

Beyond medical schemes: why South African healthcare cover may need to evolve into integrated, layered protection

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ABSTRACT

Private healthcare funding in South Africa has traditionally been anchored by medical schemes as the primary mechanism for accessing private care. In recent years, the environment has become characterised by rising healthcare costs, affordability pressures, benefit design constraints, and growing out-of-pocket exposure for members. These trends have renewed consideration of the extent to which medical schemes – operating largely as standalone funding vehicles – are able to respond effectively to the evolving demands of a complex, cost-intensive healthcare system.

While medical schemes remain central to private healthcare funding, their ability to address systemwide cost and access pressures in isolation is inherently constrained. Efforts to maintain sustainability have led to increased reliance on managed care interventions and benefit restructuring, which, while supporting solvency, may also widen funding gaps and increase member cost participation. In parallel, gap cover and primary health insurance (PHI) products have expanded to address specific unmet healthcare needs: with gap cover offsetting shortfalls in scheme reimbursement and PHI facilitating access to targeted areas of care, particularly primary healthcare services. However, when operating independently, these products tend to address discrete risks while leaving adjacent vulnerabilities unresolved.

Against this backdrop, there is growing interest in the potential role of more integrated or bundled healthcare solutions that align medical schemes with complementary products such as gap cover and PHI. Such approaches may offer a pathway to enhanced financial protection, improved affordability and more coherent cover across the continuum of care. This paper adopts an exploratory perspective to examine the viability and implications of these coordinated models. At the same time, any movement toward greater integration introduces a range of complexities that warrant careful examination. Structural and regulatory distinctions between product types, differences in risk pooling and pricing mechanisms, potential misalignment of incentives, and increased administrative complexity may all present material barriers. In addition, questions relating to governance, distribution dynamics, and the potential for unintended consequences within an already fragmented healthcare system remain unresolved.

Accordingly, this research seeks to explore both the opportunities and constraints associated with coordinated healthcare solutions. In doing so, it aims to contribute to a more nuanced understanding of whether, and under what conditions, such models could support a more holistic and sustainable approach to healthcare financing in South Africa.

KEYWORDS

South African healthcare landscape; complementary health insurance; bundled healthcare solutions; healthcare affordability and financing

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1. INTRODUCTION

1.1.1 South Africa's private healthcare funding system faces increasing affordability and sustainability pressures. Economic constraints continue to place pressure on medical scheme participation within households, while rising healthcare utilisation and an ageing beneficiary population contribute to higher claims costs. These pressures are compounded by partial regulatory reform. While measures such as open enrolment, community rating and Prescribed Minimum Benefits (PMBs) were implemented, complementary mechanisms such as mandatory membership and a Risk Equalisation Fund were not, contributing to structural pressures within the medical scheme environment. These structural challenges are unlikely to be resolved in the short term, particularly while the timing and practical implications of National Health Insurance (NHI) remain uncertain. In February 2026, the President agreed to delay the proclamation of provisions of the NHI Act pending judgments from the Constitutional Court. Even as the broader healthcare funding framework continues to evolve, significant reform is unlikely to provide an immediate response to the affordability and sustainability pressures facing the medical scheme environment.

1.1.2 In response to gaps in medical scheme funding and access to day-to-day healthcare, health insurance products such as gap cover and primary health insurance (PHI) have gradually become more established within the private healthcare market. The existence of these products is, to some extent, a response to the imperfections within the regulatory environment. Although the private healthcare funding landscape has increasingly evolved towards a more layered model, these products remain largely designed, regulated and managed independently of medical schemes, despite operating alongside them and addressing different components of the same healthcare funding journey.

1.1.3 While the increasing role of health insurance products alongside medical schemes may not represent the ideal structure for the private healthcare funding system, it reflects the market as it exists today. This paper examines whether greater coordination between medical schemes, gap cover and PHI could provide a more coherent and affordable healthcare funding solution in the short to medium term. The practical feasibility of greater integration, including regulatory, data governance, pricing, risk alignment and administrative considerations that may enable or constrain such an approach is also assessed.

1.1.4 Ultimately, the paper considers how greater coordination between existing healthcare funding components could improve member protection, affordability and care outcomes, while maintaining medical schemes as the foundation of private healthcare funding and recognising the distinct regulatory roles of medical schemes and health insurance products.

2. METHODOLOGY

2.1 Research approach

2.1.1 The study adopted a qualitative research approach to assess the proposition of closer coordination between medical schemes and health insurance products. A literature review of the current state of the private healthcare environment was undertaken, focusing on the regulatory framework governing medical schemes and health insurance providers, as well as broader industry developments relevant to healthcare affordability and healthcare funding. Semi-structured interviews with selected industry experts were conducted. The interviews explored participants' views on current industry challenges, emerging trends over the next five to ten years, and the potential opportunities and risks associated with greater alignment between medical schemes and health insurance products. Finally, the quantitative component of the study included an analysis of in-house data from medical schemes, a gap cover provider and a primary health insurer to identify relevant trends and contextualise the industry and interview findings.

2.2 Interview participants

2.2.1 To complement the literature review and provide practical perspectives on the evolution and potential integration of medical schemes and health insurance

products, interviews were conducted with experienced stakeholders from across the South African healthcare funding landscape. The interviewees are presented below in alphabetical order by surname. Collectively, they bring perspectives spanning medical scheme consulting, health insurance, actuarial practice, healthcare policy, regulation, managed care and product development.

2.2.2 Paul Cox

Paul is the founder of NextWave Advisory, an independent strategic advisory practice serving the financial services, health insurance and managed care industries. He holds a master's degree from the University of Cape Town, with a focus on employee benefits, and has extensive executive-level experience in building and leading health insurance businesses. He previously served as managing director of Essential Medical (Pty) Ltd, trading as EssentialMED, where his responsibilities spanned product design, underwriting philosophy, distribution and regulatory compliance. He has worked closely with major South African insurers on health strategy, product structuring and market development.

2.2.3 Tiago de Carvalho

Tiago, CEO of Ambledown Financial Services, was instrumental in launching South Africa's first modern gap cover product.

2.2.4 Martin le Roux

Martin is an executive at Centriq, responsible for the Underwriting Management Agency(UMA) portfolio. His role encompasses strategic oversight of portfolio performance, governance, regulatory compliance and partner relationships. He has worked in the insurance industry since 1991 and joined Centriq as a UMA Client Manager in 2006. He holds a Bachelor of Commerce, a Master of Business Leadership and Master of Divinity.

2.2.5 Farai Mbumbwa

Farai heads the actuarial consulting team at Medscheme. He is a Fellow of the Actuarial Society of South Africa (ASSA), secretary of ASSA's Healthcare Committee and holds a Practising Certificate in Healthcare. He has 18 years of healthcare experience spanning traditional medical scheme pricing and managed care and has consulted to several medical schemes as well as a hospital group. His experience provides an actuarial, funding and managed-care perspective on the issues considered in this research.

2.2.6 Charlton Murove

Charlton is an actuary with more than 20 years' experience across healthcare and retirement funds. He has led the Board of Healthcare Funders of Southern Africa's specialised research unit since 2018 and has completed a Master's degree in Epidemiology

at the University of the Witwatersrand. His experience provides a research and actuarial perspective on healthcare financing, medical schemes and the broader healthcare funding environment.

2.2.7 Dr Rajesh Patel

Dr Patel is a senior healthcare executive and healthcare policy expert associated with the Board of Healthcare Funders of Southern Africa. He has extensive experience in healthcare funding, policy development and stakeholder engagement within the South African healthcare sector. His work focuses on healthcare financing, regulatory frameworks, medical schemes and collaborative solutions aimed at improving healthcare access and sustainability across both the public and private sectors.

2.2.8 Michael Settas

Michael has worked in multiple roles across the healthcare sector since 1991. His experience spans the development of best-practice tools for healthcare intermediaries, consulting to medical schemes on pricing and risk management, and undertaking investigations on behalf of the industry regulator. He has delivered numerous talks and written extensively on sustainable health financing, required reforms to South Africa's private-sector regulatory environment and the proposed NHI. He is currently managing director of Cinagi, a health and life insurance provider.

2.2.9 Rachael van Zyl

Rachael has 14 years of experience in healthcare and holds qualifications in Financial Mathematics and Actuarial Science. Her work includes actuarial consulting to open and restricted medical schemes, covering benefit design, contribution reviews, financial monitoring, claims analysis and outstanding claims reserve assessments. Her managed care experience includes disease and intervention analysis, quality-of-care measurement, assessment of disease-management programmes and the development and monitoring of medical scheme strategy.

3. OVERVIEW OF THE SOUTH AFRICAN HEALTHCARE ENVIRONMENT

3.1 Evolution of South African healthcare

3.1.1 The South African private healthcare funding environment has undergone significant regulatory change over the past three decades. This evolution has largely reflected the need to balance two competing objectives: strengthening consumer protection and equitable access to healthcare, while maintaining the affordability and long-term financial sustainability of the medical scheme system.

3.1.2 Prior to the Medical Schemes Act 131 of 1998 (MSA), medical schemes operated in an environment that allowed for risk rating, underwriting, selective membership practices and greater discretion in benefit design. These mechanisms provided schemes

with greater flexibility to manage their risk pools and pricing but also resulted in unequal access to medical scheme coverage, particularly for older, high-risk and lower-income individuals. It should be noted that ‘insurance products offering healthcare services had already been in existence prior to the enactment’ of the MSA. ‘This pre-existing landscape laid the foundation for the emergence of a multifaceted regulatory environment, characterised by various entities attempting to navigate this intricate framework to their advantage.’ (Council for Medical Schemes (CMS), Low-Cost Benefit Option (LCBO) Recommendations and Guidelines, 2023b, p.12).

3.1.3 The MSA fundamentally changed the healthcare regulatory environment by embedding principles of social solidarity through open enrolment, community rating and prescribed governance requirements. Open enrolment requires medical schemes to accept all eligible applicants, while community rating limits contribution differentiation based on individual age or health status. The introduction of PMBs further strengthened member protection by requiring medical schemes to fund a defined package of healthcare services in accordance with the regulatory framework. While these principles support access to medical scheme coverage, they also reduce schemes’ ability to price directly for individual risk. The broader reform envisaged at the time was not fully implemented, ‘leaving in place a partial framework which included open enrolment, community rating and regulated minimum benefits but excluded, inter alia, risk equalisation’ (Van den Heever, 2024). In particular, mandatory medical scheme membership and a risk equalisation mechanism were not introduced.

3.1.4 The publication of the NHI Green Paper in 2011 and White Paper in 2015, followed ultimately by the signing of the National Health Insurance Act in 2024, marked a further shift in South African healthcare policy towards universal health coverage by introducing the government’s long-term vision of universal health coverage. These developments signalled growing recognition that the entire healthcare funding system is fragmented and that structural reform would be required to address inequities between the public and private sectors.

3.1.5 Collectively, these reforms have materially strengthened consumer protection and access within the medical scheme environment. At the same time, they have shaped the financial and operational framework within which schemes fund and manage healthcare expenditure. Against this regulatory backdrop, medical schemes face a further challenge: healthcare costs that have consistently risen faster than broader inflation, placing increasing pressure on affordability and sustainability.

3.2 Cost pressures shaping medical scheme sustainability and the impact on members

3.2.1 Medical schemes need to keep contributions affordable for members while also maintaining comprehensive and sustainable healthcare benefits. This balance has become difficult to maintain as claims costs are driven upward by demographic change, healthcare inflation, provider pricing, technological advancement and increasing

utilisation, while the incomplete implementation of intended regulatory reforms constrains the mechanisms available to schemes to manage these pressures.

3.2.2 For instance, the PMBs and Chronic Disease List (CDL) frameworks have not undergone the regular comprehensive review originally envisaged under the regulatory framework, despite significant developments in clinical practice and healthcare costs. While PMBs are intended to be reviewed at least every two years, the CMS acknowledges that this process has not been consistently followed (CMS, Circular 15 of 2023a). Since schemes must fund this treatment at the regulatory prescribed level of care, they have limited flexibility to manage expenditure on these benefits. This has resulted in scheme cost containment efforts and risk transfer to members in the non-PMB benefit categories.

3.2.3 In response to rising claims, schemes employ a range of cost-containment measures, including benefit design, managed care, provider contracting and utilisation management. While these interventions are important to scheme sustainability, some may shift a greater proportion of healthcare cost or utilisation risk to medical scheme members. The interaction between upward cost pressures, scheme responses and member impact is illustrated below.

3.2.4 *Upward pressures driving up scheme costs*

3.2.4.1 *PMB obligations*

3.2.4.1.1 In the Health Market Inquiry (HMI), it is stated that PMB regulations have ‘played an important part in shaping benefit design in the market, particularly the move towards benefit limited hospital plans. These plans lead to additional costs as patients are unnecessarily admitted to hospitals in order to qualify for treatment’ (Health Market Inquiry, 2019, p.115).

3.2.4.1.2 Figure 1 illustrates that, in 2025, the PMB package accounted for over 70% of risk benefit expenditure, that is, excluding benefit expenditure paid from medical savings accounts. This demonstrates the significant proportion of scheme expenditure attributable to benefits for which schemes have limited flexibility to reduce the scope of cover. Furthermore, as illustrated in Figure 1, PMBs have accounted for an increasing proportion of overall risk claims over time, further concentrating scheme expenditure within this regulated benefit package.

3.2.4.2 *Ageing beneficiary population*

3.2.4.2.1 South African medical schemes operate under the principles of social solidarity. This framework relies on cross-subsidisation between younger and/or healthier lives, and older members who typically require more healthcare services. The long-term sustainability of medical schemes therefore depends on maintaining a balanced risk pool.

3.2.4.2.2 Age distribution data published by the CMS illustrates the gradual ageing of the medical scheme population between 2018 and 2024, shown in Figure 2. This

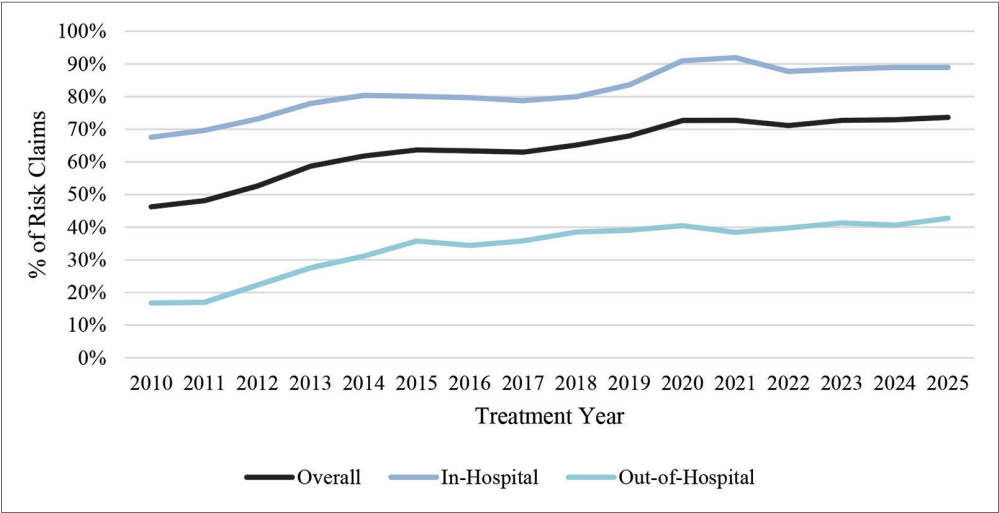


FIGURE 1. Percentage of total risk claims attributable to PMBs
Source: Medscheme (2026)

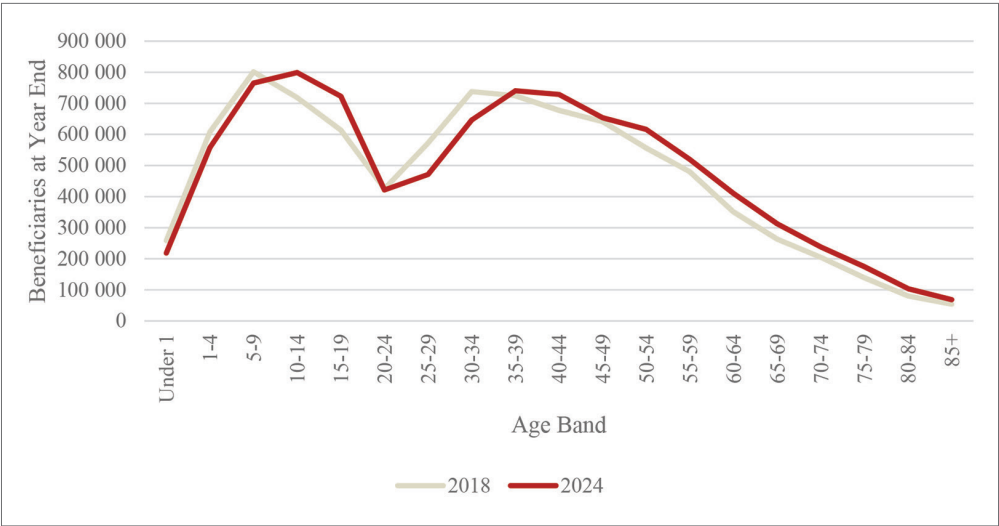


FIGURE 2. Total medical scheme beneficiaries at year end by age (2028 and 2024)
Source: CMS (2025b)

demographic shift is significant because healthcare utilisation and expenditure generally increase with age, as shown in Figure 3.

3.2.4.2.3 The ageing of the beneficiary population places structural pressure on medical scheme claims. As the proportion of older beneficiaries increases, the average expected healthcare cost of the risk pool rises, all else being equal. In a community-rated environment, these higher costs cannot simply be attributed to individual members based

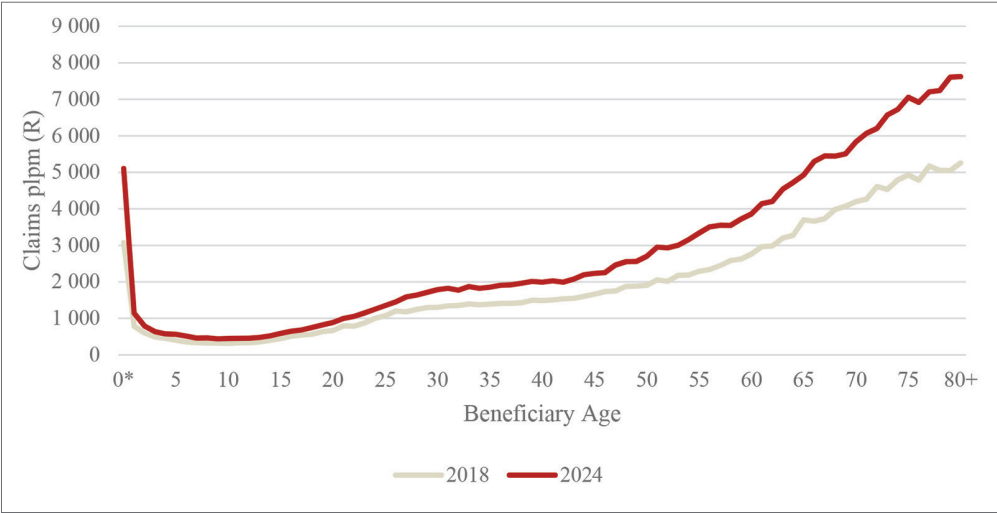


FIGURE 3. Claims per life per month by beneficiary age (2018–2024)
Source: Medscheme (2026)

on their health risk and must instead be absorbed across the broader membership base through contribution-setting and other scheme management interventions.

3.2.4.3 Healthcare cost inflation

3.2.4.3.1 Healthcare expenditure is influenced by a combination of price and utilisation effects and therefore does not necessarily move in line with general consumer inflation. The Parliamentary Budget office states that currently medical scheme contributions are ‘rising three times faster than CPI inflation’ (Parliamentary Budget Office, 2025, p.15). Medical scheme claims and contribution increases have historically tended to exceed CPI over the longer term. ‘The growing incongruity between medical scheme contributions and Consumer Pricing Index (CPI)’ effectively renders medical schemes more financially unattainable for a large segment of the population. (CMS, LCBO Recommendations and Guidelines Report 2023b, p.16)

3.2.4.3.2 A structural affordability challenge is established: where healthcare costs grow faster than household incomes and general inflation, maintaining an equivalent level of cover requires healthcare expenditure to consume an increasing proportion of household resources. Statistics South Africa (StatsSA, 2026) reported that 9.3% of total household expenditure is directed towards insurance and financial services, of which 36.2% was contributed towards medical scheme contributions between 2022 and 2023.

3.2.4.3.3 This affordability challenge is further illustrated through the fact that medical scheme coverage has declined over time from 16.4% in 2023 to 14.6% in 2024 as illustrated in Figure 4.

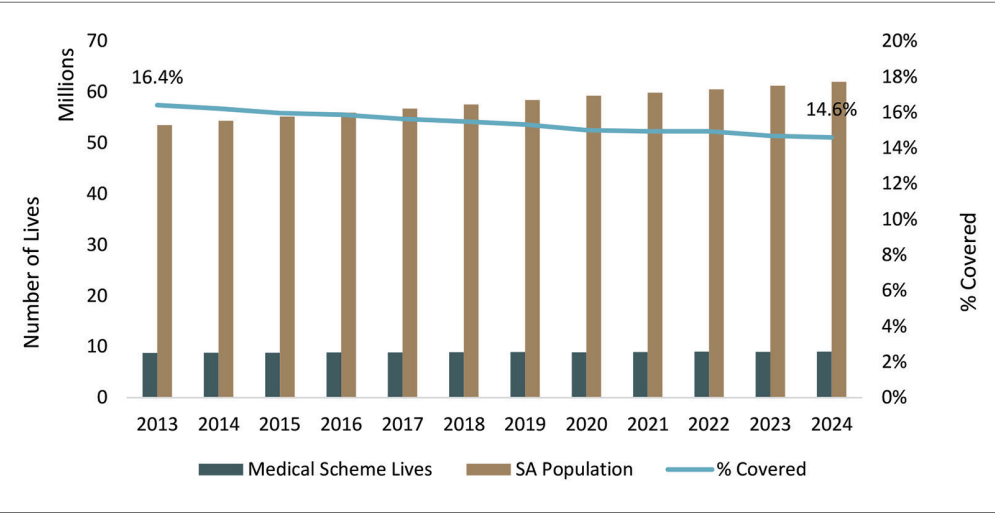


FIGURE 4. Percentage of the South African population covered by medical schemes
Source: StatsSA, Medical Scheme Population sourced from CMS Annexures (2025)

3.2.4.4 Provider reimbursement and tariff inflation

3.2.4.4.1 Prior to 2003, tariff setting between funders and practitioners ‘occurred centrally between the South African Medical Association (SAMA) and the Board of Healthcare Funders (BHF). This practice ceased following the intervention by the competition authorities to prohibit collective bargaining.’ (Health Market Inquiry, 2019, p.178)

3.2.4.4.2 Currently scheme reimbursement rates are determined through benefit design and contractual arrangements, while healthcare providers choose to either benchmark their fees to the scheme reimbursement rates in return for direct payment, or charge at higher rates. Where provider charges exceed the amount reimbursed by the medical scheme, the resulting shortfall may be borne by the member.

3.2.4.4.3 As noted by one interview participant, the cumulative effect of a sustained divergence between provider charges and scheme reimbursement levels can result in a substantial impact over time. Small annual differences compound, creating significant exposure for members when specialist care or hospital treatment is required. This widening reimbursement gap is one of the primary drivers of increasing out-of-pocket healthcare expenditure for medical scheme members.

3.2.4.4.4 In addition to practitioners’ ability to set their own fees, the requirement for PMBs to be reimbursed at cost, can limit scheme’s ability to incentivise specialist participation in provider networks. (Health Market Inquiry, 2019)

3.2.5 Scheme responses to cost pressures

3.2.5.1 In response to sustained claims pressure, medical schemes employ a range of mechanisms to manage expenditure and protect financial sustainability. These

include changes to benefit design, managed care interventions, provider contracting and negotiation and utilisation management. While these mechanisms can improve efficiency and affordability, they may also influence where financial and utilisation risk ultimately sit within the healthcare funding system.

3.2.5.2 *Benefit design changes*

3.2.5.2.1 Schemes have increasingly sought to contain contribution increases through benefit design changes allowed under the Medical Schemes Act. Examples of such changes include the introduction or expansion of co-payments, deductibles, sub-limits, network restrictions and benefit exclusions.

3.2.5.2.2 In a paper authored by D McIntyre and H Mcleod (2020, p.401), it is stated that medical schemes 'provide less financial protection than previously because of rapidly rising healthcare costs and reductions in benefits ... There are considerable limits and co-payments ... and large out-of-pocket payments for care outside the PMB package.'

3.2.5.2.3 While the benefit design measures outlined above may improve affordability at a contribution level, they often transfer a greater proportion of healthcare costs directly to members at the point of care. Consequently, affordability pressures are not eliminated but rather shifted from monthly contributions to out-of-pocket healthcare expenditure. In a 2022/23 report, it was estimated that households in South Africa spend an out-of-pocket amount of R31.5 billion on healthcare, which is equivalent to 1% of total household expenditure (StatsSA, 2026).

3.2.5.3 *Managed care*

3.2.5.3.1 The Regulations to the Medical Schemes Act define managed care as:

The clinical and financial risk assessment and management of healthcare, with a view to facilitating the appropriateness and cost effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical programmes. (Medical Schemes Act 131 of 1998, Regulation 5(f))

3.2.5.3.2 Managed care encompasses a range of clinical and financial interventions, including among others managed care network management, pre-authorisation, case management, active disease risk management services, formularies and clinical protocols (CMS, Circular 54 of 2022). Unlike benefit restrictions that primarily limit financial liability, managed care seeks to influence the appropriateness, setting, quality and cost-effectiveness of healthcare utilisation.

3.2.5.3.3 Effective managed care can therefore reduce avoidable utilisation and improve the efficiency with which scheme resources are deployed. Evidence from the South African medical scheme's environment suggest that coordinated care and provider-network arrangements can reduce healthcare expenditure and hospital utilisation. However, its effectiveness depends on access to appropriate clinical information, provider

participation, member engagement and the ability to coordinate interventions across the healthcare journey.

3.2.5.4 Provider contracting and reimbursement

3.2.5.4.1 Any scheme's ability to manage healthcare expenditure is influenced by the structure of the provider market and the mechanisms available for healthcare purchasing. Following competition law interventions prohibiting collective tariff negotiating, 'creating what has been called a price vacuum' (Health Market Inquiry, 2019, p.32), purchasing has become increasingly decentralised, with schemes and administrators negotiating arrangements independently.

3.2.5.4.2 The Health Market Inquiry (2019) highlighted concentration in segments of the private healthcare market and weaknesses in strategic purchasing. These structural characteristics may limit the extent to which medical schemes can rely on purchasing power alone to constrain healthcare cost increases.

3.2.5.4.3 The predominance of fee-for-service reimbursement has a number of drawbacks and is generally regarded as a less effective payment model in healthcare (Health Market Inquiry, 2019). Where provider remuneration is linked primarily to the volume and intensity of services rather than outcomes, provider and funder incentives may not be fully aligned. Schemes have therefore increasingly explored network arrangements, alternative reimbursement models, risk-sharing mechanisms and coordinated care pathways to improve value and manage expenditure.

3.2.5.5 Member affordability and financial exposure

3.2.5.5.1 Despite the range of mechanisms available to schemes to manage expenditure, sustained growth in healthcare costs ultimately creates pressure on member affordability. This pressure manifests primarily through two channels: higher medical scheme contributions and increased out-of-pocket healthcare expenditure.

3.2.5.5.2 The contribution increases illustrated in Figure 5 demonstrate the ongoing affordability challenge facing medical scheme members. 'The problem of medical scheme affordability is considered to be the greatest obstacle to growth in the industry' (Mcintyre & Mcleod, 2020, p.385).

3.2.5.5.3 As healthcare expenditure and medical scheme contributions continue to outpace general inflation over time, maintaining medical scheme membership requires an increasing allocation of household resources (StatsSA, 2026). These affordability pressures may influence members to migrate to lower-cost benefit options and seek insurance products to protect against selected financial exposures outside the medical scheme benefit structure. Industry evidence supports this trend, with gap cover providers reporting increasing levels of medical scheme buy-down activity and a growing proportion of households downgrading from comprehensive cover for affordability reasons within their client bases (Rimmer, 2025).



FIGURE 5. Average headline contribution increases across the eight largest open medical schemes (2022–2026)
Source: Medscheme (2026)

3.2.5.5.4 When analysing member option changes across the three option-change periods (202312–202401, 202412–202501 and 202512–202601), the available scheme-level data show a consistent pattern of members buying down to lower-cost options. The analysis covers schemes representing approximately 31% of total medical scheme membership in South Africa, based on CMS (2025a) industry membership figures. Across this dataset, the proportion of members buying down consistently exceeded the proportion of members buying up to more comprehensive options. This trend persisted despite an increase in the average age of the membership cohort over the same period. Given that healthcare utilisation and expenditure generally increase with age, one might ordinarily expect demand for more comprehensive healthcare coverage to increase over time. The observed pattern may therefore indicate that affordability considerations are influencing member behaviour, with some members electing to reduce the scope of their medical scheme cover in order to manage rising contribution costs.

TABLE 1. Option change overview (202312–202401, 202412–202501 and 202512–202601)

Option change	23/24	24/25	25/26
Buy down %	2.40%	4.50%	4.00%
Buy up %	1.60%	1.30%	1.80%
Average age	49.28	49.40	49.80
Source: Medscheme (2026)			

3.2.5.5.5 Moving to lower-cost benefit options can reduce monthly contributions, it can also change the level of members' financial cover. Lower-cost options may provide less comprehensive non-PMB benefits, make greater use of provider networks or require higher co-payments. Affordability pressures can therefore result not only in changes in benefit selection, but also in a greater proportion of healthcare financing risk being retained by members.

3.2.5.5.6 Consequently, the mechanisms used to preserve medical scheme affordability and sustainability can alter the distribution of financial risk between schemes and members. Where members retain greater exposure to costs outside their scheme benefits as a result of buy-downs or scheme risk management techniques, a need for out-of-scheme protection is created, especially where members cannot afford to buy up to a more expensive plan.

3.3 Health insurance within the South African healthcare funding landscape

The affordability and funding pressures described above have contributed to the development of a health insurance market alongside medical schemes. While these products operate under different regulatory frameworks and fulfil different functions, they address financial exposures and healthcare needs that may fall outside medical scheme benefits. Two key components of this market are gap cover and PHI products.

3.3.1 *Emergence and role of gap cover*

3.3.1.1 The first modern gap cover product, pioneered by Tiago de Carvalho at Ambledown, emerged to provide medical scheme members with financial protection against growing out-of-pocket healthcare expenditure as a result of medical expense shortfalls. As a non-life insurance product, it indemnifies policyholders against specified healthcare costs that arise after a medical scheme has funded its portion of an eligible claim. It therefore operates as a complementary mechanism to medical scheme cover, rather than a substitute for it.

3.3.1.2 Over time the scope of gap cover has expanded beyond tariff shortfalls to include benefits such as co-payment cover, penalty co-payment cover, sub-limit cover and certain oncology-related benefits. Despite this evolution, for providers under consideration in this paper, tariff shortfalls remain a significant driver of gap cover claims, accounting for approximately 70% of claims incurred during a given benefit year. This illustrates the continued financial exposure arising where provider charges exceed medical scheme reimbursement levels.

3.3.1.3 In an analysis done by De Carvalho, it was found that the probability of an in-hospital event resulting in a shortfall increased materially from the early 1990s through to 2024. Building on this analysis, the authors estimate that approximately 75% of hospital admissions result in some level of out-of-pocket payment by the end of 2025, as illustrated in Figure 6.

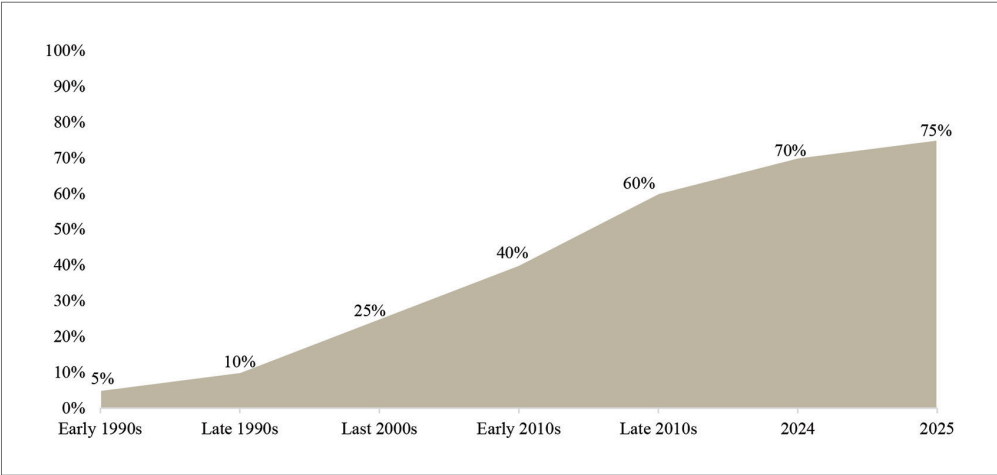


FIGURE 6. Estimated likelihood of a shortfall arising from an in-hospital healthcare event
Source: Medscheme (2026)

3.3.1.4 The above trend illustrates an important evolution in the role of gap cover. What originated as protection against relatively infrequent financial exposure has become increasingly relevant as the likelihood and potential magnitude of medical scheme reimbursement shortfalls have grown.

3.3.2 The role of PHI products

3.3.2.1 The affordability of medical scheme membership remains a barrier for a significant proportion of the South African population, thereby creating demand for lower-cost mechanisms through which individuals can access private healthcare services. ‘Insurance companies identified this affordability gap and responded by offering low-cost insurance alternatives’ (CMS, LCBO Recommendations and Guidelines Report, 2023b).

3.3.2.2 PHI products fulfil a different role within the complementary health insurance market. The products may be underwritten under life or non-life insurance licences and typically provide access to defined private healthcare services, with a strong focus on day-to-day primary healthcare. Insurance-based hospital or emergency benefits under PHI products are not structured to indemnify the policyholder for the actual cost of hospital treatment. Instead, benefits may be defined as a fixed amount per day of hospitalisation or a stated lump-sum benefit linked to a specified event or procedure.

3.3.2.3 PHI products have historically been the subject of longstanding debate regarding their potential positioning as alternatives to medical scheme cover. There is a risk that consumers may buy out of medical schemes entirely in favour of PHI products, or buy down to less comprehensive medical scheme options and supplement their cover with PHI, without fully understanding the differences in benefit scope, regulatory protections

and the extent of healthcare costs covered. According to the CMS, the growing popularity of PHI among the younger and healthier demographics may also contribute to the erosion of the long-term viability of medical schemes. (CMS, LCBO Recommendations and Guidelines Report, 2023b).

3.3.3 *Related regulatory changes*

3.3.3.1 The growth of complementary health insurance prompted regulatory attention to the boundary between health insurance products and medical scheme business. The introduction of the Demarcation Regulations in 2017 represented a pivotal development, establishing clearer parameters for health insurance products that could operate alongside medical schemes.

3.3.3.2 The first draft Regulations proposed to ban gap cover products. Comments received suggested that in the current environment there could be a role for gap cover. Its continued operation was permitted subject to parameters intended to ensure that it remained complementary to, rather than a substitute for, medical scheme membership. The regulatory evolution therefore reflects a pragmatic recognition that, notwithstanding concerns regarding the interaction between health insurance and medical schemes, gap cover performs a legitimate function within the prevailing healthcare funding environment.

3.3.3.3 The Demarcation framework acknowledged that certain insurance products had moved into healthcare funding activities traditionally associated with medical schemes. The regulatory response, however, recognised an important market reality: a significant number of consumers had come to rely on lower-cost insurance products to access private healthcare. The Exemption Framework therefore permitted certain PHI products to continue operating, protecting existing policyholders while a longer-term policy solution was developed.

3.3.3.4 The development of the LCBO was closely linked to this process. The CMS expressly described the Exemption Framework as a ‘transitional arrangement whilst the National Department of Health is busy developing a LCBO Guideline for medical schemes.’ (CMS, Circular 9 of 2022).

3.3.3.5 LCBOs are defined as being ‘strategically designed medical scheme benefit options meticulously crafted to address the specific needs of lower-income families ... These options seek to strike a balance between affordability and the provision of essential healthcare services, targeting those who find themselves on the margins of the current system’ (CMS, LCBO Recommendations and Guidelines Report, 2023b).

3.3.3.6 LCBOs sought to address a similar affordability need to PHI, but from within the medical scheme environment. LCBO benefit options could be ‘developed consistent with the principles of current primary healthcare insurance products within a social solidarity framework.’ (CMS, Circular 53 of 2022, p.10).

3.3.3.7 What was intended as a transitional arrangement has persisted. The

repeated renewal of the Exemption Framework meant that the insurance products grew stronger in the continued absence of LCBO implementation or any other meaningful scheme regulatory reform.

3.3.4 Implications of this regulatory evolution

3.3.4.1 Gap cover and PHI have been important innovations in the South African private healthcare market, responding to genuine gaps in affordability, access and financial protection. However, by developing alongside – rather than as part of – the medical scheme ecosystem, these products have also altered incentives, redistributed risk and, in some instances, weakened mechanisms intended to manage healthcare costs.

3.3.4.2 The historical regulatory response has fundamentally sought to protect the boundary between medical schemes and health insurance, allowing insurance products to complement medical scheme cover, without undermining the social-solidarity principles underpinning the medical scheme environment.

3.3.4.3 While this regulatory separation remains important, the products operating on either side of the boundary have become increasingly interconnected. The challenge may therefore no longer be simply how to preserve separation, but rather how to optimally manage these interactions to limit the impact on the medical scheme risk pool. The question is therefore whether greater coordination can occur across regulatory boundaries, while preserving the distinct purpose of each product.

4. CURRENT LANDSCAPE OF HEALTH INSURANCE PRODUCTS

4.1 The increasing funding role of gap cover

4.1.1 Having established the emergence and evolution of gap cover, this section considers the extent to which its funding role has changed, drawing on claims experience from a select Gap provider and industry interviews.

4.1.2 An analysis of claims data from a specific gap cover provider undertaken as part of this study found that the number of claimants experiencing a shortfall exceeding R50 000 for a single healthcare event increased by an average of 31% per annum between 2021 and 2025. Similarly, the number of claimants with cumulative annual shortfalls exceeding R50 000 increased by an average of 31% per annum over the same period. Furthermore, utilisation of gap cover increased by more than 10% per annum between 2021 and 2025. These findings are consistent with broader industry experience, with Sirago reporting that the number of Mega Gap claims exceeding R50 000 increased by 512% in volume and 437% in value between 2020 and 2024 (Rimmer, 2025).

4.1.3 The increase in both utilisation and the incidence of high-cost claims is reflected in the underlying cost of providing gap cover. Between 2021 and 2025, claims cost per policy per month increased by an average of 13.8% per annum.

4.1.4 The most recent year shows a similar trend, with gap cover claims increasing by 14.1% in 2025. Figure 7 breaks down this increase across the underlying

benefit categories, with tariff shortfalls contributing 9.2%, followed by penalty co-payments at 3%, co-payments and deductibles at 1.8% and other factors accounting for the balance.

TABLE 2. Average annual increase % of claim cost per policy per month 2021–2025

	Average annual % increase
Claim cost pppm*	13.8%
*pppm = per policy per month	Source: Afrocentric HealthInsure (2026)

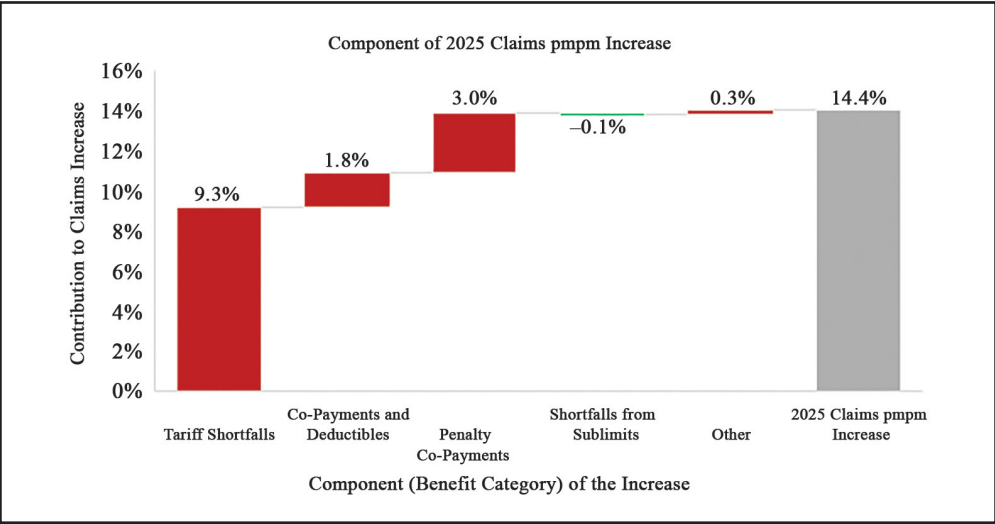


FIGURE 7. Components contributing to the 2025 Gap Cover claims cost increase
Source: Afrocentric HealthInsure (2026)

4.1.5 The 2025 experience demonstrates that tariff shortfalls remain the dominant contributor to gap cover claims costs. These increases reflect broader dynamics within the healthcare funding environment, including medical tariff inflation, widening differences between healthcare provider charges and medical scheme reimbursement rates, changes in medical scheme benefit design and the underlying healthcare needs of the insured population.

4.1.6 The sustained increase in gap cover claims costs should be interpreted alongside changes in medical scheme funding and reimbursement. According to the CMS (Circular 21 of 2026, p.5), ‘overall industry-weighted tariff increase assumption for 2026 was 3.97%’. Where gap cover claims costs increase at a faster rate than medical scheme contributions or reimbursement tariffs, this may indicate that a growing proportion of healthcare costs is being transferred from medical schemes to gap cover products. This trend has implications for the long-term sustainability of gap cover products. Industry interviews support this view, with several participants indicating that gap cover premium increases

above prevailing medical scheme contribution increases may be required to maintain product sustainability.

4.1.7 A recurring theme across industry interviews was the potential influence of gap cover on healthcare provider charging behaviour. While the Health Professions Council of South Africa’s (HPCSA) ethical guidelines emphasise professional independence and caution against perverse incentive that may influence clinical decision-making or patient treatment (HPCSA, 2021), several interviewees suggested that some providers may take the availability of gap cover into account when determining fees. If present, this behaviour could contribute to widening shortfalls and place further upward pressure on gap cover claims costs.

4.1.8 The interaction between medical schemes and gap cover is evident in benefit design. The head of actuarial pricing for several prominent medical schemes confirmed that the availability of gap cover is considered in certain benefit design and reimbursement decisions. This provides further evidence that the risks funded by medical schemes and gap cover are not developing independently, with decisions in one funding environment potentially affecting the exposure carried by the other.

4.1.9 There is evidence that the fundamental nature and quantum of risk sitting in gap cover products may be changing. Due to the inherent dependence of gap cover on medical schemes, changes in medical scheme benefit design and reimbursement structures directly influence the risks funded through gap cover. The increasing cost of these products therefore highlights the importance of considering the medical scheme and gap cover environments together, particularly in accessing the longer-term sustainability of both funding mechanisms.

4.2 Case studies demonstrating the complementary role of gap cover

4.2.1 To illustrate how medical scheme and gap cover benefits interact to fund members’ healthcare costs, three case studies were analysed. These cases were selected because they represent three of the highest gap cover claims observed for the medical scheme under review during 2025.

4.2.2 In the first case study, a member experienced three significant hospital events during 2025, all of which resulted in partial reimbursement from their gap cover policy. The events are summarised below.

TABLE 3. Case study 1 partial reimbursement summary

Events	Account amount	Medical scheme	Gap cover
1. Mouth and salivary gland procedures	R780 000	R555 000	R207 000
2. Maxillofacial surgery		(71%)	(27%)
3. Local excision and removal of internal fixation devices			
Source: Medscheme (2026) and Afrocentric HealthInsure (2026)			

4.2.3 In the first event, the member elected to utilise an out-of-network provider and consequently incurred a penalty co-payment, which the gap cover policy reimbursed. For the maxillofacial surgery, the gap cover policy paid approximately R100 000 towards specialist tariff shortfalls, in addition to covering benefit sub-limit shortfalls of approximately R24 000. The third event similarly resulted in tariff shortfalls, which were reimbursed through the gap cover policy. Furthermore, the gap cover claims included several additional co-payments related to out-of-hospital procedures.

4.2.4 The second case study involved a member who incurred substantial specialist tariff shortfalls and penalty co-payments associated with two significant urological interventions.

TABLE 4. Case study 2 partial reimbursement summary

Events	Account amount	Medical scheme	Gap cover
1. Kidney, ureter and major bladder procedures	R370 000	R247 000	R123 000
2. Circumcision procedure		(67%)	(33%)
Source: Medscheme (2026) and Afrocentric HealthInsure (2026)			

4.2.5 Both events triggered claims for specialist tariff shortfalls, as well as penalty co-payments – demonstrating the significant role played by gap cover products in mitigating provider-related co-payments, even where the underlying procedures are covered by the medical scheme.

4.2.6 While the first two case studies highlight high-cost surgical interventions, the next case demonstrates how repeated healthcare utilisation over a single year can also generate substantial out-of-pocket exposure.

TABLE 5. Case study 3 partial reimbursement summary

Events	Account amount	Medical scheme	Gap cover
Spinal disorders	R205 000	R88 000	R101 000
Back and neck procedures		(43%)	(49%)
Source: Medscheme (2026) and Afrocentric HealthInsure (2026)			

4.2.7 Analysis of scheme data revealed that the beneficiary covered under this policy experienced two spinal-related hospital events during 2025. The first admission, relating to a spinal disorder, did not result in any gap cover claims. However, the second event generated costs of approximately R140 000, of which the gap cover policy paid approximately R33 000 towards tariff shortfalls. In addition to these hospital-related claims, the beneficiary incurred co-payments totalling approximately R67 000 throughout the year. As a result, total gap cover claims exceeded R100 000 during 2025.

4.2.8 Collectively, these case studies illustrate that while medical schemes remain the primary funders of healthcare services, gap cover products have become an

increasingly important mechanism for protecting members against residual financial exposure.

4.3 PHI products fulfil a distinct but constrained healthcare funding role

4.3.1 PHI products occupy a distinct position within the private healthcare funding landscape. They extend access to defined private healthcare services but do not provide the comprehensive financial protection associated with medical scheme membership, including the statutory protection provided through PMBs. PHI should therefore not be viewed as a lower cost equivalent to medical scheme membership, but as a distinct healthcare funding mechanism addressing a different segment of healthcare need – access to private primary care.

4.3.2 The significance of PHI within the broader healthcare funding landscape is reinforced by the scale of the market. One interview participant estimated that the PHI policy base exceeds one million lives. This suggests that PHI is no longer a peripheral component of private healthcare funding but provides access to private healthcare services for a substantial segment of the population.

4.3.3 Analysis of PHI claims further demonstrates the nature of this funding role. For the PHI provider analysed, general practitioner (GP) consultations account for approximately 63% of claims, followed by basic dentistry at 13% and medication at 8%. Therefore, it can be seen that PHI predominantly addresses an ongoing need for accessible primary healthcare.

TABLE 6. Top three benefit categories on a PHI provider analysed for the 2025 benefit year

Benefit category	Claim frequency pppa*	% of total claims
General practitioner consultations	5.0 visits	63%
Basic dentistry	2.6 visits	13%
Medication (acute + chronic + OTC)	5.8 claims	8%
*pppa: per policyholder per annum		Source: EssentialMED HealthInsure (2026)

4.3.4 PHI products provide an entry point to private healthcare for individuals who cannot afford medical scheme cover. In terms of product development, the regulatory distinction between insurance and the business of a medical scheme materially influences the way PHI products can evolve. This highlights an important distinction between PHI and gap cover products. While gap cover has expanded its benefit scope in response to changing funding shortfalls within the medical scheme funding environment, PHI products have developed and operate within a more constrained benefit design framework, and cannot evolve into increasingly comprehensive healthcare. Product development therefore focuses on improving affordability, access and value within these parameters, including through provider network arrangements, negotiated healthcare tariffs and effective utilisation management.

4.3.5 PHI occupies an important but constrained position in the healthcare funding. It addresses affordability and access needs but cannot readily expand to meet broader healthcare needs such as comprehensive in-hospital care because of the regulatory boundary between health insurance and medical scheme business.

4.3.6 This differs from the challenge facing gap cover. Gap cover is exposed to developments within the medical scheme environment, while PHI currently primarily serves individuals for whom comprehensive medical scheme membership may be unaffordable. Both respond to limitations in the healthcare funding system, but from opposite sides on the medical scheme boundary.

5. IMPACTS OF CURRENT FRAGMENTATION

5.1 The preceding sections demonstrate that medical schemes, gap cover and PHI each fulfil distinct roles within the private healthcare funding landscape. While these products respond to different healthcare funding needs, they do not operate as an integrated funding system. The result is a fragmented environment in which responsibility for healthcare expenditure is distributed across medical schemes, health insurance products and members themselves.

5.2 It could be argued that in a more efficient and complete regulatory environment, the need for health insurance products to address gaps within the current healthcare funding system would likely be materially reduced.

5.3 The practical reality, however, is that these products form part of the current healthcare funding landscape. The relevant question is therefore how the fragmentation arising from separately regulated, designed and managed funding mechanisms affects the functioning of the broader system. This section explores the fragmentation that arises due to gap cover and PHI in the current healthcare funding environment.

5.4 Potential fragmentation arising from gap cover products

5.4.1 Gap cover provides valuable financial protection by funding healthcare costs not fully covered by medical schemes. However, because gap cover products are generally designed independently of medical schemes, their benefits may inadvertently weaken or contradict managed care mechanisms intended to influence member and provider behaviour. This creates a potential tension between the financial protection provided by gap cover and the cost-containment objectives of the underlying medical scheme. The examples below illustrate this interaction.

— **Tariff shortfall benefits:** Medical schemes negotiate reimbursement tariffs with network specialists to limit overcharging, encourage the use of Designated Service Providers (DSPs), and support affordability. By reimbursing claims above scheme tariffs, gap cover reduces the financial consequence to the members of consulting

providers outside of these arrangements. This may weaken member incentives to use network providers and, consequently reduce the effectiveness of tariff negotiations, and schemes' purchasing power. Industry interviews provided some support for this potential interaction. A managed care actuary noted that provider participation in network arrangements is influenced by several factors including anticipated patient volumes from network participation and the financial implications for patients utilising non-network providers. Where gap cover reduces these financial consequences, it may, alongside other factors, weaken the incentives supporting network participation and utilisation.

- **Co-payments benefits:** Medical schemes utilise co-payments to influence member behaviour, manage utilisation and support cost-containment. Where gap cover reimburses these co-payments the financial impact on the member is reduced. While this provides valuable financial protection, it may also alter the behavioural incentives embedded within the medical scheme's benefit design.
- **Penalty co-payment benefits:** Medical schemes use penalty co-payments to encourage members to use DSPs and contracted provider networks. Where gap cover reimburses these penalties, the financial incentive to remain within the network is reduced, potentially weakening network compliance and the effectiveness of scheme contracting arrangements.
- **Sub-limit extenders:** Medical schemes may use sub-limits on selected benefit categories to manage utilisation of discretionary healthcare services and support cost containment. Gap cover sub-limit extenders reduce the financial impact of these limits on members and may therefore weaken this utilisation-management mechanism.

5.4.2 These examples highlight a broader structural tension. Gap cover has become entrenched in the industry, changing member and provider behaviour. Individually, gap cover benefits provide valuable protection against financial exposure; collectively, however, they may offset some of the behavioural and financial incentives through which medical schemes seek to manage utilisation and costs. This points to the importance of considering how gap cover benefits interact with medical scheme benefit design, and whether greater alignment could support both member protection and the effectiveness of medical scheme cost-management mechanisms.

5.5 Incentives arising from interaction between PHI and medical scheme products

5.5.1 PHI products and medical schemes operate within separate regulatory and funding environments, despite there being overlap in some of the healthcare services covered by each. Where an individual holds both products, the interaction between the two products may create financial and behavioural incentives.

5.5.2 For example, the existence of PHI may influence a member's choice of medical scheme option. In particular, a member may select a lower-cost, less

comprehensive medical scheme option and use PHI to supplement certain out-of-hospital benefits that would otherwise have been available under a more comprehensive medical scheme option.

5.5.3 The financial incentive associated with such a decision can be material. The example below compares the cost of a more comprehensive medical scheme option with a combination of a lower-cost scheme option and a PHI product.

TABLE 7. 2026 Contributions for a medical scheme option versus an existing combination of a less comprehensive scheme option paired with a PHI product for a single member (P) and a family of three (PAC).

	Hospital plan with day-to-day benefits	Entry-level hospital plan + PHI	% Difference
P	2 630	1 665	–37%
PAC	5 654	4 374	–23%
Source: EssentialMED (2026)			

5.5.4 In the example above, the combined arrangement results in a contribution and premium saving of 37% for a single member and 23% for a family of three. This demonstrates the potential financial incentive for members to buy-down their medical scheme option and supplement some of the reduced out-of-hospital benefits through PHI. Importantly, in buying down, members may reduce certain medical scheme benefit entitlements and supplement only selected elements through PHI, resulting in a different overall level and composition of healthcare coverage. Furthermore, the hospital networks utilised under the PHI products may differ in quality and geographical coverage when compared with scheme out-of-hospital benefits.

5.5.5 From a medical scheme perspective, such buy-downs may have broader funding implications. The reduction in contribution income associated with a buy-down may exceed the corresponding reduction in expected claims costs, potentially affecting the financial performance of the options concerned.

5.5.6 Differences in pricing structures may further influence this dynamic. PHI premiums may be risk-rated, whereas medical scheme contributions are community rated within each benefit option. PHI may therefore be relatively more affordable for younger individuals, who are also generally lower risk from a healthcare claims perspective. This may strengthen the financial incentive for these members to combine PHI with a less comprehensive medical scheme option. If this behaviour occurred at sufficient scale, it could alter the distribution of risks across medical scheme benefit options and weaken existing patterns of cross-subsidisation. For example, a migration of younger, lower-risk members towards PMB-only or lower-cost options may leave mid-level and comprehensive options with a relatively older and higher-risk membership base, increasing contribution pressure on those options over time. Although medical scheme options are required

to be financially self-sufficient, inter-option subsidisation is often observed in practice. Consequently, shifts in member composition may place pressure on the sustainability and ultimately affordability of certain scheme options.

5.5.7 A further interaction may arise from differences in provider reimbursement arrangements. Medical schemes and PHI providers may negotiate different tariffs for the same healthcare service. Where an individual holds both forms of cover, differences may influence which product funds the service. For example, where a medical scheme reimburses a GP consultation at a higher tariff than the PHI provider, there may be a greater financial incentive for the service to be funded through the medical scheme, where permitted. This highlights how independently negotiated reimbursement arrangements may contribute to the broader challenges associated with achieving consistent and transparent tariff determination within the private healthcare landscape.

5.5.8 Collectively, these interactions highlight the complexities that can arise where PHI and medical scheme products operate alongside one another under different regulatory, pricing and benefit-design frameworks. This should be considered alongside the important affordability and access role that PHI currently fulfils. The proposed LCBO (CMS, 2023b) framework may address several of the affordability challenges currently affecting medical schemes, but the same issues of cross-subsidisation and buy-downs would need to be considered. A key distinction is that LCBOs seek to provide lower-cost cover within the medical scheme regulatory environment with beneficiaries participating in only one benefit option at a time, rather than through the interaction of separate medical scheme and PHI products.

6. THE CASE FOR INTEGRATED HEALTHCARE SOLUTIONS

6.1 Existing integration between medical schemes and gap cover

6.1.1 National Treasury explicitly recognised that appropriately designed health insurance products can play a role in protecting individuals against unexpected health events, provided that they ‘complement medical schemes and support the social solidarity principle embodied in medical scheme cover’ (National Treasury, 2014, p.1). This principle of complementarity provides an important foundation for considering greater coordination between medical schemes and gap cover.

6.1.2 In practice, a degree of integration already exists. Although medical schemes and gap cover remain distinct products operating under separate legislative and regulatory frameworks, they are frequently distributed through overlapping intermediary channels. Consequently, medical scheme membership and gap cover may be considered together as complementary components of a broader healthcare funding solution.

6.1.3 This integration, however, occurs primarily at the distribution level and seldom extends to the coordinated design of benefits, funding incentives or provider reimbursement arrangements. This paper considers whether greater coordination during product development could better align funding incentives, manage interconnected risks

and support the objectives and long-term sustainability of medical schemes, rather than simply transferring financial pressure between funders.

6.1.4 Importantly, greater coordination does not imply a departure from the principle of demarcation. Medical schemes and gap cover would retain their distinct purposes, funding responsibilities and regulatory positions. The proposed approach therefore does not seek to change the fundamental role of either product, but rather to explore how they can be more deliberately designed to operate alongside one another within their existing regulatory boundaries.

6.2 Medical schemes and gap cover: a coordinated model

6.2.1 *Principles of a coordinated model*

6.2.1.1 The proposed model seeks to better align the incentives of medical schemes, gap cover providers, healthcare professionals and members within a coordinated healthcare funding framework, rather than each stakeholder responding independently to rising healthcare costs. The objective is to improve alignment in areas where their incentives overlap, while supporting affordability, appropriate utilisation and sustainable healthcare funding.

6.2.1.2 The proposed model does not seek to integrate the funding responsibilities of medical schemes and gap cover providers. Coordination would instead occur through mechanisms such as provider networks, reimbursement arrangements and complementary benefit design. The proposals and discussion that follow assume a largely unchanged regulatory environment and recognise that gap cover and PHI products are established components of the current health risk protection landscape and are likely to continue to play a role in some form.

6.2.1.3 Under the possible integrated model:

- The medical scheme continues to fund healthcare services in accordance with its registered rules and benefits;
- The gap cover product continues to operate as an indemnity insurance product;
- Participating providers may contract within a preferred provider network that supports the objectives of both products;
- Members are encouraged to utilise network providers through enhanced financial protection;
- Provider reimbursement arrangements are negotiated within an agreed reimbursement framework, improving pricing certainty while preserving appropriate clinical autonomy;
- Gap cover benefits are designed, where appropriate, to complement rather than undermine medical scheme managed care and cost-containment mechanisms.

6.2.1.4 An existing example of this principle can be seen in the design of certain oncology shortfall benefits. Medical schemes may apply an oncology benefit limit to non-PMB treatment, after which a proportion of the related healthcare costs remains payable

by the member. A gap cover product may fund this defined shortfall, subject to the terms and overall annual limit of the policy. This provides an example of complementary benefit design in which gap cover extends financial protection without necessarily undermining member adherence requirements or negotiated reimbursement arrangements between healthcare providers and the medical scheme. While similar examples remain relatively limited, the principle illustrates how the respective products can be designed to operate alongside one another.

6.2.2 *Coordinated provider networks and reimbursement arrangements*

6.2.2.1 A persistent challenge in the private healthcare funding market is the tension between medical schemes and healthcare providers regarding reimbursement rates. Healthcare providers may argue that scheme tariffs do not adequately reflect the costs of delivering healthcare services, while medical schemes may contend that some providers charge materially above scheme reimbursement rates. Where members have gap cover, qualifying differences between provider charges and scheme reimbursement may subsequently be funded by the insurer. This can reduce the incentive for providers to moderate charges and leaves the underlying reimbursement tension unresolved.

6.2.2.2 A coordinated provider network could provide an opportunity to address this tension more directly. Rather than the medical scheme negotiating a reimbursement rate and gap cover subsequently funding qualifying shortfalls arising above that rate, participating providers could agree to a defined reimbursement framework that recognises the respective funding roles of the medical scheme and gap cover product. This could provide greater certainty regarding the total cost of care and the portion payable by each funder, while reducing unexpected shortfalls for members.

6.2.2.3 Such an arrangement could also create a stronger value proposition for participating providers. Providers may be willing to accept negotiated reimbursement rates that fall between traditional medical scheme reimbursement levels and standard private tariffs in exchange for increased patient volumes, greater reimbursement certainty and reduced administrative complexity. This differs from the current fragmented model, in which medical schemes and providers negotiate reimbursement arrangements while gap cover providers generally respond retrospectively to qualifying shortfalls generated by those arrangements.

6.2.2.4 Importantly, the objective is not to increase the proportion of healthcare costs transferred to gap cover. Rather, it is to strengthen the relationship between medical schemes and gap cover providers, enabling gap cover providers to play a more active role in supporting coordinated arrangements aimed at moderating overall reimbursement levels. Under such an approach, each product would continue to fund only those amounts that fall within its respective benefit design and funding responsibilities. By reducing reimbursement differentials at source, the model could support greater price certainty and cost containment while maintaining meaningful financial protection for members.

6.2.2.5 This approach is consistent with the Health Market Inquiry's (2019) view that the private healthcare sector would benefit from more formalised and transparent tariff determination processes to address the limitations of fragmented bilateral negotiations between funders and providers.

6.2.2.6 The development of such an arrangement would, however, be a complex and resource-intensive endeavour. Successful implementation would require establishment of reimbursement levels that appropriately reflect the efficient cost of delivering care, while addressing existing distortions in negotiated tariffs structures that contribute to disparities between provider charges and medical scheme reimbursement levels. Achieving this would require extensive engagement and alignment among healthcare providers, medical schemes, gap cover providers and other stakeholders to agree on reimbursement levels that are regarded as fair, sustainable and capable of supporting the long-term objectives of the coordinated network.

6.2.3 *Coordinated benefit design and managed care*

6.2.3.1 The opportunity for coordination extends beyond provider reimbursement to the design of gap cover benefits themselves. Certain gap cover benefits may inadvertently reduce the effectiveness of medical scheme cost-containment and managed care mechanisms by reimbursing costs that those mechanisms are intended to influence. Greater alignment in benefit design could instead preserve financial protection for members while reinforcing network utilisation, clinical pathways and appropriate healthcare utilisation.

6.2.3.2 Co-payment benefits provide one of the clearest opportunities for greater alignment. Importantly, a distinction should be drawn between penalty co-payments and other co-payments arising under the medical scheme benefit design.

6.2.3.3 Penalty co-payments may be imposed where a member voluntarily uses a non-network provider or fails to follow specified treatment, referral or authorisation requirements. These co-payments are deliberately designed to influence member behaviour and support the scheme's managed care and cost-containment objectives. Where gap cover reimburses such penalties, it may effectively remove the financial incentive created by the scheme. Under a coordinated model, gap cover could therefore reduce or remove cover for penalty co-payments arising from a member's voluntary decision not to follow applicable network or managed care requirements.

6.2.3.4 Co-payments embedded in an options design arise as a mechanism to control utilisation and contain costs. Under the coordinated model, the gap cover co-payment benefit could be redesigned to align with adherence to provider networks, treatment protocols and referral pathways. Through this design, members would continue to receive protection against qualifying co-payments when the coordinated network is adhered to, specifically co-payments that represent genuine financial shortfalls and not co-payments designed to influence member behaviour. This allows gap cover to maintain

its complementary financial protection role without inadvertently neutralising the medical scheme's managed care incentives.

6.2.3.5 A similar principle could apply to sub-limit extender benefits. Where gap cover automatically extends a scheme benefit once its sub-limit has been exhausted, it may reduce the effectiveness of the underlying cost-containment mechanism. Under a coordinated model, additional funding could instead be linked to predefined clinical criteria, authorisation requirements, network conditions or treatment protocols. The objective would therefore shift from automatically extending the available funding to supporting continued access to clinically appropriate care within a controlled and managed framework.

6.2.3.6 A further opportunity for coordination may exist within targeted managed care programmes. Medical schemes frequently fund programmes aimed at improving long-term health outcomes and reducing downstream healthcare costs, including weight management initiatives, musculoskeletal rehabilitation, chronic disease interventions and other preventative care pathways. Under a coordinated model, gap cover benefits could potentially provide additional funding linked to member participation in, and adherence to, these programmes, subject to the applicable regulatory framework. In this context, complementary funding could be directed towards qualifying consultations, allied health services, monitoring, rehabilitation or other interventions that support the objectives of the underlying managed care programme. Gap cover would therefore move beyond responding only to medical expense shortfalls after they arise and could, where legally permissible, contribute towards earlier intervention intended to reduce the likelihood of future high-cost healthcare events. The medical scheme would nevertheless retain responsibility for the design and management of the underlying programme and associated healthcare funding decisions.

6.2.3.7 Taken together, these examples illustrate how coordinated benefit design could progressively strengthen the relationship between gap cover and medical scheme managed care. Gap cover could minimise its impact on existing cost-containment mechanisms, reinforce network and clinical pathway incentives and, where permissible, contribute towards targeted interventions that support longer-term health outcomes. The common principle is that gap cover continues to provide complementary financial protection while being designed in a manner that supports, rather than works against, the medical scheme's broader managed care and affordability objectives.

6.2.3.8 The proposed model does not seek to alter the legal nature or respective funding responsibilities of medical schemes and gap cover providers. Medical schemes would continue to operate under the Medical Schemes Act and their registered rules, while gap cover would remain subject to the applicable insurance and demarcation framework. The model therefore envisages greater coordination in benefit design, provider networks and reimbursement arrangements, rather than the integration of the underlying funding responsibilities. The practical regulatory, governance and competition considerations associated with implementation are considered further in Section 7.

6.3 Proposed future role and integration of PHI

6.3.1 *Defining the future role of PHI*

6.3.1.1 Before considering how PHI could be integrated with medical schemes, it is necessary to consider its appropriate future role within the broader private healthcare funding environment. A fundamental question is whether PHI should primarily be positioned as an affordable healthcare solution for lower-income individuals who do not have medical scheme cover, or whether it should additionally be permitted to operate as a complementary product alongside medical scheme membership. For individuals unable to afford medical scheme contributions, PHI can provide access to private primary and day-to-day healthcare that may otherwise be funded out of pocket or accessed through the public healthcare system. In this way, appropriately designed PHI products may also relieve some demand on an already constrained public healthcare system.

6.3.1.2 This gives rise to two possible roles for PHI. Under the first, PHI would primarily serve as a stand-alone affordable access product for lower-income individuals who do not have medical scheme cover, reflecting broadly the access objective that underpinned the development of the proposed LCBO framework. Under the second, this access role would be retained, but PHI would also be permitted to operate as a complementary product for medical scheme members, with the respective products funding different components of, and coordinating across, the member's healthcare journey. The question is therefore not whether PHI should serve lower-income individuals outside the medical scheme environment, but whether its future role should be limited to this population or extend to complementary use within the medical scheme environment.

6.3.1.3 The distinction is important because the policy implications of the two roles differ. Where PHI serves individuals who cannot afford medical scheme membership, the primary objectives are improving access to meaningful healthcare and reducing reliance on the public system. Where PHI is permitted to complement medical scheme membership, the focus shifts towards coordinating benefits, funding responsibilities and clinical pathways across the two products. In either case, the framework should avoid creating an alternative that encourages individuals who can afford medical scheme membership to substitute PHI for medical scheme cover, thereby weakening medical scheme risk pools and the cross-subsidies on which they depend.

6.3.2 *PHI as an affordable access product: lessons from the proposed LCBO framework*

6.3.2.1 The proposed LCBO framework provides a useful comparator when considering the first of these roles. LCBOs were developed in response to the affordability barriers preventing lower-income individuals from entering the medical scheme environment, with the intention of expanding access to a more affordable package of private healthcare services. Although LCBOs were contemplated within the medical scheme regulatory environment, whereas PHI products operate under a different regulatory framework, the underlying policy challenge is similar, essentially considering

how to provide meaningful access to private healthcare for individuals for whom existing medical scheme membership remains unaffordable.

6.3.2.2 The LCBO work demonstrates that affordability should not be considered independently of benefit adequacy. A product may achieve a lower contribution or premium by substantially restricting benefits, but this may leave consumers with insufficient healthcare protection. The proposed LCBO (CMS, 2023b) framework therefore sought to establish a defined minimum benefit package, with a particular focus on primary and preventative healthcare, rather than relying solely on market competition to determine the scope of cover.

6.3.2.3 If PHI is to continue serving individuals who cannot afford medical scheme membership, consideration could similarly be given to establishing a more consistent minimum benefit standard for this category of PHI product. The proposed LCBO minimum benefit package provides a useful starting point. Relevant elements could include access to GP or primary care consultations, basic pathology and radiology, medicines and chronic disease management, supported by defined provider networks, formularies, referral pathways and managed care arrangements.

6.3.2.4 The intention would not be to replicate an LCBO within the insurance environment or to make PHI equivalent to a medical scheme. Rather, relevant principles developed through the LCBO process could inform the design of a more coherent and meaningful PHI offering. A defined minimum package could reduce the risk of insurers competing primarily on price through progressively narrower benefits and provide greater protection against individuals unknowingly purchasing cover that is insufficient for their basic healthcare needs.

6.3.2.5 It should be noted that expanding access to lower-cost healthcare funding cannot be considered independently of its implications for the existing medical scheme risk pools (CMS, 2023b). If a lower-cost PHI product providing a meaningful package of healthcare benefits was available as an alternative to medical scheme membership, irrespective of affordability, it could increase the attractiveness of remaining outside, or moving out of, the medical scheme environment. This could facilitate the selective movement of younger or healthier individuals and weaken the cross-subsidies underpinning medical schemes.

6.3.2.6 Any future framework would therefore need to consider how PHI products fulfilling this stand-alone access role should be targeted. This could include mechanisms that preserve access for individuals who genuinely cannot afford medical scheme membership, for example, income or affordability criteria. A key consideration would be the need to, as far as possible, limit any unnecessary administrative complexity. The objective would be to retain an affordable pathway to private primary healthcare, and the associated potential to reduce pressure on the public healthcare system, without creating an alternative that facilitates inappropriate migration away from medical schemes.

6.3.2.7 The LCBO framework therefore provides guidance extending beyond

the specification of a minimum benefit package. It demonstrates the need to consider benefit adequacy, affordability, provider networks, managed care, eligibility and protection of medical scheme risk pools together. These principles could provide a useful foundation for determining how PHI should operate as a stand-alone access product for lower-income individuals outside the medical scheme environment.

6.3.3 *PHI as a complementary product alongside medical scheme membership*

6.3.3.1 The second question is whether PHI should additionally be permitted to operate alongside medical scheme membership. If this role is retained, there is an opportunity to move beyond the current largely fragmented relationship between the products towards more deliberate coordination. Rather than PHI and medical scheme benefits operating independently, the respective products could be designed to fund different components of, but coordinate across, the same healthcare journey.

6.3.3.2 A fundamental question remains why a member would combine PHI with a medical scheme rather than simply purchasing a more comprehensive medical scheme option incorporating greater day-to-day benefits. The potential rationale lies primarily in affordability and flexibility. For some members, the incremental contribution increase required to move to a more comprehensive medical scheme option may be greater than the cost of combining a lower-cost medical scheme option with a targeted PHI primary healthcare package. A combined model could therefore potentially provide an intermediate affordability option between a stand-alone PHI and a more comprehensive medical scheme option.

6.3.3.3 The combined cost and benefits provided by PHI and the medical scheme would need to be considered against those available through a more comprehensive medical scheme option. A complementary model would only provide meaningful value where it improves affordability, access or healthcare delivery without materially reducing overall protection or introducing unnecessary fragmentation for members.

6.3.3.4 This is particularly important from a medical scheme sustainability perspective. If complementary PHI primarily enables existing members to buy down from more comprehensive medical scheme options and replace the removed day-to-day benefits through health insurance, healthcare costs may simply be shifted outside the medical scheme environment. This could weaken medical scheme risk pools and cross-subsidies rather than address the underlying affordability challenge. The objective should be to create a more affordable and effective healthcare funding arrangement, rather than facilitating arbitrage between medical scheme and PHI benefit structures.

6.3.3.5 If a complementary role for PHI is retained, consideration should be given to whether any changes to PHI benefit design would assist in enabling the product to perform this role more effectively. Pulling from the principles developed through the proposed LCBO framework, PHI could be more deliberately focused on a defined package of primary and day-to-day healthcare benefits, supported by provider networks,

formularies, referral pathways and managed care arrangements. Any non-indemnity hospital benefits currently available through PHI products could be removed, creating a clearer distinction between PHI's primary and day-to-day healthcare role and the medical scheme's role in providing hospital and more comprehensive healthcare cover.

6.3.3.6 Clearly defined funding responsibilities would be a key enabler in driving effective integration. This would be particularly important where a healthcare interaction funded through PHI identifies a condition that gives rise to an entitlement under the medical scheme, including a PMB. For example, a PHI-funded GP consultation or diagnostic test may result in the identification of a condition that subsequently falls within a medical scheme-funded treatment or managed care pathway.

6.3.3.7 Integration therefore requires more than simply determining which product pays a particular claim. It requires funding rules, clinical protocols and referral pathways that allow members to move appropriately between PHI-funded primary healthcare and medical scheme-funded care while avoiding duplication and maintaining continuity of care. This would include clearly defining the respective roles and responsibilities of scheme and PHI in relation to primary healthcare services, particularly when interactions involve PMBs, the management of chronic conditions as prescribed by the Medical Schemes Act, and the funding dynamic of Diagnostic Treatment Pairs (DTPs).

6.3.3.8 Taking the above into consideration, two illustrative models are considered below. The models represent different approaches to allocating and coordinating funding responsibilities between PHI and medical schemes. These should be viewed as illustrative proposals demonstrating how greater integration could operate in practice, rather than as prescriptive solutions.

6.3.3.9 *Model 1: separate funding responsibilities*

6.3.3.9.1 This model is most naturally suited to hospital-focused medical scheme options, where there is a relatively clear separation between hospital and day-to-day funding. The medical scheme and PHI product would fund clearly defined and, as far as possible, mutually exclusive categories of healthcare services. The medical scheme would primarily fund eligible in-hospital and other scheme benefits, while PHI would fund specified primary and day-to-day healthcare services.

6.3.3.9.2 Although funding responsibilities would remain distinct, complexity arises as both products could participate at different stages of the same healthcare journey. A PHI-funded GP consultation, pathology test or other primary care service may identify a chronic condition or another condition that triggers a medical scheme entitlement. Clear clinical protocols and referral pathways would therefore be required to manage the transition from PHI-funded primary care to medical scheme-funded benefits, in accordance with the relevant DTP, CDL condition and PMB regulation, to ensure continuity of care.

6.3.3.10 Model 2: rules-based funding intervention

6.3.3.10.1 A rules-based funding model may be more appropriate for savings and traditional medical scheme options, where day-to-day healthcare is already funded through the member's Personal Medical Savings Account (PMSA) or the medical scheme risk pool. In these instances, a clear division between PHI-funded day-to-day care and medical scheme-funded hospital care is less obvious. Instead, predefined rules could determine the appropriate source and sequence of funding for eligible day-to-day healthcare services.

6.3.3.10.2 For savings options, the rules could coordinate the allocation of eligible day-to-day expenditure between PHI and the member's PMSA. Depending on the product design and regulatory framework, PHI benefits could apply before or after the PMSA. This could improve overall benefit utilisation and potentially preserve members' savings for healthcare expenses not covered under the PHI benefit offering.

6.3.3.10.3 For traditional options, where day-to-day benefits are funded from the medical scheme risk pool, the rules could determine which services are to be funded by the scheme and which are to be allocated to PHI. Eligible services excluded from the scheme benefit package could, for example, be funded through PHI, or PHI funding could apply once a relevant scheme benefit limit has been reached. Clear rules would be required to avoid duplicate payments and inappropriate shifting of claims between funders.

6.3.3.10.4 In a more advanced form, the rules-based framework could extend beyond funding allocation to coordinated provider networks, referral pathways, authorisation requirements and managed care interventions. This would allow the products to retain distinct funding responsibilities while supporting a more coordinated member healthcare journey.

6.3.4 Clinical, managed care and network coordination

6.3.4.1 Primary healthcare is generally an individual's first point of contact with the healthcare system and may include GP consultations, medication, basic radiology and pathology, pharmacy-based healthcare and appropriate allied healthcare services. These services support early diagnosis, disease prevention and the ongoing management of chronic conditions. PHI has significant potential to support medical schemes' managed care objectives by improving access to primary and preventative healthcare.

6.3.4.2 However, coordination may become challenging where medical schemes use targeted managed care programmes to provide services beyond a member's standard benefit entitlement. For example, a member on a hospital plan may be granted access to consultations, pathology tests, rehabilitation services, psychological services or other condition-specific interventions funded from the scheme risk pool. Where PHI covers similar services, responsibilities would need to be clearly defined to allow the two funders to support different elements of the same healthcare journey without duplicating benefits or interventions.

6.3.4.3 Effective integration would therefore require coordination between the

clinical and funding arrangements of the two products. This could include alignment of clinical protocols, referral pathways, authorisation requirements and provider networks, along with clear rules governing the transition between PHI and medical scheme benefits. The objective would be to ensure that the respective products operate as complementary components of the member's healthcare journey rather than as independent funding mechanisms.

6.3.4.4 This would require enhanced coordination between insurers and schemes in the development of funding rules and effective communication processes. Such integration has the potential to improve access to primary care, strengthen preventative care, optimise benefit utilisation and contribute to the long-term sustainability of private healthcare financing.

6.3.4.5 One of the key strategic considerations in any integrated PHI model is the alignment of incentives between funders. PHI may fund interventions intended to improve health outcomes or reduce future healthcare utilisation, while the resulting financial benefits are realised primarily within the medical scheme risk pool through reduced hospitalisation admissions and/or reduced claim severity. Sustainable integration may therefore require mechanisms that align incentives between health funders participating in the member's healthcare journey. An example could be a shared savings arrangement, where part of the realised cost savings arising from reduced hospital admissions and claims severity is shared with the PHI provider. This is consistent with shared-savings mechanisms commonly used in value-based healthcare models.

6.3.4.6 Beyond improving funding coordination and healthcare outcomes, greater coordination between medical schemes and PHI products may also create opportunities to reduce waste, fraud, abuse and unnecessary duplication within the healthcare funding system. Under the current fragmented environment, healthcare events are often assessed across multiple funding mechanisms operating independently, making it more difficult to identify duplicate claims, inappropriate utilisation, provider upcoding, repeated consultations and conflicting treatment pathways. A coordinated framework supported by shared data, coordinated provider networks, aligned authorisation processes and common funding rules could improve transparency, strengthen fraud detection, reduce unnecessary duplication and promote more appropriate utilisation of healthcare resources.

6.3.4.7 Effective coordination also creates an opportunity for greater alignment of provider networks across the two products. Rather than PHI and medical scheme networks operating independently, aligned networks could support continuity across primary, secondary and hospital care, facilitate referral pathways and reduce fragmentation in the member's healthcare journey. This does not necessarily require identical networks: where full alignment is not practical, coordination between the respective networks and clearly defined referral pathways could achieve many of the same objectives.

6.3.4.8 Beyond improving care coordination, aligned networks may create opportunities to consolidate patient volumes across both products. This may strengthen

provider engagement, improve the effectiveness of managed care interventions and support the development of coordinated reimbursement arrangements linked to preventative care, primary healthcare utilisation and treatment outcomes.

6.3.4.9 The extent of network alignment will depend on the commercial arrangements and benefit designs of the respective products, as well as applicable regulatory considerations. Significant complexities may arise where schemes and insurers rely on different administrators, managed care organisations or network partners. Greater integration may nevertheless improve operational efficiency and simplify the member experience.

6.3.4.10 In its most mature form, integration between medical schemes and PHI products extends beyond benefit coordination towards a genuinely coordinated healthcare funding and delivery model. Primary care, preventative care, managed care interventions and hospital funding become components of a single healthcare continuum, with funding responsibilities remaining appropriately allocated across products while clinical care is coordinated through an integrated operational framework that simplifies the member experience. This represents the progression from fragmented healthcare funding towards a more connected, efficient and sustainable private healthcare system.

7. PRACTICAL CONSIDERATIONS FOR GREATER PRODUCT INTEGRATION

Greater integration across medical schemes, gap cover and PHI products presents significant opportunities to improve the coordination of healthcare funding and strengthen the overall member value proposition. However, moving towards a more integrated healthcare funding model introduces a number of practical design and implementation considerations. These include regulatory and governance requirements, distribution, data sharing, member communication, risk management, operational integration and the alignment of commercial incentives. These considerations are outlined below.

7.1 Regulatory and governance

7.1.1 *Regulatory landscape and demarcation*

7.1.1.1 Greater product integration would need to operate within the legislative and regulatory frameworks applicable to medical schemes and insurance products. Medical schemes would continue to operate under the Medical Schemes Act and remain responsible for funding healthcare services in accordance with their registered rules, managing provider networks and implementing managed care interventions. Gap cover and PHI products would remain insurance products subject to their respective regulatory requirements. Greater coordination should preserve the distinct legal nature, funding responsibilities and regulatory accountability of each healthcare product.

7.1.1.2 The Demarcation Regulations remain particularly important as insurance products should not perform functions reserved for registered medical schemes.

These Regulations provide a practical boundary around the extent to which benefits, funding responsibilities and healthcare delivery arrangements can be integrated under the current framework. The continued operation of PHI products under exemption also creates uncertainty regarding their longer-term role. Future regulatory reform would need to provide greater clarity on the respective roles of affordable medical scheme options and PHI products and the extent to which they may operate alongside one another.

7.1.1.3 As highlighted by interview participants, greater integration may also require closer coordination between the CMS and the Financial Sector Conduct Authority. Where a member's healthcare journey extends across products regulated by different authorities, clear regulatory accountability would be required. Future work may therefore need to consider whether the proposed models can operate effectively within the existing framework or whether targeted regulatory reform would be necessary.

7.1.2 Governance and accountability

7.1.2.1 Medical scheme trustees would retain their existing governance responsibilities. Any coordinated arrangement would need to demonstrate that it operates in the interests of scheme members

7.1.2.2 The responsibilities of each participating entity would need to remain clearly defined. Medical schemes would retain responsibility for healthcare funding decisions falling within their registered rules, while insurers would remain accountable for benefits provided under their policies. Greater coordination should not obscure these respective responsibilities.

7.1.2.3 This becomes particularly important where commercial objectives differ. Medical schemes operate for the benefit of their members, while insurers operate on a commercial basis. Governance arrangements would therefore need to ensure that the commercial objectives of the insurer do not improperly influence medical scheme healthcare funding decisions or compromise the responsibilities of trustees.

7.1.3 Competition considerations

7.1.3.1 Greater coordination between medical schemes, insurers and healthcare providers would need to comply with competition law. In particular, coordinated provider contracting, reimbursement arrangements and network development would need to avoid arrangements that could constitute inappropriate collective purchasing or other anti-competitive conduct.

7.1.3.2 Partnerships between particular medical schemes and insurers should similarly not unfairly disadvantage other market participants. This may be particularly relevant where integrated products create access to preferred provider networks, negotiated reimbursement arrangements or other commercial advantages not available to competing products.

7.1.4 Data sharing and information governance

7.1.4.1 Greater coordination and information sharing would be required to support meaningful product integration. At present, medical schemes and health insurance products generally operate within separate entities and systems, limiting the ability of individual funders to obtain a holistic view of a member's healthcare funding journey.

7.1.4.2 Appropriate data sharing could support more effective claims allocation, managed care coordination and assessment of healthcare utilisation across products. It could also strengthen the identification of duplicate claims, inappropriate utilisation, fraud, waste and abuse and facilitate the development of products that respond more directly to observed funding gaps.

7.1.4.3 The sharing of member information, particularly health information, would need to comply with the Protection of Personal Information Act (POPIA) and the relevant confidentiality requirements. Members should be appropriately informed of how their information will be used and, where required, provide the necessary consent for information to be shared.

7.1.4.4 Practical interoperability challenges would also need to be addressed. Issues such as differences in benefit classifications, clinical coding, provider identifiers, claims definitions and legacy systems may make data exchange challenging. Standardisation of data structures and interfaces may therefore be necessary to support meaningful integration; this is in itself an added complexity.

7.2 Commercial and member considerations

7.2.1 Member journey and product communication

7.2.1.1 Integration presents an opportunity to simplify the member experience through more aligned onboarding, communication, authorisation and claims processes and better coordination across the member's healthcare journey.

7.2.1.2 Members would, however, need to understand how the respective products interact and how funding decisions are made. It should be clear which entity is responsible for particular benefits and claims, the limitations applicable to each product and where members should direct queries, complaints or appeals.

7.2.1.3 Different regulatory and dispute-resolution processes may apply depending on whether a matter relates to a medical scheme or insurance product. A more seamless member experience should be achieved without compromising the distinct legal nature of the underlying products or the accountability of each funder.

7.2.2 Distribution and intermediary considerations

7.2.2.1 Greater integration would also affect how products are distributed and advised upon. Although medical schemes, gap cover and PHI may increasingly be presented as components of a coordinated healthcare funding solution, they remain separate products subject to different distribution and regulatory requirements.

7.2.2.2 In particular, the different licensing and accreditation requirements applicable to medical scheme and insurance products create practical complexity for intermediaries. Advising across an integrated solution may therefore require intermediaries to hold appropriate licences and accreditations, or for advice to be coordinated across appropriately licensed parties.

7.2.2.3 Intermediary remuneration and incentives would also need to support appropriate product selection rather than encouraging members towards a particular product or combination of products because it is commercially more attractive for an intermediary. This becomes increasingly important where members may choose between stand-alone PHI, medical scheme membership or combinations of medical scheme, PHI and gap cover.

7.2.3 *Commercial alignment and incentives*

7.2.3.1 The commercial incentives of participating funders will not always be aligned. This is particularly relevant where one funder incurs the cost of an intervention while another receives most of the resulting financial benefit. For example, PHI may fund primary or preventative healthcare that reduces subsequent hospital utilisation, with the resulting savings primarily accruing to the medical scheme risk pool. Sustainable integration may therefore require mechanisms that assist in better alignment of incentives between participating funders, potentially including shared-savings arrangements where outcomes and savings can be appropriately measured.

7.2.3.2 Greater alignment may also require insurers to modify or remove benefits that undermine medical scheme managed care and cost-containment objectives. While such changes may improve the overall healthcare funding arrangement, they may make the insurance product less competitive in the market when considered on a stand-alone basis.

7.2.3.3 This creates a situation where other insurers remain able to offer more extensive benefits, including benefits that may undermine network utilisation or other managed care mechanisms. These products may appear more attractive to members even though their design is less aligned with the objectives of the broader healthcare funding system. An insurer participating in a coordinated model could therefore be commercially disadvantaged if broader market alignment was not reached.

7.2.3.4 Sustainable integration may consequently require broader market alignment and potentially regulatory support, rather than relying solely on individual schemes and insurers voluntarily changing their benefit structures.

7.3 **Risk management**

7.3.1 *Underwriting, pricing and risk alignment*

7.3.1.1 Pricing methodologies differ materially between medical schemes and health insurance products. Medical schemes operate on community-rating principles,

whereas insurance products may incorporate risk-rating and commercial profit margins. Greater integration therefore requires careful consideration of how differently priced and funded products interact.

7.3.1.2 PHI policyholders may have materially different risk profiles depending on how the product is purchased. Stand-alone PHI policyholder profiles may differ from the profile of members purchasing PHI alongside medical scheme cover. As raised by an interview participant, combining these populations within a single pricing pool could create unintended cross-subsidies and obscure the underlying performance of each segment. In particular, care would be required to ensure that lower-income individuals purchasing PHI without medical scheme membership do not inappropriately subsidise members able to purchase both products.

7.3.1.3 Members holding both medical scheme and PHI cover may use health-care differently from those holding only one product. Pricing assumptions would need to reflect differences in utilisation and claims experience. Reliable pricing may initially be challenging where integrated populations are small and limited claims experience is available.

7.3.2 *Anti-selection and unintended risk impacts*

7.3.2.1 Voluntary participation may produce materially different risk profiles across stand-alone and integrated products. Members anticipating greater healthcare expenditure may be more likely to purchase broader combinations of cover, while lower-risk members may select less comprehensive cover.

7.3.2.2 Similar selection effects are already seen in the gap cover environment, where members anticipating hospital treatment or specialist claims may be more likely to purchase or retain cover. Product switching and lapsing may further increase selection risk if member movement is not adequately managed.

7.3.2.3 PHI may generate positive risk effects for medical schemes where improved access to primary and preventative healthcare reduces avoidable disease progression and downstream hospital utilisation. As the cost of earlier care and the resulting financial savings may accrue to different funders, this reinforces the need for appropriate incentive alignment.

7.3.3 *Medical scheme option migration/buy-down risk*

7.3.3.1 Integrated products may materially affect medical scheme option selection. Members may, for example, move from more comprehensive medical scheme options towards lower-cost hospital plans where PHI provides day-to-day healthcare benefits and gap cover provides protection against certain medical expense shortfalls.

7.3.3.2 As highlighted by a managed care actuary interviewed, such movement could weaken existing cross-subsidies between in-hospital and out-of-hospital benefits within more comprehensive options. If the reduction in contribution income exceeds the

corresponding reduction in claims, large-scale buy-downs could weaken the financial performance of affected options.

7.3.3.3 The impact would depend on the number and risk profile of members migrating. Option migration should therefore be explicitly considered when pricing and designing integrated products rather than treating the performance of each product independently.

7.4 Operational implementation

7.4.1 *Claims routing and sequence of funding*

7.4.1.1 Integrated funding arrangements would require clear rules to determine which product is responsible for each healthcare service. These rules would need to take into account the nature of the service, PMB status, applicable medical scheme benefits, available PMSA balances where relevant, PHI and gap cover benefits and policy terms.

7.4.1.2 Where more than one product may contribute to a specific healthcare event, the sequence of funding would need to be established in advance. This is particularly important where PHI-funded primary care identifies a condition that subsequently triggers a medical scheme PMB entitlement, or where rules-based integration allocates day-to-day expenditure between PHI and medical scheme benefits.

7.4.1.3 Clear clinical protocols and referral rules would therefore be required alongside claims-routing rules to ensure that funding transitions do not interrupt the member's clinical journey.

7.4.2 *Administration and reconciliation*

7.4.2.1 Responsibilities would need to be clearly defined across participating schemes, insurers, administrators and managed care organisations. Administrative processes should enable coordinated funding without obscuring which entity remains responsible for each payment or decision.

7.4.2.2 Controls would be required to identify claims submitted to more than one funder and to differentiate between legitimate coordinated funding and duplicate reimbursement. Where multiple funders contribute to the same healthcare event, reconciliation processes would be necessary to confirm payment accuracy and resolve any discrepancies.

7.4.2.3 Aligned authorisation processes would also be important. Members should not be required to navigate conflicting authorisation, referral or claims requirements because different stages of the same healthcare journey are funded by different products.

7.4.3 *Systems and interoperability*

7.4.3.1 Systems capable of exchanging sufficiently current information on member eligibility, benefits, claims, authorisations and available funding would be a requirement for integration.

7.4.3.2 Medical schemes and insurers may use different technology platforms, administrators and managed care partners. Shared interfaces or the use of a central coordination layer may be a more practical solution than attempting to consolidate systems completely.

7.4.3.3 The objective should be sufficient interoperability to support accurate funding allocation and a coordinated member journey, while retaining the systems, controls and accountability structures of the respective participating entities.

7.4.4 *Implementation/phasing*

7.4.4.1 Given the regulatory, operational and commercial complexity involved, greater product integration is likely to require a phased implementation approach. Initial models could focus on areas where funding responsibilities are relatively clear.

7.4.4.2 Early implementation could focus on aligned product design, defined claims-routing rules, selected provider networks and improved data exchange between participating entities. More complex arrangements, including rules-based allocation of expenditure, shared-savings mechanisms and deeper managed care integration, could be introduced as experience, data and regulatory certainty develop.

7.4.4.3 Pilot arrangements could be utilised to provide an opportunity to test member behaviour, claims experience, operational requirements and unintended impacts on medical scheme option selection before proceeding with implementation at scale. This would allow the proposed models to evolve in response to observed experience rather than requiring the full integrated framework to be implemented from inception.

8. CONCLUSION

8.1 The South African private healthcare funding environment is complex and increasingly interconnected. While medical schemes, gap cover and PHI fulfil distinct roles, the analysis in this paper demonstrates that they do not operate independently in practice. Decisions relating to benefit design, provider reimbursement, managed care and member behaviour in one part of the system can materially affect the risks and costs carried elsewhere.

8.2 The key challenge is in addressing a healthcare market plagued by fragmentation. Where products are designed and managed independently, there is potential for misaligned incentives, duplication, inappropriate cost shifting and unintended consequences for healthcare utilisation and medical scheme sustainability. In some instances, mechanisms intended to protect members financially may inadvertently weaken the cost-containment or managed care mechanisms of another funder.

8.3 This paper argues that there is an opportunity to move towards more deliberate coordination. For gap cover, this could include greater alignment of provider networks, reimbursement arrangements, benefit design and managed care incentives. For PHI, it

could involve clearer definition of its future role as a primary care provider and, where appropriate, coordination with medical scheme benefits, clinical pathways and funding responsibilities.

8.4 Medical schemes remain the foundation of private healthcare funding and any greater coordination must avoid creating incentives that weaken medical scheme risk pools or facilitate inappropriate buy-down. At the same time, the affordability and access challenges that have contributed to the growth of health insurance products should be recognised. The focus should therefore be on defining the respective and complementary roles of medical schemes, gap cover and PHI to improve affordability, access and financial protection, while supporting the sustainability of the broader healthcare funding system.

8.5 The proposed models demonstrate that meaningful opportunities for coordination exist without removing the fundamental legal and regulatory distinctions between the products. However, implementation would require careful consideration of regulation, competition, governance, data sharing, pricing, risk selection, intermediary incentives and operational complexity. These considerations support a phased approach, beginning in areas where responsibilities are clear and coordination can be achieved within existing regulatory boundaries.

8.6 Importantly, coordination alone cannot resolve the underlying structural challenges of the private healthcare system. Broader reform remains necessary to address healthcare affordability, provider reimbursement, medical scheme sustainability and gaps in the existing regulatory framework.

8.7 However, within the current regulatory environment, there is an opportunity to move away from accidental interaction towards purposeful coordination. Medical schemes, gap cover and PHI already influence one another; the question is whether those interactions continue to develop independently or whether they are deliberately structured to support common objectives. A more coordinated approach, while preserving appropriate regulatory boundaries and the central role of medical schemes, has the potential to improve member protection, affordability and healthcare outcomes while supporting a more sustainable private healthcare funding system.

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