Comments on the
2008 PMB Review consultation document
Proposed construct and work plans
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Contents:

1. Introduction........................................................................................................................................ 2
2. The PMB’s within the South African Health Sector context ............................................................. 2
   2.1. It’s about priorities ..................................................................................................................... 2
   2.2. Constitutional and legislative mandate .................................................................................... 3
   2.3. The social determinants of health ........................................................................................... 4
   2.4. Health care provision .............................................................................................................. 4
3. Primary Health Care .......................................................................................................................... 4
4. Co-payment or excess in primary care settings ................................................................................ 5
5. Suggested approaches to PMB design ............................................................................................. 5
1. Introduction


The initiative of the Council for Medical Schemes to review the current PMB’s is to be welcomed – especially the stated aims – which include:

...“ensure adequate comprehensive coverage…” (section 4.1),
...“the PMB package should be defined in a manner that removes inappropriate gaps in cover resulting from exclusive reliance on the DTP approach…” (section 4.2),
“...the new framework for the PMB’s should initiate a shift toward more appropriate coverage consistent with social security objectives…” (section 4.3).

We are also in agreement with the broad recommendation that the “…comprehensive set of minimum benefits (be) based on a hybrid model construct…” (section 4.2)

The consultation document represents an important step towards greater equity and efficiency in the design of the PMB’s and this is wholeheartedly supported.

This PMB review occurs before the initiation of the Risk Equalisation Fund (REF) and therefore presents an important window of opportunity. As future reviews will be guided by the then existing REF basket, future changes are likely to be at the margins rather than a review of the actual design and construct of the PMB’s. It is therefore critical to maximally utilise this particular window of opportunity. The following comments are put forward with this imperative in mind and in the spirit of seeking ways to strengthen aspects of the proposals contained in the consultation document.

2. The PMB’s within the South African Health Sector context

While considering the proposed framework in detail, it is important to consider context and the impact of the PMB’s. It is important to recognise that these proposals are not simply of relevance to the private health insurance industry; they present a major policy lever for addressing key health sector challenges. Thus, it is necessary to explicitly review the proposed framework in the context of the challenges currently facing the South African health sector.

2.1. It’s about priorities…

A criticism of the existing PMB package is that there has not been any explicit efficiency, effectiveness or equity criteria published against which current PMB’s can be judged. This results in perceptions of ad-hoc decision making, and the suspicion that resources are not allocated optimally in support of those most in need (the sick and the poor).
What is important is that the principles on which any priority setting in health care is based should ensure that available resources are allocated in such a way that not only maximizes the benefits received from the given financial investment, but importantly, reflects the priorities and health construct of the community being served.

What this means is that in order to set priorities we first need to determine society’s health construct, including the role of health care and the desired outcomes of health services. Based on this understanding, the ‘guiding principles’ on which to base priority decisions, can be defined and made explicit. Ideally these principles would be set by the community itself, but at the very least, in the South African situation, these principles should adhere firstly to the Constitution of South Africa, and secondly, reflect health policy as set out in legislation.

These are social issues and not professional ones in the first instance. Priority setting (which the PMB process undoubtedly is) therefore first involves determining objectives, criteria and principles and then setting up decision-making mechanisms to meet competing objectives as well as possible.

If we continue to ignore the social context in we find ourselves and forgo this opportunity to seek to more explicitly to allocate resources in order to reduce inequities and disadvantage between social groups, we would be remiss. The priority we give to our vulnerable populations should reflect our social values. The regulated minimum package of cover should therefore be determined by our health care priorities and in this context, now becomes a powerful tool for ensuring equity objectives.

2.2. Constitutional and legislative mandate

The right to health care services is provided for in three sections of the South African Constitution. These provide for access to health care services including reproductive health, basic health care for children, emergency services and medical services for detained persons and prisoners. (Section 27 (1) (a), (b), & (c) and section 35 (2) (e) of the Constitution of the Republic of South Africa, Act 108 of 1996).

Access is a precondition to health services utilisation where such services are needed. Access is best defined as freedom to use. By taking into account personal capacity, the idea of freedom to use goes a step beyond the concept of opportunity to use. Freedom to use describes the social possibility and the individual ability to give direction to one’s will to use health services.

Section 3(1)(d) of the National Health Act requires the Minister of Health to ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic.

The International Review Panel to the Risk Equalisation Task Group (2004) recommended the extension of the existing PMB’s with the aim of the establishment of a mandatory essential healthcare package for South Africa as a strategy to improve population access to basic health care. The package was to include additional benefits including primary care and outpatient drugs.
2.3. The social determinants of health

There is a substantial literature on what is known as ‘the social determinants of health’ which recognises that there are many social factors such as poverty that have an effect on the health of people. vii

In summary:

- the poor are less healthy than the rich;
- the rich are more likely to use health care when sick; and
- the poor are more strongly affected by public spending on health care in comparison with the non poor. For example ‘a 1% increase in public spending on health reduces child mortality by twice as many deaths among the poor.vi

There is also an extensive literature documenting pervasive and persistent socio-economic gradients in health in both developed and developing countries, and the paradox that those in more disadvantaged social circumstances are less likely than their more advantaged counterparts to accept the existence or magnitude of socioeconomic inequalities in, or determinants of, health. vi While income, education and occupation have independent effects on health status, there is a health gradient by socioeconomic status that extends well into the upper reaches of the status hierarchy.viii People in higher social positions have access to resources of income, wealth, knowledge and power that allow them to take advantage quickly of opportunities to improve health.ix There is no reason for South Africa (and the group of South Africans who have health insurance) to be any different.

2.4. Health care provision

What has to be borne in mind is the influence over the provision of health care exerted by the design and contents of the PMB package. Promotion of new, possibly expensive, technologies and services will be influenced by / respond to the types and range of services defined in the PMB’s. It is our view that the health care needs of the whole country should be considered before concentrating private health care service resources around tertiary care.

3. Primary Health Care

Unlike tertiary and specialized care, primary care is less expensive, more responsive and more accessible to broader populations. International evidence demonstrates the health-promoting effect of primary care. A study of OECD countries showed lower costs and improved health outcomes, measured by low birth weight and post neonatal mortality among countries with greater primary care infrastructure.x Proactive primary and preventative care has been shown to affect the incidence of disease,x and reduced access to primary care has been shown to lead to delays in diagnosis and treatment which in turn contributes to disparities in health.xi

Other studies show lower mortality and better self-rated health among areas with higher ratios of primary care physicians, while controlling for socio-demographic measures and lifestyle factors.xii

It is well established that some relatively poorer countries have achieved levels of infant survival and adult life expectancy superior to more affluent countries. Examples include Kerala in India, Costa Rica,
Cuba and Sri Lanka. Three factors appear to differentiate poor countries with favourable mortality: emphasis on educational attainment, empowerment of women, and importantly in the context of this document, well organized primary medical care systems.viii

4. Co-payment or excess in primary care settings

Most studies, in low-income and affluent nations alike, have found that the price elasticity of demand for clinical services is greater than zero but less than one (i.e. price-inelasticity). Thus, cost-sharing by patients reduces demand. The RAND experiment with different models of health insurance deductibles and co-payments in the United States, found that for most consumers, higher prices reduced demand but did not reduce the use of less cost-effective services: ‘cost sharing reduces the appropriate and inappropriate care in about the same way’. However, poor people, and especially poor people needing preventative care, tended to reduce utilisation in ways that substantially threatened their health. ix

This needs to be borne in mind when considering co-payments in primary care settings. It is our view that the aim of the PMB’s should be to eliminate out of pocket payments for the services defined completely, especially primary care services.

5. Suggested approaches to PMB design

Designing a basic benefit package with a particular target population in mind requires detailed knowledge of the specific population, their need of services, the community’s values regarding how to frame the basic benefit package, as well as awareness of the mandates and requirements imposed by our Constitution and our law.

Important for us to bear in mind is that, for the poorer populations, the PMB package becomes the only set of benefits that can be afforded. It is this ‘poorer’ population we are concerned about and we suggest that consequently, traditional approaches to benefit design, such as the protection of assets, have to be weighed against the concept of access promotion.

An argument can also be made that the Council for Medical Schemes must ensure the provision of some interventions if they are to be provided adequately or at all, because private markets are likely to under-provide public goods and goods with substantial positive externalitiesxiv. This is shown in the fact that South African medical aid schemes have been very slow to fund preventative services. It is our view that when compared to secondary and tertiary services, primary health care services provide many more services with positive externalities.

The discussion above supports the argument that PMBs should include comprehensive primary health care services as required our law, and to avoid inequity at the point of first contact. Opportunistic prevention (e.g. blood pressure screening during a consultation for acute infection) is probably the most efficient and cost-effective means providing services to a population, as opposed to a ‘list of preventative services’ which are included in isolation from the individual’s health construct.

A positive / negative list is also potentially inequitable at the primary care level as patients present with illnesses, usually undefined, rather than diagnosis. Provision should be made for cover of the diagnosis and acute treatment of ‘simple’ illnesses (not on the positive list), e.g. acute bronchitis, with drugs on the Essential Drug List, as well as for further diagnostic workups. This will address the concerns raised in
the RAND experiment above, and will reduce the administrative burden associated with disagreements over case definitions and hence what is included or excluded on the positive or negative list.

While essential benefit packages started out as an attempt to improve health service efficiency, theoretical and practical factors suggest that they are actually more suited to preventing catastrophic illness events, ensuring risk pooling and eliminating inequitable access to care, especially where they form part of regulatory, rather than rationing exercises. 

We respectfully propose that the comprehensive PMB definition be changed as follows: (changes highlighted in red)

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

2. **Out-of-hospital services:** subject to

2.1 Primary Care:
   
   Cover for a limited number of annual visits per individual which will include diagnostic workup and treatment for the presenting complaint (limited to acute treatment from the EDL) as well as appropriate opportunistic preventative services.

2.2 Specialist / Referral Care
   
   The Positive list (currently DTPs & CDL);
   
   a Negative list;

   Other specified services;

6. **References**

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