Discover Healthier Podcast: Costly Healthcare

Speaker	Start time		End time
Azania	0:00	Welcome to Discover Healthier: everything you need to know about health, brought to you by Discovery Health. I'm Azania Mosaka. You can join the conversation as we explore some of the most pressing matters in the healthcare environment today. Our wide variety of topics and specialist guests will empower you to care for your health, now and in the future.	0:23
Azania	0:23	So the sky rocketing cost of healthcare both in South Africa and on the global scale affect us all! And South Africans who are lucky enough to afford private healthcare have rapid and convenient access to some of the best quality of care available anywhere in the world, provided by outstanding health professionals. But the reality is that public and private healthcare systems around the world are grappling with rapidly rising healthcare costs, and South Africa is no exception. So why is this the case and what can you do to manage your healthcare costs day to day? So joining me now are 3 minds that will hopefully help us understand his picture a little bit better. The CEO of Discovery Health, Dr. Jonny Broomberg. We're also joined by the Head of Research & Development at Discovery Health, Deon Kotze, and also the CEO of Percept Shivani Ranchod. I want to quickly understand, everybody welcome, welcome. Let's get straight into it. So, Jonny let me start with you. If we look at the past ten years, the cost of healthcare has been increasing, what are some of the driving forces behind this?	1:28
John	1:28	Azania, there are a number of driving forces. They divide our analysis into changes in the population that are covered by medical schemes and that population has been getting older, it's also been getting sicker as a result of increasing chronic diseases which is a global phenomenon, and those trends of aging and higher prevalence of chronic diseases are themselves very powerful drivers of health care costs. Older people and people with a chronic disease use much more health services, up to 3-4 times the average if you registered for chronic disease. So, for each year of aging in a medical scheme, the claims on average go up by between 3% and 4%. So, just those what we call demographic trends are one very big part of the cost increases. The second bucket is things that are happening, if you like, on the delivery side of medicine. So, technological advancements, new medicines that are typically much more expensive than old ones, new procedures which use more expensive equipment. In our country, one of the unique factors has been a proliferation in the number of private hospital beds. So, the number of beds has gone up dramatically in the last decade. And when there are more hospital beds, quite magically, there are more hospital admissions. So, the number of hospital admissions isn't directly related only to the disease of the underlying population. The fact is hospitals get get built, shareholders need them to be filled, and they get filled. So, you get supply side issues and demographic issues and when you pull the two together, we see this very significant cost	3:38

		pressure. I do want to emphasize, Azania, that this is not a South African problem alone. You can talk to any governments in the world or any private insurer and literally every country in the world will tell you that they're struggling with health care inflation. It's not always the identical picture and the balance of forces leading to it may vary, but it's a very common global problem.	
Azania	3:38	So it's actually us; it's the members.	3;41
John	3:41	No, I don't think it's the members. The last thing I would be doing here is sort of pointing fingers. It's nobody's fault, it's a system, but it's a global trend. It's not about the members or the population. I believe the population is aging and that's because of good health care and better lifestyles; people are living longer. So if you're in the UK or Japan, those governments are struggling with cost because as people, you know, they don't die from heart disease anymore, they live into their 80s and 90s and they get more chronic conditions. So, it's things happening in the population but that's different to saying it's the fault of individual members.	4:18
Azania	4:18	Right. So, I want to come back to the age and young people, the imbalance- it sounds like an imbalance- within the members of a particular scheme. But help me understand, Shivani, especially from a global health care perspective. Johnny's just touched on the fact that we're not unique in this picture. What can we see, what can we draw from what's happening elsewhere?	4:40
John	4:40	I mean, I agree with Johnny completely that this is a global phenomenon and I think there are two sets of lessons to draw on. I think the one is the observations around what those drivers are elsewhere in the world because, even if we're not experiencing those now, we might experience them in the future. And then also, I guess, looking for lessons around how one contains those costs or manages the system. And I think one of the things to appreciate is the demand for health care. So, I guess what we want as consumers of healthcare, in terms of the quantity of services and the mix of services and goods, that there isn't a limited demand...	5:18
Azania	5:18	So there is a supply and demand relationship?	5:20
Shivani	5:20	I mean, there is a supply and demand relationship but then, you know, what we see in health care systems around the world is that the demand for health care actually has the potential (almost counter-intuitively) to just sort of keep growing and keep growing, and the US is almost the most extreme example of that, where they now spend close to 20% of their GDP on health care. So it's, you know, such a fundamental part of being human and our needs for it are so extensive that if you don't take a very deliberate approach to thinking about ways of containing costs, it will actually just keep rising. It does require quite a strong approach to think about.	5:59
Azania	5:59	Right. And Deon, I think this brings us into your area because you're an actuary, you analyze the financial consequences of risk. So, can you pick up from what Shivani is saying regarding how to manage this particular risk?	6:13

Deon	6:13	Yes, I think it's useful to remind ourselves what insurance is. I guess, insurance is this...you're trying to protect yourself against a cost that you otherwise wouldn't be able to afford. And there's lots of people that feel the same way about that so they all pool their money together. And if one of the people in that pool experience that event, then everybody's money is used to pay for that one event, because the single person can't afford to cover the cost of that event by themselves. So, when you start thinking about health care and the demand for health care and people that buy insurance, you naturally are going to have people that are in that pool of insurance that are going to be claiming, and as Johnny mentioned, the older that pool of people, the higher their demand for health care just naturally, because of the increase in need for health care services as you age. What you're hoping is that you have sufficient, younger, healthier individuals in that pool who are not claiming, because they're the ones that would be subsidizing. So, I guess when you're talking about product design and risk management, I would almost separate the two because risk management sometimes happens as part of product design and sometimes it happens in terms of managing what you've designed. One feature of the product design needs to be that it has to be attractive to the person that feels invincible. The 22 year old that thinks "I don't need health insurance." But at the same time, it needs to meet the needs of the person who's just been diagnosed with cancer, or whose child has been diagnosed with a chronic condition that they'll need to live with for the rest of their life. So you have to balance that need to have comprehensive cover with something that's appealing to the one that feels that that's too much, I don't need that.	7:51
Azania	7:51	What is the average age of Discovery Health members?	7:54
Deon	7:54	It's around 34. It's interesting that the average age of the new joiners, so the average age of new life joining, is younger than that, which helps. Because as Johnny mentioned, if the population of the medical scheme ages by a year, so say you have 100 people with an average age of 34, next year, the hundred people will be 35. It's a natural consequence of life which means that the cost will go up by between 1% and 4%, depending on the health of the underlying population. But if you manage to add lives in and you can keep the age at that same level, then the need for increases is muted. And it's the addition of lives that are younger than the average [that] is so important.	8:32
Azania	8:32	Are we seeing an increase annually on average age?	8:34
Deon	6:34	Yes, you do, but less than a year though. So I could say that Discovery Health medical scheme ages by about five months per annum now.	8:43
Azania	8:43	Does that present any threats, though, to the medical scheme, or is it just about cost?	8:48
Johnny	8:48	No, I think it's worthwhile mentioning where we are right now in terms of our economy, and what impact that is having on medical schemes.	10:14

		Because that's a uniquely South African challenge right now which is, as you know, the economy is struggling; employers are not employing, in fact there's lots of retrenchment, because premiums are high and families are under a lot of economic pressure, people are staying out of medical aid until they get sick or until they're planning a family. So, actually what all medical schemes are seeing is quite a big slowdown in growth. So, you're losing some of that protective effect of young and healthy members joining, you're also seeing people joining later, or family kind of joining and then you know, have a sick child and then one parent leaves and only one stays on with the sick child. So, these are all phenomena that the actuaries here would describe as selection or anti-selection or adverse selection. It's where people with poor risk are selectively joining the medical scheme and the healthier and the younger are selectively staying out. When that happens. You lose the subsidy between the young and the healthy and the older and the sick, and that is one of the reasons why premiums are also going up, you know, more quickly in recent years. So, if this economy started growing quickly, companies started hiring lots of people, I think that trend would reverse to some extent.	
Azania	10:14	So, how do we incentivize younger, healthier people to join at an earlier age?	10:19
Johnny	10:19	It's a good question. You know, I think in some countries, Australia, as an example, the government uses tax incentive system to encourage people to join. You get quite a big deduction off your tax liability if you pay health insurance premiums. We have the medical aid tax credit in this country. In Australia, it's much more powerful, it's much more valuable. So we do have that here. I think we need to provide information to people. One of the problems Deon talked about sort of, you know, young people feeling immortal and invulnerable. You never really know when the accident is around the corner, when a traumatic incident is around the corner and these days, unfortunately, cancer is occurring in more and more and more young people. I think there's an information issue. I think people feel like they don't need health care 'til they're planning to, you know, have children or get married or be older. And actually, they really do need health insurance. It's also our job, I think, to find products that meet their needs and keep them affordable. Because today, even an entry level medical aid premium is quite high if you're a young person just starting in the job market.	11:28
Azania	11:28	What do you think of that, Shivani?	11:30
Shivania	11:30	Yes, absolutely. I think affordability is part of the story because in tough economic circumstances, people are having to make trade-offs. And if you don't feel the strong need for a product and the minimum cost of the product is high...But some of the factors that drive the product costs are not in the direct control of the medical schemes themselves. There are regulatory issues and system-wide issues that influence that as well. So I mean, I think it's also something that requires, across the system, looking at ways of creating affordable entry points.	12:08

Azania	12:08	So, I think we also need to understand how a medical scheme works because it's a not-for-profit organization. And if there's ever a need for additional funding, it can't come from outside. It's just solely funded by the group of members.	12:24
Johnny	12;24	That's right. I like to think of it as an institution that's very well known in our society, [which] is a stokvel; a small little club of people who come together, make a weekly or monthly contribution, and that's a pool of money that can be there either for distribution or, if someone in that stokvel has a funeral, the money can go to them. I think a medical scheme is just a very large version of a stokvel. So, people pay their premium; depending on what plan you're on, each plan you pay the same premium and never mind if you're 90 with 4 chronic diseases or 25 and healthy, you pay the same premium. You know, if you're on Plan A or Plan B. And as you say, the total amount of money that's paid in every year has to be enough to meet all the claims and other expenses. And if there's a shortage, there needs to be some reserves- a buffer. And medical schemes by law have to keep a buffer of 25% of their premiums every year. So, if the premiums in the case of Discovery Health medical scheme are in the order of 70 billion Rand, the scheme needs to keep at least 25% of that in reserves on a continuous basis. And if in one year, the claims exceed the premium income, you can dip into the reserves but the next year the medical scheme has to put up the premiums to make sure there's enough coming in again, the next year. So, it really is a not-for-profit. When a claim is not paid...I think this is something I struggle to explain even to my wife after all these years that she's been listening to me...when a claim is not paid, nobody's making profit out of that. People do confuse medical aid with your motor car or your household, or your life insurance, where when a motor insurance says no, I'm not paying you for this accident, they are improving their bottom line. And I think many people think when Discovery Health medical scheme says no, this claim is against the rules, and we can't pay, they think that somebody's making money at their expense. But actually all that's happening is a set of rules are being applied to everybody on a very consistent basis. And that means that the system then works for everybody. In my job, I get these escalated complaints and I get a CEO saying, if you don't pay for this claim for my daughter, I'm going to withdraw all of the business from all of the Discovery products and, you know, our response to that is we're really sorry, but we can't make exceptions for you because every member is treated in the same way, regardless of whether they're a CEO, or a blue collar worker.	15:04
Azania	15:04	Because that will put the rest of the scheme at risk if we keep making these exceptions?	15:09
Johnny	15:08	And because it is, in a sense, a mutual...it's a society owned by the members. You can't treat one member differently to another because they happen to be rich and powerful.	15:17
Azania	15:17	And the question around rules, the medical aid scheme rules, probably is one of the most difficult areas of offering the service. So, Deon, talk to me about how you decide on the increase, because the	15:51

		picture that we've just painted suggests that there's a lot of pressure to design products that will be attractive, right. And also, when people see these increases, that they don't feel that they are unwarranted. So, you have the tough job of making these increases palatable, but also these increases have to work for the future of the scheme.	
Deon	15:51	Yeah, I think if I can add to what Johnny said, if I can get one message across to members [it] is: when you put in a claim to the medical scheme, think about it this way, it's not the medical scheme that's paying the claim it's the other members of the medical scheme that's paying the claim. That's how a stokvel works. You know, I'm asking the stokvel on a valid basis that you should be making a payment to me. It's not the stockvel that's paying, it's the other people in the stokvel. It's exactly the same. If you start thinking about it that way it starts making a lot more sense why the medical scheme doesn't pay for certain things. It's actually the membership that says, given everything that we've put into the pot, what you're asking, we can't pay from the pot, there simply isn't enough in the pot. And when we all put our money into the pot, we agreed that the pot would only pay for these things. You're asking us to pay for something that we all agreed we wouldn't be paying for.	16:39
Azania	16:39	And governed by these rules.	16:40
Deon	16:40	Correct, correct, yes. So when it comes to increasing the amount that goes into that part for next year, there's a couple of things that we need to consider. We need to firstly consider so what did people claim for this year, and then we need to figure out based on what they claimed this year, what are they going to claim next year? Because once we know how much people are going to be claiming next year, we know how much we need to ask the people to put into the pot for next year. So that's effectively saying, if the claims are expected to go up by 10% next year, then people need to contribute 10% more into the pot next year, otherwise, we can't pay the claims. Now, it comes to the question as to what that 10%...is that palatable or not? Say the 10% isn't palatable, what do you do around getting that 10% down? So you could simply say, well, actually, if everybody only wants to pay 8% more next year, the pot can only pay out 8% more next year, so we need to take away 2% of the benefits. That's a piece that members find very hard to say, uh, well, you know, you paid for it this year, why wouldn't you pay for it next year? So, then you have to start finding different ways and Shivani spoke about it earlier that you start managing the supply side. So, there's another element that determines that increase from one year to the next and that's the increase in the cost of claims next year is determined in one way by the demand for- so the people that are claiming from the pot- but also those that are supplying the services. So, healthcare professionals, their tariffs go up but they're also supplying more services because people demand more of the services. And in some instances, they replace the service with a new technology. Rather than prescribe this particular medicine, they prescribe a different type of medicine, or they use a different procedure in hospital rather than a previous procedure and that comes with a higher cost, then. In order to fund that we they need to understand what technology will	19:38

		be replaced and at what cost it being replaced. By how much are going to people going to be claiming more? So, all of those elements go into the calculation of how much more do we need to ask members next year? Then it becomes a point of, well, if we want to offer all the same benefits, but we don't want to ask people what it's actually going to cost. You have to start going back and saying, well, how do we manage that cost? How do we make sure that that cost doesn't go up by too much? And then there's lots of different mechanisms that you can start introducing, then. So these are networks, so you go and you create networks of providers. Some providers are happy to take a discount in return for volume and that discount volume then reduces the cost of health care next year, and helps us to keep the contributions down. New drugs that are being introduced, we negotiate with the providers for those drugs for a lower price. So, they would say we'll bring it onto the market at this price, we'll say we're happy to put you on to the formulary, but then you have to reduce the price of that, and that helps in terms of the cost increases. And there's many other examples of things that people would find boring if I had to tell them about it, but those are the critical things that I think Discovery Health does on behalf of Discovery Health medical scheme to keep those contribution increases on an acceptable level.	
Azania	19:38	What are some of the other means that you're seeing, Shivani? Because as you said, there are ways of managing this cost.	19:44
Shivani	19:44	I think it's useful to think about the medical scheme, purchasing healthcare on your behalf, right. If you didn't have the medical scheme involved, and you are going out and you had to go and get enough to pay for your doctor consultation and pay for your hospital admission, you know, you would actually be negotiating the prices of all of those things, nevermind managing the variation in your risk over time. So, it's useful to think about the role of the medical scheme in terms of that they act on the behalf of the consumer to actually go out and figure out how best to repurchase care. And a massive part of tht is, as John said, is around negotiating prices effectively as a collective. But it's also [that] the bigger the funder is, the more influence that they have. You know, a small funder, it's difficult for a small funder to say to a pharmaceutical company, can you moderate your price. Well, no, because...	20:36
Azania	20:36	The power of numbers.	20:37
Shivani	20:37	Yes, the power of numbers. So that is, so I think that's a useful concept for members to understand that. There's some power in that, in that collective action. But I mean, you asked me about other examples of controlling costs...I think one of the key features is actually the basis on which we pay healthcare providers. The system that we have at the moment is very skewed towards what we call fee-for-service where health care providers get paid for every activity that they do. And what you can imagine is when you've paid per activity, what you actually incentivize is more activity. So if we want to move towards a system which is actually more sustainable and not kind of having this increase in activity from year to year, we have to think	21:23

		about new ways of rewarding health care providers.	
Azania	21:23	I didn't know that. Did not know that.	21:26
Deon	21:26	In that concept of moving away from fee-for-service or the negotiating of prices, sometimes the criticism that we get as well [is] it's easy to replace an expensive technology with a cheap technology, but like, I don't want the cheap technology because the expensive one has to be better. It's like wine, you know, the expensive wine has to be better than the cheap wine. So, that's why in that process, we always make sure that the quality of the care is never compromised. And in fact, some of the newer models which Shivani is alluding to is that you're not paying on a fee-for-service basis, you're not incentivizing utilization, it's that you actually incentivize the quality of care in addition to, I guess, other things that [are] important to the member.	22:12
Azania	22:12	Here are a few tips on how you can stretch your medical aid Rand. Know your plan. Read material from your medical scheme, use the website and talk to your financial advisor. Know your doctor's rates. Ask what your doctor charges and if you'll have a co-payment. You can shop around for a provider who charges standard rates. If choice is more important than cost, you will know your co-payment upfront. Pay cash for over the counter medicines. To avoid running out of medical savings. Don't claim for headache tablets, cough preparations and vitamins, the money in your savings account can rather be used to pay for more important, out of hospital treatments.	22:58
Azania	22;58	Well, Deon mentioned the specialist, what the provider actually charges and this is another source of questioning and curiosity from members. How come we have medical aid rates? And how come we have private rates and so on? Because this can be an area of confusion. Is there any impact that you can have or role to play in making sure that this gap between the two is as small as possible?	23:22
Johnny	23:22	We work very hard on that. We play this quite delicate balancing act keeping premiums affordable, while at the same time allowing members to access the benefits that they need, and the doctors and other health professionals to use, you know, the treatments that they need. So that's, that's a very delicate balancing act that we continually have to play. One of the interesting aspects of this is that when you do focus on quality, you actually can bring down the cost. And the reason for that- it's quite counterintuitive- but the reason for that is that there's actually quite a large amount of waste in the healthcare system for exactly the reasons Shivani was describing. You know, when you pay per activity, you get more activity, and quite a lot is done that doesn't need to be done and some things are done that are done poorly. So if you focus on the result, on the outcome, and you reward health professionals and teams and hospitals for producing better results, actually, you can find that both quality can improve, and the cost of the service can go down. So, health care is quite paradoxical in that way. It's also paradoxical because it's one of the very few industries in this day and age where still large parts of the system everywhere are really not accountable for the results	25:40

		of the service they deliver. If you take your car for a service and as you drive out, you're hearing huge noises and then it grinds to a halt, you will immediately go back, demand that they repeat the service and probably ask for your money back. But if you're going for a hip replacement, and something goes wrong, guess what, you know, you have to have it again. But the medical aid pays again. Get an infection in the hospital and spend 6 months in ICU, R5 million, your medical scheme is expected to pay. So, we do need to...and some of the more progressive health systems around the world are moving to a point where you reward better results, and you penalize worse results. And actually, the hospital can't charge the medical scheme if there's a big infection, or if a patient fell out of bed and broke their leg, and we are trying to move our healthcare delivery system in that direction. It's not straightforward, there's quite a lot of resistance, yes, but we are moving in that direction.	
Azania	25:40	Speaking of waste. Shivani, this is probably part of what inspired you to establish Align. So, speak to Align and how actually it helps to reduce waste, particularly when it comes to Palliative care .	25:52
Shivani	25:52	Yes, so end of life care, which is not the same as palliative care, palliative care is sort of a broader concept. I think it's useful to sort of define it, because not everybody knows what it means. But it's essentially care that's focused on making the patient... dealing with their symptoms and making them more comfortable. It's an additional layer of support in the health care system, It has applications in, you know, dealing with chronic diseases and it's not only focused on the end of life. But at Aligned we've been particularly interested in what goes on at the end of life. And I think it tells us an enormous amount about the ways in which our health care system fails. So, what we currently have in our... in the end of life space is a system that doesn't serve the patient or the medical scheme. So, what we have is a system that's sort of skewed towards patients being treated in hospital and receiving what we refer to as non-beneficial care. So care that is, doesn't actually contribute to their quality of life, or extending their life actually. So, we pay very little attention to what it is that the patient actually wants, and the research shows that 70% of patients at the end of life would actually prefer to die at home, not in an acute facility, nevermind in an ICU or high care unit. And then the reality in the private sector is actually, it's almost the opposite of that statistic that 65% of patients actually do die in ICU and high care facilities. So, it's not great for the patient or their families, and actually in some ways adds to the sort of trauma of what goes on at the end of life, but also not great for the medical scheme, because that care is very expensive.	27:29
Azania	27:29	And you can actually get that care at a much lower cost.	27:31
Shivani	27:31	Yes, yes. So a lot of, I mean, given that the patient would prefer to be at home, actually with a good multidisciplinary palliative care team	28:28

		in place, they are very able to manage the patient in the home setting. And there's simple things you know, like a patient having an advanced health care plan, which actually articulates what it is that they want, nominating a proxy to make decisions on their behalf if they can't make those decisions. Those simple interventions actually completely change the trajectory of care. And then what we've experimented with at Aligned is putting in place one of the sort of contracting mechanisms that we were talking about. So, actually paying the palliative care teams firstly, to work as a team (which in itself is not our healthcare system is set up) and then secondly, actually paying them for good quality care. So, we measure the quality of care, and they get rewarded if they do a good job. So, we're kind of testing out this idea of, you know, what happens if you pay for good outcomes and not pay for more activity?	
Johnny	28:28	Can I jump in there, Azania? In Discovery Health medical scheme, about 3 years ago now, we instituted a benefit exactly along these lines called the advanced illness benefits. The idea was that, for patients who elected to be treated at home, they could get all of what they needed at home paid for because prior to that, and I think most schemes are still the same, actually, you get everything in hospital but not that much out. So, the nurses that you need 24/7 towards the end, you know, the hospital visits and all of that doesn't get paid for. So, we provided this very rich benefit for in-home care and it's made a massive impact. So, we've seen quite a big shift away from people dying in hospital to dying at home. Not enough yet, but a big shift, incredible feedback from families about the experience and actually now, I think approaching R100 million a year in savings. So, it's a win win all around. What I find very interesting is why not everybody does this. I'm very fascinated by that and I think one of the reasons is that the oncologists find it very hard to have that conversation with the family to say, you know, we are approaching that stage now, we're not going to extend life here, why are we going to put this person in hospital? I think they're busy, but also they're not well trained to have that tough chat with the family. So, it takes quite a strong, assertive family to say, even though now feels like we should go to a hospital, we're not going.	30:01
Azania	30:01	And I think let's stay with this theme of various disease burdens. Cancer on its own is one of the greatest challenges facing the world today, it's incidences increasing rapidly. Can we look at cancer as a case study? What do you see there.	30:16
Deon	30:16	So we're certainly seeing the increase in cancer incidence in the medical scheme at any point...to give, sort of, numbers to it at any point in time in the Discovery Health medical scheme...so as of today, it might be 37,000 people receiving active treatment for cancer, most common cancers being breast cancer and prostate and then going to rarer cancers, but much more expensive. There's something that's coupled with that, which is not just a higher incidence of cancer, but it's also the higher cost of treating cancer. So whereas in the past, perhaps there was one molecule that was designed to treat multiple sort of indications, now molecules have been designed very specifically for a particular indication and some	31:59

		even to the point where they're actually being designed for the individual. If your research and development team is developing a drug which is applicable to a million people, the R&D costs will effectively be divided by a million people so the cost will be low. If you're dividing the R&D cost by a patient of one, the cost is very high. So, what we're seeing is this increase of costs, increase of incidence of cancer, which is driving up costs, but at the same time, we're also seeing the increase in the cost of treating treating the cancer. So it's a bit of a double-edged sword for medical schemes. That said, that's the piece that I think, if I think about the invincibles, the young and the healthy that remain outside of the medical scheme, that's the thing that I would be concerned about if I'm outside of a medical scheme, that I become one of those prostate cancer patients or someone with malignant melanoma and end up with a bill for 3/400,000 Rand over the course of 12 months to treat it effectively, where that cost is completely covered by the medical scheme.	
Azania	31:59	Yes. I think...what was the biggest bill that Discovery paid?	32:02
Johnny	32:02	I think often, each year, the highest is in the region of 6-8 million Rand. [...] That's usually a long hospital admission sometimes with very expensive medication. What I wanted, to just draw a link between what we were talking about before of selection, and cancer, is one of the trends we also see in the environment is people buying down. So, families facing financial pressure, they talk to their broker, the broker says, Why don't you just, you know, buy down, you know, to a lower plan, you'll save X per month. And people do this and then lo and behold, you know, 6 months later or 3months later, there's a bad cancer and they suddenly have a huge shortfall, because the plan that they've now downgraded to has got inferior cancer cover. So, I must say I'm having many, many conversations at the moment with families who are now desperate, they want to upgrade again, but the rules only allow you to upgrade at the beginning of the year for exactly this reason.	33:02
Azania	33:02	But just have to protect the broader membership.	33:05
Johnny	33:05	Exactly. So, you can't let people downgrade and then when they find out they're gonna have to claim 2 million Rand for a cancer drug they can suddenly upgrade.	33:11
Azania	33:11	es. Because it's not fair on people that have been paying the higher premium for a longer period.	33:16
Johnny	33:16	But we're chatting to these families but also to brokers and advisors saying, please, please think very hard before you glibly advise people to buy down because you just never know when the family you've just advised is going to, you know, have a really serious problem. That's critical.	33:33
Azania	33:33	Yes. And now there's also a global pandemic of chronic lifestyle diseases. That must have a big impact as well.	33:39
Deon	33:39	It does. To Johnny's point earlier that a member diagnosed with a chronic condition- and for those that don't understand the concept of	33:54

		a chronic condition, it effectively just means that you've been diagnosed as sick and it's not going to go away; that you're always going to have it.	
Azania	33:54	Lifelong management	33:56
Deon	33:56	You can't take it away and by definition, you're going to have to spend the rest of your life managing it, you're going to have to spend the rest of your life seeing your doctors on a regular basis, being screened on a regular basis taking medicine on a regular basis. And if you don't manage it, you may end up in hospital with complications. And it's because of that cost of the chronic condition that that's very detrimental to, I guess, to the members that are contributing to the medical scheme, because it pushes up the amount that they have to put into the pot to pay for everybody's claims. So certainly, we see it on our side as a driving factor in the cost of care and again, hence our focuses to sort of how you design those benefits very effectively around the concept of quality, because again, it's easy to diagnose a member with chronic and make benefits available to them. But if the benefits aren't effective in terms of managing what the person has been diagnosed with, you might as well not pay for it. So, you have to make sure that there's effective management. So again, it comes down to sort of how do you design the benefits effectively? How do you wrap a program around the member? How do you make sure the member's care is coordinated? Especially ones with multiple morbidities, those that have different chronic conditions and they're seeing different doctors for the different conditions, it's quite important that the doctors know how they're treating the patient and that care is coordinated for them. If that care is not coordinated, again, it just adds to the medical scheme and you're actually not seeing the benefit of that for the patient, ultimately.	35:25
Azania	35:25	The advanced illness benefit gives Discovery Health medical scheme members with advanced cancer access to comprehensive care. In partnership with the Hospice Palliative Care Association, trained doctors, nurses and care workers look after you in the comfort of your home. Visit discovery.co.za for more information.	35:52
Azania	35:52	I want to take a few questions from members because there's also the medical savings account which we actually haven't really focused on, which can bring about changes to what you pay every single month, not just towards the medical aid, but also towards your health care costs. So let's take a listen to some of the more general questions, what's sitting in the hearts of our members. Here's a call that we got.	36:15
Esther	36:15	My name is Esther, I have a medical savings account linked to my medical aid and I noticed that I always start the year with savings in this account. But what I don't understand is why my monthly premiums don't add up to the amount I see in my medical savings account.	36:29
Azania	36:29	This is a common issue. And how do you answer her?	36:32
Deon	36:32	So, I think, let me explain the medical savings account. So, what you	37:13

		effectively have if you take your contribution is you have two components to the contribution. You have what we call the risk contribution, that's effectively your insurance premium that's akin to the premium that you pay to your short term insurer for your car, for your household insurance, that's the piece that goes into the pool, and it's pooled with everybody else's risk contributions and when something bad happens to one of the members, we draw on that pool to pay for that, that's the risk contribution part. There's another part of your contribution called the medical savings account and there's a contribution that's specifically for that, that's your money, we don't pull that with the other members' money, someone else can claim from my medical savings account, it's my medical savings.	
Azania	37:13	And this is the part that you can control. If you have children, they need dental work, there's the flu every year, maybe the whole family gets it, you know, so you know the kind of structure or the kind of need that you have.	37:25
Deon	37:25	Correct. There are some restrictions around it. So, by law, we can't contribute more than 25% of your total contribution towards a ... medical savings account. For some families, that actually causes frustration because the actual need for the medical savings account is higher than the 25%. And that's typically the families that would say, like, my savings have run out in April. It's simply because of the restriction on the 25%. They weren't able to allocate enough savings in order to pay for day-to-day claims. [The] medical savings account, it changes your mentality towards claiming in some instances, not always in all instances, but when you approach the medical savings account as 'my money', you start to think differently about it, you know. Should I go to the network GP instead? Because the network GP charges less than the the GP that's contracted that decides to stay outside the network. You start thinking in very much the same way that you would approach buying anything else, really. [...]	38:23
Azania	38:23	Yeah. So you know, this year, little Themba is going to need braces, so you're quite conscious about what you pay out of your own pocket for that consultation on the flu versus allowing the bigger spend towards the whatever need it may be. So, let's take a listen to Devin. Devin also gave us a call.	38:41
Devin	38:41	Hi, my name is Devin and I pay a lot towards my monthly medical aid premium, around R5000 per month. But sometimes I still have to pay in order to cover medicines and dentists and doctor visits. I mean, I don't understand this and it's so frustrating.	38:54
Azania	38:54	So, let's talk about the threshold or what could be going on here. Is it a question of the issue of the threshold within the MSA or not?	39:02
Deon	39:02	Devin's issue could be multiple, multiple, multiple things. So let me put it this way: the plan is designed in such a way to offer you obviously as rich benefits as possible, we put certain things in place to reduce the cost of that. So on some things, we have co-payments. So for example, if Devon was on, Devon was on a network plan, and he decides to use non-network providers, he'd have to pay the co-	40:04

		payment because he chose to say, Well, I'd rather reduce my contribution, but then I'll knowingly have to pay a co-payment outside of the network. The same happens sometimes in the instances of pharmacies, where they charge above say, the agreed levy which we contract with, there would be a co-payment on medicines. It could be that he's taking medicine that's not on the formulary, in which case there might be a co-payment on his medicine. It might be that he's seen a doctor who, because tariffs are not regulated, the doctor charges above the rate at which the medical scheme will reimburse. It's very hard to pinpoint exactly what's causing Devon's shortfalls, but it could be one of a multiple element of things all coming down to plan design.	
Johnny	40:04	Can I jump in? We are very careful to offer members on any plan a very wide range of choice, which gives them full cover with no co-pays. So on all of the examples that Deon gave, there's over 90% of GPs who are contracted with us at a rate that the scheme covers in fault, over 80% of specialists, you know, nearly 3000 pharmacies. So actually, if a member is consciously wanting to avoid co-payments, you can do that and never have a co-payment. Of course, there can be emergency, so you are very badly injured or something happens and you get admitted to a hospital and treated by a specialist who is not contracted. Well, in those life threatening emergencies, the scheme will pay in full as well when you had no choice. My diagnosis of Devon's problem is that he's not fully aware of all the providers who are contracted with us and of the ways he can avoid the co-pays and that's on us. We should communicate that better and we do try. But my advice to Devin would be the next time you need a GP, make sure your GP is covered in full by us. And you can find that on the website. We have a tool called find a provider, and it gives you a geolocation you can look for, I need a pediatrician in Randburg and you'll see the pediatricians in Randburg, and you'll see whether they're covered in full or not. Same with pharmacies, etc, etc.	41:29
Azania	41;29	So that information is there.	41:30
Johnny	41:30	It's there. I think too often, members just go with their friends tell them to go or they go to the specialist that their GP was at medical school with and they don't stop and say, Hey, is this fully covered by my plan?	41:49
Azania	41:49	Avoid co-payments by using a provider in the network because Discovery Health has a payment arrangement with these providers. This extensive network includes doctors, specialists, hospitals and pharmacies. You'll have no unexpected costs as long as you have benefits available on your plan. To find a provider in the network, go to discovery.co.za and click on Find A Doctor.	42:20
Azania	42:20	Can we then look at the self-payment gap and above threshold benefits? How does that work?	42:26
Deon	42:26	So, it's not a feature of all plans. Let me start with that. So, for the plans that have this feature- this would be our executive plans, the comprehensive plans, the priority plans- effectively how it works is	43:52

		that you've got that money that you contribute towards your medical savings account. So, you know that that's how much I've contributed to the medical savings account. In addition to the medical savings account, you've got another benefit called the above threshold benefit. The reason why it's called the above threshold benefit [is] because it's a benefit that kicks in above the threshold, so probably an actuary that named that. What it effectively means is that once my claims for a particular year exceeds a threshold (and that threshold varies by plan) then the medical scheme starts paying your claims now. See, it is that every time I have a healthcare expense this year, it's accumulating towards that threshold, and once I get to that threshold, then the medical scheme will start paying my claims above that threshold. What the self-payment gap refers to is effectively the period during which you're paying claims out of your pocket and not out of your medical savings account. By design, the medical savings account is less than that threshold that we set. So, what's going to happen is you'll claim from the medical scheme, it'll pay out of your medical savings account once your medical savings account is depleted; you're still not at the threshold, which means you're going to pay some of your expenses out of your own pocket. Once you've paid enough to reach that threshold, then the above threshold benefit kicks in and you have the benefits paid for by the medical scheme.	
Azania	43:52	So Deon, how is it decided what treatment is paid from where? Which benefit is paid from where.	43:58
Deon	43:58	We typically distinguish between, sort of, 3 benefit buckets on a broad basis and typically advisors advise on that basis as well. So we typically see hospital benefits, so this is when you're admitted into hospital, or you having a procedure that is can be done in a hospital or out out of hospital, but that's typically the hospital benefit. The cost of that is such that you can't ask a member to pre-fund it because otherwise, why would insurance exist? So, that typically is paid from risk benefits. Does that make sense? That's paid from the pool, so the contributions that are going into the pool, everybody's money is pooled together and when one of the members have a hospital admission, it's paid from that. So, that's how we decide that hospital benefits are paid from risk benefits. Then we have the chronic illness benefits. So, this is for members, as I said, that have been diagnosed with this chronic condition. That's also paid from risk benefit, because again, it's hard to pre-fund for that. So again, you ask members to pool their money, if you're diagnosed with this condition [then] you get the benefit from it being paid from risk benefits. Then you have day-to-day benefits. This is your, sort of, day-to-day health care needs. This is going to the GP when your child is feeling unwell, this is going to the dentist once a year, this is going to the optometrist once a year for new glasses, this is your day-to-day health care needs. Some of that we insure, some of that we don't. If we had to pull all of...if we had to insure all of that, the cost would simply be too much. So, what you're actually allowing members [to do] through the medical scheme is to pre-fund that through the medical savings account. Sometimes with members don't bear in mind with the medical savings account is that if I'm contributing R100 a month	46:06

		towards the medical savings account, over the course of the year, I'm going to be contributing R1200 towards my medical savings account. What the medical scheme does is it gives you the benefit of the R1200 on day one. So, it's effectively almost like a loan that the medical scheme gives you, so it gives you the credit for everything that you're going to be contributing over the year. You can claim it all on day one because we know you're going to be contributing it for the balance of the year. So, that's the benefit of the medical savings account, in addition to pre-funding, but it's really the distinction between day-to-day, hospital benefits and chronic illness benefits that determines the allocation of benefits.	
Azania	46:06	So, now we know how the medical savings account works. We have the big macro and micro picture about what's driving medical health care costs. But there's also the issue of medical aid fraud that goes on. How much of a risk is this? How much of an impact does it have on costs?	46:22
Johnny	46:22	Azania, it's a great question and very topical, as you know. Nobody has a really scientifically validated answer to how big is medical aid fraud in this country or anywhere else. So, numbers have been thrown around. Our regulated council for medical scheme says it could be 20 to 30 billion Rand. So, up to 15% of all claims are fraudulent. [...] We know what we see. It's a bit like, sort of, you know, looking for the bottom of an iceberg. We send down divers and we keep getting deeper and we send more divers and we haven't got to the bottom yet. So, we currently recover more or less 600/ 700 million Rand a year for our medical scheme clients. We think we avoid another billion Rand odd of fraud by a very effective policing, so call it 1.5 to 2 billion a year. But that's, you know, out of probably close to 100 billion of total premium. So, that's probably 2-3% that we're actually touching. Does that mean we're at half or a third? We just really don't know how big the problem is. But it's definitely a very significant problem.	47:34
Azania	47:34	So, the more that goes up, the higher the cost of...	47:37
Johnny	47:37	That's adding to the waste and the abuse, and that's adding to the cost inflation. Exactly. I mean, we estimate that if we, for 10 years had done none of the fraud management and recoveries at all, Discovery Health medical scheme premiums would probably be 20-25% higher today than they are, and they're already high as we all know. So, you know, it's a very, very significant problem.	47:58
Azania	47:58	So Deon, do you know what the rates will be in the coming year already?	47:58
Deon	47:58	Yes, I do.	48:06
Azania	48:06	We'll wait for the release.	48:09
Azania	48:12	Shivani, let me end off with you because you also, you do great work as part of Percept and you're also a great vadvocate for how the healthcare system needs to change in South Africa. How does it need to change in your view?	48:24

Shivania	48:24	I mean, there's so many changes that we need. And I mean, of course, today, we've been talking about medical schemes but actually, you know, there's the country as a whole. I think so many of the challenges that we face as a country are located in our public sector. There's a health system strengthening that's required in terms of the service that's actually delivered in our public facilities. I think that's well recognized, and the interplay between the two systems... we've got... there so many...and they're not insurmountable but they do require strong leadership, clear thinking, and I think commitment from both sectors to actually be able to tackle the problems that we face.	49:04
Azania	49:04	Yes, because we've got to see these matters in a bigger context. Johnny, a final word for our listeners about cost of healthcare.	49:11
Johnny	49:11	I think that informing yourself about how to stretch your health care rand, your medical aid rand as far as it'll go, is really the best advice we can give. There are ways to stretch it, there are ways to make sure you never have co-payments, but you do have to invest the time and effort to be an informed consumer. I often say people spend much more time figuring out the best cell phone package to buy than they do, you know, figuring out their medical scheme, how it works, and where to go for an operation. So you know, given how important your health care and your family's health care is, we really should spend more time on the medical aid and less on the cell phone package.	49:52
Azania	49:52	Yes, I just felt like I've been sent to detention.Thank you to all of you. Thank you for listening to this episode of Discover Healthier, brought to you by Discovery Health. Join the conversation on social media with the hashtag #discoverhealthier and tag @discovery_sa. You can subscribe to our podcast channel Discovery South Africa on your favorite podcast app or visit discovery.co.za to listen to our shows.	50:24