Your guide to medical aids

Many South Africans do not realise the importance of good medical coverage and research has shown a dangerous disregard for healthcare coverage is the norm amongst many people.

Most economists and advisers recommend that for good financial security most people should have adequate home insurance, sufficient retirement savings and good healthcare cover. Yet medical cover is the most unpopular of these three important elements, with many individuals prioritising their home insurance and retirement planning over spending money on medical schemes.

Currently South Africa has a dual health care system, consisting of public and private providers. Private hospitals are mostly used by members of a medical scheme or people who pay for these services out of their pocket.

What is a medical scheme?

A medical scheme helps you to pay for your healthcare needs, such as nursing, surgery, dental work, medicines and hospital costs. It can be described as “insurance” you take out to cover your health costs.

You (and in certain cases your employer) pay regular contributions to the scheme. A medical scheme is a non-profit organisation and should be registered at the Registrar of Medical Schemes. A medical scheme is managed by a board of trustees who are elected by the schemes’ members. The trustees are responsible for managing the scheme to the benefit of its members.

Why should I have a medical scheme?

There are many advantages to belonging to a medical scheme.

- You have the security of knowing your medical needs will be looked after
- A portion of your contribution can be deducted from your taxable income
- You can budget for your medical expenses
- You can get the best medical care available in facilities with state of the art equipment and infrastructure
- You can undergo surgery and medical treatment when you need it most and not be put on a waiting list until a suitable doctor becomes available to perform the surgery, or until the right resources are available, as in the case of state hospitals
- You will be treated immediately in an emergency without having to worry whether funds are available
- You can benefit on a personal level through the different wellness and vitality options that many schemes offer

How do I choose a medical scheme?

This is by far the most important question of all. Choosing a medical scheme for the first time can be overwhelming. The best advice is to look at your specific needs and talk to an objective independent healthcare consultant (broker) to assist you in choosing the right scheme and product options. Once you are covered by a medical scheme make sure to evaluate your situation regularly so you can adapt the cover to your changing needs.

The following three points are the most important considerations to take into account before making a decision:

- Your medical history;
- Your first choice regarding medical care; and
- What you can afford.

In addition, you need to be aware of the late joiner or waiting periods that may be imposed when joining a medical scheme. These are applicable to applicants who have never belonged to a medical scheme, as well as those who have had a break in coverage for more than 90 days from 1 April 2001, when they choose to join a medical scheme after the age of 35.

Different options?

Choosing between different options within a specific medical scheme will depend on your needs. Most schemes offer a full comprehensive option (hospital costs and out-of-hospital benefits) or a basic hospital plan (cover only for hospital procedures).

Some schemes limit you to a particular hospital group or manage care facilities, depending on the option you choose. The more limited the option you choose, the less your monthly contribution will be, but make sure you investigate all options. Best advice again is to contact an independent healthcare consultant (broker).

Other points to consider when choosing a medical scheme option include:

- Your option may have benefit limits
- Your option may have a limit on what it pays doctors
- Your option has a network or it is a capitated option
- Your option has a DSP for PMBs and you aren't using it
- Your scheme has a medicine formulary and your medicines are not on it
- Your scheme has managed care protocols
- Your scheme has co-payments or deductibles
- You have a medical savings account but the contributions are insufficient for your needs
- You want treatment for which your scheme excludes cover
- You get what you pay for

What should a medical scheme pay for?

In 2004 the Medical Schemes Act of 131 of 1998 introduced Prescribed Minimum Benefits (PMB), which is a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and to make healthcare more affordable.

PMBs determine that medical schemes have to cover the costs related to the diagnosis, treatment and care of certain medical conditions. (Under which a set of 270 medical conditions and the basic 25 chronic disease list are included).

The aim of the PMBs is to prevent medical schemes from imposing fees on their members because of the state of their health.

What are my rights according to the law?

The Medical Schemes Act (No 131 of 1998) came into effect on 1 January 2001. It offers a compulsory minimum package of benefits, ensuring the exclusion of risk rating and discrimination on the basis of health, age, race, gender or medical history.