PMB review consultation document

Third draft

25 March 2009
Contents

List of figures................................................................. iii
List of text boxes ........................................................ ii
List of annexures........................................................... iii
List of abbreviations ....................................................... iii
1  Introduction and purpose of this document .................... 4
2  The mandate for the PMB review .................................... 5
   2.1 Medical Schemes Act 131 of 1998 .............................. 5
   2.2 Other legislation ..................................................... 5
3  Context of the PMB review ............................................. 7
   3.1 Imminent reforms in healthcare funding ...................... 7
   3.2 Potential objectives that could be met through PMBs ....... 8
   3.3 Other requirements specific to the insurance environment .. 9
   3.4 Sustainability threats to the current PMB framework ...... 9
   3.5 Clarity of the PMB package ....................................... 10
4  Recommendations ......................................................... 11
   4.1 Recommendations on objectives of PMBs in the medical schemes environment ............................................. 11
   4.2 Recommendations on the PMB construct relating to the implementation of REF and revised benefit design .......... 12
   4.3 Recommendations on affordability constraints and pricing of PMB benefits .................................................. 12
   4.4 Recommendation on measures to improve clarity on entitlements and liabilities ................................................. 13
   4.5 Recommendation on a continuous review process .......... 13
   4.6 Recommendation on transitional arrangements ............. 14
   4.7 Recommendations on the development of the revised PMB construct .............................................................. 14
   4.8 Recommendations to control moral hazard ..................... 15
5  Proposed PMB construct ................................................ 16
   5.1 Principles guiding the PMB definition process ............... 16
   5.2 Objectives of protocol-driven benefit definitions ............ 17
   5.3 Principles applicable to the development of condition-specific BDs and CDL algorithms ......................................... 17
   5.4 Guidelines for the development of specified primary care services ................................................................. 17
   5.5 Guidelines for the development of a list of essential drugs ................................................................................. 17
   5.6 Guidelines for the development of a negative list in respect of services and conditions ................................................. 18
   5.7 Guidelines on step-down care ....................................... 18
   5.8 Recommended comprehensive PMB construct ................ 18
List of figures

Figure 1: Revised benefit structure introduced in the MSAB ........................................7
Figure 2: Key differences between the private and public healthcare sectors ..................11
Figure 3: Access to essential healthcare .........................................................................13
Figure 4: The impact of the proposed benefit construct on individuals .........................15
Figure 5: PMB decision matrix ......................................................................................16

List of text boxes

Box 1: Explanatory note to Annexure A of the Regulations to the Medical Schemes Act 131 of 1998: on prescribed minimum benefits ..............................................5
Box 2: Potential objectives of a minimum set of defined benefits ................................8
Box 3: Recommended PMB construct ............................................................................19

List of annexures

Annexure A: List of definitions ..........................................................................................20
Annexure B: Diagnosis treatment pairs ...........................................................................21
Annexure C: Chronic disease list and CDL algorithms ....................................................38
Annexure D: List of basic dentistry services ....................................................................62
Annexure E: List of basic optometry services ..................................................................63
Annexure F: List of basic preventative services .............................................................64
Annexure G: Essential drugs for adults ...........................................................................66
Annexure H: Essential drugs for children ........................................................................74
Annexure I: List of exclusions ........................................................................................78
Annexure J: Summary of stakeholder comments on the second draft of the PMB review consultation document .................................................................85
Annexure K: List of stakeholders who have submitted comments on the second draft of the PMB review consultation document .................................................104

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
LIMS - Low income medical scheme
MSA - Medical Savings Account
MSAB - Medical Schemes Amendment Bill
NHI - National Health Insurance
REF - Risk Equalisation Fund
RETAP - Risk Equalisation Technical Advisory Panel
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 PMB review process on 27 March 2008*. Stakeholder comments on this document were considered and incorporated in the second draft of the PMB review consultation document, which was published in September 2008†. A list of stakeholder comments on the second draft appears in Annexure K (page 104). Considering these comments and other considerations, the PMB review steering committee incorporated numerous revisions into this document. The committee’s responses to stakeholder comments are included in Annexure J (page 85).

The PMB review has the following terms of reference:

- 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) if not the broad set of essential healthcare benefits;
- identify the specific constraints associated with the implementation of a broad set of essential healthcare benefits;
- identify the interventions that should be undertaken to ensure the financial 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, while section 3 presents the context of the review. Section 4 presents the recommendations on the PMB review, while the principles for the revised PMB construct and a framework for the revised PMBs is presented in section 5.

---

2 The mandate for the PMB review

The context and legislated mandate for the PMB review impact on the principles that are applicable to this review. The existing regulations, an extract of which is presented in Box 1, make provision for the consideration of the current context and developments in health policy, which are presented in section 3 below. This review therefore takes account of the REF and related reforms, which are not mentioned in the regulations.

2.1 Medical Schemes Act 131 of 1998

The explanatory note on PMBs in the Medical Schemes Act 131 of 1998 (Act) is presented in Box 1.

Box 1: 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, 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 PMB review, and are elaborated on in section 3.

2.2 Other 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. The 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 process. It is therefore required that this PMB review must be aligned with the progressive realisation of the right to healthcare of the population.
3 Context of the PMB review

The private healthcare sector forms part of the overall national health system, and consumes the majority of healthcare funds while less than 20% of the public are members of medical schemes. Health policy needs to realise the right of access to healthcare irrespective of whether services are offered in the public or private sectors.

3.1 Imminent reforms in healthcare funding

The role played by PMBs in the protection of risk pools is complementary to other reforms presented in draft legislation.

The Medical Schemes Amendment Bill (MSAB) makes provision for strengthening medical scheme governance, introduces REF, and makes provision for a revised benefit structure and medical scheme products for low-income individuals. These reforms will introduce a strict version of community rating.

The revised benefit structure will remove the de facto risk rating through benefit design, and introduce scheme community rating. The implementation of REF will lead to industry-wide community rating in respect of the PMBs. The revised benefit structure will permit a distinction between “basic benefits” that must conform to strict community rating and “supplementary benefit options” that may be subject to limited age rating (see Figure 1).

Figure 1: Revised benefit structure introduced in the MSAB

An analysis of public comments on the draft MSAB has demonstrated that the introduction of risk equalisation without the expansion of PMBs will reduce the positive effects of risk equalisation. The larger the non-PMB in-hospital portion is, the smaller is the portion that is equalised, reducing the impact of REF (Figure 1). For REF to have its required impact, the PMBs must be broadened to improve the positive effects of REF.
3.2 Potential objectives that could be met through PMBs

During the revision to the PMBs, careful attention needs to be paid to the potential objectives that could be attained through the mandating of a package of minimum benefits in different contexts. Box 2 lists eight possible objectives; some of these objectives are in conflict and could not be met simultaneously. These potential objectives are considered in relation to the role of minimum benefits in the private and public sectors, the achievement of public health goals and the use of burden of disease data, the need for regulation in the medical schemes environment, other requirements specific to the medical scheme environment, and sustainability threats to the PMB framework.

Box 2: Potential objectives of a minimum set of defined benefits

| 1. Facilitating catastrophic insurance cover | 5. Improving equity |
| 2. Ensuring risk based cross subsidies     | 6. Controlling moral hazard and cost escalation |
| 3. Improving allocative efficiency         | 7. Fostering competition |

Source: Söderlund

3.2.1 The distinction between mandating minimum benefits in different contexts

The fundamental distinction between PMBs in the insurance (and fee-for-service) environment, as opposed to a minimum package of services offered in the public sector (applying a service provider model), must be observed.

The supply-driven public sector model has a distinct focus on being a planned gatekeeper and referral system. This focus is consistent with a publicly provided and tax-funded vertically integrated system.

The medical schemes environment, which is demand-driven and faces specific market failures, requires a different focus to protect the served population.

3.2.2 Achievement of public health objectives and the use of burden of disease data

The achievement of public health objectives, such as the Millennium Development Goals (MDGs), requires strategic public and community health interventions, which may include non-medical interventions.

Burden of disease data is important in the selection of priority public health interventions to improve population health status. Public sector interventions should be aimed at alleviating commonly occurring and serious conditions. However, in the medical schemes environment, it is important to address catastrophic costs and to prevent discrimination based on health status. The aim is to prevent restriction of access to health insurance for high-risk individuals.

---

‡ Neil Söderlund, Possible objectives and resulting entitlements of essential health care packages, Health Policy 45 (1998) 195–208
3.2.3 Need for regulatory intervention in the medical schemes environment

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 based on risk selection rather than on price, efficiency, and the quality of coverage. The natural consequence of this market conduct is the permanent exclusion of individuals or groups with predictably high healthcare costs. In other forms of insurance, this problem does not arise as the risks of claiming are not known in advance or, where they are, 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. PMBs structurally reduce discrimination based on health status because if PMBs are broad enough, the ability to separate insurable and uninsurable individuals through benefit design is eliminated.

3.3 Other requirements specific to the insurance environment

In the health insurance environment, it is not necessary or socially beneficial for regulatory interventions to impose risk pooling for events that are low-cost, occur frequently, and are subject to a high degree of member discretion. These are Rand-for-Rand benefits and need not be risk-pooled.

Given that the need to insure these benefits is 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.

3.4 Sustainability threats to the current PMB framework

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

3.4.1 Affordability and access to medical scheme membership and private healthcare

If the PMB package is too broad and adequate measures to protect it against abuse are not in place, the underwriting risk to medical schemes may be too high, leading to unsustainably high increases in contributions. 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, further reducing access to care.

3.4.2 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.

3.4.3 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 may 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.

3.5 Clarity of the PMB package

The manner in which PMBs are currently defined makes it difficult for members to know in advance 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 and Treatment Pair (DTP) list.

Another factor that reduces the ability for members to know their entitlements in advance lies therein that, due to inadequate clarity in the regulations in respect of some DTPs, there is presently no uniformity of benefit entitlements. This contributes to the complexity that consumers face when choosing between schemes.

Conditions of similar severity, affecting similar systems, with similar underlying pathology for which treatment of similar cost and effectiveness is available are included or excluded without apparent reason in the current PMB construct.
4 Recommendations

4.1 Recommendations on the objectives of PMBs in the medical schemes environment

The protection of risk pools is critical in a contributory third-party system. In the medical schemes environment, the focus must be on risk pooling to eliminate significant financial impacts on households through the protection that insurance offers against catastrophic healthcare expenses.

Due to extensive gaps in the current PMB package, the PMBs do not provide adequate protection against risk selection activities, particularly out-of-hospital benefits, by schemes. This weakens the capacity for risk pooling within the medical schemes environment.

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.

The outcome of unregulated competition in the medical schemes environment undermines the constitutional imperative to give effect to the right of access to healthcare. The social security objective of medical schemes, whereby access to healthcare is protected and catastrophic out-of-pocket payment is prevented, will be thwarted unless conditions are established for insurable groups to be risk-pooled together with otherwise uninsurable individuals and groups. PMBs therefore protect access to healthcare by protecting access to “insurance” for less preferred risks.

Due to the differences in the private and public sectors, the mandating of a minimum set of benefits plays distinctively different roles. In the medical schemes environment, PMBs predominantly represent regulatory interventions to address market failure, while a mandated minimum set of benefits in the public sector chiefly represents rationing of scarce resources (Figure 2).

Figure 2: Key differences between the private and public healthcare sectors

<table>
<thead>
<tr>
<th>Public sector</th>
<th>Private sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax funded publicly provided services</td>
<td>Private funds</td>
</tr>
<tr>
<td>Supply driven, means tested system</td>
<td>Insurance environment</td>
</tr>
<tr>
<td>PMBs have a rationing function</td>
<td>Purchaser provider split</td>
</tr>
<tr>
<td></td>
<td>Voluntary, demand driven system</td>
</tr>
<tr>
<td></td>
<td>PMBs have a regulatory function</td>
</tr>
</tbody>
</table>
**Recommendations**

1. The primary objectives of the PMBs must be recognised to facilitate medical schemes cover that offers protection against catastrophic healthcare expenses, and to ensure risk-based cross-subsidies. Through the attainment of these objectives, the constitutional right of access to healthcare is guaranteed.

2. Secondary objectives include control of moral hazard and cost escalations, and the fostering of competition (see recommendations 13 and 14, and Figure 1 respectively).

**4.2 Recommendations on the PMB construct relating to the implementation of REF and revised benefit design**

The implementation of the revised benefit structure and REF will lead to much stricter community rating, but requires a broadening of the PMB package to meet its objectives.

**Recommendations**

3. The PMBs must be broadened to give adequate effect to the stricter community rating requirements introduced in draft legislation.

4. The impact that these would have on contributions must be carefully studied and the impact on the industry must be modelled.

**4.3 Recommendations on affordability constraints and pricing of PMB benefits**

Some low-income beneficiaries cannot afford an expansion of the PMBs in the absence of income cross-subsidies.

The previous draft of this consultation document has linked PMB payments to the National Health Reference Price List (NHRPL). Considering public comments and other considerations, the committee agreed that this would convert the NHRPL to a tariff schedule, which is not appropriate.

**Recommendations**

5. A separate dispensation must be established for low-income earners. Figure 3 indicates possible funding arrangements for access to essential healthcare by income group. Note that the current medical population will continue to be funded through medical schemes, who would continue to purchase services in the private or public sector. Exemption from some of the PMB provisions must be made for yet-to-be-developed low-income options. These exemptions must include provisions to prevent anti-selection and risk-pool splitting through “buy-down” to low-income options.

6. More work must be done to investigate mechanisms whereby PMB remuneration is based on a negotiated fee that does not result in any balance billing for patients.
4.4 **Recommendation on measures to improve clarity on entitlements and liabilities**

Disputes frequently arise between medical scheme members or service providers and the schemes because of uncertainty about member entitlements and scheme liabilities in respect of PMBs.

**Recommendation**

7. Benefit Definitions (BDs) must be expanded to consist of 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.

8. The CDL algorithms meet most of these conditions, but much more work needs to be done on the DTPs.

4.5 **Recommendation on a continuous review process**

The complete review of PMBs will be an ongoing process that must be constantly reviewed and updated.
Recommendation

9. The PMB review steering committee will make recommendations to ensure that a satisfactory mechanism is introduced to achieve an effective continuous review process.

4.6 Recommendation on transitional arrangements

The revision of the PMBs may result therein that individuals currently receiving benefits may not qualify for these benefits after the implementation of the various provisions recommended in this draft.

Recommendation

10. Adequate transitional arrangements must be made to ensure that individuals currently enjoying prescribed benefits are not compromised through this review.

4.7 Recommendations on the development of the revised PMB construct

Protection for low-cost events must be 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). 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.

Recommendations

11. Modalities applied to describe the PMB package must include a categorical list of conditions that must be covered, a list of services that must be covered, a list of essential drugs that must be covered (which must be developed), and a list of conditions or services that are not included (negative list).

12. To meet the primary objectives, Figure 4 illustrates the benefits that must be included in the revised PMB construct. High-cost but less frequently occurring events, such as hospitalisation, would be covered from first Rand, but will affect a small number of beneficiaries. Conditions on a categorical list will also be covered from first Rand and will affect more individuals. Most individuals will make use of the specified services and be covered from first Rand. Other instances that do not enjoy first-Rand cover will be covered by above-threshold benefits to protect individuals with predictable high healthcare costs for some chronic conditions that do not appear on the categorical list.
4.8 Recommendations to control moral hazard

The committee recognises that moral hazard could be worsened through the expansion of the PMBs, and that specific measures need to be implemented to prevent these.

Recommendations

13. Benefit definitions must be developed in order to assist in the control of moral hazard for services that have to be covered form first Rand.
14. The level of the threshold for full cover of essential services must be investigated to limit moral hazard for services that have only above-threshold benefits.
5 Proposed PMB construct

Note that the construct as presented here is the broad set of essential healthcare benefits (see the review’s terms of reference in section 1), and does not necessarily represent the package that will be implemented with REF. After this package has been costed, it may be altered before the package that will be implemented with REF is developed. The broad package of essential healthcare benefits may be phased in over time.

5.1 Principles guiding the PMB definition process

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

1. There must be legislative and regulatory consistency.
2. Risk-pooling must be ensured. Access to essential healthcare for people with and without predictable health needs must be assured, with PMBs providing an effective basis for risk equalisation.
3. Essential healthcare, within the context of a contributory third-party payer system, must be defined. This includes the removal of gaps in the existing DTP and CDL structures.
4. Evidence-based medicine principles must be upheld.
5. In accordance with the decision matrix presented in Figure 5 below, conditions where the treatment is associated with higher member and provider discretion and which are not medically essential, are excluded. By contrast, conditions with low member discretion, which are medically necessary, will be included.

Figure 5: PMB decision matrix
5.2 Objectives of protocol driven benefit definitions

1. Members must have certainty concerning their coverage.
2. Schemes must be able to unambiguously identify member entitlements.
3. Schemes must be enabled to fairly and reasonably manage their liabilities in respect of members.
4. PMBs must not reinforce inefficient provider or patient conduct.
5. PMB regulations must not result in the unfair exclusion of defined vulnerable groups.

5.3 Principles applicable to the development of condition-specific BDs and CDL algorithms

The envisaged 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 factors must inform the development of BDs:

1. Evidence-based medicine;
2. Cost-effectiveness, including the specification of the most appropriate level and setting of care;
3. Administrative simplicity;
4. Commonly occurring conditions, with high cost implications or that result in frequent disputes due to inadequate clarity, must be prioritised; and
5. Exposure to member abuse.

5.4 Guidelines for the development of specified primary care services

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

1. Special care must be taken to ensure that preventative care is cost-effective.
2. In accordance with the overriding principles, a list of basic essential dentistry services should be developed. Some condition-specific guidelines should also be developed.
3. Basic specific optometry services must be considered. Specific descriptions around limitations for corrective lenses must be considered.

5.5 Guidelines for the development of a list of essential drugs

A list of essential drugs, which would not be prone to abuse, with ample international evidence of being essential, of offering superior clinical efficacy when compared to other drugs in the same class, of being cost-effective and efficient, must be developed.
5.6 Guidelines for the development of a negative list in respect of services and conditions

Conditions and services that do not meet the “essential care” requirements or any of the other principles in these sections must be excluded from care.

5.7 Guidelines on step-down care

To ensure that hospitalisation is used only in an appropriate and cost-effective manner, step-down care must be offered where it could lead to demonstrable cost savings.

5.8 Recommended comprehensive PMB construct

Considering the context as discussed in detail in the preceding sections, the PMB review steering committee recommends that a PMB structure be adopted that provides first-Rand cover for:

- Hospitalisation (excluding items on a negative list);
- In-and-out-of-hospital treatment for specified items on a categorical list (DTPs and CDLs);
- Specified services (including basic optometry, dentistry, basic primary care and preventative services); and
- Essential drug list.

In addition to the first-Rand cover specified above, the PMB regime should require mandatory risk pooling for individual expenses exceeding a yet-to-be-specified amount per annum.

Supporting the conclusions reached in this section, the PMB review steering committee proposes a PMB construct as depicted in Box 3 below.

Note that the construct suggested here might not be affordable to lower-income groups, and the regulations should prescribe exemptions from these PMBs for low-income earners (see recommendation 5).
Box 3: Recommended PMB construct

1. In-hospital services: subject to –
   1.1. a general definition of hospital services
   1.2. step-down services, including home-based nursing care
   1.3. a categorical list of conditions and treatments (DTPs and the CDL)
   1.4. a negative list

   NOTE: All hospitalisation is covered in this framework. The categorical list of conditions serves to limit scheme liability to the extent defined in the list. The negative list serves to exclude inter alia, specific types of treatment, or treatment(s) provided under specific conditions. First-Rand cover must be offered for these services

2. Out-of-hospital services: subject to –
   2.1. a general definition of out-of-hospital service
   2.2. a categorical list of conditions and treatments (DTPs and the CDL)
   2.3. specified primary care services inclusive of:
      2.3.1. a basket of defined preventative care
      2.3.2. a basket of defined basic dentistry
      2.3.3. a basket of defined basic optometry
   2.4. a basket of essential drugs
   2.5. a negative list

   NOTE: First-Rand cover must be offered for the services specified in paragraphs 2.2, 2.3, and 2.4, while above-threshold benefits must be available for all out-of-hospital services not specified in paragraph 2.5.

   This structure must be interpreted in consideration of the principles, objectives and caveats presented in this section.

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.

The following Annexures support the PMB construct:

<table>
<thead>
<tr>
<th>Annexure</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annexure A:</td>
<td>20</td>
</tr>
<tr>
<td>Annexure B:</td>
<td>21</td>
</tr>
<tr>
<td>Annexure C:</td>
<td>38</td>
</tr>
<tr>
<td>Annexure D:</td>
<td>62</td>
</tr>
<tr>
<td>Annexure E:</td>
<td>63</td>
</tr>
<tr>
<td>Annexure F:</td>
<td>64</td>
</tr>
<tr>
<td>Annexure G:</td>
<td>66</td>
</tr>
<tr>
<td>Annexure H:</td>
<td>74</td>
</tr>
<tr>
<td>Annexure I:</td>
<td>81</td>
</tr>
</tbody>
</table>

Annexure C: Chronic Disease List (CDL) and CDL algorithms
Annexure A: List of definitions

1 Essential healthcare

Essential healthcare is made up of critical and relevant services that are:

a. necessary to preserve or improve the health of an individual;
b. scientifically sound, cost-effective, and of good quality;
c. if not available, will result in death or serious morbidity; and
d. delivered in a timely manner.

2 Evidence-based medicine and healthcare

Evidence-based healthcare is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of healthcare, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors. Evidence-based clinical practice is an approach to decision-making in which the clinician uses the best evidence available in consultation with the patient to decide upon the option that suits that patient best. Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

3 Out-of-hospital services

Any services rendered to a beneficiary while that beneficiary is not an in-patient in a hospital.

4 In-hospital services

Any admission to hospital overnight or several weeks or months and inclusive of:

a. bed and board;
b. nursing and related services;
c. drugs and biologicals;
d. supplies, appliances and equipment;
e. other diagnostic and therapeutic services; and
f. medical or surgical services provided by healthcare professionals.

§ http://www.cochrane.org/docs/ebm.htm Last sourced on 26 January 2009
## Annexure B: Diagnosis Treatment Pairs (DTPs)

Throughout Annexure B, text included in blue font represents additions while text in red font represents words that will be removed in accordance with this proposal.

### 1. BRAIN AND NERVOUS SYSTEM

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>906A</td>
<td>Acute generalised paralysis, including polio and Guillain-Barre</td>
<td>Medical management; ventilation and plasmapheresis</td>
</tr>
<tr>
<td>341A</td>
<td>Basal ganglia, extra-pyramidal disorders; other dystonias NOS</td>
<td>Initial diagnosis; initiation of Medical management</td>
</tr>
<tr>
<td>950A</td>
<td>Benign and malignant brain and spinal cord tumours, treatable</td>
<td>Medical and surgical management which includes radiation therapy and chemotherapy</td>
</tr>
<tr>
<td>49A</td>
<td>Compound/depressed fractures of skull</td>
<td>Craniotomy/craniectomy</td>
</tr>
<tr>
<td>213A</td>
<td>Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury</td>
<td>Medical and surgical management; ventilation</td>
</tr>
<tr>
<td>83A</td>
<td>Encephalocele; congenital hydrocephalus</td>
<td>Shunt; surgery</td>
</tr>
<tr>
<td>902A</td>
<td>Epilepsy (status epilepticus, initial diagnosis, candidate for neurosurgery)</td>
<td>Medical management; ventilation; neurosurgery</td>
</tr>
<tr>
<td>211A</td>
<td>Intraspinal and intracranial abscess</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>905A</td>
<td>Meningitis – acute and sub acute</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>513A</td>
<td>Myasthenia gravis; muscular dystrophy; neuro-myopathies NOS</td>
<td>Initial diagnosis; initiation of Medical management; therapy for acute complications and exacerbations</td>
</tr>
<tr>
<td>510A</td>
<td>Peripheral nerve injury with open wound</td>
<td>Neuroplasty</td>
</tr>
<tr>
<td>940A</td>
<td>Reversible CNS abnormalities due to other systemic disease</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>1A</td>
<td>Severe/moderate head injury; haematoma/oedema with loss of consciousness</td>
<td>Medical and surgical management; ventilation</td>
</tr>
<tr>
<td>84A</td>
<td>Spina Bifida</td>
<td>Surgical management</td>
</tr>
<tr>
<td>941A</td>
<td>Spinal cord compression, ischaemia or degenerative disease NOS</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>901A</td>
<td>Stroke – due to haemorrhage, or ischaemia</td>
<td>Medical management; surgery</td>
</tr>
<tr>
<td>28A</td>
<td>Subarachnoid and intracranial hemorrhage/hematoma; Compression of brain</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>305A</td>
<td>Tetanus</td>
<td>Medical management; ventilation</td>
</tr>
<tr>
<td>265A</td>
<td>Transient cerebral ischaemia; life-threatening cerebrovascular conditions NOS</td>
<td>Evaluation; medical management; surgery</td>
</tr>
<tr>
<td>109A</td>
<td>Vertebral dislocations/fractures, open or closed with injury to spinal cord</td>
<td>Repair/reconstruction; medical management; inpatient rehabilitation up to 2 months</td>
</tr>
<tr>
<td>684A</td>
<td>Viral meningitis, encephalitis, myelitis and encephalomyelitis</td>
<td>Medical management</td>
</tr>
</tbody>
</table>
### 2. EYE

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>47B</td>
<td>Acute orbital cellulitis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>394B</td>
<td>Angle-closure glaucoma</td>
<td>Iridectomy; laser surgery; medical and surgical management</td>
</tr>
<tr>
<td>586B</td>
<td>Bell’s palsy; with exposure keratoconjunctivitis</td>
<td>Tarsorrhaphy; medical and surgical management</td>
</tr>
<tr>
<td>950B</td>
<td>Cancer of the eye and orbit - treatable</td>
<td>Medical and surgical management, which includes radiation therapy and chemotherapy</td>
</tr>
<tr>
<td>901B</td>
<td>Cataract; aphakia</td>
<td>Extraction of cataract; lens implant</td>
</tr>
<tr>
<td>911B</td>
<td>Corneal ulcer; Superficial injury of eye and adnexa</td>
<td>Conjunctival flap; medical management</td>
</tr>
<tr>
<td>405B</td>
<td>Glaucoma associated with disorders of the lens</td>
<td>Surgical management</td>
</tr>
<tr>
<td>386B</td>
<td>Herpes zoster &amp; herpes simplex with ophthalmic complications</td>
<td>Medical management</td>
</tr>
<tr>
<td>389B</td>
<td>Hyphema</td>
<td>Removal of blood clot; observation</td>
</tr>
<tr>
<td>485B</td>
<td>Inflammation of lacrimal passages</td>
<td>Incision; medical management</td>
</tr>
<tr>
<td>909B</td>
<td>Open wound of eyeball and other eye structures</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>407B</td>
<td>Primary and open angle glaucoma with failed medical management</td>
<td>Trabeculectomy; other surgery</td>
</tr>
<tr>
<td>419B</td>
<td>Purulent endophthalmitis</td>
<td>Vitrectomy</td>
</tr>
<tr>
<td>922B</td>
<td>Retained intraocular foreign body</td>
<td>Surgical management</td>
</tr>
<tr>
<td>904B</td>
<td>Retinal detachment, tear and other retinal disorders</td>
<td>Vitrectomy; laser treatment; other surgery</td>
</tr>
<tr>
<td>906B</td>
<td>Retinal vascular occlusion; central retinal vein occlusion</td>
<td>Laser surgery</td>
</tr>
<tr>
<td>409B</td>
<td>Sympathetic uveitis and degenerative disorders and conditions of globe; sight threatening thyroid optopathy</td>
<td>Enucleation; medical management; surgery</td>
</tr>
</tbody>
</table>
### 3. EAR, NOSE, MOUTH AND THROAT

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>33C</td>
<td>Acute and chronic mastoiditis</td>
<td>Mastoidectomy; medical management</td>
</tr>
<tr>
<td>482C</td>
<td>Acute otitis media</td>
<td>Medical and surgical management, including myringotomy</td>
</tr>
<tr>
<td>900C</td>
<td>Acute upper airway obstruction, including croup, epiglottitis and acute laryngotracheitis</td>
<td>Medical management; intubation; tracheostomy</td>
</tr>
<tr>
<td>950C</td>
<td>Cancer of oral cavity, pharynx, nose, ear, and larynx - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>241C</td>
<td>Cancrum oris</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>38C</td>
<td>Choanal atresia</td>
<td>Repair</td>
</tr>
<tr>
<td>133C</td>
<td>Cholesteatoma</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>910C</td>
<td>Chronic upper airway obstruction, resulting in cor pulmonale</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>901C</td>
<td>Cleft palate and/or cleft lip without airway obstruction</td>
<td>Repair</td>
</tr>
<tr>
<td>12C</td>
<td>Deep open wound of neck, including larynx; fracture of larynx or trachea, open</td>
<td>Medical and surgical management; ventilation</td>
</tr>
<tr>
<td>346C</td>
<td>Epistaxis – not responsive to anterior packing</td>
<td>Cautery / repair / control hemorrhage</td>
</tr>
<tr>
<td>521C</td>
<td>Foreign body in ear &amp; nose</td>
<td>Removal of foreign body; and medical and surgical management</td>
</tr>
<tr>
<td>29C</td>
<td>Foreign body in pharynx, larynx, trachea, bronchus &amp; oesophagus</td>
<td>Removal of foreign body</td>
</tr>
<tr>
<td>339C</td>
<td>Fracture of face bones, orbit, jaw; injury to optic and other cranial nerves</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>219C</td>
<td>Leukoplakia of oral mucosa, including tongue</td>
<td>Incision/excision; medical management</td>
</tr>
<tr>
<td>132C</td>
<td>Life-threatening diseases of pharynx NOS, including retropharyngeal abscess</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>457C</td>
<td>Open wound of ear-drum</td>
<td>Tympanoplasty; medical management</td>
</tr>
<tr>
<td>240C</td>
<td>Peritonsillar abscess</td>
<td>Incision and drainage of abscess; tonsillectomy; medical management</td>
</tr>
<tr>
<td>347C</td>
<td>Sialoadenitis; abscess / fistula of salivary glands</td>
<td>Surgery</td>
</tr>
<tr>
<td>543C</td>
<td>Stomatitis, cellulites and abscess of oral soft tissue; Vincent's angina</td>
<td>Incision and drainage; medical management</td>
</tr>
</tbody>
</table>
## 4. RESPIRATORY SYSTEM

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>903D</td>
<td>Bacterial, viral, fungal pneumonia</td>
<td>Medical management, ventilation</td>
</tr>
<tr>
<td>158D</td>
<td># Respiratory failure, regardless of cause</td>
<td># Medical management; oxygen; ventilation</td>
</tr>
<tr>
<td>157D</td>
<td>Acute asthmatic attack; pneumonia due to respiratory syncytial virus in persons under age 3</td>
<td>Medical management</td>
</tr>
<tr>
<td>125D</td>
<td>Adult respiratory distress syndrome; inhalation and aspiration pneumonias</td>
<td>Medical management; ventilation</td>
</tr>
<tr>
<td>315D</td>
<td>Atelectasis (collapse of lung)</td>
<td>Medical and surgical management; ventilation</td>
</tr>
<tr>
<td>340D</td>
<td>Benign neoplasm of respiratory and intrathoracic organs</td>
<td>Biopsy; lobectomy; Medical management; radiation therapy</td>
</tr>
<tr>
<td>950D</td>
<td>Cancer of lung, bronchus, pleura, trachea, mediastinum &amp; other respiratory organs - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>170D</td>
<td>Empyema and abscess of lung</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>934D</td>
<td>Frank haemoptysis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>203D</td>
<td>Hypoplasia and dysplasia of lung</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>900D</td>
<td>Open fracture of ribs and sternum; multiple rib fractures; flail chest</td>
<td>Medical and surgical management, ventilation</td>
</tr>
<tr>
<td>5D</td>
<td>Pneumothorax and haemothorax</td>
<td>Tube thoracostomy / thoracotomy</td>
</tr>
</tbody>
</table>
## 5. HEART AND VASCULATURE

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>155E</td>
<td>Myocarditis; cardiomyopathy; transposition of great vessels; hypoplastic left heart syndrome</td>
<td>Medical and surgical management; cardiac transplant</td>
</tr>
<tr>
<td>108E</td>
<td>Pericarditis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>907E</td>
<td>Acute and sub acute ischemic heart disease, including myocardial infarction and unstable angina</td>
<td>Medical management; surgery; percutaneous procedures</td>
</tr>
<tr>
<td>284E</td>
<td>Acute pulmonary heart disease and pulmonary emboli; pulmonary hypertension.</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>35E</td>
<td>Acute rheumatic fever</td>
<td>Medical management</td>
</tr>
<tr>
<td>908E</td>
<td>Pericarditis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>907E</td>
<td>Acute and sub acute ischemic heart disease, including myocardial infarction and unstable angina</td>
<td>Medical management; surgery; percutaneous procedures</td>
</tr>
<tr>
<td>26E</td>
<td>Arterial Embolism/thrombosis: abdominal aorta, thoracic aorta, vena cava and other major blood vessels</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>204E</td>
<td>Cardiac failure: acute or recent deterioration of chronic cardiac failure</td>
<td>Medical treatment</td>
</tr>
<tr>
<td>98E</td>
<td>Complete, corrected and other transposition of great vessels. Congenital malformations of great large vessels</td>
<td>Repair</td>
</tr>
<tr>
<td>97E</td>
<td>Coronary artery anomaly</td>
<td>Anomalous coronary artery ligation</td>
</tr>
<tr>
<td>309E</td>
<td>Diseases and disorders of aortic valve NOS</td>
<td>Aortic valve replacement</td>
</tr>
<tr>
<td>210E</td>
<td>Diseases of endocardium; endocarditis</td>
<td>Medical management</td>
</tr>
<tr>
<td>314E</td>
<td>Diseases of mitral valve</td>
<td>Valvuloplasty; valve replacement; medical management</td>
</tr>
<tr>
<td>902E</td>
<td>Disorders of arteries: visceral</td>
<td>Bypass graft; surgical management</td>
</tr>
<tr>
<td>18E</td>
<td>Dissecting or ruptured aortic aneurysm</td>
<td>Surgical management</td>
</tr>
<tr>
<td>915E</td>
<td>Gangrene; severe atherosclerosis of arteries of extremities; diabetes mellitus with peripheral circulatory disease</td>
<td>Medical and surgical management including amputation</td>
</tr>
<tr>
<td>294E</td>
<td>Giant cell arteritis, Kawasaki disease hypersensitivity angiitis; polyarteritis nodosa</td>
<td>Medical management</td>
</tr>
<tr>
<td>450E</td>
<td>Hereditary hemorrhagic telangiectasia</td>
<td>Excision and medical management</td>
</tr>
<tr>
<td>901E</td>
<td>Hypertension – acute life-threatening complications and malignant hypertension; renal artery stenosis and other curable hypertension</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>111E</td>
<td>Injury to major blood vessels - trunk, head and neck, and upper limbs</td>
<td>Repair</td>
</tr>
<tr>
<td>19E</td>
<td>Injury to major blood vessels of extremities</td>
<td>Ligation</td>
</tr>
<tr>
<td>903E</td>
<td>Life-threatening cardiac arrhythmias</td>
<td>Medical and surgical management, pacemakers, cardioversion</td>
</tr>
<tr>
<td>900E</td>
<td>Life-threatening complications of elective cardiac and major vascular procedures</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>497E</td>
<td>Multiple valvular disease</td>
<td>Surgical management</td>
</tr>
<tr>
<td>355E</td>
<td>Other aneurysm of artery – peripheral</td>
<td>Surgical management</td>
</tr>
<tr>
<td>905E</td>
<td>Other correctable congenital cardiac conditions</td>
<td>Surgical repair; medical management</td>
</tr>
<tr>
<td>100E</td>
<td>Patent ductus arteriosus; aortic pulmonary fistula - persistent</td>
<td>Ligation</td>
</tr>
<tr>
<td>Code</td>
<td>Condition</td>
<td>Management</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>209E</td>
<td>Phlebitis &amp; thrombophlebitis, deep</td>
<td>Ligation and division; medical management</td>
</tr>
<tr>
<td>914E</td>
<td>Rheumatic pericarditis; rheumatic myocarditis</td>
<td>Medical management</td>
</tr>
<tr>
<td>16E</td>
<td>Rupture of papillary muscle</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>627E</td>
<td>Shock / hypotension – life-threatening</td>
<td>Medical management; ventilation</td>
</tr>
<tr>
<td>99E</td>
<td>Tetralogy of Fallot (TOF)</td>
<td>Total repair tetralogy</td>
</tr>
<tr>
<td>93E</td>
<td>Ventricular septal defect - persistent</td>
<td>Closure</td>
</tr>
</tbody>
</table>
### 6. GASTRO-INTESTINAL SYSTEM

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>920F</td>
<td>Anal Fissure; Anal fistula</td>
<td>Fissurectomy; Fistulectomy; medical management</td>
</tr>
<tr>
<td>41F</td>
<td>Abscess of intestine</td>
<td>Drain abscess; medical management</td>
</tr>
<tr>
<td>489F</td>
<td>Acquired hypertrophic pyloric stenosis and other disorders of the stomach and duodenum</td>
<td>Surgical management</td>
</tr>
<tr>
<td>254F</td>
<td>Acute diverticulitis of colon</td>
<td>Medical and surgical management, including colon resection</td>
</tr>
<tr>
<td>124F</td>
<td>Acute vascular insufficiency of intestine</td>
<td>Colectomy</td>
</tr>
<tr>
<td>337F</td>
<td>Amoebiasis; typhoid</td>
<td>Medical management</td>
</tr>
<tr>
<td>264F</td>
<td>Anal and rectal polyp</td>
<td>Excision of polyp</td>
</tr>
<tr>
<td>9F</td>
<td>Appendicitis</td>
<td>Appendectomy</td>
</tr>
<tr>
<td>952F</td>
<td>Cancer of retroperitoneum, peritoneum, omentum &amp; mesentery - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>950C</td>
<td>Cancer of the gastro-intestinal tract, including oesophagus, stomach, bowel, rectum, anus - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>95F</td>
<td>Congenital anomalies of upper alimentary tract – excluding tongue</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>214F</td>
<td>Oesophageal stricture</td>
<td>Dilatation; surgery</td>
</tr>
<tr>
<td>516F</td>
<td>Oesophageal varices</td>
<td>Medical management; surgical shunt; sclerotherapy</td>
</tr>
<tr>
<td>902F</td>
<td>Gastric or intestinal ulcers with hemorrhage or perforation</td>
<td>Surgery; endoscopic diagnosis; medical management</td>
</tr>
<tr>
<td>901F</td>
<td>Gastroenteritis and colitis with life-threatening haemorrhage or dehydration, regardless of cause</td>
<td>Medical management</td>
</tr>
<tr>
<td>6F</td>
<td>Hernia with obstruction and/or gangrene; uncomplicated hernias under age 18</td>
<td>Repair; bowel resection</td>
</tr>
<tr>
<td>20F</td>
<td>Intestinal obstruction without mention of hernia; symptomatic foreign body in stomach, intestines, colon &amp; rectum</td>
<td>Excision; surgery; medical management</td>
</tr>
<tr>
<td>232F</td>
<td>Paralytic ileus</td>
<td>Medical management</td>
</tr>
<tr>
<td>498F</td>
<td>Peritoneal adhesion</td>
<td>Surgical management</td>
</tr>
<tr>
<td>3F</td>
<td>Peritonitis, regardless of cause</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>555F</td>
<td>Rectal prolapse</td>
<td>Partial colectomy</td>
</tr>
<tr>
<td>292F</td>
<td>Regional enteritis; idiopathic proctocolitis – acute exacerbations and complications only</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>900F</td>
<td>Rupture of intra-abdominal organ</td>
<td>Repair; splenectomy; resection</td>
</tr>
<tr>
<td>507F</td>
<td>Thrombosed and complicated haemorrhoids</td>
<td>Haemorrhoidectomy; incision</td>
</tr>
</tbody>
</table>
### 7. LIVER, PANCREAS AND SPLEEN

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>325G</td>
<td>Acute necrosis of liver</td>
<td>Medical management</td>
</tr>
<tr>
<td>327G</td>
<td>Acute pancreatitis</td>
<td>Medical management, and where appropriate, surgical management</td>
</tr>
<tr>
<td>36G</td>
<td>Budd-Chiari syndrome, and other venous embolism and</td>
<td>Thrombectomy / ligation</td>
</tr>
<tr>
<td>910G</td>
<td>Calculus of biliary duct with cholecystitis</td>
<td>Medical management; cholecystectomy; other open or closed surgery</td>
</tr>
<tr>
<td>950G</td>
<td>Cancer of liver, biliary system and pancreas – treatable</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>255G</td>
<td>Cyst and pseudocyst of pancreas</td>
<td>Drainage of pancreatic cyst</td>
</tr>
<tr>
<td>156G</td>
<td>Disorders of bile duct</td>
<td>Excision; repair</td>
</tr>
<tr>
<td>910G</td>
<td>Gallstone with cholecystitis and/or jaundice</td>
<td>Medical management; cholecystectomy; other open or closed surgery</td>
</tr>
<tr>
<td>743G</td>
<td>Hepatorenal syndrome</td>
<td>Medical management</td>
</tr>
<tr>
<td>27G</td>
<td>Liver abscess; pancreatic abscess</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>911G</td>
<td>Liver failure; hepatic vascular obstruction; inborn errors of liver metabolism; biliary atresia</td>
<td>Liver transplant, other surgery, medical management</td>
</tr>
<tr>
<td>231G</td>
<td>Portal vein thrombosis</td>
<td>Shunt</td>
</tr>
<tr>
<td>Code</td>
<td>Diagnosis</td>
<td>Treatment</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>353H</td>
<td>Abscess of bursa or tendon</td>
<td>Incision and drainage</td>
</tr>
<tr>
<td>32H</td>
<td>Acute osteomyelitis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>950H</td>
<td>Chronic osteomyelitis and osteonecrosis</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>206H</td>
<td></td>
<td>Incision and drainage</td>
</tr>
<tr>
<td>902H</td>
<td>Closed fractures/dislocations of limb bones / epiphyses – excluding fingers and toes</td>
<td>Reduction/relocation</td>
</tr>
<tr>
<td>85H</td>
<td>Congenital dislocation of hip; coxa vara and valga; congenital clubfoot</td>
<td>Repair/reconstruction</td>
</tr>
<tr>
<td>147H</td>
<td>Crush injuries of trunk, upper limbs, lower limbs, including blood vessels</td>
<td>Surgical management; ventilation; acute renal dialysis</td>
</tr>
<tr>
<td>491H</td>
<td>Dislocations/fractures of vertebral column without spinal cord injury</td>
<td>Medical management; surgical stabilisation</td>
</tr>
<tr>
<td>500H</td>
<td>Disruptions of the achilles / quadriceps tendons</td>
<td>Repair</td>
</tr>
<tr>
<td>178H</td>
<td>Fracture of hip</td>
<td>Reduction; hip replacement</td>
</tr>
<tr>
<td>445H</td>
<td>Injury to internal organs</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>900H</td>
<td>Open fracture/dislocation of bones and joints</td>
<td>Reduction/relocation; medical and surgical management</td>
</tr>
<tr>
<td>34H</td>
<td>Pyogenic arthritis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>901H</td>
<td>Traumatic amputation of limbs, hands, feet, and digits</td>
<td>Replantation / amputation</td>
</tr>
<tr>
<td>Code</td>
<td>Diagnosis</td>
<td>Treatment</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>465J</td>
<td>Acute lymphadenitis</td>
<td>Incision and drainage; medical management</td>
</tr>
<tr>
<td>900J</td>
<td>Burns, greater than 10% of body surface, or more than 5% involving head, neck, hands, perineum</td>
<td>Debridement; free skin graft; medical management</td>
</tr>
<tr>
<td>950J</td>
<td>Cancer of breast - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>954J</td>
<td>Cancer of skin, excluding malignant melanoma - treatable</td>
<td>If histologically confirmed, Medical and surgical management, which includes radiation therapy</td>
</tr>
<tr>
<td>952J</td>
<td>Cancer of soft tissue, including sarcomas and malignancies of the adnexa - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>349J</td>
<td>Cellulitis and abscesses with risk of organ or limb damage or septicaemia if untreated; necrotizing fasciitis</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>901J</td>
<td>Disseminated bullous skin disease, including pemphigus, pemphigoid, epidermolysis bullosa, epidermolytic hyperkeratosis</td>
<td>Medical management</td>
</tr>
<tr>
<td>951J</td>
<td>Lethal midline granuloma</td>
<td>Medical management, which includes radiation therapy</td>
</tr>
<tr>
<td>953J</td>
<td>Malignant melanoma of skin - treatable</td>
<td>Medical and surgical management, which includes radiation therapy</td>
</tr>
<tr>
<td>373J</td>
<td>Non-superficial open wounds – non life-threatening</td>
<td>Repair</td>
</tr>
<tr>
<td>356J</td>
<td>Pyoderma; body, deep-seated fungal infections</td>
<td>Medical management</td>
</tr>
<tr>
<td>112J</td>
<td>Toxic epidermal necrolysis and staphylococcal scalded skin syndrome; Stevens-Johnson syndrome</td>
<td>Medical management</td>
</tr>
</tbody>
</table>
## 10. ENDOCRINE, METABOLIC AND NUTRITIONAL

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>331K</td>
<td>Acute thyroiditis</td>
<td>Medical management</td>
</tr>
<tr>
<td>951K</td>
<td>Benign and malignant tumours of pituitary endocrine glands with/without hypersecretion syndromes</td>
<td>Medical and surgical management; radiation therapy</td>
</tr>
<tr>
<td>30K</td>
<td>Benign neoplasm of islets of Langerhans</td>
<td>Excision of tumour; medical management</td>
</tr>
<tr>
<td>950K</td>
<td>Cancer of endocrine system, excluding thyroid - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>952K</td>
<td>Cancer of thyroid - treatable; carcinoid syndrome</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>61K</td>
<td>Congenital hypothyroidism</td>
<td>Medical management</td>
</tr>
<tr>
<td>902K</td>
<td>Disorder of adrenal secretion NOS</td>
<td>Medical management; adrenalectomy</td>
</tr>
<tr>
<td>447K</td>
<td>Disorders of parathyroid gland; benign neoplasm of parathyroid gland</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>904K</td>
<td>Hyper and hypothyroidism with life-threatening complications or requiring surgery</td>
<td>Medical management; Surgery</td>
</tr>
<tr>
<td>31K</td>
<td>Hypoglycemic coma; hyperglycemia; diabetic ketoacidosis</td>
<td>Medical management</td>
</tr>
<tr>
<td>236K</td>
<td>Iron deficiency; vitamin and other nutritional deficiencies – life-threatening</td>
<td>Medical management</td>
</tr>
<tr>
<td>901K</td>
<td>Life-threatening congenital abnormalities of carbohydrate, lipid, protein and amino acid metabolism; cystic fibrosis</td>
<td>Medical management</td>
</tr>
<tr>
<td>903K</td>
<td>Life-threatening disorders of fluid and electrolyte balance, NOS</td>
<td>Medical management</td>
</tr>
</tbody>
</table>
## 11. URINARY AND MALE GENITAL SYSTEM

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>354L</td>
<td>Abscess of prostate</td>
<td>TURP; drain abscess</td>
</tr>
<tr>
<td>904L</td>
<td>Acute and chronic pyelonephritis; renal and perinephric abscess</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>903L</td>
<td>Acute glomerulonephritis and nephritic syndrome</td>
<td>Medical management</td>
</tr>
<tr>
<td>954L</td>
<td>Cancer of penis and other male genital organ - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>953L</td>
<td>Cancer of prostate gland - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>950L</td>
<td>Cancer of testis - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>952L</td>
<td>Cancer of urinary system including kidney and bladder - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>906L</td>
<td>Congenital anomalies of urinary system - symptomatic and life-threatening</td>
<td>Nephrectomy/repair</td>
</tr>
<tr>
<td>901L</td>
<td>End stage renal disease regardless of cause</td>
<td>Dialysis and renal transplant where Department of Health criteria are met only (see criteria published in GPS 004-9001)</td>
</tr>
<tr>
<td>900L</td>
<td>Hyperplasia of the prostate, with acute urinary retention or obstructive renal failure</td>
<td>Transurethral resection; medical management</td>
</tr>
<tr>
<td>905L</td>
<td>Obstruction of the urogenital tract, regardless of cause</td>
<td>Catheterisation; surgery; endoscopic removal of obstructing agent: lithotripsy</td>
</tr>
<tr>
<td>436L</td>
<td>Torsion of testis</td>
<td>Orchidectomy; repair</td>
</tr>
<tr>
<td>43L</td>
<td>Trauma to the urinary system including ruptured bladder</td>
<td>Cystorrhaphy; suture; repair</td>
</tr>
<tr>
<td>289L</td>
<td>Ureteral fistula (intestinal)</td>
<td>Nephrostomy</td>
</tr>
<tr>
<td>359L</td>
<td>Vesicoureteral reflux</td>
<td>Medical management; replantation</td>
</tr>
<tr>
<td>Code</td>
<td>Diagnosis</td>
<td>Treatment</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>539M</td>
<td>Abscesses of Bartholin’s gland and vulva</td>
<td>Incision and drainage; medical management</td>
</tr>
<tr>
<td>288M</td>
<td>Acute pelvic inflammatory disease</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>954M</td>
<td>Cancer of cervix - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>952M</td>
<td>Cancer of ovary - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>950M</td>
<td>Cancer of uterus - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>953M</td>
<td>Cancer of vagina, vulva and other female genital organs NOS - treatable</td>
<td>Medical and surgical management, which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>960M</td>
<td>Cervical and breast cancer screening</td>
<td>Cervical smears; periodic breast examination</td>
</tr>
<tr>
<td>645M</td>
<td>Congenital abnormalities of the female genitalia</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>266M</td>
<td>Dysplasia of cervix and cervical carcinoma-in-situ; cervical condylomata</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>53M</td>
<td>Ectopic pregnancy</td>
<td>Surgery</td>
</tr>
<tr>
<td>460M</td>
<td>Fistula involving female genital tract</td>
<td>Closure of fistula</td>
</tr>
<tr>
<td>951M</td>
<td>Hydatidiform mole; choriocarcinoma</td>
<td>D &amp; C; hysterectomy; chemotherapy</td>
</tr>
<tr>
<td>902M</td>
<td>Infertility</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>528M</td>
<td>Menopausal management, anomalies of ovaries, primary and secondary amenorrhoea, female sex hormones abnormalities NOS, including hirsutism</td>
<td>Medical and surgical management, including hormone replacement therapy</td>
</tr>
<tr>
<td>434M</td>
<td>Non-inflammatory disorders and benign neoplasms of ovary, fallopian tubes and uterus</td>
<td>Salpingectomy; oophorectomy; hysterectomy; medical and surgical management</td>
</tr>
<tr>
<td>237M</td>
<td>Sexual abuse, including rape</td>
<td>Medical management; psychotherapy</td>
</tr>
<tr>
<td>903M</td>
<td>Spontaneous abortion</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>435M</td>
<td>Torsion of ovary</td>
<td>Oophorectomy; ovarian cystectomy</td>
</tr>
<tr>
<td>530M</td>
<td>Uterine prolapse; cystocele</td>
<td>Surgical repair</td>
</tr>
<tr>
<td>296M</td>
<td>Voluntary termination of pregnancy</td>
<td>Induced abortion; Medical and surgical management</td>
</tr>
</tbody>
</table>
### 13. PREGNANCY AND CHILDBIRTH

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>67N</td>
<td># Low birth weight (under 1000g) with respiratory difficulties</td>
<td># Medical management not including ventilation</td>
</tr>
<tr>
<td>967N</td>
<td># Low birth weight (under 2500 grams &amp; &gt; 1000g) with respiratory difficulties</td>
<td># Medical management, including ventilation; intensive care therapy</td>
</tr>
<tr>
<td>71N</td>
<td>Birth trauma for baby</td>
<td>Medical management; surgery</td>
</tr>
<tr>
<td>901N</td>
<td>Congenital systemic infections affecting the newborn</td>
<td>Medical management, ventilation</td>
</tr>
<tr>
<td>904N</td>
<td>Haematological disorders of the newborn</td>
<td>Medical management</td>
</tr>
<tr>
<td>54N</td>
<td>Necrotizing enterocolitis in newborn</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>74N</td>
<td>Neonatal and infant GIT abnormalities and disorders, including malrotation and atresia</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>902N</td>
<td>Neonatal endocrine, metabolic and toxin-induced conditions</td>
<td>Medical management</td>
</tr>
<tr>
<td>903N</td>
<td>Neurological abnormalities in the newborn; including cerebral palsy</td>
<td>Medical management</td>
</tr>
<tr>
<td>52N</td>
<td>Pregnancy</td>
<td>Antenatal care, and Obstetric care necessitating hospitalisation, and Delivery</td>
</tr>
<tr>
<td>56N</td>
<td>Respiratory conditions and correctable congenital abnormalities of newborn</td>
<td>Medical management; ventilation</td>
</tr>
</tbody>
</table>
## 14. HAEMATOLOGICAL, INFECTIOUS AND MISCELLANEOUS SYSTEMIC CONDITIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>50S</td>
<td>Syphilis - congenital, secondary and tertiary</td>
<td>Medical management</td>
</tr>
<tr>
<td>168S</td>
<td># HIV-infection</td>
<td># HIV voluntary counselling and testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Co-trimoxazole as preventative therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening and preventative therapy for TB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis and treatment of sexually transmitted infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain management in palliative care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment of opportunistic infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prevention of mother-to-child transmission of HIV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-exposure prophylaxis following occupational exposure or sexual assault</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical management and medication, including the provision of anti-retroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector</td>
</tr>
<tr>
<td>260S</td>
<td># Imminent death regardless of diagnosis</td>
<td># Comfort care; pain relief; hydration</td>
</tr>
<tr>
<td>113S</td>
<td>Acquired haemolytic anaemias</td>
<td>Medical management</td>
</tr>
<tr>
<td>901S</td>
<td>Acute leukemias, lymphomas</td>
<td>Medical management, which includes chemotherapy, radiation therapy, bone marrow transplantation</td>
</tr>
<tr>
<td>277S</td>
<td>Anaerobic infections – life threatening; and complications of radiation therapy</td>
<td>Medical management; hyperbaric oxygen</td>
</tr>
<tr>
<td>48S</td>
<td>Anaphylactic shock</td>
<td>Medical management; ventilation</td>
</tr>
<tr>
<td>900S</td>
<td>Aplastic anaemia; agranulocytosis; other life-threatening hereditary immune deficiencies</td>
<td>Bone marrow transplantation; medical management</td>
</tr>
<tr>
<td>197S</td>
<td>Botulism</td>
<td>Medical management</td>
</tr>
<tr>
<td>338S</td>
<td>Cholera; rat-bite fever</td>
<td>Medical management</td>
</tr>
<tr>
<td>196S</td>
<td>Chronic Granulomatous disease</td>
<td>Medical management, which includes radiation therapy</td>
</tr>
<tr>
<td>916S</td>
<td>Coagulation defects</td>
<td>Medical management</td>
</tr>
<tr>
<td>246S</td>
<td>Cysticercosis; other systemic cestode infection</td>
<td>Medical management</td>
</tr>
<tr>
<td>903S</td>
<td>Deep-seated (excluding nail infections), disseminated and systemic fungal infections</td>
<td>Medical management; surgery</td>
</tr>
<tr>
<td>44S</td>
<td>Erysipelas</td>
<td>Medical management</td>
</tr>
<tr>
<td>179S</td>
<td>Hereditary angioedema; angioneurotic adema</td>
<td>Medical and surgical management</td>
</tr>
<tr>
<td>174S</td>
<td>Hereditary haemolytic anaemias (e.g. sickle cell); dyserythropoietic anaemia (congenital)</td>
<td>Medical management</td>
</tr>
<tr>
<td>201S</td>
<td>Herpetic encephalitis; Reye’s syndrome</td>
<td>Medical management</td>
</tr>
<tr>
<td>913S</td>
<td>Immune compromise NOS and associated life-threatening infections NOS</td>
<td>Medical management</td>
</tr>
<tr>
<td>912S</td>
<td>Leprosy and other systemic mycobacterial infections, Excluding tuberculosis</td>
<td>Medical management</td>
</tr>
<tr>
<td>336S</td>
<td>Leptospirosis; spirochaetal infections NOS</td>
<td>Medical management</td>
</tr>
<tr>
<td>Page</td>
<td>Condition</td>
<td>Management</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>252S</td>
<td>Life-threatening anaemia NOS</td>
<td>Medical management; transfusion</td>
</tr>
<tr>
<td>908S</td>
<td>Life-threatening conditions due to exposure to the elements, including hypo and hyperthermia; lighting strikes</td>
<td>Medical management</td>
</tr>
<tr>
<td>907S</td>
<td>Life-threatening rickettsial and other arthropod-borne diseases</td>
<td>Medical management</td>
</tr>
<tr>
<td>172S</td>
<td>Malaria; trypanosomiasis; other life-threatening parasitic disease</td>
<td>Medical management</td>
</tr>
<tr>
<td>904S</td>
<td>Metastatic infections; septicaemia</td>
<td>Medical management</td>
</tr>
<tr>
<td>910S</td>
<td>Multiple myeloma and chronic leukaemias</td>
<td>Medical management which includes chemotherapy and radiation therapy</td>
</tr>
<tr>
<td>247S</td>
<td>Poisoning by ingestion, injection, and non-medicinal agents</td>
<td>Medical management</td>
</tr>
<tr>
<td>911S</td>
<td>Sexually transmitted diseases with systemic involvement not elsewhere specified</td>
<td>Medical management</td>
</tr>
<tr>
<td>128S</td>
<td>Tetanus; anthrax; Whipple's disease</td>
<td>Medical management</td>
</tr>
<tr>
<td>122S</td>
<td>Thalassemia and other haemoglobinopathies – treatable</td>
<td>Medical management; bone marrow transplant</td>
</tr>
<tr>
<td>316S</td>
<td>Toxic effect of gasses, fumes, and vapours</td>
<td>Medical therapy</td>
</tr>
<tr>
<td>11S</td>
<td>Tuberculosis</td>
<td>Diagnosis and acute medical management; successful transfer to maintenance therapy in accordance to DOH guidelines. Medical and surgical management.</td>
</tr>
<tr>
<td>937S</td>
<td>Tumour of internal organ (excludes skin): unknown whether benign or malignant</td>
<td>Biopsy</td>
</tr>
<tr>
<td>15S</td>
<td>Whooping cough, diphtheria</td>
<td>Medical management</td>
</tr>
</tbody>
</table>
### 15. MENTAL ILLNESS

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>182T</td>
<td>Abuse or dependence on psychoactive substance, including alcohol. Mental and behavioural disorders due to psychoactive substance use.</td>
<td>Hospital-based management up to 3 weeks/year or up to 15 outpatient contacts.</td>
</tr>
<tr>
<td>910T</td>
<td>Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse. Reaction to severe stress, and adjustment disorders</td>
<td>Hospital-based management admission for psychotherapy/counselling up to 3 days or up to 12 outpatient psychotherapy/counselling contacts.</td>
</tr>
<tr>
<td>901T</td>
<td>Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse.</td>
<td>Hospital admission for psychotherapy/counselling up to 3 days, or up to 12 outpatient psychotherapy/counselling contacts.</td>
</tr>
<tr>
<td>910T</td>
<td>Alcohol withdrawal delirium; alcohol intoxication delirium.</td>
<td>Hospital-based management up to 3 days leading to rehabilitation.</td>
</tr>
<tr>
<td>908T</td>
<td>Anorexia Nervosa and Bulimia Nervosa Eating disorders.</td>
<td>Hospital-based management up to 3 weeks/year or minimum of up to 15 outpatient contacts.</td>
</tr>
<tr>
<td>903T</td>
<td>Attempted suicide, irrespective of cause.</td>
<td>Hospital-based management up to 3 days or up to 6 outpatient contacts.</td>
</tr>
<tr>
<td>184T</td>
<td>Brief reactive psychosis Acute and transient psychotic disorders.</td>
<td>Hospital-based management up to 3 weeks/year.</td>
</tr>
<tr>
<td>910T</td>
<td>Delirium: Amphetamine, cocaine, or other psychoactive substance.</td>
<td>Hospital-based management up to 3 days.</td>
</tr>
<tr>
<td>902T</td>
<td>Major Mood (affective) disorders, including unipolar or bipolar depression.</td>
<td>Hospital-based management up to 3 weeks/year (including inpatient electro-convulsive therapy and inpatient psychotherapy) or up to 15 outpatient psychotherapy contacts.</td>
</tr>
<tr>
<td>907T</td>
<td>Schizophrenic and paranoid delusional disorders.</td>
<td>Hospital-based management up to 3 weeks/year or up to 15 outpatient contacts.</td>
</tr>
<tr>
<td>909T</td>
<td>Treatable dementia.</td>
<td>Admission for initial diagnosis; management of acute psychotic symptoms - up to 1 week.</td>
</tr>
</tbody>
</table>
Annexure C: Chronic Disease List (CDL) and CDL algorithms

Addison’s Disease  Epilepsy
Asthma  Glaucoma
Bipolar Mood Disorder  Haemophilia
Bronchiectasis  Hyperlipidaemia
Cardiac Failure  Hypertension
Cardiomyopathy  Hypothyroidism
Chronic Renal Disease  Multiple Sclerosis
Chronic Obstructive Pulmonary Disease  Parkinson’s Disease
Coronary Artery Disease  Rheumatoid Arthritis
Crohn’s Disease  Schizophrenia
Diabetes Insipidus  Systemic Lupus Erythematosus
Diabetes Mellitus Type 1 & 2  Ulcerative Colitis
Dysrhythmias
1. BIPOLAR MOOD DISORDER

DSM-IV Diagnosis

ACUTE PHASE

Manic Episode
- Mania or hypomania with euphoric mood
  - Lithium and/or Valproate and/or Typical or atypical anti-psychotic (If IMI Olanzapine given, no Benzodiazepine within 2 hours)
  - Valproate and/or Carbamazepine and/or atypical anti-psychotic (Discontinue antidepressant) (If IMI Olanzapine given, no Benzodiazepine within 2 hours)
  - Mania with psychosis
    - Typical or atypical anti-psychotic and/or Lithium and/or Valproate and/or Carbamazepine and/or Benzodiazepine (lorazepam) (If IMI Olanzapine given, no Benzodiazepine within 2 hours)

Cyclothymia
- Mid to Moderate
  - Lithium and/or Valproate and/or Lamotrigine
- Severe
  - Lithium and/or Valproate and/or Lamotrigine and/or antidepressant and/or mood stabilizer (Do not give antidepressant without mood stabilizer)
- Depression with psychosis
  - Lithium and/or Valproate and/or Lamotrigine and/or typical or atypical anti-psychotic and/or antidepressant (Do not give antidepressant without mood stabilizer)

Depressive Episode
- Depression with psychosis
  - Lithium and/or Valproate and/or Lamotrigine and/or typical or atypical anti-psychotic and/or antidepressant (Do not give antidepressant without mood stabilizer)

Remission

Response

Continuation Phase
- Poor response within 4-6 weeks
  - Check adherence and/or optimize medication
Glossary:
- DSM-IV – Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition
- ECT – Electroconvulsive Therapy

Applicable ICD-10 Coding:
- F31 Bipolar Affective Disorder
  - F31.0 Bipolar affective disorder, current episode hypomanic
  - F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms
  - F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms
  - F31.3 Bipolar affective disorder, current episode mild or moderate depression
  - F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms
  - F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms
  - F31.6 Bipolar affective disorder, current episode mixed
  - F31.7 Bipolar affective disorder, currently in remission
  - F31.8 Other bipolar affective disorders
  - F31.9 Bipolar affective disorder, unspecified

Note:
1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
2. Chronic Obstructive Pulmonary Disease

Diagnosis

All patients should stop smoking, avoid infections and have an annual influenza immunisation
Early effective treatment of exacerbations

Stage I
FEV1 60-79% of predicted value
6-minute walking distance <600-200m
BMI ≤ 25-21

Bronchodilators: relieve symptoms, do not alter decline in FEV1
β2 agonist inhaler: 2 puffs 6 hourly as needed or Ipratropium bromide inhaler: 2 puffs 6 hourly as needed or
Combination of above: 6 hourly as needed
Oral theophylline 6-8mg/kg/day in divided doses adjusted to plasma trough levels

Inadequate response?
Yes
Consider oral corticosteroid trial
Prednisone 40mg/day for 14 days

Stage II
FEV1 40-59% of predicted value
Limits activities performed at normal pace
6-minute walking distance <600-200m
BMI ≤ 25-21

Bronchodilators: relieve symptoms, do not alter decline in FEV1
β2 agonist inhaler: 2 puffs 6 hourly as needed or Ipratropium bromide inhaler: 2 puffs 6 hourly as needed or
Combination of above: 6 hourly as needed
Oral theophylline 6-8mg/kg/day in divided doses adjusted to plasma trough levels

Inadequate response?
No objective response:
Stop corticosteroids
Optimise bronchodilator therapy
Consider the addition of a Long-acting β2 stimulant

Stage III
FEV1 ≤ 40% of predicted value
Impairs activities of daily living, to virtual inactivity
6-minute walking distance <600m
BMI ≤ 21

Severe advanced disease
Consider long-term domiciliary oxygen
Treat complications
Prevent weight loss
Review for further management

Objective improvement in FEV1 of ≥12% and >200mL to more than 80% predicted
Treat as for Asthma

Improvement of FEV1 < 10% and significant symptomatic improvement
Optimise bronchodilator therapy
Consider the addition of a Long-acting β2 stimulant

No objective response:
Stop corticosteroids
Optimise bronchodilator therapy
Consider the addition of a Long-acting β2 stimulant
and other supportive therapy
Glossary:
- FEV1 – Forced expiratory volume in 1 second
- R2 – Beta-2 receptor
- PFT – Predicted

Applicable ICD-10 Coding:
- J43 Emphysema
  - J43.0 MacLeod’s syndrome
  - J43.1 Panlobular emphysema
  - J43.2 Centrilobular emphysema
  - J43.8 Other emphysema
  - J43.9 Emphysema, unspecified
- J44 Other chronic obstructive pulmonary disease
  - J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
  - J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified
  - J44.8 Other specified chronic obstructive pulmonary disease
  - J44.9 Chronic obstructive pulmonary disease, unspecified

Note:
1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.
2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998
3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
3. CHRONIC RENAL DISEASE

**Progressive Management Stage 1 to Stage 5:**

- Ideal target is proteinuria <1g/24h to induce remission in deterioration and <0.3g for regression.
- Aim for a stable or increasing GFR. Note that a normal decline is observed with ageing at a GFR decline of 1 mL/min/1.73 m² per year after 45 years.
- Start with low dose sodium diet or Thiazide diuretic therapy, or both.
- Add low dose ACE inhibitor or start immediately with an ACE inhibitor (Best effects when used with a diuretic e.g. hydrochlorothiazide or loop diuretic if required)
- Up titrate the ACE inhibitor to the maximum dose tolerated every one to two weeks. A decline in function may occur but patients should be observed every one to two weekly allowing GFR to settle. (Consult a specialist if necessary)
- Checking of serum potassium only required when using higher doses of ACE inhibitors and CRD stage 3 or greater is present. If hypokalaemia a problem then use other anti-proteinuric drugs i.e. beta blocker or calcium antagonist. Note: These drugs are not as good as ACE inhibitors for proteinuria reduction.
- Add and up titrate beta blocker and/or non-dihydropyridine CCB’s even if blood pressure is controlled.
- Optimise blood pressure control with other antihypertensive agents; Blood Pressure <130/80mmHg; lower if diabetes or proteinuria (morning pre-treatment value)
- Patients require early nephrological referral for management and assessment for dialysis and transplant when GFR < 60mL/min.
Prevent Osteodystrophy
- Give phosphate binder with meals (Calcium carbonate)
- Maintain normal calcium and phosphate levels, monitor PTH levels
- Reserve 1α-hydroxy cholecalciferol for hypocalcaemia or progressive hyperparathyroidism
  Monitor serum calcium and/or PO₄ for high levels

Prevent Anaemia
- Annual Screen for anaemia Hb<11g/dl
  - Assess type of anaemia – RBC indices
  - Assess iron status – serum ferritin (target 200-500ng/ml) and TSAT (20-50%)
  - Exclude blood loss and other causes of anaemia – faecal occult blood test, etc.
  - Ensure adequate dialysis dose
  - Exclude inflammation

  - If iron deficient then supplementary iron to reach and then maintain targets
    Trial of Oral Fe for 1 month at 2-3 mg/kg/day elemental then switch to IV iron if still Fe deficient

  - Iron status good but Hb still <11g/dl

  - Erythropoietin (EPO) required if patient enrolled on chronic dialysis
    Subcutaneous route preferred
    Once target Hb reached (not greater than 12g/dl), reduce EPO and/or frequency to maintain at target

  - Treat folate deficiency 2.5-5mg/day folic acid
  - Poor response to EPO

Glossary:
- 1α-hydroxy – 1-alpha-hydroxy
- ACE inhibitor – Angiotensin converting enzyme inhibitor
- CCB – Calcium channel blocker
- CRD – Chronic renal disease
- EPO – Erythropoetin
- ESRD – End stage renal disease
- Fe – Iron
- GFR – Glomerular filtration rate
- Hb – Haemoglobin
- PO₄ – Phosphate
- PTH – Parathyroid hormone
- RBC – Red blood cell
- TSAT – Total iron saturation

Applicable ICD-10 Coding:
- N03 Chronic nephritic syndrome
  - N03.0 Chronic nephritic syndrome, minor glomerular abnormality
  - N03.1 Chronic nephritic syndrome, focal and segmental glomerular lesions
  - N03.2 Chronic nephritic syndrome, diffuse membranous glomerulonephritis
Applicable ICD 10 Coding: (continued)

- N03.3 Chronic nephritic syndrome, diffuse mesangial proliferative glomerulonephritis
- N03.4 Chronic nephritic syndrome, diffuse endocapillary proliferative glomerulonephritis
- N03.5 Chronic nephritic syndrome, diffuse mesangiopcapillary glomerulonephritis
- N03.6 Chronic nephritic syndrome, dense deposit disease
- N03.7 Chronic nephritic syndrome, diffuse crescentic glomerulonephritis
- N03.8 Chronic nephritic syndrome, other
- N03.9 Chronic nephritic syndrome, unspecified
- N11 Chronic tubulo-interstitial nephritis
  - N11.0 Nephroblastomatosis
  - N11.1 Chronic obstructive pyelonephritis
  - N11.2 Chronic pyelonephritis
- N11.9 Chronic tubulo-interstitial nephritis, unspecified
- N18 Chronic renal failure
  - N18.0 End-stage renal disease
  - N18.8 Other chronic renal failure
  - N18.9 Chronic renal failure, unspecified
- I12.0 Hypertensive renal disease with renal failure
- I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
- O10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
- O10.3 Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium

Note:

1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
4. EPILEPSY

Diagnosis

Primary partial seizures

Disease identification card or disc recommended

Primary generalised seizures

Start with phenytoin or carbamazepine or sodium valproate or valproic acid or lamotrigine or phenobarbitone

Not tolerated or controlled?

Alternatives: Phenytoin or carbamazepine or sodium valproate or valproic acid or topiramate

Ongoing seizures?

Add second drug: Suggested combinations: Carbamazepine and sodium valproate or valproic acid, Phenytoin and sodium valproate or valproic acid, Sodium valproate or valproic acid and lamotrigine, and/or topiramate

Uncontrolled seizures Review for further management

Start with carbamazepine or sodium valproate or valproic acid or lamotrigine

Not tolerated or controlled?

Alternatives and/or addition: For absence seizures: ethosuximide For myoclonic seizures: clonazepam For tonic-clonic seizures: carbamazepine or phenytoin or topiramate

Ongoing seizures?

Add second drug: If taking sodium valproate or valproic acid for absence seizures add ethosuximide, If taking sodium valproate or valproic acid for myoclonic seizures add clonazepam If taking sodium valproate or valproic acid for tonic-clonic seizures add lamotrigine

Uncontrolled seizures Review for further management
Applicable ICD-10 Coding:

- G40 Epilepsy
  - G40.0 Localization-related (focal)(partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset
  - G40.1 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures
  - G40.2 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
  - G40.3 Generalized idiopathic epilepsy and epileptic syndromes
  - G40.4 Other generalized epilepsy and epileptic syndromes
  - G40.5 Special epileptic syndromes
  - G40.6 Grand mal seizures, unspecified (with or without petit mal)
  - G40.7 Petit mal, unspecified, without grand mal seizures
  - G40.8 Other epilepsy
  - G40.9 Epilepsy, unspecified

- G41 Status epilepticus
  - G41.0 Grand mal status epilepticus
  - G41.1 Petit mal status epilepticus
  - G41.2 Complex partial status epilepticus
  - G41.8 Other status epilepticus
  - G41.9 Status epilepticus, unspecified

Note:

1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 191 of 1998

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
5. GLAUCOMA

- **Closed angle**
  - Advanced and high-risk glaucoma
  - Miotics
  - Review for surgery

- **Open angle**
  - Start with \( \beta \)-blocker eye drops

- **Congenital**
  - Surgery

**Contraindications?**
- Second-line topical monotherapies: \( \alpha \)-agonist, carbonic anhydrase inhibitor, prostaglandin analogue, pilocarpine

**Intolerance?**
- Decrease dose or switch to alternative second line agent

**Inadequate response?**
- Check adherence
- Increase dose if possible
- Switch to alternative second line agent

**Inadequate response to monotherapy?**
- Check adherence
- Try combination therapy

- **Intolerance?**
  - Decrease dose or switch to alternative combination

- **Inadequate intra-ocular pressure reduction or disease progression despite maximum medical therapy?**
  - Check adherence

- **Review for further medication or surgery**
Glossary:
- β-blocker – Beta-receptor blocker
- α-agonist – Alpha-2 receptor agonist

Applicable ICD-10 Coding:
- H40 Glaucoma
  - H40.0 Glaucoma suspect
  - H40.1 Primary open-angle glaucoma
  - H40.2 Primary angle-closure glaucoma
  - H40.3 Glaucoma secondary to eye trauma
  - H40.4 Glaucoma secondary to eye inflammation
  - H40.5 Glaucoma secondary to other eye disorders
  - H40.6 Glaucoma secondary to drugs
  - H40.8 Other glaucoma
  - H40.9 Glaucoma, unspecified
- Q15.0 Congenital glaucoma

Note:
1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.
2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1988
3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
6. HYPERLIPIDAEMIA

- Fasting plasma TC > 5mmol/l
  - YES: Manifest vascular heart disease? Other risk factors? E.g. diabetes, smoking, hypertension
  - NO: Characterise hyperlipidaemia: Full risk assessment, Fasting TG, TC, HDLC, LDLC, Screen for secondary causes e.g. diabetes, hypothyroidism
  - YES: Primary hyperlipidaemia
    - Genetic dyslipidaemia present?
      - YES: Treat cause of secondary hyperlipidaemia: Lifestyle modification, Modify other risk factors, Follow up
      - NO: Manifest / established vascular disease present?
        - YES: Persistent hyperlipidaemia
          - 10 year MI risk < 20% (if age < 60 years, extrapolate to age 60): Utilise Framingham Risk Score
            - YES: Consider drug therapy: Life style & risk-factor modification
            - NO: Lifestyle modification: Modify other risk factors, Follow up
        - NO: Resolved hyperlipidaemia
          - YES: Lifestyle modification: Follow up
          - NO: Lifestyle modification: Modify other risk factors, Follow up
  - NO: Secondary hyperlipidaemia
    - YES: Lifestyle modification: Follow-up in 5 years
Glossary:
- TC – Total cholesterol
- TG – Triglycerides
- HDLC – High density lipoprotein cholesterol
- LDLC – Low density lipoprotein cholesterol
- MI – Myocardial infarction

Applicable ICD-10 Coding:
- E78.0 Pure hypercholesterolaemia
- E78.1 Pure hyperglycaemia
- E78.2 Mixed hyperlipidaemia
- E78.3 Hyperchylomicronaemia
- E78.4 Other hyperlipidaemia
- E78.5 Hyperlipidaemia, unspecified

Note:
1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
# HYPERTENSION

## Assessment
- **Major Risk Factors:**
  - Levels of systolic & diastolic BP
  - Smoking
  - Dyslipidemia
  - Diabetes Mellitus
  - Men > 55 years and Women > 65 years
  - Family history of early onset of cardiovascular disease
  - Waist circumference-abdominal obesity
  - Target Organ Disease:
    - Left Ventricular Hypertrophy
    - Microalbuminuria: albumin creatinine ratio
    - Slightly elevated creatinine

- **Associated Clinical Conditions:**
  - Coronary Heart Disease
  - Heart Failure
  - Chronic Renal disease
  - Stroke or transient ischaemic attack
  - Peripheral arterial disease
  - Advanced retinopathy

## Measure Blood Pressure

<table>
<thead>
<tr>
<th>OTHER RISK FACTORS AND DISEASE HISTORY</th>
<th>NORMAL (SBP &lt;120-129 or DBP &lt;80-84 mmHg)</th>
<th>HIGH NORMAL (SBP 130-139 or DBP 85-89 mmHg)</th>
<th>STAGE 1 MILD hypertensive (SBP 140-159 or DBP 90-99 mmHg)</th>
<th>STAGE 2 MODERATE hypertensive (SBP 160-179 or DBP 100-109 mmHg)</th>
<th>STAGE 3 SEvere hypertensive (SBP &gt;180 or DBP &gt;110 mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No other major risk factors</td>
<td>Average risk</td>
<td>Average risk</td>
<td>Low added risk</td>
<td>Moderate added risk</td>
<td>High added risk</td>
</tr>
<tr>
<td>1-2 major risk factors</td>
<td>Low added risk</td>
<td>Low added risk</td>
<td>Moderate added risk</td>
<td>Moderate added risk</td>
<td>Very High added risk</td>
</tr>
<tr>
<td>≥ 3 major risk factors or target organ damage or diabetes mellitus</td>
<td>Moderate added risk</td>
<td>High added risk</td>
<td>High added risk</td>
<td>High added risk</td>
<td>Very High added risk</td>
</tr>
</tbody>
</table>

## Determine Risk

- **Low Added Risk**
- **Moderate Added Risk**
- **High / Very High Added Risk**

LIFESTYLE MODIFICATION AS APPROPRIATE

- Monitor BP and other risk factors for 6-12 months
- SBP ≥ 140 or DBP ≥ 90...
- SBP < 140 or DBP < 90...

CONTINUE TO MONITOR

BEGIN DRUG TREATMENT

Is there SEVERE HYPERTENSION? SBP >180 or DBP >110 mmHg
Are there compelling indications?

**Compelling indications:**
- Angina: β-blocker or CCB (rate lowering preferred)
- Prior myocardial infarct or CAD: β-blocker and ACE inhibitor (ARB if ACE intolerant). Verapamil if β-blockers contraindicated.
- Heart Failure: ACE inhibitor (ARB if ACE intolerant) and certain β-blocker and aldosterone antagonist. Loop diuretics for volume overload.
- Left ventricular hypertrophy: ACE inhibitor or ARB.
- Stroke – secondary prevention: ACE inhibitor and diuretic, or ARB.
- Diabetes type 1 or 2 with or without evidence of microalbuminuria or proteinuria: ACE inhibitor or ARB, usually in combination with diuretic.
- Isolated systolic hypertension: Low dose thiazide or thiazide-like diuretic or long-acting CCB.
- Chronic renal disease: ACE inhibitor or ARB, usually in combination with diuretic.

**Routine Management:**
1. Low dose hydrochlorothiazide (12.5mg preferred up to a maximum of 25mg) or thiazide-like diuretic.
2. ACE inhibitor or CCB long-acting dihydropyridines or nondihydropyridines (ARB if ACE intolerant).
3. Add second agent from different class (especially diuretic if not already used).

**Inadequate response?**

**Review Management**

---

**TARGETS FOR BP-LOWERING TREATMENT**

Ideally these targets should be reached in 3 months

<table>
<thead>
<tr>
<th>Stage</th>
<th>BP Level (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All stages</td>
<td>&lt;140/90</td>
</tr>
<tr>
<td>Isolated Systolic Hypertension</td>
<td>Do not lower the DBP to &lt; 85</td>
</tr>
<tr>
<td>High-risk patients (e.g. stroke, transient ischaemic attack, heart failure, angina, MI, diabetes, renal disease, etc.)</td>
<td>&lt;130/80</td>
</tr>
</tbody>
</table>
### Glossary:
- BP – Blood pressure
- SBP – Systolic blood pressure
- DBP – Diastolic blood pressure
- α-blocker – Alpha-receptor blocker
- ACE inhibitor – Angiotensin converting enzyme inhibitor
- ARB – Angiotensin receptor blocker
- β-blocker – Beta-receptor blocker
- CCB – Calcium channel blocker
- MI – Myocardial infarct

#### Applicable ICD-10 Coding:
- **I10** Essential (primary) hypertension
- **I11** Hypertensive heart disease
  - I11.0 Hypertensive heart disease with (congestive) heart failure
  - I11.9 Hypertensive heart disease without (congestive) heart failure
- **I12** Hypertensive renal disease
  - I12.0 Hypertensive renal disease with renal failure
  - I12.9 Hypertensive renal disease without renal failure
- **I13** Hypertensive heart and renal disease
  - I13.0 Hypertensive heart and renal disease with (congestive) heart failure
  - I13.1 Hypertensive heart and renal disease with renal failure
  - I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
  - I13.9 Hypertensive heart and renal disease, unspecified
- **I15** Secondary hypertension
  - I15.0 Renovascular hypertension
  - I15.1 Hypertension secondary to other renal disorders
  - I15.2 Hypertension secondary to endocrine disorders
  - I15.8 Other secondary hypertension
  - I15.9 Secondary hypertension, unspecified
- **C10** Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
  - C10.0 Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium
  - C10.1 Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium
  - C10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
  - C10.3 Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium
  - C10.4 Pre-existing secondary hypertension complicating pregnancy, childbirth and the puerperium
  - C10.9 Unspecified pre-existing hypertension complicating pregnancy, childbirth and the puerperium
- **C11** Pre-existing hypertensive disorder with superimposed proteinuria
Note:

1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.
8. MULTIPLE SCLEROSIS

Glossary:
- IV – Intravenous
- EDSS – Expanded Disability Status Scale

Applicable ICD-10 Coding:
- G35 Multiple sclerosis
Note:

1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998.

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.

4. Entry Criteria for the use Beta-interferon:
   a. The occurrence of at least 2 clinically significant attacks/relapses in the previous 2 years.
   b. Patients must be aged 18 years or older.
   c. Patients must be able to stand and step/walk independently with an EDSS score of < 5.5 in the stable/remission phase / walk 100 meters or more without assistance.
   d. The patient must not have any contraindications to the use of Beta-interferon.

5. Exit criteria for the use of Beta-interferon:
   a. The presence of intolerable adverse side effects (medical contraindications).
   b. Being pregnant or planning pregnancy.
   c. Development of non-relapsing secondary progressive multiple sclerosis with loss of ability to walk.
   d. Occurrence of 2 disabling relapses within a 12 month period.
   e. Loss of ability to walk, with or without assistance that has persisted for longer than 6 months (i.e. EDSS score of 7 or more).
9. RHEUMATOID ARTHRITIS

Diagnosis

Assess disease activity & define treatment goals

Non drug measures (rest, range-of-motion exercises)

Drug therapy

Choice of DMARD depends upon activity and severity of disease. Start singly, in combination or sequentially

DMARD

Analgesics

NSAID

Prednisone ≤ 7.5 mg/day orally can be utilized for all stages and intra-articular steroids consisting of 4 / joint / year can be added

Chloroquine

Methotrexate Oral or SC

Sulphasalazine

Adequate response?

NO

Review management

Consider other DMARD combinations:
Add lefunamide singly or in combination in adequate responders or consider azathioprine or penicillamine

Tumor necrosis factor (TNF)

NO

YES

Continue therapy

NO

YES

Continue therapy

Review for further management:
Consider agents that inhibit tumor-necrosis factor (TNF)
Glossary:
- **DMARD** – Disease modifying antirheumatic drugs
- **NSAID** – Non-steroidal anti-inflammatory agents
- **SDAI** – Simplified Disease Activity Index

Applicable ICD-10 Coding:
- M05 Seropositive rheumatoid arthritis
  - M05.0 Felty’s syndrome
  - M05.1 Rheumatoid lung disease (J99.0*)
  - M05.2 Rheumatoid vasculitis
  - M05.3 Rheumatoid arthritis with involvement of other organs and systems
  - M05.8 Other seropositive rheumatoid arthritis
  - M05.9 Seropositive rheumatoid arthritis, unspecified
- M06 Other rheumatoid arthritis
  - M06.0 Seronegative rheumatoid arthritis
  - M06.1 Adult-onset Still’s disease
  - M06.2 Rheumatoid bursitis
  - M06.3 Rheumatoid nodule
  - M06.4 Inflammatory polyarthropathy
  - M06.8 Other specified rheumatoid arthritis
  - M06.9 Rheumatoid arthritis, unspecified
- M08.0 Juvenile rheumatoid arthritis

Note:
1. Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.

2. To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –
   a. not be inconsistent with this algorithm;
   b. be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
   c. comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998

3. This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.

4. Entry Criteria for the use of tumor-necrosis factor (TNF) inhibitors:
   a. Active disease defined as a SDAI score of ≥ 20. The swollen and tender joint must at least be 6 each
   b. A history of at least 3 DMARDs used serially or in combination at maximum tolerated doses. Methotrexate must be one of the DMARDs unless contra-indicated.
   c. DMARD use, as described for at least 6 months.

5. Exit criteria for the use of tumor-necrosis factor (TNF) inhibitors:
   a. Failure to achieve adequate improvement in SDAI score; defined as an improvement of ≥ 7 points from entry score, after 3 months of a tumor-necrosis factor (TNF) inhibitor use.
   b. Failure to achieve a low disease state; defined as a SDAI score ≤ 11 or a major SDAI response of ≥ 17 points after 8 months of treatment.
   c. Intolerance to tumor-necrosis factor (TNF) inhibitor.
Annexure D: List of basic dentistry services

1. Preventative services
   a. Basic oral examinations (up to two per year)
   b. Intraoral X-rays
   c. Non-surgical treatment, e.g. scaling, polishing, periodontal treatments, oral hygiene instruction (up to two per year)
   d. Fluoride for children under 16 years

2. Basic services
   a. Relief of oral pain and drug therapy for oral infections
   b. Restorative services for dental caries, e.g. treatment of dental cavities, sealants, marginal fillings, fillings
   c. First aid for oral infections and dento-alveolar trauma, e.g. suture of wounds
   d. Extractions under local anaesthesia (tooth, exposed roots, residual roots, impacted teeth/wisdom teeth)
   e. Post-extraction complication treatment such as dry sockets, septic sockets, bleeding
   f. Incision and drainage of localised abscesses
   g. Removal of jaw cyst
   h. Root canal treatment

3. Emergency dental care includes:
   a. Diagnosis of acute dental problem, including exam and radiographs
   b. Procedures to arrest bleeding of dental origin, including suturing, packing, dressing
   c. Preliminary case of trauma to the mouth
   d. Procedures for the immediate relief of pain, including sedative fillings, incision/open and drainage, pulpectomy, pulpotomy, extraction
Annexure E: List of basic optometry services

1. Optometric primary and preventive services
   a. Eye and vision examination, annually for children below 16 and annually for adults
   b. Eye and vision examinations include the following:
      i. case history
      ii. external examination of the eye
      iii. assessment of visual acuity
      iv. profile of ocular motility
      v. objective and subjective measurement of refraction
      vi. assessment of binocular coordination
      vii. glaucoma tests for adults >40 years or at risk (retinal threshold test with computer disc storage (Delta / Statpak programs) to be performed by an ophthalmologist)
   c. Screening for refractive errors >60 years (assessment of amplitude of accommodation, when required)
   d. Screening for major ocular diseases >60 years (using direct ophthalmoscope)

2. Appliances to be paid in full
   a. One pair of clear single vision, bifocal or multifocal lenses with basic frame, or basic contact lenses per person bi-annually
Annexure F: List of basic preventative services

1. Maternal and child health preventive services
   a. Family planning
      i. Contraception should be offered up to the age of 21 years and only up to options available in public Primary Heath Care (PHC) facilities
      ii. Termination Of Pregnancy (TOP) and sterilization services
      iii. TOP services should include anaesthetist, surgical and medical intervention
   b. Antenatal visits
      i. Four visits at the primary care level, with referral to higher levels according to protocols, must be allowed
      ii. Women must register with scheme to qualify for these benefits and
   c. Prevention of mother to child transmission, and occupational and traumatic exposure to HIV
      i. Subject to HIV tests and PEP public sector guidelines

2. Communicable diseases
   a. Routine child immunisation in accordance with DoH guidelines
      i. DoH guidelines are available on the national department website at www.doh.gov.za/factsheets/guidelines
   b. Adult immunisation: anti-tetanus, hepatitis B, pneumococcal and influenza vaccine
      i. Pneumococcal vaccine should be provided to people ≥ 65 years and high-risk individuals
      ii. Influenza vaccines should be provided to people ≥ 18 and 65 years and high-risk individuals
      iii. Anti-tetanus vaccination to be provided every 10 years and Hep B for occupational exposure
   c. Male circumcision
   d. Human Papilloma Virus (HPV) vaccine
      i. For women 9-26 years of age or not sexually active

3. Non-communicable diseases
   a. Routine general physical checks performed by a GP
      i. People 30-40 years every three years
ii. People 41-59 years every two years
iii. People ≥ 60 years annually

(The above will be subjected to co-payment if performed by a specialist)

b. Unlimited HIV screening tests
i. Both Elisa and rapid (finger pricks) acceptable
ii. HIV Western Blot / HIV Nucleic Acid Amplification Test (NAAT) tests are excluded

c. Baseline body mass index (BMI), blood sugar, cholesterol, blood pressure (BP) and glaucoma tests
i. People ≥ 35 years are entitled to preventive medical checkups focusing on diseases that impose a high burden of disease can be effectively treated or screened.
ii. Baseline tests will be reimbursed once a year only.
iii. Further investigations performed due to abnormal baseline tests should be paid from risk pool.

d. Breast cancer screening
i. Physical examination and mammograms for women ≥ 40 years every two years

e. Cervical cancer screening
i. Pap smears done by a GP for women above 15 once a year. Will be subjected to co-payment if performed by a specialist

f. Dual Energy X-ray Absorptiometry (DEXA) bone density scan
i. People ≥50 years every two years (performed by a radiologist, GP, specialist)


g. Screening tests for prostate cancer
i. Men 40-49 years every five years
ii. Men 50-59 years every three years
iii. Men 60-70 years every two years
Annexure G: Essential drugs for adults


1. ANAESTHETICS
   1.1 General anaesthetics and oxygen
   Halothane
   Ketamine
   Nitrous oxide
   Oxygen
   Thiopental
   1.2 Local anaesthetics
   Bupivacaine
   Lidocaine
   Lidocaine + epinephrine (adrenaline)
   Ephedrine
   1.3 Preoperative medication and sedation for short-term procedures
   Atropine
   Diazepam
   Morphine
   Promethazine

2. ANALGESICS, ANTIPYRETICS, NON-Steroidal ANTI-INFLAMMATORY MEDICINES (NSAIMs), MEDICINES USED TO TREAT GOUT AND DISEASE MODIFYING AGENTS IN RHEUMATOID DISORDERS (DMARDs)
   2.1 Non-opioids and non-steroidal anti-inflammatory medicines (NSAIMs)
   Acetylsalicylic acid
   Ibuprofen
   Paracetamol
   2.2 Opioid analgesics
   Codeine
   Morphine
   2.3 Medicines used to treat gout
   Allopurinol
   2.4 Disease modifying agents used in rheumatoid disorders (DMARDs)
   Chloroquine
   Azathioprine
   Methotrexate
   Penicillamine
   Sulphasalazine

3. ANTIALLERGICS AND MEDICINES USED IN ANAPHYLAXIS
   Chlorphenamine
   Dexamethasone
   Epinephrine (adrenaline)
   Hydrocortisone
   Prednisolone

4. ANTIDOTES AND OTHER SUBSTANCES USED IN POISONINGS
   4.1 Non-specific
   Charcoal
   4.2 Specific
   Acetylcysteine
   Atropine
   Calcium gluconate
   Dextrose
   Dimercaprol
   DL-methionine
   Methylthioninium chloride (methylene blue)
   Naloxone.
   Penicillamine
   Potassium ferric hexacyano-ferrate(II)-2H2O (Prussian blue)
   Sodium calcium edetate
   Sodium nitrite
Sodium thiosulfate

5. ANTICONVULSANTS / ANTIJEPILEPTICS
Carbamazepine
Diazepam
Magnesium sulfate*
Phenobarbital
Phenytoin
Valproic acid
Ethosuximide

6. ANTI-INFECTIVE MEDICINES
6.1 Anthelminthics
6.1.1 Intestinal anthelminthics
Albendazole
Levamisole
Mebendazole
Niclosamide
Praziquantel
Pyrantel
6.1.2 Antifilarials
Ivermectin
Diethylcarbamazine
Suramin sodium
6.1.3 Antischistosomals and antitrematode medicine
Praziquantel
Triclabendazole
Oxamnique
6.2 Antibacterials
6.2.1 Beta Lactam medicines
Amoxicillin
Amoxicillin + clavulanic acid
Ampicillin
Benzathine benzylpenicillin
Benzy1penicillin
Cefazolin
Cefixime
Cloxacillin
Phenoxy-methylpenicillin
Procaine benzylpenicillin
Ceftazidime
Ceftriaxone
Imipenem + cilastatin
6.2.2 Other antibacterials
Azithromycin
Chloramphenicol
Ciprofloxacin
Erythromycin
Gentamicin
Metronidazole
Nitrofurantoin
Spectinomycin
Sulfamethoxazole + trimethoprim
Trimethoprim
Clindamycin
Sulfadiazine
Vancomycin
6.2.3 Antileprosy medicines
Clofazimine
Dapsone
Rifampicin
6.2.4 Antituberculosis medicines
Ethambutol
Isoniazid
Isoniazid + ethambutol
Pyrazinamide
Rifampicin
Rifampicin + isoniazid
Rifampicin + isoniazid + ethambutol
Rifampicin + isoniazid + pyrazinamide
Rifampicin + isoniazid + pyrazinamide + ethambutol
Streptomycin
Amikacin
Capreomycin
Cycloserine
Ethionamide
Kanamycin
Ofloxacin*(" levofloxacin may be an alternative based on availability and Programme considerations.)
P-aminosalicylic acid
6.3 Antifungal medicines
Clotrimazole
Fluconazole
Griseofulvin
Nystatin
Amphotericin B
Flucytosine
Potassium iodide

6.4 Antiviral medicines
6.4.1 Antiherpes medicines
Acyclovir

6.4.2 Antiretrovirals
6.4.2.1 Nucleoside/Nucleotide reverse transcriptase inhibitors
Abacavir (ABC)
Didanosine (ddi)
Emtricitabine (FTC)
Lamivudine (3TC)
Stavudine (d4t)
Tenofovir disoproxil fumarate (TDF)
Zidovudine (ZDV or AZT)

6.4.2.2 Non-nucleoside reverse transcriptase inhibitors
Efavirenz (EFV or EFZ)
Nevirapine (NVP)

6.4.2.3 Protease inhibitors
Indinavir (IDV)
Lopinavir + ritonavir (LPV/r)
Nelfinavir (NFV)
Ritonavir
Saquinavir (SQV)

FIXED-DOSE COMBINATIONS
Efavirenz + emtricitabine* + tenofovir
Emtricitabine* + tenofovir
Stavudine + lamivudine + nevirapine
Zidovudine + lamivudine
Zidovudine + lamivudine + nevirapine

6.4.3 Other antivirals
Ribavirin

6.5 Antiprotozoal medicines
6.5.1 Antiamoebic and anti- giardiasis medicines
Diloxanide

Metronidazole

6.5.2 Antileishmaniasis medicines
Meglumine antimoniate
Paromomycin
Amphotericin B
Pentamidine

6.5.3 Antimalarial medicines
6.5.3.1 For curative treatment
Amodiaquine
Artemether
Artemether + lumefantrine
Artesunate
Chloroquine
Doxycycline
Mefloquine
Primaquine
Quinine
Sulfadoxine + pyrimethamine

6.5.3.2 For prophylaxis
Mefloquine
Proguanil (For use only in combination with chloroquine)

6.5.4 Antipneumocystosis and antitoxoplasmosis medicines
Pyrimethamine.
Sulfamethoxazole + trimethoprim
Pentamidine

6.5.5 Antitrypanosomal medicines
6.5.5.1 African trypanosomiasis
Pentamidine
Suramin sodium
Eflornithine
Melarsoprol

6.5.5.2 American trypanosomiasis
Benznidazole
Nifurtimox

7. ANTIMIGRAINE MEDICINES
7.1 For treatment of acute attack
Acetylsalicylic acid
Paracetamol

7.2 For prophylaxis
Propranolol
8. ANTIMICROBIALS, IMMUNOSUPPRESSIVES AND MEDICINES USED IN PALLIATIVE CARE

8.1 Immunosuppressive medicines
Azathioprine
Ciclosporin

8.2 Cytotoxic medicines
Asparaginase
Bleomycin
Calcium folinate
Chlorambucil
Cisplatin
Cyclophosphamide
Cytarabine
Dacarbazine
Daunorubicin
Doxorubicin
Etoposide
Fluorouracil
Mercaptopurine
Methotrexate
Procarbazine
Vinblastine
Vincristine

8.3 Hormones and antihormones
Dexamethasone
Hydrocortisone
Prednisolone
Tamoxifen

8.4 Medicines used in palliative care

9. ANTIPARKINSONISM MEDICINES
Biperiden
Levodopa + Carbidopa

10. MEDICINES AFFECTING THE BLOOD
10.1 Antianaemia medicines
Ferrus salt
Ferrous salt + folic acid
Folic acid
Hydroxocobalamin

10.2 Medicines affecting coagulation
Heparin sodium
Phytomenadione
Protamine sulfate
Warfarin

11. BLOOD PRODUCTS AND PLASMA SUBSTITUTES
11.1 Plasma substitutes
Dextran 70

11.2 Plasma fractions for specific use
Human normal immunoglobulin
Factor VIII concentrate Dried.
Factor IX complex (coagulation factors, II, VII, IX, X) concentrate Dried.

12. CARDIOVASCULAR MEDICINES
12.1 Antianginal medicines
Atenolol
Glyceryl trinitrate
Isosorbide dinitrate
Verapamil

12.2 Antiarrhythmic medicines
Atenolol
Digoxin
Epinephrine (adrenaline)
Lidocaine
Verapamil
Procainamide
Quinidine

12.3 Antihypertensive medicines
Amlodipine
Atenolol
Enalapril
Hydralazine
Hydrochlorothiazide
Methyldopa
Sodium nitroprusside

12.4 Medicines used in heart failure
Digoxin
Enalapril
Furosemide
Hydrochlorothiazide
Dopamine

12.5 Antithrombotic medicines
Acetylsalicylic acid
Streptokinase

12.6 Lipid-lowering agents
Simvastatin

13. DERMATOLOGICAL MEDICINES (topical)

13.1 Antifungal medicines
Benzoic acid + salicylic acid
Miconazole
Sodium thiosulfate
Selenium sulfide

13.2 Anti-infective medicines
Methyrosanilinium chloride (gentian violet)
Neomycin sulfate + Bacitracin
Potassium permanganate
Silver sulfadiazine

13.3 Anti-inflammatory and antipruritic medicines
Betamethasone
Calamine lotion
Hydrocortisone

13.4 Astringent medicines
Aluminium diacetate

13.5 Medicines affecting skin differentiation and proliferation
Benzoyl peroxide
Coal tar
Dithranol
Fluorouracil
Podophyllum resin
Salicylic acid
Urea

13.6 Scabicides and pediculicides
Benzyl benzoate
Permethrin

14. DIAGNOSTIC AGENTS

14.1 Ophthalmic medicines
Fluorescein

14.2 Radiocontrast media
Amidotrizoate
Barium sulfate
Lohexol.
Meglumine iotroxate

15. DISINFECTANTS AND ANTISEPTICS

15.1 Antiseptics
Chlorhexidine
Ethanol
Polyvidone iodine

15.2 Disinfectants
Chlorine base compound
Chloroxylenol
Glutaral

16. DIURETICS
Amiloride
Furosemide
Hydrochlorothiazide
Mannitol
Spironolactone

17. GASTROINTESTINAL MEDICINES

17.1 Antacids and other antiulcer medicines
Aluminium hydroxide
Ranitidine
Magnesium hydroxide

17.2 Antiemetic medicines
Metoclopramide
Promethazine

17.3 Anti-inflammatory medicines
Sulfasalazine
Hydrocortisone

17.4 Laxatives
Senna

17.5 Medicines used in diarrhoea

17.5.1 Oral rehydration
Oral rehydration salts

17.5.2 Medicines for diarrhoea in children
71

Zinc sulfate

17.5.3 Antidiarrhoeal (symptomatic) medicines in adults

Codeine

18. HORMONES, OTHER ENDOCRINE MEDICINES AND CONTRACEPTIVES

18.1 Adrenal hormones and synthetic substitutes
Addison’s disease is a rare condition; adrenal hormones are already included in section 3.

18.2 Androgens
Testosterone.

18.3 Contraceptives

18.3.1 Oral hormonal contraceptives
Ethinylestradiol + Levonorgestrel
Ethinylestradiol + Norethisterone
Levonorgestrel

18.3.2 Injectable hormonal contraceptives
Medroxyprogesterone acetate
Medroxyprogesterone acetate + Estradiol cypionate
Norethisterone enantate

18.3.3 Intrauterine devices
Copper containing device

18.3.4 Barrier methods
Condoms
Diaphragms

18.3.5 Implantable contraceptives
Levonorgestrel releasing implant

18.4 Estrogens
Ethinylestradiol

18.5 Insulins and other antidiabetic agents
Glibenclamide
Insulin injection (soluble)
Intermediate acting insulin
Metformin

18.6 Ovulation inducers
Clomifene

18.7 Progestogens
Norethisterone
Medroxyprogesterone acetate

18.8 Thyroid hormones and antithyroid medicines
Levothyroxine
Potassium Iodide
Propylthiouracil

19. IMMUNOLOGICALS

19.1 Diagnostic agents
Tuberculin, purified protein derivative (PPD)

19.2 Sera and immunoglobulins
Anti-D immunoglobulin (human)
Antitetanus immunoglobulin (human)
Antivenom immunoglobulin
Diphtheria antitoxin
Rabies immunoglobulin

19.3 Vaccines
As per NDOH guidelines – see Annexure F, page 64.

20. MUSCLE RELAXANTS (PERIPHERALLY-ACTING) AND CHOLINESTERASE INHIBITORS

Alcuronium
Neostigmine
Suxamethonium
Pyridostigmine
Vecuronium

21. OPHTHALMOLOGICAL PREPARATIONS

21.1 Anti-infective agents
Aciclovir
Gentamicin
Tetracycline

21.2 Anti-inflammatory agents
Prednisolone

21.3 Local anaesthetics
Tetracaine

21.4 Miotics and antiglaucoma medicines
Acetazolamide
Pilocarpine
21.5 Mydriatics
Atropine
Epinephrine

22. OXYTOCICS AND ANTIOXYTOCICS

22.1 Oxytocics
Ergometrine
Oxytocin
Misoprostol
Mifepristone – Misoprostol

22.2 Antioxytocics (tocolytics)
Nifedipine

23. PERITONEAL DIALYSIS SOLUTION
Intraperitoneal dialysis solution (of appropriate composition)

24. PSYCHOTHERAPEUTIC MEDICINES

24.1 Medicines used in psychotic disorders
Chlorpromazine
Fluphenazine
Haloperidol

24.2 Medicines used in mood disorders

24.2.1 Medicines used in depressive disorders
Amitriptyline
Fluoxetine

24.2.2 Medicines used in bipolar disorders
Carbamazepine
Lithium carbonate
Valproic acid

24.3 Medicines used in generalized anxiety and sleep disorders
Diazepam

24.4 Medicines used for obsessive compulsive disorders and panic attacks
Clomipramine

24.5 Medicines used in substance dependence programmes
Methadone
Buprenorphine.

25. MEDICINES ACTING ON THE RESPIRATORY TRACT

25.1 Antiasthmatic and medicines for chronic obstructive pulmonary disease
Beclometasone
Epinephrine (adrenaline)
Ipratropium bromide
Salbutamol

25.2 Other medicines acting on the respiratory tract
Caffeine citrate

26. SOLUTIONS CORRECTING WATER, ELECTROLYTE AND ACID-BASE DISTURBANCES

26.1 Oral
Oral rehydration salts (See section 17.5.1.)
Potassium chloride

26.2 Parenteral
Glucose
Glucose with sodium chloride
Potassium chloride
Sodium chloride
Sodium hydrogen carbonate
Sodium lactate, compound solution

26.3 Miscellaneous
Water for injection 2-ml; 5-ml; 10ml ampoules.

27. VITAMINS AND MINERALS
Ascorbic acid
Ergocalciferol
Iodine
Nicotinamide
Pyridoxine retinol
Riboflavin
Sodium fluoride
Thiamine
Calcium gluconate
Annexure H: Essential drugs for children


1. ANAESTHETICS
   1.1 General anaesthetics and oxygen
   Halothane
   Ketamine
   Nitrous oxide
   Oxygen
   Thiopental
   1.2 Local anaesthetics
   Bupivacaine
   Lidocaine
   Lidocaine + epinephrine (adrenaline)
   1.3 Preoperative medication and sedation for short-term procedures
   Atropine
   Diazepam
   Morphine

2. ANALGESICS, ANTIPYRETICS, NON-STEROIDAL ANTI-INFLAMMATORY MEDICINES (NSAIMs), MEDICINES USED TO TREAT GOUT AND DISEASE MODIFYING AGENTS IN RHEUMATOID DISORDERS (DMARDs)
   2.1 Non-opioids and non-steroidal anti-inflammatory medicines (NSAIMs)
   Ibuprofen
   Paracetamol
   Acetylsalicylic acid
   2.2 Opioid analgesics
   Codeine
   Morphine
   2.3 Medicines used to treat gout
   2.4 Disease modifying agents used in rheumatoid disorders (DMARDs)

3. ANTIALLERGICS AND MEDICINES USED IN ANAPHYLAXIS
   Chlorphenamine
   Diphenhydramine
   Dexamethasone
   Epinephrine (adrenaline)
   Hydrocortisone
   Prednisolone

4. ANTIDOTES AND OTHER SUBSTANCES USED IN POISONINGS
   4.1 Non-specific
   Charcoal
   4.2 Specific
   Acetylcysteine
   Atropine
   Calcium gluconate
   Deferoxamine
   Dimercaprol
   Naloxone
   Penicillamine
   Sodium calcium edetate

5. ANTICONVULSANTS/ANTIEPILEPTICS
   Carbamazepine
   Diazepam
   Phenobarbital
   Phenytoin
   Valproic acid (sodium valproate)
   Ethosuximide

6. ANTI-INFECTIVE MEDICINES
   6.1 Anthelmintics
   6.1.1 Intestinal anthelmintics
   Albendazole
   Levamisole
Mebendazole
Niclosamide
Praziquantel
Pyrantel
6.1.2 Antifilarials
Ivermectin
Diethylcarbamazine
6.1.3 Antischistosomals and antitrematode medicine
Praziquantel
Triclabendazole
Oxamnique
6.2 Antibacterials
6.2.1 Beta Lactam medicines
Amoxicillin
Amoxicillin + clavulanic acid
Ampicillin benzathine benzylpenicillin
Benzylpencillin
Cefazolin
Ceftriaxone
Clavulanate
Cloxacillin
Phenoxymethylpenicillin
Procaine benzylpenicillin
Ceftazidime
Imipenem + cilastatin
6.2.2 Other antibacterials
Azithromycin
Chloramphenicol
Ciprofloxacin
Doxycycline
Erythromycin
Gentamicin
Metronidazole
Nitrofurantoin
Sulfamethoxazole + trimethoprim
Trimethoprim
Clindamycin
Sulfadiazine
Vancomycin
6.2.3 Antileprosy medicines
Clofazimine
Dapsone
Rifampicin
6.2.4 Antituberculosis medicines
Ethambutol
Isoniazid
Pyrazinamide
Rifampicin
Rifampicin + isoniazid
Rifampicin + isoniazid + pyrazinamide
Streptomycin
Amikacin
Capreomycin
Cycloserine
Ethionamide
Kanamycin
Ofloxacin
Levofloxacin may be an alternative based on availability and programme considerations.
P-aminosalicylic acid
6.3 Antifungal medicines
Fluconazole
Griseofulvin
Nystatin
Amphotericin b
Flucytosine
Potassium iodide
6.4 Antiviral medicines
6.4.1 Antiherpes medicines
Acyclovir
6.4.2 Antiretrovirals
6.4.2.1 Nucleoside/Nucleotide reverse transcriptase inhibitors
Abacavir (ABC)
Didanosine (ddi)
Emtricitabine (FTC)
Lamivudine (3TC)
Stavudine (d4t)
Zidovudine (ZDV or AZT)
6.4.2.2 Non-nucleoside reverse transcriptase inhibitors
Efavirenz (EFV or EFZ)
Nevirapine (NVP)
6.4.2.3 Protease inhibitors
Lopinavir + ritonavir (LPV/r)
Nelfinavir (NFV)
Ritonavir
Saquinavir (SQV)

**FIXED-DOSE COMBINATIONS**
Stavudine + lamivudine + nevirapine
Zidovudine + lamivudine
Zidovudine + lamivudine + nevirapine

6.4.3 Other antivirals
Ribavirin

6.5 Antiprotozoal medicines
6.5.1 Antiamoebic and anti- giardiasis medicines
Diloxanide
Metronidazole

6.5.2 Antileishmaniasis medicines
Paromomycin
Meglumine antimoniate
Amphotericin b

6.5.3 Antimalarial medicines
6.5.3.1 For curative treatment
Amodiaquine
Artemether
Artemether + lumefantrine
Artesunate
Doxycycline
Mefloquine
Primaquine
Quinine
Sulfadoxine + pyrimethamine

6.5.3.2 For prophylaxis
Doxycycline
Mefloquine
Proguanil (for use only in combination with chloroquine)

6.5.4 Anti-pneumocystosis and antitoxoplasmosis medicines
Pyrimethamine
Sulfamethoxazole + trimethoprim

6.5.5 Antitrypanosomal medicines

6.5.5.1 African trypanosomiasis
Pentamidine
Suramin sodium
Eflornithine melarsoprol

6.5.5.2 American trypanosomiasis
Benznidazole
Nifurtimox

7. ANTIMIGRAINE MEDICINES
7.1 For treatment of acute attack
Ibuprofen
Paracetamol

7.2 For prophylaxis
Propranolol

8. ANTINEOPLASTIC, IMMUNOSUPPRESSIVES AND MEDICINES USED IN PALLIATIVE CARE
8.1 Immunosuppressive medicines
Azathioprine
Ciclosporin

8.2 Cytotoxic medicines
Allopurinol
Asparaginase
Bleomycin
Calcium folinate
Chlorambucil
Cisplatin
Cyclophosphamide
Cytarabine
Dacarbazine
Dactinomycin
Daunorubicin
Doxorubicin
Etoposide
Fluorouracil
Mercaptopurine
Methotrexate
Procarbazine
Vinblastine
Vincristine

8.3 Hormones and antihormones
Dexamethasone
8.4 Medicines used in palliative care
Medicines still under review by WHO

9. ANTI-PARKINSONISM MEDICINES

10. MEDICINES AFFECTING THE BLOOD
10.1 Antianaemia medicines
Ferrous salt
Folic acid
Hydroxocobalamin

10.2 Medicines affecting coagulation
Phytomenadione
Heparin sodium
Protamine sulfate
Warfarin

11. BLOOD PRODUCTS AND PLASMA SUBSTITUTES
11.1 Plasma substitutes
11.2 Plasma fractions for specific use
Human normal Immunoglobulin.
Factor VIII concentrate Dried.
Factor IX complex (coagulation factors, ii, vii, ix, x) concentrate Dried.

12. CARDIOVASCULAR MEDICINES
12.1 Anti-anginal medicines
12.2 Anti-arrhythmic medicines
The WHO will review medicines submitted under this section to determine if they are essential for children

12.3 Antihypertensive medicines
The WHO will review medicines submitted under this section to determine if they are essential for children

12.4 Medicines used in heart failure
Digoxin

12.5 Antithrombotic medicines
The WHO will review medicines submitted under this section to determine if they are essential for children

13. DERMATOLOGICAL MEDICINES (topical)

13.1 Antifungal medicines
Benzoic acid + salicylic acid
Miconazole
Selenium sulfide

13.2 Anti-infective medicines
Methylrosanilinium chloride (gentian violet)
Neomycin sulfate + Bacitracin
Potassium permanganate
Silver sulfadiazine

13.3 Anti-inflammatory and antipruritic medicines
Betamethasone
Calamine lotion
Hydrocortisone

13.4 Astringent medicines

13.5 Medicines affecting skin differentiation and proliferation
Benzoyl peroxide
Coal tar
Dithranol
Podophyllum resin
Salicylic acid
Urea

13.6 Scabicides and pediculicides
Benzyl benzoate
Permethrin

14. DIAGNOSTIC AGENTS
14.1 Ophthalmic medicines
Fluorescein
Tropicamide

14.2 Radiocontrast media
Barium sulfate
15. DISINFECTANTS AND ANTISEPTICS
15.1 Antiseptics
Chlorhexidine
Ethanol
Polyvidone iodine
15.2 Disinfectants
Chlorine base compound
Chloroxylenol
Glutaral

16. DIURETICS
Furosemide
Hydrochlorothiazide
Mannitol
Spironolactone

17. GASTROINTESTINAL MEDICINES
17.1 Antacids and other antiulcer medicines
Aluminium hydroxide
Magnesium hydroxide
Ranitidine
17.2 Antiemetic medicines
Metoclopramide
Promethazine
17.3 Anti-inflammatory medicines
17.4 Laxatives
The WHO will review medicines submitted under this section to determine if they are essential for children
17.5 Medicines used in diarrhoea
17.5.1 Oral rehydration
Oral rehydration salts
17.5.2 Medicines for diarrhoea in children
Zinc sulfate

18. HORMONES, OTHER ENDOCRINE MEDICINES AND CONTRACEPTIVES
18.1 Adrenal hormones and synthetic substitutes

18.2 Insulins and other antidiabetic agents
Insulin injection (soluble)
Intermediate-acting insulin
Metformin
18.3 Thyroid hormones and antithyroid medicines
Levothyroxine
Lugol’s solution
Potassium iodide
Propylthiouracil

19. IMMUNOLOGICALS
19.1 Diagnostic agents
Tuberculin, purified protein Derivative (PPD)
19.2 Sera and immunoglobulins
Antitetanus immunoglobulin (human)
Antivenom immunoglobulin
Diphtheria antitoxin
Rabies immunoglobulin
19.3 Vaccines
As per NDoH guidelines – see Annexure F, page 64.

20. MUSCLE RELAXANTS (PERIPHERALLY-ACTING) AND CHOLINESTERASE INHIBITORS
Neostigmine
Suxamethonium
Vecuronium
Pyridostigmine

21. OPHTHALMOLOGICAL PREPARATIONS
21.1 Anti-infective agents
Acyclovir
Gentamicin
Tetracycline
21.2 Anti-inflammatory agents
Prednisolone
21.3 Local anaesthetics
Tetracaine
21.4 Mydriatics
Atropine
Epinephrine (adrenaline)

22. OXYTOCICS AND ANTIOXYTOCICS
22.1 Oxytocics
22.2 Antioxytocics (tocolytics)

23. PERITONEAL DIALYSIS SOLUTION
Intraperitoneal dialysis - Solution (of appropriate Composition)

24. PSYCHOTHERAPEUTIC MEDICINES
24.1 Medicines used in psychotic disorders
Chlorpromazine
Haloperidol

24.2 Medicines used in mood disorders
24.2.1 Medicines used in depressive disorders
Fluoxetine
24.2.2 Medicines used in bipolar disorders

24.3 Medicines used in generalized anxiety and sleep disorders
24.4 Medicines used for obsessive compulsive disorders and panic attacks
24.5 Medicines used in substance dependence programmes

25. MEDICINES ACTING ON THE RESPIRATORY TRACT
25.1 Antiasthmatic and medicines for chronic obstructive pulmonary disease
Budesonide
Epinephrine (adrenaline)
Salbutamol

25.2 Other medicines acting on the respiratory tract
Caffeine citrate

26. SOLUTIONS CORRECTING WATER, ELECTROLYTE AND ACID-BASE

DISTURBANCES
26.1 Oral
Oral rehydration salts
Potassium chloride

26.2 Parenteral
Glucose
Glucose with sodium chloride
Potassium chloride
Sodium chloride
Sodium hydrogen carbonate
Sodium lactate, compound
Solution

26.3 Miscellaneous
Water for injection

27. VITAMINS AND MINERALS
Ascorbic acid
Cholecalciferol (ergocalciferol can be used as an alternative).
Iodine
Pyridoxine
Retinol
Riboflavin
Sodium fluoride.
Thiamine
Calcium gluconate.

Table 1: Medicines with age restrictions
Atropine >3 months
Azithromycin >6 months
Benzyl benzoate >2 years
Betamethasone topical preparations, hydrocortisone preferred in neonates
Cefazolin >1 month
Chlorphenamine >1 year
Clindamycin >1 month
Diloxanide >25 kg weight
Doxycycline >8 years
Efavirenz >3 years or >10 kg weight
Emtricitabine >3 months
Fluoxetine >8 years
Ibuprofen >3 months
Mefloquine >5 kg or >3 months
Metoclopramide not in neonates
Procaine benzylpenicillin not in neonates >1 month
Promethazine >2 years

Saquinavir >25 kg weight
Silver sulfadiazine >2 months
Tetracaine not in preterm neonates
Trimethoprim >6 months
Annexure I: List of exclusions

1. Hospitalisation for diagnostic work-up
   a. All endoscopies such as:
      i. Gastroscopy
      ii. Arthroscopy
      iii. Diagnostic cystoscopy
      iv. Colonoscopy
      v. Sigmoidoscopy
      vi. Breast biopsy
      vii. Diagnostic laparoscopy
      viii. Diagnostic Dilatation and Curettage (D&C)

2. Minor surgical procedures that do not require hospitalisation, including but not limited to:
   a. Marsupialisation of a Bartholin’s cyst
   b. Dilation and curettage
   c. Laparoscopic sterilization
   d. Cone biopsy
   e. Cauterisation of warts
   f. Colposcopy
   g. Tonsillectomy
   h. Nasal polypectomy
   i. Nasal cautery
   j. Meibomian cyst excision
   k. Cataract removal
   l. Bunionectomy
   m. Circumcision
   n. Drainage of superficial abscess
   o. Superficial foreign body removal

3. Hospitalisation where alternatives are available
   a. Hospitalisation is excluded for conditions / circumstances where alternative clinically appropriate options are available. These include step-down care, hospice care or rehabilitation facilities, where available.

4. Hospitalisation at a level that is not required
   a. Hospitalisation in an ICU or high-care ward where explicit clinical indications are not present must be reimbursed at the level of a standard ward.
   b. Similarly, clear medical indications must exist for hospitalisation in a private ward.

5. Alternative and/or complementary health services that are not supported by evidence-based medicine are excluded from the benefit. These may typically include the following services:
   a. Acupuncture
b. Alternative medicine  
c. Aromatherapy  
d. Ayurvedics  
e. Chiropractors, except where these services meet clinical protocol  
f. Herbalists  
g. Homeopathy  
h. Iridology  
i. Masseurs  
j. Osteopathy  
k. Phytotherapy  
l. Reflexology  
m. Traditional medicine

6. Medical or health conditions that do not meet the criteria set for essential health care Annexure A, page 20, and are typically covered in higher options
   a. Behavioural problems  
b. Chronic fatigue syndrome, myelo-encelopathy, yuppie flu  
c. Complications resulting from excluded conditions unless complication is a PMB  
d. Concentration / learning / reading problems  
e. Coordination abnormalities  
f. Costs incurred for surrogate parenting  
g. Delayed speech development  
h. Dyslexia  
i. Oral appliances specified for the treatment of headaches  
j. Posture abnormality  
k. Ptosis repairs  
l. Sexual disorders / sex changes / loss of libido

7. Consultative services and professional fees are excluded under the following circumstances
   a. After-hour consultation through member’s preference and not because of an emergency  
b. Appointments not honoured by beneficiaries  
c. Charges for interest by healthcare provider, if due to member negligence  
d. Costs incurred for medical examinations for licensing purposes, such as pilot or motor-sport licenses  
e. Fees for medical reports and motivations by any service provider, unless required by scheme  
f. Fees of services or prescriptions by the member in respect of him-/herself or any of his/her dependants  
g. Discretionary conditions and services with hospital admissions not authorised
h. NOTE: Consultations / writing of a repeat script for six months for a PMB chronic condition and other non-health related services such as motivations, requested by the scheme, must be covered.

8. Cosmetic services
   i. All cosmetic procedures / treatment / medication are excluded, except if these services are rendered to rectify the effects of defects / abnormalities due to accidents, illness or disease.
   j. The following are excluded:
      i. Cosmetics and beauty preparations
      ii. Face lifts
      iii. Genioplasty
      iv. Hair removal
      v. Periodontal plastic procedures for cosmetic purposes
      vi. Removal of scars, tattoos by salabrasion, chemosurgery or any other skin abrasion procedures
      vii. Removal of skin blemishes
      viii. The treatment of these conditions is discretionary to the scheme, and the scheme may exclude benefits for these conditions

9. Dental procedures and treatments
   a. Discretionary procedures: elective treatments and surgery for personal reasons that are not directly caused or related to illness, accident or disease, are excluded.
   b. Dental claims that are not consistent with the clinical protocols of the scheme are excluded.

10. Optometry
    a. Discretionary procedures such as surgery to correct refractive errors, other elective treatments and surgery, appliances such as spectacles and contact lenses not listed in Annexure E, page 63.

11. Facilities
    a. Healthcare facilities not related to basic life support services or not registered as a relevant health service or a healthcare facility, which may include:
       i. Chiropractic / homeopathic resorts
       ii. Clinics for the treatment of headaches
       iii. Health farm (exercise) treatment
       iv. Health resorts / spas
       v. Places of rest
       vi. Resorts for recuperative or other similar purposes
       vii. Resorts for slimming
       viii. Respite care
       ix. Stress relief clinics
b. Schemes may exclude benefits for services that are not life-supporting. Basic life-support services where applicable medical interventions occur may not be excluded from the scheme rules.

12. **Non-evidence-based medicine or the treatment of low medically necessity conditions, healthcare services with low impact on healthcare status are excluded and the following are excluded:**
   a. Adjustment of frames
   b. Chelation therapy
   c. Examination for lawsuits or similar purposes, admission to schools or universities, emigration or immigration, medical court reports, fitness examination, employment, school camp, visas, medical insurance, executive examinations
   d. Group exercises
   e. Gymnasium exercise treatment

13. **Certain pharmaceuticals are excluded**
   a. Aphrodisiacs
   b. Appetite suppressants
Annexure J: Summary of stakeholder comments on the second draft of the PMB review consultation document

All submissions were supportive of the PMB review process and grateful for the inclusiveness of the process. The stakeholders are committed and keen to participate in the BD working group and other working groups. The submissions covered comments centred on: context, benefits, primary healthcare, definitions, algorithms, access, affordability, risks / sustainability, positive / negative lists, managed care, and protocols. In addition, concerns regarding non-competitiveness of standardised guidelines, lack of a specific plan for defining the essential package, consensus and clarification of the terms evidence-based medicine (EBM) and cost-effectiveness were prominent in the submissions. Some submissions gave lengthy substantiations of their arguments using reason, clinical data, and reports. 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 K (page 104) for details).
<table>
<thead>
<tr>
<th><strong>1. Context</strong></th>
</tr>
</thead>
</table>

**Comment** *(Note that comments on the second draft are presented in red)*  

*Discovery Health* – PMB revisions should recognize that the inclusion of “less insurable individuals” in the insured pool is only one of the pertinent policy objectives of the PMB regulations. They appreciate the clearer context of the second draft, which will strengthen the realisation of access to affordable health care. They however caution that a PMB package should be designed such that it does not encourage anti-selection, option down–grading or scheme-splitting

*PIASA* - suggests that the proposed PMB standardization exercise should take notice of the implications of the limitations of cover. They need clarity on how PMB assessments will be undertaken. They are of the opinion that the exercise should focus on cost reductions of the PMBs. They need clarity on the essential health care and essential services and the principles that would be employed to realise these concepts. They need clarity as to how the principles of EBM will assist in prioritisation and rationing, as well as the actual process to be followed in the revision of the PMBs. They are also questioning the linkages to NHI in the absence of legislation.

*SASP* - Supports the inclusion of physiotherapy as part of the essential health care package. Further, motivates for physiotherapists to be recognised as first line practitioners/ “gate-keepers” as endorsed by HPCSA both in the public and private sectors and particularly in rural areas

| **PMB review steering committee response**  
*(limited to comments on second draft)* |
| --- |

The cost information and economic impact model currently developed will address these concerns. The risk of scheme splitting and option downgrading will be mitigated through the REF in conjunction with the revised benefit package, proposed efficiency discounts, limited risk rating for supplementary benefits and demarcation for low–income options.

The principles are laid out clearer in this document and draft categorical lists are attached.

Physiotherapists are included as primary care providers – the revised PMB construct makes provision for specific primary care services. BD development will included more details.
| **Comment (Note that comments on the second draft are presented in red)** | **PMB review steering committee response**  
_(limited to comments on second draft)_ |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMSA</strong> – 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. Standardization 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. The 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 &amp; transparent review mechanism is a requirement. Despite the need to ensure that PMBs are aligned with NHI, the current PMB design should reflect the needs of the current insured population. They accept that the LIMS proposal needs to be considered in the context of NHI but request clarity on the principles that will underpin that process. They are still strongly convinced that standardisation contravenes competition laws; examples given are that the system will reduce patient choice, and potentially limit provider clinical independence. Needs more information on the transitional measures that will be taken to protect patients who currently enjoy PMBs. Request a concrete framework within which EBM will be applied in the PMB review and the next plan of action.</td>
<td>The section on context in this document has been largely reviewed. The committee is of the view that standardisation will lead to improved competition.</td>
</tr>
</tbody>
</table>
| **Comment** (Note that comments on the second draft are presented in red) | **PMB review steering committee response**  
(limited to comments on second draft) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BHF</strong> – the definition of the PMB package must take place in the context of the Governments current constitutional mandate to progressively realize the right to access to 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, must not create or contribute to balances of power between providers and suppliers, and 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 would allow a review of PMBs every 2 years, mechanisms to be put in to identify problems early, monitor access etc through a Health Impact Assessment mechanism, monitor other key indicators, and ensure that administrators, managed care companies, and service providers are able to manage, collect, and submit necessary data. Low cost events must be included if they are considered to be part of an essential care package that includes PHC. Affordability must be considered in the inclusion of high cost events. They do not support the use of CDL in future, as they believe that all chronic conditions should be part of PMBs, which are equivalent to essential health care, making positive lists unnecessary. Guiding principles for the review should be prioritised as essential care including PHC, SA’s burden of disease followed by other ‘insurable events’ as prioritised by Oregon.</td>
<td>The section on context in this document has been extensively changed to reflect the importance of the protection of risk pools, the importance of recognising the difference between mandating minimum benefits in the public health and insurance environments respectively is documented in this draft.</td>
</tr>
<tr>
<td><strong>Momentum</strong> – PMBs should be offered with limits. Vague terminology such as EBM and cost benefit should be defined.</td>
<td>The document deals with the preferred PMB benefit construct and has a section on definitions.</td>
</tr>
</tbody>
</table>
| **Comment** (Note that comments on the second draft are presented in red) | **PMB review steering committee response**  
*(limited to comments on second draft)* |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arthritis Foundation</strong> - believes that LIMS should be made self-funding when decisions are made regarding the contents of baskets of care. LIMS should not be subsidised by members of other types of medical insurance packages in the same scheme. They do not believe that the current PMB review should be delayed by a lengthy political process of the proposed health sector reform (NHI).</td>
<td>The third draft of the PMB Review consultation document makes provision for possible future health policy developments. Risk cross-subsidies between existing scheme members and future LIMS members have not yet been considered in depth.</td>
</tr>
<tr>
<td><strong>SpesNet</strong> - Many medical schemes are very inefficient in implementing or communicating the full extent of the PMBs to their brokers, patients, and health care providers. Schemes exclude conditions and certain procedures, which should part of PMBs, they also have complex managed care, and administrative processes which are barriers to access to care. There should be better systems in place for arbitration of urgent PMB issues by the funding industry, patients, and providers. The PMBs should be reviewed on a regular basis as stipulated in the legislation.</td>
<td>The proposed PMB construct would improve clarity on entitlements and liabilities.</td>
</tr>
<tr>
<td><strong>Ben Broens</strong> - Agrees with the principles, which will foster should equity and efficiency. Concerns are: the emphasis placed on the catastrophic cover by the current PMBs, supplier induced demand, inadequate public health facilities.</td>
<td>This document deals with this argument.</td>
</tr>
<tr>
<td><strong>SAMED</strong> - Needs more information on the constituency of the PMB review steering committee and the manner in which interactions with stakeholders are structured. They are suggest that membership of work groups should be open to all. They are concerned that the level of limits set in the current PMBs contravene Competition Laws and propose that advice be solicited from the Competition Commission.</td>
<td>The PMB Review Steering Committee is a management body of the CMS, with members consisting of officials from the DOH and CMS.</td>
</tr>
<tr>
<td><strong>Comment (Note that comments on the second draft are presented in red)</strong></td>
<td><strong>PMB review steering committee response (limited to comments on second draft)</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Roche</strong> - Welcomes legislative framework for the continuing review of the PMBs and would suggest specified timeframes and frequency.</td>
<td>Noted</td>
</tr>
<tr>
<td><strong>PHANGO</strong> - Welcomes the broader health sector reforms (NHI) and acknowledge that it may cause elements of BDs and PMBs to change but are of the opinion that the two processes should be separated but run concurrently. Believe that DoH and CMS have failed in their mandate to review PMBs every two years. Would like to see other pieces of legislation, which affect access to health care such as the Medicines and Related Acts, mentioned in the document. Argue that SA lacks data to quantifying the burden of disease and risk and would advise that independent epidemiologic and economic studies be commissioned.</td>
<td>The third draft of the consultation document addresses this concern.</td>
</tr>
<tr>
<td><strong>NETCARE</strong> - It is their opinion that the NHI and PMB review processes are separate and the PMB review should continue with its legislative mandate.</td>
<td>The third draft of the consultation document addresses this concern.</td>
</tr>
<tr>
<td><strong>CANSA</strong> - Would like to see the PMB review separated from the broader health care reform (NHI) and the former taking precedence to address their concerns. They support the proposed changes to the legislation to allow for timely and speedy review of the PMBs.</td>
<td>The third draft of the consultation document addresses this concern.</td>
</tr>
</tbody>
</table>
## 2. Primary healthcare versus catastrophic cover

<table>
<thead>
<tr>
<th>Comment (Note that comments on the second draft are presented in red)</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMSA</strong> – supports the move to include primary care, basic dentistry, and basic optometry. They also recommended explicit criteria on aspects that constitute a PHC package as it could potentially increase costs because of quantity involved. EBM and cost factors must be considered in the definition of a PHC package. The document refers to both ‘essential and primary’ healthcare without making distinctions, they require clarity on what constitutes ‘essential healthcare’.</td>
<td>The 3rd draft of the PMB review consultation document addresses these concerns.</td>
</tr>
<tr>
<td><strong>SASP</strong> - Believes that physiotherapy should be included as an integral part of both in- and out- hospital care. The out-patient preventative and primary basket of care should include the skills and the expertise of physiotherapy. They have started developing guidelines as a matter of priority</td>
<td>Agreed and noted, details to be included in the BDs</td>
</tr>
<tr>
<td><strong>SAOSA</strong> - Welcomes the move to include basic optometry into PMB package and motivates that it should start at school going age.</td>
<td>The 3rd draft of the PMB review consultation document includes a definition of the proposed optometry benefit.</td>
</tr>
<tr>
<td><strong>PHANGO</strong> - Patients should be involved in the definition of PHC packages and the parameters for preventative care.</td>
<td>Stakeholders are free to submit proposals to the steering committee.</td>
</tr>
</tbody>
</table>
### 3. Expansion

**Comment** *(Note that comments on the second draft are presented in red)*

<table>
<thead>
<tr>
<th><strong>Arthritis Foundation</strong></th>
<th>Believes that there is need to expand PMBs to include neglected conditions to the list such as osteoporosis, clarify confusions regarding RA, and add other related RA conditions.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SpesNet</strong></td>
<td>Recognises the challenge in defining the current PMB conditions and ICD-10 codes but believes that some conditions are not fully covered or are incorrectly excluded, they advocate for the review and expansion of PMBs.</td>
</tr>
<tr>
<td><strong>Heart and Stroke Foundation</strong></td>
<td>The preventative basket of care should include risk scoring for women at risk of IHD, regular lipograms for high risk individuals and monitoring tests for side effects arising from medication.</td>
</tr>
<tr>
<td><strong>Medihelp</strong></td>
<td>Are of the opinion that REF should be implemented before the PMB list is expanded.</td>
</tr>
<tr>
<td><strong>CANSA</strong></td>
<td>BDs should cover both solid and haematological tumours and palliative care as well as oncology emergencies that can be treated by cancer modalities.</td>
</tr>
</tbody>
</table>

**PMB review steering committee response (limited to comments on second draft)**

<table>
<thead>
<tr>
<th><strong>Arthritis Foundation</strong></th>
<th>Noted, but the principles and criteria for the definition of BDs will be upheld for all conditions to be considered.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SpesNet</strong></td>
<td>The document argues that the expansion of PMBs should be aligned with the introduction of REF.</td>
</tr>
<tr>
<td><strong>Heart and Stroke Foundation</strong></td>
<td>Noted, but the principles and criteria for the definition of BDs will be upheld for all conditions to be considered.</td>
</tr>
<tr>
<td><strong>Medihelp</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CANSA</strong></td>
<td></td>
</tr>
</tbody>
</table>
### 4. Definitions

**Comment (Note that comments on the second draft are presented in red)**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Comment</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discovery Health</strong></td>
<td>The review should provide the highest level of clarity and certainty for application of PMBs. This round should aim for complete clarity on conditions and treatments in the PMB package. Entry and verification criteria, level of care, duration of care, definition of treatment failure, cost-effectiveness, and baskets of care, formularies, and protocols should be defined and published for the industry as a whole. Criteria (inclusion and exclusion) for the selection of specific conditions to the DTPs and CDLs should be clearly defined.</td>
<td>The development of BDs should address this matter.</td>
</tr>
<tr>
<td><strong>IMSA</strong></td>
<td>Current PMBs should be clarified so that scheme’s obligations are clear. A model is proposed in their submission to derive greater clarity.</td>
<td>This draft addresses this matter.</td>
</tr>
<tr>
<td><strong>SAMED</strong></td>
<td>Concerned that the definition of benefits will lead to reduction in PMB cover for beneficiaries, increase co-payments, and arbitrations. They acknowledge that the adoption of EBM will mitigate this. The definition of the PMBs should not constitute ‘minimum set of care’ but rather ‘standard care’. They request criteria to be used to establish ‘essential care/conditions should be clearly defined. The current PMBs are medicine focused and should be broadened to include all aspects of treatment.</td>
<td>The development of BD’s would address this concern.</td>
</tr>
<tr>
<td><strong>SAOSA</strong></td>
<td>Criteria for defined basic optometry are already in place and will tailor them for the definition group.</td>
<td>The third draft contains the first draft of the optometry package.</td>
</tr>
<tr>
<td><strong>CANSA</strong></td>
<td>Medical insurers currently not clear or transparent on the benefits covered in risk pools e.g. ‘unlimited funds’ for oncology often not the case.</td>
<td>This draft addresses the concerns.</td>
</tr>
</tbody>
</table>
5. Algorithms

<table>
<thead>
<tr>
<th>Comment (Note that comments on the second draft are presented in red)</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Roche</strong> – 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. Rheumatoid arthritis where several new technologies and drug classes are available, and chronic renal disease). An independent review committee could meet regularly to fulfil this function. Propose that various expert panels such as clinical and surgical professional bodies be consulted in the development of guidelines.</td>
<td>Experts will be involved in the BD development process.</td>
</tr>
<tr>
<td><strong>IMSA</strong>- Opposes EDL arguing that it is accompanied by algorithms in the state sector to ensure appropriate care rather than limit care; furthermore, principles for the development of the EDL have not been outlined.</td>
<td>The PMB definitions task group must consider this when BDs are developed.</td>
</tr>
<tr>
<td><strong>SpesNet</strong>- they believe the algorithms are outdated and in many instances, the state does not have protocols. Certain drugs are also excluded for out of hospital treatment, adversely affecting patient control.</td>
<td></td>
</tr>
<tr>
<td><strong>Heart and Stroke Foundation</strong>- Current algorithm should be modified for high risk individuals such as patients with DM to allow them access to statins and lifestyle modifications as part of PMBs. Treatment targets for cholesterol are outdated and need to be in line with current trends.</td>
<td></td>
</tr>
<tr>
<td><strong>SAOSA</strong>- Optometry algorithms are in place; there are recommended time frames (annually for children and every two years for adults-in the absence of pathology- and criteria for basic appliances.</td>
<td>The PMB definitions task group must consider this when BDs are developed.</td>
</tr>
<tr>
<td><strong>PHANGO</strong>- Does not agree that the current PMB algorithms meet treatment guidelines for most conditions; some are outdated and often misinterpreted by schemes.</td>
<td>The draft CDL algorithms are included in this draft for comments.</td>
</tr>
<tr>
<td><strong>Comment</strong> <em>(Note that comments on the second draft are presented in red)</em></td>
<td>*<em>PMB review steering committee response (limited to comments on second draft)</em></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Medihelp</strong> - Has previously submitted comments requesting the review of the PMB BD algorithm prompted by the request on circular 45 of 2006. Have experienced difficulty accessing public sector algorithm where no PMB algorithm exists. Will welcome standardised protocols for all DTPs.</td>
<td>The draft CDL algorithms are included in this draft for comments</td>
</tr>
<tr>
<td><strong>Sanofi-Aventis</strong> - They do not support the use of the EDL because of procurement and supply constraints (which are peculiar to the public sector and not necessarily accessible to the private sector) but support the CMS CDL molecule based formulary.</td>
<td>The draft CDL algorithms are included in this draft for comments</td>
</tr>
</tbody>
</table>
6. Access and affordability

<table>
<thead>
<tr>
<th>Comment</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discovery Health</strong> – 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. Council should research and publish the cost impact of proposed expansion. They welcome the proposal that the maximum reimbursement price should not exceed NHRPL.</td>
<td>The PMB review steering committee is in discussion with providers.</td>
</tr>
<tr>
<td><strong>Momentum</strong> – State protocols are not easily accessible or publicised. Should co-payments be considered?</td>
<td>The BD process will identify priority DTP conditions that will receive attention before less critical DTPs.</td>
</tr>
<tr>
<td><strong>Ben Broens</strong> – Impact of introducing PHC should be low as these costs represent only 7% of the total spend. Capping fees for PMBs as well as use of DSPs is welcomed in order to ensure affordability. A ‘vertically integrated’ and a ‘gate-keeper and referral’ system should not be viewed as inappropriate for the third-party (medical cover) system.</td>
<td>This argument is considered in the proposed PMB construct.</td>
</tr>
<tr>
<td><strong>Arthritis Foundation</strong> – They do not support capping the fee at NHRPL whilst “forcing” the patient to frequently consult specialists at frequent intervals. The patients are left to co-pay for these visits. In addition, they argue that they have mechanisms to control the costs of new technologies such as a self-regulating revolving committee made up of rheumatologists who examine applications for biologicals.</td>
<td>The benefit structure proposed in this draft makes provision for above-threshold benefits.</td>
</tr>
<tr>
<td><strong>SpesNet</strong> – Supports the payment of reasonable rates – rates which the specific health care provider would have charged irrespective of PMB condition and not necessarily the NHRPL rate.</td>
<td>The PMB review steering committee is engaging with providers and requests proposals to deal with the pricing of consultation services.</td>
</tr>
<tr>
<td>Comment</td>
<td>PMB review steering committee response (limited to comments on second draft)</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>SAMED</strong>: Proposes that the utilisation of cost-effectiveness and affordability criteria must be clearly defined in the PMB and that cost-effectiveness evaluations be done by independent agencies.</td>
<td>With the assistance of RETAP, the REF working group will deal with this issue.</td>
</tr>
<tr>
<td><strong>SAOSA</strong>: Support the use of NHRPL rates to ensure affordability</td>
<td></td>
</tr>
<tr>
<td><strong>PHANGO</strong>: Does not endorse limiting fees to NHRPL rates, as patients will be subject to balance-billing but support capping of fees. They hope that a reasonable fee can be negotiated. They would like to see the definition of cost-effectiveness negotiated and agreed upon.</td>
<td>The PMB review steering committee is engaging with providers and requests proposals to deal with the pricing of consultation services.</td>
</tr>
<tr>
<td><strong>NETCARE</strong>: Wants to clarify that they do not view PMBs as blank cheques and have instituted cost saving measures in the past such as discounting PMB related expenses. They have also been active participants in the determination of current NHRPL rates, a process that has delayed due to disagreements with methodology. A study commissioned by them has shown they would lose 15 cents for every value of Rand billed.</td>
<td></td>
</tr>
<tr>
<td><strong>Medihelp</strong>: Welcomes statutory initiatives to determine tariffs at which PMBs should be reimbursed.</td>
<td></td>
</tr>
<tr>
<td><strong>Sanofi-Aventis</strong>: Have provided a model of health technology assessment (HTA) which can be used for prioritising and assessing health interventions and technologies for inclusion in the PMB package.</td>
<td>The PMB review steering committee will consider this.</td>
</tr>
</tbody>
</table>
### 7. Risks / sustainability

<table>
<thead>
<tr>
<th>Comment (Note that comments on the second draft are presented in red)</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discovery Health</strong> – 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. A key concern still remains cost-effectiveness and sustainability; willing to provide CMS with data that may be required in this regard.</td>
<td>Careful attention to the development of the BDs could address this concern. Costs and pricing are discussed in the document.</td>
</tr>
<tr>
<td><strong>Momentum</strong>– Pricing mechanism should consider the tariff codes to be applied, the level of remuneration, define maximum tariffs, and establish whether prices would be regulated by MSA or by the NH Amendment Bill.</td>
<td>The PMB review steering committee is engaging with providers and requests proposals to deal with the pricing of consultation services.</td>
</tr>
<tr>
<td><strong>SA Society of Head &amp; Neck Surgery</strong>- Believes NHRPL rates should only be used if costed properly (which they are currently not in his opinion); believes that discounting NHRPL will lead to reimbursement rates below those of the public sector (provincial)</td>
<td></td>
</tr>
<tr>
<td><strong>NETCARE</strong>- Does not support capping prices at NHRPL rates are still actively engaging the NDoH in reviewing the 2009 price list.</td>
<td></td>
</tr>
</tbody>
</table>
8. Positive / negative lists

<table>
<thead>
<tr>
<th>Comment (Note that comments on the second draft are presented in red)</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovery Health – disagrees with using all hospital admissions excluding a negative list. Rather ensure clarity of information of members. Recognizes 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 recommend 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. Discovery is of the opinion that it is not appropriate to include CDL list in in-hospital (IH) positive list, as this would increase admission unnecessarily. Hospitalisation should only be limited to treatment that cannot be administered elsewhere or to life-threatening conditions.</td>
<td></td>
</tr>
<tr>
<td>THE requirements for the BDs deal with mechanisms to promote the use of appropriate levels and setting of care. The first draft of the negative list is included in this draft, suggestions on how to improve the list to specifically prevent unnecessary hospitalisation is requested.</td>
<td></td>
</tr>
<tr>
<td>Momentum – Caution to be exercised about including ALL in-hospital cases as this would increase the cost of PMBs. Specific definition of the conditions and services to be included essential. Affordability of the main package should be the focus.</td>
<td></td>
</tr>
<tr>
<td>The first draft of the negative list is included in this draft.</td>
<td></td>
</tr>
<tr>
<td>Arthritis Foundation - They are concerned that the positive and negative lists might leave patients without access to certain treatment needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart and Stroke Foundation - they do not endorse the use of these lists as patients might be denied access to medication because it falls under a negative list</td>
<td></td>
</tr>
<tr>
<td>Without these measures, the PMBs would simply be too costly and unaffordable. The benefit design and above threshold benefits does address some of these concerns.</td>
<td></td>
</tr>
<tr>
<td>SAMED - Does not support the use of ‘lists’ related to treatment or procedures but for the conditions included in PMBs.</td>
<td></td>
</tr>
<tr>
<td>PHANGO - Agree with principle of positive and negative lists for controlling in and out-of hospital expenditure but are concerned that the design of the lists will not be weighted in the interests of patients- want a degree of flexibility.</td>
<td></td>
</tr>
<tr>
<td><strong>Comment</strong></td>
<td><strong>(Note that comments on the second draft are presented in red)</strong></td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>IMSA</strong></td>
<td>Does not support the use of lists as these have proven to be rigid, may potentially result in the exclusion of vulnerable groups (severely diseased), hospital lists might be used by schemes to deny patients care (co-morbidities in hospital denied because they do not fall in the positive list).</td>
</tr>
</tbody>
</table>
9. Managed care and protocols

<table>
<thead>
<tr>
<th>Comment (Note that comments on the second draft are presented in red)</th>
<th>PMB review steering committee response (limited to comments on second draft)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMSA</strong> – 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. Fear that medical schemes will still impose limits through managed care in the already limited PMB package. With the implantation of REF, managed care should be evaluated so that it is cost-effective and affordable. Protocols and processes of managed care (often viewed as intellectual property of the MCO) should also be transparent and open to public scrutiny.</td>
<td>The committee is of the view that managed care tools should be applied to PMBs and that a standardised package must be developed.</td>
</tr>
<tr>
<td><strong>Momentum</strong> – PMBs should be limited to a maximum rate of NHRPL. PMBs should include guidelines for developing ‘SEPs’ for non medication benefits. A ‘case rate’ should be considered for standard procedures to prevent padding of the accounts. MCC should be requested to register a medication for a specific condition.</td>
<td>This document suggests a framework to deal with costs and pricing, “alternative reimbursement” strategies are supported and may in future support the development of BDs.</td>
</tr>
<tr>
<td><strong>PIASA</strong>-They are concerned that “cost-effectiveness” in the criteria for managed care regulations does not appear in the over-arching principles set out in part 4.1 but is mentioned for condition-specific PMBs and other health technologies. They suggest that the related terms of ‘affordability and pricing’ used throughout then report should be defined and not be restricted only to medicine but to other health interventions. They are also questioning whether cost-effectiveness analysis will be determined by schemes or by the Council</td>
<td>Noted, the definition of essential health care refers to cost-effectiveness.</td>
</tr>
<tr>
<td>Comment</td>
<td>PMB review steering committee response (limited to comments on second draft)</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>SASP</strong>- the guidelines for the management of stroke and COPD are the final phase of development. They will await guidance from the CMS on how their input will be incorporated in the next phase of the PMB review.</td>
<td>The CMS will include the SASP on the relevant PMB working groups.</td>
</tr>
<tr>
<td><strong>SpesNet</strong>- Instead of promoting pharmaceutical formularies for PMB conditions, they suggest costing or attaching a monetary value to each condition and leaving the patient and service provider to discuss best treatment options before deciding on the financial considerations and co-pays. Schemes appoint DSPs (especially state institutions) without ensuring access and availability for the patients and penalise them for non-compliance. SpesNet is of the opinion that schemes should detail the capacity of the DSP in the SLA.</td>
<td>The proposed PMB benefit construct is incorporated into this draft of the document.</td>
</tr>
<tr>
<td><strong>SAMED</strong>- Are concerned that schemes and MCO will impose further limits to the PMBs through their contracted agents and suggests that they should not be allowed to override standards set by CMS.</td>
<td>The CMS will monitor compliance with regulations.</td>
</tr>
<tr>
<td><strong>Sanofi-Aventis</strong> - Are critical of the current regulations that give medical schemes and their contracted agents (managed care organisations) the responsibility to develop criteria used to assess cost-effectiveness</td>
<td>Noted.</td>
</tr>
<tr>
<td><strong>CANSA</strong>- Current PMB does not address scientifically best practise modules for the treatment of cancer- therefore urge for the development of EDL for cancer care to include drugs such as rituximab, imatinib, and capecitabine, which have been proven to be cost-effective</td>
<td>The teams working on the development of BDs will consider these statements.</td>
</tr>
</tbody>
</table>
## 10. Benefits

### Comment  *(Note that comments on the second draft are presented in red)*

<table>
<thead>
<tr>
<th><strong>Roche</strong> – conditions covered as PMBs should not be restricted only to high profile infectious diseases but should also include asymptomatic diseases (e.g. Hepatitis C). Similarly, patients with conditions representing a low burden disease should not be penalised with co-payments.</th>
<th><strong>PMB review steering committee response (limited to comments on second draft)</strong> This document specifies the objectives of the PMBs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PIASA</strong>: The vagueness of ‘medical and surgical management’ of DTPs lends itself to uncertainty as what is covered under PMBs for beneficiaries. PIASA further argues that the lack of clarity, information, and transparency of medicals scheme rules exacerbate confusion. They do not believe that standardisation of current PMBs will resolve the issue but rather EBM, risk–sharing between providers and schemes as well as outcomes-based systems will provide better outcomes.</td>
<td>The development of BDs should address this concern.</td>
</tr>
<tr>
<td><strong>CANSA</strong>: Schemes should clearly define benefit structure and desist from using ‘unlimited’ oncology benefits, which are often misleading.</td>
<td>The development of BDs should address this concern.</td>
</tr>
</tbody>
</table>
## Annexure K: List of stakeholders who have submitted comments on the second draft of the PMB review consultation document

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Comments available at:</th>
</tr>
</thead>
</table>