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Boshoff Steenekamp

REF Project Specialst

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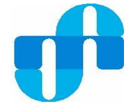
Dear Boshoff

2008 PMB review consultation document

Thank you for the opportunity to comment on the most recent PMB review process. The collaborative approach regarding review of the existing PMB's which is mandated by Annexure A of the regulations to the Medical Schemes Act no.131 of 1998 is welcomed. As such we submit the following comments relating to the '2008 PMB Review consultation: Proposed construct and work plans' document circulated 27 March 2008:

1. We are fully supportive of the fact that gaps and inconsistencies in the current regulations must be identified and addressed. We also agree that there should be a framework within which 'essential' healthcare services are defined, starting with a definition of essential healthcare within the context of a contributory third-party payer system. Given that the concept of minimum or essential care is a product of resource limitations, monetary constraints must be defined as part of this. Prior to commencement of the project, the Department of Health should define the monthly contributions that would be deemed 'affordable' for coverage of a minimum package as such limits would ultimately define how much care is prioritized and with that regarded as essential. Furthermore, there should be avoidance of the term *'comprehensive'* benefits as this is misleading and contradicts the concept of *'essential'* healthcare benefits. The focus of defining an essential package is indeed the acceptance that not all care can be covered, i.e. the package by definition is non-comprehensive.

2. Based on the documentation circulated, it is our interpretation that the *'common benefits'* (as per circular 8) are indeed synonymous with the Basic Benefit Package (as per international



review panel) and the Prescribed Minimum Benefits. We agree that these packages must be the same.

3. With regard to *what* is included in the reviewed package, we furthermore agree with Council's stance that *'in the health insurance environment it is not desirable that regulation imposes risk-pooling in respect of events that are low-cost, occur frequently and are subject to a high degree of discretion on the part of the insured'* and '*that the central challenge is to risk-pool for those health needs that will impose a significant financial burden on individuals and/or families'* . With this, we are conceptually most supportive of the potential benefit construct depicted in figure 4. (We note in this context that Council's graphic presentation of its interpretation of current PMB benefits - i.e. that they are reflected by figure 1 rather than 4 - is surprising). We nevertheless disagree with the concept that PMB's should be expanded, as the current package is already too expensive to promote medical scheme membership and social health reform. Instead, the focus should be on re-definition of PMB's within a transparent framework and with the aim of enhancing access to costly care, including by those with pre-existing illness. This would be achieved by ensuring extensive chronic medication cover and related hospital-care.

4. Regarding the technical definition of specific entitlements, Medscheme overall supports the concept of a hybrid approach. However, we do not support positive disease lists as this readily predisposes to unfair discrimination on the basis of underlying disease status. Instead, where disease lists are applied, these should be on the basis of negative lists. Not only are such lists anticipated to be shorter, and thus easier for members to understand, but they are more likely to lead to fair rationing (with each individual disease – or disease category - exclusion having to be substantiated). Contrary to this, specific services can be defined on the basis of both inclusions and exclusions (depending on which services are defined). Nevertheless, given budgetary limitations (with the view that the cost of the current PMB package cannot be increased above its current value, lest meaningful subsidies are introduced), the inclusion of a defined basket of basic dentistry and optometry cannot be supported. Preventative care should only be considered in as far as it has been demonstrated convincingly that it is cost-saving (or at a minimum cost neutral to the healthcare system). Contrary to common belief, many preventative strategies are in fact an incremental cost to the healthcare system. Although detailed protocols dealing with specifically ambulatory care have been called for, it is questioned to what extent these can be communicated, understood and thus administered in an efficient manner. Furthermore, in an environment of negative disease lists and defined services, their need is likely to be significantly less than in an environment where care is defined – as it is currently - in terms of comprehensive services relating to specific diseases.

5. Although the focus of the current document is revision of the PMB's, such a process should take cognizance of the eventual goal of defining a standardized benefit package, i.e. the concept of defining supplementary packages in addition to the PMB's. As per Medscheme's previous CMS submission in response to Circular 8, we are supportive of limited risk-rating relating to such supplementary packages.

6. As identified in the section on principles that must be adhered to when developing the entry, inclusion, exclusion and exit criteria of the minimum package, it is noted that *'moral hazard concerns in respect of both medical scheme members and health service providers'* should be taken into consideration. We agree with the opinion that this may mandate co-pays. However, contrary to the current document, we believe that this may also have to be extended to some in-hospital services where admissions are open to abuse.

7. Although PMB's are focused on defining entitlements, it is important that a sense of member responsibility is also introduced. Inextricably linked to the right to access of healthcare is the responsibility of each individual to behave in a manner that protects scarce resources, which includes respect for and protection of one's own health. In this regard, clauses that allow some degree of risk-rating on the basis of eg. smoking, non-adherence to therapy, should be considered.

Lastly, the review of PMB's is only meaningful if informed by broader health policy reform, in particular developments relating to income-related mandatory medical scheme membership (and/or other subsidies aimed at supporting lower income members). Lest risk-cross-subsidization is supported in parallel by meaningful financial subsidies, there may be unintended negative consequences relating to access to healthcare.

Kind regards

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