 and the medical schemes industry policy position on these proposals at present.

### **Policy Position**

It is the view of the medical schemes industry that Circular 8 and the issue of benefit design cannot be meaningfully considered in isolation of the broader system within which it operates. Benefit design is fundamental not only to the role that medical schemes play in providing for the cost of health services but to the long term survival of medical schemes themselves.

The point made in paragraph 2 of Circular 8 is conceded that benefit options currently fragment risk pools and that this facilitates risk rating by medical schemes or at the very least encourages adverse selection by potential members so as to defeat the objective of community rating across schemes. The dilemma is how one encourages broader participation by communities in medical scheme membership such that medical schemes become increasingly more affordable for the average working person as opposed to increasingly less affordable. Benefits must be of a nature and price that attracts both young relatively healthy working people as well as older less healthy people where there is no legally mandatory membership requirement in place. Even where membership of a medical scheme is obligatory benefits have to be such that they are affordable to those to whom the law applies.

The Board of Healthcare Funders also concedes that the point made in paragraph 3 of Circular 8 to the effect that section 29(1)(n) of the Medical Schemes Act is too restrictive and does not encourage price saving innovation by medical schemes but is not convinced of the legitimacy of arguments that suggest that competition between providers of health care services exists or is effective in controlling or bringing down the costs of health care services in the private sector. The reasons for this are canvassed in detail below.

The Board of Healthcare Funders is also not convinced that competition between medical schemes can truly exist or be effective in a stagnant risk pool where the

stagnation is the result of system factors arising from the manner in which the medical schemes industry is regulated. The churning of medical scheme members benefits no-one except the brokers and is a contributor to unacceptably high non-health care costs within the sector. The need for brokers in an environment where the normal market rules concerning competition operate weakly at best is debatable. False competition stimulates the creation of false economies in benefit design and encourages undesirable risk rating practices that ultimately lead to the failure of medical schemes to adequately design and provide funding for benefits that genuinely positively contribute to the health status of the larger risk pool.

It is the considered view therefore, of the Board of Healthcare Funders that Circular 8 does go far enough in seeking to address the real challenges within the medical schemes benefit framework. It serves rather to further entrench the current framework which is no longer consistent with broader policy objectives and which compounds the challenges currently faced by medical schemes.

## **2. Defects within Current Benefit Framework**

The current medical scheme benefit framework is problematic for the following reasons:

- (a) It revolves around a set of Prescribed Minimum Benefits (PMB) which has not been properly reviewed since its implementation six years ago in January 2000. This is despite the statement in the introduction to Annexure A that -

“The Department of Health recognizes 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 by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives.”;

The Prescribed Minimum Benefits are therefore supposed to be reviewed on the basis contemplated in the Explanatory Note to Annexure A and these reviews must 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.

The Explanatory Note to Annexure A of the Regulations expressly states items (i) to (iv) above. Although the title of the relevant paragraph is “Explanatory Note” the review provisions are couched in peremptory language thus “the Department *shall* monitor the impact effectiveness and appropriateness of the Prescribed Minimum Benefit conditions” and “A review *shall* be conducted *at least* every two years” (writer’s italics). This is the language in which law is generally written and there is room for argument that the provisions of the Explanatory Note set out the legal obligations of the Department of Health with regard to the Prescribed Minimum Benefits package.

The review of the PMB package must involve not only the regulator but also stakeholders, provincial health departments and consumer representatives. It would have to take into account relevant changes in policy and approach within the health sector regarding the funding of health care. Effectiveness has to be measured with reference to a policy intention as do appropriateness and impact. One cannot answer these questions in a vacuum. If medical schemes are to be vehicles for the implementation of a social health insurance system (SHI) then it is necessary to consider the impact, effectiveness and appropriateness of the PMB in light of this. The questions to be asked are “effectiveness for what purpose?”; “impact on which aspects of medical schemes business and to what end?” and “appropriate in what sense?”

- (b) The PMBs were not set with regard to other elements within the medical schemes system such as the fact that while the PMBs are diagnosis and severity based, the current coding system for billing within the NHRPL and CPT4 coding system is procedure based. The ICD10 coding system is diagnosis based but it does not indicate severity and therefore is not effective in identifying prescribed minimum benefit conditions with any certainty. This renders the implementation of the PMB package by medical schemes very difficult since the current coding systems do not assist with the accurate identification of PMB claims.
- (c) It is a widely recognised peculiarity of health markets that financing of particular services fuels demand for those services<sup>1</sup>. This is a factor that has not been reviewed, assessed or measured in the years since the implementation of the PMB. There has been much comment on the increasing portion of medical schemes expenditure that is being taken up by private hospitals but the reasons for this have not been properly canvassed or interrogated.
- (d) The focus of the current Diagnosis-Treatment Pairs (DTPs) in the Prescribed Minimum Benefits (PMB) is predominantly on hospital based care and conditions that are likely to require hospitalization. This is in line with the stated objective of Annexure A of the General Regulations to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilization of public hospitals. However the PMBs are a major cost driver within the structure of medical schemes benefits because of the focus on hospital based care. They are too wide to allow significant growth in medical schemes membership from the ranks of the middle and lower income groups<sup>2</sup>.
- (e) The cause of stagnation of the medical schemes risk pool is systemic and attributable to the manner in which the funding industry is regulated. The PMB, because its focus is cost-shifting, focuses on high cost interventions and thereby indirectly encourages them. For example, the treatment of tetanus by way of medical management is a PMB but a tetanus vaccination following upon an injury that could lead to tetanus is not. Yet tetanus is a disease which has a high mortality rate<sup>3</sup> and the reported incidence of tetanus declined substantially since the mid-1940s, when tetanus toxoid (TT) became available for widespread use<sup>4</sup>;
- (f) The Prescribed Minimum Benefits as they are at present are geared towards the avoidance of cost-shifting from the private to the public sector. They do not address the internationally and constitutionally recognised issues of redistribution, universality, comprehensiveness, quality, accountability, and

- equity<sup>5</sup> because they were designed as a 'fix' for a highly specific problem experienced some six or more years ago.
- (g) The PMBs do not take into consideration the health needs of different socio-economic groups. It is widely recognised that different socio-economic groups have different health needs<sup>6</sup>. The current PMB is geared to address the health needs primarily of the high income socio-economic groups. Although it does include diseases such as tuberculosis, malaria, HIV it also includes heart disease, gastric or intestinal ulcers and many other non-communicable diseases. It is significant that the Oregon Health Plan (OHP), which was influential on the PMBs at the time they were drawn up has been amended considerably since that time. OHP standard offers reduced benefits, higher co-payments and requires premiums<sup>7</sup>. Socio-economic status does affect health status and the efficacy and efficiency of treatment modalities as recent experience with HIV/AIDS has graphically shown<sup>8</sup>.
- (h) Many individual medical schemes have no bargaining power with regard to PMBs because they are obliged to pay for them in full no matter what the cost. This is compounded by the fact that many schemes are unable to guarantee sufficient patient volumes to specific providers. This may be because an individual scheme is too small or because the decision of which hospital to go to is affected by the admission privileges of the specialist treating the patient, or because the patient wants to be admitted to a hospital near his or her home or because the scheme's members are scattered throughout the country rather than confined to a single geographic area.
- (i) Medical schemes particularly have no bargaining power with regard to PMBs because they are predominantly hospital oriented and the private hospital market in South Africa is not competitive. Competition between the three major hospital groups seems to be notional at best with the result that only very large schemes would have the weight necessary to be able to negotiate favourable rates. This could even result in subsidization by smaller schemes of larger ones. Public sector hospitals have been found to have an extremely limited capacity to adequately admit, process and bill medical scheme patients and many schemes are finding it difficult to secure the necessary contracts with the provincial health authorities. It is the experience of medical schemes generally that the capacity of the public health sector to render health care services to medical scheme members in the context of a contractually regulated relationship between the scheme and the health authorities is severely limited.
- (j) The medical schemes risk pool is fragmented not only in terms of options but also in terms of open as opposed to restricted membership schemes. Membership of the latter is often not open to retirees and persons no longer able to work due to ill health. The former cannot turn such persons away if they apply for membership while the latter is only concerned with the very narrow portion of the total risk pool that qualifies for membership of the restricted scheme in question. There is competition between open membership schemes which creates a niche for brokers who add their own expenses to the open schemes market. In the restricted membership schemes arena, brokers are largely superfluous and there is no competition between restricted membership schemes. There is at best indirect competition between restricted membership schemes and open schemes. Open schemes cannot therefore afford to be as generous with *ex gratia* payments as restricted membership schemes. Their benefit structures are more rigid. Schemes that do grant *ex gratia* benefits more readily than others have the capacity to structure "common benefits" as

proposed in Circular 8, more circumspectly than those that do not. Open schemes are not necessarily employment based unlike most restricted membership schemes. They are therefore more susceptible to risk and there are greater incentives for them to avoid high risk members in whatever way they can.

Although the risk equalization fund (REF) is intended to address some of these challenges it is likely to be problematic because restricted membership schemes, which are generally smaller and have lower levels of risk than open schemes, may not be sustainable in the long term under the REF system. Those restricted membership schemes that allow pensioner members will be favoured by the REF system over those that do not, thereby exacerbating inequities in health cover amongst the elderly, retired population. Furthermore if open medical schemes start to admit elderly and infirm members more readily than they may have done in the past in order to benefit from the REF system, this is likely to create significant pressure on smaller restricted membership schemes - even those who do have pensioner members. This possibility coupled with the continuing stagnation of the risk pool and the current PMB package is likely to lead to higher overall costs of medical scheme membership. One result will be that the elderly will find it increasingly unaffordable to belong to medical schemes and the wheel will turn full circle but with significantly fewer restricted membership schemes in existence. It is not clear at this stage whether this is a premeditated development falling within the scope of government policy or an unanticipated consequence of the policy proposals in Circular 8.

- (k) The proposal in Circular 8 with regard to common benefits will raise the bar for medical scheme members in terms of contributions resulting in less access for fewer people to medical schemes membership because of the large package of services that common benefits and the PMB could make when combined. This is likely to extend and reinforce the pattern of negative growth in overall medical scheme membership in recent years in the absence of a systemic review of PMBs.
- (l) The proposal around Low Income Medical Schemes (LIMS) (external to Circular 8) is likely to further fragment the market and significantly reduce the possibility of cross-subsidization of the low and middle income groups by upper income groups. This is because of the structure of the PMB combined with the fact that the health needs of different socio-economic groups vary. The application of the REF to LIMS is likely to exacerbate their position and in the event of significant differences in PMB structure between LIMS and ordinary schemes, may set them up for total failure. There would probably have to be a separate REF for LIMS which could complicate the operations of medical scheme administrators administering both kinds of schemes and may add to the administration costs within the industry overall. It is noted that no detailed study appears to have been conducted on the so-called industrial medical schemes which would indicate how low income groups relate to and interact with schemes and what they can afford to pay. Examples of these are the Furnmed Sick Benefit Society, the NUFAWSA Sick Benefit Society, the Sick Benefit Fund of the Cape Town and District Laundry Cleaners' and Dyers' Association and the Sick Benefit Fund of the Leather Industry which assists members of the labour unions NULAW and SACTW with medical expenses.
- (m) The medical schemes industry and the health policy that affects it is poorly integrated with other social mechanisms such as the Road Accident Fund (soon

to be the Road Accident Benefit Scheme) and the Compensation Commission for Occupational Injuries and Diseases with the result that from a broad sociological perspective there is significant duplication of benefits as far as trauma and occupational disease are concerned. Medical schemes, because of the cost shifting focus of the PMB tend to pick up far more of the medical costs of road accidents and occupational injuries than they should and due to the inefficiencies of the other agencies, recovery from them is difficult, expensive, time consuming and heavily dependent on the honesty of the medical scheme member in question. The result is that medical schemes are picking up the costs of medical expenses for which other social agencies are primarily responsible due to the manner in which the PMB has been designed. This draws appropriate focus and social accountability away from these other agencies to a significant extent and promotes inefficient and unsympathetic administration on their part. It reduces legitimate claims upon these agencies by those they are intended to benefit since a medical scheme member whose medical expenses have already been paid by the scheme is unlikely to actively pursue a claim for such expenses from one of the other agencies.

Medical practitioners wanting to be paid within a relatively short period of time may even encourage members of schemes to claim from the scheme rather than from the compensation commissioner or the road accident fund. A number of medical practitioners simply refuse to treat workmen's compensation cases where the patient is not a member of a medical scheme due to the length of time it takes the compensation commissioner to process claims in comparison with medical schemes.

The number of PMBs that involve significant injury due to trauma is considerable and naturally the focus is on the high cost interventions due to the cost-shifting rationale. The BHF is busy with a study that attempts to identify trauma based medical expenses and their associated costs but it will take some time to complete.

### **3. Circular 8 Assumptions**

There are a number of elements that need to be taken into account when critically considering the proposals in Circular 8. These elements are likely to have a fundamental impact on some of the underlying assumptions in the Circular.

For ease of reference these assumptions are listed as follows:

- (a) Correcting for risk related pricing of common benefits requires that common benefits be offered, and priced, according to the risk pool of the scheme and not a sub-set of that risk pool.
- (b) Competition is effective within the health sector to ensure the satisfaction of the health needs of target populations
- (c) Medical schemes are in a position of bargaining strength vis-à-vis providers
- (d) Price competition alone is desirable between medical schemes
- (e) Medical schemes have the ability to compete with each other

These assumptions are discussed individually in more detail below.

**(a) Correcting for risk related pricing of common benefits requires that common benefits be offered, and priced, according to the risk pool of the scheme and not a sub-set of that risk pool.**

This assumption apparently contains within it some further assumptions – notably:

- (i) that there are easily ascertainable common benefits between various scheme options;
- (ii) that pricing of common benefits according to the risk pool of the scheme as opposed to that of an option will maintain the level and nature of "common benefits" offered by the scheme;
- (iii) that all scheme members will be happy to continue to pay the increased contributions necessitated by the new pricing system;
- (iv) that size and profile of the scheme's risk pool will be unaffected by the "common benefits" approach

The fundamental challenge with regard to all of these assumptions is that they are based upon the further assumption of a static environment that is unresponsive to change or that responses by scheme members and medical schemes to counter the new measures can and will be avoided.

In practice it is unlikely to be that easy to identify common non-PMB benefits between options. It may be in the interests of schemes wishing to retain as many members as possible to further differentiate between existing options to the point where it is not possible to identify "common benefits". For example, is a benefit that allows three GP visits a year and a benefit that allows ten GP visits a year 'common' because they both relate to GP visits or not common because they allow for a different number of visits with a very different cost implication? Similarly, is a benefit that allows treatment for an unlisted chronic disease in terms of a formulary within a network and a benefit in another option that allows treatment of the disease without a formulary by a doctor of the patient's choosing a common benefit? On what basis will "common" be determined? It is not clear how the concept of common benefits will cater for the possibility of different benefit designs based on technological innovation for example laparoscopic surgery as opposed to older but cheaper surgical procedures to achieve the same objective.

It is proposed in Circular 8 that "common benefits" be defined as "benefits which are available on a mandatory basis to all members of the scheme". This definition is itself problematic. What does "available on a mandatory basis" mean? Does it mean that members have a choice to buy the 'common' benefits or not? If the benefit is not mandatory is it not a common benefit? The definition simply begs the question "what is common?" since "mandatory" must surely be determined with reference to what is "common". Alternatively does it simply mean that schemes are obliged to make such benefits available to members no matter which option they choose and that the members cannot refuse to buy the "common benefits"?

One of the stated objectives of circular 8 is to stop schemes denying benefits to members. This is a compliance issue and not one that will necessarily be addressed by further regulation.

Industry experts have stated that Circular 8 will increase the cost of medical scheme membership to those members subscribing to low cost options. It is likely to raise barriers to access rather than lower them and many people including the young and healthy, may drop out of the system rather than pay unaffordably high contributions. If this were to happen then government may have to answer on the basis of the

Constitution how the legislative amendments implementing Circular 8 fulfill its obligations under section 27(2) to progressively increase the realization of the right of access to health care services.

The alternative is that the so-called “common benefits” across options may disappear altogether as schemes deliberately differentiate benefits between options in order to retain members. Such differentiation would complicate the administration of medical schemes and encourage even more expenditure on managed health care services all of which would have the effect of diminishing the expenditure of schemes on relevant health services.

### **(b) Competition is effective within the health sector to ensure the satisfaction of the health needs of target populations**

Circular 8 attaches undue weight to price competition between medical schemes. Price competition between schemes could result in compromises in quality of health care services funded. In the health sector in particular, price competition must always be balanced with other forms of competition. In any event price has been shown to be at best the tip of the iceberg when it comes to influencing consumer decisions to take out health insurance or change schemes<sup>9</sup>.

“Cheap” health care services can be just as undesirable as overpriced health care services if it means compromises in quality and professional standards. Cost-effectiveness is only one measure of the desirability of a health care service. The importance to a patient of his or her dignity and of being treated with attention, compassion and respect by a healthcare provider should not be underestimated. The value of the trust placed by some patients in their medical practitioners cannot be translated into monetary terms. Once a patient’s health status has been adversely affected by a health care provider, it is too late for him or her to be selective. One cannot restore quality of life lost by means of awards of monetary compensation by the courts even assuming a patient has the significant amount of money required for such litigation.

There are certain forms of competition that in themselves can be costly. Competition between schemes requires expenditure on marketing, broker commissions, advertising etc<sup>10</sup>. Such expenditure is obviously non health related. Competition can also take the form of increased efficiency in benefit utilization by members which translates directly into managed care costs and the costs of member education.

As far as restricted membership schemes are concerned they have an advantage over open schemes in that they do not have to advertise their existence, their position is usually entrenched by way of the employment contract and their target population is easily identifiable and accessible. Open schemes do compete with restricted membership schemes to a certain extent in that it is possible for an employer to decide to abandon a restricted membership scheme in favour of an open membership scheme for its employees or to allow employees a choice between a restricted membership scheme or an open scheme. However the fact that longstanding restricted membership schemes still exist. Open schemes also compete amongst themselves for members. Brokers play a major role in this aspect of medical schemes competition and contribute significantly to the non health care costs of medical schemes in this area. Broker fees are very much a cost of competition.

Where the supply of human resources is relatively low, for instance in South Africa there is a shortage of medical specialists, medical schemes are unlikely to be able to compete on a price basis since the providers are in a position of bargaining strength<sup>11</sup>. Private hospitals have not been able to get medical specialists to adopt common practices with regard to the use of medical devices and surgical procedures in order to achieve cost savings. It is thus even less likely that medical schemes would be able to get them to do so with a view to standardized benefit design.

In a situation where medical specialists are in short supply, the patients and the medical schemes are price takers. At best the larger schemes will be able to obtain decreased prices at the expense of smaller ones as already indicated. Generally speaking regulation has been shown to increase the transaction costs of SMEs which makes them less competitive. Where the transaction costs of smaller or marginal schemes are increased by the proposals in Circular 8, they may disappear due to their inability to compete with larger schemes that are better able to absorb increased transaction costs. It is noteworthy that it seems to be more than just a local phenomenon that private funders of health care have less bargaining power over the price and quantity of care as compared with their public counterparts<sup>12</sup>. This is attributable to the relative size of the risk pools within the public sector as opposed to the private sector but also the fact that the state is also a regulator, that most stakeholders want to remain "on its good side" and they are aware that it has the capacity to regulate undesirable business practices. The state is influential in some instances as a large purchaser of health care products such as medicines and medical devices and therefore has the bargaining weight that many private funders lack as individual medical schemes.

As regards competition within the health sector, logically speaking one cannot simultaneously approbate and reprobate. One cannot expect free market efficiencies and the benefits of competition from a market that is not free to compete or in which the forces of competition operate abnormally. Stiglitz<sup>13</sup> points out that -

"in standard competitive analysis, pooling (community rating, or more broadly charging individuals with easily observable different risk profiles the same rate) makes little sense; and it is indeed remarkable how much of such pooling we see (e.g. with insurance companies charging the same premium for small and large families). Yet, commitments to such pooling may be welfare-increasing, when viewed from the veil-of-ignorance perspective. While observed market practices seem to exhibit more pooling than the theory of adverse selection would suggest, it is possible (if not likely) that as competitive prices increase in the market there will be less pooling."

It has been noted that "a system based on competing primary insurers can improve responsiveness and consumer choice but at increased cost....Regulations to address market failures and promote equity have costs, in terms of government resources and diminishes insurer flexibility to innovate."<sup>14</sup> The OECD points out that "incentives or regulatory requirements might facilitate efforts to improve cost-effectiveness of care...Systems to compensate insurers with worse risk structure can help reduce insurers' incentives to select good risks, thus promoting equitable risk pooling. However they can also reduce or remove incentives for insurers' efficiency."<sup>15</sup>

In a commercial environment, accessibility is based on affordability or, conversely, the financial means one has to purchase the commodity in question. Competition is about the distribution, or redistribution, of goods and services according to wealth or the ability to pay for them. Competition means that someone goes without in order for someone else to have the goods or services in question. It means that in a situation of limited resources allocation is based on the power of individuals to obtain the

desired commodity. The more desirable the commodity, the higher the price that can be asked for it. Health care is a highly desirable commodity. Small wonder then that the ruling of the Competition Commissioner some three or four years ago has had no effect in bringing down the prices of hospital and other health services.

In terms of the logic of competition, the rich are entitled to more or better health care than the poor because they are in a better position to compete for it. They can afford to pay more. The rich are therefore entitled to be healthier than the poor? This logic is unconstitutional. The Constitution states that everyone has a right of access to healthcare services irrespective of their means. Public health programs tend to cater for the indigent and unemployed. The rich can afford a fancy medical schemes package that allows them access to most health interventions. It is the people in between these two extremes that tend to fall out of the system. They are not “poor” enough to benefit from public health programmes but not “wealthy” enough to access high cost private funding schemes or to adequately fund their own treatment out of pocket. Competition is a commercial concept that works well for commercial goods. Health care products and services are public goods irrespective of whether they are funded by the state or by the private sector<sup>16</sup>.

It is overly simplistic to think that in the health care context, consumers make their decisions on price alone. Nobody wants “cheap” health care. Choice is not only based on price but also on cost-effectiveness and quality of service. Several studies have found that consumers consider trust in their insurer and health care provider to be of paramount importance and would therefore be less prone to change plan, even if this would save them money. Consumers are able to perceive quality differences across health systems and base their decisions upon such quality knowledge<sup>17</sup>.

Much of the literature assumes that the choices of consumers are mainly driven by financial incentives. Also, most policies towards consumer choice focus on these financial incentives. However, a number of studies address the fact that there exists a whole range of other issues consumers want to choose on, for example quality, coverage, waiting time or travelling distance. The authors conclude that *consumer choice in health care can deal with more than just financial incentives, in principle leading to better matching on many dimensions of care*<sup>18</sup>.

There have been attempts in Germany, Israel and the Netherlands to introduce competition in the form of consumer choice of insurance fund. Evidence from these countries suggests, however, that balancing equity and competition is not easy. In the 2002 European Health Report it is noted that:

“Adjusting the amounts received by competing funds to match their revenues with the expected health care costs of those enrolled (risk adjustment) is technically demanding and the existing formulae for doing so are imperfect. Competing insurers still have an incentive to select preferred risks resulting in inequities across risk pools. While it is possible to compensate for these with other methods, the introduction of markets in health financing is risky.”<sup>19</sup>

The model of risk equalization in the Netherlands has apparently influenced the proposals of the Council for Medical Schemes around a Risk Equalisation Fund for South Africa. This observation is therefore particularly pertinent within a local context. It also smacks very much of approbation and reprobation or having one’s cake and eating it - competition at one level that is nullified at the next.

Supply can create demand in the health sector. It can therefore push prices up instead of down as one would normally expect. However a consequence of this is

clearly that if the cost of belonging to a medical scheme is too high and the already limited capacity of medical schemes to compete is further eroded by increased regulation as to what they must purchase it stands to reason that the market will eventually shrink as contributions increase. Studies on price elasticity within the health insurance market indicate that it is those whose health status is poor who are most likely to remain till the last. The remaining risk pools will therefore get “sicker and sicker” before they dry up.

### **(c) Medical schemes are in a position of bargaining strength vis-à-vis providers**

The statement in Circular 8 that “These benefits are the common benefits of the industry and should not vary in price except to account for different service provider contracts” is highly problematic from a quality perspective. There is an underlying assumption in Circular 8 that price competition amongst funders will equate to price competition amongst providers having the effect of lowering the prices of health care services. This assumption is flawed because the negotiating position of many medical schemes in relation to providers of health care services is weak.

Schemes are legally obliged to assume liability for and guarantee the benefits offered to their members and their dependants in terms of their rules. The reduction of the autonomy of a scheme through regulation of the nature and structure of the benefits it offers demands a corresponding increase in the responsibility of government to ensure that it is possible for schemes to meet their obligations to members.

This would include legislative and other measures to control the fees that providers of health care services charge, to regulate the distribution of health care services and health technology so as to ensure that there is no overservicing and that there is adequate access to affordable health services, that the relevant medical specialists are available and accessible at fees that will not bankrupt schemes etc. Already there is a problem with the prescribed minimum benefits in that providers of health care services can charge what they like, as a result of the efforts of the Competition Commissioner to eliminate collective bargaining between subsectors, and schemes are obliged to pay the bill in full. It is thus ironic that one of the stated objectives of the proposed framework in Circular 8 is to stimulate price competition between medical schemes.

The capacity of medical schemes to come up with innovative ideas on benefit design and to truly compete with each other in terms of quality, accessibility and affordability of health care is severely restricted by the current Prescribed Minimum Benefits and will be even more restricted should Circular 8 be implemented. The rationale of the Council for Medical Schemes that schemes should compete on the basis of cost in such an environment is less than understanding of the realities of the environment. If medical schemes are essentially price takers from health service providers, their ability to compete on price is ultimately non-existent no matter how efficient their administration becomes. Where it is legally obligatory to buy certain services no matter what the price, the bargaining position of the purchaser of those services is tenuous to say the least. The normal rules of competition do not work in the health sector<sup>20</sup> especially given the manner in which the funding sector is currently regulated.

### **(d) Price competition alone is desirable between medical schemes**

Circular 8 proposes a system in which access is to be promoted by ensuring the availability of a certain 'core' of common health care services to all members. On the face of it this seems highly supportive of the notion of access as the freedom to use these services. However in the context of health care funding there are two kinds of access. There is access to the health services themselves but this is dependent on access to the funding system. Price sensitivity in the context of health care services is only part of the picture. Price sensitivity to health insurance or in local terms medical scheme contributions, is the other part. It has been observed that the picture of price responsiveness is not as clear for health insurance as it is for health services. There has not been a single unifying study that addressed the key issues in a systematic and consistent fashion<sup>21</sup>.

If access to the funding system is diminished then one is in effect only increasing access of a greatly reduced membership to a range of health services that may itself be fairly narrow. This translates into elitism. It is not the kind of access envisaged by section 27(3) of the Constitution.

The Circular 8 proposals are based on an unwritten assumption that consumers are price sensitive. This needs to be unpacked further as it is a high level assumption based on certain other assumptions. It is true that price sensitivity can have the desired result of competition which forces prices down. However certain other elements have to be in place before this result can materialize:

- There has to be no other access to health care services and no other funding mechanisms;
- There has to be a certain level of consumer education in order for consumers to be able to "shop around" for medical scheme cover;
- Consumers must be able to appreciate and evaluate the differences in relative value of what they are leaving behind and what they are getting themselves into – i.e. they must have a basis for comparison;
- Consumers must be fairly literate and able to understand the mechanics of their scheme rules in relation to their personal situation.

These prerequisites do not presently exist. Consumers have a safety net in the form of the public health sector. They therefore have an alternative source of health funding to some extent depending on what they earn. They may even decide that out of pocket expenditure is more affordable for them.

Consumers in South Africa are by and large illiterate, whether functionally or factually. They do not read and they find medical schemes benefits complex and difficult to understand. The Competition Commissioner has effectively stifled to a significant degree any published bases for comparison or points of reference for consumers in the form of guideline tariffs, reference price lists and the like. Price sensitivity to medical scheme contributions is therefore a double edged sword. It can produce the undesirable result that people decide to take their chances with the public health system, that they purchase event related health insurance to deal with specific risks to which they are averse and that they drop out of the medical schemes system altogether.

With regard to health services, according to Morrissey an extensive literature survey reveals that "...there is only moderate price sensitivity in the use of health services.

Described in terms of elasticities, economists' measure of price responsiveness, health services in general have an elasticity of about -0.2. That means that a 1 percent increase in the price of health services generally, will result in about a two-tenths of 1 percent reduction in use. Stated differently a 10 percent increase in price reduces use by about 2 percent.... Thus health services are among the less price responsive consumer goods."<sup>22</sup> He also observes that price responsiveness of different health services is different. Hospital care is the least responsive to price. This is particularly significant in the South African context where the PMBs, and no doubt a considerable number of the common benefits, are hospital oriented.

Not surprisingly, higher income groups were found to be less sensitive to price changes than lower income groups. In South Africa where information asymmetry may be greater than that in the United States, many people may be even less sensitive to the price of health care services than they are in developed countries.

Against the factor of price sensitivity in South Africa to the cost of medical scheme coverage one must weight the regulated disincentives to change from one medical scheme to another – a three month waiting period in which no benefits can be claimed, the ability of schemes to pro-rate benefits, the power to impose condition specific waiting periods of up to a year. Assuming that price competition is effective at all, the healthy will be more able and more likely to respond by changing medical schemes whilst the sick will not. The healthy will relocate to the more 'competitive schemes' leaving the ailing behind with the less 'competitive schemes'. The Council's proposed REF may address these complications but at what expense to the system as a whole?

Information asymmetry exists not only within the health provider side of the market but also within the funder side. Consumers are not always in a position to be able compare the relative advantages and disadvantages of medical schemes or their benefits with reference to their own unique circumstances. Brokers do not necessarily adequately address this deficit. They tend to operate in an area where perverse incentives are the norm rather than the exception to the rule.

Competition in health care funding markets on the basis of price alone can lead to adverse selection by consumers who are induced to consider price alone. They do not take into account their health care needs for the present and the future but tend instead to think about what they are prepared to pay. It is also conducive to deterioration in the quality of health care services as industry stakeholders cut corners in order to get the best prices so as to be able to compete<sup>23</sup>.

Even in a scenario where "all cats are grey in the dark" with regard to uniformity of benefits there are still the "soft" issues that in health care can make a significant difference to consumers. Those issues are quality of health care services, quality of medical schemes administration, responsiveness to customer enquiries, fast and effective processing of claims etc. The cats are in fact, not all grey and never will be – even in the dark. Consumers of health care services know this even if they are in the dark as to the details a result of information asymmetry.

#### **(e) Medical schemes have the ability to compete with each other**

Medical schemes are not for profit, mostly paper entities run by Boards of Trustees with varying degrees of business acumen. They are not by any stretch of the imagination commercial enterprises. They are, however, usually surrounded by a

bevy of commercial enterprises intent on making money out of them. If the medical scheme is not 'profitable' then this affects the profitability of these commercial enterprises. The pressure on medical schemes to be 'profitable' is therefore external as much as it is internal from members wanting a financially healthy scheme.

In pure terms a medical scheme's sole rationale for competing would be in order to benefit its members by increasing the risk pool with people who are comparatively wealthy and comparatively healthy. As long as a medical scheme is able to meet its obligations to its members, to offer benefits that reasonably address the health needs of its members at a price they find acceptable and has healthy financial reserves it has served its purpose. This generally depends on the size and nature of the membership risk pool and the contributions it can afford to pay. However in order to help schemes achieve this apparently simple objective, commercially enterprising people have devised a large number of services to sell to them ranging from scheme administration to broker services to managed care to actuarial services. The competition in which medical schemes can engage thus becomes far more complex in practice. Which broker will secure the most desirable members? Which administrator gives the most cost effective service? Which actuaries are the most accurate and knowledgeable about medical schemes' business?

Restricted membership schemes cannot compete for members except in an extremely limited way. They essentially compete to keep their members from joining open medical schemes. They do not generally compete with other restricted membership schemes. Open schemes compete with each other and with restricted membership schemes for members. However this ability is restricted by the fact that they cannot refuse membership to the old or ailing. They have to offer prescribed minimum benefits without the option of a co-payment and their capacity to terminate membership of a member is strictly regulated by the Medical Schemes Act.

From a member's perspective, no-one wants to join a medical scheme whose membership profile reflects an elderly and ailing population – least of all the young and healthy. This reality is reflected in 'market' terms as price – the level of contributions payable. In a 'perfect' market therefore, medical schemes with young and healthy populations will eventually outperform those with old and ailing populations to the point where the latter disappear altogether. Medical schemes with old and ailing populations cannot, in reality, assure patient volume to providers. They cannot therefore negotiate better rates than medical schemes whose membership profiles are younger and healthier.

Employers still play a very strong role in medical scheme membership decisions by individuals due to employer subsidies of certain pre-selected medical schemes. This further impacts on the ability of schemes to compete for members since very often the membership of an employer's pre-selected scheme, which could be an open scheme or a restricted membership scheme, is a condition of employment. The employer's choice of scheme does not necessarily promote competition within the medical schemes 'market' since employers do not necessarily choose schemes that are the most competitive or the most cost-effective. In fact the influence of the labour market on the medical schemes market in South Africa is still profound. This is a weakness from a policy perspective that seeks to use medical schemes as a vehicle for social health insurance since it is dependent on employer subsidization and less directly, employer governance of schemes and their benefits.

It has been observed that concern is increasing about the use of payroll contributions as a mechanism for collecting revenue. In a recent study on financial protection in Latin America, Baeza and Packard (2005) argue that to extend effective risk pooling

to the informal and nonsalaried sectors and to achieve universal participation in risk pooling arrangements, policy makers need to delink health insurance financing and eligibility from labor market status or employment sector, by gradually reducing and eventually eliminating payroll contribution financing. In addition to extending protection against health shocks, this delinking might also have a positive effect on labor market mobility and formalization. This delinking can be achieved through shifting health financing toward general taxation, which is likely preferred on equity and efficiency grounds, or through risk-rating premiums as a transition if fiscal constraints do not permit full fiscal financing<sup>24</sup>. Furthermore, in a market where some schemes means rate and others do not, there is a likelihood that higher earners will gravitate towards the latter.

#### **4. BHF Recommendations**

In view of the foregoing BHF recommends that before the implementation of the principles contained in Circular 8 and before the implementation of the Risk Equalisation Fund legislation -

- 4.1 Department of Health conducts a review of the PMB as stated in the regulations to the Medical Schemes Act looking at its impact, effectiveness and appropriateness;
- 4.2 That the review involves all stakeholders;
- 4.3 That current policy initiatives and the concerns of access, quality and equity delineated in the Health Charter be taken into consideration when the review is conducted;
- 4.4 That a PMB is designed in such a way as to enable medical schemes to offer a mix of primary, secondary and tertiary level benefits that is attractive and affordable to low and middle income groups;
- 4.5 That upper income groups are legally obliged to buy 'through' the PMB layer of benefits to obtain the high-tech high cost benefits they need in order to achieve true cross subsidization of low income groups;
- 4.6 That the Act should allow for differentiation of contributions not only on the basis of restricted provider networks but also on the basis of clinical protocols.
- 4.7 That PMBs are not disease focused but rather health intervention focused<sup>25</sup> so that out of pocket expenditure is incurred by upper income groups wanting more health services than the scheme provides as opposed to by low and middle income groups that cannot afford medical scheme membership or who are only able to access care when their condition is severe enough to be very expensive to treat or requires hospitalization;
- 4.8 That consideration is given to legislating mandatory membership of a medical scheme by all persons earning above a certain amount;
- 4.9 That the prices that health care providers may charge for PMBs are regulated by law and that no balance billing or split billing is permissible;
- 4.10 That tariffs for non-PMB benefits are set by means of collective bargaining processes between stakeholders and that an expert technical committee is

- appointed to advise the Minister on the outcome of such processes before a National Health Reference Price List is gazetted by the Minister;
- 4.11 That the limitation of 3 beneficiaries for the purpose of determining contributions is removed.
- 4.12 That income based contributions are made mandatory. If income cannot be adequately verified then the default contribution applicable to the member must be the highest registered rate. This arrangement was applied by open schemes in the past. The provision could be reviewed later when the state subsidy system is in place.
- 4.13 That medical savings accounts be retained within the medical scheme environment but that their uses be revised in consequence of the review of the prescribed minimum benefits.
- 4.14 That collective action by the funding industry is legalized where its purpose is to contain the costs of healthcare services;
- 4.15 That the certificate of need system contemplated within the National Health Act is implemented as a matter of urgency and that mechanisms are built into the relevant regulations that enable the National Department of Health to take corrective action against business practices by providers of health care services that threaten or undermine access to such services;
- 4.16 That there is explicit co-operation between the Departments of Health, Labour and Transport with regard to the funding of medical expenses and the dovetailing of the Road Accident Benefit Scheme and the Compensation Fund for Occupational Injuries and Diseases with the medical schemes industry so as to eliminate unnecessary duplication of funding at legislative and policy levels;
- 4.17 That risk based capital reserving be considered for implementation so as not to penalize medical schemes through the REF system for sound corporate governance and management practices;
- 4.18 That the sequence of implementation of measures to reform the medical schemes industry is as follows:
- (a) Review of PMB;
  - (b) Review of LIMS proposals in light of PMB review;
  - (c) Review of common benefits proposal in light of PMB review;
  - (d) In depth investigation should be conducted into proposals around limited for profit medical schemes if it is felt that this option is worthy of exploration from a policy perspective;
  - (e) Amendment of legislation in line with outcome of (a), (b), (c) and (d) above and other recommendations in this section where appropriate;
  - (f) Publication of legislation for comment;
  - (g) Processing through Parliament after consideration and where appropriate amendment of proposed legislation in light of comments from stakeholders

#### **4 Conclusion**

The policy principles within Circular 8 have not been substantiated by in depth studies of the various aspects of benefit design highlighted above. The information

upon which the assumptions within Circular 8 is based has not been supplied by the Council for Medical Schemes in support of those assumptions or the conclusions drawn in Circular 8. The Circular purports to be a basis for consultation with stakeholders but there has been no update from the Council for Medical Schemes on responses received from stakeholders. The status of the Circular is that it is a consultative document and not an accepted policy document with which the Minister and the National Department of Health concur. There has been no indication that the National Department of Health has interrogated the proposals within Circular 8 or the stakeholder responses thereto despite the fact that it is the constitutional function of the Minister of Health to determine policy in such matters.

It is rumoured that a draft Bill on the REF will be published for comment very soon but the policy behind it in terms of the proposals within Circular 8 does not seem to have been developed beyond the proposals in the Circular.

The Board of Healthcare Funders, while it agrees with the identification by the Council of most of the problems within the current system, cannot at this stage support the proposed solutions within Circular 8 until the further work indicated within this document has been conducted.

## **Board of Healthcare Funders of Southern Africa 20 November 2006**

<sup>1</sup> Van Den Heever AM in an Affidavit in Case No 4183/98, Pharmaceutical Manufacturer's Association of South Africa and Others v President of the Republic of South Africa and Others and Treatment Action Campaign (Amicus Curiae) states the following in paragraph 16: "Private markets for health care traditionally invert normal market behaviour. Whereas demand leads supply in other sectors, the supply of services within the health sector creates demand. It is for this reason that most countries reserve the right to constrain growth in the supply of services in the public interest. In many countries, for example, controls are placed on the creation and deployment of new services and equipment. Although this needs to be done with care, it is by no means unusual within an international context within market driven economies."

<http://www.tac.org.za/Documents/MedicineActCourtCase/affiavd.doc>

Ministry of Social Affairs and Health 'Trends in Social Protection In Finland: 2005-2006' 2006:17 ISBN 952-00-2088-8 (PDF), 952-00-2087-X (paperback) , ISSN 1236-2050

<http://www.stm.fi/Resource.phx/publishing/documents/7581/index.htm?template=print>

Sorkin AL 'Some Economic Aspects of the Demand for Health Services' *Gaoxiang Yi Xue Ke Xue Za Zhi*.(Khaosing Journal of Medical Sciences) 1989 Nov 5(11):610-20

Meza D 'Health Insurance and the Demand for Medical Care' *Journal of Health Economics*1983 Mar;2(1):47-54. The interesting conclusion drawn by this study is that with rare exceptions the provision of actuarially fair health insurance tends to substantially increase the demand for medical care by redistributing income from the healthy to the sick. This suggests that previous studies which attribute all the extra demand for medical care to moral hazard effects may overestimate the efficiency costs of health insurance.

<sup>2</sup> Hakimi M, Dasuki D and Setiawan A 'Health Needs, Demand for Health Services and Expenditure Among the Poor' state that the assessment of health status (self assessment, total number of illness episodes, restricted activity days, severity scale) across social groups showed the weakest social groups as the most vulnerable. A bad health status was more frequent among people with lower education, under five and old age. They found that there was a strong concentration of needs, uses and expenditures. The last five percentile of the population accounted for 22.6% of total illness episodes and was responsible for 21.6% of the health services used and 77.2% of expenditure. The total concentrations according to the severity index were even more striking : 0.4% of the total population, namely the hospitalized, accounted for 57.4% of total health expenditure with only 1.7% of total illness episodes. The authors conclude that the study showed there was a high concentration of utilization of health services and health expenditure for severe illnesses, indicating the need for programs to promote the utilisation of health services and health expenditure toward preventive health care. The study was conducted in Indonesia under the auspices of Gadjah Mada University, Yogyakarta, Indonesia.

- <sup>3</sup> Chen FC, Sheen-Chen SM, Chou FF 'Hugh Incidence of Tetanus in the Middle-Aged and Elderly' *Changgeng Yi Xue Za Zhi*. (Chang Gung Medical Journal) 1990 Dec; 13(4):296-303
- <sup>4</sup> 'Tetanus Surveillance: United States 1991-1994' <http://www.cdc.gov/mmwr/preview/mmwrhtml/00046462.htm>  
Dire DJ 'Tetanus' 01 December 2005 "Worldwide, tetanus is predominantly a disease of underdeveloped countries located in warm, damp climates. Tetanus affects all age groups, with the highest prevalence found in newborns and young people. In 1992, an estimated 578,000 infant deaths occurred due to neonatal tetanus. In the beginning of the 1990s, an estimated 360,000 cases and 140,000 deaths occurred each year from nonneonatal tetanus. Tetanus is one of the target diseases of the World Health Organization Expanded Program on Immunization. Overall, the annual incidence of tetanus is 0.5-1 million cases...Overall, the mortality rate is approximately 45%. Clinical tetanus is less severe among patients who have a history of receiving a primary series of tetanus toxoid sometime during their life as compared with patients who are inadequately vaccinated or unvaccinated. The mortality rate in the United States is 6% for individuals who had previously received 1-2 doses of tetanus toxoid compared with 15% for individuals who were unvaccinated.  
The case-fatality ratio in the United States was 18% from 1998-2000 and 11% from 1995-1997; a case-fatality ratio of 91% was reported in 1947.  
The mortality rate is highest for people older than 60 years (40%) compared with those aged 20-59 years (8%). From 1998-2000, 75% of the deaths in the United States were in patients older than 60 years.  
The mortality rate is 30% for people who require mechanical ventilation but only 4% for those who do not." <http://www.emedicine.com/emerg/topic574.htm>
- <sup>5</sup> Abel-Smith B, Mossialos E (1994) 'Cost containment and health care reforms: a study of the EU.' *Health Policy* 28: 89-132. 'Privatising health care -Two decades of marketising reforms: Basis for a case study on Chile.' [http://www.ucl.ac.uk/spp/download/teaching/mphil\\_phd/Ximena.doc](http://www.ucl.ac.uk/spp/download/teaching/mphil_phd/Ximena.doc)
- <sup>6</sup> *Priorities in Health* "Many of the diseases and health conditions that account for a large part of the disease burden in low- and middle-income countries are far less common in high-income countries. These burdens are primarily associated with infectious diseases, reproductive health, and childhood illnesses. Just eight diseases and conditions account for 29 percent of all deaths in low- and middle-income countries: TB,HIV/AIDS, diarrheal diseases, vaccine-preventable diseases of childhood, malaria, respiratory infections, maternal conditions, and neonatal deaths. Approximately 17.6 million people in low- and middle-income countries die each year from communicable diseases and maternal and neonatal conditions. Both the occurrence of and the death rates from such diseases and conditions are far lower in all high-income countries.  
This is due in part to greater wealth, better general living conditions, and different climatic and environmental factors, but also to the use of cost-effective health interventions. Many of the diseases that account for the largest differences in health status between low- and middle income countries and high-income countries are also diseases for which cost-effective strategies are known, available, and feasible...Infectious diseases die each year account for less than 2 percent of deaths in high income countries, but are responsible for 21 percent of deaths in low and middle-income countries. Infectious diseases reveal a glaring difference in health status between rich and poor countries precisely because cost-effective interventions are available to prevent and treat so many of them."  
<http://www.ncbi.nlm.nih.gov/books/bookres.fcgi/pih/ch4.pdf>
- <sup>7</sup> Oregon Department of Human Services 'Oregon Health Plan: an Historical Overview July 2006'  
[http://www.oregon.gov/DHS/healthplan/data\\_pubs/ohpoverview0706.pdf](http://www.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdf)
- <sup>8</sup> Booyesen F, 'The heart in ART: socio-economic status as determinant of treatment and prevention outcomes in the public sector antiretroviral treatment programme in the Free State province of South Africa'  
<http://www.saldru.uct.ac.za/proposals/booyesen.pdf>
- <sup>9</sup> 'Consumer Price Sensitivity in Health Insurance' *CPB Discussion Paper No 56 February 2006* CPB Netherlands Bureau For Economic Analysis <http://www.cpb.nl/eng/pub/cpbreksen/discussie/56/disc56.pdf>  
'The Price Sensitivity of Demand For Non-Group Health Insurance' August 2005 Congress of the United States Congressional Budget Office <http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>  
Marquis MS, Long SH, 'To Offer or Not to Offer: The Role of Price In Employers' Health Insurance Decisions – Statistical Data Included' *Health Services Research* October 2001;  
Colombo F, Tapay N 'Private Health Insurance in Australia: A Case Study' *OECD Health Working Papers* <http://www.oecd.org/dataoecd/5/54/22364106.pdf>  
Sapelli C, Torche A, 'The Mandatory Health Insurance System In Chile: Explaining the Choice Between Public an Private Health Insurance' *International Journal of Health Care Finance and Economics* Vol 1 No 2 June 2001
- <sup>10</sup> There is evidence that internal and quasi markets within the health sector have led to an increase in transactions costs that has outweighed the possible efficient gains of 'marketization'.
- <sup>11</sup> McPake B and Mills A, 'What can we learn from international comparisons of health systems and health system reform?' *Bulletin of the World Health Organization*  
[http://www.scielosp.org/scielo.php?script=sci\\_arttext&pid=S0042-9686200000600013&lng=e&nrm=iso](http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-9686200000600013&lng=e&nrm=iso)
- <sup>12</sup> 'Private Health Insurance in OECD Countries' Policy Brief *OECD Observer* September 2004

- 13 Stiglitz JE, Senior Vice President and Chief Economist, The World Bank 'Inventives and Institutions in the  
Provision of Health Care In Developing Countries' IHEA Meetings, Rotterdam, June 7, 1997.  
<http://www.worldbank.org/knowledge/chiefecon/articles/rotter.pdf>
- 14 'Private Health Insurance in OECD Countries' Policy Brief *OECD Observer* September 2004.
- 15 Note 7 above
- 16 "For Profit Public Good: A Contradiction In Terms" [http://www.paytonpapers.org/output/ESS0031\\_1.shtml](http://www.paytonpapers.org/output/ESS0031_1.shtml)
- 17 Van Beusekom I, Tönshoff S, De Vries H, Spreng C, Keeler E B 'Possibility or Utopia: Consumer Choice  
in Health Care, A Literature Review' RAND Europe, March 2004. Prepared for the Bertelsmann  
Foundation [http://www.rand.org/pubs/technical\\_reports/2005/RAND\\_TR105.pdf](http://www.rand.org/pubs/technical_reports/2005/RAND_TR105.pdf)
- 18 Note 7 above [http://www.rand.org/pubs/technical\\_reports/2005/RAND\\_TR105.pdf](http://www.rand.org/pubs/technical_reports/2005/RAND_TR105.pdf)
- 19 2002 European Health Report Part Three. The Report goes on to state that "Whichever reform strategy is  
chosen, it is essential that countries include explicit mechanisms to ensure access to needed care for the  
poor and protection for all against financial impoverishment. In addition the socioeconomic differences in  
the health status of vulnerable groups should be taken into account. One way to account for this is to  
exempt persons in defined population groups (based on disease or socioeconomic characteristics) from  
cost-sharing obligations. Another way is to subsidize the participation of the non-working or self-employed  
population in social health insurance schemes. In Switzerland, the government subsidizes the participation  
of those with a low income in private health insurance.
- 20 Van den Heever A, 'Administered Prices: HEALTH, A report for National Treasury' states that "Incentives  
throughout the market are so skewed that the normal rules of competition do not work. Prices remain high  
even when volumes traded are high. Technology remains expensive even when widely used. Hospitals and  
doctors remain in business even when they charge excessive prices for equal quality or fail to provide high-  
quality services. Incentives exist only for innovations that raise costs or increase quality regardless of cost  
(Teisberg et al, 1994)...Although the precarious and complex nature of health markets are well known by  
now, each country must follow its own path in addressing such issues. Costs rather than prices are focused  
on as healthcare service suppliers are in a position to manipulate utilization of services – diminishing the  
importance of price constraints as a cost control measure."
- 21 Morrissey MA 'Price Sensitivity in Health Care – Implications for Health Care Policy' July 2005
- 22 Note 11 above
- 23 Light D W 'The Sociological Character of Health Care Markets' *Handbook of Social Studies in Health  
and Medicine* "...price competition in health care is so fraught with dangers of selective marketing,  
inequalities, worsening care, and ironically higher costs that it is unclear how many countries will employ  
it for how long. Already, one of the most sweeping adaptations, the transition of the NHS from the world's  
largest administered managed care system, to the world's largest competitive internal market contracts  
between purchasers and providers, has been replaced by reforms that emphasize cooperation and  
partnership, because competition was found to be too disruptive, demoralizing and costly. Competitive  
markets in health care, then, may be a phase in the historical process of rebalancing relations between the  
countervailing powers of professions, patients, payers and states."  
[http://www.pnhp.org/news/2001/september/the\\_sociological\\_cha.php](http://www.pnhp.org/news/2001/september/the_sociological_cha.php)
- 24 Scheiber G, Baeza C, Kress D, Maier M 'Financing Health Systems in the 21<sup>st</sup> Century' *Disease Control  
Priorities in Developing Countries* Ch 12 <http://www.ncbi.nlm.nih.gov/books/bookres.fcgi/dcp2/ch12.pdf>
- 25 The Oregon Health Plan (OHP) was very much a benchmark at the time when the PMB package was  
developed. It is therefore interesting to note that in 2001 the Oregon legislature passed a Bill outlining a  
process by which the state would restructure the Plan into three benefit packages. OHP Plus is equivalent to  
the previous OHP package. It covers all mandatory populations and some optional populations including  
pregnant women and children in families with incomes up to 185 percent of the federal poverty level  
(FPL). The OHP Standard package has reduced benefits that will be offered to optional and expansion  
populations not included in OHP Plus and that do not have employer sponsored insurance. In doing its  
research leading up to the Bill the Health Services Commission found that the pharmacy benefit was  
considered overwhelmingly to be the most important element and transportation the least important.  
Among many of the benefits the community was trying to balance, dental was more highly valued than the  
state had originally thought, tracking similarly with mental health benefits. As HSC approached its goal of  
reaching a 20% reduction in actuarial value of the OHP package it became clear that the state would need  
to impose a cost-sharing requirement in order to keep some crucial benefits.  
By creating OHP Standard the state would use savings from this reduced package to expand coverage to  
those previously ineligible for the programs including parents of children enrolled in Medicaid and  
childless adults with incomes up to 185% of the federal poverty level. This is a streamlined benefits  
package that is budgeted at approximately 78 percent of the actuarial value of OHP Plus. OHP Standard's  
premium structure requires all beneficiaries to pay a percentage of the premium share based on their  
income. Beneficiaries who fall within 0 to 10 percent of the FPL will be required to pay 2.4 percent of the  
premium of \$6 per person while those falling at the top of the income eligibility range – 170 to 185 percent  
of FPL- must pay 50 percent or \$125 per person.  
The state of Utah has done some interesting work on benefit design. In March 2002 the state received a  
first of its kind Medicaid waiver to implement its Primary Care Network (PCN) which provides primary

care and preventive services to 25 000 low income adults who would otherwise lack health insurance. The PCN benefits package has a preventive care focus that covers primary care office visits, flu immunizations, urgent care visits, laboratory, X-ray, ambulance transport, medical equipment, medical supplies, oxygen, basic dental care, hearing tests and vision screening. Eyeglasses and prescription drugs are not covered. As of March 2003, PCN enrolled more than 13 000 beneficiaries. The growth in enrollment equates to a lower cost per member per month. At the inception of the program in July 2002 the average per member per month was more than \$100. By December 2002 it had gone down to \$66.03. Almost 70% of expenditures are on pharmacy and outpatient hospital services. Source : Friedenzohn I, 'States Experience With Benefit Design' Issue Brief *State Coverage Initiatives* Vol IV No 4 April 2003