

HASA Conference 2026

Topic: CONNECTED CANCER CARE - How Real-Time Interoperability Is Changing the Economics and Experience of Oncology in South Africa

Opening/Intro: The Patient Behind the Data

Good morning, distinguished guests, healthcare leaders, clinicians, colleagues and friends. It is a privilege to be here at HASA and contribute towards the topic set out on Connected Cancer Care.

I want to begin today not with technology. Not with artificial intelligence. Not with interoperability standards, and certainly not with another digital transformation strategy..... Today I want to begin with a patient.....

Imagine a patient who has just been told:

“You have cancer.”

In that single moment, the patient's world changes but what happens next is often far more complicated than it needs to be.

The patient sees a general practitioner. Then a specialist. A pathology laboratory. A radiologist. An oncologist. A hospital. A medical scheme. A pharmacy. Perhaps a multidisciplinary team, and increasingly, a network of digital platforms sitting behind all of them.

Every one of these organisations may hold a piece of the patient's cancer journey.

But the question we need to ask is:

Who holds the whole story?

Because cancer does not happen in episodes, Cancer is a journey, and that journey generates an extraordinary amount of information.

Diagnosis. Histology. Staging. Imaging. Molecular information. Treatment protocols.

Authorisations. Appointments. Medication. Laboratory results. Clinical notes. Hospital admissions. Treatment responses, and, importantly, the patient's own experience.

Yet too often, these pieces of information remain trapped inside organisational, technological or administrative boundaries.

And when information becomes fragmented, **care becomes fragmented.**

That is the problem I want to explore today.

1. THE ONCOLOGY PROBLEM IS NO LONGER JUST ACCESS TO INFORMATION

South Africa faces a significant cancer burden.

The latest GLOBOCAN estimates available for South Africa recorded more than **111,000 new cancer cases and more than 64,000 cancer deaths in 2022**, with more than 282,000 people living with cancer diagnosed within the preceding five years. ([Global Cancer Observatory](#))

But the challenge is not simply the volume of cancer, It is the complexity of cancer.

Modern oncology has become extraordinarily specialised. We have more sophisticated diagnostics. More personalised therapies. More complex treatment protocols. More multidisciplinary decision-making. More stakeholders. More regulation. More financial pressure and more data than ever before.

Yet our ability to move that information intelligently between the people who need it has not always kept pace..... So we have created a paradox.

Healthcare is becoming more connected clinically, while remaining fragmented operationally, and that fragmentation has a cost.

2. THE HIDDEN COST OF FRAGMENTATION

When we talk about the economics of oncology, we usually talk about the price of medicines. We talk about hospitalisation. We talk about technology. We talk about medical scheme expenditure. We talk about utilisation, and YES all of those things matter, BUT there is another cost that is much harder to see..... **The cost of friction.**

Friction is created when information has to be requested rather than received.

When a clinician waits for a report. When a patient repeats their history. When a practice captures information twice. When an authorisation requires manual intervention. When a hospital does not immediately have the treatment context.

When a medical scheme does not have the complete clinical picture. When a patient does not know what happens next. Each individual event may appear small but multiply that friction across thousands of patients, thousands of treatment cycles and thousands of interactions, the economic impact becomes substantial.

This is why I believe we need to rethink interoperability.

Interoperability should not be measured by whether two systems can exchange data. That is too low a bar. The real question is:

Does the movement of information improve a clinical decision, remove an operational burden, reduce unnecessary cost, or improve the patient's experience?

If the answer is no, we may have connectivity but we do not yet have connected care.

3. FROM DATA EXCHANGE TO REAL-TIME INTELLIGENCE

There is an important distinction between **digital information** and **connected information**. Digital information sits in a system whilst connected information moves to where it is needed. However real-time interoperability goes one step further, It means the right information becomes available:

to the right person, at the right time, in the right context, and in a form that can be acted upon.

Consider something as simple as an oncology treatment authorisation.

Traditionally, this can involve multiple parties exchanging information.

The oncologist submits. The administrator follows up. The medical scheme assesses.

The authorisation is returned. The practice responds. The patient waits.

Now imagine a connected ecosystem where the relevant clinical information, treatment protocol, patient history and supporting evidence are already available through interoperable systems. The question changes from, **“Where is the information?”**

To, **“What should we do with the information?”**

That is a profound shift. We move from administration to orchestration.

From searching to decision-making. From chasing information to using information.

And ultimately, from fragmented transactions to connected care.

HL7's FHIR standard is one example of the standards-based architecture enabling structured health-data exchange, while oncology initiatives such as HL7 CodeX are increasingly applying interoperability specifically to oncology workflows, including prior authorisation and structured cancer data. ([HL7](#))

4. THE ECONOMICS: EVERY HANDOFF IS AN OPPORTUNITY

Let us look at the economics differently. Imagine a patient's cancer journey as a series of handoffs. Every handoff introduces risk.

Risk of delay. Risk of duplication. Risk of error. Risk of miscommunication. Risk of unnecessary utilisation. And risk of the patient becoming the messenger between professionals. Now imagine reducing friction at each handoff.

A pathology result reaches the oncologist without manual intervention.

A treatment plan informs the relevant stakeholders.

An authorisation request contains the clinical context required for a decision.

A hospital knows what treatment the patient is receiving.

A patient sees their appointments and treatment information.

A multidisciplinary team works from the same clinical picture.

None of these are particularly glamorous technology demonstrations.

But collectively, they can fundamentally change the economics of care.

Because the objective is not to make healthcare **more digital**, the objective is to make healthcare **less wasteful**.

5. AND THEN THERE IS THE PATIENT

This is perhaps the most important part of the conversation.

We often talk about interoperability from the perspective of systems.

We talk about APIs. Interfaces. Standards. Data structures. Platforms...but the patient does not experience an API, the patient experiences uncertainty.

And cancer creates an enormous amount of uncertainty.

“Where must I go?”

“What happens next?”

“Has my treatment been authorised?”

“What did my scan show?”

“When is my next appointment?”

“Who do I contact?”

“Does everyone treating me know what the other team has done?”

Connected cancer care can change that experience.

When the patient's information moves with the care journey, the patient no longer needs to become the integration layer.

The patient should not have to carry their cancer history from one institution to another, that should be the responsibility of the healthcare ecosystem.

And this is closely aligned with the direction of global digital health thinking: WHO emphasises interoperability and data sharing as mechanisms for informed decision-making and more integrated, people-centred care. ([World Health Organization](#))

6. SOUTH AFRICA HAS A UNIQUE OPPORTUNITY

I believe South Africa has an opportunity to do something particularly powerful.

We do not need to simply replicate international healthcare models, we can build interoperability around our own realities. A mixed public-private healthcare system.

Multiple medical schemes. Hospital groups. Independent specialists. Pathology and radiology networks. Managed care organisations. Pharmaceutical and life-sciences partners. Primary healthcare. Community care. And increasingly sophisticated digital-health platforms.

The Department of Health itself recognises that a comprehensive interoperable digital-information system is fundamental to the future health system, including the ability for patient records to become portable and for information to move between providers.

([Health South Africa](#))

And importantly, this is no longer theoretical.

In January 2026, the Department of Health, CSIR and IHE Catalyst hosted South Africa's first Digital Health Interoperability Projectathon to test the ability of systems to communicate and exchange information effectively. ([Health South Africa](#))

That is an important signal. The conversation is moving. But technology alone will not solve this.

7. INTEROPERABILITY IS A BUSINESS MODEL ISSUE

This is where I want to challenge healthcare leaders. If interoperability sits only inside the IT department, we have already limited its potential because interoperability affects:

Clinical outcomes. Operational efficiency. Patient experience. Revenue. Risk.

Quality. Resource utilisation. Population health. And ultimately **Sustainability.**

The executive question therefore should not be, “Can our systems integrate?”

It should be, **“Where does fragmentation cost us money, time, quality or patient trust and where can connected information change that?”**

That is a very different conversation. It takes interoperability from an IT budget discussion into the boardroom.

8. BUT CONNECTIVITY WITHOUT GOVERNANCE CAN CREATE CHAOS

There is an important warning. More data does not automatically mean better healthcare. If we connect everything without agreeing on:

What information should move. Who should have access. When they should receive it.

What it means. How it is coded. How consent is managed. How privacy is protected.

And who is accountable when something goes wrong, we have not created connected care.

We have created **connected complexity**. Interoperability therefore requires three things.

1. Technical interoperability

Systems must be able to communicate.

2. Semantic interoperability

They must understand the information in the same way.

3. Clinical interoperability

The information must actually support the way clinicians work.

And I would add a fourth:

4. Human interoperability.

Because healthcare is ultimately delivered by people.

If the technology does not fit the workflow, clinicians will work around it.

If it creates more administrative burden, adoption will suffer.

If the patient cannot understand it, the technology has failed the patient.

9. THE NEXT FRONTIER: FROM INTEROPERABILITY TO ORCHESTRATION

I believe the next phase of oncology technology will be defined by a move from:

systems that exchange information to ecosystems that orchestrate care.

That distinction matters. Imagine an ecosystem where a patient's diagnosis initiates a connected sequence.

The pathology result becomes available. The oncologist receives the relevant information. The treatment pathway is initiated. The appropriate authorisation process

is triggered. The patient's appointment pathway is coordinated. The clinical team has access to the relevant history. The patient receives the information they need.

And every subsequent interaction contributes to a continuously evolving clinical picture.

That is not simply interoperability. That is **care orchestration** and this is where artificial intelligence will become increasingly relevant, but AI should not be our starting point.

Data quality is our starting point.

AI built on fragmented, inconsistent or poorly governed data simply produces faster uncertainty.

Connected, structured, trustworthy data creates the foundation upon which AI can responsibly add value.

The global direction is increasingly toward standards-based, interoperable data that can be reused across care, research and decision-support environments. HL7's current oncology interoperability work illustrates this movement toward structured oncology information and “collect once, use everywhere” principles. ([HL7 News](#))

10. WHAT SHOULD SOUTH AFRICA DO NEXT?

So where do we go from here? I would suggest five priorities.

1. Start with the patient journey.

Do not start with the technology. Map the cancer journey from diagnosis to survivorship or palliative care. Find the points where information gets lost, delayed or duplicated.

That is where interoperability should begin.

2. Prioritise high-value use cases.

Do not attempt to connect everything to everything. Start where interoperability can improve outcomes, reduce friction or remove cost.

Authorisation..... Referral.... Pathology....Radiology.....Treatment plans.....Hospital admissions.....Medication.....Patient communication.....These are tangible opportunities.

3. Adopt standards, not proprietary islands.

Interoperability should create an ecosystem, not another technology silo.

International standards such as HL7 FHIR provide an important foundation for structured health-information exchange. ([HL7](#))

4. Measure the economics.

We need to move beyond “How many systems did we integrate?”

Instead measure:

Time saved.....Duplicate work eliminated.....Treatment delays reduced.....

Administrative effort reduced....Avoidable utilisation reduced.....Patient engagement improved.....Clinical outcomes improved.

Because what gets measured gets prioritised.

5. Make the patient part of the ecosystem.

The patient should not simply be the recipient of care they should be a participant in their care. Their information should be accessible, Understandable, Portable, Secure and useful.

11. THE BIGGER VISION

I want to leave you with a picture of what I believe connected cancer care could become.

Imagine a South African oncology ecosystem where:

A patient's information follows the patient.

A clinician sees the information they need before the patient enters the room.

A hospital knows the patient's treatment context.

A medical scheme has better clinical visibility.

A multidisciplinary team works from a shared picture.

A patient understands what is happening next.

A treatment decision is supported by complete and timely information.

And healthcare leaders can see where the system is working and where it is failing.

That is when data stops being documentation, it becomes infrastructure and when information stops being a by-product of care, It becomes an enabler of care.

CONCLUSION — THE QUESTION WE SHOULD BE ASKING

Let me return to the patient I introduced at the beginning.

A person who has just heard:

“You have cancer.”

That patient does not care which software system holds their information.

They do not care which organisation owns the database.

They do not care which vendor built the interface.

They care that the people looking after them know what is happening.

They care that decisions happen quickly.

They care that information is not lost.

They care that they do not have to repeat their story.

They care that someone is coordinating their journey.

And ultimately, they care that the healthcare system is working **with them**, not making them work their way through it.

So perhaps the future of oncology interoperability can be reduced to one simple principle:

The patient should experience one connected journey, even when that journey crosses many organisations, technologies and professionals.

Because the future of cancer care is not simply about better medicine, It is about connecting the medicine..... Connecting the people.....Connecting the information.....

Connecting the economics.....And most importantly, **connecting the experience around the patient.**

If we get that right, interoperability stops being an IT capability. It becomes a clinical capability. It becomes an operational capability. It becomes an economic capability.

And ultimately, **it becomes a patient-care capability. This now allows us to build Longer Tables rather than Higher Walls**

That, to me, is the real promise of connected cancer care in South Africa.

Thank you.