
RETHINKING END-OF-LIFE CARE

DEATH

“Death is the enemy. But the enemy has superior forces. Eventually, it wins. And in a war that you cannot win, you don’t want a general who fights to the point of total annihilation. You don’t want Custer. You want Robert E. Lee, someone who knows how to fight for territory that can be won and how to surrender it when it can’t, someone who understands that the damage is greatest if all you do is battle to the bitter end.”

Atul Gawande, Being Mortal: Medicine and What Matters in the End

THE STATUS QUO

End-of-life benefits in South Africa are usually limited to the last two weeks of life – this often means that the benefit can only be claimed retrospectively (how else do you know when the last two weeks commence?).

Can we really defend having a benefit that can only be accessed after the beneficiary has died? Are there alternatives that allow for real choices and effective planning?

In general, scheme benefits are curative and hospital-centric with little in the way of palliative benefits.

THE STATUS QUO IS EXPENSIVE

3

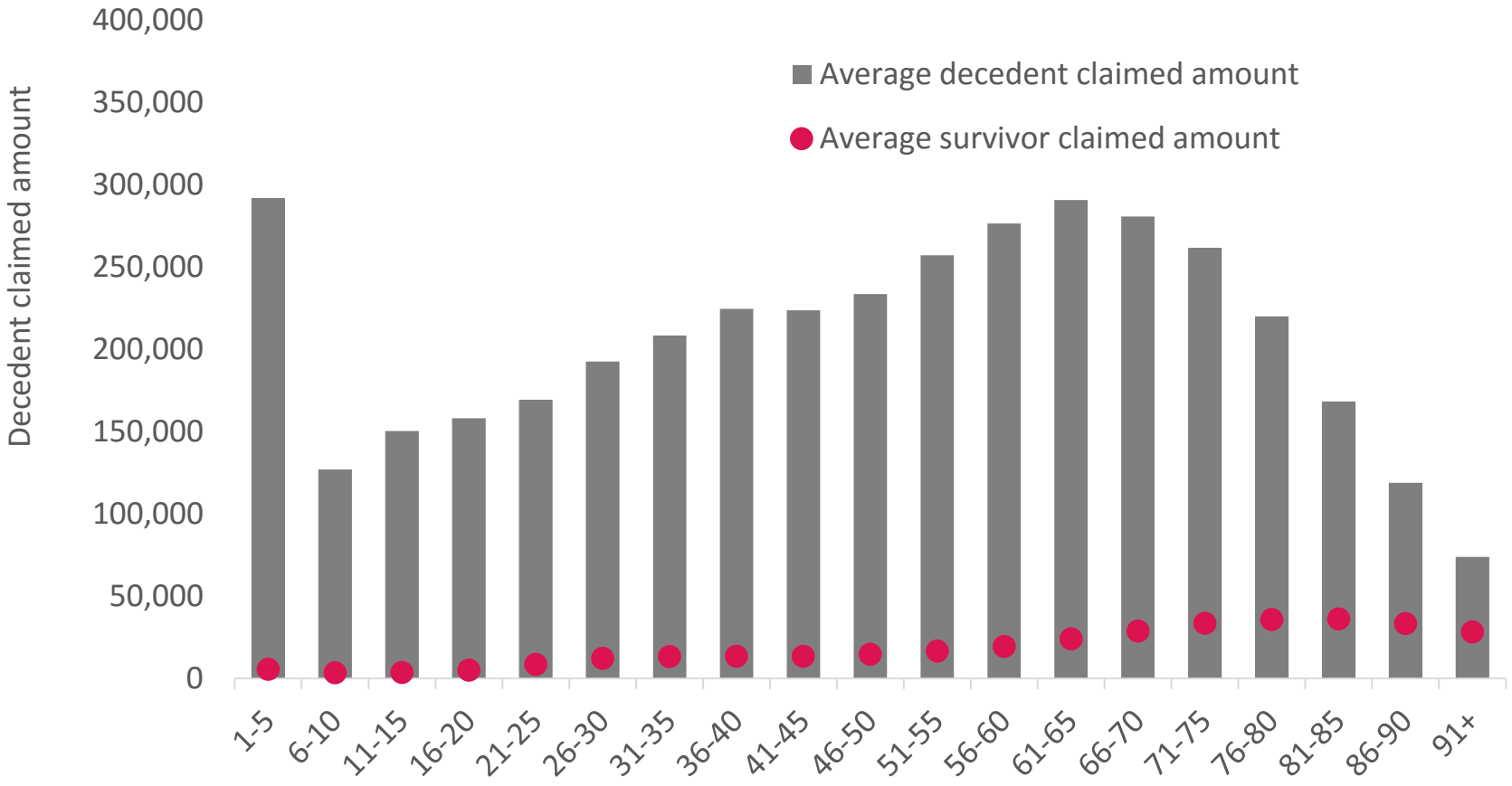
Healthcare costs in the last year are more than three times higher than in the second last year of life

12

Medical schemes spend more than 12 times as much on those in the last year of their lives than they do on survivors (even once we adjust for differences in age between the two groups)

Ranchod, S., Abraham, M. and Bloch, J., 2015. An actuarial perspective on healthcare expenditure in the last year of life. *South African Actuarial Journal*,*15*, pp.31-49.

THE STATUS QUO IS EXPENSIVE



Ranchod, S., Abraham, M. and Bloch, J., 2015. An actuarial perspective on healthcare expenditure in the last year of life. *South African Actuarial Journal*,*15*, pp.31-49.

THE STATUS QUO IS ALSO OFTEN PAINFUL AND SUBOPTIMAL FOR THE PATIENT AND THEIR FAMILY

R1 million

(So far. Excluding the hospital bill)

A month in ICU. Surviving on a ventilator.

INHERENT TENSION FOR FUNDERS

Balancing between meeting the needs of a group of members and managing scheme risk profile

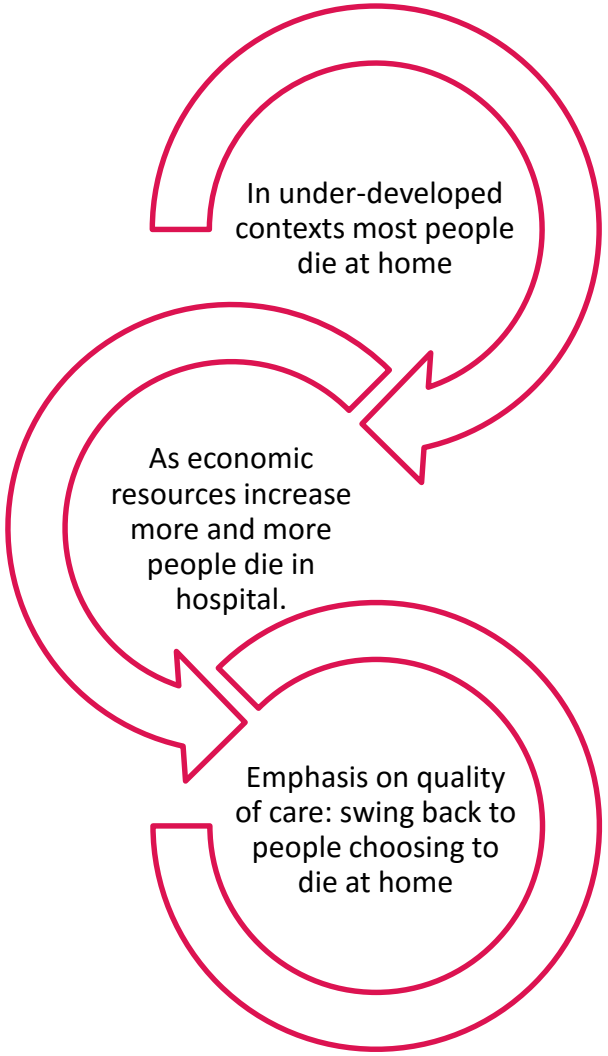
insight

WHAT IF WE COULD SAVE MONEY, IMPROVE QUALITY AND DO THE RIGHT THING?

1. Think about the place of dying
2. Provide a hospice/palliative benefit in addition to curative benefits
3. Partner with the supply side and improve care-coordination
4. Think about how to measure quality (and value)

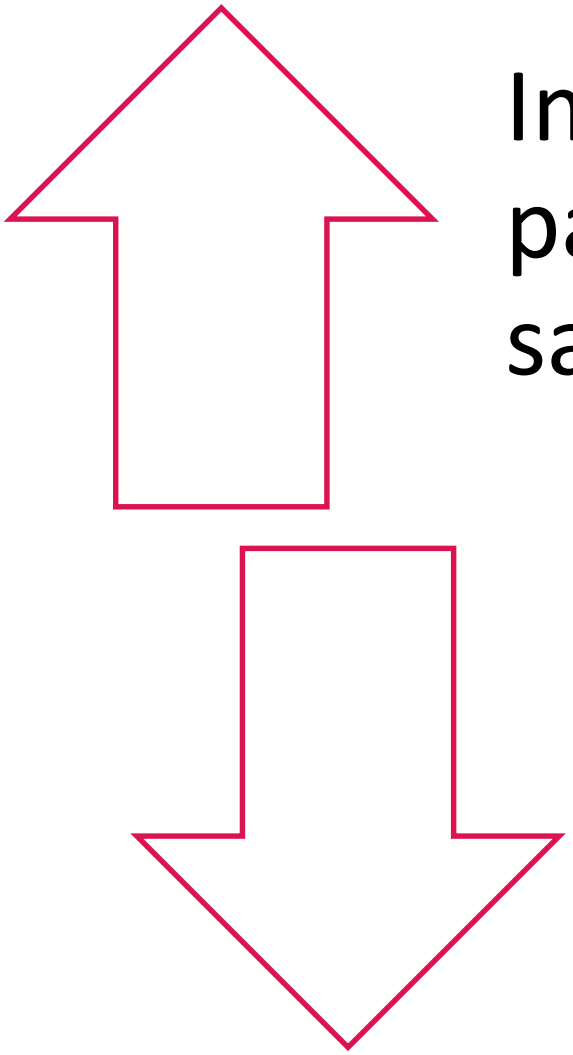
THE PLACE OF DYING

This reversion is happening in the US. An astounding 25% of Medicare spend is on healthcare costs incurred in the last year of life.



ACCESS TO A PALLIATIVE BENEFIT

In the US insurers have tried giving policyholders access to a hospice or palliative benefit in addition to their curative benefits (i.e. not taking anything away). This makes the hospice/palliative option known, and take-up more likely



Improved patient satisfaction

Reduced healthcare costs

SCOPE TO WORK TOGETHER WITH PROVIDERS

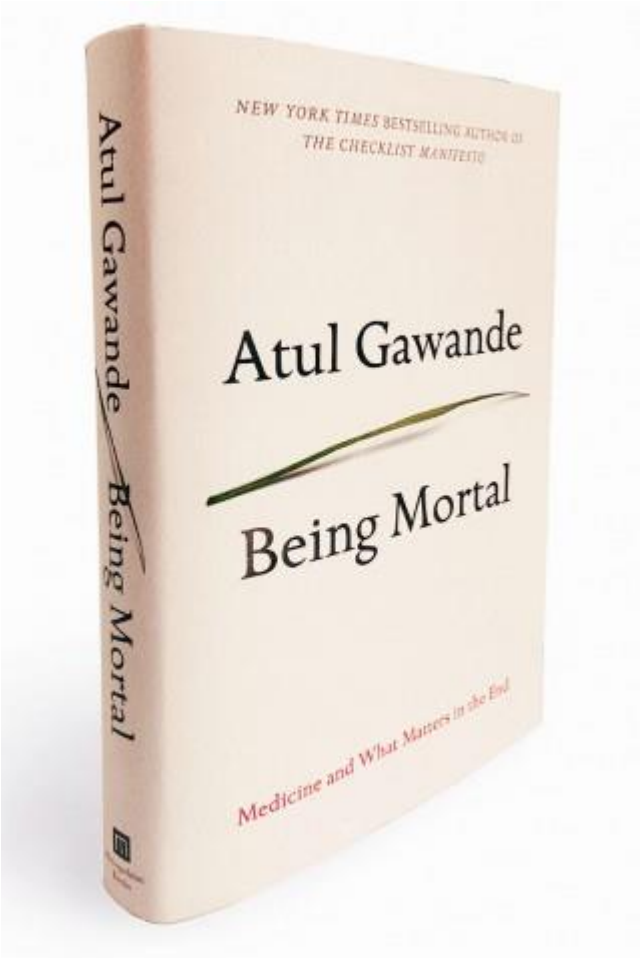
29%

The proportion of patients at a particular hospice that belong to medical schemes

0.2%

The proportion of the total estimated cost of running the service covered by medical scheme reimbursement

QUALITY OF CARE AT THE END OF LIFE



Survival as an outcome

Ice cream and football

Considering the family and not just the patient

THE OPPORTUNITY TO TRANSFORM END-OF-LIFE CARE

1. Benefit design: redefine palliative and end-of-life entitlements
2. Managed care: mechanisms to actively increase palliative take up
3. Work with providers: care-coordination, aligning incentives, contracting
4. Accountability: build and refine appropriate quality measures

A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one's story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives.

Atul Gawande, Being Mortal: Medicine and What Matters in the End