

Issues with the current PMB

Abbreviations

PMB	Prescribed Minimum Benefits
DTP	Diagnosis and Treatment Pairs
SA	South Africa
MSA	Medical Schemes Act
MDG	Millennium Development Goals
NDoH	National Department of Health
CDL	Chronic Disease List
ICD10	International Statistical Classification of Diseases and Health Related Problems, Tenth revision
EDL	Essential Drug List
LIMS	Low Income Medical Scheme
CMS	Council for Medical Schemes
SHI	Social Health Insurance

Concerns

1. The original principles and methodology of the current PMBs were developed in the State of Oregon based on its priorities, burden of disease and demographics. Soderlund and Peprah used the methodology and proposed essential hospital benefit package for the private SA health sector. This work formed the template for the DTPs of the PMBs.
2. SA demographic, burden of disease and health priorities are different to the State of Oregon. The benefit needs will be different.
3. Catastrophic cover
 - a. The driving policy framework for inclusion in the PMB was the provision of "catastrophic" health cover. However, the inclusion of non catastrophic cover items in the DTP list blurs the original intent.

- b. Catastrophic healthcare cover has its origin in the commercial insurance environment and not in health and human development.
 - c. It is usually explicit, disease focused and based on the needs of the individual rather than meeting the health needs of the community for the development of the community. Its development is based on high cost items, usually less frequent conditions and health events, which often have an emotive component.
 - d. Provision of catastrophic cover presupposes that the insured population can self insure day to day health needs. This is thus a product of choice in a developed economy with low unemployment and a large middle to upper income population, with a small low income population.
 - e. Do we want to provide insurance or to provide aid?
 - f. SA private health sector population cannot be described to be the same as any developed economy. It has a far larger lower income population. A non randomised sample of medical schemes from which masked income information could be obtained revealed that approximately 28 percent of the lives are from families with the members earning under R4500 (2006). There is therefore the need to meet the day to day health needs, and provide health benefits (primary care based) that would make the most efficient impact on the health status of the population, and contribute to SA meeting its MDG targets.
4. PMB is predominantly referred care (catastrophic cover) focused, while NDOH policies foremost promote primary care and places greater emphasis on it. This represents a dichotomy in policy recommendation that needs to be resolved in the light of the Health Charter developments.
5. PMB is disease and severity based. Therefore it covers a smaller group of people with greater depth of benefit. If patient's disease or severity is not listed then it is not necessarily

covered and therefore this benefit not considered equitable, nor can healthcare provision be considered to be accessible – a stated objective of the PMB.

6. DTPs are not explicit as the Oregon benefit proposals are – there are no inclusion and exclusion criteria, no definition for “life threatening”, and no minimum non medicinal benefit entitlement for the CDLs, amongst others. These structural inadequacies lead to different interpretations of entitlement, conflict, and appeals that are often referred to the CMS. Five years since implementation of the PMB, there is no clarity on entitlement.

Except for the CDL, the provision of an ICD10 list by the Regulator, merely acts as a trigger for a potential DTP benefit, severity must be confirmed where applicable. To date there is some disagreement with the content of the ICD-10 list published by the office of the CMS, as well as the process leading to its publication.

BHF has gone some way to specify the minimum benefit for the industry for some of the DTPs and CDLs.

7. The current PMB is inadequate for childhood illnesses and health needs. Its benefits are heavily weighted towards adult health problems.
8. CDL has approximately 26 treatment and benefit algorithms, while NDOH has the EDL. There is a need for alignment of benefits including the review process. No objective public health policy or principles were used nor published in the selection of the CDL conditions. It appears that the most common chronic conditions were selected for inclusion excluding major depression and osteo-arthritis.
9. CDL benefit entitlement could include biologics if the disease is multiple sclerosis or rheumatoid arthritis but if the diagnosis is

osteo-arthritis then paracetamol (EDL) is not necessarily a benefit. Need for these anomalies to be addressed.

10. If there is an expectation of outpatient chronic cover in the DTP (both in and out of hospital treatment), why then is there a CDL that covers outpatient treatment only? Why are some chronic diseases specified in both lists e.g. Cardiac failure? If rheumatic valvular disease in DTP was expected to be covered on an outpatient basis why is it not in the CDL list as well?

The PMB benefit therefore can be considered not to be well structured and often described as "patchwork".

11. There is no adequate provision to address the allocative inefficiency in health spend, but in practice entrenches it i.e. PMB at cost.
12. If LIMS principle is adopted (notwithstanding its limitations) then a differential benefit for existing medical scheme members cannot be considered to be equitable i.e. LIMS benefit is primary care focused while existing medical aid members have a predominant referred care mandated benefit.
13. The PMB benefit was implemented with no Health Impact Assessment program in place. We therefore have no report to estimate the change in health status of the population, nor the actual costs of PMB.
14. Estimates of PMB cost for 2006 is R290-R390 per beneficiary. The methodology used to estimate this cost was not validated.
15. PMBs were conceived in the late 1990s. There have been significant developments in the private sector arena during the past two years notably Health Charter, LIMS initiative and emphasis on the MDG. These national initiatives must be considered in the policy framework that defines the content of the PMBs as we move towards the development of a SHI in SA.

