CANSA
Cancer Association of South Africa

Research • Educate • Support

Toll-Free 0800 22 66 22
www.cansa.org.za

HEAD OFFICE
Bedfordview

+27 11 616 7662 Tel
+27 11 622 3424 Fax
26 Concorde Road West Address
Bedfordview, 2008
PO Box 2121 Postal
Bedfordview, 2007

11 February 2016

Attention: Mr Sipho Mtombeni

55 Meintjies Street
Block 2A
Trevenna Campus
PRETORIA

THE CANCER ASSOCIATION OF SOUTH AFRICA: ORAL SUBMISSION

Cancer is part of the non- communicable diseases that requires priority intervention in South Africa. The overall burden of cancer and the quality adjusted life years (QALY) and disability adjusted life years (DALY) in South Africa are unknown and therefore present a risk, in that it is, and remain under-serviced.

Health legislation and policy is focusing on most aspects in addressing the healthcare burden as outlined in the Medical Schemes Amendment Bill, National Health Amendment Bill, and the Medicines and Related Substances and Amendment Bill.

While we wholeheartedly endorse any initiative aiming to reform healthcare in South Africa, we are firmly of the opinion that the macro process cannot be allowed to prevent the continuation of the PMB review process as originally envisaged. Patients have already waited too long for the Council for Medical Schemes (CMS) to fulfil its current mandate of Prescribed Minimum Benefit Review (PMB) reviews. The final resolution of the macro reform initiative is years away, with possible policy changes along the way as South Africa's political landscape unfolds. It is simply not tenable for patients to wait, while an as yet unclear process gets under way, for the CMS to review the current PMBs.

Benefit design terminology such as "treatable" should be re- defined. In the explanation for treatable cancers, it states that the cancer must only:

- involve the organ of origin,
- have no evidence of metastatic spread,
- have not, by means of compression, infarction, or other means, brought about irreversible and irreparable damage to the organ within which they originated,
- if, this does not apply, there should be a well demonstrated five year survival rate of greater than 10% for the given therapy for the condition concerned

Patients diagnosed with metastatic cancer are excluded according to the legal interpretation of this definition, it also does not explain lymphatic spread which is often the case. In the case of cancer of unknown origin there are no terms of reference. This is a serious oversight and in conflict with the National Health Act and the Constitution.

CANSA agrees with the South African Oncology Consortium Policy Statement released in November 2007 that the term '*Ttreatable" cancers' cannot be used as a motivation to deny patients adjuvant or definitive therapy; spread to draining lymph nodes cannot be interpreted as "adjacent organs", as lymph nodes are not considered organs. The use of adjuvant or definitive chemotherapy and radiotherapy has had a profound effect on survival in such instances e.g. anal, breast, cervix, colorectal, endometrial, gastric, head and neck, or nasopharynx carcinoma'.*

"Broker services", as defined in the Medical Schemes Act should be highlighted in the PMB construct to ascertain clear, concise information transfer is adhered to when members are recruited, oncology benefits, especially, are said to be "unlimited" ,this creates anxiety and helplessness in already stressful situations for patients when clinically appropriate treatment is declined by medical insurers.

The management of symptoms and the therapeutic management of pain in adults and children are key elements that require attention in respect of the Prescribed Minimum Benefits (PMB).

Consideration for oncological emergencies related to metabolism, obstruction, and treatment must be given to be included in the PMB. Risk based cross subsidies are essential in cancer as every individual diagnosed with cancer have unique a disease profile. Medical schemes should have effective control mechanisms in place to address efficiency through risk adjustment. Individuals should not be excluded from care due to benefit design and risk pool exclusion, especially for persons with pre- existing conditions.
We agree that patients to whom PMBs apply must not be compromised. In truth however, they already have.

CANSA supports the National Department of Health engagement with stakeholders to align the National Health Insurance (NHI) and PMB initiatives, however, it is subject to the legislative processes and necessitates for the PMB to be adjusted to include the listed concerns.

We support the principles and objectives of the PMB in the goal to enable equitable, cost effective access to care ensuring maximum quality of life for cancer patients. However, this should be reflected in the Benefit Design (BD) to cover both solid and haematological tumours and palliative care as well as oncological emergencies that can be effectively treated with cancer treatment modalities.

In the control of moral hazard and cost escalation, protocol development is essential. CANSA advocates for prevention and cancer control strategies that will significantly reduce cost in cancer care. Moral hazard control should be driven through expert, experienced, managed care practice in oncology. High cost events should be improved by consultative processes for the best interest of the cancer patient with evidenced based, cost effective medicine. Provision should be made for ongoing diagnostic and monitoring processes. The majority of medical schemes do not have a specific oncology disease management approach. Patients are often stranded with depleted radiology or pathology benefits and instances occur when no benefit is allocated for nuclear medicine in the event of a patient requiring a bone scan for the detection of metastases. CANSA recommends a comprehensive minimum allocation by means of an disease management oncology plan.

Yours sincerely

Magdalene Seguin
CANSA: Head Advocacy