How can private healthcare become more affordable for the average South African?

By Kevin Aron , issued by Stone

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Medical aid versus health insurance - where can the average South African get real value for money whilst still having the medical cover they need? Many complain that medical aid cover is prohibitively expensive and that only a small percentage of employed South Africans can afford it. Statistics show that a medical scheme covers only 16.1% of South Africans.

Kevin Aron, principal officer of Medshield Medical Scheme

However, the pricing is significantly influenced by the fact that medical schemes are required to provide members with prescribed minimum benefits (PMBs) that cover at least 271 conditions and 26 chronic diseases, whilst health insurers have no obligation to cover PMBs. The costs of the cover are high. But the industry has developed solutions over the years to be more inclusive. Consumers now have options and a way to determine the best value for money for the individual or family.

What makes premiums so high?

For even the most basic plan, the principal member of a medical scheme would pay around R1,500 to R2,000 per month. A single parent with a child could expect to pay at least R2,300 a month. It would require a take-home pay of at least R20,000 a month for the medical cover not to exceed 10% of the household budget. There is however some tax benefit available to

members, who are allowed to claim medical tax credits on their tax returns. In the current tax year, taxpayers can claim R347 per month for the first two members and R234 for additional members. The member must submit a tax return to receive their tax credit.

The most critical driver of medical scheme contributions is the requirement to cover PMBs at full cost. There is a list of 271 life-threatening conditions and 26 chronic illnesses that a medical plan must fully cover. Medical schemes frequently have little effective control over the fees charged by healthcare practitioners for a PMB condition, with some practitioners charging up to 700% of the medical scheme rate. These would have to be paid in full by the medical scheme.

According to the Council for Medical Schemes' 2020 Industry Report, the cost of providing cover for these PMBs is R866.02 per average beneficiary per month. It means that before the medical scheme can even start covering its members for non-PMB events, the premium must be at least R866 per month. To provide even a basic hospital plan, the scheme would have to cover the PMBs at R866 and then add on the cost to cover additional conditions, hospitalisation, preventative care, and administration costs. To address the cost drivers behind PMBs, the Council for Medical Schemes is reviewing PMBs to develop a comprehensive set of Preventative and Primary Healthcare packages for incorporation into the current hospital-centric and diagnosis-based standard PMB package.

Another driver of medical expenses is hospitalisation, especially when it comes to elective procedures. During the Covid lockdowns, non-emergency surgery was halted, which resulted in most medical schemes reporting an increase in scheme reserves. The increase in reserves allowed many schemes to delay annual increases, and in fact some schemes were even able to reduce premiums. As hospitalisation is a significant expense for all schemes, any increase in hospitalisation utilisation by members will continue to drive up costs.

Is health insurance the way to go?

As medical insurance is not a medical scheme, or a medical aid if you will, it is not required to provide full coverage for PMBs. Several new players have entered the health insurance sector by partnering with life insurance providers or recognised financial service providers. Because it is an insurance product, risk rating, waiting periods, and limited cover are allowed to be applied, making it more affordable. However, the medical tax credit does not apply to health insurance policies. It is thus vital for people to understand the limits of health insurance.

In essence, health insurance typically covers day-to-day out-of-hospital medical costs and is unlikely to cover private hospitalisation for non-emergency events, and even the pay-out received for emergency hospital admissions frequently only covers a day or two of the costs. Without a hospital plan, a policyholder would still need to rely on State hospitals. Health insurers often recommend their primary healthcare products as an add-on to a medical scheme's basic hospital plan, so it is crucial to understand how much coverage you have on even a basic medical insurance hospital plan. For instance, maternity benefits such as scans, lactation consultations and blood tests could be included, while chronic medication and hormone therapy are excluded or limited on health insurance.

Medshield's MediSwift hospital plan, for example, is aimed at healthy, active individuals. It includes physiotherapy and biokinetics benefits with two family practitioner visits annually. In addition to comprehensive hospital cover, the plan provides for active and generally healthy people, who might require treatment but whose injuries are not severe enough for a hospital admission. The MediSwift plan also features an annual Medshield Wellness benefit that includes the Covid vaccine, flu vaccine and birth control, as well as tests for cholesterol, blood pressure, glucose and BMI, amongst others. The premium is R1,908 per month for the primary member, R1,860 for the adult-dependent and R489 for a child. For two parents and a child, the total premium would be R4,257 per month (R3,329 after applying for the tax credit).

You can reduce your day-to-day spending using the Designated Service Provider recommended by your medical scheme. These are providers who have an agreement with the scheme on how much they will charge. You are then unlikely to land up with a bill from the specialist that charges more than your medical scheme rate. The bottom line is that if you can afford a basic hospital plan, it is the smart choice. In addition to access to a private hospital, you will receive cover for 271 life-threatening conditions and 26 chronic illnesses and many preventative care benefits.

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