

# **2008 PMB Review consultation document**

## **Second draft**

**12 September 2008**



**COUNCIL FOR MEDICAL SCHEMES**



**health**

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Department:  
Health  
**REPUBLIC OF SOUTH AFRICA**

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## List of Abbreviations

BD	- Benefit Definition
CDL	- Chronic Disease List
CMS	- Council for Medical Schemes
DoH	- Department of Health
DSP	- Designated Service Provider
DTP	- Diagnosis Treatment Pair
EDL	- Essential Drug List
MSA	- Medical Savings Account
NHI	- National Health Insurance
REF	- Risk Equalisation Fund
UPFS	- Uniform Patient Fee Schedule

# **1 Introduction and purpose of this document**

Following two workshops on prescribed minimum benefits (PMBs) with stakeholders and affected parties in February and March 2008, the Department of Health (DoH) and the Council for Medical Schemes (CMS) published a consultation document on the 2008 PMB Review process on 27 March 2008\*. The comments that stakeholders have submitted are available on the CMS website (see Annexure B on page 33 for the list of commentators). After reviewing these comments, the PMB Review steering committee incorporated numerous revisions into this document. The committee's responses to stakeholder comments are included in Annexure A (page 15).

The 2008 PMB Review has the following foci:

- identify gaps and inconsistencies in PMBs and make recommendations to address them;
- specify a broad set of essential healthcare benefits;
- identify those PMBs that should accompany the implementation of the Risk Equalisation Fund (REF);
- identify constraints associated with the implementation of a broad set of essential healthcare benefits;
- identify actions that should be undertaken to ensure the sustainability of any PMB package;
- identify measures required to ensure cost-effectiveness; and
- document the relationship between PMBs and the public healthcare system.

Section 2 deals with the legislated mandate and context of the review. Section 3 presents an appropriate framework for the revised PMBs. Section 4 lists the principles that are applicable to the PMB Review. Section 5 describes the work process that will be followed to finalise the package and constitutes an invitation to stakeholders, provincial health departments and consumers to engage with the contents of the document and to assist in the development of a revised set of PMBs.

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\* "2008 PMB Review consultation document. Proposed construct and work plans. 27 March 2008", available at <http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/PMB%20Review%20consultation%20document.pdf>

## **2 The legislated mandate and the context of the 2008 PMB Review**

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

### **2.1 *Legislated mandate***

#### **2.1.1 Medical Schemes Act 131 of 1998**

The explanatory note on PMBs in the Medical Schemes Act 131 of 1998 (Act) is presented below.

#### **Explanatory note to Annexure A of the Regulations to the Medical Schemes Act 131 of 1998: on prescribed minimum benefits**

The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness, and appropriateness of the prescribed minimum benefits provisions. A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, provincial health departments and consumer representatives. In addition, the review will focus specifically on the development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of:

- i. inconsistencies or flaws in the current regulations;
- ii. the cost-effectiveness of health technologies or interventions;
- iii. the consistency with developments in health policy; and
- iv. the impact on medical scheme viability and its affordability to members.

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

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

#### **2.1.2 Other relevant legislation**

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 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.

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 the grasp of 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.

In the context of a developing country with limited resources, the progressive realisation of these rights to healthcare services requires an effective and equitable prioritisation process. It is therefore required that this 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 4. The determination of which minimum benefits should be prescribed is therefore based on rational principles that do not discriminate against individuals.

## **2.2 Context**

### **2.2.1 Current healthcare financing reform initiatives and the drive towards the implementation of an NHI system**

The private healthcare sector forms part of the overall national health system. Health policy needs to realise the right of access to healthcare irrespective of whether services are offered in the public or private sectors. This is especially important as the private health system consumes more than 50% of total health resources while providing access to a relatively small minority of the population. Only about 15% of the population has access to medical scheme coverage. It is therefore important that this review is not viewed as being relevant to the private sector only, but that it represents an important element in addressing health sector challenges and is consistent with the initiatives to implement a National Health Insurance (NHI) system.

#### *2.2.1.1 Relationship between the NHI initiative and the 2008 PMB Review*

The DoH is currently engaging with stakeholders on the determination of the NHI framework for the country and the package of services to be covered under such a system. It is important that the NHI and PMB Review initiatives are aligned, and that the PMB Review process, which is a joint initiative between the DoH and the CMS, results in a framework that is sufficiently flexible to accommodate the unfolding of the NHI process (see section 5.2). This review therefore 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 (see section 2.2.2). 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.

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

#### *2.2.1.2 Restricted access to the private health insurance environment for high-risk individuals*

A systemic outcome of unregulated competition in the private sector is greater exclusivity rather than inclusivity. Unguided commercial imperatives largely contradict the obligation on government to ensure access as it is easier for schemes to

compete on the basis of risk selection than on price or efficiency. The natural consequence of this market conduct is the permanent exclusion of individuals or groups with predictable health needs. In other forms of insurance this problem does not arise as the risks of claiming are not known in advance or, where they are (for instance an individual with a fatal condition taking out life insurance), it is appropriate to exclude such individuals. In healthcare, excluding individuals with known health conditions or those known to be at a higher risk of claiming results in a loss of access to health insurance as well as access to healthcare – which undermines the constitutional imperative to give effect to the right of access to healthcare.

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

### *2.2.1.3 Current legislation introduced to Parliament*

Even though PMBs play an important role in the protection of risk pools (see section 2.2.2), it is important that these are implemented along with complementary reforms and that adequate cognisance is given to the current NHI process (see section 2.2.1.1).

The Medical Schemes Amendment Bill has been introduced to Parliament. This Bill further strengthens community rating, improves open enrolment, and introduces risk equalisation – key elements required for the protection of risk pools. An analysis of public comments on the draft Medical Schemes Amendment Bill has demonstrated that the introduction of risk equalisation without the expansion of PMBs will to a large degree negate the positive effects of risk equalisation. Along with other reform initiatives, including the review of NHI implementation, the introduction of REF necessitates the review of the current PMBs.

Other legislation before Parliament that has an impact on PMBs includes the Medicines and Related Substances Amendment Bill (2008) and the National Health Amendment Bill (2008).

## **2.2.2 Role of PMBs in the protection of risk pools**

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

In the insurance environment, the focus is on risk-pooling to eliminate significant financial impact on households. 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 PMBs represent a key element of health system financing and – along with community rating, open enrolment and risk equalisation – play an important role in the protection of risk pools.

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

On its own, the existing set of PMBs does not provide adequate protection against risk selection activities (particularly benefit design) by 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 is not a PMB, it becomes a basis for risk selection and the permanent exclusion from insurance of sicker and less healthy risk groups and individuals.

### **2.2.3 Other requirements specific to the insured environment**

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

#### *2.2.3.1 Rand-for-Rand cover in the insurance environment*

In the health insurance environment<sup>†</sup>, it is not desirable that regulation imposes risk-pooling in respect of events that are low-cost, occur frequently, and are subject to a high degree of discretion on the part of the insured. Given that the need to insure these benefits is in any case low (because most people will claim what they contribute up to a certain level of contribution), gaps in cover here have limited social and risk-pooling implications. However, systemically sicker people will need protection over and above a particular threshold, as their needs are bigger than of those with good health status. The central challenge is therefore to risk-pool for those health needs that will impose a significant financial burden on individuals and/or families such that their access to healthcare will be compromised without incentivising over-servicing of the healthy.

#### *2.2.3.2 Potential benefit constructs*

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

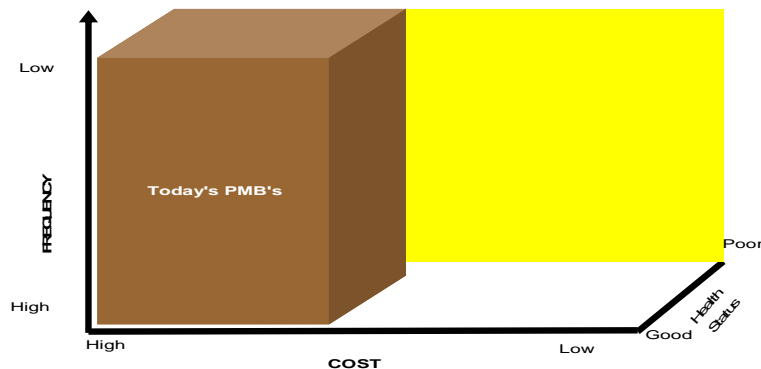
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<sup>†</sup> The health insurance environment is characterised by considerable non-healthcare costs as well as provider and member moral hazards associated with a third-party payer in a fee-for-service remuneration system.



Figure 1 below provides an illustration of where the existing PMB set is prioritised. It shows that the current PMB construct includes benefits representing events that occur frequently as well as rarely. In general, the cost of these events is high and minimal protection is offered for low-cost events. Even though the Z-axis is not truly linear, it attempts to describe that some benefits are more applicable to people with poor health status than to individuals in good health. This construct prevents discrimination against people with poor health status for high-cost events. Figure 2 illustrates the construct whereby, in addition to the existing PMBs, primary care with utilisation limits (low-cost, high frequency cover) is included.

**Figure 1: Current PMBs by cost, frequency and health status**



**Figure 2: Current PMBs broadened by the inclusion of primary care with utilisation limits**

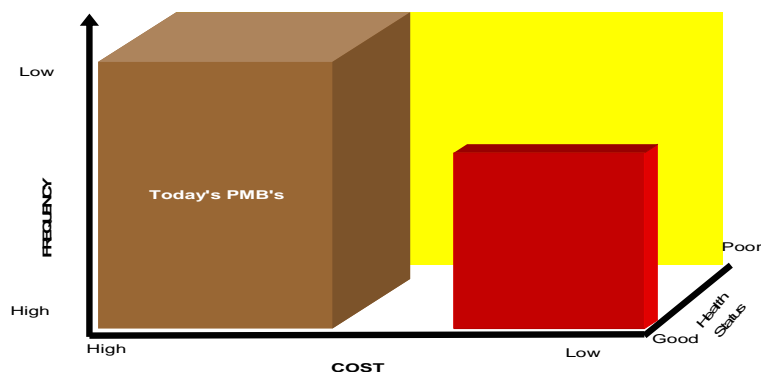
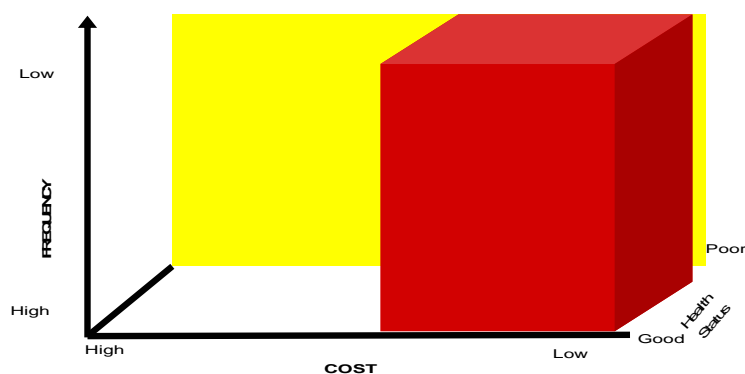


Figure 3 illustrates a construct whereby cover is offered for low-cost events of both high and low frequency, with specific protection for individuals with poor health status. This construct implies that there would be no protection against catastrophic high-cost events for any individuals.

**Figure 3: PMB construct that protects individuals with poor health status against low-cost events**



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

**Figure 4: PMB construct that expands current PMBs through the protection of individuals with poor health status against low frequency and cost events**

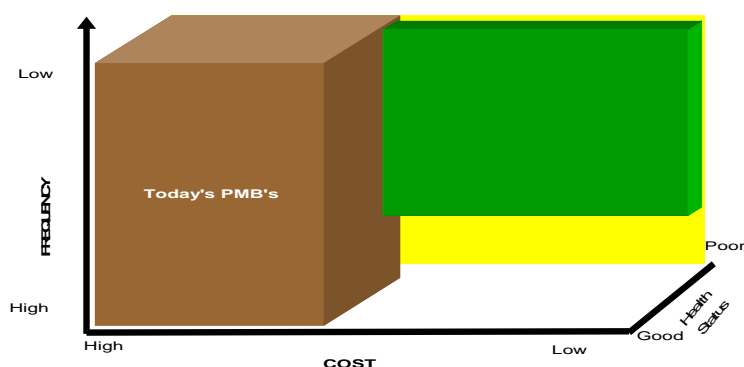
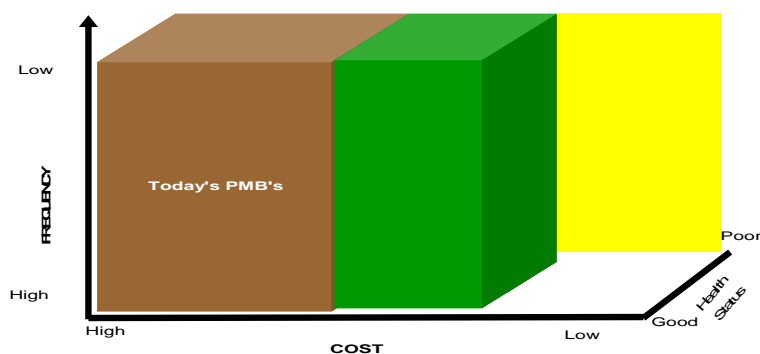


Figure 5 below illustrates an alternative whereby the existing PMBs are expanded to include protection for all individuals, regardless of health status, for relatively low-cost and low frequency events.

**Figure 5: PMB construct that expands existing PMB cover to give more protection against relatively low-cost events and protects individuals with poor health status**



## 2.2.4 Sustainability threats to the current PMB framework

Threats to the sustainability of the revised PMB package are categorised as being related to affordability, quality or pricing.

### 2.2.4.1 Affordability and access to medical scheme membership and private healthcare

These factors include those that would threaten access to private healthcare by consumers. If the PMB package is too broad, the underwriting risk to insurers could become too high, leading to an unbearably high increase in premiums. Given the fact that there is no mandatory membership, young and healthy members may choose not to belong to a medical scheme, resulting in further cost increases to the sicker and older members remaining on schemes. This scenario could lead to stagnant

membership and increases in non-healthcare costs such as managed care, further reducing access to care.

#### *2.2.4.2 Quality of care, utilisation of services and the efficiency of care*

An inappropriate definition of PMBs might contribute to increases 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.

An uncontrolled introduction of new healthcare technology may result in cost increases without an improvement in the quality of care.

These factors are a further motivation for the development of Benefit Definitions (BDs) discussed in section 4.2.

#### *2.2.4.3 Pricing and the cost of the PMB package*

Poor harmonisation of regulatory provisions for the determination of the scope of provider practice and tariffs could lead to the abuse of PMB legislation by providers. In addition, a poor definition of “at cost” in the legislation could result in a “blank cheque” approach by some healthcare providers charging excessively high fees for PMB conditions.

Diagnosis creep, whereby related conditions are coded as PMB conditions, could become commonplace if PMB services are remunerated at higher-than-average levels.

In the consideration of pricing alternatives to the current “at cost” specification, due consideration must be paid to the tensions between the current level of supplier-induced demand and supplier market power on the one hand and, on the other hand, the potential negative impact on suppliers that may result in reduced access, a decrease in equity and impaired health outcomes if done irresponsibly.

In the absence of a regulatory framework that regulates healthcare prices, the PMB Review committee recommends that:

- the maximum benefit that schemes would be legally obliged to pay in respect of PMBs in terms of the proposed new regulations would be the NHRPL rate;
- schemes would be encouraged to negotiate fees at lower rates; and
- schemes may provide benefits that remunerate providers at rates higher than the NHRPL rate. (But this practice will not be part of the minimum entitlement that members have.)

### **2.2.5 Competing objectives related to the PMB Review**

The key role that the PMB Review plays in the insurance environment healthcare financing reform elaborated on in sections 2.2.1 to 2.2.3 is in competition with some other key objectives of the healthcare system in the current context. Within the constraints of affordability and sustainability, the benefits of primary healthcare and preventative care cannot be ignored. In addition, the burden of disease that the public faces must be considered as well. More specifically, the impact of PMB regulation in achieving an inclusive, cost-effective, efficient and non-discriminatory environment must be noted. The larger context of this review must be cognisant of the progressive realisation of rights to healthcare (see section 2.1.2). This represents a shift towards more appropriate coverage consistent with social security objectives.

#### **2.2.6 Clarity of the PMB package and the need to develop standardised benefit definitions**

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 work and expensive procedures may need to be performed only to establish that a beneficiary suffers from a condition that is not included in the Diagnosis Treatment Pair (DTP) list. In accordance with the current regulation, there is little uniformity of benefit entitlements with regard to PMBs, contributing to the fact that consumers have difficulty in making informed choices between schemes.

An Essential Drug List (EDL) specifically developed for PMB purposes and a list of procedures that are only performed for essential conditions may potentially assist in clarifying PMB benefits, but the existing PMBs make no provision for these.

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

Subsequent to the PMB Review workshops and public comments received on the PMB Review consultation document, it became clear that comprehensive standardised BDs must be developed (see section 4.2).

### 3 Structure of an appropriate PMB package

Considering the various principles and objectives of the PMB Review, the following construct considers stakeholder comments on the initial proposal in the March 2008 consultation document.

1. ***In-hospital services: subject to –***
  - 1.1. *a positive list (currently DTPs and the Chronic Disease List (CDL))*
  - 1.2. *a negative list*
2. ***Out-of-hospital services: subject to –***
  - 2.1. *a positive list (currently DTPs and the CDL);*
  - 2.2. *a negative list*
  - 2.3. *specified services inclusive of:*
    - 2.3.1. *a basket of defined preventative care*
    - 2.3.2. *a basket of defined primary care*
    - 2.3.3. *a basket of defined basic dentistry*
    - 2.3.4. *a basket of defined basic optometry*

Note that this structure must be interpreted in consideration of the principles, objectives and caveats presented in section 4 below.

## **4 Principles and practices applicable to the PMB Review**

### **4.1 Overriding principles guiding the PMB definition process**

The current PMBs – consisting of 270 DTPs, 25 CDLs and HIV/AIDS – have served a very useful function in ensuring cover for these specific conditions, often catastrophic (financially or health-wise) in nature. But the current PMBs fall short in providing broad essential cover. This narrow approach is only useful in protecting members retrospectively where a dispute arises in respect of coverage. It provides cover for existing conditions once diagnosed but fails in the provision for the prevention of diseases by early detection. Consultative services, in particular primary care services, are necessary to achieve this. In addition, the current framework provides little upfront certainty to members with regard to the extent of coverage they enjoy under the current regulations.

The key objectives that must be met and the principles that must be applied in the definition of PMBs during the 2008 Review are:

- 4.1.1 Legislative and regulatory consistency must be achieved.
- 4.1.2 Risk-pooling must be ensured. It must permit access to essential healthcare for people with and without predictable health needs, with PMBs providing an effective basis for risk equalisation.
- 4.1.3 Essential healthcare, within the context of a contributory third-party payer system, must be defined. This includes the removal of inappropriate gaps in the existing DTP and CDL structure.
- 4.1.4 Evidence-based medicine principles must be upheld in the priority setting process. Special care must be taken to ensure that financial resources are allocated to maximise benefits reflecting the priorities of the community being served.
- 4.1.5 Standardised BDs must be developed to ensure that:
  - 4.1.5.1 *members have certainty concerning their coverage;*
  - 4.1.5.2 *schemes can identify member entitlements;*
  - 4.1.5.3 *schemes can fairly and reasonably manage their liabilities in respect of members;*
  - 4.1.5.4 *PMBs do not reinforce inefficient provider or patient conduct; and*
  - 4.1.5.5 *PMB regulations do not result in the unfair exclusion of defined vulnerable groups.*
- 4.1.6 Due cognisance must be given to the impact of regulations and consideration must be given to at least:
  - 4.1.6.1 *the affordability of the new PMB package; and*
  - 4.1.6.2 *the impact of pricing, supplier-induced demand and provider market power.*

### **4.2 Principles applicable to the development of condition-specific benefit definitions**

BDs are comprehensive descriptions of benefits available under PMB regulations and must include condition-specific standardised entry and verification criteria, defined baskets of services and goods associated with this entitlement, formularies as well as treatment protocols that include specification of the most appropriate setting and level of care for the provision of these services. The CDL algorithms meet most of these conditions, but much more work needs to be done on the 270 DTPs.

The following must be adhered to in the development of BDs:

- 4.2.1 Uphold evidence-based medicine principles.
- 4.2.2 Cost-effectiveness, including the specification of the most appropriate level and setting of care, must be taken into account.
- 4.2.3 Administrative simplicity in the implementation of BDs is favourable.
- 4.2.4 There are moral hazard concerns in respect of both members and healthcare service providers.
- 4.2.5 Conditions representing a high burden of disease, with high cost implications, or that result in frequent disputes due to inadequate clarity, must receive priority attention in the development of BDs.
- 4.2.6 Special care must be taken to ensure that, by giving access to specific benefits required by people in poor health, these benefits cannot be abused by people in good health.

The complete review of PMBs will be a continuous process that must be constantly reviewed and updated. The PMB Review steering committee will make recommendations in this regard to ensure that a satisfactory mechanism is introduced to achieve this (see section 5.2).

### **4.3 Principles applicable in the specification of specified services**

A significant benefit of a broad general definition is the removal of any ambiguity in benefit entitlements for members who are unable to relate to condition-specific entitlements when joining a medical scheme.

Over and above these limitations, a negative list of conditions or treatments that can be excluded from the basic package is necessary. This negative list is particularly important in respect of hospitalisation as an additional measure to prevent the unnecessary hospitalisation of cases that could be treated more appropriately on an out-of-hospital basis.

#### **4.3.1 Guidelines for the development of a negative list in respect of hospitalisation**

A list of conditions that do not meet the “essential care” requirement for hospitalisation described in paragraph 4.1.3 above must be developed.

#### **4.3.2 Guidelines for the development of a basket of defined preventative care**

Special care must be taken to ensure that preventative care is cost-effective. If not applied appropriately, some forms of preventative care may be an incremental cost to the system.

#### **4.3.3 Guidelines for the development of a basket of defined primary care**

Due to its very nature, this basket cannot be diagnosis- or condition-specific. It must be clearly defined in respect of minimum service entitlements and must include a list of providers that are licensed to provide primary care. Primary care should be included in BDs, increasing the “gatekeeper role” of primary care practitioners.

#### **4.3.4 Guidelines for the development of a basket of defined basic dentistry**

In accordance with the overriding principles, a list of basic essential services must be developed. Some condition-specific guidelines should also be developed.

#### **4.3.5 Guidelines for the development of a basket of defined basic optometry**

Basic specific optometry services must be considered. Specific descriptions around limitations for corrective lenses must be considered.

### **4.4 *Transitional arrangements***

Adequate transitional arrangements must be made to ensure that individuals currently enjoying PMBs are not unduly compromised through this review.



## **5 Future work**

### **5.1 *Functional work groups***

On review of previous work plans, it was agreed that much of the work listed in the PMB sustainability work group has been considered by the PMB Review steering committee. The technical work supporting an understanding of the sustainability and affordability issues would in future be performed by the REF work group.

A PMB definition work group meeting will be scheduled soon. Once the final structure and broad contents of the package are agreed on, the major administrators will submit costing studies which will be used as a basis to refine the definitions. Detailed work on BDs will then commence, followed by an iterative costing process by the REF group.

### **5.2 *Recommendations on the continuous review process***

Many stakeholders have commented that the current PMBs are not responsive enough to changes in healthcare needs of the population, current health technology and best clinical practice, disease burden, health policy and financial impact on schemes.

The PMB Review committee will recommend a legislated framework that includes a mechanism to improve responsiveness in these areas. These recommendations may include a structured process involving a stakeholder forum that continuously reviews BDs in accordance with the principles set out in section 4.

## **Annexure A: Summary of comments made to the PMB Review steering committee regarding the 2008 PMB Review**

This summary gives an overview of the feedback from stakeholders who commented on the Council for Medical Schemes (CMS) March 2008 consultation document entitled *2008 PMB Review consultation document, proposed construct and work plans*. This summary is not intended to be an exhaustive list of all the points made in these submissions, but is rather an overview of different stakeholders' comments pertaining to some of the key issues. Areas where stakeholders are in agreement with the discussion document are not listed in the summary. In instances where similar comments were made by different stakeholders, the comments are not necessarily repeated in the summary below. The points made by each stakeholder should be considered in the context of the whole submission made, which is available on the CMS website (see Annexure B for details).

All submissions were supportive of the PMB Review process and, in general, thankful for the participative process being followed. The submissions covered many areas of the PMB Review process. In broad headings, these were: Context, Benefits, Primary Healthcare, Definitions, Algorithms, Access, Affordability, Risks / Sustainability, Positive / Negative Lists, Managed Care and Protocols. The issues have had to be dealt with in broad categories instead of specific questions as authors of comments each had their own view of what the issues were. Comments on a particular issue were sometimes raised at different points in submissions which led to some duplication and disjointed reporting in the summary below. Some submissions gave lengthy substantiations of their arguments using reason, clinical data and reports. These points are not included in this summary.

## 1. Context

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – PMB revisions should recognise that the inclusion of “less insurable individuals” in the insured pool is only one of the pertinent policy objectives of the PMB regulations.	This is acknowledged in sections 2.1.2 (page 2) and 2.2.5 (page 8) and reflected in the comprehensive PMB definition (Section 3, page 10.).
<u>Medscheme HRS</u> – Essential health services should be defined bearing in mind our contributory third-party payer system. Clarity is needed on the terms “comprehensive” and “essential” as they are contradictory.	Section 2 (page 2) reflects on the context for this review, and considers the contributory third-party environment (Sections 2.2.1 to 2.2.3, page 5). This contradiction in terms (“essential comprehensive”) is recognised and has been corrected in this version.
<u>Novartis</u> – Their understanding of PMBs is such that no co-payments can be applied. Allowing for co-payments on out-of-hospital services is against this policy and other key government objectives.	In this context, the PMB Review committee does not consider co-payments as being in conflict with policy objectives. Co-payments constitute a possible mechanism to manage costs.
<u>Primecure</u> – The current review presents a window of opportunity before the initiation of REF since future changes are likely to be at the margin. PMBs must be placed in their proper social context to ensure priorities are set so as to spread available resources to reflect the priorities of the community being served. The priority assigned to vulnerable groups should reflect social values. The National Health Act requires the Minister to ensure provision of essential health services, including at least primary care.	The context for the review has been reconsidered and is broadened (see Section 2.2.1, page 3). The comprehensive PMB definition in Section 3 (page 10) has been revised to include primary care, basic dentistry, preventative care and basic optometry. The competing objectives of the review are acknowledged in Section 2.2.5 (page 8). Other relevant legislation is considered in Section 2.1.2, page 2.

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<p><u>IMSA</u> – The review should consider inconsistencies in current regulations, cost-effectiveness, consistency in health policy, and the impact on medical scheme viability and affordability. PMBs should be monitored in the areas of impact, effectiveness and appropriateness. Current problems with PMBs relate to poor clarity of definitions, which leads to poor interpretation, which in turn leads to poor implementation. Standardisation in the current environment would be equivalent to collusion since benefit payouts would be set, but not scheme income or design. Patients have existing rights created by the current PMBs which must be considered in the review process. LIMS discussions should be kept separate from the current PMB review. The entry criteria for REF should not become the access criteria for PMBs as this may limit access to care. Clarity of definitions could increase competition and level playing fields. The institution of regular and transparent review mechanisms is a requirement.</p>	<p>The REF and sustainability task group deals with viability and affordability.  Sections 2.2.6 and 4.2 (pages 9 and 11 respectively) deal with the clarity of definitions.  The committee does not agree that regulated standardisation amounts to collusion.  The committee agrees that transitional arrangements must be made where individuals might be compromised through changes in PMBs (see Section 4.4, page 13).  LIMS proposals need to be considered in the context of NHI.  The committee agrees that, where possible, the REF entry and verification criteria will be consistent with PMB definitions, but that these have a different function with a different emphasis.  The PMB Review committee will consider the most appropriate monitoring, evaluation and review mechanisms (see Sections 4.4 and 5.2, page 13 and 14).</p>

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<p><b><u>BHF</u></b> – The definition of the PMB package must take place in the context of government's current constitutional mandate to progressively realise the right to access healthcare for everyone in the context of the constitutional prohibition on denial of emergency care and in the context of the right of the child to basic health services. The definition of the package should not cause undue complexity to scheme benefits. The revision must not lead to an increase in non-health expenditure and must not create or contribute to balances of power between providers and suppliers. It must not be over-prescriptive with regard to treatment modalities or protocols. The review should also take place within the proper regulatory framework, including the Constitution, the National Health Act, the Medical Schemes Amendment Bill, the Health Charter and public-private partnerships. A review framework should be established that will allow: a review of PMBs every two years, mechanisms to be put in to identify problems early, access monitoring etc. through a health impact assessment mechanism, the monitoring of other key indicators. It should ensure that administrators, managed care companies and service providers are able to manage, collect and submit necessary data.</p>	<p>This PMB revision is done in accordance with the various pieces of legislation to which the BHF refers (see Section 2.1.2, page 2). The comprehensive PMB definition in Section 3 (page 10) has been revised.</p> <p>The need to improve clarity and thereby reduce non-healthcare costs has been considered (Section 2.2.6, page 9).</p> <p>The PMB Review committee will consider the most appropriate monitoring, evaluation and review mechanisms (see Section 5.2, page 14).</p>
<p><b><u>Momentum</u></b> – Recommends that the revised PMBs are not implemented until REF is in place.</p>	<p>The Medical Schemes Amendment Bill makes provision for the phased implementations of the respective sections of the Bill.</p>
<p><b><u>Enabled</u></b> – Service a group earning less than R7 000 per month and suggest the poor are not represented in the review document. If lower income people are to be included then REF, income cross-subsidisation and mandatory membership should be initiated at the same time.</p>	<p>LIMS proposals need to be considered in the context of NHI.</p> <p>Affordability constraints are recognised and will be considered by the task groups.</p> <p>The Medical Schemes Amendment Bill allows flexibility for the introduction of the various provisions.</p>

## 2. Primary Healthcare versus Catastrophic cover

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – Expansion of benefits to people in poor and good health must be done only if savings balance out additional costs. They support PHC expansion provided this does not increase costs excessively. Introduction of PHC (including dentistry and optometry) should be a lower priority than other PMB priorities. Supplier-induced demand will increase costs if blanket setting is in hospital. Payment will be guaranteed, incentivising relative use, as illustrated in the hospital costs document of the CMS. Alternatively PMBs defined by condition will allow managed care to pay for care in the most appropriate setting.	Unless the PMB package is broadened, the impact of PMBs to prevent risk selection is inadequate. Many competing objectives need to be considered (Section 2.2.5, page 8). The scope and affordability of the specified services identified in the comprehensive PMB definition in Section 3 (page 10) will be the subject of the task groups. A specific principle relevant in the review and BDs is to ensure that services are rendered in the most appropriate cost-effective setting (Section 2.2.6, page 9).
<u>Medscheme HRS</u> – Because PMB costs cannot rise above current levels, dentistry and optometry cannot be added. Preventative care should be supported to the extent that it is demonstrably cost-saving. Many preventative strategies are incremental costs to the system.	The competing objectives as specified in Section 2.2.5 (page 8) will be considered by the task groups. Section 4.3.2 recognises that care needs to be exercised to identify preventative strategies.
<u>Novartis</u> – The restriction to in-hospital-only treatments may increase the overall cost of care. The provision of primary or secondary care for certain disease conditions reduces the risk of hospitalisation.	A specific principle in the review is to ensure that services are rendered in the most appropriate cost-effective setting (Section 4.2, page 11). The comprehensive PMB definition in Section 3 (page 10) includes primary care and other specified services.
<u>Old Mutual HC</u> – Supports prospective identification and management of members at risk of chronic disease. They are also supportive of improved access to primary care and the role of the GP as coordinator of care.	The comprehensive PMB definition in Section 3 (page 10) includes primary care and other specified services.
<u>Gary Riley (Osteopathy)</u> – Specific reference should be made to the inclusion of statutorily complimentary therapies.	All conditions and services included in the PMB package will be evidence-based, regardless of whether they consist of orthodox or alternative complimentary therapies (see Section 4, page 11).

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Primecure</u> – Healthcare service resources should not be concentrated around tertiary care. Primary care is less expensive, more responsive, and more accessible to broader populations than tertiary and specialised care.	The competing objectives as specified in Section 2.2.5 (page 8) will be considered by the task groups. BDs must specify appropriate setting and level of care (Section 2.2.6, page 9). The comprehensive PMB definition in Section 3 (page 10) includes primary care and other specified services.
<u>Roche</u> – By limiting out-of-hospital services to defined baskets of care (primary, dentistry, optometry etc.), the package will not be comprehensive and balanced.	The competing objectives as specified in Section 2.2.5 (page 8) will be considered by the task groups.
<u>PSSA</u> – Supports focus on preventative and primary care treatments.	The comprehensive PMB definition in Section 3 (page 10) includes primary care and other specified services.
<u>IMSA</u> – Supports the move to include primary care, basic dentistry, and basic optometry.	
<u>BHF</u> – The current PMBs are unreasonably skewed in favour of catastrophic conditions. Catastrophic cover is inconsistent with public health management principles. Primary care benefits as core benefits are shown to be cost-effective, but not all primary care services are cost-effective (e.g. prostate screening). Benefits should be designed as a list of specified services at the primary care level. Hospital-based conditions could be added on a case value-added prioritisation basis (e.g. the Oregon prioritisation method).	The competing objectives as specified in Section 2.2.5 (page 8) will be considered by the task groups.
<u>Momentum</u> – Preventative care should be evidence-based and cost-beneficial. They are supportive of early detection of diseases through increased primary care benefits.	All conditions and services included in the PMB package must be evidence-based (see Section 4.1.4, page 11).
<u>Enabledmed</u> – Providing cover for high-cost events results in more people in lower income brackets being excluded from membership. Open access to primary care reduces the total healthcare bill. Where the GP is an effective gatekeeper, countries have lower health spending and better outcomes.	LIMS proposals need to be considered in the context of NHI. This review introduces primary care in addition to high-cost catastrophic events (Section 4, page 11).
<u>Ben Broens</u> – Retention of current DTPs and CDLs promotes hospitalisation and is procedure-driven, leading to inefficiency. PHC is the lowest cost level of care and arguably the most cost-effective, leading to downstream savings. The GP should be empowered to make informed decisions on behalf of members to promote appropriate PMB benefit usage. Reliance should be placed on the present network of independent GPs.	A specific principle in the review is to ensure that services are rendered in the most appropriate cost-effective setting (Section 2.2.6, page 9). The comprehensive PMB definition in Section 3 (page 10) includes primary care and other specified services.

### 3. Expansion

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<p><u>Discovery Health</u> – Expansion of package will increase cost of PMBs. Considering Circular 8, low-income options will experience a sharp increase, and there will be downgrades to lower options which will lead to a cost spiral. Scheme splitting may be a consequence. Expansion should therefore be limited. Any expansion must come with controls for packages that promote efficiency and promote quality. Strongly disagree that package be expanded to provide access to comprehensive hospital cover, even with a negative list. The most efficient setting may change over time. Discovery urges that extreme caution is displayed when considering any expansion of the PMB package based on the assumption that costs can be contained.</p>	<p>The policy objectives of REF will not be met if the PMB package, which is the basis of REF, is too small (see Section 2.2.1, page 3). Expansion will only be considered after considering the cost impact by REF and sustainability task group.</p>
<p><u>Medscheme HRS</u> – Disagree that PMBs should be expanded as current package is too expensive. Focus should rather be on redefinition to enhance access.</p>	
<p><u>BHF</u> – Does not agree that PMBs need expansion to protect access, especially expanded hospital cover.</p>	
<p><u>HAS</u> – The Homeopathic Society of South Africa proposes that CAM modalities (professionals and medicines) are included in the definitions and algorithms of primary or preventative baskets in PMBs and REF. They are currently discriminated against by their current exclusion from definitions.</p>	<p>All conditions and services included in the PMB package will be evidence-based, regardless of whether they consist of orthodox or alternative complimentary therapies (see Section 4, page 11).</p>



## 4. Definitions

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – The review should provide the highest level of clarity and certainty for the application of PMBs. This round should aim for complete clarity on conditions and treatments in the PMB package. Entry and verification criteria, baskets of care, formularies and protocols should be defined and published for the industry as a whole.	The development of BDs should address this concern (see Section 4.2 on page 11 and Section 2.2.6 on page 9).
<u>Novartis</u> – Current definitions of DTPs are broad and open to misinterpretation, and reduction or exclusion by schemes. The actual meaning of the Act and the interpretation thereof by schemes do not always coincide.	The PMB Review committee has agreed that algorithms should be developed for DTPs. This is reflected in Section 4.2 on page 11 and Section 2.2.6 on page 9.
<u>Primecure</u> – Main criticism of current PMBs is lack of efficiency, effectiveness and equity criteria.	This revision considers efficiency, effectiveness and equity (see Sections 2.2.4.2 (page 8), 2.2.5 (page 8), 4.1.5.4 (page 11), and 2.1.2 (page 2)).
<u>IMSA</u> – Current PMBs should be clarified so that scheme's obligations are clear. A model is proposed in their submission to derive greater clarity.	See Section 4.2 on page 11 and Section 2.2.6 on page 9.
<u>BHF</u> – Reference to severity of disease in a positive list of diseases covered by PMBs should be avoided unless objective measurable criteria exist.	The PMB definitions task group must consider this when BDs are developed.
<u>Momentum</u> – Treatable cancer should be defined more clearly.	

## 5. Algorithms

<u><b>Comment</b></u>	<u><b>PMB Review committee response</b></u>
<u><b>National Renal Care</b></u> – The original definition of the algorithm related to transplantation and renal care was based on a draft document setting out public sector guidelines. These have now been updated and so the PMB / REF algorithms should be updated. The update was attached with the submission.	The PMB definitions task group must consider this when BDs are developed. Task teams must consider the principles for prioritisation listed in Section 4.2.5 on page 12.
<u><b>Roche</b></u> – Algorithms for the treatment of cancer need to be updated to reflect advances in technology with improved survival benefits. The definition of treatable cancers should also be reviewed and extended. Algorithms need to be updated more frequently (e.g. for rheumatoid arthritis where several new technologies and drug classes are available, and chronic renal disease). An independent review committee could meet regularly to fulfill this function.	
<u><b>Momentum</b></u> – Algorithms should be developed for more expensive conditions (e.g. CVA, IHD). Algorithms for CDLs should be referenced to established guidelines to avoid becoming outdated.	
<u><b>Ben Broens</b></u> – Cost-sharing applied to discretionary services may result in denial of treatment as members may not make informed decisions, and inequity as co-payments might be barrier to some members. Co-payments on higher cost services have the potential to make bigger savings, but should be set at a reasonable level.	

## 6. Access and Affordability

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – PMBs should be affordable to the current scheme population, and assist in cost containment for expansion to low-income populations. If benefit options pay the same price for common benefits, then low income options will experience a sharp increase. Affordability is a key consideration, especially for low-income options. The CMS should research and publish the cost impact of proposed expansion.	Consideration is given to this in Section 2.2.5 (page 8) and will be considered further by the REF and sustainability task team (Section 5, page 14).
<u>Medscheme HRS</u> – Prior to the PMB Review, the Department of Health should define the monthly affordability level for contributions to assess affordability level for the essential package.	Costs and affordability are key responsibilities of the task teams.
<u>National Renal Care</u> – Schemes often provide benefits for treatment only at public sector facilities limiting access. Affordability is also impacted by increasing out-of-pocket payments.	
<u>Novartis</u> – There are issues with current methods of cost-effectiveness measurement as an indicator for inclusion or exclusion in algorithms and treatments. These issues form a bias in favour of the privileged. The decisions are usually products of models that consider budget savings, not improvement in societal outcomes. Patient quality of life often not factored into decisions.	The committee welcomes suggestions on economic evaluation techniques that could be applied to develop the package and BDs.
<u>Old Mutual HC</u> – There should be no increase in PMBs without salary-based mandatory membership and REF. PMB legislation should be modified to allow introduction of low-cost medical schemes as a means to overcome stagnant membership. Cost-effectiveness does not guarantee affordability. Affordability is what affects premiums.	Costs and affordability are key responsibilities of the task teams.
<u>Roche</u> – There are inconsistencies between public and private patient access to certain treatments, where in some cases patients get better access to treatment in the public domain (e.g. drug therapy for breast cancer and certain investigations and procedures). Evaluations for cost-efficiency should be appropriate for the South African setting in terms of thresholds etc. An independent review committee should transparently assess new treatment modalities.	The PMB definitions task group must consider this when BDs are developed. The PMB Review committee will consider the most appropriate monitoring, evaluation and review mechanisms (see Sections 4.4 and 5.2, page 13 and 14).

<u>IMSA</u> – PMB Review must take into account new technologies. Mechanisms should be set up to ensure regular reviews of what constitutes evidence-based medicine. Cost-effectiveness and affordability decisions must also take place in the review framework. Affordability is not well-defined. Cost-effectiveness should not equate to a cost-minimisation and technology excluding exercise, but should rather relate to health outcomes, downstream and balloon costs, and should be done in a transparent and principled manner. More innovative models for measuring cost-effectiveness should be explored which would be discussed by the sustainability group.	The PMB Review committee will consider the most appropriate monitoring, evaluation and review mechanisms (see Sections 4.4 and 5.2, page 13 and 14). The committee welcomes suggestions on innovative models for measuring cost-effectiveness.
<u>BHF</u> – The PMB package is too expensive and unsustainable, and unreasonably skews the system in favour of hospital-based care. The current PMB package is unconstitutional because it discriminates on the basis of diagnosis. The broad objective of PMBs should be access for a broad spectrum of health services by all scheme beneficiaries. Current PMBs and wording in the review documents steer PMB cover toward catastrophic cover at the expense of the broader spectrum of health services that should be mandatory. The affordability cap in 2008 terms should not exceed R300 per beneficiary per month, as long as there are no mandatory membership and income cross-subsidy policies in place.	The committee is of the view that the PMB Review is a rational and equitable process that meets constitutional requirements (Section 2.1.2, page 2). The PMB Review happens in the insurance environment but acknowledges other social security objectives (Section 2.2 on page 3 and specifically Section 2.2.5 on page 8). Affordability must be considered by the task teams.
<u>Momentum</u> – Evidence-based medicine protocols should be developed where public health equivalents do not exist. Cost limits based on QALYs / DALYs should be used.	Evidence-based principles must be held in the development of BDs (Section 4.2.1, page 12).
<u>Enabled</u> – Higher community rates for PMBs will worsen accessibility for the bulk of employed South Africans who earn less than R4 000 per month. Income cross-subsidisation and mandatory membership must be introduced before REF is implemented.	LIMS proposals need to be considered in the context of NHI. The Medical Schemes Amendment Bill makes provision for the progressive implementation of REF and the various provisions in the Bill.
<u>Ben Broens</u> – GP rooms are conveniently located in communities or near the workplace, limiting transport costs.	Primary care is included in the benefit construct (Section 3, page 10).

## 7. Risks and sustainability

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – Expansion of services for the sick is difficult since services will be provided to the healthy and the sick. Over-servicing of PMBs depends on tariff prices (high price: incentive to over-service), setting, and subjectivity of diagnosis. Cost of PMBs dependent on tariffs for providers – currently without upper limits. Conversely, setting prices too low will put additional pressure on supply and will incentivise abusive coding behaviour.	Careful attention to the development of BDs could address this concern (see Section 4.2.6, page 12). Costs and pricing are discussed in Section 2.2.4.3 on page 8.
<u>Old Mutual HC</u> – “At cost” application on PMBs must be amended.	
<u>Qualsa</u> – “At cost” reference for PMBs is of concern. There is a risk that providers are using PMBs to drive healthcare costs and creatively utilising services.	

## 8. Positive and negative lists

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – Disagrees with using all hospital admissions excluding a negative list. Rather ensure clarity of information of members. Recognises issue of members not knowing condition until diagnosed, however risks of the alternative are greater. Recommends positive condition list, since managed care protocols can only be applied to a condition list. Strongly recommends that PMBs be based on positive condition / treatment list(s). Supplier-induced demand is strengthened if benefits are defined by setting and will discourage the development of alternate, more cost-effective settings.	Section 4.2 (page 11) and Section 2.2.6 (page 9) deal with mechanisms to promote the use of appropriate levels and setting of care. Careful attention to the development of the negative list is specified in Section 4.3.1 (page 12). Task teams should further elaborate on this to anticipate behavioural changes in the market.
<u>Medscheme HRS</u> – Supports a hybrid approach, but does not support a positive disease list. Disease lists should be negative to avoid discrimination on the basis of underlying disease.	The purpose of PMBs is to identify a broad package of essential health services within the constraints of affordability. The development of a positive list of benefits is viewed as a rational and equitable basis for rationing (see Section 2.1.2, page 2).
<u>Primecure</u> – Positive or negative lists could be inequitable at the primary care level since patients present with symptoms not diagnosis. Opportunistic prevention is probably the most efficient means of providing services. Avoidance of lists will also avoid administrative burden of disputes over definitions.	Committee agrees that positive / negative lists are not appropriate for primary care (Sections 4.3.2 and 4.3.3 on page 12).
<u>BHF</u> – Supports a positive list for in-hospital conditions provided this does not detract from constitutional right to access to essential healthcare services. Prioritisation should be based on public health priorities, including maternity- and pregnancy-related services, notifiable diseases, trauma etc. A negative list is useful to identify non-essential services. Benefits should be designed as a list of specified services at the primary care level.	The committee is in agreement with the broad principles, however PMBs are operative in the insurance environment, and cognisance must be paid to competing objectives (Section 2.2.5, page 8).
<u>SAMA</u> – A comprehensive hybrid system comprising diagnostic and therapeutic components for a designated list of diseases based at least in part on data on the burden of diseases in South Africa should replace the current PMBs.	The PMB construct is built on a hybrid system (Section 3, page 10).
<u>Momentum</u> – The current DTP list should remain and be supplemented with a negative list.	

## 9. Managed care and protocols

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – Medical schemes are not able to decline the majority of admissions nor to enforce length of stay rules in the majority of cases. Managed care tools should be allowed (pre-authorisation, formularies, baskets of care, networks, bill audit review etc.).	The committee agrees that managed care tools should be applied in the management of PMB conditions. The standardisation of BDs (Section 2.2.6, page 9) will assist in this regard; more specifically, Section 4.2.2 on page 12 has relevance.
<u>Medscheme HRS</u> – Agrees that co-payments may be necessary, and should be extended to hospital care where admissions are open to abuse.	See above. Details to be considered by task teams.
<u>Primecure</u> – Poor people tend to reduce utilisation in ways that threaten their health when faced with co-payments. The aim of PMBs should be to remove co-payments for defined services, especially primary care services.	The committee agrees that task teams must consider this.
<u>Roche</u> – Co-payments are currently applied inappropriately.	Must be considered by task teams.
<u>Qualsa</u> – Exact treatment protocols should be specified, as well as levels of care and reimbursement levels.	The committee agrees that managed care tools should be applied in the management of PMB conditions. The standardisation of BDs (Section 2.2.6, page 9) will assist in this regard; more specifically, sSection 4.2.2 on page 12 has relevance.
<u>PSSA</u> – Does not support DSPs for pharmaceutical services, especially since a maximum fee has already been set removing any price benefit that might have been gained.	The committee is of the view that managed care tools should be applied by medical schemes. The use of DSPs as a tool within the context of managed care will not be opposed and is the prerogative of the specific schemes.
<u>IMSA</u> – PMBs should be provided for in full without co-payments. This application should remain in the revised PMBs. DSP contracting should be done within a proper framework that enables mutually beneficial contracting between providers and schemes. Managed care and savings tools should be defined more clearly. Price capping for PMBs should not be considered before quality monitoring measures are in place. Argues that healthcare professionals should be allowed to provide benefits in excess of the standard package. Payment in full must be maintained and not watered down.	The committee is of the view that managed care tools should be applied to PMBs and that a standardised package must be developed. Section 2 on page 2 gives the context wherein a rational basis for the progressive realisation of right to healthcare is being established (see Section 2.2, page 3).
<u>BHF</u> – The absence of a health impact assessment framework is noted. Its purpose would be to monitor the impact on health development of medical scheme membership, utilisation of services, anti-selection, moral hazard, cost trends and sustainability.	The PMB Review committee will consider the most appropriate monitoring, evaluation and review mechanisms (see Sections 4.4 and 5.2, page 13 and 14).

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<p><u>Momentum</u> – PMBs should be limited to a maximum rate of NHRPL. PMBs should include guidelines for developing SEPs for non-medication benefits. Schemes should be able to manage liabilities by refusing treatment for members who do not comply with treatment plans.</p>	<p>Section 2.2.4.3 (page 8) deals with costs and pricing. The committee views it as unethical to refuse treatment for patients who are not compliant.</p>



## 10. Benefits

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Discovery Health</u> – Most important protection is for catastrophic and other insurable risks. Downgrading can be mitigated if strict formularies and algorithms are developed. Supports use of cost-containment measures such as co-payments / excesses, especially if services are discretionary.	The standardisation of BDs (Section 2.2.6, page 9) will assist in this regard. See Section 4.2.6 (page 12) dealing with the development of mechanisms to prevent the abuse of benefits by people in good health.
<u>Medscheme HRS</u> – Enhancing access to costly care could be achieved by ensuring extensive chronic medication cover and related hospital care. Prefers the benefit construct depicted in Figure 4.	The committee must consider the competing objectives listed in Section 2.2.5 (page 8).
<u>National Renal Care</u> – The current PMBs do not promote prevention of end-stage chronic kidney disease. Any person with diabetes, repeated kidney infections, has blood or protein in their urine, has a family history of kidney disease, and patients with hypertension should be evaluated for kidney disease. Details on criteria for treatment for chronic dialysis and renal transplantation in the private sector were provided as an attachment.	Task teams must consider these proposals.
<u>Novartis</u> – Chronic care for specific DTP PMBs should be added once DTPs have been properly redefined. Recommended methods of care should not be limited to in hospital care only. Conditions defined should be covered comprehensively, including preventative care.	BDs will be developed to ensure the most appropriate setting (Sections 2.2.6 and 4.2.6 on pages 9 and 12).
<u>Old Mutual HC</u> – Supports the addition of defined baskets of: preventative care, primary care, basic dentistry, and basic optometry. However, certain existing PMB conditions will need to be removed to maintain affordability.	Affordability must be considered by the task teams.
<u>Performance Health</u> – Certain mental health conditions are omitted from current CDLs (unipolar depression, obsessive-compulsive order, Alzheimer's disease, anorexia nervosa and others). Hospital benefits for mental wellness differ greatly between schemes and are typically very limited, one admission for alcohol abuse for example. These limits do not apply to hospitalisation benefits for other "physical" conditions. Similar problems exist on discriminatory limits for mental wellness out-of-hospital treatments compared with other conditions.	Task teams must consider these proposals.
<u>Profmed</u> – Motivates for the inclusion of certain high-cost conditions (Lysosomal Storage Disorders – ICD-10 901k) to be included as part of REF. Since it is already a PMB presumably they mean added to the CDL..	Task teams must consider these proposals.

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<u>Primecure</u> – PMB package will be the only set of benefits that can be afforded for poorer populations. PMBs should include a comprehensive primary care package. Cover for a limited number of annual visits per individual, including diagnostic work-up and treatment for diagnostic complaint (limited to acute treatment from the EDL) should be included.	Task teams will consider the details of the PMB package. LIMS proposals need to be considered in the context of NHI.
<u>Roche</u> – Conditions covered as PMBs should not be restricted only to high-profile infectious diseases but should also include asymptomatic diseases (e.g. Hepatitis C).	See Section 4.2.5 on the prioritisation of conditions (page 12).
<u>Qualsa</u> – Some chronic diseases absent from CDLs have seen sharp increases in incidence (e.g. depression).	
<u>IMSA</u> – Gaps in current PMBs include: visual field tests for glaucoma, osteoporosis, retinal detachment (code 904B), schizophrenia and paranoid disorders (three weeks is not sufficient for many patients), codes 155E 911G 901I – vulnerable patients don't get appropriate care for transplant treatments, treatable cancers, conditions related to CDLs and PMBs should be included, diabetes algorithm needs updating, depression, ADHD.	The task teams will consider these suggestions and include them in the development of BDs. Section 4.2.5, page 12, contains guidelines for the prioritisation of conditions for the development of BDs.
<u>BHF</u> – Current DTPs fall short in providing for adequate prevention of diseases by early detection, but caution is needed since medical diagnostic technology costs are currently high and expected to remain so. Consultative services and in particular primary care are necessary to avert this problem. Out-of-hospital benefits should enable access to care for illness and chronic disease other than a negative list, should be based on specific services (essential procedures, tests etc.), and should include the LIMS benefit as the core PMB benefit. A single benefit design will not meet PMB objectives. A hybrid design of services for primary care and diagnosis for referral and hospital care is ideal.	The committee agrees; see Sections 4.3.2 and 4.3.3 on page 12.
<u>SAMA</u> – Supports that benefits must be designed in a way such that members have certainty of their coverage, schemes are able to manage their liabilities, inefficient provider and patient conduct is avoided and vulnerable groups are not excluded. Out-of-hospital benefits should be limited to the positive list of conditions, a basket of defined preventative care, a basket of defined primary care, and baskets of defined basic dentistry and optometry.	The committee agrees; see Section 4 on page 11.
<u>Momentum</u> – Should consider addition of Sarcoid, and limiting HRT to premature menopause. Basic outpatient benefits should be based on numbers of consultations, not financial limits. Some specific comments were also made on certain of the CDLs.	The task teams will consider these suggestions and include them in the development of BDs. Item 4.2.5, page 12, contains guidelines for the prioritisation of conditions for the development of BDs.

<b><u>Comment</u></b>	<b><u>PMB Review committee response</u></b>
<b><u>AFA</u></b> – Aid for AIDS made extensive recommendations for revisions of benefits and treatment algorithms for the treatment of HIV, including VCT, opportunistic infections, and mother-to-child transmission.	Task teams must consider these proposals.

## Annexure B: List of stakeholders who have submitted comments on the PMB Review consultation document

Organisation	Comments available at:
1. South African Medical Association (SAMA): comments	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/SAMA%20-%20Dr%20Gantsho.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/SAMA%20-%20Dr%20Gantsho.pdf</a>
2. South African Medical Association (SAMA): letter	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/SAMA%20-%20Covering%20letter.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/SAMA%20-%20Covering%20letter.pdf</a>
3. Roche	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Roche%20-%20Alvina%20Vos.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Roche%20-%20Alvina%20Vos.pdf</a>
4. Qualsa	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Qualsa%20-%20Riaan%20Smit.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Qualsa%20-%20Riaan%20Smit.pdf</a>
5. Pharmaceutical Society of Southern Africa	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/PSSA.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/PSSA.pdf</a>
6. Profmed	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Profmed%20Submission%20for%20the%202008%20PMB%20Review%20Consultation%20Document.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Profmed%20Submission%20for%20the%202008%20PMB%20Review%20Consultation%20Document.pdf</a>
7. Performance Health	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Profmed%20-%20PH%20comments%20on%20Mental%20Health%20Conditions%20in%20PMB%20setting.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Profmed%20-%20PH%20comments%20on%20Mental%20Health%20Conditions%20in%20PMB%20setting.pdf</a>
8. Primecure	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Primecure%20-%20Mark%20Ferreira.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Primecure%20-%20Mark%20Ferreira.pdf</a>
9. Gary Riley	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Osteopathy%20-%20Gary%20Riley.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Osteopathy%20-%20Gary%20Riley.pdf</a>
10. Old Mutual	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Old%20Mutual%20-%20Martin%20de%20Villiers.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Old%20Mutual%20-%20Martin%20de%20Villiers.pdf</a>
11. Novartis	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Novartis%20Pharma%20-%20Princess%20Majola.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Novartis%20Pharma%20-%20Princess%20Majola.pdf</a>
12. National Renal Care: letter	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/National%20Renal%20Care%20-%20Noeleen%20Philipson.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/National%20Renal%20Care%20-%20Noeleen%20Philipson.pdf</a>
13. National Renal Care: attachment	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/National%20Renal%20Care%20-%20Noeleen%20Philipson%20Attachment.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/National%20Renal%20Care%20-%20Noeleen%20Philipson%20Attachment.pdf</a>
14. Momentum	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Momentum%20-%20Manono%20Mdoda.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Momentum%20-%20Manono%20Mdoda.pdf</a>
15. Medscheme	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Medscheme%20-%20Bettina%20Taylor.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Medscheme%20-%20Bettina%20Taylor.pdf</a>
16. Innovative Medicines SA	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/MSA%20-%20Elsabe%20Klinck.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/MSA%20-%20Elsabe%20Klinck.pdf</a>
17. Homeopathic Association of South Africa: letter	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Homoeopathic%20Association%20of%20SA,%20Letter%20-%20Dr%20Neil%20Gower.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Homoeopathic%20Association%20of%20SA,%20Letter%20-%20Dr%20Neil%20Gower.pdf</a>
18. Homeopathic Association of South Africa: comments	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Homoeopathic%20Association%20of%20SA,%20Comments%20-%20Dr%20Neil%20Gower.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Homoeopathic%20Association%20of%20SA,%20Comments%20-%20Dr%20Neil%20Gower.pdf</a>
19. Enabledmed	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Enabledmed%20Sam%20Fehrsen.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Enabledmed%20Sam%20Fehrsen.pdf</a>
20. Discovery Health	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Discovery%20comments%20on%20PMB%20review.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Discovery%20comments%20on%20PMB%20review.pdf</a>
21. Board of Healthcare Funders	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/BHF.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/BHF.pdf</a>
22. Ben Broens	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Ben%20Broens.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Ben%20Broens.pdf</a>
23. Aid for AIDS (AfA)	<a href="http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/AfA%20-%20Leon%20Regensberg.pdf">http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/AfA%20-%20Leon%20Regensberg.pdf</a>