Innovative Pharmaceutical Association of South Africa (IPASA)

Submission

on the

Review of the Prescribed Minimum Benefits
Circular 6 of 2018

Submitted to:

Council for Medical Schemes

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Executive Summary

IPASA is supportive of Universal Health Coverage recognising that access to healthcare can be achieved through various channels. These include increasing or strengthening access to health insurance in the form of medical schemes and other health financing models, in addition to innovative, collaborative contracting arrangements each contributing towards a single health system. All must be underpinned by a strong health system strengthening approach to ensure socio-economic sustainability. Recognising the importance of PMBs within defining the benefit package envisioned for NHI.

In response to CMS Circular 6 of 2018, dated 8 February 2018, we appreciate the opportunity to submit our inputs. Having studied the proposed framework, we wish to share some general comments for considerations, along with three high-level direct inputs.

- The proposed PMB Framework benefits are similar/identical to the **benefit package envisioned for NHI.**
- The call for inputs is **general nature** and we contend that it is difficult to comment in a meaningful way at this stage. Extensive consultation and work is required to ensure there is clarity on what services may be provided and funded by the private sector. We therefore volunteer to participate in this process.
- When considering Annexure A, it is not clear whether the current **eight categories** will be extended to more than eight, or whether it implies that the actual detail of the services provided under the eight categories will be expanded to a more granular level. The constructs of the "services" should be unpacked and clearly defined to avoid misinterpretations and high expectations. We believe a second version for comment would be required to allow for a robust engagement in this regard.

IPASA strongly supports the need for **PMBs to remain** and suggest that treatment algorithms be updated to reflect minimum standard of care. The Review of PMBs must not replace the current PMBs and must rather serve to supplement the PMBs and ensure holistic healthcare (beyond disease specificity), as envisaged by Universal Health Coverage objectives.

1. Opening Remarks

The Innovative Pharmaceutical Association of South Africa (IPASA) welcomes the opportunity to comment on the PMB Review (Circular 6). IPASA is a trade association with 27 of some of the world's leading global pharmaceutical research and biotechnology companies devoted to inventing medicines that have and continue to contribute to patients living longer, healthier, and more productive lives. With nearly $65.5 billion invested in R&D worldwide in 2016,[1] more than 300 new medicines approved in the last decade, and about 7,000 medicines in development globally our members are world leaders in medical research.[2]

IPASA is supportive of Universal Health Coverage recognising that access to healthcare can be achieved through various channels. These include increasing or strengthening access to health insurance in the form of medical schemes and other health financing models, in addition to innovative, collaborative contracting arrangements each contributing towards a single health system. All must be underpinned by a strong health system strengthening approach to ensure socio-economic sustainability Recognising the importance of PMBs within defining the benefit package envisioned for NHI.

We recognise the **two fundamental shifts** in the approach presently. Firstly, from diagnostic-based treatment to a services-based offering. We see this as an improvement as this allows for the removal of prior exclusions whose exclusion criteria were unclear, namely treat bipolar but not depression. The second shift is the move of the basic concept of the PMBs from a fall-back insurance, from being financially divested by a disease condition, to now being an adjunct to primary healthcare as presented in the NHI approach.

2. General Comments

- The law stipulates an ***update*** **of the PMBs (not a repeal-and-replace)**, to ensure alignment with new approaches in care, and consistency (not duplication etc.) with health policy;
- We are concerned that the PMB entitlements patients have will now be removed, and patients with conditions that were explicitly listed before, will **no longer have any legal entitlements to the funding of treatment of those conditions**;
- The NHI White Paper (i.e. health policy) makes clear that medical schemes will provide top-ups to NHI care, and not the same or duplicate care;
- The rationale behind the Medical Schemes Act has been **to ensure cover for catastrophic and hospital-based care**, which are unaffordable to individuals, the proposals are therefore a fundamental departure from this premise;
- The **population of schemes are older and also differs per scheme**, and the needs in particular in terms of the impact of age and disease profile (as per the HMI reports) for self-funded (medical scheme) healthcare may be different to that what the public sector would focus on (primary care);

[1] See slide 35 http://phrma-docs.phrma.org/files/dmfile/Biopharmaceuticals-in-Perspective-2017.pdf.
[2] See slide 24 http://phrma-docs.phrma.org/files/dmfile/Biopharmaceuticals-in-Perspective-2017.pdf

- Although primary care interventions align with global and public health policy - offering these services to an older population that **rather requires TAVI than contraception** (as an example), would not assist in increasing access to healthcare and may just lead to the TAVI-population having to obtain their heart valve care in the public sector, the reality and practicality of the situation is an important consideration;
- In the absence of mandating medical scheme cover to all employed persons, the medical scheme population will not mirror the public sector population, and, as research from the **LIMS process has shown**, healthcare needs and preferences may also differ; and
- As a result of the above, assessments of cost-effectiveness, health impact and outcomes of selected interventions, would also differ, as well as the "money behind it all" (i.e. affordability) will differ between various public sectors (provincial departments of health) and various schemes.

3. Response to the CMS Circular 6 of 2018

In response to CMS Circular 6 of 2018, dated 8 February 2018, we appreciate the opportunity to submit our inputs. Having studied the proposed framework, we submit three high-level inputs for consideration.

Firstly, we submit that the proposed PMB Framework benefits are similar/identical to the **benefit package envisioned for NHI**. In the light of this and the clear intention stated in the NHI White Paper that private medical schemes will be allowed to provide top-up insurance and not duplicate NHI services, we contend that this poses a conflict in policy direction. With the NHI benefit package being defined in its current draft form, should this PMB Review not rather focus on the benefits that will be provided by Medical Schemes within a NHI Policy Framework as the two sets of benefits are deemed mutually exclusive? This will create clarity and remove ambiguity as to what services will be insured by medical schemes and what benefits may legally be paid for via medical scheme insurance.

The proposed Service Benefits Categories are conceptual to ensure that services are defined and covered. However, if one considers the current PMB legislation and specifically the 270 medical conditions in the Diagnosis Treatment Plans, as well as the 25 CDL's, all can be mapped to these Categories. This speaks to the **generality of the current document** and we contend that it is difficult to comment in a meaningful way at this stage. However, we submit that, while this is a significant **move towards defining benefits** under a new health policy dispensation, extensive consultation and work is required to ensure there is clarity on what services may be provided and funded by the private sector. We therefore volunteer to participate in this process.

In Annexure A (Proposed Services Benefit Categories) it states that "These categories will be expanded further to incorporate specific services that should be covered…". This statement appears ambiguous in that it is not clear whether the current **eight categories** will be extended to more than eight, or whether it implies that the actual detail of the services provided under the eight categories will be expanded to a more granular level. For the purpose of this submission, we submit that we understand the statement in

terms of the last interpretation. Based on this interpretation we foresee that a **second version of the PMB Structure will be circulated for comment** and that this will pave the way to an enforceable, non-ambiguous and clearly delineated benefit package (i.e. services provided under NHI and under Medical Schemes respectively). This more detailed document will move the debate from concept to content and we request that we are involved in this process from an early stage and be allowed to submit our position with supporting data and evidence.

Some General Comments on Annexure A:

- In comparison with 83/2016, besides Pharmaceutical Services which are listed in the construct of both the Primary Care & Hospital Level Package, Categories such as Curative Services, Diagnostic, Laboratory Services & Diagnostic Imaging Services are not referred to in the latest circular. Have these been omitted or are they implied in the detailed contents under each new category? If so how can one determine their relevance in the package
- Pharmaceutical Services form a pivotal part of acute, chronic and OTC treatment of a package of services for primary and hospital package but are not referred to in 6/2018
- In reviewing the document there is concern that there is no reference made to the National Department of Health's Standard Treatment Guidelines (STG's). Yet these are seen as an essential starting point for addressing treatment services for all South Africans.
- There is no mention of the Essential Drugs List (EDL) which is paired with the STG's. Whilst both circulars 83 and 6 place emphasis on financial aspects (cost effectiveness of health technologies; scheme viability; affordability etc) little reference is made to clinical outcomes of patients. These can and should where necessary, be obtained through essential as well as newer innovative medicines where appropriate.
- Under Category D, provision is made to refer to higher levels of healthcare when required in a number of conditions listed (although the intention is to move to Services rather than conditions, a number of these are listed). Does this mean from nurse to GP or GP to Specialist? In the case of the latter in particular, the most appropriate pharmaceutical treatment should be applied including innovative medicines. These can form part of a cost-effective approach and can further prevent downstream hospital costs.
- Neither under the Services Categories listed nor the activities under these is there any reference to minor ailments, coughs, colds, flu etc. Neither is there any reference to dental or optical services which should form part of any basic healthcare package. This appears to be an omission

4. Concluding Remarks

IPASA welcomes the opportunity to comment on Circular 6 of 2018. Based on the interpretation above we foresee that a **second version of the PMB Structure will be circulated for comment** and that this will pave the way to an enforceable, non-ambiguous and clearly delineated benefit package (i.e. services provided under NHI and under Medical Schemes respectively). This more detailed document will move the debate from concept to content and we request that we are involved in this process from an early stage and be allowed to submit our position with supporting data and evidence.