2008 PMB Review consultation document

Proposed construct and work plans

27 March 2008
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List of Abbreviations

DSP - Designated service provider
EDL - Essential drug list
DTP - Diagnosis treatment pair
MSA - Medical savings account
UPFS - Uniform patient fee schedule
1 Introduction and purpose of this document

The 2008 PMB review by the Department of Health in conjunction with the Council for Medical Schemes has the following foci:

- Identify gaps and inconsistencies in the PMBs, and make recommendations to address them
- Specification of a comprehensive set of essential healthcare benefits
- Identify the PMBs that should accompany the implementation of the REF
- Identify constraints associated with the implementation of a comprehensive set of essential healthcare benefits
- Identify actions that should be undertaken to ensure the sustainability of any PMB package
- Identify measures required to ensure cost effectiveness
- Document the relationship between the PMBs and the public healthcare system

This document serves to contextualise the 2008 PMB review.

Section 2 describes the context of the review; section 3 (page 11) lists the principles that are applicable to the review, and influences the proposed prescribed minimum benefit package described in section 4 on page 14. Section 5 (page 17) describes the work process that will be followed to finalise the package and constitutes an invitation to stakeholders, provincial health departments and consumers to engage with the contents of the document and to assist in the development of a revised set of prescribed minimum benefits in the medical scheme environment.
2 The legislated mandate and the context of the 2008 PMB review

The context and the legislated mandate for the 2008 PMB review impacts on the principles that are applicable to this review, and are therefore presented in the sections below.

2.1 Legislated mandate

The explanatory note on the PMBs in the Medical Schemes Act is presented in Box 1 (page 2).

Box 1: Explanatory note to Annexure A of the regulations to the Medical Schemes Act No. 131 of 1998

“The Department of Health recognises 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. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall 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.”

Since these regulations have become effective there has been considerable development in the management of HIV/AIDS; a number of inconsistencies and flaws in the current regulations have been identified; the cost-effectiveness of health technologies or interventions has changed; further development of health policy with respect to the protection of risk pools are to be introduced (See section 2.2.1) and the impact of PMBs on medical scheme viability and affordability has been considered.

These matters all have an impact on the context that influences the 2008 PMB review, and are elaborated on in section 2.2 below.
2.2 Context

2.2.1 Current health care financing reform initiatives

The private health care sector forms part of the overall national health system and health policy therefore needs to realise the right of access to healthcare irrespective of whether services are offered in the public or private sectors. This is especially important as the private health system consumes more than 50% of total health resources while only providing access to a relatively small minority of the population. Only about 15% of the population has access to private health insurance.

A systemic outcome of unregulated competition in the private sector is greater exclusivity rather than inclusivity. Unguided commercial imperatives largely contradict the obligation on government to ensure access as it is easier for schemes to compete on the basis of risk selection than on price or efficiency. The natural consequence of this market conduct is the permanent exclusion of individuals or groups with predictable health needs. In other forms of insurance this problem does not arise, or does not present a problem, as the risks of claiming are not known in advance, or where they are (e.g. an individual with a fatal condition taking out life insurance), it is appropriate to exclude the individuals. In healthcare, excluding individuals with known health conditions or known to be at a higher risk of claiming, results in a loss of access to health insurance as well as access to healthcare – which undermines the Constitutional imperative to give effect to the right of access to health care.

The challenge of public policy is to establish the conditions for insurable groups to be risk-pooled together with otherwise uninsurable individuals and groups.

Even though the PMBs have an important role in the protection of risk pools (see section 2.2.2, page 4), it is important that these are implemented along with complementary reforms. On 5 March 2008 Cabinet has approved the draft Medical Schemes Amendment Bill for introduction to Parliament soon. This Bill further strengthens community rating, improves open enrolment and introduces risk equalisation – key elements required for the protection of risk pools.

Analysis of public comments on the draft Medical Schemes Amendment Bill has demonstrated that the introduction of risk equalisation without the expansion of the
PMBs will to a large degree negate the positive effects of risk equalisation. The introduction of the REF therefore necessitates the review of the current PMBs.

Included in the Government’s Programme of Action for 2008 is the Social Cluster objective to continue work on health insurance and to conclude this work by the end of the year.

2.2.2 Role of PMBs in the protection of risk pools

PMBs operate in an insurance environment, in contrast to a vertically integrated publicly provided health-care provision system where the focus is on a planned gatekeeper and referral system. This approach is consistent with a public funder approach.

In the insurance environment, the focus is on risk pooling to eliminate significant financial impact on households and is consistent with contributory third-party payer systems.

People with pre-existing conditions, or who exhibit characteristics that are strongly correlated with poor health status, are uninsurable in a conventional insurance market. In this context PMBs represent a key element of health system financing and along with community rating, open enrolment and risk equalisation, play an important role in the protection of risk pools.

PMBs structurally reduce discrimination on the basis of health status because if these are comprehensive enough, they remove the ability of schemes to separate insurable and uninsurable (or less insurable) individuals through benefit design. PMBs therefore protect access to healthcare by protecting access to “insurance” for less preferred risks.

The existing set of PMBs are however minimalist and do not provide adequate protection against risk selection activities (particularly benefit design) by medical schemes. In other words, they do not provide sufficient risk pooling outcomes resulting in the combination of insurable and uninsurable risk groups due to the non-inclusion of much essential health care. Whenever essential healthcare is not a PMB, it becomes a basis for risk selection and the permanent exclusion from insurance of sicker and less healthy risk groups and individuals.
2.2.3 Other requirements specific to the insured environment

Section 2.2.3.1 deals with the manner in which benefits could be constructed to provided rand-for-rand cover while section 2.2.3.2 presents potential PMB constructs in terms of cost, frequency and protection in relation to health status.

2.2.3.1 Rand-for-rand cover in the insurance environment

In the health insurance environment\(^1\), 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. Given that the need to insure these benefits is in any case low, given that most people will claim what they contribute up to a certain level of contribution, gaps in cover here have limited social and risk pooling implications. However, systemically sicker people will need protection over-and-above a particular threshold, as their needs exceed that of those with good health status. The central challenge is therefore to risk pool for those health needs that will impose a significant financial burden on individuals and/or families such that their access to healthcare will be compromised.

2.2.3.2 Potential benefit constructs

In addition to its role in the protection of risk pools in the insured environment, the cost of specific healthcare interventions and their frequency also determines whether a benefit should be regulated as insurable or not (See paragraph 2.2.3.1). Through the application of mechanisms such as co-payments, thresholds, and limits, insurance benefits may systematically discriminate against individuals with poor health status.

Figure 1 (page 6) provides an illustration of where the existing PMB set is prioritised. It shows that the current PMB construct includes benefits representing events that occur frequently as well as rarely. In general, the cost of these events is high and minimal protection is offered for low cost events. This construct prevents discrimination against

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\(^1\) The health insurance environment is characterised by considerable non-health costs and provider and member moral hazard associated with a third party payer in a fee-for service remuneration system.
people with poor health status for these high cost events. Figure 2 (page 7) illustrates where a PMB focusing on low cost high frequency cover would lie.

Figure 3 (page 7) illustrates a construct whereby cover is offered for low cost events of both high and low frequency, with specific protection for individuals with poor health status. This construct implies that there would be no protection against catastrophic high cost events for any individuals.

An alternative whereby protection for low cost events is extended to individuals with poor health status (e.g. through above threshold benefits and a requirement that there be no limits applicable to specific conditions) is presented in Figure 4 (page 8). Systemically sicker people need protection over and above a particular threshold, as their needs exceed that of those with good health status. The central challenge is therefore to risk pool for those health needs that will impose a significant financial burden on individuals and / or families such that their access to healthcare will be compromised.

Figure 5 (page 8) illustrates an alternative whereby the existing PMBs are expanded to include protection for all individuals regardless of health status for relatively low cost and low frequency events.

**Figure 1: Current PMBs by cost, frequency and health status**
Figure 2: Current PMBs broadened by the inclusion of primary care with utilisation limits

Figure 3: A PMB construct that protects individuals with poor health status for low cost events
2.2.4 Sustainability threats of the current PMB framework

Threats to the sustainability of the revised PMB package are categorised as being related to cost, quality or access.
2.2.4.1 Access / selection to scheme

These factors include those that would threaten access to private healthcare by consumers. The following factors were identified as potential threats:

- Underwriting risk
- Lack of mandatory membership
- Stagnant membership
- Premium pricing
  - Non healthcare cost
  - PMB package

2.2.4.2 Quality / utilisation / efficiency

Factors that could present potential threats to utilisation, quality and efficiency include the following:

- Managed Care – Non health cost /efficiency
- Ability to manage member expectations
- Distribution of healthcare delivery services including DSP
- Definition of the role of the gatekeepers
- Outcomes of healthcare delivery services – value proposition
- Inadequate PMB package and its relationship with perverse utilisation
- Uncontrolled introduction of new healthcare technology
- Inadequate PMB Guidelines
- Creative utilisation of services by consumers
- Supplier induced demand

2.2.4.3 Pricing / cost

Threats to the PMB package that are a result of pricing of services include:

- Poor harmonisation of regulatory provisions for the determination of scope of provider practice and tariffs
- Poor definition of “at cost” in the legislation which often result in the blank cheque approach to PMB by healthcare providers: price unlimited
- Add on fees: e.g. facility fees
- Co payments – based on UPFS as a reference price
- MSA / out of pocket
- Lack of clarity to consumers
- Creative billing to increase price (diagnosis creep)

2.2.5 Other problems with the existing PMBs

The manner in which PMBs are currently defined makes it difficult for a member to prospectively know whether specific benefits are covered or not. This is because it frequently does involve costly diagnostic work, and possibly expensive procedures need
to be performed, only to establish that a beneficiary suffers from a condition that is not included in the DTP list.

Even though an EDL specifically developed for PMB purposes, and a list of procedures that are only performed for essential conditions may potentially assist in clarifying PMB benefits, the existing PMBs makes no provision for these.

Another concern is the lack of consistency in clarity with which the current PMBs are defined. Conditions of similar severity, similar systems and underlying pathology, for which treatment of similar cost and effectiveness is available, are included or excluded without apparent reason (e.g. tonsillitis, otitis media and sinusitis).

Another area where uncertainty around entitlements or responsibility to offer benefits is apparent is ascribed to the fact that there are no protocols for the DTPs. A possible solution is the development and maintenance of protocols or “baskets of care” for the 270 DTPs.
3 Proposed principles applicable to the PMB review

The DTPs have served a very useful function in ensuring cover for a list of specific conditions, often catastrophic (financially or health wise) in nature, but fall short in providing comprehensive and essential cover. It provides cover for existing conditions, once diagnosed e.g. appendicitis, or diabetes mellitus, or cancer, etc., but fails in the provision for prevention of diseases by early detection. Consultative services, in particular primary care services, are necessary to achieve this.

The term “basic benefit package” has been introduced by the international review panel that has evaluated the REF proposals developed by the REF task team. They have identified the need for a more comprehensive essential basic benefit package to simplify benefit option design and to enhance the impact of the REF. The applicable mechanism in South Africa would be through the expansion of the PMB package that, in its current form is minimalist and not commercially viable on a stand-alone basis. Circular 8 of 2006 introduced the concept of “common” benefits, which were those benefits that were offered by schemes to all of its members. The correct term for the “basic benefit package” (in the sense used by the international review panel), constituting a comprehensive package of essential benefits is therefore the “prescribed (minimum) benefits (PMBs)”. This is a regulated set of minimum benefits which must be offered by all medical schemes. It seeks to specify a standardised benefit design with certain general requirements for coverage. This differs from the existing specification of prescribed minimum benefits (DTPs and the CDL) which focuses exclusively on specifying conditions and treatments that require coverage.
3.1 **In defining the PMBs, the following principles must guide the process**

- Legislative and regulatory consistency must be achieved
- Risk pooling must be ensured which permits access to essential healthcare for people with and without predictable health needs
- Essential health care, within the context of a contributory third-party payer system, must be defined
- Benefits must be defined in such a way that:
  - medical scheme members are able to have certainty concerning their coverage;
  - medical schemes are able to identify member entitlements\(^2\)
  - medical schemes are able to fairly and reasonably manage their liabilities in respect of members
  - they do not reinforce inefficient provider or patient conduct
  - they do not result in the unfair exclusion of defined vulnerable groups

3.2 **Principles that are applicable in defining the mechanism applied to selection criteria**

To date PMBs have been primarily defined in accordance with one approach, namely disease treatment pairs. This narrow approach is only useful in protecting members retrospectively where a dispute arises as to coverage. Members have little advanced understanding of their rights. In reality PMBs can be defined in many different ways.

To address these concerns the full set of PMBs should be framed in any reasonable manner which supports the principles outlined in section 3.1. The construct of the PMBs could be based on:

- Disease treatment pairs (Condition specific);
- General definitions of coverage (Service specific) subject to negative lists of what is not covered; and
- Specified procedures and essential drug lists for specific conditions where applicable and supported by utilisation evidence (Hybrid / mix between conditions and services)\(^2\)

\(^2\) To meet this requirement, clear entry, inclusion, exclusion and exit criteria (treatment baskets) for the PMB conditions must be developed in such a manner that these could be applied consistently and with adequate information available on what treatment modalities are included and what not. (See section 3.3, page 13.)
3.3 **Other principles that must be adhered to when developing the entry, inclusion, exclusion and exit criteria (treatment baskets)**

- Uphold evidence-based medicine principles
- Cost-effectiveness
- Administrative implementation of such a package
- Moral hazard concerns in respect of both medical scheme members and healthcare service providers
- Conditions representing a high burden of disease or have high cost implications must receive priority attention in the development of the entry, inclusion, exclusion and exit criteria.
4 A Proposed Structure of an appropriate Prescribed Minimum Benefit Package

4.1 Introduction

The prescribed minimum benefits offered by schemes must reflect essential benefits and ensure adequate comprehensive coverage within a medical scheme. These common benefits will permit their risk-equalisation, thus ensuring that no inter-scheme instability arises from the community rating of these common benefits.

4.2 Proposed mechanism for the application of inclusion / exclusion criteria

The PMB package should be defined in a manner that removes inappropriate gaps in cover resulting from exclusive reliance on the DTP approach. Consequently, it is recommended that a comprehensive set of minimum benefits based on a hybrid model construct be developed. It should contain both specified services defined through use of general definitions of cover, as well as a list of specified conditions. The ‘List of Specified conditions’ would make it possible to more precisely identify which conditions are covered (Positive List) and by developing baskets of care based on guidelines and protocols to ensure appropriate clinical and financial risk management. Over and above these limitations, a negative list of conditions or treatments that can be excluded from the basic package is necessary.

A significant benefit of a broad general definition is the removal of any ambiguity in benefit entitlements for members, who are unable to relate to condition-specific entitlements when joining a medical scheme. Moreover, uniformity of benefit representation leads to consumers being placed in a position where they can make informed choices between schemes.

4.3 Proposed framework

To meet the other requirements set out in section 3 of this document, and in order to assist consumers in selecting a preferred scheme, the following framework for PMBs is recommended to initiate a shift toward more appropriate coverage consistent with social security objectives:
4.3.1 The set of PMBs should be increased to protect:

- Access to comprehensive hospital cover; and
- Access to appropriate out-of-hospital cover;

4.3.2 Out-of-hospital services shall be limited to:

- The positive list of conditions covered (currently the DT pairs and the CDL list).
- A basket of defined preventative care;
- A basket of defined primary care;
- A basket of defined basic dentistry;
- A basket of defined basic optometry;

4.3.3 Limitations on cover:

These are appropriate where they permit a degree of financial risk management. Based on this approach, a co-payment or excess could be allowable in relation to “out-of-hospital services” as defined in the baskets. Reasonable cost-sharing with medical scheme members should be permissible for healthcare services where the demand for these services is subject to high member discretion, and for healthcare services that are more routine in nature and consequently do not require insurance.

Furthermore, it would be necessary to develop protocols dealing with maximum efficiency\(^3\) to ensure appropriate clinical and financial risk management.

\(^3\) The best healthcare money can buy with maximum efficiency and cost-effectiveness, including appropriate level of care and setting
4.4 **The comprehensive PMB definition:**

1. **In-hospital services:** subject to-
   - the Positive list (currently DTPs & CDL);
   - a Negative list,

2. **Out-of-hospital services:** subject to-
   - The Positive list (currently DTPs & CDL);
   - a Negative list;
   - Specified services;
5 Functional group work plans

5.1 The PMB review project

Figure 6 below demonstrates that the definitional work needs to be performed by the PMB definition group before the PMB sustainability and REF groups could finalise their work. After the definitions have been finalised by July, the details on the REF work and the recommendations from the sustainability group could be expanded on during the following months.

Figure 6: Timelines for the PMB 2008 review
5.2 The PMB Definition group work plan

Stakeholders are invited to submit comments on the framework specified in section 4 (page 14). Comments must be limited to 5 pages and will be considered by the PMB review committee. Stakeholders may be invited to discuss these submissions, after which more detailed work on the details of the package and the treatment baskets would commence.

5.3 The PMB Sustainability group work plan

5.3.1 Introduction

The assessment of the sustainability of the revised PMB package is essential to ensure that appropriate measures are developed in order to mitigate the negative effects of identified constraints and hindrances to the effective implementation of the package.

This process will augment constraints that would have been identified in the definition groups that threaten the sustainability of the package.

5.3.2 Key activities

- Development of principles that needs to be applied to consider the threats to sustainability
- Recommendations on how to limit overcharging and balance billing for PMB benefits
- Recommendations on the measures that must be applied to ensure the sustainability of the full package

5.3.3 Potential threats to the sustainability of the PMB package

5.3.3.1 PMB sustainability group focus areas

To address the key threats to the sustainability of the PMBs are listed in section 2.2.4 (page 8), focus areas for the PMB sustainability group have been identified:

- Support for mandatory cover
- Capping of the level of reimbursement for PMB services
- Standardisation of the PMB package
- Improved value proposition
- Measures for control of increase in medical costs
- Consideration of price sensitiveness of consumers, particularly, low income earners
- Proper coding of diagnosis and procedures by healthcare providers
- Improved standards of and contracting with managed care entities
5.3.3.2 Work Plan

There are primarily three levels on which to approach the work on sustainability. The first level entails an evaluation of the package completed by the definition groups in terms of its affordability to members. As a result, work on this aspect will only commence after the process of the determination of the PMB package has been completed.

The second level entails the process of the determination of the reimbursement level of healthcare services. This process falls under the jurisdiction of the DoH and is receiving attention through amendments to the National Health Act. It will nevertheless dovetail with the initiative on defining the “at cost” part of the regulation with regard to reimbursement of PMBs or allow for the determination of the level at which PMBs are reimbursed.

The last level is with regard to harmonisation of regulatory approaches pertaining to health. This process involves interaction with other regulators on areas of concurrent jurisdiction in order to eliminate potential threats to the sustainability of the package arising from differing legislative provisions.

5.4 The REF Group work plan

The REF process will kick off as soon as the so-called first principles, broad outline of the PMB package and the definitions are defined. The PMB definition group will provide the REF group with at least one PMB model.

A first order explanatory analysis (quick and dirty analysis) will be conducted by Discovery Health (Pty) Ltd and Metropolitan Health Group (Pty) Ltd to get initial estimates of these model(s) in total and for the individual components. Other administrators and schemes are welcome to join them in this exercise, and to include their findings in their submissions to the PMB definition group.

The preliminary findings will be circulated and discussed within the REF group. Once the REF group is satisfied with the results, the results will be considered by the PMB definition group. Thereafter the process may become iterative where certain components may be expanded or discarded up to a point where there are “reasonable” alternatives of the PMB package for consideration. (The REF group will also advise the PMB definition group on the reliability and availability of the different data components.)
The REF group will then meet to specify the data outline that would be necessary to do the final costing of the PMB package. The dataset should be comprehensive and robust enough to slice and dice benefits and to calculate reliable estimates for the individual components and the package in total.

Once the data outline and scope of the costing exercise is defined, the REF group will table their findings to the REF Steering Committee and RETAP. All participants (actuaries, statisticians, accountants, etc.) will be invited to give a short presentation at these meetings on the methodology (sample size, GLM, simple averages, etc.) that they will follow to do the final costing of the PMB package, the identification of the REF risk factors and the REF weighting table. The REF formula and REF risk factors should be measured and tested against the current guiding principles.

The REF Steering Committee must approve the final data-outline and methodology. CMS will then formally ask industry for data to do the final costing of the PMB package.

The following are estimates for each of REF groups’ activities:

- Explanatory analysis: 1 month
- Collection and cleaning of final dataset: 4 - 6 months
- Analysis of the data: 6 months
- Information dissemination: 2 months

During the analysis phase, the REF group will work closely with the Sustainability group to make sure that the PMB package is sustainable and affordable. Due to possible changes in claiming patterns (behavioural impact); it is recommended that the costing exercise is reviewed every two years.

It is important that CMS is actively involved with industry (participating administrators and schemes) in the costing of the final product.

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4 The Determination of the Formula for the Risk Equalisation Fund in South Africa By Professor Heather McLeod, Shaun Matisonn, Dr Izak Fourie, Pieter Grobler, Susan Mynhardt and George Marx: January 2004.