LEARNER GUIDE

Unit Standard Title:	**Analyse the product design/structure of different medical schemes to evaluate the benefits of each scheme Apply the law of contract to insurance**
Unit Standard No:	**242567**
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Analyse the product design/structure of different medical schemes to evaluate the benefits of each scheme

A medical scheme is allowed to be registered in South Africa if it complies with criteria that are set out in the Medical Schemes Act No. 131 of 1998. This ensures that they are financially sound, have sufficient members and do not discriminate against any of its members.

The definition of the business of a medical scheme is found in the Medical Scheme Act and reads as follows:

"Business of a medical scheme" means the business of undertaking liability in return for a premium or contribution:

- *To make provision for the obtaining of any relevant health service*
- *To grant assistance in defraying expenditure incurred in connection with the rendering of any health service;*
- *Where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme*

This learner guide will cover in details how to analyse the product design/structure of different medical schemes to evaluate the benefits of each scheme for different clients be it individuals, corporates or other business entities.

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Module 1

Theories of product development used by medical schemes

This Module deals with:

- Knowledge of insurance principles is applied to explain the structure of medical schemes. (SO 1, AC 1)
- Knowledge of the current Medical Schemes Act and the demarcation debate is applied to differentiate between a medical scheme and medical insurance. (SO 1, AC 2)
- The impact of the National Health Policy and relevant legislation is explained with reference to governance and equitable, affordable and equitable healthcare for all. (SO 1, AC 3)
- Selected products are analysed to identify the principles of health risk management. (SO 1, AC 4)
- The income statement and balance sheet of a medical scheme are analysed to identify financial limitations on decisions about product design. (SO 1, AC 5)

Introduction

Medical Insurance and Medical Aid Schemes are the heart of healthcare. Although there is still need for room for improvement, today over 6 million people are covered by some type of medical insurance or medical aid scheme in South Africa. This Module covers theories of product development used by medical schemes, looking at each concept in some depth.

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1.1 Applying knowledge of insurance principles to explain the structure of medical schemes

- ***Insurance,*** *in law and economics, is a form of risk management primarily used to hedge against the risk of a contingent loss. Insurance is defined as the equitable transfer of the risk of a loss, from one entity to another, in exchange for a premium.*

- *An **insurer** is a company selling the insurance.*

- *The **insurance rate** is a factor used to determine the amount, called the premium, to be charged for a certain amount of insurance coverage.*

- ***Risk management**, the practice of appraising and controlling risk, has evolved as a discrete field of study and practice.*

Apart from the principles governing all contracts insurance is also governed by its own unique principles:

a) Indemnity

Indemnity is perhaps the most fundamental principle of insurance law. The objective of indemnity is to place the insured after the loss in the same position he occupied immediately before the loss. He is not to be placed in a better or worse position.

- Not all insurance contracts are contracts of indemnity e.g. life insurance.
- Indemnity is important as it deals in part with moral hazard.
- Indemnity does not imply that the insured will be indemnified to the full value of his loss e.g. a person whose factory is destroyed by fire cannot recover for loss of profits or against any liability that may arise from the fire unless he has appropriate policies in place specifically designed to deal with these losses.

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Indemnity can be achieved through the following methods:

- Cash
- Reinstatement e.g. where a building is destroyed, insurers may reinstate it.
- Repair e.g. where a motor vehicle is partially damaged.
- Replacement-instead of paying cash a replacement item may be tendered.
- New for old-used for household contents. This is not a violation of the principle of indemnity as there is no principle of law that requires indemnity to be determined in terms of the market value of the asset.
- Valued policies-in terms of which the insurer and the insured agree before hand on the value to be paid should a particular asset be destroyed or stolen.

This method of indemnity is used for assets with a sentimental rather than a commercial value e.g. jewellery, works of art etc. The principle of indemnity is supported by 2 corollaries namely-subrogation and contribution.

b) Subrogation

Subrogation literally means “to stand in place of”. It is the right of one person to stand at law in the place of another and to avail him of all rights and remedies of that other person.

Often when a claim occurs there may be 2 avenues of recovery. Suppose A drives negligently and causes an accident damaging B’s car. If B’s car is insured 2 options are open to him to recover his loss-he can sue “A” in delict for damages or he can claim from his insurer. If “B” pursues both avenues he will receive double compensation.

To prevent “B” from profiting from his loss subrogation is used in terms of which once the insurer has paid “B” the insurer assumes all “B’s” rights to sue “A”. This ensures that the principle of indemnity is preserved.

Subrogation has a number of sub-principles namely:

- The insurer cannot be subrogated to the insured’s right of action until it has paid the insured and made good the loss.

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- The insurer can be subrogated only to actions which the insured would have brought himself.
- The insurer must not prejudice the insurer's right of subrogation. Thus the insured may not compromise or renounce any right of action he has against the 3rd party if by doing so he could diminish his loss.
- Subrogation against the insurer. Just as insured cannot profit from his loss the insurer may not make a profit from the subrogation rights. The insurer is only entitled to recover the exact amount they paid as indemnity nothing more. If they recover more the balance should be given to the insured.
- Subrogation gives the insurer the right of salvage.

c) Contribution

Contribution is another principle that aids indemnity. Often a person has more than one policy on the same asset. Following a loss the position of the 2 policies is governed by the principle of contribution. Since indemnity forbids the insured from recovering more than the loss then he cannot recover the full value of the loss from each of the 2 policies.

The law does not forbid people from engaging in double insurance it only forbids profiting from a loss. Under the common law a person who has double insurance can look to any of the insurers involved for compensation. The insurer who would have paid can then claim contribution from the other insurer involved.

Essentially for contribution to apply the following conditions must be met:

- The 2 policies must cover the same insured.
- They must cover the same subject matter.
- They must cover the same interest.
- The peril causing the loss must be covered by both policies albeit for different amounts.
- Both policies must be current.

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Normally the policies contribute pro-rata to the loss. In some markets the independent liability method is used to determine the levels of contribution. Under this method if the loss is within the sums insured of both policies they contribute equally to the loss.

(d) Average

Average is a concept used by insurers to deal with under-insurance. Underinsurance occurs when an item is insured for less than its market value.

In terms of the common law the general rule is that a person who under-insures his property is entitled to the full amount of his loss whether total or partial subject to the limits of the policy in the absence of any provision in the policy to the contrary e.g. if a house worth R500 000 is insured for R300000 and a loss of R100 000 occurs the insured in the absence of an average clause in the policy would be entitled to R100 000. By implication therefore average is an alien concept to the common law.

Reduced to its logical conclusion average entails that if there is under-insurance the insured shall be his own insurer to the extent of the under- insurance. This means the insured will bear part of the loss as a penalty for underinsurance.
Because average is not recognised by the common law its application in insurance is not automatic. Insurer would have to include the average condition in the policy for average to apply.

(e) Insurable Interest

Insurable interest distinguishes contracts of insurance from gambling in order to define the legitimate area of insurance business. Insurable interest is required for all types of insurance and its absence renders the contract void and hence unenforceable.

The leading Roman-Dutch law case on insurable interest is Littlejohn v Norwich Union Fire Insurance Society 1905 TH 374 where it was held that if the insured can show that he stands to lose something of an appreciable commercial value by the destruction of the thing insured then his interest will be an insurable one. The Court

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went further to state that as a general rule insurable interest should exist at the time of taking the policy and at the time the loss is incurred.

If a person has insurable interest in an asset at the time of taking the policy but loses the interest thereafter e.g. if he sells the car, the policy ceases to have any validity. Insurable interest can be acquired in various ways notably:

- Ownership
- Legal possession
- Custody of property belonging to others e.g. bailees.
- Marriage-spouses have an insurable interest in each other's life.
- A lien-holder has insurable interest in the property subject to the lien.
- A debt creates insurable interest between debtor and creditor.
- An employer has an insurable interest in the life of an employee.
- In life insurance the general rule is that insurable interest need only exist at the time of taking the policy. Thus if A who is married to B takes a life policy on his life and they later divorce the policy will pay on B's death even if technically insurable interest no longer exists because the parties divorced.
- As far as insurable interest of parents in the lives of their children is concerned the position in SA is largely governed by legislation.

Utmost Good Faith ("Uberrima Fides") and the Duty of Disclosure Insurance contracts are characterized by information asymmetries between the parties.
Generally the insured knows more about the risk to be insured than the insurer. To rectify this imbalance the law compels disclosure of information between the parties. To act in good faith entails that parties must deal openly and honestly with each other without suppressing material facts that may influence the judgment of the other party.

The duty to act in good faith applies to all types of insurance contracts. In contracts of sale the maxim caveat vendito applies meaning let the buyer beware. This maxim places an obligation on the buyer to take all reasonable steps to verify that the item he intends to buy meets his expectations. In insurance this maxim does not apply.

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In England the doctrine of utmost good faith is incorporated in the Marine Insurance Act 1906. The requirement of utmost good faith is complimented by the duty of disclosure which places an obligation on both parties to the insurance contract to disclose material facts relevant to the contract to each other.

In England the Marine Insurance Act 1906 defines a material fact as every circumstance that would influence the judgment of a prudent insurer in fixing the premium or determine whether he will take the risk. Hence in England a material fact is defined from the perspective of a prudent insurer. This can result in a heavy burden on the insured.

In SA Courts have accepted the need for disclosure but have rejected the definition of materiality as used in English law. In Mutual and Federal Insurance Co v Oudtshoorn Municipality 1985 1 SA 419 the Court rejected the expression uberrima fides as being alien to our law. The Court also went further to hold that the proper test of materiality should be the standard test of a reasonable man and not that of a prudent insurer.

Failure to disclose material facts renders the contract void-able at the instance of the insurer. Of course the insured is only expected to disclose facts that he knows or ought to know. In life insurance facts commonly regarded as material include-medical history, financial status, family medical history, state of health, life style etc.

In short term insurance common material facts would include-previous convictions, financial status, and whether another insurer has cancelled insured's policy in the past. Some facts though material need not be disclosed. Thus the insured has no obligation to disclose the following facts:

- Any circumstance that diminishes the risk.
- Any fact known or presumed to be known by the insurer.
- Facts on which insurers have waived information.
- The duty of disclosure lasts for the duration of the negotiations and terminates when the contract is concluded. Material facts that come to light after the contract has been concluded are deemed to be part of the risk that the insurer would have assumed.

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- Naturally in short-term contracts the duty to disclose material facts is revived at renewal of the policy. Life insurance contracts are continuing contracts hence the duty to disclose is not revived unless there is a specific duty in the policy obliging the insured to do so.
- To avoid liability on grounds of non-disclosure the onus is on the insurer to prove that:
- The undisclosed facts were material.
- That the facts were within the actual or presumed knowledge of the insured.
- That the facts were not communicated to the insurer.

Upon discovering the non-disclosure the insurer must exercise the right to repudiate the contract within a reasonable time. Thus if upon discovering the nondisclosure the insurer continues to accept the premium for example, the insurer would be deemed to have waived the right to repudiate and the contract will be binding as if there was no non-disclosure.

In summary therefore the duty of disclosure is justified on the following grounds:

- There is information asymmetry between the insured and the insurer. The insured knows more about the risk than the insurer hence the law must compel disclosure.
- Without the duty of disclosure the insurance market cannot operate efficiently such that the supply side of insurance can be disrupted.
- Disclosure enables the insurer to quantify and price the risk appropriately.
- Disclosure also enables the insurer to determine appropriate policy terms and conditions to be incorporated in the policy. It enables the insurer to determine the extent to which the risk being presented deviates from the norm.
- Disclosure also helps insurers manage the problem of adverse selection.
- On the other hand critics of the duty of disclosure point to the following in support of their argument:
- The duty is unduly burdensome on the insured depending on the test used to determine what constitutes material facts.
- Insurers rarely warn the insured about the consequences of non-disclosure.
- Given the current technological advances it is no longer true to say insurers know less about the risk than the insured. The reverse may well be true.

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- The duty of disclosure may be abused by insurers seeking to avoid their obligations.
- There is an element of self-serving hypocrisy by insurers by insisting that facts that lessen the risk need not be disclosed yet these may benefit the insured by way of reduction of premium. Why are insurers only interested in the bad and not the good?

1. Research, define and explain the following terms with examples:
   - medical scheme
   - Insurance principles
2. Explore insurance principles with examples.
3. Explain the structure of medical schemes with examples.

1.2 Applying Knowledge of the current Medical Schemes Act and the demarcation debate to differentiate between a medical scheme and medical insurance

In groups, read the following article and differentiate between a medical scheme and medical insurance.

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Demarcation – What is the debate about?

In April 2012 – The Treasury published draft regulations to both the Long-term and Short-term Insurance Acts, which aim to draw a clear distinction between medical schemes and health insurance policies.

The draft regulations propose scrapping most gap-cover products, but will allow health insurance for loss of income, travel, emergency travel, HIV/AIDS and frail care. The proposals, which are open for public comment until April 23, are the government's response to a court case on the legality of gap-cover products which the Council for Medical Schemes lost on appeal in 2008. The council took Alexander Forbes's short-term insurance subsidiary, Guardrisk, to court, arguing that its gap-cover products were illegal because they were doing the business of a medical scheme but were not registered to do this. The council was denied permission to take the matter to the Constitutional Court, and so turned to the government to amend legislation to deal with the threat it sees in gap-cover products.

For several years now, growing numbers of employers and consumers have been buying top-up health insurance to deal with the payment gaps facing medical scheme members. Medical schemes typically set a ceiling on how much they will pay for healthcare providers' fees, and leave their members to pay the difference if a doctor or dentist charges more. Many medical scheme members face co-payments if they want to use medicines or doctors not on their scheme's approved lists. They often have to pay a lump sum contribution for medical devices or for certain procedures. Into this breach stepped companies selling health insurance products aimed at two categories of consumers: those who already belong to medical schemes and need extra cover, and those who cannot afford even the most basic medical scheme package but want some protection should they face illness or injury. Whether these gap-cover products are a good or bad thing is open to debate. The Council for Medical Schemes believes gap-cover products destabilise the industry because they encourage younger and healthier people to "buy down" and join less comprehensive medical scheme packages, which they then complement with a health insurance "top-up". The other problem with health insurance products, it says, is that they are not subject to the close scrutiny faced by medical schemes, which have to comply with the Medical Schemes Act. This leaves consumers in a weak position if they buy health insurance products that turn out not to give them the cover they expect. Wits health economist Prof Alex van den Heever agrees with concern about the lack of protection for consumers, saying the rights of medical scheme members are spelt out in the Medical Schemes Act. Unlike medical schemes, which must charge members the same rate regardless of health or age, health insurance products can "risk rate" and charge more as people grow older. Companies selling insurance products are also under no obligation to take on an individual, whereas medical schemes by law may not exclude anyone. Prof van den Heever says the regulations do not go far enough and should give the Council for Medical Schemes final say over which products are harmful, rather than the registrar of the Financial Services Board.

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Jonathan Broomberg, the CEO of SA's biggest medical scheme administrator, Discovery Health, says the main impact of gap-cover products is to encourage members and employers to buy down to cheaper options that provide less cover than they actually need.

He says schemes are being undermined in their ability to provide lifetime cover, which is based on those who are healthy subsidising those who are ill over time. Many smaller schemes, and those with relatively poor risk profiles, are already experiencing these negative impacts, he says. Broomberg says gap-cover products offer poor value for money, as many policyholders fail to claim, adding that typical payout ratios of health insurance products are in the range of 30 percent-50 percent, whereas medical scheme payout ratios for hospitalisation or cancer are typically above 98 percent. He says the low payout ratios of health insurance products make them artificially cheap at present. However, they will become more expensive over time, as policyholders claim more and as they age and experience health events. However, the Board of Healthcare Funders, argues that consumers need the protection offered by gap-cover products. Spokeswoman Heidi Kruger says that without set tariffs for doctors, consumers would be disadvantaged if we were to lose gap-cover products completely. Mike Settas, MD of gap-cover seller Xelus, says the government's proposals fail to distinguish between products that complement medical schemes and those that compete directly with them.

Tamar Kahn: Business Day, 8 March 2012

Source: http://www.zestlife.co.za/intermediaries/product-processes/

Review of the History and Legislative Landscape of the South African Market for Hospital Cash Plan Insurance
http://cenfri.org/documents/health%20insurance%20and%20financing/Review%20of%20the%20History%20and%20Legislative%20Landscape%20of%20the%20South%20African%20Market%20for%20Hospital%20Cash%20Plan%20Insurance.pdf

Note: Review of Concerns Regarding the Demarcation between Medical Schemes and Insurance Products
http://hsf.org.za/siteworkspace/demarcation-regulation-review.pdf

January 2000- Press Release: Discovery Health Members Still Fully Covered

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https://www.discovery.co.za/investor.jhtml?p_content=/company_profile/fully.jhtml&_loopback=1

Draft Demarcation Regulations – the chicken or the egg?
http://news.psgkcorporate.co.za/newsletter/draft-demarcation-regulations-the-chicken-or-the-egg/
Health insurance regulations up for comment
http://www.golegal.co.za/legislation/health-insurance-regulations-comment

1.2.1 Medical Schemes Act

The following are excerpts from the Medical Schemes Act:

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Registration of medical scheme

2. (1) Every application for registration of a medical scheme must be in writing and signed by the person applying for the registration of the medical scheme and must contain —

(a) the full name under which the proposed medical scheme is to be registered;

(b) the date on which the proposed medical scheme is to come into operation;

(c) the physical and postal addresses of the registered office of the proposed medical scheme;

(d) two copies of the rules of the proposed medical scheme, which must comply with regulation 4(1), and must be duly certified by the applicant as being true copies of the rules which will come into operation on the date of registration of the proposed medical scheme or the date of commencement of the medical scheme, whichever date is applicable;

(e) the full names, physical and postal addresses and *curriculum vitae* of the principal officer and trustees of the proposed medical scheme;

(f) in the case of a restricted membership medical scheme, the name or names of the participating employer(s);

(g) the name and address of the person who will administer the medical scheme;

(h) a copy of the administration agreement, in the case where the proposed medical scheme is to be administered by an administrator;

(i) a copy of any other joint-administration agreement between a medical scheme and any other party;

(j) the guarantees and the guarantee deposit vouchers as the Registrar may require;

(k) a detailed statement of services to be undertaken, directly or indirectly, on behalf of the proposed medical scheme by an administrator, broker and managed care organisation;

(l) a detailed business plan; and

(m) such other information as the Registrar may require.

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Prescribed Minimum Benefits

8. (1) From the date of commencement of these regulations, the prescribed minimum benefits that medical schemes must offer in terms of the Act consist of the provision of treatment for all the categories of Diagnosis and Treatment Pairs listed in Annexure A subject to any limitations specified in Annexure A.

(2) Any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in Annexure A in at least one provider or provider network which must at all times include the public hospital system.

(3) Cover in the public hospital system must include all the costs of diagnosis, treatment and care for the prescribed minimum benefit Diagnosis-Treatment Pairs in Annexure A to a level and entitlement that is not different in terms of quality and intensity to the services provided to publicly funded patients.

(4) Medical schemes may offer enhanced options to their members through additional cover for any specific entitlements: Provided that diagnosis, treatment and care under the prescribed minimum benefits is provided.

(5) The options referred to in sub regulation (4) may include the use of alternative providers or provider networks and could incorporate member co-payments, or enhanced options for other benefits that fall outside of the prescribed minimum benefits or both.

(6) If cover for a prescribed minimum benefit as defined in Annexure A under an enhanced option is exhausted while the patient still requires diagnosis, care or treatment for that prescribed minimum benefit , that patient may be transferred to a lower cost provider or provider network, but the medical scheme must continue to be fully liable

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for all costs incurred in delivering the prescribed minimum benefit care that is required.

(7) A member or dependant shall not lose his or her entitlement to any prescribed minimum benefit, regardless of any enhanced option they may choose or as a result of any condition associated with that enhanced option.

(8) Medical schemes may employ appropriate interventions aimed at improving the efficiency and effectiveness of health care provision provided that every option offered by a medical scheme must at least provide full cover for prescribed minimum benefits in at least the public hospital system.

(9) These regulations must not be construed to prevent medical schemes from employing techniques such as the designation of preferred providers, requirements for Pre-Authorization and the application of Treatment Protocols: Provided that in the case of Pre-Authorization a medical scheme must not refuse authorization for the delivery in a public hospital of standard treatment for a prescribed minimum benefit as defined in Annexure A.

(10) Every Medical Scheme must make provision in its rules for the reimbursement of the cost of care that is considered to fall within the Prescribed Minimum Benefits prescribed under these Regulations within all the membership options that the medical scheme offers.

(11) Medical schemes must refer to these Regulations in their rules and such reference may not be a full reproduction of these Regulations.

(12) Medical schemes must specify in their rules whether they restrict the provision of the prescribed minimum benefits under specific membership options to a named network of providers.

(13) The Registrar must determine whether a medical scheme's rules are consistent with the provisions of the Act and these Regulations before approving such rules.

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(14) Disputes and complaints between a member or a provider and the medical scheme in relation to minimum prescribed benefits must be dealt with in terms of Chapter 10 of the Act.

Limits on benefits

9. A medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the prescribed minimum benefits, *pro-rata* to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned.

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Conditions to be complied with by brokers

28. (1) A medical scheme must not compensate any person in terms of section 65 for acting as a broker unless such person —

(a) has been accredited by the Council to act as a broker or apprentice broker;

(b) has been issued with a certificate by the Council;

(c) is a fit and proper person for purposes of acting as broker or apprentice broker;

(d) enters into a prior written agreement with the medical scheme concerned, and the nature and compensation payable to such person must be fully disclosed in the financial statements of the medical scheme concerned;

(e) discloses to the prospective member the name of the medical scheme concerned and the fact that he or she is acting in terms of an agreement;

(f) discloses to the prospective member the registered contributions for the cover;

(g) discloses to the prospective member the nature of the services rendered by the broker;

(h) provides best advice and acts at all times in good faith towards the member, the prospective member and the medical scheme concerned;

(i) provides documentary proof to the member or prospective member that he or she has obtained accreditation from the Council;

(j) discloses to the member or prospective member the compensation payable to the broker, which shall not be in excess of the maximum amount as determined in terms of sub regulation (2);

(k) complies with the minimum level of services provided for in the accreditation requirements;

(l) complies with the recognised educational qualifications contemplated in sub regulation (8);

(m) complies with the code of ethics for appropriate behaviour provided for in the accreditation requirements; and

(n) undertakes not to receive any other incentive, reward or compensation from any other source in addition to the disclosed compensation as contemplated

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in subparagraph (d).

(2) A maximum amount payable in a given year in respect of the performance of services relating to the introduction of a member to a medical scheme by any number of brokers shall not exceed 3% plus value added tax (VAT) of the contributions payable in respect of members introduced by such broker during that year.

(3) Sub regulation (2) must not be construed to restrict a medical scheme from applying a sliding fee scale based on the size of the group being introduced provided that the maximum amount in respect of a member introduced as specified in sub regulation (2) is not exceeded.

(Incorporating amendments published in Government Notice R.570 Gazette Nr 21256 dated 5 June 2000)

(4) No compensation is payable unless such compensation has been indicated in the rules of the medical scheme concerned.

(5) A medical scheme must not prevent a person form applying for membership of a medical scheme for the reason that that person is not using a broker to apply for such membership.

(Incorporating amendments published in Government Notice R.570 Gazette Nr 21256 dated 5 June 2000)

(6) A person is disqualified from performing broker services if he or she is an unrehabilitated insolvent or has previously received a disqualifying rating as a broker or apprentice.

(7) Any person desiring to be accredited as a broker must apply in writing to the Council and the application must be accompanied by documentary proof of a recognized educational qualification and appropriate experience.

(Incorporating amendments published in Government Notice R.570 Gazette Nr 21256 dated 5 June 2000)

(8) A recognised educational qualification and appropriate experience, for the

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purposes of this regulation, means —

- ❒ Grade 12 education; and
- ❒ a minimum of two years demonstrated experience as broker or apprentice broker in health care business;

1.3 The impact of the National Health Policy and relevant legislation

The principles for developing National Health Insurance (NHI) as described in the Green Paper are to improve access to quality healthcare services for the whole population and to provide financial risk protection against health-related catastrophic expenditures. Comprehensive healthcare should be provided through accredited and contracted public and private providers, with a strong focus on health promotion and prevention services at the community and household level. (***Important note: with reference to the National Health Insurance- the government is currently reviewing this***)

The objectives of the National Health Policy include:

- To improve access to quality health services for all South Africans, irrespective of whether they are employed or not
- To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund
- To procure services on behalf of the entire population and efficiently mobilise and control key financial resources
- To strengthen the under-resourced and strained public sector so as to improve health systems performance

Various legislations are in place to ensure that all South Africans can receive and afford good healthcare services.

The purpose of the National Health Act is to unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa. It also provides the opportunity for a system of cooperative governance and management of health services, within national

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guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services.

The act establishes a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation. It promotes a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans.

Explain the impact of the National Health Policy and relevant legislation with reference to governance and equitable, affordable and equitable healthcare for all.

1.4 Health Risk Management

In some ways the challenges involved in personal health risk management are the same as those presented for death and disability. However, here there is another aspect to be considered - the management of health conditions to maintain a financially feasible/optimum plan. This includes seeking out the optimum approach to funding healthcare costs - the most suitable combination of medical aids, health insurance, etc. Increasingly this is being combined with health cost curtailment programs such as managed health care schemes.

Preventative Care

There is a growing awareness of the need to focus on the preventative side of medical care. On the one hand this involves truly precautionary steps such as diet,

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exercise and general lifestyle, whilst on the other hand it also involves early diagnosis of conditions with suitable medical intervention.

Traditionally medical aids have been somewhat hesitant to offer cover for preventative issues. Indeed, it is only in the past few years that we have seen some schemes including repayments for costs associated with sterilisation or other birth control measures, even though they were happy to meet the (heavier) costs of childbirth. Similarly, most of us would not expect to be able to claim the costs of a health club subscription from medical aids.

The role of funding

Funding involves three main areas:

Ensuring sufficient funds for appropriate medical attention whilst the simplest form of this is an especially ear-marked savings account, the danger in this approach lies in the possibility that a fairly large demand could be placed on the funds early on, before sufficient cushion has been built up. Another issue is the fact that it is generally true that some people are just “unhealthy”, mainly through genetic causes, and for them the cost of funding adequately could be prohibitive. The normal solution to these problems has been in the basic concept of insurance as applied in medical aid schemes - pooling of the risk and cross-subsidisation.

Maintaining a control over costs

The system of health treatment is such that it is sometimes difficult to ensure that cost increases are genuine. After all, without wishing to be disparaging of the medical profession, we find that there is often pressure on them to make 100% sure that the treatment is totally successful, since patients would otherwise have cause for complaint. There is also the simple financial matter that suggests that a practitioner should seek to “get as much out of the patient as possible”. With the general lack of medical knowledge on the part of most patients, over-treatment is a definite possibility, since the matter is really out of the patient’s hands and mostly paid for by the medical aid.

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In all of this there is a need to maintain a balance between the care and the costs. For example, surgery may be expensive, but if it cures the condition swiftly and effectively it may ultimately be a better choice than an alternative prolonged “half-measure” treatment. However, increasingly a new perspective is being introduced in the so-called “new generation” medical schemes, where recognition is given to the fact that there are some procedures where the patient does have control (for example, whether to take a minor ailment to the doctor or to the chemist) and so increasingly the insurance cover is being offered only for the more major conditions, where the patient is more reliant on the medical practitioner.

Managed health care schemes seek to solve the problem in one of two ways - either through the introduction of professional checks by more than one practitioner (either after the treatment or, preferably, before) or through arrangements with specific practitioners or groups of practitioners where a flat fee is negotiated for treatment as a whole, thereby putting the onus on the practitioner to provide the most cost-effective treatment (hopefully without sacrificing quality).

Ensuring post-retirement care

Most medical expenses are incurred in one’s later years and there is an increasing realisation of the need for funding for this. However, such funding has an impact on current expendable income. While pre-funding through savings schemes is one consideration another approach, largely confined to several more advanced countries overseas, is that of frail care, where the individual contributes to a fund during his or her working life and, in return, is guaranteed suitable postretirement care.

Personal choice

One should not forget that medical attention is essentially an intensely personal matter. People become familiar and comfortable with certain practitioners, whilst it is also fair to say that we each have a different value scale when it comes to medical expenses. (For example, one person may be happy to pay the higher costs associated with a private ward at a private hospital, whereas for another the general ward at a Government facility serves the purpose adequately.)

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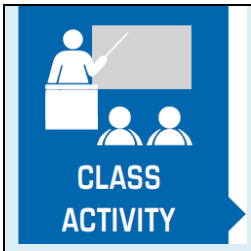
Whilst this reality makes it important to ensure sufficient choice, it is also necessary to ensure that certain people do not "abuse" any scheme unduly at the expense of others.



Instructions to the facilitator

1. Demonstrate how to anayse different products in order to identify the principles of health risk management.
2. Give learners time to practice.

1.5 Financial limitations on decisions about product design

Medical schemes respond with a range of product designs and solutions and managed care initiatives to avert insolvency. It is very important to always know the financial limitations on decisions about product design of a medical scheme.

This can be achieved by analysing the income and expenditures of the scheme which is stipulated in its income statement and the scheme's assets and liabilities as stipulated in its balance sheet.

Analysing the income statement and balance sheet of a medical scheme will enable you to identify financial limitations on decisions about product design. This is so because you will be able to tell how much the scheme is generating as Income per

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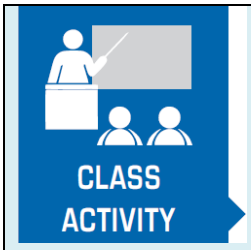
year, how much it is spending, how much it own as assets and how much it owe in terms of liabilities.



a) Obtain the income statement and balance sheet of a medical scheme of your choice.

b) Analyse the income statement and the balance sheet to identify financial limitations on decisions about product design.

c) Discuss your findings with the rest of the class.

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Module 2

A needs analysis of a client or target market

This Module deals with:

- The needs of an individual member or group are analysed with reference to demographic information. (SO 2, AC 1)

- The expectations of a selected client or target market regarding membership of a medical scheme are analysed in terms of perceptions, healthcare needs and other drivers that influence the choice of option. (SO 2, AC 2)

2.1 Analysing the needs of a client with reference to demographic information (AC 1, AC 2)

As a healthcare consultant one of the most important requirements in delivering a good service is to understand the needs of the client and to provide him with good and objective advice. In order to do this, the healthcare consultant must perform a Needs Analysis. This will enable you to analyse the needs of an individual member or group with reference to health status, income, family size and age, geographic distribution, membership of other medical schemes, occupation and level of education.

2.1.1 The Needs Analysis

Individual healthcare needs depend on the individual's circumstances, financial position and priorities. It is important to remember that each individual is unique. It is tempting to use the usual stereotype; high income-earners require comprehensive medical cover, regardless of the cost whilst a low income-earner is only able to provide for more basic cover. However, this approach is not professional and could expose the broker to accusations, and even litigation for providing poor advice. A proper needs analysis must be done.

What does a healthcare needs analysis then look like? Healthcare funding needs could comprise the following:

- Cover for Hospitalisation (In-hospital cover)
- Cover for day-to-day expenses (Out- of-hospital cover)

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- Minimum benefits
- Auxiliary benefits
- Affordable premiums
- Sustainability
- Simplicity
- Accurate and prompt administration

A healthcare needs analysis can be defined as an examination or interpretation of what the client requires or wants. The result of this needs analysis can never cloud the judgment of a health benefit advisor. The client will judge for himself. The health benefit advisor's role is to guide the client to make an informed decision. You should put into consideration the expectations of clients or target market regarding membership of a medical scheme. A process that could be followed in a needs analysis is to:

Step 1:
Determine the affordability level of the client.

Step 2:
Determine the family circumstances, in respect to …

- Principal Member,
- Spouse,
- Children,
- Health circumstances – pre existing condition and current health risks.

Step 3
Match the specific product type e.g.: Traditional, New Generation or cafeteria products with the client's needs.

Step 4
Determine the level of cover needed by the client. Is the cover needed at cost (South African Medical Association (SAMA) or reduced rates (Board of Health Funders (BHF))?

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Step 5:

Determine the level of hospital cover. Is the need for unlimited cover, or is the client prepared to self-insure, and if so, to what extent?

Step 6:

What specific day-to-day or out of hospital conditions will be covered and to what extent? If the specific plan has a savings portion, to what level must provision *for* savings be made?

Step 7:

Must the minimum benefits be topped up and if so to what level?

Step 8:

Compare the benefits on a like-for-like basis across a number of medical scheme products available on the market. This means that benefits must be compared in an easily understandable basis.

Step 9:

Advise the client of the disadvantages and advantages of each benefit option and give the client the opportunity to choose a preferred option. The expectations of a selected client or target market regarding membership of a medical scheme

Step 10:

Advise the client about the need for pre- funding, and should such a need arise; advice must be sought from an expert to provide for that need.

The preferred solution for a client may be at one or more health administrator and therefore step 8 is very important. Some clients may rather not want to go the route of choosing a medical aid according to the level of cover, but more in terms of the financial stability of the medical scheme. Steps 3 to 7 might therefore be changed to look into financial aspects such as:

- Current reserve ratios.
- Current solvency ratios.

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- Previous years underwriting profit (loss).
- Administration costs.
- Date registered.
- Membership base.
- Membership growth.

Read the following scenario and complete the questions that follow

Scenario 1

Mr Jackson is a single male living on his own and having reached the age of 35 years, now decides that he needs to insure his health needs. He approaches you, as a recognised healthcare broker to research the best option at the best price. He would like to start as soon as possible, but is concerned that he will have waiting periods placed on him. He also wants to be reassured that he will be admitted onto the scheme. Mr Jackson has no current medical conditions but did suffer from appendicitis 6 months ago, broke a leg 4 years ago and his family has a history of Hypertension.

Scenario 2

Mr and Mrs Naidoo (36 and 34 years old respectively) are a well to do married couple, who have belonged to a medical scheme for nearly ten year. However, Mr Naidoo, who was the principal member was retrenched two month ago and as a result was forced to cancel his membership with the scheme. He has recently found new employment but his new job does not prescribe membership to a medical scheme.

Mr Naidoo comes from a sickly family and has already been diagnosed with Metabolic Syndrome (Diabetes, High Cholesterol and Hypertension) due to his sedentary life style. He is obviously concerned that he needs to be placed on a Medical Scheme that caters for the above condition.

You are approached by Mrs Naidoo to research and suggest some alternatives to them.

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Module 3

Benefits to a selected client or target market

This Module deals with:

- Different benefit structures are analysed and compared with reference to exclusions, limitations and additional insurance cover. (SO 3, AC 1)
- Issues or factors that influence member choice are identified for a selected client or target market. (SO 3, AC 2)
- A set of scheme rules, member benefits guides and rate tables are analysed to determine cover, exclusions and limitations. (SO 3, AC 3)

Not all benefit structures across various schemes are the same. Structures vary in terms of various elements. These include exclusions and limitation, which usually plays the largest role when it comes to claiming.

Where the rules and mandates state what the scheme covers and what the parameters are, exclusions and limitations state what does not fall within the scheme. In some events, based on the unique needs of the client, the financial advisor might have to apply for additional cover. These needs and factors should be identified to ensure ideal fit between needs and cover.

3.1 Analysing and comparing different benefit structures with reference to exclusions, limitations and additional insurance cover (AC 1, AC 3)

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The main differences between different medical aids and options within them, is the cover provided with regards to specialists and other suppliers while you are in hospital. In South Africa we have two types of medical schemes:

- **Closed medical aid schemes**: These schemes are only open to a particular company, profession, trade, industry, calling, association or union that has established a scheme exclusively for their employees and members.

- **Open medical aid schemes**: These schemes are open to the public. There are currently 26 open medical schemes in South Africa. Their benefits are much more innovative.

Exempted Schemes

These schemes are exempt (for historic reasons) from the provisions of their legislation such as the Industrial Council Act. Although they are not legally obliged to do so, the majority of these schemes do report to the Registrar and for all practical reasons operate as if they were registered in terms of the Medical Schemes Act. Different products in the South African Market

In South Africa we have two types of Products

1. Traditional Medical Scheme

All medical expenses are paid with money from your medical schemes account

- Money in a risk pool
- Limits start fresh each year
- If you don´t use the benefit, you lose

In essence, traditional cover generally means all your medical expenses are paid in full. Whenever you need medical attention or day to day visits to the General Practitioner (GP), it is paid for by the scheme.

2. New Generation Medical Schemes

This product can be divided into TWO:

1. **Risk Pool** - This benefit covers your hospitalisation and includes uncontrollable expenses or major claims e.g.: major surgery and chronic benefits.

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These can be typical low frequency events but high cost items that you really have no control over.

2. **Medical Savings Accounts** - This benefit cover day to day expenses or controllable expenses. Day-to-day expenses like visits to the GP, Dentist, Optometrists, over-counter medication and other out of hospital benefits is normally paid out of the savings account.

   Under these schemes you can have the high risk benefit as a standalone product, called a hospital plan or a combined benefit between the two, called a full medical plan. In the latter, once your savings are depleted your day to day account falls away.

The New Generation Medical Savings Account (Cumulative)

By definition, the medical savings account is an account into which the member can accumulate money up to a maximum amount of 25% of his total annual sum of medical scheme contribution. These monies belong to the member and usually the medical scheme will allow it to be used for the following purposes,

- Surgery and other procedures for the purpose of correcting refractive errors.
- In-Vitro Fertilisation and Infertility treatment.
- Treatment relating to sexual dysfunction.
- Treatment relating to or forming part of Organ Transplants including maintenance medication in the private sector.
- Treatment for cosmetic purposes.
- Treatment relating to or arising from participation in professional sporting activities.
- Examinations for insurance, school, association, emigration, visa, employment or similar purposes.
- Anti-alcohol and anti-smoking drugs.
- Obesity
- Educational Therapy

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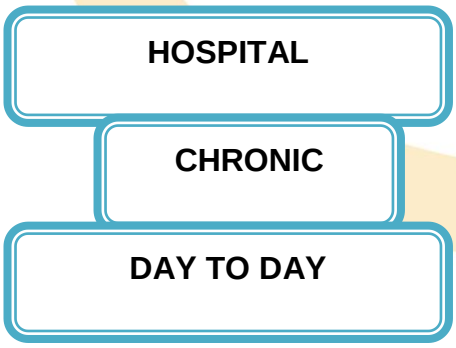
- Protective gear
- All costs relating to or forming part of the treatment of HIV/AIDS
- Costs associated with, or arising out of willful self-injury, suicide or attempted suicide.
- Hearing devices including cochlear implant devices, whether introduced internally or not, as well as the maintenance of these devices.
- Household remedies, contraceptives, patent medicines, non-ethical and all proprietary preparations including but not limited to vitamins, minerals, face creams, body lotions, soaps, shampoos, laxatives.
- All costs arising from injury or illness for which any other party is liable unless the scheme is satisfied that there is no reasonable prospect of the member recovering adequate damages from the other party.
- All treatment and costs incurred for which benefits are not specifically provided.

Medical aid services can be differentiated as follows:



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1. **Hospitalisation** - This is the expensive part of the medical aid, commonly known as RISK. Different medical aids pay different tariffs, ranging from 100%-300% of the local charging structure.

2. **Chronic Medication** - The top 25 commonly known chronic diseases must be paid by all medical aid societies. The more comprehensive your plan, the better the chronic benefits will be.

3. **Day to Day** - This benefit is for all out of hospital benefits, such as Doctors, Dentists, Specialists, Optometrists and prescription medication.

   In this area we have a Traditional Option (set benefits and what you do not use in the year will fall away), and a new Generation Option (medical savings account from which out of hospital expenses are paid.

   It is an upfront Rand value amount and can be carried over to the following year.) Each of these options is divided into different plans, ranging from Hospital plans to Comprehensive plans.

All medical aid companies have an open door policy, so no medical aid can decline your application. Therefore, the medical aid societies need to assess the risks they are taking on. To do so, they may apply the following penalties on application:

On admission to membership a scheme may impose:

1. A 3 month general waiting period
2. A 12 month condition-specific waiting period, or
3. A waiting period on certain prescribed minimum benefits (PMB´s)
4. A Late joiner´s penalty - (LJP´s)

The late joiner´s penalties are as follows:

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1-4 years (of break or not being insured): 5% loading on premium

5-14 years: 25% loading on premium

15-24 years: 50% loading on premium

25+ years: 75% loading on premium

Except:

1. A child born to a member
1. Change between benefit options
2. Termination of membership due to employment or employer changing schemes.

In addition, medical schemes provide members with a range of benefit options that best suit their/their family's unique needs.

Plans may offer excellent hospital and medical benefits at very competitive and affordable rates. In particular, some medical schemes ensure that families with children benefit from low cost child premiums.

Example of rate table:

Monthly contributions	**Private choice**	**Private**	**Private plus**	**Private comprehensive**
Adult	R855	R1 265	R1 550	R2 045
First child dependant	R320	R340	R340	R340
Each additional child dependant	R115	R125	R125	R125

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3.2 Issues or factors that influence member choice

Not all medical schemes offer the great benefits and cover levels for a client. You should identify issues or factors that influence member choice. Factors that influence a member's choice includes:

- Does the medical aid scheme offer the type of medical aid plan I like?
- Does the scheme offer plans that i can afford? Rates should be affordable, and increases should remain consistently low.
- Does the scheme I am considering will cover for any existing medical ailments i may have?
- Professional sports injuries
- Cover for extreme sports
- Contraception
- Malaria
- Precautions
- Hormone Replacement Therapy (HRT)
- The use of formularies
- designated service providers
- Gap cover
- Medical cover outside of South Africa.

- *Don't be distracted by bells and whistles. Some medical aid schemes in South Africa offer a range of attractive extras, such as discounts on movie tickets, cheaper airline flights, gym memberships or cheaper groceries. But all these "nice to haves" mean very little if you are not sufficiently covered when you need it most.*

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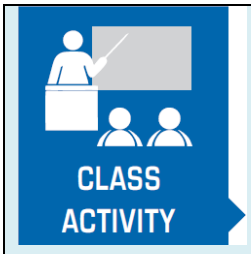
- *Make sure that the medical aid scheme offers chronic illness cover and prescribed minimum benefits.*



Instructions to the facilitator

Provide learners with examples of different benefit structures. In front of the class demonstrate how to:

1. Analyse and compare different benefit structures with reference to exclusions, limitations and additional insurance cover.
2. Identify issues or factors that influence member choice for a selected client or target market.
3. Analyse a set of scheme rules, member benefits guides and rate tables to determine cover, exclusions and limitations.
4. Give learners time to practice.

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Module 4

Current developments in benefit design and the potential impact on schemes and options

This Module deals with:

- Limitations on benefit design are explained with reference to legislation and Government healthcare policy. (SO 4, AC 1)
- Current industry responses to the burden of disease are investigated with reference to management of chronic and dread disease, anticipated health threats and pandemics, high cost claims and other high cost drivers. (SO 4, AC 2)
- The role of wellness initiatives is researched with reference to the contribution of wellness to the management of risk. (SO 4, AC 3)
- Challenges to the industry as a result of the introduction of low cost options are discussed with reference to threats and opportunities. (SO 4, AC 4)

4.1 Explaining limitations on benefit design with reference to legislation and Government healthcare policy

Recently it has become the norm not to exclude most things from the benefits of a medical scheme, however medical scheme product designers are very careful in what they include in the insured benefit portion of their scheme. The items listed below usually do not qualify for payment from insured benefits but may be payable from the Day-to-Day Cover or Individual Medical Savings Account if funds are available:

Common Exclusions

- Surgery and other procedures for the purpose of correcting refractive errors.
- In-Vitro Fertilisation and Infertility treatment.
- Treatment relating to sexual dysfunction.

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- Treatment relating to or forming part of Organ Transplants including maintenance medication in the private sector.
- Treatment for cosmetic purposes.
- Treatment relating to or arising from participation in professional sporting activities.
- Examinations for insurance, school, association, emigration, visa, employment or similar purposes.
- Anti-alcohol and anti-smoking drugs.
- Obesity.
- Educational Therapy.
- Protective gear.
- All costs relating to or forming part of the treatment of HIV/AIDS (although now most medical schemes cover this specifically).
- Costs associated with or arising out of wilful self-injury, suicide or attempted suicide.
- Hearing devices including cochlear implant devices, whether introduced internally or not, as well as the maintenance of these devices.
- Household remedies, contraceptives, patent medicines, non-ethical and all proprietary preparations including but not limited to vitamins, minerals, face creams, body lotions, soaps, shampoos, and laxatives.
- All costs arising from injury or illness for which any other party is liable unless the scheme is satisfied that there is no reasonable prospect of the member recovering adequate damages from the other party.
- All treatment and costs incurred for which benefits are not specifically provided.

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- Pre-existing conditions: A pre-existing condition is an illness or injury that began or occurred before you were covered under your policy. These conditions are sometimes excluded from coverage, but are often covered after a specified waiting period (e.g., six months with no treatment or six months on the plan).

- Non-duplication of payments/coordination of benefits: To prevent double coverage, many policies specify that benefits will not be paid for expenses that are reimbursed by other insurance companies. This provision limits the total payment of benefits to 100 percent of covered expenses.

Limitations and exclusions can vary quite a bit among policies. The best way to find out what's covered (and to what extent) and what's not is to read your policy carefully and ask your insurer. The policy should specifically list all of the coverage limitations and exclusions.

According to the Council for Medical Aid Schemes in South Africa, no restrictions, co-payments, waiting periods, or exclusions may apply to any person in respect of the prescribed minimum benefits, if the services are rendered by State hospitals or DSPs. In circumstances where services are voluntarily obtained by the patient from a non-DSP, co- payments may apply or waiting periods may be imposed. However, a waiting period only applies to patients who have never belonged to a medical scheme, or have been a member for 90 days or less.

Laws have been put in place to guide people when it comes to medical schemes.

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Examples include:

- *The National Health Act*

- *Medical Schemes Act: Because of the nature of medical schemes and the service they provide, legislation has been put in place to protect the interests of the consumer. It covers the following important elements:*
  - *Administrative requirements*
  - *Contributions and benefits*
  - *Managed Health Care*
  - *Administrators*
  - *Conditions to be complied with by brokers*

Explain limitations on benefit design with reference to legislation and Government healthcare policy.

4.2 Investigating current industry responses to the burden of disease with reference to management of chronic and dread disease, anticipated health threats and pandemics, high cost claims and other high cost drivers

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Disease management (DM) is the concept of reducing healthcare costs and/or improving quality of life for individuals with chronic disease conditions by preventing or minimising the effects of a disease, usually a chronic condition, through integrative care. DM is also often known as: demand management, health management programs, or disease self-management.

Disease Management has evolved from managed care, specialty capitation, and health service demand management, and refers to the processes and people concerned with improving or maintaining health in large populations. As opposed to epidemiology, which is generally concerned with sudden or persistent virulent outbreaks of disease, Disease Management is concerned with common chronic illnesses, and the reduction of future complications associated with those diseases.

Illnesses that Disease Management would concern itself with:

- Coronary heart disease
- Kidney failure
- Hypertension
- Heart failure
- Obesity
- Diabetes mellitus
- Asthma
- Cancer
- Arthritis
- Clinical depression
- Sleep apnea
- Osteoporosis, and
- Other common ailments.

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Private and public policymakers and health insurance plans increasingly are examining and introducing disease management programs to help treat chronic illnesses such as cardiovascular disease and stroke. This trend highlights the importance of assessing the clinical and public policy implications of this phenomenon from the perspectives of patients' best interests and quality of care.

Disease Management experts recommend the following guiding principles for the development, implementation, and evaluation of disease management initiatives:

- The main goal of disease management should be to improve the quality of care and patient outcomes.
- Scientifically derived, peer-reviewed guidelines should be the basis of all disease management programs. These guidelines should be evidence based and consensus driven.
- Disease management programs should help increase adherence to treatment plans based on the best available evidence.
- Disease management programs should include consensus-driven performance measures.
- All disease management efforts must include ongoing and scientifically based evaluations, including clinical outcomes
- Disease management programs should exist within an integrated and comprehensive system of care in which the patient-provider relationship is central.
- To ensure optimal patient outcomes, disease management programs should address the complexities of medical co-morbidities.
- Disease management programs should be developed for all populations and should particularly address members of the underserved or vulnerable populations.
- Organisations involved in disease management should scrupulously address potential conflicts of interest.

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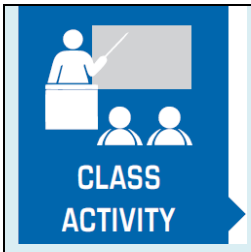

Instructions to the facilitator

In front of the class,

1. demonstrate how to investigate current industry responses to the burden of disease with reference to:
    - management of chronic and dread disease
    - anticipated health threats and pandemics
    - high cost claims, and
    - other high cost drivers

2. Provide learners with guidelines to implement lessons learned.

3. Give learners an assignment where they can apply lessons learned.

4.3 The role of wellness initiatives

Wellness can be defined as a state of physical and psychological harmony with external factors and each other.

As an emerging epidemic of non-communicable (lifestyle-related) diseases threatens South Africans, wellness initiatives are being increasingly viewed as a primary channel for delaying/ minimising the effects of the disease process, thereby reducing the final expenditure of the scheme.

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Wellness initiatives are not only vital in countering the increased absenteeism and reduced performance at work (presenteeism) that result from an escalation in these diseases, but they can also be a primary channel for controlling medical schemes' loss ratios and improving solvency.

It makes sense to promote wellness initiatives in order to but delay the process, minimize the effects of the disease process, thereby reducing the final expenditure of the scheme. In terms of wellness, a proactive approach should be encourages in policy holders and service providers.

Health and Wellness Programme

Information, education and communication are crucial aspects of a successful, integrated Health and Wellness Programme. Key aspects of the programme include health risk assessments, clinical health screenings (through wellness days), relaxation interventions and lifestyle management for executives.

In pairs,

I. Obtain access to the internet.
II. Research the role of wellness initiatives with reference to the contribution of wellness to the management of risk.
III. Print copies of wellness initiative articles and discuss with the rest of the class.

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4.4 Challenges to the industry as a result of the introduction of low cost options

Opening the private healthcare sector to low-income earners through affordable medical scheme membership is part of a broader agenda to transform healthcare in South Africa.

Opportunities

- Low-income earners are a vast largely untapped market for the medical schemes industry.

- Low-income options present the only real opportunity for growth in the medical schemes industry, as the higher-income market is already saturated.

Challenges

- Despite the need for access to medical schemes, there has been little growth in new membership. Low income earners hardly join medical schemes. The reasons why people are not joining schemes include: shrinking employment in the formal sector of the economy; the unaffordability of membership; and, falling disposable incomes.

- The medical schemes industry is highly competitive, with a substantial number of members moving between schemes. A significant portion of new members consist of people moving from one scheme to another, cheaper scheme, or from a high- to a low-cost option within their scheme.

- In the past schemes have structured their benefits in such a way that many members who are in poor health are forced to join the more expensive options if, for example, they want to access chronic medicine benefits.

  This has forced members who cannot afford to pay the higher rates to buy down into the lower-cost options. As a result, the low-cost options have a lot less healthy members and their claims soar. The ultimate consequence of this

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is that the contributions on these options increase, making them less affordable.

Discuss challenges to medical aid scheme industry as a result of the introduction of low cost options with reference to threats and opportunities.

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