Prescribed Minimum Benefit Reform in South Africa:

Solidarity, Equity and the Limits of Product Affordability

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A Regulatory Perspective

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Abstract

Background: Proposals to revise South Africa's prescribed minimum benefits (PMBs) have returned to the policy agenda, framed largely as a means of making medical scheme cover more affordable for lower-income households.

Objective: This commentary examines whether the available evidence and the governing legal framework support narrowing the statutory minimum entitlement as a route to affordability.

Approach: We undertook a structured documentary analysis of the Medical Schemes Act 131 of 1998 and its regulations, the Health Market Inquiry, the National Health Insurance Act 20 of 2023, relevant case law and the Council for Medical Schemes' industry reporting, and interpreted these sources against the international health-financing literature.

Findings: The analysis supports two interrelated arguments about the purpose and evidentiary basis of PMB reform. First, PMBs function as a social-protection and market-regulation instrument rather than solely as catastrophic insurance, so reducing the entitlement does not remove the disease, the clinical need or the cost but relocates them to households, savings accounts and the public sector. Second, the empirical case for a reduced package rests on aggregate indicators, notably the share of scheme expenditure attributed to PMBs and total out-of-pocket spending, which have not been disaggregated in ways that would identify the entitlement as the cause of unaffordability. Industry data for 2024 point instead to rising unit costs, utilisation and an ageing membership.

Conclusion: PMB reform should modernise benefit design through transparent, evidence-informed priority setting, strengthen risk pooling and income-related contributions, and regulate provider tariffs, rather than achieve affordability by contracting the minimum entitlement. These complementary financing measures should not, however, be allowed to delay benefit reforms that have been recommended since 2004.

Keywords: *prescribed minimum benefits; medical schemes; social solidarity; risk pooling; universal health coverage; benefit design; health technology assessment; South Africa*

1. Introduction

The debate on prescribed minimum benefits (PMBs) has resurfaced in South Africa. Earlier this year, a prominent industry commentator argued that revising the compulsory benefit package is the first practical step towards affordable medical scheme cover, a position foreshadowed in earlier commentary on structural cost pressures in the industry.[1,2] The underlying concern is considerably older than the current exchange. In 2004, an international review panel observed that no medical scheme marketed or sold the PMBs as a distinct package, that the benefit was defined almost entirely through diagnosis and treatment pairs (DTPs) oriented towards hospital admission and specialist care, and that the PMBs would need to become a marketable package; it accordingly recommended a basic benefit package comprising the PMB conditions together with primary care.[3] The Council for Medical Schemes (CMS) subsequently initiated a formal review of the PMBs in 2016, issued an update and call for inputs in 2018, and consulted on draft primary healthcare (PHC) services in 2019.[4–6] Nevertheless, the CMS Strategic Plan for 2025 to 2030 records that no specific timeline can yet be given for completing the review.[7]

The Health Market Inquiry (HMI), which reported in 2019, reached a conclusion similar to that of the 2004 panel, criticising the hospital-centric orientation of the PMBs and recommending a standardised base benefit package.[8] More recently, industry commentators have argued that the existing benefit structure is outdated, hospital-centric, inefficient and costly, and have increasingly presented a narrower compulsory package as the appropriate response.[1,2] This position overlooks the fact that many of the structural weaknesses now attributed to the PMBs have been recognised for more than two decades and have been accompanied by repeated, but unimplemented, recommendations for reform.[3,4,8] Treating these unresolved deficiencies as evidence for narrowing the package produces a circular argument, because the failure to implement longstanding reforms is used to show that PMBs are inherently deficient and then to justify a reduced minimum entitlement. Health policy analysis has long cautioned that the outcome of reform depends on actors, context and process as much as on policy content,

which suggests that the more productive question is why the recommended reforms have stalled.[9]

The CMS, in exercising its statutory responsibility to protect the interests of beneficiaries, ***therefore calls on stakeholders who advocate a reduced package to demonstrate precisely what problem a reduced minimum package is intended to solve that cannot be addressed through the implementation of the previously recommended reforms to PMBs***, including the incorporation of primary healthcare and the development of a standard base benefit package.[4,10] The critical questions concern not only what a revised package would contain, but also who would be entitled to it, how it would be financed, how risks would be pooled across income and health-risk groups, and whether the reform would strengthen or dilute the solidarity on which medical scheme regulation rests.[11,12] International guidance on benefit design holds that changes to an entitlement should be preceded by explicit specification, costing and assessment of equity and distributional effects.[13,14] Because the Medical Schemes Act 131 of 1998 obliges the regulator to protect beneficiaries rather than to secure the commercial viability of particular products, the CMS cannot endorse any contraction or differentiation of statutory entitlements in the absence of such analysis.[10,15]

PMBs are not features of an insurance product that may be removed or substituted according to consumer willingness to pay. They constitute a regulatory minimum applicable to all medical scheme beneficiaries, determined by the Minister of Health under section 67(1)(g) of the Medical Schemes Act and given operational effect through Regulation 8 and Annexure A of the regulations.[10,15] Any proposal for a differentiated, lower tier of minimum protection therefore raises an unresolved legal and policy question about whether such a tier can be accommodated within a framework that establishes PMBs as a generally applicable statutory entitlement. The evidentiary case for such a departure has not yet been made, because it would need to specify what a reduced package would cover, how its contents would be determined, what it would cost, how excluded needs would be financed and how benefits, costs and financial risks would be distributed across lower-income beneficiaries, medical schemes and the public health system.[13,16,17]

Dr Clarence Mini, who chaired the Council of the CMS until he died in 2020, called on the industry to pursue reform through “inclusive solutions and consensus”.[18,19] His appeal remains apposite, since sustainable reform of the medical schemes environment cannot rest on the preferences of any single constituency, whether funders, providers, the regulator or government. The WHO Consultative Group on Equity and Universal Health Coverage similarly emphasised that fair choices on the path to universal coverage depend on transparent, accountable and participatory processes as well as on substantive criteria.[14] Consensus in

this sense does not require agreement on every policy choice; it requires a process through which competing interests, evidence and trade-offs are weighed openly before a defensible reform position is adopted, and through which trust in the institutions of the health system is sustained.[9,20] The principle applies in both directions, because inclusive reform can be achieved neither through regulatory prescription without adequate engagement nor through changes to statutory entitlements driven principally by sustained advocacy or litigation.

This commentary therefore engages with the evidence, legal architecture and health-financing principles that bear on the arguments advanced in recent public commentary, rather than with the motives of any party. Its objective is to establish what would be required for a proposed reform of the PMB framework to be legally coherent, economically sustainable and equitable. The analysis contributes to the literature and to policy in three related ways. Theoretically, it situates PMBs within the functional framework of revenue raising, pooling and purchasing, and argues that they are best understood as an instrument of solidarity rather than as a residual catastrophic benefit.[11,12,21] Methodologically, it proposes a disaggregation test for the expenditure and out-of-pocket evidence advanced in support of benefit contraction. Practically, it identifies the conditions under which tariff reform and benefit modernisation could improve affordability without dividing the minimum entitlement by income, which is a concern with a long pedigree in the literature on solidarity and actuarial fairness.[22]

2. Approach

We adopted a qualitative, document-based policy analysis, an approach suited to examining how legal instruments, regulatory reports and public argument construct a policy problem and its proposed solutions.[9,23,24] The primary documents comprised the Medical Schemes Act and its regulations, the National Health Insurance Act 20 of 2023, the final report of the HMI, CMS review documents, circulars, strategic plans and industry reports, and the judgment of the full bench of the Gauteng Division of the High Court in *KeyHealth Medical Scheme v Ngoepe NO and Others*.[8,10,15,25–27] The published arguments were analysed as the principal statement of the position under examination.[1,2]

The documents were read against an analytical frame derived from the health-financing literature, which distinguishes the functions of revenue collection, risk pooling, purchasing and benefit entitlement and evaluates arrangements against the goals of financial protection, equity in finance and use according to need.[11,12,21,28] Equity and financial protection were assessed with reference to established measures of catastrophic and impoverishing expenditure and to South African studies of financing and benefit incidence.[29–32] Empirical claims were traced to their primary source wherever possible. Where an indicator from the

CMS Industry Report 2024 could be confirmed only through contemporaneous secondary reporting, both the report and the secondary source are cited, and this limitation is discussed in Section 11.

3. Product affordability and entitlement are distinct policy questions

The central analytical weakness of the case for a reduced package is that it frames PMB reform primarily as a product affordability problem rather than as a health financing and benefit entitlement problem.[1] Asking how the compulsory package can be redesigned so that scheme products can be sold at a lower contribution is a different question from asking how entitlements, financing and pooling should be structured so that access is determined by need while contributions reflect ability to pay.[12,21] The second question corresponds to the principle of universal coverage adopted in South African health policy, which seeks to separate the use of services from the capacity to pay for them.[33] It also reflects a longstanding distinction in the insurance literature between solidarity, in which the healthy subsidise the sick and the rich subsidise the poor, and actuarial fairness, in which each person pays according to expected cost.[22]

An approach that begins with an affordable price point and adjusts the benefit package to fit within it resembles the method used in designing the original PMBs, which drew on the diagnosis and treatment pair methodology of the Oregon Health Plan and arrived at a positive list of 270 DTPs.[4,34] A medical scheme product can be made cheaper in four broad ways: by reducing the benefits it covers, by lowering the prices paid for services, by improving the efficiency with which care is delivered, or by transferring part of the financial risk to beneficiaries or to the public sector. These mechanisms are not economically equivalent, because supply-side measures act on the cost of producing care whereas demand-side cost sharing shifts expenditure to patients.[35,36] Reducing or excluding benefits does not remove the underlying disease or need, and transferring uncovered risk to households or the State may lower scheme expenditure without reducing the total cost borne by society.[37,38]

The appropriate test of PMB reform is therefore whether it reduces the cost of meeting healthcare need, improves allocative and technical efficiency, strengthens financial protection and distributes contributions and risk more equitably, and not merely whether it yields a cheaper product.[12,21] This test is consistent with the trajectory set by the 2017 National Health Insurance Policy and the National Health Insurance Act, which pursue financial protection through pooling, cross-subsidisation and strategic purchasing rather than through minimum entitlements that vary with individual purchasing power.[25,33,38] The Organisation for Economic

Co-operation and Development (OECD) has observed that a revised PMB package should be simple to implement and that reform will require a clearer classification of health services and a universally agreed coding system.[39]

The OECD's observation is sound but requires qualification in the South African context. Diagnostic coding is already standardised through the ICD-10, which is used across the public and private sectors and underpins the identification of PMB conditions.[40] The more significant gaps lie in the absence of a universally agreed procedure-coding standard and of a transparent mechanism for determining provider tariffs, both of which constrain effective purchasing.[8] The HMI identified weaknesses in price determination as a structural feature of the private healthcare market, and stakeholders across the medical schemes environment acknowledge that South Africa lacks a transparent and predictable mechanism for setting provider prices.[1,8] Coding reform is therefore necessary, but coding identifies a service and does not determine its appropriate price or the manner in which it should be purchased.[41,42]

On tariff reform, there is substantial common ground. Proponents of a reduced package support the negotiation of fair tariffs within a properly regulated framework, The HMI recommended a multilateral tariff negotiation forum alongside a supply-side regulator for healthcare, and the Registrar of the CMS has publicly described tariff regulation as an area requiring structural reform.[1,8,43] The disagreement therefore concerns the linkage between tariff reform and a reduction in minimum benefit protection rather than the need for tariff reform itself. Lowering inefficient provider prices can reduce the cost of purchasing care without reducing entitlement, whereas reducing benefits makes a product cheaper by moving part of the financial risk elsewhere.[35,41] These are fundamentally different policy instruments, and conflating them obscures where the burden of adjustment would ultimately fall.

4. The statutory purpose of prescribed minimum benefits

PMBs are more accurately characterised as a statutory minimum entitlement within a regulated system of contributory risk pooling than as a catastrophic insurance benefit. The Medical Schemes Act of 1998 was enacted after a period of deregulation during which risk rating and benefit exclusions had fragmented risk pools and increased costs, and it reintroduced open enrolment, community rating and minimum benefits as mutually reinforcing protections.[10,44,45] The 1997 White Paper for the Transformation of the Health System placed these protections within a broader policy of equity and of a complementary relationship between private financing and the public health system.[46] Taken together, these sources indicate that the historical purposes of PMBs encompass beneficiary protection, solidarity and

risk pooling, protection of public resources, and the allocation of responsibility for healthcare expenditure between medical schemes and the State.

Recent commentary characterises PMBs as having been created principally to protect members against catastrophic illness and to avoid reliance on an over-burdened public sector during medical emergencies.[1] This characterisation is too narrow and confuses the content of the original benefit package with its statutory purpose. Section 67(1)(g) of the Medical Schemes Act empowers the Minister to determine the scope and level of minimum benefits without confining that power to catastrophic conditions, and the Act's definition of the business of a medical scheme establishes schemes as contributory mechanisms for financing access to healthcare.[10] Read alongside the social health insurance proposals of the 1990s and the 1997 White Paper, PMBs are better understood as a minimum healthcare entitlement informed by need, equity and solidarity.[45,46] This interpretation is consistent with section 27 of the Constitution, which obliges the State to take reasonable measures to achieve the progressive realisation of the right of access to healthcare services.[47]

This broader conception also explains the regulatory function of PMBs within the medical schemes framework. Economic theory has long recognised that competitive insurance markets characterised by asymmetric information tend towards risk selection, so that insurers compete by attracting low-risk members and excluding costly needs rather than by improving efficiency.[48–50] By establishing a common minimum entitlement across benefit options, PMBs give practical effect to open enrolment and community rating and limit the scope for such competition.[10] The HMI found that schemes nonetheless faced incentives to compete on the risk profile of their membership rather than on efficiency and value, and it recommended a standardised base benefit package as part of its remedy.[8] Subsequent analysis has questioned whether the preconditions for equitable and efficient managed competition are present in the South African market, which reinforces the importance of a common minimum entitlement as a safeguard.[51] PMBs should accordingly be regarded as an integral component of the solidarity architecture of the medical schemes system rather than as an additional benefit layered upon it.

Regulation 8(1) requires every benefit option to pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of PMB conditions, subject to the lawful use of designated service providers, and Regulation 10(6) provides that funds in a member's medical savings account may not be used to pay for a PMB.[15] In *KeyHealth Medical Scheme v Ngoepe NO and Others*, a full bench of the Gauteng Division of the High Court held that a scheme is obliged to pay PMBs from its risk pool rather than from a member's personal savings account.[27] The court characterised the scheme's practice as a stratagem to avoid

drawing on the risk pool and reaffirmed that parties may not contract out of protections enacted for the benefit of a class of persons who do not negotiate from a position of equal strength.[27,52] The effect of the judgment is that the statutory minimum entitlement must be financed from pooled resources rather than from funds attributable to the individual member.[10]

The significance of this requirement extends beyond the mechanics of claims payment, because funding from the risk pool is what gives the entitlement its redistributive character. Where expenditure is met from an individual savings account, the member effectively finances his or her own care, and the cross-subsidies from the healthy to the sick and from higher to lower earners that define pooled financing do not occur.[11,22,53] PMB reform must therefore address not only the scope of the entitlement but also the manner in which it is financed. A recent review of PMB complaints lodged with the CMS found that disputes concerning chronic conditions predominated, which indicates that the practical realisation of the entitlement remains contested even under the existing framework.[54] A minimum benefit that is formally guaranteed but financed predominantly from an individual's own resources would preserve the appearance of coverage while undermining the solidarity on which the entitlement rests.[27,52]

5. Narrowing the minimum entitlement: segmentation or solidarity?

Any proposal must be assessed against this conception of PMBs as a minimum healthcare entitlement supported by collective risk pooling. Recent commentary proposes that schemes be permitted to offer a narrower package comprising a subset of revised PMBs, with benefits based in part on services rendered in public-sector clinics.[1] The proposal is not, however, accompanied by the costing, utilisation or distributional analysis required to show that such an arrangement would improve equity, strengthen risk pooling or reduce the underlying cost of care. International guidance on the design of health benefit packages treats explicit costing, budget-impact assessment and evaluation of equity effects as preconditions for defining or revising an entitlement.[13,14,16]

The difficulty raised by this proposal is conceptual as well as financial in nature. If lower-income households receive a reduced statutory entitlement because they can afford only a lower contribution, while higher-income members retain a broader package, the scope of minimum protection becomes differentiated by purchasing power. South African evidence already shows that the burden of ill health is concentrated among poorer households and that the benefits of health services are not distributed in accordance with need.[31,32,55] Access to care is also unequal across the dimensions of availability, affordability and acceptability.[56] Segmenting the minimum entitlement by ability to pay would therefore compound existing

inequities and move the system away from the principle of need-based allocation that underpins accounts of justice in health.[22,57]

Benchmarking a narrower package against services currently available in public-sector clinics raises a related concern. The historical development of the South African health system has produced marked differences in resources and quality between sectors and provinces, and these constraints should not determine the normative ceiling of entitlement for lower-income members of medical schemes.[58,59] A minimum entitlement should set out the services that beneficiaries ought to receive according to health need and national policy, consistent with the constitutional commitment to progressive realisation, rather than reproduce differences in availability that arise from present resource limits.[33,47]

The proposal also raises a question about the relationship between private financing and the obligations of the State. If a narrower package were to consist predominantly of PHC services that the State already undertakes to provide, it would be unclear whether it represented an extension of entitlement or a private repackaging of services that form part of an existing public commitment.[25,33,47] A further question is whether members enrolled on such a package would enjoy the same minimum entitlement as members of higher-priced options; if they would not, the statutory minimum would become differentiated according to purchasing power. Survey evidence indicates that only about a third of medical scheme members are willing to pay for a dedicated PHC package, which suggests that demand for such products cannot be assumed and should be tested empirically before regulatory change.[60]

Expanding scheme membership by offering a narrower entitlement may increase the number of people who hold a medical scheme product, but it does not necessarily expand equitable access to healthcare or strengthen solidarity. Unaffordable contributions have long been documented as a barrier to private cover in South Africa, and the policy response to that barrier matters.[61] If lower contributions are achieved principally by reducing the entitlement available to lower-income households, the proposal represents a distributional trade-off between affordability and comprehensiveness. Frameworks for fair priority setting require that such trade-offs be made explicit, that their consequences for financial protection be assessed, and that they be defended on those terms rather than presented simply as an extension of access.[14,17,37]

Framed as a product-affordability exercise, the policy objective risks being inverted. PMB reform should not amount to replacing a package described as expensive catastrophic cover with a cheaper and narrower collection of PHC benefits. It should instead use the Minister's power under section 67(1)(g) to define a coherent minimum entitlement that supports continuity across prevention, diagnosis, treatment, rehabilitation and palliative care.[10]

Evidence from comparative health systems research indicates that strong primary care improves outcomes, equity and efficiency when it is integrated with, rather than substituted for, the wider continuum of care.[62,63] The Lancet Global Health Commission on high-quality health systems similarly cautioned that coverage gains which are not accompanied by continuity and quality of care deliver limited health benefit.[64]

PMB reform framed as a reduction in entitlement would risk institutionalising differentiated levels of protection, with a narrower package for those who can afford only lower contributions and more comprehensive protection for those with greater purchasing power. Comparative evidence on private health insurance indicates that markets segmented by price and risk can reinforce inequalities in access and financing unless they are closely regulated.[65] Rather than advancing universal health coverage, such an approach could perpetuate the fragmentation that the 2017 National Health Insurance Policy and the National Health Insurance Act seek progressively to overcome.[25,33,38] The central task of PMB reform is therefore to strengthen the role of medical schemes as contributory risk-pooling mechanisms within the wider health system, progressively aligning the minimum entitlement with solidarity, equity and access according to need.[12]

6. Prevention and treatment: a false dichotomy

The argument that PHC and prevention have been undervalued, and the clinical illustrations it offers, including the modest cost of early diagnostic imaging for breast cancer, are compelling.[1] The underlying insight is not new, however, and has featured in successive reviews of the benefit framework. The 2004 review panel recommended that a basic benefit package include primary care, the HMI criticised the hospital-centric bias of the PMBs, and the CMS has since defined and costed a PHC package as part of its strategic programme.[3,7,8,66] Prevention is therefore common ground in the debate, and the point in dispute is whether its expansion must be financed by withdrawing cover for treatment.

Early detection may improve outcomes and may reduce downstream expenditure, but not every preventive or screening intervention is cost-saving. A widely cited analysis of the economic evidence found that most preventive services add to total expenditure and should be judged by the value they provide rather than by an expectation of savings.[67] Screening may also generate false positives, overdiagnosis and further investigation and treatment, so that its net effect depends on the condition, the characteristics of the test, the screening interval and the population screened.[68,69] These considerations have informed the criteria for justified screening since the classic formulation by Wilson and Jungner.[70]

Whether a service should enter a mandatory package must therefore be determined through transparent health technology assessment (HTA) that considers clinical effectiveness and safety, cost-effectiveness, budget impact, equity, feasibility and the opportunity cost of displaced services.[17,71,72] The National Health Insurance Act contemplates this institutional architecture by establishing a Benefits Advisory Committee and by requiring that the health care services to be purchased be determined through HTA.[25] South Africa has made uneven progress in building HTA capacity, and recent legal analysis has emphasised that a sound HTA process must be grounded in constitutional and administrative-law principles of fairness.[73–75] Revision of the PMB package should be routed through such processes rather than settled through assertion in public debate.

Prevention should not be funded by withdrawing clinically necessary treatment from people who already live with serious conditions. The distributional consequence of such a reallocation would not be neutral, because the beneficiaries of a prevention-weighted package are, on average, younger and healthier than those who would lose treatment cover, so that a revenue-neutral shift would transfer resources from the sick to the well. This concern is heightened by the ageing of the insured population: the average age of medical scheme beneficiaries reached 34.2 years in 2024, compared with 32.5 years in 2016.[26,76] Chronic disease burden is already a strong predictor of service use among scheme members, and decision rules that ignore financial protection may disadvantage precisely those patients who face the highest and most persistent costs.[30,37,77] A package consistent with the right of access to healthcare must therefore support both prevention and treatment across the continuum of care.

7. What the expenditure evidence shows

Citing actuarial advice, recent commentary claims that PMBs absorb approximately 60% of scheme expenditure, compared with about 40% when the package was amended in 2003.[1] The figure cannot be reproduced from the CMS's published reporting, which decomposes expenditure by provider and service category rather than by PMB status, and no methodology, data source or definition of the numerator has been published.[26] Whether PMB expenditure is measured through ICD-10 coding, through benefit-option rules for the DTPs and chronic conditions, or through actuarial imputation materially affects the result.[4,15,40] A figure advanced in support of contracting a statutory entitlement should be published together with its method so that it can be independently verified.

More fundamentally, the share of expenditure attributable to PMBs would not by itself establish that the entitlement causes unaffordability. Table 1 summarises the principal expenditure indicators reported for 2024. Total healthcare benefits paid amounted to R259.3 billion, an

increase of 8.52% on 2023, with hospitals accounting for 35.95% of benefits, specialists for 28.02% and medicines dispensed for 14.05%.[26,43,76] Cost per hospital admission rose by 9.88% while admission rates declined slightly, a combination that signals rising unit prices and intensity of care rather than an expansion of covered conditions.[26,35,41] Relevant healthcare expenditure grew by 9.03%, ahead of growth in insurance revenue of 8.65%, so that for every R100 of insurance revenue schemes incurred R96.18 in healthcare claims and R6.89 in directly attributable insurance service expenditure, leaving a shortfall of R3.07 on insurance operations.[26,43] The CMS attributed claims growth to utilisation, demographic change and ageing, and supplier-induced demand, and its Registrar identified tariff regulation as a key area requiring structural reform.[43] None of these drivers is reducible to the existence of the PMB entitlement as such.

Table 1. Selected medical scheme industry indicators, South Africa, 2024

Indicator	Value reported for 2024
Total healthcare benefits paid	R259.3 billion (an increase of 8.52% on 2023)
Share of benefits paid to hospitals	35.95%
Share of benefits paid to all specialists	28.02%
Share of benefits paid for medicines dispensed	14.05%
Change in cost per hospital admission	Increase of 9.88%, with admission rates declining slightly
Growth in relevant healthcare expenditure	9.03%
Growth in insurance revenue	8.65%
Healthcare claims per R100 of insurance revenue	R96.18
Directly attributable insurance service expenditure per R100 of insurance revenue	R6.89
Shortfall on insurance operations per R100 of insurance revenue	R3.07
Average age of beneficiaries	34.2 years (32.5 years in 2016)
Out-of-pocket payments by beneficiaries	Approximately R46.3 billion (about R3 billion higher than in 2023)

Source: Council for Medical Schemes, Industry Report 2024, as reported in contemporaneous summaries of the report.[26,43,76] Shares are percentages of total healthcare benefits paid; growth rates are year-on-year changes from 2023 to 2024.

PMBs include many services that members would require even if the regulatory classification were removed. Removing a service from the package does not remove the disease, the clinical need or the underlying cost; it transfers the cost from the common risk pool to the patient, from pooled benefits to medical savings accounts, from schemes to households, from private provision to the public sector, or from early treatment to more expensive downstream care.[12,37] International evidence shows that greater reliance on out-of-pocket payment is the principal driver of catastrophic and impoverishing health expenditure, and South African

survey data indicate that such expenditure, while comparatively low, has been rising.[29,30,78] The first of these transfers is not hypothetical, since it is precisely the practice that the full bench prohibited in *KeyHealth*.[27,52] The relevant counterfactual is therefore not a choice between PMBs and no PMBs, but a comparison of the total system cost and distributional effects of alternative ways of financing necessary care.

8. Out-of-pocket expenditure requires disaggregation before diagnosis

The CMS agrees that out-of-pocket expenditure is a growing concern and that it is right to treat it as a signal of coverage failure.[1] The figure of more than R40 billion cited in recent commentary understates the problem, however, since out-of-pocket payments by medical scheme beneficiaries reached approximately R46.3 billion in 2024, roughly R3 billion more than in 2023.[26,43] This trend mirrors international evidence that catastrophic health spending has increased in many countries, which threatens progress towards universal health coverage.[79] South African analyses of household surveys have likewise found that the incidence of catastrophic out-of-pocket expenditure, though relatively low, has been increasing over time.[78]

A single aggregate cannot establish that reducing PMBs is the appropriate remedy, because out-of-pocket expenditure is not a single phenomenon. Table 2 sets out its principal components and the policy response that each implies. Balance billing above scheme tariffs calls for tariff regulation rather than benefit reduction, and the exclusion of clinically necessary services calls for expansion rather than contraction of the entitlement.[8,13,41] Unaffordable contributions point towards income-related financing and cross-subsidisation, depleted savings accounts raise the risk-pool question adjudicated in *KeyHealth*, and expenditure by uninsured households reflects a failure of population coverage that no redesign of scheme products can address.[21,27,38,53] Using an undisaggregated total to justify contracting the entitlement therefore inverts the inference, treating evidence of insufficient financial protection as an argument for less of it.

Table 2. Components of out-of-pocket expenditure and the policy response each implies

Component of out-of-pocket expenditure	Underlying cause	Implied policy response
Co-payments and deductibles	Benefit design and cost-sharing rules	Enforce Regulation 8(1) for PMB conditions; review cost sharing for other necessary care
Balance billing above scheme tariffs	Unregulated provider prices	Tariff regulation and multilateral price negotiation

Component of out-of-pocket expenditure	Underlying cause	Implied policy response
Clinically necessary services excluded from benefits	Gaps in the benefit package	Expansion of the minimum entitlement through HTA
Depleted medical savings accounts	Use of individual savings for care that should be pooled	Payment of PMBs from the risk pool, as required by Regulation 10(6) and *KeyHealth*
Elective or preference-sensitive services	Individual choice beyond clinical need	No change to the entitlement required
Non-healthcare expenditure	Spending outside the scope of health benefits	Exclusion from coverage-failure indicators
Spending by people without medical scheme cover	Gaps in population coverage	Universal coverage measures beyond scheme product design

Source: Authors' analysis drawing on the Medical Schemes Act regulations, the KeyHealth judgment, the Health Market Inquiry and the health-financing literature.[8,15,27,29] HTA, health technology assessment; PMB, prescribed minimum benefit.

The disaggregation set out in Table 2 also defines a methodological agenda for the regulator and the industry. Established frameworks distinguish catastrophic expenditure, measured against household income or capacity to pay, from impoverishing expenditure, measured against a poverty line, and each requires data on the composition of spending and on household resources.[29,30,79] Applying these measures to medical scheme beneficiaries, disaggregated by component and by income band, would allow policymakers to identify which elements of out-of-pocket expenditure arise from benefit design and which arise from pricing, savings-account depletion or contribution affordability.[32,78] Reform proposals advanced without such evidence cannot demonstrate that the remedy they offer corresponds to the problem they identify.

9. Negotiated tariffs, strategic purchasing and the conditions for pass-through

Negotiated tariffs can advance affordability, but only under conditions that are frequently left unstated. Savings must be passed through to members, and providers must be unable to offset lower prices through increased volumes, greater coding intensity or reduced access, responses that are well documented in the literature on provider payment.[35,36,41] The 2024 data illustrate this risk, since cost per admission rose by 9.88% while admission rates declined, which is consistent with price and intensity offsetting restraint in volume.[26] The CMS's identification of supplier-induced demand as a driver of claims growth reinforces the point that a negotiation framework without monitoring of utilisation and coding may produce announced savings alongside unchanged expenditure.[43]

Credible tariff reform would therefore require a regulated negotiation framework that is multilateral rather than bilateral, transparent published reference tariffs or price corridors, and

standardised coding and billing rules.[8,41] It would also require routine reporting on quality and outcomes, monitoring of utilisation and coding intensity, accessible dispute and appeal mechanisms, and safeguards against anti-competitive conduct.[42,64] Finally, public reporting on whether realised savings have reduced contributions or improved benefits would be needed to demonstrate pass-through to members, since the performance of financing arrangements depends on institutional design and organisational practice as much as on formal rules.[41,80]

PMB reform should accordingly be connected to strategic purchasing and value rather than treated as an exercise in reducing the compulsory claims bill.[42,81] At this point the positions of the regulator and those of stakeholders converge more than the public exchange suggests. The CMS has defined and costed a PHC package, the HMI recommended a supply-side regulator to govern pricing, licensing and reporting together with a multilateral tariff negotiation forum, and most stakeholders have expressed support for regulated tariff negotiation.[1,7,8] Without a broader financing framework that supports effective pooling, affordability, appropriate tariff arrangements and equitable access, however, a revised package could operate mainly as a standardised commercial offering rather than contribute meaningfully to wider health-system objectives.[65,81]

10. Towards a reform agenda grounded in solidarity

The alternative to a reduced package is not to preserve the existing package unchanged, but to reform it in a manner consistent with its statutory and policy purpose. The appropriate objective is a standardised minimum entitlement covering priority services across the continuum of care, rather than a smaller package designed principally to make entry-level products commercially viable.[8,13] Such an entitlement should be defined through transparent, evidence-informed processes that include HTA and public participation, guarantee access according to clinical need, and be financed through broad pooling and progressively structured contributions supported by explicit subsidies where required.[14,25,81] It should also protect beneficiaries against inappropriate co-payments for necessary care, rest on regulated tariffs and strategic purchasing, and converge over time with the benefit framework developed under National Health Insurance.[15,25,42]

This direction is firmly rooted in South African health policy. The 2017 National Health Insurance Policy locates universal coverage within the principles that care should be available according to need irrespective of socio-economic status, that households should be protected from financial hardship, and that pooled financing should facilitate both income and risk cross-subsidisation.[33] These principles give effect to the constitutional right of access to healthcare and continue the equity commitments of the 1997 White Paper.[46,47] Multi-country research that

included South Africa has examined the conditions under which insured members are willing to tolerate risk- and income-related cross-subsidies, underlining that social solidarity is a precondition for pooled financing.[53] Modelling of future financing options has shown that progressively structured, pooled financing would be both affordable and redistributive.[38]

There is nevertheless substantial common ground with proponents of a reduced package, who correctly identify the need to modernise PMBs, strengthen prevention and address provider tariffs, and these objectives coincide with priorities already identified by the regulator in its strategic and annual performance plans.[1,2,7,66] They also correspond to the HMI's recommendations on benefit standardisation and price regulation.[8] The disagreement concerns what those reforms are ultimately intended to achieve, because a technical review of the benefit package is necessary but does not by itself constitute an equity reform.

PMB reform should therefore not be designed around the commercial objective of enabling schemes to offer cheaper products by narrowing the statutory entitlement. Its purpose should be to strengthen the minimum entitlement while addressing the underlying drivers of affordability through strategic purchasing, regulated pricing, broader pooling and appropriate cross-subsidisation.[12,41,42] Without such an orientation, reform risks converting a statutory social-protection floor into a stratified system in which access to the minimum entitlement itself varies with income.[22] For the so-called missing middle, the policy objective should be equitable participation in a progressively integrated system of pooled financing rather than access to a thinner medical scheme product.[33,38]

11. Limitations and implications for future research

Several limitations should be borne in mind when interpreting this commentary. The analysis relied on documentary analysis and did not generate new primary data or undertake formal costing or actuarial modelling.[23,24] Several 2024 indicators were confirmed through contemporaneous secondary reporting of the CMS Industry Report because the full report could not be accessed for every figure, and readers should consult the primary report for definitive values.[26,43,76] The authors are employed by the regulator whose mandate is discussed, and although the analysis has been grounded in published law, judgments and peer-reviewed evidence, the positionality of the authors should be considered in interpreting it, as the literature on policy analysis advises.[9]

Several priorities for future research and policy evaluation follow directly from the analysis. First, PMB expenditure should be estimated using a published and reproducible method that distinguishes diagnosis, benefit-option rules and actuarial imputation, so that claims about the share of expenditure attributable to the entitlement can be tested.[4,40] Second, out-of-pocket

expenditure among scheme beneficiaries should be decomposed by component and income band using established measures of financial protection.[29,78] Third, the costing and budget impact of the defined PHC package, and of any revised minimum entitlement, should follow accepted methods for economic evaluation and be accompanied by benefit-incidence analysis.[32,71,82] Finally, evaluations of tariff negotiation should examine whether negotiated savings are passed through to members, while studies of demand should assess how members value alternative benefit designs.[41,60]

12. Conclusion

The PMB framework requires systematic and evidence-informed review, and central to that review should be a benefit-design framework aligned with South Africa's burden of disease, population health needs and legal and policy prescripts. Reform should not begin by modifying an inherited list of diagnoses and treatments and then asking what can be afforded. It should begin with the statutory and policy purpose of the entitlement and establish transparent criteria for determining which needs and services belong in the minimum package, giving appropriate weight to prevention and primary care, chronic disease, hospital and emergency care, rehabilitation and palliative care. The regulatory framework itself envisages that the PMBs will be reviewed at least every two years by the National Department of Health in consultation with the CMS, provincial health departments and other stakeholders.[83]

The objective should be to move from a historically defined list of conditions towards a coherent and transparent framework for benefit design that reflects the country's epidemiological and health-system context. The scope of the entitlement should be determined through evidence-informed priority setting that is consistent with the definition of the business of a medical scheme, the Minister's powers under section 67(1)(g), national health policy and the constitutional commitment to progressively improving access to healthcare. The fact that comprehensive review has not proceeded at the pace originally contemplated strengthens the case for reform, but it provides no basis for narrowing the minimum entitlement.

Benefit redesign should not be considered in isolation from the structural factors that shape the affordability of medical scheme cover. Provider prices, purchasing arrangements, risk pooling, market structure, utilisation, benefit design and out-of-pocket expenditure are interrelated, as the HMI demonstrated, and the evidence reviewed here warrants a broader assessment of expenditure drivers before reducing the scope of minimum benefits is accepted as the appropriate response. This caution is particularly important where changes to benefit

design may transfer costs from pooled scheme funding to individual beneficiaries or, ultimately, to the public health system.

Measures involving income-related financing, public subsidies, mandatory participation or closer integration with National Health Insurance would require decisions by government and, where necessary, legislative, fiscal and institutional reform beyond the regulatory authority of the CMS. Within its statutory mandate, the position of the CMS is that PMB reform should strengthen equity, solidarity, financial protection and access to healthcare rather than achieve affordability primarily by reducing the entitlement. There is substantial common ground on the need to modernise PMBs and to address the structural drivers of healthcare costs, and the task now is to translate that agreement into an appropriately sequenced reform programme. Consistent with Dr Clarence Mini's call for inclusive solutions and consensus, the CMS remains committed to constructive engagement towards a framework that modernises benefit design around South Africa's health needs while strengthening solidarity, equity and access to care.

Declarations

Conflict of interest: All authors are employed by the affiliated entity listed on the title page, a statutory body whose regulatory mandate and policy positions are discussed in this commentary. The views expressed in this commentary are those of the authors and are informed by the statutory mandate of that entity. The authors declare no other competing interests that could have influenced the work reported here.

Use of AI-assisted tools: QuillBot and Grammarly were used solely for language editing, including grammar, spelling, punctuation and readability. No AI-assisted tools were used to generate the study findings, analysis, interpretation or substantive intellectual content of the manuscript.

Data availability: No new data were generated or analysed for this commentary. All sources analysed are publicly available and are listed in the reference list.

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