Managed Care and Oncology in the Medical Scheme Environment

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Burden of Disease

Before one embarks on “managing care” there need to be an understanding of the burden of disease
Incidence of Cancer

- Difficult to accurately state the true incidence

- Challenges to accurate assessment
  - Cancer registry has fallen away
    (attempts to resurrect it underway)
  - Many figures pathology based
  - Lack of access to health care may result in under diagnosis
  - Data on deaths from cancer are collected by StatsSA, but data limitations and availability make it very difficult to use
The Cancer Association of South Africa (CANSA) is quoted as saying that one in six South African men and one in seven women will get cancer during their lifetime.

In South Africa, and elsewhere in Africa, the incidence of cancer has been steadily increasing as the populations urbanizes and adopt different lifestyles.

When considering cancer an aging population will experience a higher incidence.

While the data over the full population is very limited as to cancer incidence in South Africa, two relatively recent studies point out that while incidence is in line with other developing countries, this is probably due to underestimation.
Incidence of Cancer

- The Medical Research Council (MRC) gives a total cancer incidence of
  - 148.9/100,000 in males and
  - 134.9/100,000 in females,

- BUT it finds dramatically different incidence rates between the race groups.
  - White South Africans have cancer incidence of 277 and 230/100,000 for males and females,
  - Black South Africans have cancer incidence of only 97.1 and 103.7/100,000 for males and females
Incidence of Cancer

- HOWEVER International experience has shown that when similar levels of care are available there is not such a significant difference in incidence between race groups.

- As we work towards less disparity in health care we ironically are expecting an increasing incidence in cancer.
Incidence of Cancer

- Most recent and accurate source of cancer incidence data for South Africa is that prepared by Prof. Heather McLeod for IMSA

- Using various sources, but specifically the GLOBOCAN estimates, a set of incidence rates was prepared for South African cancer incidence by age and gender

- The GLOBOCAN incidence rates are measured using only five age intervals and this is not ideal for detailed modeling

- Adjustments were made to the GLOBOCAN incidence levels (for the perceived underreporting), but it is not known whether this potentially also includes the lower levels of diagnosis mentioned by practitioners in the field
Incidence of Cancer

South Africa 2009
74,431 expected cases for all sites except skin

Figure 1: Expected Incidence of Cancers in South Africa in 2009. Source: GLOBOCAN 2002
Incidence of Cancer

- South African data are quite similar to international age specific data on the incidence of cancer that is biased towards much higher incidence in later years.

- We can expect a dramatic increase in cancer incidence with age in South Africa as health care to the wider population improves, i.e. apparent that the older the population becomes, the higher the relative incidence is likely to be.

- An article in The Lancet indicated experience elsewhere in the world where perceived cancer incidence increased dramatically, from similar levels to South Africa’s, following the introduction of proper diagnostic facilities such as a screening program.
Incidence of Cancer

- South Africa is faced with the grave reality that life expectancies across racial groups still differ dramatically and therefore also the likely cancer incidence among specific groups.
- The black community has by far the shortest life expectancy at birth.
- In addition, the age structure also differs substantially among the race groups.
- A black population with a large number of very young people.
- The lower life expectancy and relatively young profile of this group may explain the lower total incidence of cancer among black South Africans.
Reality Check

- Population as a whole mid 2012 estimate 50.6 million
  - Of which ±8 million (± 16%) covered by medical schemes
  - Public sector required to care for around 84% of population – ± 42 million

- Public sector under the current model would not be ideal to manage an increasing incidence of cancer BUT effective planning and retention of expertise can increase the capacity
Managing Care

- Private revisiting model of care
  - Very important to maintain quality of health care provided while balancing cost of care

- Regularly reviewed treatment protocols to provide best possible patient outcomes BUT in a tiered approach
  - to allow for the lower end market to access what would be considered minimum standard of care in any private facility (certainly not less than would be available in the state)
  - to allow for higher option patients to get access to higher spend treatments
  - to update treatment guidelines so as to improve patient outcomes and overall survivals
Managing Care

- MC programs must be “protected” by a strong set of standardised treatment guidelines.
- Most of the private sector uses SAOC tiered protocols.
- The current anonymous Peer Review panels minimise the manipulation of the tiered approach.
- The SAOC guidelines and the peer review process help to optimise the use of drugs in line with approved indications as advocated in a statement released by ASCO.
- The tiered approach also risk manages and discourages the administering of a marginally beneficial drugs to patients with advanced cancer.
Managing Care

- The ASCO policy statement went on to state that “We cannot ignore the cumulative costs of the tests and treatments we recommend and prescribe.”

- “As the agents of change, professional societies, including their academic and practicing oncologist members, must lead the way in reviewing guidelines.”
Managing Care

- The initiation of a particular treatment protocol is thus guided by a rigorous set of treatment guidelines used in an appropriate clinical scenario, as reviewed by a panel of oncologists.

- Prior to initiation of treatment the pre-authorisation process in line with guidelines assists with a more predictable expenditure.

- Clear exit criteria for treatment and a defined number of approved cycles before review of treatment prevents spend on treatment where the response is not optimal.
The QOL/Spend Dilemma

- ASCO recognized the problem in determining the economic value we put on a person’s life or quantifying the financial value of one extra year of life.
- That leads us to cost-benefit or cost-effectiveness analyses (CEA).
- Cost of outcomes such as years of life, quality of life or efficiency can be useful for informing complex decisions, which are based on average outcomes.
- We MUST guard against saying that a treatment should be used where the result of a study was statistically significant but the outcome clinically unimportant.
The QOL/Spend Dilemma

- Every new treatment available needs to be weighed up considering the treatment’s benefit and the potential cost of the treatment under consideration.
- Where a curative outcome is possible the expenditure may be more acceptable than in the palliative.
- However we need to be careful not to withhold an expensive treatment when studies show the advantage to be statistically significant and is also shown to be clinically significant.
Broader access to quality cancer care can be achieved with all the role players coming together to increase patient access to QUALITY care, used RATIONALLY and in the most APPROPRIATE setting.

- Treatment guidelines
- Peer review
- Treatment exit criteria
- Outpatient care
- Maximize resources available