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COVER

LEARNING FROM THE MEDICAL MALPRACTICE CRISIS: AVOIDING THE BOILED FROG

A recent article by Larisse Prinsen published in The Conversation provided a wide-ranging perspective on the causes behind increasing cases of medical malpractice.

According to Prinsen, medical malpractice claims have been on the rise since 2014 – in the last financial year alone, more than R6.5 billion (over US$390 million) was raised in medico-legal claims. This article got me thinking about the ways in which risk management in South Africa's corporates could benefit from lessons in the crisis from the medical malpractice sector.

We know that insurance premiums/membership fees in SA for Obstetricians (incl Gynae) increased from about R100 000 per annum in 2010 to R1,2 million in 2020. This information is based on the Losses Occurring Product supplied by the Medical Protection Society – an unregistered UK insurance mutual. Fees for most other types of specialist medical practitioners also increased by multiples of 3 to 5 times over this 10-year period.

When premiums became unaffordable – to the extent of driving specialists out of business– urgent solutions were sought to address this critical need. The situation can be compared to a corporation that struggles to obtain reasonable insurance cover once underwriters either refuse extensions on outstanding risk improvement requirements or retract capacity following substantial claims.

This information begs the question: Why do we not prepare better for emerging risks? Are we too optimistic about our "maak 'n plan" capabilities?

Why do we think that unexpected losses are "Black Swans" when in reality many "Black Swan" events provide strong indications of their pending occurrence prior to the event?

One of the key errors we're making here is mistaking risk for consequence.

Let me explain further. Fire is not a risk but a consequence. It is the consequence of an uncontrolled heat source in an area of fuel to propagate a fire. If we're relating this to medical malpractice, doctors experienced the "risk" of unaffordable premiums, which was actually a consequence of significant risk drivers in the medical malpractice sector that had been in place for 10-20 years. These include:

- Adversarial, litigious, high-cost ways of resolving allegations of medical malpractice
- These costs were funded by insurers with deep pockets, defending the actions of litigants with high fee expectations
- The contingency legal fee model introduced in SA
- Inadequate data in the SA context, undermining the analysis of the underlying causes of adverse medical events, the appropriate costs of remedies and tracking outcomes to mitigate future risks
- Poorly argued and defended medical malpractice cases, particularly in the state health sector, creating many precedents with high settlements
- Fraudulent claims facilitated by both medical staff and litigants

These risk drivers are similar to many other sectors in the non-life insurance industry. The good news is that applying thorough analysis and risk mitigation to these identified risk drivers had immediate and material benefits, nearly halving premiums.

The medical malpractice situation also illustrates two other important risk concepts – risk velocity and herd thinking.

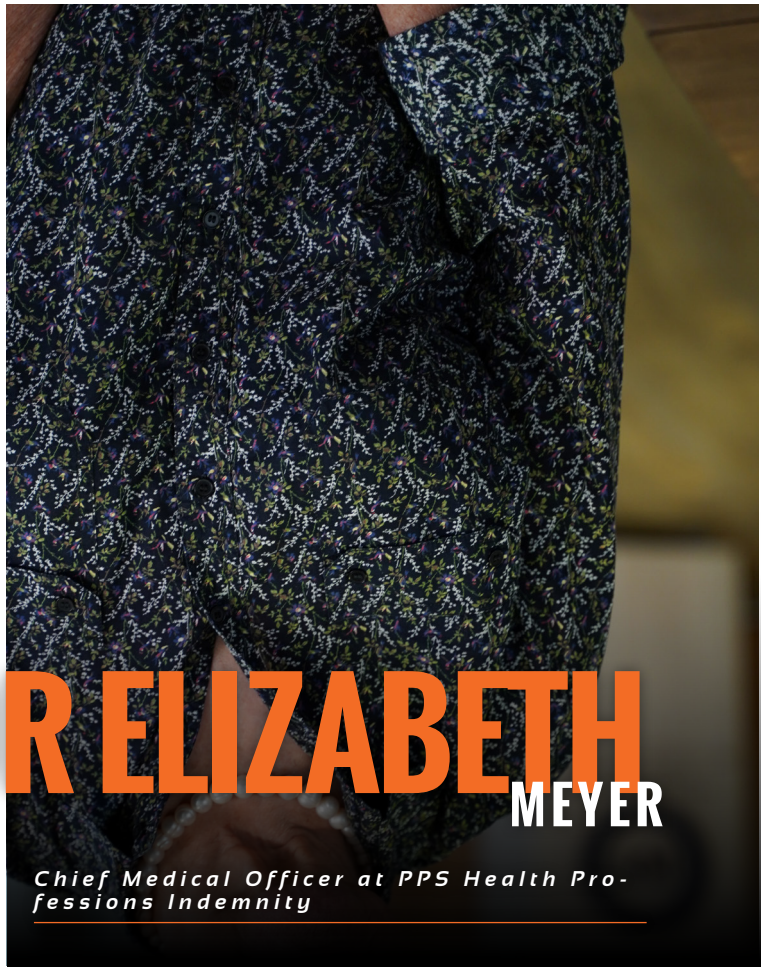
If premiums double off a base of R100 000 for 8 years, the result is R12,8M. The first few years of increases are bearable but soon become a crisis. The forecast cost factors that drive premiums are shared across the market and are accelerated so that the underwriters can be confident that today's premium will be sufficient for tomorrow's claims (also called inflationary effects).

Finally, the current state of the medical malpractice industry brings another analogy to add to the list – that of the boiled frog. Had doctors and corporates in today's market been told that premiums would be 200% higher in 2 years, an immediate alternative would have been required. It was only when premiums were 500% higher and the metaphorical water was boiling, that our frogs (doctors) responded to the cumulative effects, at which stage some of their practices were not viable.

Ultimately good risk management comes down to the same formula, no matter which industry we're operating in. Risk analysis and management should include a thorough scenario analysis of the risk drivers applicable to the key exposures – whether these come from perils, supply chains, inflation, weather and the like.

Now is the time to get ahead of your risk registers and make a meaningful difference to your risk exposures in future.

TELEMEDICINE: A MODERN MARVEL OR AN INDEMNITY HEADACHE?



Telemedicine allowed medical professionals to interact during lockdown with patients regardless of the physical limitations caused by the COVID-19 pandemic. But is this a future solution for medical care or rather a massive new indemnity headache for health professionals?

The COVID-19 pandemic changed the world irrevocably and it had a significant effect on the medical industry. It accelerated a worldwide shift to telemedicine and this will certainly lead to insurance and regulatory change. The emergency caused the Health Professions Council of South Africa (HPCSA) to relax the previous strict regulations regarding telemedicine and allow virtual consultations. It also changed the name "telemedicine" to that of "telehealth" to allow other health specialists, such as psychologists, to practice virtually.

The HPCSA has subsequently been urged by many medical aids to bring about permanent regulatory acceptance and has confirmed that the regulations will be reconsidered after the pandemic ends. Be as it may, telemedicine is here to stay and is increasingly gaining traction. Patients have gotten used to the ease of a virtual consultation in the comfort of their own homes and doctors can consult more patients.

Although doctors are now allowed to consult with patients outside South Africa, insurers are generally not indemnifying Healthcare Professionals (HCPs) consulting outside the borders of South Africa.

Will telemedicine increase insurance premium rates? It remains to be seen exactly what the situation is after the pandemic, but a gut response is that if more patients are seen, there may be more potential liability. Experienced doctors have expressed concerns that the chances of a misdiagnosis or failure to identify important signs are much higher as there is no face-to-face contact and physical examination.

Most patients are notoriously incorrect in their descriptions of symptoms and signs and often have pre-conceived diagnoses which may influence their description of the complaint. Many doctors have expressed concern that telehealth will weaken the doctor-patient relationship and lead to more long-term dissatisfaction. This may ultimately lead to more complaints and claims.

Medical practitioners, especially those doing elective surgery, took a massive knock during the pandemic. Patient numbers were down between 60% and 90%. Generally, there were fewer complaints and claims. Most insurers decreased their premiums or gave premium holidays to policyholders. However, now with the patient numbers rising and elective surgery fully scheduled, it is expected that complaints and claims will increase significantly.

Insurance premium rate increases have slowed but are expected to return to more normal increase patterns as the pandemic becomes part of our lives. It is expected that most practices will be busier than ever post-pandemic. Unfortunately, there is no immediate end in sight for opportunistic claims, the increase in pay-outs and rising legal costs.

However, change may, in the long term, be on its way to help the medical profession and indemnity providers out of the existing chaos. The South African Law Reform Commission (SALRC) was requested by Dr Aaron Motsoaledi – at that stage Minister of Health – to investigate medical-legal claims in South Africa.

At the end of 2021, the commission published an in-depth discussion paper.

Data was cited indicating that approximately 50% of medical negligence claims are of the cerebral palsy type (of which a small fraction result truly from a birth injury and obstetrician negligence). The report also indicates that in South Africa no legislation exists to specifically address medical-legal claims.

The issues identified and the interventions proposed by the SALRC are praiseworthy, sensible and the body should be highly commended. However, as stated in the paper: "The best legislation in the world will not make any difference unless it is applied, implemented, complied with and monitored."

Economic factors are increasing the risk of litigation. The cost of appropriate care continues to rise and is more technical, specialised and depersonalised.
With the advent of managed healthcare more than 20 years ago, healthcare funders have increasingly vetoed clinicians' decisions, making it impossible to provide the appropriate care. In these situations, a number of adverse results may occur and may lead to complaints or claims. This situation is unlikely to improve. HCPs must consider very carefully before entering into contracts with funders.

The healthcare and professional indemnity systems are both undergoing rapid change. Unfortunately, although there are opportunities for better care, economic factors may increase risks.

The possibility of legislative change exists but finally, the importance of the patient-doctor relationship and the duty of care, can never be over-emphasised.

THE RIGHT COMBINATION OF COVERAGE IS KEY

Many people are facing difficulties at the moment, with decreased take home pay and increased everyday expenses.

Medical expenses too have gone up and will continue to rise, but the one thing that Covid taught us was the importance of having private healthcare in place. So, while many people have a knee-jerk reaction and look to cut grudge expenses like medical aid and insurance, this is not a sound move from a financial stability perspective. Financial advisors have never had a more important role to play in ensuring that their clients can balance coverage with costs to protect their long-term health and financial well-being.

The consequences could be severe

Especially for young, healthy people, it can be tempting to reduce or even cancel medical aid and gap cover products as an unnecessary expense in the current economic climate. However, while this may save money upfront, from a long-term view it could end up costing even more. Without the right coverage in place, for example, with a reduced medical scheme plan, people will end up paying more out of pocket when accidents or illness occur.

Lower premiums and lower medical plans typically come with increased co-payments and reduced cover, which means increased shortfalls when healthcare is needed. If clients do not then also have appropriate gap cover in place, these shortfalls and co-payments will become out of pocket expenses that can be financially crippling.

If clients stop their medical aid altogether, and then decide to re-join at a later stage, there are also late joiner penalties that may apply if they are over the age of 35. These involve an increased premium of between 5 and 75% every month, so it is essential that clients are made aware of this upfront.

The right advice is essential

It is a harsh reality that many people are left with no choice but to downgrade their medical aid, but this is where financial advisors have a critical role to play. By recommending the right medical scheme cover coupled with an appropriate gap cover product, they can help their clients make the best financial and healthcare decisions.

While gap cover is often considered in light of chronic illness and cancer, it is an affordable solution for many more scenarios. It protects against medical expense shortfalls for in-hospital treatment and co-payments, and certain products have value-added offerings like a casualty benefit that can protect against out-of-pocket expenses for out of hospital treatment.

Financial advisors need to help their clients make informed decisions and map out the correct basket of products to meet their needs, because the consequences of getting this wrong can be life-altering.

Gap cover is an affordable way of augmenting cover from medical schemes and can save clients from financial difficulties while allowing them to access the best quality healthcare with peace of mind that they will be able to afford the care they need.

WHAT DOES THE NHI HOLD FOR MEDICAL SCHEMES?

The South African government started discussing the NHI (National Health Insurance) in 2003. After several poor attempts at starting, most people thought that a fully funded first-world healthcare system could never become a reality. Furthermore, the role of medical schemes was not clear since no policy direction exists in this regard from the Department of Health. Many medical schemes have since come out supporting the NHI, realising there is room for collaboration and more fundamental co-existence of the two healthcare systems.

The NHI is a healthcare financing system that aims to pool funds to provide universal access to quality, affordable primary healthcare services for all South Africans and long-term residents. Under Section 27 of the Constitution, the purpose of NHI is to:

- achieve universal access to quality healthcare services in South Africa;
- establish a National Health Insurance Fund (NHIF) and define its powers, functions, and governance
- structures; and
- provide a framework for the fund to strategically purchase healthcare services on users' behalf.

Attitudes, opinions and research

PWC recently launched a study on NHI, where 50% of the survey participants believe that NHI will guarantee or partially guarantee equal access to healthcare, whilst 100% of respondents support the intent of NHI and the model of universal health coverage. Most people felt they needed more clarity on the scope and range of benefits, governance structures, the risk of corruption, healthcare worker capacity, and the impact on the private sector.

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Others expressed an interest in learning more about the NHI implementation plan, governance, and funding. According to participant responses, access to funding, effective management, meaningful public-private partnerships (PPPs), transparency and communication between key players will be critical success factors for the NHI.

Medical schemes and pharmaceutical companies are especially concerned about their roles in NHI. Of particular concern is Section 33 of the NHI Bill, which states that Schemes may only provide cover that constitutes complementary or top-up cover that does not overlap with the personal health care service benefits purchased by the NHI fund on behalf of users. The bill, therefore, does make provision for private medical schemes to provide gap cover, ultimately meaning that these schemes will cease to operate and their members would be forced to use the NHI.

Over 52% of schemes have begun engaging with the National Department of Health and developed some NHI plans and strategies. In contrast, 47% of organisations do not have a plan for NHI, and 26% of those do not consider it a priority. The industry is increasingly concerned about a lack of clarity regarding the various private sector players' roles and responsibilities.

Many expressed a willingness to work across sectors to form successful partnerships. It would necessitate open dialogue between the public and private sectors, as well as careful consideration of all aspects of fund implementation, including legal, governance, and policy frameworks, as well as sociopolitical factors like public sector capacity and the financial implications of partnerships. These collaborations will most likely be managed per global and local best practices in healthcare purchasing, provisioning, procuring, and management. Best practices will improve access, equity, quality, and innovation while serving the currently uninsured population and levelling the playing field for access to high-quality healthcare.

Where do medical schemes fit?

The fears around medical schemes ceasing to exist in an NHI world are misplaced. The NHI will not bring about the end of private healthcare in South Africa. Instead, medical schemes will adopt new models to co-exist with the NHI by contributing to different minimum benefit packages. Suppose one looks at Canada, the UK, Australia and Europe – their national health systems co-exist with private health and are complementary in providing access to quality healthcare. The NHI framework places the state as a central purchaser of primary care and funds it through a single source of some taxation model. Private health in South Africa has shown its capability, especially during the pandemic. In its quest to implement a national health framework, the government can rely on the private sector for systems, healthcare professionals, management and administration skills to implement universal healthcare at a primary level with family practitioners as gatekeepers.

The NHI would suffer if medical schemes were limited in their role. Simply put, there aren't enough resources to meet the needs of all South Africans. Through the NHI, the state can rely on the private sector for different benefits packages, like optometry, pharmaceutical, preventative screening, and other supportive infrastructure to deliver services. It is certainly not the end of private health, and the model of co-existence is a debate where Medshield is making its voice count. Our position is to contribute to developing the NHI minimum benefit package. Most of all, attempting to prevent those who can afford it from using their medical scheme coverage and forcing them into the NHI system would increase the NHI's burden, depleting resources intended for healthcare. The structural change is essential and will help to strengthen and improve the healthcare system for all South Africans. Medical schemes should not be sidelined in this but should instead assist in building it and making it sustainable, with the ultimate goal of strengthening the public and private healthcare systems for all.

NHI's success depends on funding, governance, partnerships, and dialogue. Collaboration necessitates communication and transparency. It is critical to ensure that sub-sectors and organisations are adequately prepared for the NHI and have incorporated the model into their organisational strategies. It is a massive, complex, and multi-decade initiative requiring significant debate and effort to make it workable.

Universal healthcare access is morally and ethically correct, but these initiatives are most successful and sustainable when they are collaboratively planned, resourced, and show resilience in partnering.

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DRIVING INNOVATIONS WHILE CONSIDERING THE FINANCIAL LANDSCAPE AND MEMBER NEEDS

In September 2022, Discovery Health Medical Scheme (DHMS) announced that its members will only pay more for their membership from 1 April 2023, instead of 1 January 2023. This is the third time the scheme has deferred annual contribution increases to provide financial relief for its members. The 2023 increase will be announced in February, to ensure careful alignment with medical inflation.

Reflecting on 2020 and 2021 and the carefully-considered contribution-increase freezes, it is pleasing to note that the brilliant actuarial calculations that informed the strategy, achieved almost exact alignment of our projections with actual claims expenditure for the Scheme.

The Scheme's reserves strengthened relative to regulated solvency requirements because of the significant decline in non-COVID healthcare claims recorded during the pandemic and into 2022. The Scheme's excess solvency has been used to the benefit of members, with R6.8 billion achieved in contribution savings during 2020 and 2021 through the deferred increases. This also achieved effective annual contribution increases that were 50 basis points below the market over these two years.

The deferral of the 2023 contribution increase generates an additional R1.9 billion in savings for members in the first three months of 2023, bringing the cumulative member savings (returned to members from excess solvency) over the past three years close on R8.7 billion.

Judicious use of excess Scheme solvency provides both financial relief and new benefits to members

In 2023, DHMS is making an unprecedented investment in members' long-term health and, by extension, into overall Scheme sustainability. The scheme's aspiration is to help members understand their health status, and take action to address elevated health risks, to ultimately extend their years of healthy living.

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It is well documented both locally and globally, and it is evident within our own database, that the COVID-19 pandemic caused people to defer non-COVID related healthcare. People who were fearful of contracting COVID-19 at healthcare facilities missed essential screening and health checks.

Discovery Health's data clearly shows screening rates among members are worryingly below pre-pandemic rates. To mention a few key tests, general health checks are down 50%, mammograms down 15%, pap smears down 12 % and prostate cancer screening checks are down 10%.

The time has come for us to focus our attention on reversing this trend. When it comes to diseases such as cancer or any form of chronic illness, early detection is fundamental to limiting serious complications and reducing costs in the long term. For example, our data confirms that on average, a person diagnosed at the age of 40 with an early-stage breast cancer has a three times higher likelihood of surviving for five years post diagnosis.

This is why we have introduced a dynamic new benefit through which to support members' health and wellbeing. Effective 1 January 2023, the Scheme will make its excess solvency reserves available to fund an expanded range of screening and preventive healthcare for members through the new WELLTH Fund.

- The WELLTH Fund is activated by completing a Health Check during 2022 or 2023 (covered by the DHMS Screening and Prevention Benefit). This sets the baseline for a member's health status. Once the member and all their dependants have completed their Health Checks, they will have access to up to R10,000 in their WELLTH Fund - R2,500 per adult and R1,250 per child - for a range of additional screening and preventative healthcare. Members have access to six broad categories of health screening and preventative healthcare services, including general health, physical health, mental health, women's health, men's health, and children's health. Medical monitoring devices for certain health measurements are also covered.

Alongside significant time and effort invested into ensuring the robustness of our deferred contribution increase strategy, we have also worked hard to strengthen our goal of making our members healthier and enhancing and protecting their lives.

The Scheme's overall strategy is clear. Our three-year contribution deferral and 2023's innovative approach to investing in the immediate and long-term health of the DHMS member base - and by extension, the Scheme itself – work hand-in-hand to ensure the Scheme's sustainability now and into the future.

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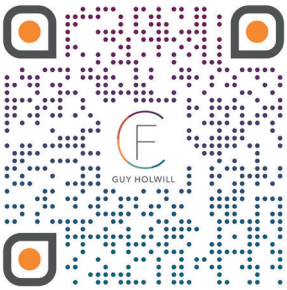

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BONITAS 2022 CONTRIBUTIONS CONTINUED FOR 2023!

Bonitas Medical Fund, which celebrates its 40th birthday this year and one of the leading medical schemes in South Africa, has announced its 2023 product line up.

"Our average increase for the year would have been 5.9% - well below the current inflation rate of 7.6%. However, we've put a price freeze on contributions for the first quarter of 2023. This effectively means an increase of 4.4% over the 12 months. We have also shared what members can expect to pay from 1 April 2023, so that they can make informed decisions."

'It's a balancing act between keeping increases as low as possible while maintaining the Scheme's stability,' says Callakoppen. By applying low contribution increases since December 2020, the Scheme has effectively passed R1.4 billion in savings to members.

The Scheme is financially stable with over R7.4 billion in reserves. We have also signed up over 190 000 new members in the last 36 months. The average age of these new members is around 15 years younger than the current membership – proof that we are attracting a younger, healthier profile, something which is coveted across the industry.

The future of healthcare is around primary and preventative care. There is a rise in non-communicable or lifestyle diseases, such as diabetes, high blood pressure and cancer. 80% of which are caused by lifestyle risk factors. This is why we offer a range of Managed Care programmes to help members understand and manage their conditions.

Cancer care

Last year, we announced our partnership with the South African Oncology Consortium, to enhance our cancer programme including screening for early detection, treatment and palliative care. For 2023, we have restructured benefits to be unlimited for PMB cancers, on all options.

Diabetes

Data from the South African Health Quality Assessment, shows that Bonitas has an effective disease management programme and better outcomes than the industry standard for diabetic members. In 2023 we introduce an annual benefit of R51 000 per family for an insulin pump or continuous glucose monitor for type 1 diabetics under 18 years.

Mental health

We will introduce an innovative digital solution, Panda, from October 2022 to support our members in managing their mental wellness. The free app offers

everything from audio sessions with peers and mental health experts to one-on-one virtual consultations with professionals. We encourage our members to complete an online mental health questionnaire to assess their mental health status.

Benefit Booster

Launched last year, the Benefit Booster is aimed at supporting our preventative care strategy. It unlocked R446 million in additional benefits for members to extend their day-to-day benefits. For 2023, we are adjusting the benefit limits in line with utilisation with enhancements seen on several plans.

Designated Service Provider (DSP)

We implement networks to negotiate the most favourable tariffs for our members so they can avoid out-of-pocket expenses and get more value. This includes:

- A GP network of over 4 400 practices
- A pharmacy network, with around 2 500 practices to dispense chronic, acute and over-the-counter medicine, through Scriptpharm
- DENIS, our dental network, provides access to around 3 000 practices
- An optical network of over 2 300 practices, through PPN

Medicine formulary

Our medicines formulary is aligned to the WHO's Essential Medicines List (EDL) to promote affordability and accessibility to clinically approved medicines, in support of medicine adherence.

Hospital-at-home

The Hospital-at-Home service brings all the essential elements of in-hospital care to a patient's home, without moving away from evidence-based clinical protocols and state-of-the-art 24hr vital sign monitoring. In 2023 we include: A programme for re-admissions, screening and disease prevention, alternative to stepdown facilities and kidney dialysis at home.

Savings

We've amended our rules to allow members to use their savings as they deem fit for the new year and increased savings by up to 9.4%, depending on the plan selected.

Exclusive offers and discounts

With the current economic challenges facing the country, we know everyone is constantly looking for added value and ways to save money every month. For 2023, we've partnered with top providers for exclusive offers across a range of categories including: Lifestyle, wellness, gap cover, short-term insurance, life insurance and credit solutions.

As South Africans face increased challenges around inflation, fuel and electricity hikes we remain committed to providing quality healthcare, at affordable prices, while ensuring

THE MEDICAL SCHEME LANDSCAPE

The Covid-19 pandemic saw two years of exceptionally low usage of medical services, and a reverse correlation with the increased reserve levels recorded by almost all medical aid schemes. As a result, most schemes opted to defer contribution increases during 2021 and 2022.

Medical schemes metronomically increase contribution rates annually, and typically by several percentage points above the consumer-price-inflation (CPI) index. Medical inflation has historically exceeded CPI by around 2% a year. This fact in itself, representing the basic principle of how inflation is created, reflects the dwindling number of medical professionals who are servicing an ever-increasing number of patients.

Household budgets under pressure

As medical aid usage returned to pre-pandemic levels these annual increases were inevitably imposed once again by the different schemes. In the meantime however, the macroeconomic environment has become one of higher inflation and persistently subdued growth.

Above-inflation scheme increases, coupled with constrained consumer buying power and limited inflation-linked salary increases, has led to increased pressure on medical aid members' budgets. With less to spend, many members are considering downgrading their cover. It is vital that members understand the resultant increase in personal risk for themselves before undertaking this commitment.

Additionally, several medical schemes, conscious of the financial pressures placed on their members during the pandemic, allowed members to review and change their plans at several points during 2020 and 2021, in addition to the standard annual January review. This placed not only medical scheme administrators, but also healthcare advisors under pressure – as multiple reviews were expected, with concomitant costs, for no increase in the level of income.

The perils of the current low-cost environment

The medical scheme landscape largely mirrors South Africa's own socio-economic landscape. Medical scheme membership has remained largely stagnant over the past

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eight years. The combined membership base - roughly 8 million primary members - increases by a marginal percentage each year. Medical aid products are generally poorly categorised and named - there were 251 different plans offered in 2021 – compounding the already complex decision-making process of selecting the most appropriate cover.

A particularly glaring gap in the medical scheme market has been the lack of affordable options for those in lower income brackets, being the overwhelming majority of South Africans. As a result, South Africa's healthcare system is divided between private healthcare for middle and high-income earners, and a public healthcare system for low-income earners.

The development of a framework for the most likely solution to meet the public's needs – the Low Cost Benefit Option (LCBO) – has been regularly postponed against the backdrop of continued discussion around the feasibility and desirability of a comprehensive National Health Insurance (NHI) Bill.

In the interim, to secure some form of healthcare cover for low income earners, the market produced a range of products known as primary-care plans. Primary-care plans typically provide Network Day-to-Day cover, with some including a rand value for specified hospitalisation events. There is often 'fine print' limiting the conditions for which reimbursement is due. Unethical marketers seek to obscure these conditions, or even to portray primary-care cover as a form of medical aid, when in fact it is a form of limited insurance. While medical aid provides cover for extensive agreed treatments and conditions, insurance can be more limited and conditional.

Those members who defaulted to primary-care plans are at risk of falling victim to the fine print. For example, when emergency cover was elected, the fine print often dictates that this is only in the case of an accident. Another common shortcoming is when a member experiences an extended hospital stay as the result of (say) a burst appendix. Marketers, being pushed by financially drained members may further convince members to downgrade to smaller (often limited) plans, such as top-up and gap-cover, in an attempt to patch-together a home-styled comprehensive medical aid. This is often a recipe for disaster down the line when (rejected) claims start to roll in.

"You get what you pay for" has never been more relevant

GTC's advice to advisers is to ensure clients are made aware of the risks associated with downgrading cover. Advisers must stay abreast of contract fine print and changes made to medical-scheme and medical-insurance options during the year and especially at year end review.

Advisers should immerse themselves in the abundance of valuable information released by the Council for Medical Schemes in their Annual Report each year. These reports are of exceptionally high quality and provide a detailed breakdown of, amongst other topics, age profiles, pensioner ratio's, usage patterns, solvency ratio's, medical scheme costs and payments to different service providers. The information can get quite granular, but it's worth reviewing, alongside their regular policy, research and monitoring publications.

Armed with this information, professional healthcare advisers will find themselves able to guide members towards schemes which offer greater longevity, better able to manage ongoing annual increases, and to dovetail healthcare increases with assumptions made in financial plans.

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GET THE BEST OUT OF YOUR MEDICAL AID IN A TOUGH ECONOMY

Financial pressures are affecting everyone and taking steps to cut down on monthly expenses is a great way to free up more of your money for the things that matter.

One of the biggest mistakes you can make, however, is to cancel your medical aid completely in the process of tightening the belt, especially when you consider the significant financial burden should you have unexpected medical emergencies.

That being said, there are ways you can make sure, firstly, that you are not spending more than you should on medical aid, and secondly, that you and your loved ones have sufficient cover for your health needs – or that the scheme you are with offers rich value-added benefits.

Get a healthcare advisor

There are many medical aid options in the market and choosing the right one is not always easy. Every person and household have different needs and different levels of affordability, which is why having a healthcare advisor who can complete a needs analysis and explain competing options is a good way to identify the correct option for your needs and your pocket. They can review your chronic conditions, and current and future healthcare needs as well as your budget, to propose the right option for you.

Consider downgrading – not cancelling

Many South Africans have decided to change their plans to suit their pockets, opting out of comprehensive plans in favour of more affordable options available to them. These range from entry-level plans that mainly cover hospitalisation, to plans with additional 'savings' or out-of-hospital accounts and comprehensive plans that provide extensive healthcare cover.

While downgrading is always preferred over cancelling your plan, it is important to ensure that your new plan and scheme provide sufficient cover as this will affect your future claims and potential out-of-pocket costs.

Whether you are on an affordable hospital plan, or a top-of-the-range comprehensive plan it is important to choose a scheme that provides a variety of options that cover not only the basics but also cover the most important items such as maternity care, preventative care as well as managed care programmes for the likes of oncology and diabetes.

Reconsider unused loyalty programs

While loyalty and rewards-based programmes offer some attractive benefits, like free or discounted gym memberships or cashback on fuel spend, many people don't take full enough advantage of these programmes to justify the monthly cost of their memberships.

If you aren't quite meeting those daily steps or fitness goals to rack up those reward points, consider cancelling the extra expenses that these programmes bring. You can always sign up again in the future if you wish, or do your homework and take advantage of free wellness programmes and inclusive benefits available with existing plans.

Bestmed focuses on innovating with wellness in all aspects of life, including fitness, nutrition and emotional wellbeing. Our Tempo Wellness Programme is available on all plans at no additional cost, allowing members to complete health assessments and visit a bio kineticist for a fitness test or dietician for a nutritional assessment, to name a few.

MEDICAL SCHEME LIQUIDATION

Members of Health Squared Medical Scheme face an uncertain future after it came to light that their scheme's reserve levels had dropped to just over 2% by the end of July 2022 (well below the minimum statutory requirement of 25%), and the Health Squared Board of Trustees had applied for voluntary liquidation.

But before the High Court ruled on the liquidation application, the scheme was placed under provisional curatorship by the Council for Medical Schemes (CMS). While the High Court ordered the scheme to continue to provide cover to its members with life-threatening conditions until the end of September, members find themselves having to seek alternative medical scheme cover, which may be subject to various underwriting requirements. Although the failure of medical schemes is a rare occurrence, the Health Squared scenario highlights the importance of medical scheme financial soundness, both in the short and long term.

It also raises questions as to how scheme members would know if their medical scheme was in financial trouble, and how members can go about selecting a scheme that will be there for them when they need healthcare funding support the most.

Lerato Mosiah, CEO of the Health Funders Association (HFA), says that by law, a medical scheme must – at all times – hold reserves of at least 25% of its annual contributions.

"These reserves aim to protect members' interests by ensuring the continued operation of the medical scheme and to ensure it is able to pay claims in the event of unforeseen circumstances".

As would have been the case for Health Squared, which reportedly suffered from high claims associated with COVID-19, these required reserves also act as a 'buffer' when the usual monthly contributions no longer cover the scheme's liabilities.

However, Mosiah says that, depending on other risk factors, warnings should sound when reserve levels fall below 25% as this could be an indication that the scheme may be in financial trouble and may not be able to pay claims in the longer term.

In the case of Health Squared, the scheme was already running at a deficit in 2019 and its solvency level had dropped to 15.4% (according to the CMS annual report) and so there were red flags even before the increased volatility brought on by COVID-19.

Apart from reserves, there are several other indicators that members can check to get a good sense of the financial health and stability of their scheme.

Ideally, schemes should be growing and not shrinking, although this is a challenge in these economic times and so comparative growth or shrinkage across medical schemes may be a valuable measure.

The age profile of the medical scheme is an indicator of risk profile and an important measure as medical schemes are required to manage their risk without being permitted to price according to age or health status at an individual or member level.

At the end of 2019, Health Squared already had the highest average age across all registered open medical schemes with almost 26% of beneficiaries older than 65, further exacerbating the risk position.

Schemes also invest their member funds to obtain returns on these funds, and positive investment returns add to a scheme's healthy financial position.

Finally, schemes, as non-profit organisations, price their contributions to be close to break even, while allowing for changes in membership, healthcare inflation and solvency requirements. A scheme's record in this regard indicates good financial management and sound actuarial practices.

Mosiah says that the scheme's annual general meeting is a good opportunity for members to ask questions about the scheme's financial and other results, which can also be found in their annual reports.

"The Trustees are responsible for making sure that the scheme is run in accordance with its rules and the Medical Schemes Act, which includes safeguarding the scheme reserves", says Mosiah.

She adds that the Council for Medical Schemes has the ultimate responsibility for making sure that schemes abide by all applicable legislation and must ensure that schemes maintain reserve levels, in the interest of protecting members.

Schemes must keep the CMS up to date with periodic reports detailing, amongst other aspects, their financial soundness and risk profile. This should enable the Council to act and take appropriate measures before a medical scheme runs into trouble - in order to protect the members of that scheme and the industry as a whole."

"Regulations are there to protect all medical scheme members," says Mosiah.

"The failure of any medical scheme has a knock-on effect on other schemes since higher risk members then require cover without any transfer of reserves which ultimately increases the burden on other scheme members".

The HFA has been an active participant in discussions on regulatory reform for medical schemes, particularly since the publication of the Health Market Inquiry (HMI) Report in 2019.

The HMI recommended a risk adjustment mechanism for medical schemes as an important component of the social solidarity approach to regulation, which would have been beneficial to a scheme like Health Squared.

Further, the implementation of a risk-based capital solvency requirement as set out in the CMS discussion document in 2015 would have more effectively flagged the risk of declining solvency and escalating risk.

The 2019 HMI report noted that: "The current solvency requirement [for medical schemes] is also out of line with other South African Prudential requirements: both long-term and short-term insurance environments have risk-based solvency frameworks in place".

Mosiah notes that the COVID-19 period has been associated with high volatility in utilisation of health services and many medical schemes have accumulated reserves as a result of lower utilisation of other health services during the focus on COVID-19 treatment.

She notes that although overall solvency levels across medical schemes are on a sound footing, this should not lead to complacency as medical schemes need to ensure they remain financially sound as healthcare utilisation and claiming patterns return to normal.

"The HFA's recommendation is that medical scheme members pay attention to the status, soundness, and sustainability of their medical scheme. A good way to do this is to discuss these indicators with their financial advisers, who should be up to date on those mentioned above," says Mosiah.

"We all need to feel confident that when we need our medical cover, especially in the event of catastrophic health events, our scheme will be there for us."

HEALTHCARE IN SA IS NOT AFFORDABLE AND INCLUSIVE ENOUGH

An urgent shift is needed

NetcarePlus GapCare offers unrivalled healthcare options

NetcarePlus GapCare from Netcare acts like a shock absorber for costs not covered by medical aid and unexpected co-payments by softening the blow of an already trying event in someone's life. With the right solution, financial constraints don't need to compromise the quality of healthcare. GapCare also offers a greater selection of affordable healthcare options creating access to Netcare's world-class facilities.

"Life can be unpredictable, but healthcare costs don't have to be," says Teshlin Akaloo, managing director of NetcarePlus. "Given the current climate of uncertainty and unemployment, there has never been a greater need for new, affordable ways to access private healthcare to ensure that taking care of medical needs does not impact household budgets with unexpected out-of-pocket expenses."

Change is urgently required to address the affordability challenges that employed people and their families face in accessing private healthcare. When a provision of care can be integrated with funding, this is possible without breaking family budgets and patients having to endure the tedious and often stressful tug-of-war between health funders (medical aids) and providers (hospitals etc).

"As Netcare, through NetcarePlus's products, we have a unique opportunity to provide a solution and creative options are needed now more than ever to answer to the complexities of the South African health environment for the benefit of more South Africans," explains Akaloo,

SA needs affordable quality healthcare with more options - now

What sets NetcarePlus GapCare apart is that it widens access to quality healthcare beyond medical scheme limitations by providing shortfall cover for both in and out-of-hospital specialists. Plus, it takes care of shortfalls for emergency department costs that are not limited to accidents, day-to-day expenses when medical scheme limits have been reached or savings have been depleted, costs for high-risk pregnancies, and other maternity-related benefits.

Many medical schemes have network restrictions limiting access to certain hospitals or specialists and do not always provide cover for shortfall expenses, and this can leave households out of pocket. Shortfalls covered by NetcarePlus GapCare are for any hospital and are not restricted to the use of Netcare hospitals only.

NetcarePlus offers GapCare, GapCare300+ and GapCare500+, a comprehensive selection of gap cover for the shortfall in medical expenses to members on any medical scheme.

Minimising financial stress and strain

Anyone requiring healthcare that is not fully covered by their medical aid might feel that the treatment options available to them are limited or even inaccessible if they do not have the finances to pay for these additional costs. NetcarePlus GapCare — underwritten by Hollard Insurance Company Limited — addresses these medical scheme limitations and provides full access to world-class treatment from specialists and hospitals within the extensive Netcare network.

THE UNCOMFORTABLE TRUTH ABOUT OUT-OF-POCKET HOSPITAL EXPENSES

As thousands of South Africans find to their horror every year, having medical aid doesn't mean you're 100% covered for hospital procedures. There's often a big difference between what medical specialists charge and what medical aids cover, and it can often leave you with an expensive headache that lingers long after the pain of the procedure has receded.

This is where gap cover plays an important role. Gap cover is a short-term insurance product which bridges the gap between all the actual costs of the medical expenses associated with the procedure and the medical aid payment. It is an effective way to ensure that you are covered for unforeseen in-hospital shortfalls.

How does Gap cover work?

Usually, purchased separately from your medical aid, gap cover has been around for many years. Now, with the cost of medical services often exceeding the re-imbursement rate at which your medical aid covers members, it is growing in popularity among South Africans looking to protect themselves from large shortfalls and soaring medical costs.

Gap cover doesn't replace comprehensive medical cover, but it complements it. It should no longer be seen as a luxury: it's an absolute necessity to make sure your family or your employees are not left financially ruined in a medical emergency. Gap cover offers people peace of mind and should no longer be ignored. People should not wait until they need to be hospitalised and then think they can take out gap cover, pre-existing conditions can be excluded for up to twelve months.

Who can buy gap cover?

It sounds obvious, but you can only buy gap cover if you're a member of a registered medical aid scheme. The good news is that it's relatively affordable and can be purchased at any time through the provider of your choice. Not all providers offer the same benefits, though, so it could be in your best interests to speak to a healthcare consultant to ensure you buy the right gap cover for your particular circumstances.

This is also important for employers, who need independent, unbiased, tailored strategic advice on gap cover that best suits their employees' needs. Remember that gap cover does not need to be compulsory for all employees. You can offer it to your employees, let them know how important it is, and give them the opportunity to take it as part of their total cost to company.