Prescribed Minimum Benefits Review

Proposed construct and work plans

12/2/2016

Table of Contents

1. Introduction

1.1 The fundamental aim of any health system is to prevent disease and reduce ill health to ensure that people remain as healthy as possible for as long as possible.

1.2 The prescribed minimum benefits (PMB) is a list of minimum benefits that medical schemes must provide to members irrespective of the benefit option that members belong to. Many stakeholders have commented that the current PMB are not responsive enough to the changes in healthcare needs of the population; current health technology and best clinical practice; burden of disease; health policy; as well as the financial impact on medical schemes.

1.3 Following the previous review conducted on the PMBs, the Council for Medical Schemes (CMS) made submissions to the National Department of Health (NDoH) for the review of the PMB based on inputs from various committees and other stakeholders. The feedback from the NDoH was that the current package does not prioritise primary healthcare and does not address the needs of the country.

1.4 The current review process is aimed at addressing the issues raised, taking into account the submissions that were previously made, and places emphasis on the following:

1.4.1 Alignment of the PMB package with development in health policy

1.4.2 Specification of a comprehensive set of essential healthcare benefits.

1.4.3 Identification of actions that should be undertaken to ensure the sustainability of the package.

1.4.4 Identification of measures required to ensure affordability of the new package.

1.5 The following is an outline of the document:

1.5.1 Section 2 deals with the legislated mandate governing the PMB review process.

1.5.2 Section 3 deals with the context that informs the PMB review.

1.5.3 Section 4 outlines the problem that warrants the review of the PMBs.

1.5.4 Section 5 lists the principles that are applicable to the PMB review.

1.5.5 Section 6 proposes a construct for the revised PMBs.

1.5.6 Section 7 describes the work process that will be followed to finalise the new package.

1.5.7 Section 8 proposes timeframes and work plans in the development of a revised set of PMBs.

2. Legislated Mandate

2.1 The Medical Schemes Act, 131 of 1998 introduced PMBs as a policy instrument for defining minimum allowable levels of benefits to be covered by medical schemes. Regulations made in terms of the Act were promulgated on 20 October 1999 and came into effect on 1 January 2000. Annexure A to the Regulations defines the PMBs in terms of a positive list of 270 diagnosis and treatment pairs (DTPs) that must be provided by each scheme, without financial limits in at least one provider setting. The currently applicable legislation is shown in Appendix B of the Medical Schemes Act.

2.2 The objective of specifying a set of PMBs was given in the 1999 Regulations as:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of private and public healthcare resources.

2.3 The NDoH is required to monitor the impact, effectiveness and appropriateness of the PMB provisions. A review is to be conducted at least every two years by the NDoH. These reviews are to provide recommendations for the revision PMBs 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 the health policy; and

(iv) the impact on medical scheme viability and its affordability to members.

2.4 Since the promulgation of these Regulations, several developments have been observed, i.e. considerable developments in the management of a number of conditions; some level of inconsistencies and flaws identified in the current regulations; as well as changes in the cost-effectiveness of health technologies or interventions. Further development of the heath policy in respect of the protection of risk pools is being considered, as well as the impact of PMBs on medical scheme viability and affordability All these factors have an impact on the PMB review

2.5 Section 3(1) of the National Health Act places the responsibility on the Minister of Health to, within the limits of available resources, develop the policies and measures which will protect, promote, improve and maintain the health status of the population. The Act specifically requires the Minister to ensure the provision of essential health services, which must include at least primary healthcare services, to the population.

2.6 Section 27 of the Constitution states that everyone has the right to access healthcare services, inclusive of reproductive healthcare, and that no one may be refused emergency medical treatment. This Section

requires of the state to take reasonable legislative and other measures within its resources to progressively realise these rights. In addition, Section 28 of the Constitution specifies that children have the right to access basic healthcare services. In accordance with Section 36, these rights may be limited in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open democratic society based on human dignity, equality and freedom.

3. Context

3.1 The private healthcare sector forms part of the overall national health system and health policy, there is therefore a need 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 16% of the population has access to private health insurance financed mainly through medical scheme cover.

3.2 The current PMB package operates in a health insurance environment in contrast to a vertically integrated publicly provided healthcare system where the focus is on a planned gatekeeper and referral system. This approach is consistent with a public funder approach. In the health insurance environment, the focus is on risk-pooling to eliminate significant financial impact on households. This is consistent with contributory third-party payer systems. People with pre-existing conditions or those who exhibit characteristics that are strongly correlated with poor health status are uninsurable in a conventional insurance market. In this context, the PMBs represent a key element of the health system financing and – along with community rating, open enrolment and waiting periods, play an important role in the protection of risk pools. The PMBs structurally reduce discrimination on the basis of health status, because if broad enough, they remove the ability of medical schemes to separate insurable and uninsurable (or less insurable) individuals through benefit design. The PMBs therefore protect access to healthcare by promoting access to health “insurance” for those with less preferred risk profiles.

3.3 The NDoH has published the National Health Insurance (NHI) white paper that will necessitate a massive reorganisation of the current healthcare system, both public and private. The NHI is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. The NDoH is currently engaging with stakeholders on the determination of the NHI for the country and the package of services to be covered under such a system. The Medical Schemes Act requires that the NDoH reviews the PMBs in order to ensure that the NHI and PMB review initiatives are aligned. It is important that the PMB review process, which is a joint initiative between the NDoH and the CMS, results in a framework that is sufficiently flexible to accommodate the unfolding NHI process. This review provides

an opportunity to rationally identify essential care that must be accessible to members of the public, and is cognisant of the competing objectives in the insurance and vertically integrated provider models. As greater clarity is achieved on the details of the NHI model being proposed and on the process of implementation, this PMB review process may need to be modified to ensure that it remains consistent with NHI objectives.

3.4 In the context of a developing country with limited resources, the progressive realisation of the rights to healthcare services requires an effective and equitable prioritisation process. It is therefore required that the PMB review must be aligned with the progressive realisation of the right to healthcare of the population. This review suggests a rational and principled basis for the prioritisation of resources on an equitable basis. Specific principles that should be applied in this rationing process are listed in section 5. The determination of which minimum benefits should be prescribed is therefore based on rational principles that do not discriminate against individuals.

4. Problem Statement

4.1 The current PMB package has been a subject of debate for the last few years. PMBs are aimed at providing medical scheme members with continuous care to improve their health and well-being, and to promote access to specific healthcare services. The PMBs are based on a positive list of medical conditions that mostly focus on catastrophic and chronic conditions, and medical schemes are mandated to cover the costs related to the diagnosis, treatment and care of such conditions. The PMB package has however been a subject of scrutiny for a number of reasons including the cost of the package, the construct of the package, inclusion and exclusion criteria, the affordability of the package and the quality of care associated with the package.

a) Pricing and the Cost of the PMB package

4.2 The cost of PMBs have increased significantly over the years. The cost increased by 13.4% from R556 per beneficiary per month (pbpm) in 2014 to R608 pbpm in 2015. The total cost of PMBs for the medical schemes in the 2015/2016 financial year amounted to R64.2 billion. Figure 1 below indicates how the beneficiary profile of medical schemes is affecting the cost of PMBs.

4.3 Poor harmonisation of regulatory provisions for the determination of the scope of provider practice and tariffs (the competition commissioner ruling on determination of tariffs) has been blamed as the source of the high fees charged for PMB conditions. In addition, a poor definition of “at cost” in the legislation has resulted in a “blank cheque” approach by some healthcare providers charging excessively high fees for PMB conditions. Diagnosis creep (upcoding), whereby related conditions are coded as PMB conditions,

has also become commonplace in instances where PMB services are remunerated at higher-than-average levels.

4.4 Comparing 2014 and 2015, the beneficiaries in the age range one year to 44 years reduced by about 45 000 beneficiaries while the membership in below one and above 45 years of age grew by almost 39 000. This unfavourable change in beneficiary profile is one of the factors contributing to the escalation in expenditure for PMBs during the reporting period.

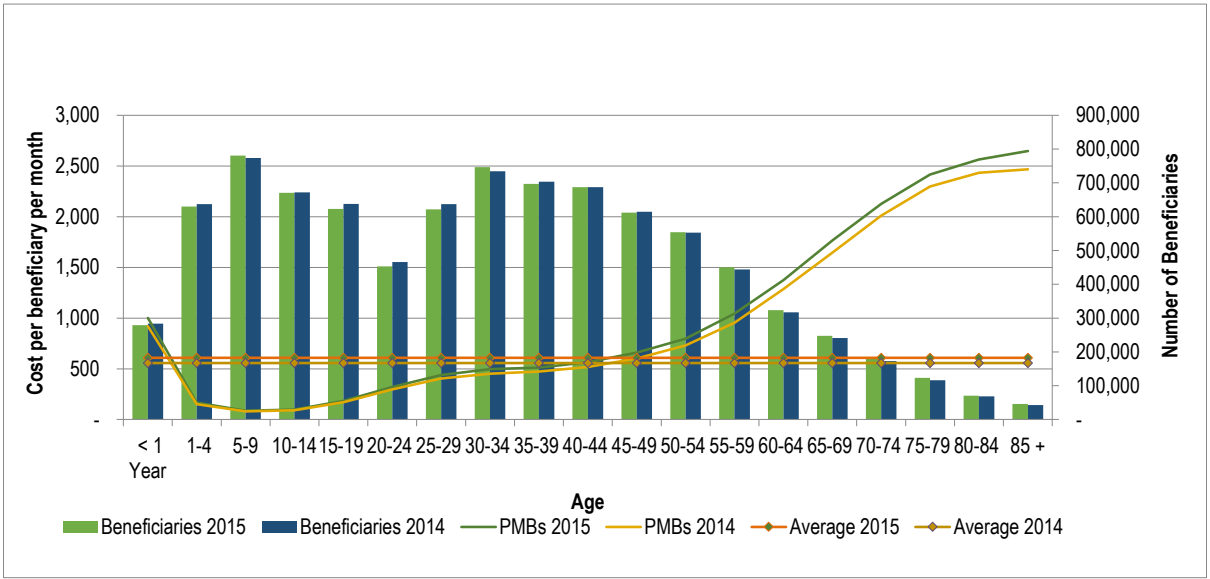

Figure1: Cost of PMBs by age band for years 2014 and 2015

b) Construct of the PMB package

4.1 The manner in which PMBs are currently defined makes it difficult for members to prospectively know whether specific benefits are covered or not. This is because diagnosis frequently involves costly diagnostic workup and expensive procedures may need to be performed only to establish that a beneficiary suffers from a condition that is not included in the PMBs' DTP list. In accordance with the current regulation, there is not much uniformity of benefit entitlements with regard to the PMBs. This makes it difficult for consumers to make informed decisions when choosing between medical schemes.

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

4.3 The current package was defined in terms of the DTPs. The Oregon Health Services Commission introduced a Diagnosis and Treatment pair system, where for each disease diagnosis appropriate medical treatments are listed. Each of the disease diagnosis is defined by an ICD-10 code and the related

treatments are listed by their CPT4 code. An ICD-10 code and its related CPT4 codes constitute one DTP.

4.4 The implication of defining a benefit package using DTPs is that the benefits are defined in terms of the CPT4 codes and are therefore explicitly defined, so that there is no doubt as to which precise medical or surgical procedures is applicable. The PMB package however does not include procedure codes, and this allows subjectivity in the interpretation of the PMB benefits.

4.5 On its own, the existing set of PMBs does not provide adequate protection against risk selection activities (particularly benefit design) by medical schemes. In other words, the existing PMBs 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 healthcare. Whenever essential healthcare condition does not form part of the PMB, it becomes a basis for risk selection and the permanent exclusion of people with a specific profile from participating in the health insurance system.

c) Affordability of the PMB package

4.6 The current PMB package has been shown to be unaffordable to low income earners such as those belonging to the bargaining council schemes.

4.7 Structural issues affecting affordability of the PMB package include the following:

(i) Absence of mandatory membership by the employed population: This limits the cross-subsidisation between the young and old, the healthy and sick.

(ii) Price regulation: Collective bargaining within the industry is important to address supply side price issues.

(iii) Healthcare technology assessment: Uncontrolled introduction of new healthcare technology may result in cost increases without an improvement in the quality of care.

(iv) Continuous PMB review: The Medical Schemes Act prescribes that the PMB Regulations must be reviewed at least every two years. A revision of the PMB definitions may identify services which are not cost effective and therefore increase the affordability of the PMB package.

(v) Fragmentation of healthcare: member movements between different providers for the same services results in overutilisation of health services which pushes up the cost of health services and therefore make healthcare unaffordable.

(vi) Absence of a risk adjustment mechanism: Such a mechanism is required to assist in the redistribution of risk among medical schemes. Its continued absence results in a skewed market structure where some schemes continue to benefit from lower risk profiles whilst others are experiencing worsening demographic profiles.

d) Quality of care

4.8 The quality of care for the current package has been shown to be poor in a number of conditions classified as PMB. The coverage of beneficiaries is very low in a vast number of conditions where for example,

best-practice monitoring tests that should be carried out as part of disease management were as low as 5% for some conditions. An inappropriate definition (outdated clinical protocol or guidelines) for a PMB condition might lead to members receiving poor healthcare services.

4.9 An inappropriate definition of the PMBs might also contribute to an increase in managed care costs that would result in inefficiencies. A poorly defined PMB package could lead to unrealistic member expectations that require extra costly initiatives to manage. A poorly defined health package might also lead to uncontrolled introduction of new healthcare technology which may result in cost increases without an improvement in the quality of care.

5. Proposed principles applicable to the PMB review

5.1 The criterion for selecting the healthcare package draws on recommendations for priority setting in different countries. The World Health Organization (WHO) and the International Labour Office (ILO) recommends that when selecting a health package, the current health situation, needs of individual countries, internationally agreed instruments, evidence based and cost effective interventions, and affordability, should be assessed. The PMB package will therefore be based on the following:

a) The current health situation

5.2 South Africa has a quadruple burden of diseases, namely; a very high prevalence of HIV and AIDS which has now entered into a synergistic relationship with TB; increased maternal and child morbidity and mortality; exploding prevalence of non-communicable diseases mostly driven by risk factors related to life-style; and violence, injuries and trauma (StatsSA, 2014). South Africa is also one of the countries with the highest burden of TB, with the WHO statistics giving an estimated incidence of 53 969 cases of active TB in 2014. Out of the 450,000 incident cases in South Africa it is estimated by WHO that about 270,000 (60%) people have both HIV and TB infection (WHO, 2014). The estimated overall HIV prevalence rate is approximately 11.2% of the total South African population. The total number of people living with HIV was estimated at approximately 6.19 million in 2015. For adults aged 15–49 years, an estimated 16.6% of the population is HIV positive (StatsSA, 2015a). Figure 2 below shows the leading cause of mortality in South Africa due to the burden of the diseases discussed.

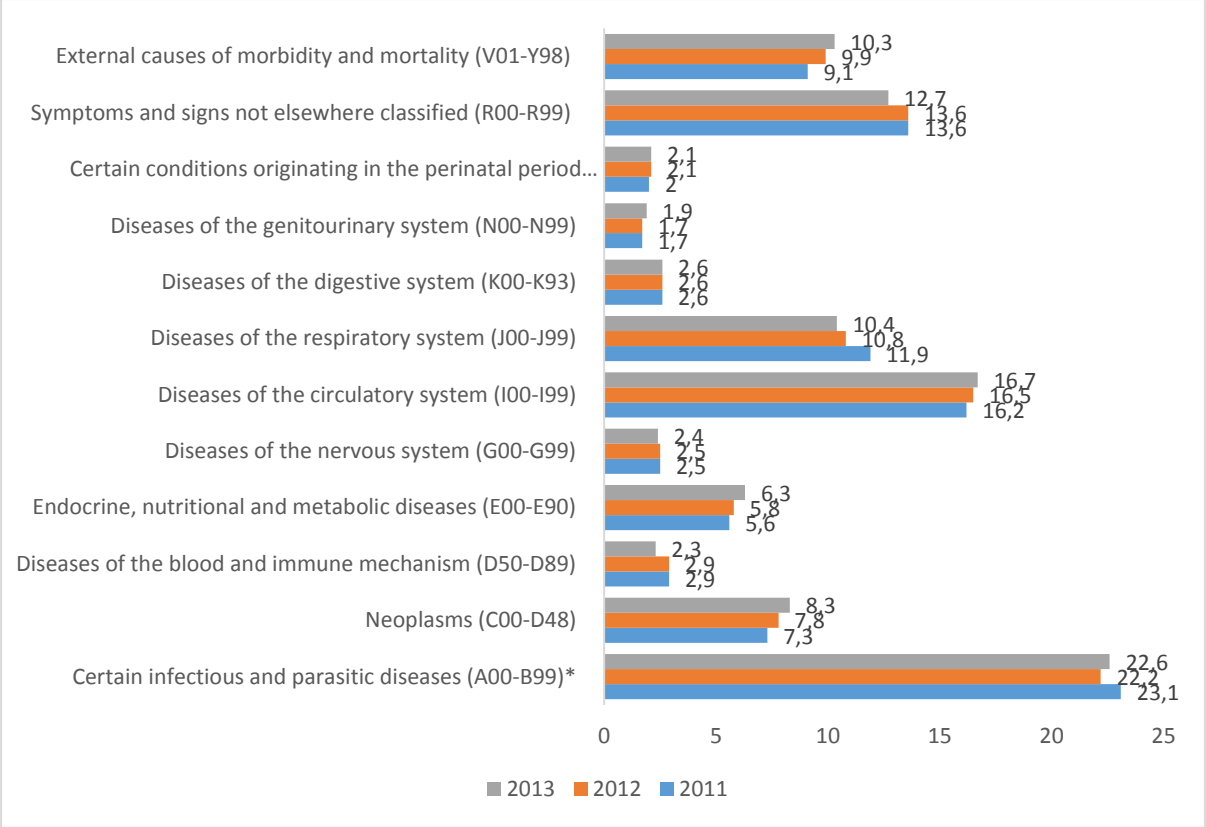

Figure 2: Percentage distribution of deaths by selected main groups of causes of death, 2011–2013*. (Source: StatsSA)

5.3 Maternal and child mortality rates still remain high in South Africa. According to Statistics South Africa (StatsSA), maternal mortality rate increased from 150 per 100 000 live births in 1998 to 369 per 100 000 live births in 2001. In 2011, maternal mortality rate was estimated at 197 per 100 000 which was far higher than the Millennium Development Goal (MDG) target of 38 per 100 000 live births by 2015. The infant mortality rate for 2014 was estimated at 29.9 per 1 000 live births (StatsSA, 2015b) higher that the MDG target of 20 per 1000 live births.

5.4 Non- communicable diseases (NCDs) are also an issue of concern globally. According to the World Health Organisation, NCDs accounted for 29% of all deaths in South Africa in 2008 – 18% due to cardiovascular disease and cancers alone. In medical schemes hypertension was the most prevalent condition at 153 per 1000 beneficiaries in 2015. Figure 3 below depicts the prevalence of PMB chronic conditions in medical schemes (number registered on diseases management programme) (CMS, 2015).

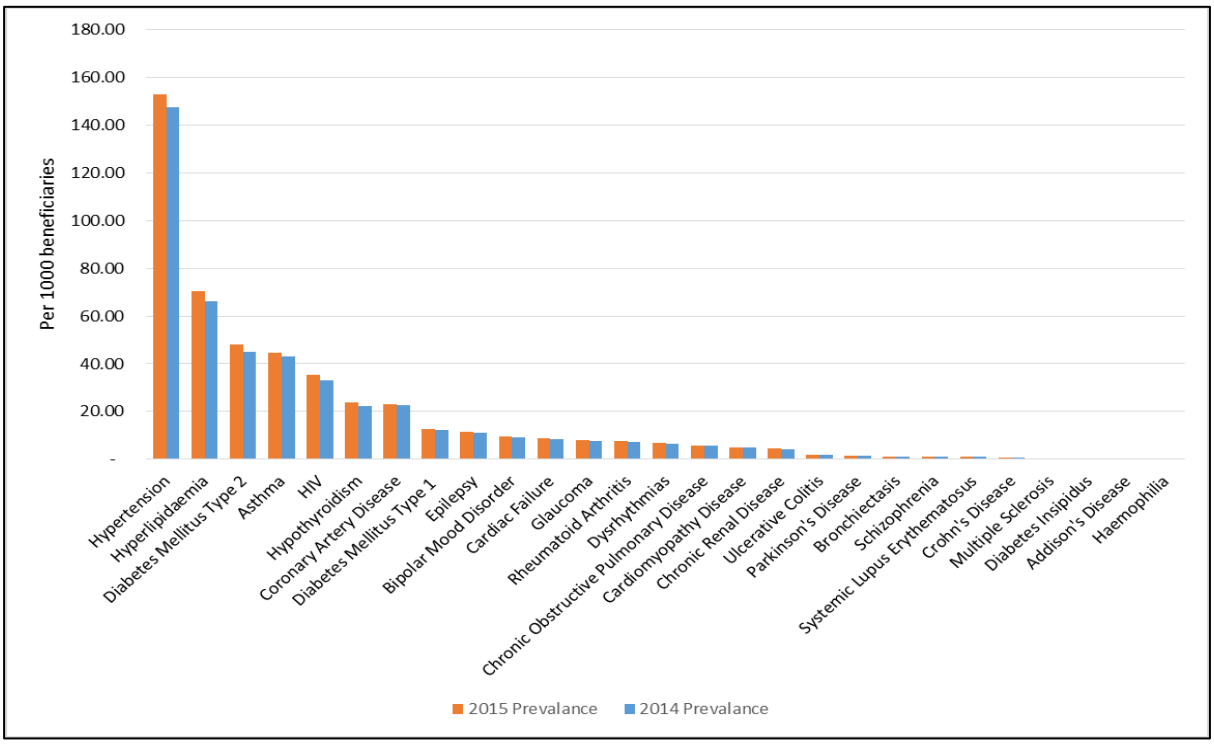

Figure 3: Prevalence of chronic conditions

b) Needs of individual countries

5.5 The following are the key priorities for the vision 2030 development plan as stipulated from chapter 10 of the National Development Plan (NDP)

5.5.1 Raise the life expectancy of South Africans to at least 70 years

5.5.2 Progressively improve TB prevention and cure;

5.5.3 Reduce maternal, infant and child mortality;

5.5.4 Significantly reduce prevalence of non-communicable diseases;

5.5.5 Reduce injury, accidents and violence by 50 percent from 2010 levels;

5.5.6 Complete Health system reforms

5.5.7 Primary healthcare teams to provide care to families and communities

5.5.8 Universal health coverage; and

5.5.9 Fill posts with skilled, committed and competent individuals

c) Internationally agreed instruments

5.6 South Africa is signatory to a number of resolutions that aim to reduce the burden of communicable and non-communicable diseases. The following are some of the resolutions that aim to address the burden of the most prevalent diseases:

5.6.1 Sustainable development goal 3 which aims to ensure healthy lives and promote well-being for all at all ages;

5.6.2 Resolutions of the World Health Assembly (WHA) 53.17 on the Prevention and control of non-communicable diseases and 61.14 on the Prevention and control of non-communicable diseases;

5.6.3 The implementation of the global strategy on Non-communicable Diseases;

5.6.4 The report of the WHO Commission on Social Determinants of Health (2008);

5.6.5 The Nairobi Call to Action for Health Promotion (2009);

5.6.6 The Mauritius Call for Action on Diabetes, Cardiovascular Diseases and Non-communicable Diseases (2009);

5.6.7 The WHO Framework Convention on Tobacco Control (FCTC-2003);

5.6.8 The Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases;

5.6.9 The Global Strategy on Diet, Physical Activity and Health and other relevant international strategies to address Non-communicable Diseases;

5.6.10 Resolution on Diet, Physical Activity and Health (WHA 55.23);

5.6.11 The African Union's Campaign for the Accelerated Reduction of Maternal, Neonatal and Child Mortality in Africa.

d) Clinical and Cost effectiveness

5.7 As with other health interventions, the new package needs to be evaluated for appropriateness, cost and effectiveness, in order to help avoid future treatment costs associated with ill-health, and wasted expenditure on what may be a poorly designed, ineffective package. Systematic reviews and randomised control trials are considered high on the hierarchy of level of evidence to support the clinical effectiveness of interventions. With regard to the cost effectiveness (CE) of interventions, South Africa has no experience in CE threshold, and therefore the selection of technology will not be based on local CE threshold until a standard threshold is defined. Internationally comparable studies are used to determine the cost effectiveness of interventions.

e) Affordability

5.8 Once the efficacy and cost-effectiveness of an intervention has been proven, affordability would need to be determined. Determining affordability will require both qualitative and quantitative assessment. Quantitative assessment to determine affordability will include:

5.8.1 Impact of cost of intervention on the PMB package especially if there are no disinvestments or replacements within the definition or package.

5.8.2 Impact of cost on beneficiary contributions as a percentage of average income.

5.9 Qualitative assessment will consider the following:

5.9.1 Prioritisation of medical condition: (severity, occurrence, morbidity and mortality)

5.9.2 Burden of disease

5.9.3 Public health impact

5.9.4 Availability of alternative treatments

5.9.5 Equity

5.9.6 Projected product utilization

5.9.7 Innovation of product (e.g. pharmacological characteristics, ease of use)

f) Efficiency

5.10 The allocation of the services should be in a manner that optimises value for money. The package should clearly define the services that should be available at different levels of care.

6. Proposed construct of the minimum package

6.1 The prescribed minimum benefits offered by schemes must reflect essential benefits and ensure adequate comprehensive coverage within a medical scheme.

6.2 Considering the various principles and objectives of the PMB review, the following construct considers the initial 1997 recommendations to align the private sector package with the public sector package, as well as stakeholder comments on the initial proposal in the March 2008 consultation document.

a) Primary healthcare level package

6.3 Primary healthcare is the cornerstone of the country's health system, and is essential for health service delivery.

6.4 A basket of primary healthcare package should be clearly defined taking into consideration the principles for defining a comprehensive healthcare package.

6.5 Due to its nature, this basket can be neither diagnosis- nor condition-specific. It must be clearly defined in respect of minimum service entitlements.

6.6 The primary health package will consist of the following:

6.6.1 Preventative services

6.6.2 Maternal and neonatal services

6.6.3 Child health services

6.6.4 Curative services

6.6.5 Mental health services

6.6.6 Diagnostic: laboratory services

6.6.7 Diagnostic: imaging services

6.6.8 Pharmaceutical services

6.6.9 A basket of defined basic dentistry services

6.6.10 A basket of defined basic optometry services

b) Hospital level package

6.7 A basket of Hospital level package should be clearly defined taking into account the principles for defining a comprehensive healthcare package.

6.8 The hospital level package should neither be condition specific nor diagnosis specific but should include a list of services that are excluded from the hospital setting. The hospital level package will consist of:

6.8.1 Maternal and neonatal services

6.8.2 Child health services

6.8.3 Curative services

6.8.4 Mental health services

6.8.5 Diagnostic, laboratory and other medical examination services

6.8.6 Surgical and medical equipment services

6.8.7 Pharmaceutical services

6.8.8 Emergency medical services

6.8.9 Inpatient education packages

6.8.10 Palliative services

6.8.11 A list of exclusions from the hospital setting

Table 1: Proposed construct of the PMB package

Primary Health care package	Hospital level package
Preventative services	Inpatient education packages
Maternal and neonatal services	Maternal and neonatal services
Child health services	Child health services
Curative services	Curative services
Mental health services	Mental health services
Diagnostic: laboratory services	Diagnostic: laboratory services
Diagnostic: imaging services	Diagnostic: imaging services
Pharmaceutical services	Pharmaceutical services
Emergency medical services	Emergency medical services
Palliative services	Palliative services
	Hospital exclusions

7 Proposed governance and working groups

7.1 The process will be governed by the PMB Review Steering Committee, comprising officials of the National Department of Health, the Council for Medical Schemes, and the leaders of the two functional groups (who will also be officials). The steering committee will be chaired by the Senior Strategist.

7.2 The purpose of the PMB review committee is to deal with the definition and specification of the comprehensive essential PMB package in an insured environment. Key activities will include:

- Consideration of first principles that will be applied in the definition of the respective packages, including the principles that would be applied to judge whether benefits are "insurable" or not;
- Application of the principles to describe an essential comprehensive package;
- Costing of the full package;
- Description of the constraints that prevents the introduction of the essential comprehensive PMB package;
- Consideration of the constraints associated with the implementation of the full PMB package;
- The relationship between the prescribed minimum benefits in the insured environment and the National Health insurance.

7.3 The Clinical Researcher will serve as the project manager and will coordinate the activities of the committees. Two functional groups will be established; the clinical advisory committees (CACs) and the costing committee. The CACs will consist of multidisciplinary teams comprising individuals from relevant

clinical disciplines, patient groups, funders and those likely to be involved in the management of the particular condition under review. Members of the CAC will be appointed to the committees by virtue of their qualifications, relevant experience and exposure, as well as technical skills. The CACs will vary in size depending on the degree of interest a discipline has generated and the number of people that have been nominated to participate in that specific CAC. The clinical advisory committee will have subcommittees that will deal with specific packages as depicted in the addendum.

7.4 The costing committee will consist of teams comprising individuals from relevant disciplines, especially those involved in the management and funding of healthcare. Members of the CAC will be appointed to the committee by virtue of their qualifications, relevant experience and exposure, as well as technical skills.

7.5 The steering committee will appoint a chair for each of the committee and will be briefed by the steering committee chair on the scope of the project. The chair will:

7.5.1 Guide the task of developing final recommendations and the process thereof.

7.5.2 Assist the team to work collaboratively and effectively together ensuring that there is balanced contribution from all members.

7.5.3 Steer the discussion according to the agenda.

7.5.4 Summarise the main points and key decisions from the debate, noting any points of disagreement.

7.5.5 Sign off minutes compiled by the secretariat.

7.6 The Steering Committee will consider the proposals by the functional groups and draft the regulations that give effect to these proposals.

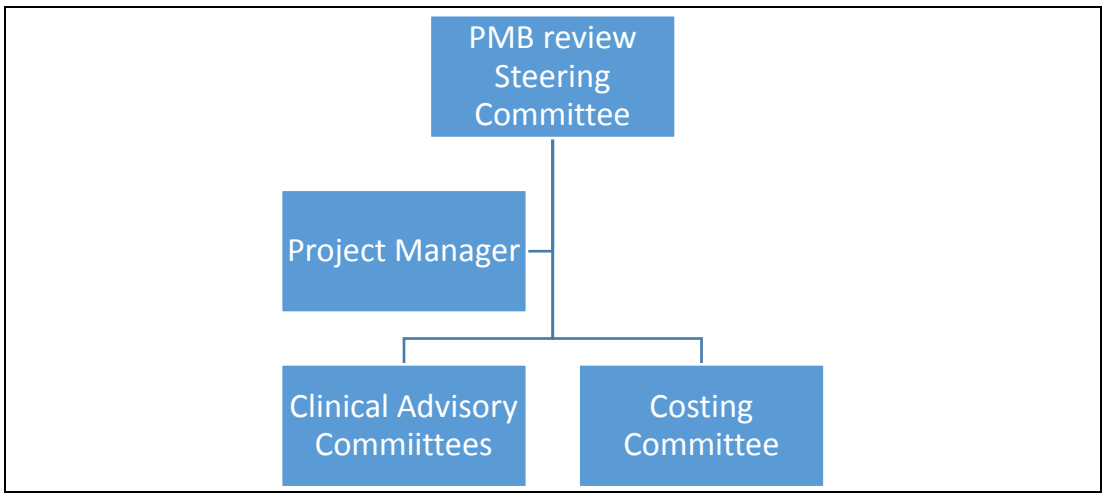

Figure 4 above illustrates the envisaged PMB review governance structure

8 Proposed timeframes and work plans

8.1 The PMB review process will start with consultation meetings with different stakeholders.

8.2 The steering committee will publish a consultation document for stakeholders to comment and to provide inputs into the construct of the new package.

8.3 Multi-disciplinary clinical advisory committees and costing committees will consider the submissions and propose recommendations regarding medical management of PMB conditions to the steering committee once consensus has been reached.

8.4 Figure 5 below depicts proposed timeframes and work plans for the PMB review process.

8.5 It is anticipated that Stakeholder engagements, publication of the consultative document and appointment of committees will take place between the months of August 2016 and January 2017. A PMB review workshop on the review will then follow in the month of February 2017.

8.6 Multidisciplinary meetings to interrogate the submissions and to propose recommendations will take place between March 2017 and August 2017.

8.7 Drafting of the regulations based on the final recommendations will then take place in the second half of the 2017/2018 financial year.

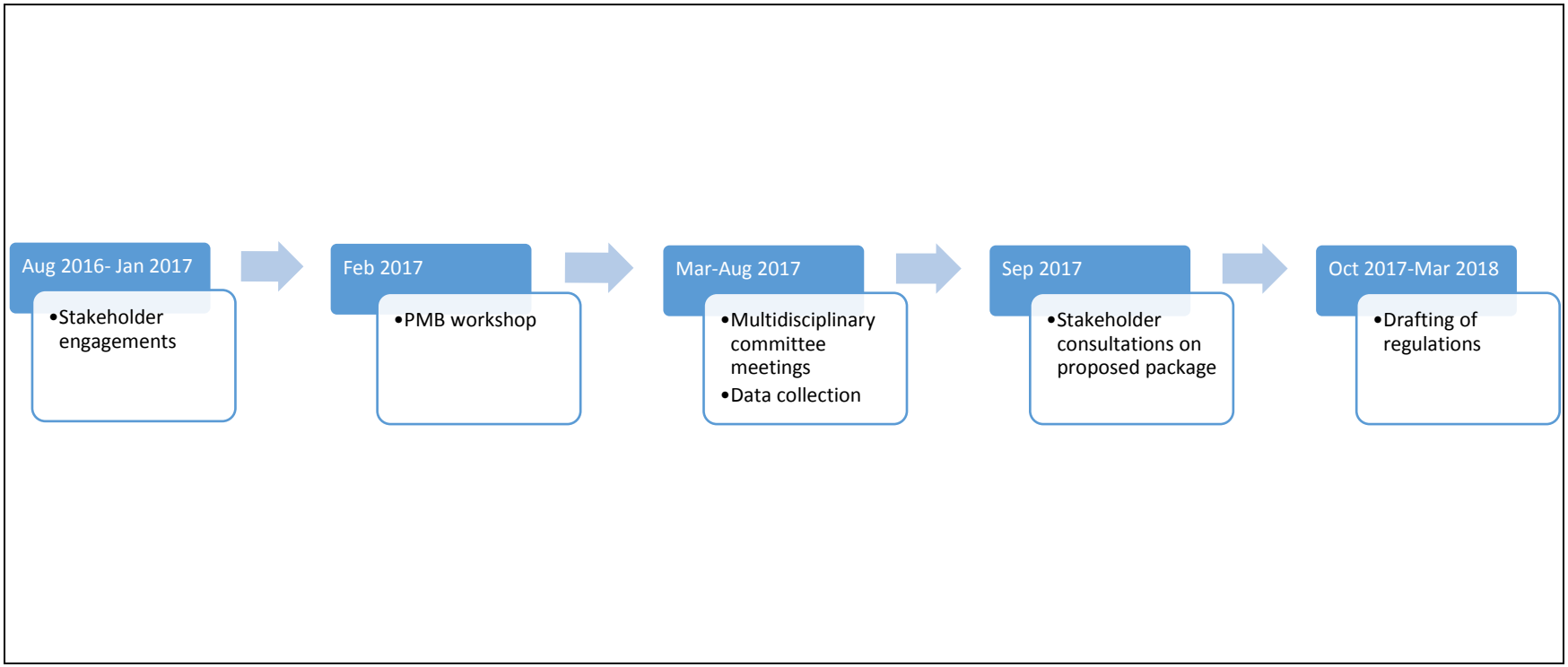

Figure 5: Proposed timeframes for the PMB review process

9. References

Council for Medical Schemes (CMS). 2016. *Annual Report 2015-2016*. Pretoria.

Council for Medical Schemes (CMS). 2009. PMB review consultation document - third draft . Pretoria

Statistics South Africa (STATSSA). 2014. *Mortality and causes of death in South Africa, 2013: Findings from death notification*. Pretoria.

Statistics South Africa (STATSSA). 2015a. Mid-year population estimates. *In: AFRICA*, S. S. (ed.). Pretoria.

Statistics South Africa (STATSSA). 2015b. Millennium Development Goals 4:Reduce child mortality. *In: STATISTICSOUTHAFRICA* (ed.). Pretoria.

World Health Organization (WHO). 2014. *Global Tuberculosis Report*. Geneva, Switzerland.

A. ADDENDUM: Clinical Advisory Committees

1. Preventative services subcommittee
2. Maternal and neonatal services subcommittee
3. Child health services subcommittee
4. Curative services subcommittee
5. Mental health services subcommittee
6. Laboratory services subcommittee
7. Imaging services subcommittee
8. Pharmaceutical services committee
9. Emergency services committee
10. Palliative services committee