Oral Submission to the Competition Commission 18 February 2016

Cancer forms part of non-communicable diseases. It requires priority intervention in South Africa – especially so in the absence of a South African Cancer Control Programme.

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 and also remains under-serviced.

According to the South African National Cancer Registry (2010), the following number of cancer cases were histologically diagnosed during 2010:

All Males	27 132
All Females	29 762
Combined Total	**56 894**

To support the above statistics, I would like to leave with the Commission CANSA's Fact Sheet on the Top Ten Cancers per Population Group.

Legislation was introduced by Dr Aaron Motsoaledi, Minister of Health, on 26 April 2011 which requires all doctors and health facilities that confirm cancer cases to report their findings to the National Cancer Registry. This means that the cancer statistics for 2010 is incomplete and a more accurate reflection will only become available with the publication of the 2012 cancer statistics by the National Cancer Registry:

- Practically all cancer diagnoses made in the private sector do not form part of the statistics quoted above
- Also, only cancer diagnoses that were confirmed histologically form part of the statistics quoted above

Health Legislation and Policy focuses on most aspects in addressing the healthcare burden as outlined in the:

- Medical Schemes Amendment Bill
- National Health Amendment Bill
- Medicines and Related Substances Control Amendment Bill

The Cancer Association of South Africa (CANSA) wholeheartedly endorses any initiative aimed at reforming health care in South Africa. CANSA is of the opinion that the macro process cannot be allowed to prevent the continuation of the Prescribed Minimum Benefits (BMB) 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. 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. CANSA believes that it is simply not tenable for patients to wait while an, as yet unclear process, gets under way for the Council for Medical Schemes to review the current Prescribed Minimum Benefits.

Benefit design terminology is problematic. Terminology such as "treatable" should be re-defined. In the explanation for treatable cancers, it states that 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

This means that patients diagnosed with metastatic cancer (cancer that has already spread) are excluded according to the legal interpretation of this definition. Cancer that has spread by means of the lymphatic system or blood circulation is also not explained.

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 of South Africa.

According to the National Cancer Registry of 2010, “cancer of unknown origin” is the second most diagnosed form of cancer in men and the third most diagnosed form of cancer in women.

- Cancer of unknown origin in men 1 528
- Cancer of unknown origin in women 1 465

Top support this, I would like to leave with the Commission, CANSA’s Fact Sheet on the Top Ten Cancers per Population Group which was already referred to earlier as well as the CANSA Fact Sheet on Cancer of Unknown Primary (CUP).

The Cancer Association of South Africa agrees with the Policy Statement released in November 2007 by the South African Oncology Consortium which states:

“The term “treatable 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 Prescribed Minimum Benefit construct to ascertain clear, concise information transfer and adhered to when members are recruited.

Oncology benefits are usually said to be ‘unlimited’ – this is clearly not the case. 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 diagnosed with cancer, are key elements that require attention in respect of Prescribed Minimum Benefits. In support of this, I would like to leave with the Commission CANSA's Fact Sheet on Pain Control in Cancer.

Consideration for oncological emergencies related to metabolism, obstruction, and treatment must be included in the Prescribed Minimum Benefits.

Risk-based cross subsidies are essential in cancer as every individual diagnosed with cancer has a unique 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.

The Cancer Association of South Africa supports the notion that patients to whom Prescribed Minimum Benefits apply, must not be compromised. In truth, the already are compromised.

The Cancer Association of South Africa supports engagement with stakeholders by the National Department of Health to align the National Health Insurance and Prescribed Minimum Benefit initiatives. However, it is subject to the legislative processes and necessitates for the Prescribed Minimum Benefits to be adjusted to include the concerns that have been mentioned.

The Cancer Association of South Africa supports the principles and objectives of the Prescribed Minimum Benefits in its goal to enable equitable, cost effective access to care, ensuring maximum quality of life for all cancer patients. However, this should be reflected in the Benefit Design to cover:

- solid and haematological tumours;
- palliative care; and
- oncological emergencies

that can be effectively treated with cancer treatment modalities.

Protocol development is essential in the control of moral hazard and cost escalation. The classic model of moral hazard suggests that health insurance may reduce preventive care because the insurer will pay for part of the treatment in case of disease. The Cancer Association of South Africa 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 practices in oncology.

High cost events should be improved by consultative processes towards the best interest of cancer patients with evidence-based, cost-effective medicines.

Provision should be made for ongoing cover for 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. 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 (spread of cancer). As far as this is concerned, the Cancer Association of South Africa recommends a comprehensive minimum allocation by means of a Disease Management Oncology Plan.

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