The PMB Review Process, presented by Boshoff Steenekamp, MMI Health

Mr Steenekamp's prefaced his presentation by commenting that the PMB Review presented a good opportunity to review the package with policy priorities, such as universal coverage, in mind. He added that the process must be iterative, transparent and participative which would require broad acceptance by all participants. He said that the process was elaborate and technically complex with a high risk of failure. He pointed out that the process should encompass sustainability interventions.

He advised that his presentation would cover the following aspects:

- Challenges with the PMB package
- Policy uncertainty – potential interventions towards Universal Health Coverage
- Proposed PMB review Process
  - Formal priority setting process
  - Iterative, transparent, participative – this reform requires broad acceptance by all participants
  - Elaborate, complex, technically difficult – high risk of failure
- Sustainability interventions
- Proposed package
- Conclusion

Contributing factors to the challenges associated with PMBs include:

- The lack of a tariff determination process, often resulting in higher charging for PMB conditions;
- The industry operates largely on fee-for-service remuneration;
- The benefit definitions are unclear;
- The current PMB package contains no incentives to maintain and improve health;
- The current PMB package is hospi-centric and has no primary care; and,
- There is no coordinated or comprehensive approach to priority setting, often resulting in lower cost options cross subsidizing the higher cost options which are pressurized into offering the latest, often costly, technology and other benefits.

Policy uncertainty – potential interventions towards Universal Health Coverage

Various policy interventions aimed at realizing UHC had been implemented, including:

- Taylor committee report - 2002;
- REF - 2008 (The REF was halted before being fully established)
- Green paper on National Health Insurance - 2011;
- The establishment of an Advisory Committee (whose report was never released into the public domain)
- The draft White Paper on NHI (2015)

Adding to the policy uncertainty is the fact that reports from the various task teams are not in the public domain.

Mr Steenekamp explained that while the role of a health system included purchasing, pooling, service delivery, creating resources, benefit design and revenue collection, the South African health system failed on most accounts except that of revenue collection. He added that this was evident by the fact that although the country spends 7.9% of its GDP on health, outcomes were bad.

He added that to address health policy challenges and implement a sound health financial strategy would require revision to raising revenue, purchasing, benefit design, overall system architecture and governance. He added that priority should be given to those areas which limit progress towards universal health coverage and which, when implemented, would provide a solid foundation for future development of a system which could be feasibly implemented given current and expected future contextual constraints.

Mr Steenekamp emphasised that interventions towards universal health care must include areas of service delivery, creating resources, stewardship, governance and oversight and more specifically that areas of revenue collection, pooling, purchasing and benefits needed to be addressed. Examples of interventions required include:

- A risk adjustment mechanism for medical schemes
- Norms and standards for equitable financing in provinces
- Priority setting authority (NICE or HITAP)
- Coding, remuneration, and outcomes authority
- Transversal contracts for medicines, surgicals, labs and equipment
- Prepare for a purchaser provider split, improve service delivery
- State sponsorship for missing middle
- Stewardship, governance and oversight
- Creating resources
- Revenue collection

Boshoff continued by highlighting the potential cost-containing policy interventions achievable through the PMB review. These included cost containment potential in the areas of outpatient, inpatient, pharmaceutical and administration services. On the supply side, for e.g. these would include provider payment mechanisms, provider competition and generic substitution. On the demand side, this would include a clear definition of a health package. From the side of public management coordination and finance, this would include health technology assessment.

Mr Steenekamp pointed out that it was important to have a mechanism to guide the use of medicines and cited the example of Vietnam where uncontrolled access to pharmaceuticals resulted in more than 50% of drugs being used in inappropriate circumstances.

Proposed PMB review process:

In reviewing the PMBs, Mr Steenekamp emphasised the importance of sequencing, citing the following key aspects:

- Clarity must be obtained on policy objectives.
- A consideration of approaches to identify priority interventions that must be included in the package is necessary.
- Define the package based on an agreed upon prioritisation mechanism.
- Develop clinical guidelines inclusive of algorithms for chronic disease management, screening for public health priorities and diagnostic guidelines.
- Costing of the revised PMB package.
- An estimation of the affordability level – even a slight increase in the cost of PMB may have a negative impact on medical scheme membership.

Mr Steenekamp suggested that the current governance structure was inadequate and proposed that an ideal governance structure for the process would include a PMB review steering committee as the overarching committee, and in addition there should be a representative advisory body which included a project manager; a clinical stream made up of multiple clinical advisory committees; a legal stream; an actuarial and economic stream; a costing team; and, an affordability assessment team.

In order to identify priority services, each service should be weighted and analysed in terms of its impact on health and social security on aspects such as the impact on healthy life years; impact on suffering, effects on the population, etc.

An example of a priority setting table is as follows:

Service	Weighting
1) Maternity & new born care	100
2) Primary prevention and secondary prevention	95
3) Chronic disease management	75
4) Reproductive services	70
5) Comfort care	65
6) Fatal conditions, where treatment is aimed at disease modification or cure	40
7) Nonfatal conditions, where treatment is aimed at disease modification or cure	20
8) Self-limiting conditions	5
9) Inconsequential care	1

Sustainability interventions:

Potential sustainability measures which could be implemented include:

- The creation of primary care teams
- Employment of health professionals by hospitals

- Tariff determination and reimbursement mechanisms
- Availability of vaccines, medicines, disposables and laboratory services at state tender prices
- Clinical coding systems and groupers
- Incentives to focus on improved health
- Protection of risk pools

Mr Steenekamp pointed out that sustainability measures should focus on improved health and outcomes and that the list of measures mentioned above could be limited to the PMB package.

The revised PMB package:

In terms of the actual package of benefits, Mr Steenekamp suggested that there be a basic tier which could become the NHI package. This tier would ensure that all beneficiaries, whether public or private have access to the same level of care. This package would include a low-cost benefit option; would address public health priorities; would address low cost, high frequency benefits; and, predictable events.

Mr Steenekamp suggested that a supplementary package be included, which could be offered by medical schemes, thereby protecting membership to medical schemes. This package would be a comprehensive package, including high cost, unpredictable, low frequency, events.

In addressing the legal issues associated with the PMB review, Mr Steenekamp emphasized the need to ensure strict adherence to all relevant legislation. He added that consultation would be critical and that consultation should be wider than the Minister, CMS and industry stakeholders. Consultation should involve the provinces and members of the public as well. Mr Steenekamp commented that the Ebersohn judgement which set aside the RPL regulations provided guidance on the depth of consultation required.

In conclusion, Mr Steenekamp highlighted the complexity of the process and the amount of effort it would require. He said that the PMBs have an enormous impact on the entire system and the process should be participative and legally sound. He suggested that HFA should lobby and should offer its resources to the process.
