CANCER ALLIANCE

Collective Voices for Cancer in South Africa

Cancer Alliance submission on the National Health Insurance Bill (B11-2019)

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28 November 2019

Response by the Cancer Alliance to the invitation by the Portfolio Committee on Health to submit written submissions on the National Health Insurance Bill (B11-2019).

Note: This document is to be read in conjunction with the document **Comments submitted by the Cancer Alliance on the White Paper issued 10 December 2015 - Version 40** submitted on 31st May 2016.

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1 Introduction

The Cancer Alliance is a collective group of 30 cancer control non-profit organisations and cancer advocates brought together under a common mandate, to provide a platform of collaboration for cancer civil society to speak with one voice and be a powerful tool to affect change for all South African adults and children affected by cancer.

The **NHI Bill** provides for a new central funding mechanism as well as a new basis on which health care services will be provided. No detail is provided at this stage of the actual services to be provided, making it difficult to comment on the impact of the **NHI Bill** on cancer patients. Nevertheless, we have provided general comment on areas of concern, and draw attention to some areas which affect cancer treatment.

2 Purpose of the Bill

2.1 Objectives

We recognise and applaud the summary objectives of the Bill as stated:

> *"To achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution;*
> *to establish a National Health Insurance Fund and to set out its powers, functions and governance structures;*
> *to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users;*
> *to create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population;*
> *to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users;*
> *and to provide for matters connected herewith."*

and further as stated in the Preamble:

> *"(To)*
>
> - *achieve the progressive realisation of the right of access to quality personal health care services;*
> - *make progress towards achieving Universal Health Coverage;*
> - *ensure financial protection from the costs of health care and provide access to quality health care services by pooling public revenue in order to actively and*

strategically purchase health care services based on the principles of universality and social solidarity;

- *create a single framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate the fragmentation of health care funding in the Republic;*
- *promote sustainable, equitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system; and*
- *ensure continuity and portability of financing and services throughout the Republic"*

3 Review of our previous submission of 31 May 2016

We refer to our previous submission ***Comments submitted by the Cancer Alliance on the White Paper issued 10 December 2015 - Version 40*** submitted on 31st May 2016.[1]

We submit that many of the concerns which were raised in this submission have not changed. In particular, the following are still of concern:

3.1 The current Bill again fails to address the special needs of cancer patients

The words 'cancer' and 'oncologist' do not appear anywhere in the Bill, and 'oncology' appears only once. The services to be provided to users of the **NHI** are not described in any way, and are to be determined by a future **Benefits Advisory Committee**.

We repeat our view that cancer, by its very nature, requires a specific approach from end to end of the health system, to prevent cancers where this is possible or practical, to early identification and detection, proper diagnosis and staging, rapid referral to levels at which it can be immediately treated, modern and effective treatment protocols, follow-up and attention to the concomitant problems which accompany a cancer diagnosis for the patient, his or her family and dependents, and employer, and provision of palliative care if this should become necessary.

[1] NHI White Paper, Comments from Cancer Alliance - Final - 31 May 2016, downloaded from https://canceralliance.co.za/official-documents/

We are particularly concerned that in striving to achieve **Universal Health Coverage** and providing "*necessary quality health care services free at the point of care*" (Section 6(a)) while "*... performing its functions in the most cost-effective and efficient manner possible (Section 10(2))*" the Bill will result in a system which provides only the most basic and immediate health services to users, and will be unable to provide for the complex services required by cancer patients.

3.2 Success of the NHI depends on adequate funding and management

All our previous comments still apply, and since then the outlook for the country to be able to afford even the minimal additional funds required to introduce the **NHI** system has substantially deteriorated. This adds further weight to our concerns in 3.1 above.

Some additional comments regarding financing of the NHI are included in later sections.

3.3 Planning for the NHI depends critically on availability of information

We previously raised concern at the lack of useful information on which to base health systems planning. In the three years since our previous submission there has been virtually no improvement in the information available regarding cancer incidence or mortality. At date of writing, the latest cancer incidence report from the **NCR** is for 2014; the most recent report from **Stats SA** on **Mortality and Causes of Death** is in respect of 2016. Both of these reports provide an incomplete picture of cancer in SA: The **NCR** reports suffer from undercounting; while the **Stats SA** reports indicate difficulty in obtaining exact causes of death.

One clear indicator which points to the lack of information can be found in the age standardized rate for cancer: According to the **World Cancer Research Fund**[2], the age-standardized rate for all cancers worldwide (including non-

[2] World Cancer Research Fund, Global cancer data by country. Retrieved 2019-11-08 from https://www.wcrf.org/dietandcancer/cancer-trends/data-cancer-frequency-country

melanoma skin cancer) for men and women combined was 197.9 per 100,000 in 2018. However, globally it is seen that rates are highest for countries with well-developed surveillance systems, with the top 50 countries ranging from Australia (469.0) down to Israel (233.6). The rates published by the **NCR** (2014)[3], excluding BCC and SCC of the skin, are 131 for men and 112 for women. If BCC and SCC figures were to be added these rates would rise by some 30-40% but would not even reach the world average, indicating that not all cases of cancer are being counted.

We note that Section 10.(1) - Functions of Fund - includes various functions relating to information, particularly:

> *(a) collate utilisation data and implement information management systems to assist in monitoring the quality and standard of health care services, medicines, health goods and health related products purchased by the Fund;*
> *...*
> *(o) undertake research, monitoring and evaluation of the impact of the Fund on national health outcomes;*
> *...*
> *(q) maintain a national database on the demographic and epidemiological profile of the population;*

In our view these functions are not adequate to assist in planning for cancer services and should be improved.

3.4 NHI success will be critically dependent on the development of human resources

We once again affirm our view that the development and retention of human resources is critical to the success of the **NHI**, and many of the points made previously are still relevant.

In particular, we are concerned that aspects of the **NHI Bill** could have unintended side effects leading to further losses of critical human resources. This is covered in more detail further below.

[3] National Cancer Registry, Cancer Statistics, from http://www.nicd.ac.za/centres/national-cancer-registry/

3.5 Serious challenges in existing healthcare services

We reiterate our listing of major problems within the existing healthcare services, and particularly the special considerations which apply to cancer management and control.

Since our last submission a series of strategic plans and policies have been compiled and approved; however, application of these within the existing health care system has been sparse if at all. These include:

- The **National Cancer Strategic Framework for South Africa – 2017-2022**
- **National Policy Framework and Strategy on Palliative Care 2017 – 2022**
- The **Breast Cancer Control Policy - June 2017**
- The **Cervical Cancer Prevention and Control Policy - June 2017**

We submit that until achievement of specific goals within all of these strategies and policies is used as input to individual performance measurements for affected management staff these policies will not be implemented.

Further comments are provided in Section (4) below.

3.6 Traditional Healers omitted

We remain concerned that Traditional Healers (Traditional Health Practitioners) are not included in the plans for the **NHI**. Only two references appear in the **Bill**, and these relate only to the **Traditional Health Practitioners Act, 2007 (Act No. 35 of 2007)** which is mentioned under "*Applicable Legislation*".

We reiterate the potential importance of traditional healers; on their pervasive influence on society; and also on the number of people who consult a traditional healer in place of, or in addition to the formal health sector. Traditional healers, suitably included in the health structure, could provide an invaluable resource to provide early warning information on the signs of cancer, as well as assisting with early detection of cancer in both adults and children.

3.7 Stigma omitted

We previously noted that patients are subject to severe effects from stigma; whether in the family, the community or in the workplace. Apart from the psychosocial problems, this can and does have serious consequences for presentation for treatment, adherence to treatment, etc.

In addition, stigma is one of the biggest challenges in identification, reporting and treatment of childhood, young adult and adult cancers.

As currently conceived, the **NHI Bill** relates only to healthcare services provided to users - IE: Patients who have a medical problem and present themselves for treatment. However, the effects of stigma are pervasive, and can have the effect of preventing or delaying presentation at a clinic or other health care centre. We submit that the activities performed by the **NHI** should be extended to include education of a general nature to citizens who are not yet patients. We submit further that it is critical for many medical conditions, and for cancer in particular, to conduct activities to encourage and support the early detection of serious illness, both to improve outcomes and to reduce costs of treatment.

3.8 Comments relating to lifecycle stages in Cancer Control

Much of our previous commentary on issues relating specifically to cancer is still highly relevant. We will repeat only the headings here:

- Research and information are key requirements
- Balance between cancer prevention and curative activities
- Awareness and education
- Cancer screening
- Entry point at PHC level and Referral
- NHI Benefits Advisory Committee
- Expanding access to various services
- Ward-Based Primary Health Care Outreach Teams (WBPHCOTS)
- Integrated School Health Programme (ISHP)
- Contracting private health care providers

3.9 Palliative care

We welcome the recognition of palliative care as an integral part of **Primary Health Care** and **Universal Health Coverage** as defined by the **World Health Organization**.

All of our previous comments are still relevant.

4 Current issues

It is agreed that there are many shortcomings within our health systems. The following summaries show the significant differences between the experience of users of the public vs the private health sectors. In the public sector the majority of issues are related to difficulties in obtaining satisfactory health services, while the predominant focus in the private sector is on cost.

4.1 Within the public health sector

The following are noted as experienced by users (patients):

- Long queues
- Bad staff attitudes
- Drug stock outs
- Dilapidated infrastructure
- Little control over treatment decisions
- Long waiting times for diagnosis and treatment
- Treatment far from home or job, with many patients travelling across provincial borders
- Costs of travel and subsistence while under treatment
- Effect on jobs
- Stigma

while some underlying reasons include:

- Inefficient management
- Ineffective referral pathways
- Staff shortages
- Shortages of relevant medical equipment especially Radiation Oncology
- Untrained staff

- Budget constraints
- Corruption / mismanagement

4.2 Within the private health sector

The recent final report of the **Health Market Inquiry**[4] provides a detailed view of the South African private healthcare market. A short list of the major findings includes:

Experienced by users (patients):

- High and rising costs of healthcare and medical scheme cover
- Complex and confusing medical aid options
- Disempowered and uninformed consumers
- No measurement of quality and health outcomes, so both the public and practitioners cannot compare outcomes or benchmark performance

Some underlying factors include:

- Significant overutilization without demonstrable improvements in health outcomes
- Highly concentrated funders and facilities markets
- General absence of value-based purchasing
- Little regulation
- Failures of accountability
- Inadequate stewardship of the private sector
- Lack of effective competition
- Lack of scrutiny of quality of services
- No reliable information regarding number and location of practitioners
- The 2004 Competition Commission prohibition on collective negotiating created a price vacuum
- Multidisciplinary teams absent from the market
- Utilization rates are higher than can be explained by the burden of disease / population
- Excessive utilization is a significant driver of healthcare costs

[4] Health Market Inquiry, Final Findings and Recommendations Report, September 2019. (PDF) download from http://www.bhfglobal.com/download/b123a1f9-6be3-e911-80e0-26b84cd77d1f

5 How will the NHI address these issues?

5.1 Understanding the NHI Bill

Our understanding of the **NHI Bill** at a high level is as follows:

1) The Bill describes two concepts:
   a. The creation of a new fund, **the NHI Fund**, to act as the single purchaser and single payer of health care services, and
   b. The creation of a **new structure** for the delivery of health services in South Africa;
2) The Bill will apply to all health establishments in South Africa, excluding military health services and establishments.
3) The Bill extends coverage of health services to all citizens, permanent residents, refugees and certain other categories of users, with some exceptions.
4) All services will be provided free to registered users at the point of care, subject to some conditions relating to use of appropriate access points and adherence to prescribed referral pathways.
5) The services provided will be determined by a new body, the **Benefits Advisory Committee**, as well as the **Formulary**, comprised of the **Essential Medicine List**, the **Essential Equipment List** and an (unnamed) list of health related products used in the delivery of health care services.
6) The prices of all health service benefits will be recommended to the Fund by a new body, the **Healthcare Benefits Pricing Committee**.
7) A new **Stakeholder Advisory Committee** is described (but its function and responsibilities are not defined.)
8) The **NHI Fund** is given extensive powers and responsibilities to procure, deliver, monitor and control all health care services and contracted service providers.
9) The Minister is given responsibility for delineating the respective roles and responsibilities of the **NHI Fund** and the national and provincial departments.
10) The role of the Department (the **NDOH**) remains as outlined in the **National Health Act** and the **Constitution**.

11) Once **National Health Insurance** has been fully implemented medical schemes may only offer complementary cover to services not reimbursable by the **Fund**.
12) Some detail is provided regarding the way in which **Primary Health Care** will be provided and managed. (Descriptions of the **District Health Management Office** and the **Contracting Unit for Primary Health Care**.)
13) The main sources of income for the Fund are briefly described as follows:
    a. Various taxes, part from general tax revenue and possibly part from additional taxes to be levied to fund the **NHI**, and
    b. Reallocation of funding for medical scheme tax credits towards the funding of the **NHI**.

5.2 Substantial new responsibilities and activities

The **Bill** describes the creation of many new responsibilities, committees, organizational structures and activities which will be required to give effect to the **NHI Bill**. It also includes some restructuring, particularly in relation to moving responsibilities, activities and funds from provinces to the **NHI.**

It is important to note that much of this work will have to be completed before the **NHI** can go live. New functions, responsibilities and structures will require new expenditure, which cannot be provided from existing funds. This new expenditure will have to be provided in advance of actual introduction of the **NHI**.

One example: Substantial work will have to be completed in defining, structuring, documenting and costing of the new health care services to be provided, and this will expend time and funds.

Successful implementation of the **NHI** will depend heavily on successful completion of this work.

5.3 Funding

5.3.1 Sources of funding

Mention is made of "mandatory prepayment" to support the funding requirements of the **NHI**. Bearing in mind that all monies will be allocated by Treasury from general taxes received and will be subject to the **Public Finance Management Act** there does not seem to be any change from the current situation, in which funds are made available by annual allocations, and the normal rules for control and administration of these funds will apply.

It is understood that funding will basically come from two sources:

1. Various taxes, part from general tax revenue and possibly part from additional taxes to be levied to fund the **NHI**, and
2. Reallocation of funding for medical scheme tax credits towards the funding of the **NHI**.

5.3.2 Diverting the provincial equitable share

The shifting of funds from the provincial equitable share and conditional grants into the **Fund** produces no new funding - it merely moves control of these amounts from the provinces to the **NHI Fund**, controlled by **NDOH**.

5.3.3 Reallocation of medical scheme tax credits

Currently the funding of medical scheme tax credits appears as a rebate on the tax payable by each taxpayer who is a member of a medical scheme, and is experienced by Treasury simply as a reduction in personal income tax received.

In its previous guise in the form of medical expenses allowed as deductions against taxable income, and now as medical tax credits against tax payable, this was introduced as a subsidy to encourage taxpayers to become members of a medical aid fund, so encouraging taxpayers to purchase a form of insurance where risk is shared, as well as removing some load from the public health system.

Removal of the medical scheme tax credits will result in an ongoing cost to taxpayers who are members of medical schemes. However, once it is removed the value of this tax credit will be delinked from individual tax payers and it will be difficult to calculate a conceptual value each year. It will then be simply included within general tax revenue, and (presumably) incorporated into the money appropriated annually by Parliament for Health services.

We are concerned about the consequences of removing the medical scheme tax credits in order to provide for part of the costs of the **NHI**, for two reasons. We refer to the research note **Medical Scheme Tax Credits and Affordability** published by Dr Paula Armstrong and Econex, widely available for download.[5]

1. In 2014/15, the total amount paid to the principal members of medical schemes in the form of medical scheme tax credits was approximately R18.5 billion. In the last 5 years the total value of tax credits granted will have increased substantially, notwithstanding that the monthly medical scheme tax credit has been recently increased at less than the rate of inflation, with no increase in the 2019-2020 tax year.

   As noted in the research note it is difficult to assess the exact effect of withdrawing the medical scheme tax credits. With some assumptions, the most likely result is summarised as follows:

   > *"Removing the rebate will likely have the effect of rendering medical scheme membership unaffordable to 22% of current beneficiaries, with the impact falling largely on poorer medical scheme beneficiaries."*

   Based on an estimated 8.9 million medical aid beneficiaries this would remove some 2 million beneficiaries from cover by medical aid funds, and they would either have to revert to the public health system, further overloading it, or pay directly for their medical needs as and when these arise, IE: Without the benefit of mutual insurance, Etc.

2. As mentioned above, the **NHI** cannot be expected to come into operation before a large amount of preliminary work is completed. Indeed, the

[5] Dr Paula Armstrong, Research Note: Medical Scheme Tax Credits and Affordability. Downloaded 11 November 2019 from http://www.mm3admin.co.za/documents/docmanager/f447b607-3c8f-4eb7-8da4-11bca747079f/00126407.pdf

Transitional Arrangements described in Section 57 show that the **NHI** will not come into full operation before 2022 at the earliest and probably not before 2026.

We believe it is therefore unconscionable for the medical scheme tax credits to be withdrawn so early in the process, with adverse effects largely falling on poorer medical scheme beneficiaries a full six years before the **NHI** comes into operation.

5.3.4 Access to current discretionary spend on private medical services

The **NHI Bill** makes mention of "*Equity*", "*pooling of funds*", "*pooling public revenue*", and "*mandatory prepayment*".

In Section 33 - Role of medical schemes - we read:

> *"Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund."*

Section 3 - Application of Act - infers that the **Bill** will apply to both public and private health establishments with the following"

> *"This Act applies to all health establishments, excluding military health services and establishments"*

Although not mentioned in the **Bill** itself, other statements and comments by various people lead to a general view that once the **NHI** is in full operation all users will be expected to receive their medical services via the **NHI**, and there will be no place for any private health care services.

Attention is drawn to the wide disparity between the public health care expenditure of approximately R 222 billion pa, covering 85% of the population, and the approximate R 250 billion pa (estimated) expended by the remaining 15% of the population. It is theorized that redistribution of the total of these two amounts to the total population would be more equitable and would allow substantial improvement of the resulting single health system.

We examine this briefly as follows:

If we assume that 100% of the private healthcare expenditure could be reallocated in this way we get the following numbers:

	Expenditure	Population	Cost / person
	R billion	Millions	R / Year
Public	222	49.9	4 449
Private	250	8.9	28 090
Total	472	58.8	8 027

From this table we see that expenditure per capita in the private sector is over ***six times*** that of the public sector. Two important consequences of this are:

(1) Even if one allows for a certain amount of over-servicing in the private sector this points to a dramatic difference between the levels of service in the public and private health care sectors; and

(2) Redistributing all funds evenly could only bring the average expenditure/person to around R 8000 pa, resulting in a combined service level nowhere near to the current private service level.

The second point above is backed up by this comment by the Minister:

> *"It will still not be adequate to say the amount that we're currently spending on health in the public sector and the one that we're spending on the private sector, that the sum total of the two is enough to run the NHI. I think we need more. "*[6]

Imposing such a draconian change would therefore have the following effects:

- The 15% of the population able to afford private health care, whether via a medical aid scheme or private funds, will constitute the top economically active part the population.
- While many will agree that the present system is inequitable, and will support the concept of improving the public health system, they will not accept such a radical reduction in healthcare services.

[6] Minister Mkhize, Daily Maverick: The shot-caller and the NHI: Can Zweli Mkhize pull this off? https://www.dailymaverick.co.za/article/2019-08-30-the-shot-caller-and-the-nhi-can-zweli-mkhize-pull-this-off/

- Those at the higher income levels will be able to pay additional amounts in order to maintain their health services at previous levels.

- However, those with lower incomes will find additional expenditure difficult and will suffer a reduction in service levels. IE: Those who are currently marginally covered will be the first to fall out of coverage - and add to the numbers which must be served by the **NHI** - similar to the argument related to withdrawal of the Medical Scheme Tax Credits described above.

Perhaps two final points should be made:

(1) The amounts expended by those covered by the private sector are entirely voluntary payments made over and above all normal contributions to income and other taxes, i.e.: Over and above their contributions which support the public health sector. These amounts are paid entirely from after tax income. Apart from the Medical Scheme Tax Credits these amounts are not in any way under the control of Treasury.

(2) Attempts to limit the way in which individuals decide to provide for their own health care could have many unintended consequences: Apart from forcing individuals to accept a lower level of health care, this could lead to the destruction of much of the private and public health care sectors, for reasons which have been widely discussed by others.

5.3.5 Comparison between funding by the State and by medical aid schemes

The **NHI Bill** aims to

> "*ensure financial protection from the costs of health care and provide access to quality health care services by pooling public revenue...*" and "*promote sustainable, equitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system;*".

Although mention is made of "*social solidarity*" meaning "*providing financial risk pooling to enable cross-subsidisation between the young and the old, the rich and the poor and the healthy and the sick*" it must be noted that all expenditure by the **NHI Fund** will nevertheless be required to take place within the confines of the **Public Finance Management Act**. Without going into the details, this Act and others will basically restrict the **NHI Fund** to only spend funds which it is granted for the current financial year, or for approved capital

projects. This could have serious consequences if expenditure for any health care services, medicines, supplies, goods etc exceeds the funds available in any one fiscal year. For example, this could lead to medicine stock-outs towards the end of the year until the following year's funds become available.

No mention is made of the creation of any reserves which could be built up to deal with such a situation - which would have serious consequences for affected users.

Contrast this with the medical schemes, which are obliged by legislation to build up large reserves to tide them over the inevitable peaks and valleys in expenditure, and cover the overall risk of providing health care services.

We recommend that this aspect be investigated and methods included for dealing with the possible adverse effects of adherence to the PFMA.

5.4 Addressing current issues in the public health sector

We noted previously the following short list of current issues experienced by users (patients) in the public health system:

- Long queues
- Bad staff attitudes
- Drug stock outs
- Dilapidated infrastructure
- Little control over treatment decisions
- Long waiting times for diagnosis and treatment
- Treatment far from home or job, with many patients travelling across provincial borders
- Costs of travel and subsistence while under treatment
- Effect on jobs
- Stigma

and noted that some underlying reasons include:

- Inefficient management
- Ineffective referral pathways

- Staff shortages
- Untrained staff
- Budget constraints
- Corruption / mismanagement

We noted also that the **NHI Bill** at the highest level describes two concepts:

a. The creation of a new fund, **the NHI Fund**, to act as the single purchaser and single payer of health care services, and
b. The creation of a **new structure** for the delivery of health services in South Africa;

Thus the main focus of the **NHI Bill** is the creation of the **NHI Fund** and everything that that requires, as well as the mechanisms for the definition, creation and use of the new services to be provided.

We are concerned at the lack of linkage between the **NHI** concept and the issues as experienced by patients. One could attempt to explain some of the current issues as the direct result of the extremely low spend per user in the current environment, but this is not addressed in the **Bill**, and no new solutions are offered. While some economies of scale may be achieved by the centralization of funding and purchasing it is our view that these will be relatively small, and could even be offset by the cost of administering the new **NHI**.

5.5 New issues which arise

5.5.1 Creation of a monopoly and the removal of competition

Section 26 lays out the (brief) structure and responsibilities of the **Health Care Benefits Pricing Committee**, which aims to set "*the pricing of health care services to be purchased by the Fund*". We understand this to apply to all "Benefits" to be provided, and will therefore introduce price control for all health care personnel and all services, materials, goods etc used in the provision of healthcare services.

Section 10 also states that the Fund must -

(g) determine payment rates annually for health care service providers, health establishments and suppliers in the prescribed manner and in accordance with the provisions of this Act;

Thus the **NHI Fund** will become the only purchaser of health care services, and in addition will have sole control over the setting of prices.

We are concerned at the direct effects as well as the unexpected consequences of this as follows:

(1) If the **Health Care Benefits Pricing Committee** sets prices at a low level, to match the low average expenditure currently experienced in the public health sector, this would act as a disincentive to many current medical professionals, who would then leave the medical profession or leave the country, both with adverse effect.

(2) When prices are administered, all incentive for competition between service providers would be lost.

5.5.2 Efficiency

Section 10 - Functions of Fund states:

(2) *"The Fund must perform its functions in the most cost-effective and efficient manner possible and in accordance with the values and principles mentioned in section 195 of the Constitution and the provisions of the Public Finance Management Act."*

The practice of medicine today, and particularly in the cancer field, recognises the importance of making the patient central to his treatment plan. However, this Section 10.(2) places cost-effectiveness and efficiency above all other considerations.

As in the present public health system this results in systems which are primarily organized to maximize the throughput of patients, without adequate booking systems; resulting in patients queuing for many hours to be seen by a doctor; queuing once again to have blood samples taken; queuing for outpatient procedures; etc to the general detriment of the patient.

5.5.3 Unworkable Complaints and Appeals structure

Chapter 9 (Sections 42 - 47) deals with a procedure for **Complaints and Appeals**. This appears to be the only mechanism provided for a user to raise an objection, complaint or query in regard to the provision of health care services.

In our view this mechanism and procedure is in total conflict with the aims of the **NHI Bill**, expressed in the Preamble as follows:

> *"... in order to:*
>
> - *achieve the progressive realisation of the right of access to quality personal health care services;*
> - *make progress towards achieving Universal Health Coverage;*
> - *ensure financial protection from the costs of health care and provide access to quality health care services by ..."*

Our reasoning includes the following:

- Users will generally access the **NHI** system only when they require health care services, so will be unaware in advance that any rejection of their request for services may arise;
- In many cases users will require immediate or relatively speedy care;
- Users requesting services will be ill and at some disadvantage in dealing with a bureaucratic system;
- In cases dealing with cancer it is of critical importance for patients to be diagnosed and treated without delay even if the patient appears to be healthy at time of presentation.

Section 6 - Rights of Users - also has relevance as in the following subsections:

> *(d) not to be refused access to health care services on unreasonable grounds;*
> *(e) not to be unfairly discriminated against as provided for in the Constitution and the Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act No. 4 of 2000);*
> *(f) to access health care services within a reasonable time period;*

We therefore recommend that the Complaints and Appeals procedure be revisited with the objective of (a) bringing the process much closer to the point at which the user presents him/herself for service, and (b) is simplified to deal with the much more likely situations which could arise, with the general intent of improving the health care service provided to each user.

5.5.4 How to determine pricing for advanced services

Section 6 - Rights of Users - Allows for the purchase of health care services that are not covered by the Fund as follows:

> *(o) to purchase health care services that are not covered by the Fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act, any other private health insurance scheme or out of pocket payments, as the case may be.*

A consequence of this subsection would be that some mechanism will be required to determine the price of such services even though these services will not form part of the health care services provided by the Fund as determined by the **Benefits Advisory Committee** in terms of Section 25 - Benefits Advisory Committee.

5.6 Cost and availability of medicines - Role of NDOH

The provision of affordable medicine remains the responsibility of the NDOH/Health Products Procurement Office within the scope of the Essential Medicine List. The majority of cancer medicines fall outside of the provision ambit of Primary Health Care, whilst Palliative Care medicines should be made available at Primary Health Care level as described in the Palliative Care Policy of 2017.

The provision of cancer treatment outside of Primary Health Care and how this will relate to benefit packages remains unclear and needs careful consideration. Globally the costs of novel cancer medicines are problematic and this has been noted by the WHO. Many novel treatments have not (yet) been proved for efficacy and long term survival benefit. Procurement of essential medicines thus needs to focus on the long-term survival benefit of the majority of the population and should be in line with the cancer disease burden. International clinical guidelines for cancer treatment should be used to determine essential cancer medicines in the absence of dedicated policies, which should be reviewed on a biannual basis.

Further, the argument that there are many cancers where the medicines will never be available on the EML but where treatment of these specific conditions

would be a necessity needs careful consideration in line with international guidelines.

6 Concerns related specifically to cancer

The **NHI Bill** provides a high level view of how the **NHI Fund** will be administered and provides a brief idea of how services will be structured and delivered. However, the Bill is silent on the actual services to be included within the system, making it difficult to assess how the NHI will impact on the delivery of services in regard to cancer.

The following points are noted as relevant to further examination:

6.1 Lack of information

We note the significant lack of useful information on cancer incidence, treatment and mortality due to cancer.

6.2 Long time delay between action and effect

Actions taken to avoid or reduce the incidence of cancer can have a significant effect on cancer incidence rates, leading to both substantial reductions in the impact on individuals as well as reductions in the number of patients treated and hence the cost of providing services.

However, the time delay between initiation of actions and the resulting effect can be substantial, of the order of tens of years. Thus, a balance must be struck between investment in education and prevention on the one hand, and the provision of services to provide treatment services at current levels on the other.

6.3 Cost of cancer medicines

We have drawn attention to the excessive cost of certain cancer medicines in our **Access to Medicine**[7] campaigns. These high costs currently put certain medicines completely out of reach of most individuals, even those covered by medical aid schemes, and particularly those reliant on the public health system.

The high costs are the result of many factors, some of which can be influenced by actions by the **National Department of Health** as well as other government departments.

6.4 Cancer is expensive to treat

Cancer is expensive to treat in many respects, including:

- Need for trained oncologists and other oncology staff
- Specialised surgery
- Expensive equipment for radiology and radiation
- Special medicines (noted above)
- Treatment and follow-up over long timescales

6.5 Extreme centralization of treatment facilities

A further consequence of the previous point is the concentration and centralization of treatment facilities, far away from large numbers of patients.

This results in patients being required to travel large distances for treatment, with heavy costs for transport, accommodation and family commitments.

6.6 Cost efficiency in treatment of cancer

Section 10 - Functions of Fund - specifies

> *"(2) The Fund must perform its functions in the most cost-effective and efficient manner possible and in accordance with the values and principles mentioned in section 195 of the Constitution and the provisions of the Public Finance Management Act."*

[7] Cancer Alliance, Access to Medicine Campaign, https://canceralliance.co.za/access-to-medicine/

Multiple medical specialities are involved in the treatment and care of cancer patients, and a patient-centred approach is highly desirable to ensure success in treatment. However, this can be seen to be in direct conflict with the "efficiency" objective, whereby activities are designed to revolve around the oncologists and other specialists as well as the expensive equipment involved in treatment.

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