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NOVEMBER 2021

FA NEWS

FINANCIAL & ADVISORY NEWS

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The end…

LETTER FROM THE EDITOR

Rianet Whitehead | Editor

The year 2021 will be remembered as a year of change, a year of getting used to the new normal… so much so that many people have become too comfortable with the way things are, that they are contemplating about returning to 'old habits'. The challenge for corporates is to get everyone back in the office, because life was good… there was no traffic, much less money was spent on petrol, there were no high heels and no office politics. How are you handling this?

Another very topical issue, linking closely to getting employees back in the office, is mental health. Unfortunately, it is a reality we cannot shy away from, because it has a big impact on what and how we deliver in the workplace. Employees need and expect sustainable and mentally healthy workplaces, which require taking on the real work of culture change. It is not enough to simply offer the latest apps or employ euphemisms like 'well-being' or 'mental fitness.' Employers must connect what they say, to what they do.

As many things are returning to a slight bit of normality, I wonder if we will ever have the amount of events we had before… but then again, I also don't think so. The question is, what are we giving up because we cannot network with peers, share our frustrations, soundboard ideas or just connect and do some business? I have no doubt that it will have an impact… what that impact is exactly, I don't know. Companies, big and small, will need to find ways to make sure people connect again… don't let the human connection get lost in between all the virtual and digital stuff. We are human, and many of us need conversations that are not planned, virtual and often without a camera on.

This is our last edition for 2021, and we hope that you have found enough meaningful and solid content in this year's editions, that will make you keep on reading FAnews. Always know that you, our readers, are the reason for our existence and we thank you for the feedback we are receiving. A reminder that you can do your CPD on our website, but also on our WhatsApp platform.

Our mission is to keep you informed, to keep you intrigued and to make sure you get all the answers you need. Please keep on sending us your feedback and request for specific topics – we enjoy the interaction.

May you have a peaceful festive season and a well-deserved break. My wish for you for 2022 is simple… health, happiness and prosperity.

Enjoy the read. Until 2022.

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THE RISE OF THE VIRTUAL FINANCIAL ADVISER

In previous years, the idea of a virtual adviser – especially for an older demographic – was not even a vague consideration.

However, as the Millennial market emerge into an even stronger digital diverse buying cycle, so too do stats show that 71% of consumers over the age of 55, would process a claim via a virtual process. This shift, intensified by COVID-19 which has demanded that both consumers and insurers take digital insurance buying more seriously, means that the opportunity for virtual financial advisers is growing in popularity.

The modern-day virtual adviser

However, the key to the success of the modern-day virtual adviser lies in providing both a quick turnaround on insurance and investment products and enabling the immediacy of changes to meet dynamic market changes, whilst ensuring that personalisation forms a cornerstone to their offering. No longer does 'one size fit all'. In fact, as digital platforms grow and advance, there needs to be a highly personalised and targeted financial planning backend to all new technologies if virtual advice is set to fulfil needs and meet client expectations and unique life stages.

To ensure technology and its related platforms are used appropriately in insurance, the sector must start with the right mindset. This means delivering solutions that help stabilise and build trust with clients in this 'new normal' environment.

Financial advisers need to consider what it really means to embrace technology and digital platforms. This means they need to find ways to adapt, to easily support their clients. This will mean a human and technology collaboration, where clients are empowered with the right information.

Striking a balance

Financial decisions can be a source of uncertainty for clients, or prospective clients. Those advisers who are adapting correctly will therefore understand that they need to engage more frequently, especially in our current climate, to provide clarity and peace of mind. It is here where the virtual adviser needs to realise the importance of striking a balance between virtual advice and the intrinsic need for consumers to have an actual person that they can still rely on. Whether it's an update on their policies, general advice or just keeping them up to date on the benefits on their policies, through technology this engagement can be reshaped, but still remain personalised, even without face-to-face interaction.

There is no doubt that there is massive benefit in far more digital automation and engagement, which itself enables hyper personalisation. Engaging on a digital platform makes things easier as the flexibility offered by these applications helps minimise or eliminate manual work arising from legacy processes. In addition, through platforms such as these, clients are given the option of self-fulfilment but are still able to gain a level of personalisation, so that when they log onto a system, their information is prepopulated and aligned with their existing financial portfolio, updated in real time.

Such personalisation is not only beneficial to the consumer, it is also key to the future success of the insurer and adviser as the digital world evolves – especially if we consider that 80% of consumers are more likely to make a purchase from a brand that provides personalised experiences and offerings. Similarly, recent research indicated that 83% of consumers are willing to share their data to create a more personalised experience. Therefore, as insurers and advisers, we will surely lose a mass of data that informs innovation and future products, services and offerings if we are not offering personalisation through our virtual channels.

A new era of virtual advice

As we move forward in this digital age, it is clear that technology has reshaped the insurance sector and that it has forced a new era of virtual advice – advice that requires solid technology, experienced and skilled advisers on the backend as well as a high level of personalisation to truly drive a unique and tailored financial services offering to the consumer market – no matter what the demographic.

Kobus Wentzel
Head of Distribution & 1Life Vantage
1Life

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INCLUSIVE INSURANCE, KEY TO ACHIEVING SDGS

There has been much speculation and many explanations given for the desperate circumstances of millions of poverty-stricken people in developing countries. When considering the potential role of insurance in financial inclusion, an understanding of the circumstances and characteristics of low-income earners is fundamental.

Financial inclusion means including underserved individuals, entrepreneurs and Small and Medium-Sized Enterprises (SME) business owners into the formal economy. The benefit is reciprocal as financial institutions and governments also benefit from the inclusion of these parties into the formal economy.

Microinsurance products

Creative insurers have developed interesting products over the years aimed at developing, emerging and previously underserviced portions of society. An example is microinsurance, which has clearly shown the benefits of insurance for low-income earners. Innovation in the form of new business models now exist in developing and emerging markets, which focus on servicing these customers.

People who participate in an informal economy, and who have no access to mainstream commercial insurance are the primary targets for microinsurance products, as well as social insurance systems. Products are developed which offer premiums and benefits that are aligned to the needs of these groups.

Inclusive insurance seeks to meet the demands of this market by providing products aligned to these demands. The focus needs to be on the inclusion of the vulnerable and previously excluded portions of our society, and the further upliftment of the lower middle class. This is important because historically, insurance has always carried the perception of being an elitist service.

Due to financial crises and pandemics like COVID-19, additional challenges have risen in addressing the plight of those living in extreme poverty. Generally, they live in 'fragile' countries and remote war-torn areas. They also live in risky environments, given their

limited capacity to cope with shocks like natural disasters and pandemics. The direct effect of these shocks on poverty reduction is that critical objectives will not be met and the goal to end extreme poverty as included in the United Nation's Sustainable Development Goals (SDGs), by 2030, will not achieved. It is estimated that by 2030, up to two-thirds of the global extreme poor may be living in fragile and conflict-affected economies, making it evident that without intensified action, the global poverty goals will not be met.

Contribution of insurance

Over the past decade, much progress has been made on the achievement of the first of the SDGs, being the reduction of poverty. The contribution of the insurance industry to achieving the UN's SDGs, cannot be underestimated. There are numerous insurance products and services which support these goals, but the occurrence of the COVID-19 pandemic during 2020-2021, brings to the fore the need for increased and sustained industry action to deliver on the SDGs. The UN's Decade of Action started with a bang in 2020, with severe disruption to a plan that aimed to achieve its outcomes by 2030.

The World Bank is focusing on helping countries address the COVID-19 crisis, by supporting the transition through saving lives, protecting the poor, securing foundations of the economy and strengthening policies and institutions for resilience. The key purpose of the insurance industry is to advance societal resilience, by strengthening the ability of society to recover after major setbacks and reignite growth. In so doing, regulators, insurers and reinsurers play a fundamental supporting role in promoting sustainable development. For the impact of the industry's contribution to be felt, there needs to be agreement and consensus on the road forward to achieve the SDGs, especially if these are to be achieved by 2030.

The need for conformity of action

By assisting individuals to mitigate risk, it results in empowering them, making them more resilient, which directly impacts on household welfare. Without insurance, low-income households are more likely to face more hardships from risk since they are less competent to mitigate and manage them. Without the ability to mitigate risk, low-income earners are usually forced to resort to emergency measures, for example child labour, malnutrition and reducing children's education and family healthcare. An example of this can be seen with the COVID-19 pandemic, which has severely impacted individuals who do not have insurance e.g., cover for loss, or reduction of income, or to provide for loss caused by business interruption.

Consensus across the industry needs to be reached regarding the role that the industry should play in contributing to the achievement of the SDGs - by strengthening the links between insurance portfolios and the SDGs. The industry needs to make a concerted effort to join forces to play its part to achieve the SDGs. Approaches that are principle based, that measure impact, focus on accessibility and consumer transparency, and on sustainable development for the future are all required in the joint effort within the industry.

In order to reach consistency, principles-based approaches are required, supported by regulators. The challenges in achieving the SDGs must be identified, in order to define the basis from which to measure improvement over time. It is imperative to evaluate progress from a qualitative and quantitative perspective. Progress in achieving SDGs will be assisted by the improvement of access to insurance for traditionally underserved parts of society.

Digitisation and its impact

Over the past year, during the COVID-19 pandemic, the one positive development was the expansion and development of digitisation. Distribution networks have been expanded and improved, driven by the demand to reduce face-to-face interactions. Partnerships were formed to improve distribution and communication networks, which were key to reaching emerging market populations. Mobile network companies, online payment companies, e-wallets and online banking are all imperative mechanisms for accelerating the outreach of insurance. An outcome of this is that this contributes to the attainment of the SDGs. Digital transformation has encouraged innovation, which has assisted with the development of more affordable products, which addresses the issue of inequality.

The industry must be proactive and use this important development to introduce products that specifically address the needs of the underserved portion of our society.

Promoting inclusive insurance

A concerted global effort is required to promote inclusive insurance. This effort between international governments, insurers, civil society, academics and NGOs, and all entities involved in developmental agendas, will ensure that insurance is inclusive, and as such, can be part of a strategy to achieve SDGs. Clear and transparent leadership in policy, market development and deliberate monitoring by regulators, innovation of regulations and supervision by regulators are imperatives which transform existing challenges and issues, which ensure the continued existence of financial exclusion. In developing countries, the impact and benefit of compulsory insurance should be revisited and aligned to public-policy and socioeconomic objectives. Regulatory authorities should focus on encouraging market innovation.

Policymakers, regulators, development organisations and all stakeholders in the insurance markets, should put together a concerted effort to promote innovation, growth, build systems, coordinate data and develop skills and capacity, which will impact and address financial exclusion. Training and education are a fundamental part of this process. Investment in infrastructure must be encouraged, which will impact on the SDGs. The regulatory environment must encourage new entrants without creating barriers of entry.

To fully realise the benefits of financial inclusion, products must be innovative and tailored to satisfy the needs of the underserved, so that the products make a difference in their lives. The agenda should be global, to focus on strengthening the role of insurance in sustainable development and inclusive growth.

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THE BROKER CONSULTANT: Conventional salesperson or invaluable resource?

Broker consultants are a key link in the chain of an adviser's experience of an insurer. Although on the surface their core function is to sell insurance products to advisers, the true role of a broker consultant encompasses so much more.

The value a broker consultant brings

From the insurer's side, broker consultants are our primary connection to the advisers we serve, and anything that needs to happen between us and the advisers is channelled through the broker consultant. If changes need to be made to policies, or beneficiaries need to be updated, or claims need to be followed up on, then the broker consultant will facilitate that process.

However, there is additional value that a broker consultant can and should bring to the adviser's table.

Made up of many parts

When looking at broker consultants and how they service advisers, I like to think of them as being part of a continuum:

1 On the one end of the continuum, there are broker consultants who focus only on collecting applications from advisers without providing other services to the financial advisers they support.

2 On the next step of the continuum is the broker consultant who is a specialist in what the company that they represent offers. This knowledge enables them to position their insurance products to advisers in a way that empowers the advisers to sell their clients the right products for their needs.

3 Then there is the broker consultant who has a good handle on the products they sell, and also on the life insurance industry in a broader sense. They know how their products compare with their competitors' policies and what differentiates their products from those of other insurers.

4 On the next step of the continuum is the broker consultant who also has a solid understanding of financial services, which goes beyond just knowledge of their products.

5 Finally, there is the broker consultant who is truly a partner in the adviser's business. They help advisers with their campaigns, help them sell the right product to the right client, and help advisers grow their business. This broker consultant becomes an adviser's go-to person, someone who can answer all their questions and has their ear to the ground on changes in the industry.

So, how do insurers ensure that their broker consultants fall on the right end of the continuum, continually providing value to advisers beyond what is expected?

A key resource for advisers

Broker consultants must be given all the tools they need to service advisers in multiple ways. This includes insurers providing them with ongoing training, not just on the insurer's products, but also on aspects of the broader economic and financial landscape that impact our advisers' clients. Broker consultants should also be technically skilled with in-depth knowledge about their competitors' offerings.

It's also important that insurers commit to keeping their broker consultants motivated and engaged so that they can focus on building relationships with the advisers they work with. This is critical in maintaining the trust and cementing the broker consultant's status as a valuable partner for the adviser.

Insurers and broker consultants should also take note of the changing landscape of the insurance market, and how the function of the broker consultant is evolving with it. New demands on broker consultants means that they need to focus more on the consulting aspect of their role and see themselves as enablers of advice.

Broker consultants certainly have a critical role to play in the insurance space, for both insurers and advisers. It's important for insurers to continually provide training for broker consultants, and for broker consultants to stay abreast of current issues that affect the industry.

By maintaining a transparent and engaged relationship with advisers, broker consultants can ensure that they are seen as a key resource for advisers to help them grow their business and keep it sustainable.

Sean Hanlon
Executive Director:
Sales & Distribution
BrightRock

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DOGECOIN TO THE MOON:

Social media can move crypto assets or crush malpractice claims!

There are countless examples of social media posts causing real world outcomes. Among the most famous is how a single tweet from SA-born Elon Musk can move the price of Tesla shares, or super-charge an unknown cryptocurrency. Musk's Tesla comments landed him in trouble with the US Securities Exchange Commission, earning him a US$20 million fine and a stern reprimand.

Facebook is forever

South Africans are cottoning on to the longevity and pervasiveness of their social media activity. In recent years, we have seen individuals crucified in the court of public opinion, losing jobs and reputations and even being criminally prosecuted for Tweets, Facebook posts or WhatsApp messages. You need only Google the name Chris Hart, Helen Zille or Penny Sparrow to learn of the consequences of an ill-thought post.

In a presentation at the 2021 Morningstar Investment Conference, social media law expert, Emma Sadler, observed that there is no difference between the online and real world. She made three observations in the context of the July 2021 civil commotion that afflicted South Africa. "First, an offence committed online is an offence committed in the real world," she said. Inciting violence using a Twitter post or WhatsApp message is no different to rallying a crowd using a loudhailer.

The myth of online anonymity

Second, Sadler busted the myth of online anonymity. "Do not think you can be anonymous online, there are forensic methods that can be used to find out who you are… and there are legal ways to get court orders against the Facebooks, Googles and Twitters of this world to hand over basic subscriber information," said Sadler. The third point was that social media is pervasive, and that it is always possible to find somebody who knows somebody.

Financial and risk advisers have long appreciated that their clients' social media profiles could lead to problems at claims stage. And there have been a number of articles commenting on the short-term insurance loss adjusting practice of taking a quick look at an insureds Facebook page following an accident. Pictures that the insured or his or her friends have posted could support further investigation and questioning. Imagine, for example, a scenario in which a late night motor vehicle accident is preceded by photo evidence of a wild party.

Social media faux pas

There are many ways in which a social media faux pas could influence a client's insurance claim. In the world of professional indemnity cover, for example, a medical malpractice claim could be defended based on social media posts that refute the extent or nature of a claimant's injuries. "Social media is a matter of public record and can be used as evidence against a claimant or insured, in certain instances," said JP Ellis, Legal and Claims Manager at EthiQal.

He referred back to a claim that he had encountered before joining EthiQal. "I found evidence on social media that a claimant who claimed to be an incomplete paraplegic, and had claimed R14 million, was participating in skydiving and gyming; and there are many other examples where insurers have used such evidence in court cases". It takes little imagination to see how data 'scraped' from a social media account could affect a disability claim.

Not as private as you think

Sadler's final warning was not to rely on privacy or comments made "in a personal capacity" as defence for an online transgression. "If you can stop something from being published, then you are responsible for it from a legal, disciplinary and reputational point of view," she warned.

She offered up the "billboard test" as a great way to limit liability: "If you would not put your content on a billboard next to a huge photograph of your face, your name and the name of your employer; then make sure that post does not exist in digital format".

Gareth Stokes
Stokes Media

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GAP COVER
a potential inconspicuous need of your client

The one common theme of some recent industry conferences that I attended, is the changing role of the broker, from that of a traditional broker to a risk manager.

Brokers who transition and who consider the needs analysis of a client as a tool to manage the risk for, and on behalf of the client, will find themselves reaping the rewards of being at the leading edge of the industry.

The risk manager's role to point out the gap

One focus area of such a risk management process is for the risk manager to identify blind-spots for the client – to actually point out the inconspicuous needs of the client. One such inconspicuous need often missed as part of the needs analysis, is the risk exposure of the client when it comes to hospitalisation cover. Why so? Despite the comprehensiveness of a hospital benefit, without Gap cover, your client is likely to be out-of-pocket.

As a basic description, Gap cover pays the difference between what your client's medical specialist charges for an in-hospital procedure and the tariff the medical scheme pays.

One of the biggest reasons for such tariff shortfalls is because of the basic economic principle of supply and demand because of the shortage of specialist skills in South Africa. In fact, in my view, South Africa's calibre of medical specialists is one of the reasons why our private health sector is considered among the best in the world. Gap cover plays an important role in this ecosystem.

Is the need for Gap cover real?

In last year's Council for Medical Schemes (CMS) Annual report, the CMS reported that the largest out of pocket expense categories for members on medical schemes related to anaesthetics, surgical specialists and hospitals.

Think about this at a practical level – when your client goes to hospital, they may have a preference for a specific surgeon, but as the surgeon works with an anaesthetist, your client is not in a position to negotiate anaesthetist tariffs at the time the procedure is about to be performed. Anaesthetists' claims make up nearly a third of Gap cover claims.

Another aspect raised in the previous CMS Annual report, was the concerning trend that medical scheme members go for a surgical procedure under the impression that because the procedure is part of a PMB (Prescribed Minimum Benefit) condition, it is covered in full, just to find out that it is a non-PMB or they have not used the designated service provider appointed by the medical scheme.

From our data, and looking at the last 18 months, the top three types of Gap cover claims (using the ICD-10 Chapters as the categories), are:

	Top three Gap cover claims (value) over the last 18 months	Average value per claim
1	Diseases of the musculoskeletal system and connective tissue such as muscles, joints and bones, autoimmune disorders, etc.	R9 271
2	Neoplasms such as tumours	R8 068
3	Pregnancy and childbirth	R10 101

Claims from these three categories alone, totalled more than R100 million.

With the average Gap cover claim for childbirth of R10 101, there will be a material hole in your client's pocket in the absence of such cover. On a different note, the sad reality is that the World Health Organisation reported an increase of 108 168 new cancer cases in South Africa in 2020. These are risks that can unfortunately not be ignored and with gap cover having evolved to include cancer and some other conditions, these should form part of the risk management strategy with any client.

A checklist

Guide your client to consider the following:

- The increased likelihood of specialist providers charging in excess of the scheme tariff;
- The cost of the bills that form part of the procedure that the client may not be aware of;
- Instances when the procedure is not actually a PMB and will not be covered in full; and
- The co-payments for cancer and for some procedures.

Brokers who identify such blind spots for the client will have clients resting assured that even the inconspicuous risks are managed, knowing that their health is covered.

Toska Kouskos
Executive Life & Health
Constantia Insurance Company

“I am Toska and I am committed to enabling our partners’ success.”

Toska Kouskos
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Astute and Sanlam partner to enhance financial advice

Astute Financial Services Exchange (FSE) and Sanlam Corporate have partnered to enhance holistic financial advice.

FAnews spoke to **Mdu Ndlovu** (Product Owner), at Astute FSE about why this partnership is critical and how the partnership services the financial advice and investment needs of clients and intermediaries.

Q Can you briefly share how Astute and Sanlam Corporate have partnered to enhance holistic financial advice?

Firstly, the Astute Employee Benefit switch/service was built as a response to the need in the financial services industry to provide more financial product data sets that will enhance a single view of a person/client, and in turn, holistic financial planning. As Employee Benefits is a critical cornerstone for financial planning, this need had come out prominently in our client surveys. As a listening organisation, we then set out to build the EB switch/service.

Sanlam Corporate, as one of the front runners in the employee benefit ecosystem, was keen from the outset to partner with Astute to provide Umbrella Fund data to the industry, via the EB switch/service. We believe they appreciated the EB value proposition and how the partnership and provision of EB data would ultimately add value to the end consumer.

Q Why do you believe this partnership was critical?

With the Sanlam Umbrella Fund being one of the biggest, in terms of assets under management, and also in terms of membership numbers, them coming on board as a content provider in the Employee Benefit switch is massive for the ecosystem, financial intermediaries and their clients.

Q Intermediaries have stressed the need to have access to the broadest range of products possible. How does the partnership service the needs of clients and intermediaries?

With this data not easily accessible to all financial intermediaries, it means the gathering of the said data becomes a time-consuming task during the financial needs analysis process and costly too. Also, provision of EB data means that the employee benefits (investment and risk products) can be factored in when formulating a financial plan for a client, which may easily be overlooked, leading to over-insurance and unnecessary premium expenditure which could otherwise be redirected to other financial needs of a client.

Q How do intermediaries gain a clear understanding of their clients' current financial status to lead them towards a sound financial planning strategy, using this platform?

Financial intermediaries have access to a consolidated insurance client portfolio instantaneously, on demand, electronically, securely and within a couple of seconds, thereby shortening the financial needs analysis data gathering process, reducing costs and enabling intermediaries to serve their clients timely.

Q You provide intermediaries with a single point-of-entry to client's portfolio data. What are the value-added features and offerings that will enhance business?

Firstly, Astute is on a drive to bring on board more funds to the Employee Benefit/Provident and Pension Fund space. So, we are in engagements with other players to bring them on board and enrich the ecosystem. We believe the more fund data is provided, via the Astute Employee Benefit ecosystem, the more measurable value and impact this will have in enabling holistic financial planning in South Africa.

Secondly, Astute has adopted digital consent practices which allow a client/data subject to grant consent digitally, via their cell phone to a duly authorised intermediary or registered financial services provider (FSP). This means that intermediary-client engagement can also be virtual, with quick and easy consenting.

Also, the ability to easily keep a record (electronically) and download a PDF file of a client's financial product portfolio view, at a certain point in time, is also a value-added feature.

Q POPI and data... how do you ensure information transfer is secure, privileged and confidential?

Astute is an ISO27001 certified organisation. This means that we are subjected to stringent international data security, and protection of personal data, and certification means that we comply to the highest standards.

Secondly, the requestor of the data is authenticated as a registered user by Astute. Over and above that, for each request, we do check and confirm that the requesting intermediary or financial services provider is registered with the Financial Services Conduct Authority (FSCA), for fit and proper, before a request can be honoured and processed.

The advent of digital consent practices has also provided an additional layer of consenting by a data subject which, as previously stated, is quick, easy, digitally auditable and convenient for both the client and intermediary.

The Astute compliance team, whose objective is to confirm the existence and validity of consent in the case of paper-based consenting, also performs different audits on intermediaries and FSPs.

Lastly, Astute also does not keep any client data. The data is only retained for a limited period (seven days) to enable an FSP or intermediary to reference that data, should there be a need. Beyond the seven-day period, the data is permanently deleted from our systems and databases.

Q Centralised and simple access... does this partnership address these needs?

Absolutely, yes. Access to Sanlam Umbrella Fund data is subject to mandatory upfront digital consent approval. This means that the policyholder/data subject/client has to approve consent digitally, before the request can be processed, and data accessed. Data is requested and accessed electronically, seamlessly and in a centralised fashion, either via the Astute Online platform or imported into different integrated Financial Needs Analysis (FNA) software applications, regardless of geographic location.

Q Why should intermediaries use the platform?

The platform is cost effective, secure and easily accessible. Making use of the Astute services, therefore, allows FSPs and intermediaries to spend more time and focus on their core business, which is financial advice.

We also provide other services and data sets that we believe really enhance the single view of a person/client.

It also creates efficiencies which every practice and business needs. Plus, it also allows FSPs and intermediaries to comply with the legislative requirements of keeping a record of advice, as dictated by the Financial Advisory and Intermediary Services (FAIS) Act.

Q Numbers... how many financial advisers are currently signed up?

We currently have more than 20 000 financial advisers making use of our services.

Q Future offerings... will there be more products or features added in the near future on the platform?

Certainly. One of our big drives is to collaborate with Sanlam and other stakeholders to keep adding any of their new product offerings to the Astute ecosystem. Related to the Astute Employee Benefit switch, as mentioned previously, we are collaboratively working with other funds to integrate and have them provide pension and provident fund data via Astute.

We have also just launched (12 August 2021) the Astute Medical Aid Service (AMAS) which provides medical scheme plan information.

We have a clear EB roadmap, and some engagements are at commitment stage, while others are gathering encouraging momentum. We hope by the end of 2022, the landscape will be looking very different, with good representation in terms of funds that would have integrated and providing data via Astute.

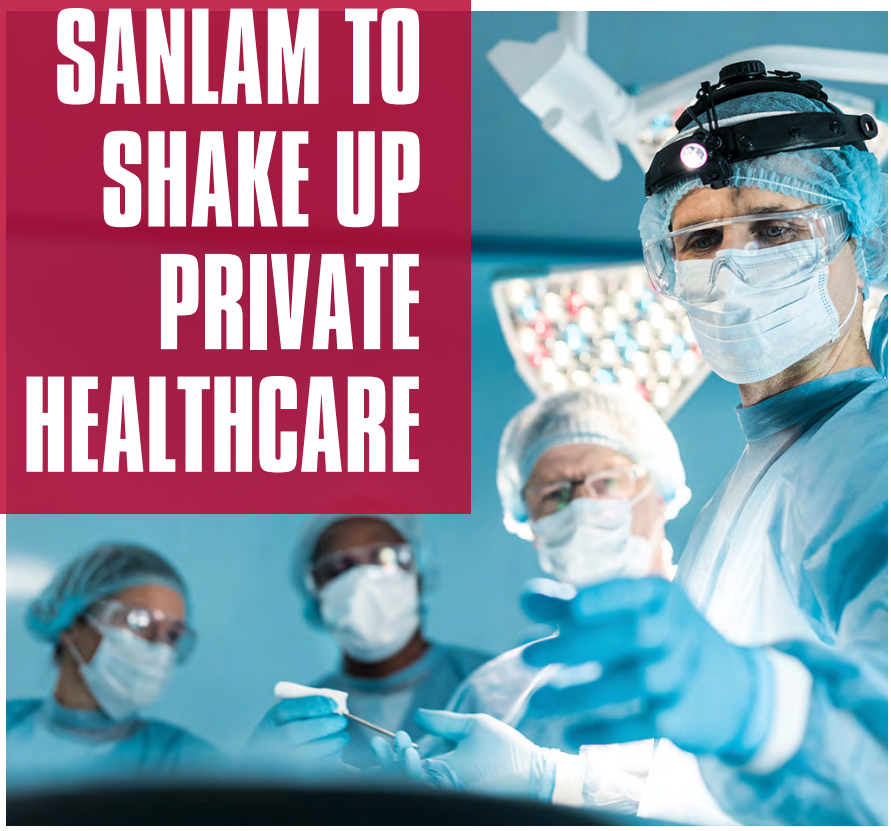
Q Any final words to intermediaries?

Astute was born to be a neutral enabler that serves the interests of the financial services industry. A lot of work is being done behind the scenes, particularly around the EB switch and we are hopeful that more funds will come on board in 2022, and beyond.

We will continue to champion and cater for the interests of financial intermediaries by ensuring that we keep adding different services and financial data sets that enables their practices, creates efficiencies, saves them costs, gives them a competitive edge, and that collaboratively, we add measurable value and impact end consumer lives, and ultimately, contribute to financial inclusion.

Mdu Ndlovu - Product Owner
Astute Financial Services Exchange (FSE)

SANLAM TO SHAKE UP PRIVATE HEALTHCARE



Sanlam announced its strategic intent to aggressively enter the South African private healthcare market with a range of new products and partnerships.

Through a newly established division - Sanlam Health Solutions - the group aims to fill a gap in the market for affordable, flexible and personalised healthcare solutions. It will also deepen existing partnerships with Bonitas and Fedhealth.

Upweighting its health focus

Medical scheme penetration is low in South Africa. Only 8.9 million South Africans - or 15.2% of the population - are members of medical schemes, either directly or as beneficiaries.

Paul Hanratty, CEO of Sanlam Group said the need for affordable private healthcare was laid bare during the COVID-19 crisis. "Unfortunately, many South Africans have found themselves unable to afford the prohibitively high costs of most medical schemes. At Sanlam we are led by a singular purpose - to help Africans live with confidence - and our clients' health is vital to their ability to live with confidence and resiliently build wealth. With this in mind, we have made the decision to significantly upweight our health focus."

"The range of options within a specific medical scheme is often limited by the risk pools within each medical scheme. Because of this, often one scheme can not stretch fully across all the need categories within an employer group or the retail market. This is why Sanlam has partnered with two schemes (Fedhealth and Bonitas) rather than one and included a Sanlam Primary Care Insurance solutions and Virtual Consults into its portfolio of solutions. Sanlam has also integrated/combined relevant Sanlam solution into our Fedhealth/Bonitas partner scheme offerings," said Gary Allen, Chief Executive of Sanlam Health Solutions.

Hanratty added that the new division will offer South African employers and consumers options which many of the existing players in the market do not. "Our range of healthcare solutions will allow South African employers and consumers to select the solution that best meets their health needs and financial situation. We also intend to become a catalyst for innovation in the space that will help drive down the cost of access to healthcare."

A new range of products

The new products, which will be rolled out in the coming months, include a low-cost primary health insurance product called Sanlam Primary Care, as well as Sanlam Gap, Sanlam Primary Care Clinics, Sanlam Occupational Health Services, Sanlam Employee Assistance Programme and Sanlam Executive Care.

Jurie Strydom, Chief Executive of Life and Savings at Sanlam said its two medical scheme partners are innovative, flexible and affordable, and their brands and client offerings are aligned with Sanlam's own. "Both Bonitas and Fedhealth are administered by Medscheme, a part of Afrocentric, and are in the top six schemes in South Africa. Bonitas being the second largest by some margin. We will give our clients the flexibility to move between medical scheme options. Our ambition is to empower people to live their best and healthiest possible lives, by enabling them to choose good wellness practices," he said.

Choose between four medical schemes

Strydom concluded that the offering will help corporates offer employees multiple medical schemes instead of just one. "We'll achieve this by integrating Sanlam products into the two open medical schemes. Packaging life insurance, gap and medical schemes options to address all of the costs associated with critical illness, rather than the current market structure where these solutions are purchased in isolation of each other, will allow us to offer a more affordable and cost-effective corporate offering and more choice to employers and employees."

"Brokers, advisers and their clients can now choose between four medical schemes (Bonitas, Fedhealth, Discovery and Momentum), integrated with a Financial Services Provider (FSP), which will bring much needed competition into the segment of the market who look for their medical scheme for this type of integration," concluded Allen.

Gary Allen
Chief Executive of Health Solutions
Sanlam

Jurie Strydom
Chief Executive of Life and Savings
Sanlam

Paul Hanratty
CEO
Sanlam

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ATTEMPTS TO DESIGN A CONSEQUENTIAL

In the first article, we pointed out that when a property loss occurs, in addition to the property damage costs, consequential losses that arise are not indemnified in terms of the property damage cover.

In the second article, we set out the fundamental principles involved, to determine the amount needed to provide indemnification against consequential losses.

In this article, we set out the attempts which were made to provide consequential loss cover.

From a practical perspective, it should be realised that the basic policy which responded to COVID-19 was a general policy, designed 120 years ago, and has worked extremely well ever since. In South African, and the UK, the issue revolved around extension to the basic policy. This will be discussed in a later article.

Early attempts

The realisation that Business Interruption (BI) losses occurred, and these could be insured, emerged in the 18th century.

The first attempt to provide cover was in 1797, by Minerva Universal, a UK insurer which introduced a policy to cover interest payments. Clearly, interest payments are one of the many forms of standing charges. It is important to note that this occurred long before the courts clarified the position that property insurance does not cover consequential losses. The absence of standard accounting practices was the main reason why this policy did not catch on.

Also, it provided very limited cover, covering only one form of standing charges and did not cover loss of profits. In 1817, the English Hamburg Fire Office began to offer loss of rental income insurance, as an extension to its fire insurance policy. Loss of rental income leads to a shortage of turnover.

In 1821, a Time Loss policy was introduced in the UK, also known as the per diem (per day) system, paying a fixed sum based on a daily or weekly rate. This system was conceptually an inadequate type of a valued policy. The possibility of providing consequential loss cover was held back by the absence of uniform accounting standards. This deficiency moved towards a solution, with the formation of the Edinburgh Society of Accountants (formed in 1854), the Glasgow Institute of Accountants and Actuaries (formed in 1854) and the Aberdeen Society of Accountants (formed in 1867), as uniform accounting standards began to emerge.

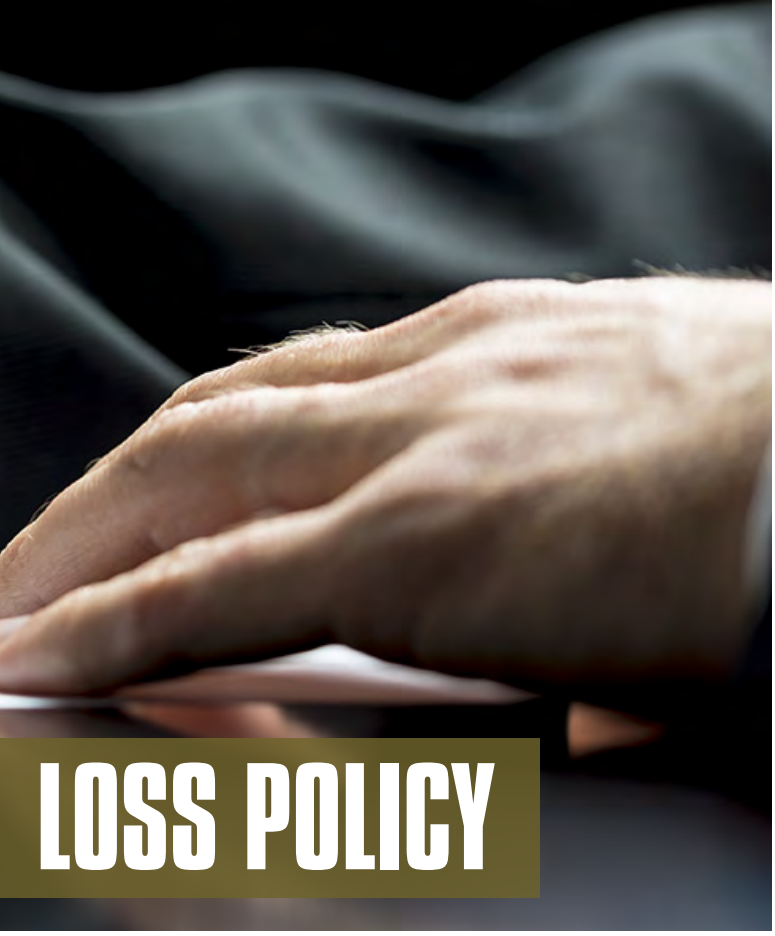
In France, in 1854, the Alsace introduced cover known as "Chômage" insurance. The payment was a fixed amount, expressed as a percentage of the asset's value. This, again, was an inadequate form of a valued policy. This concept was also introduced by some insurers in the UK, in 1868.

In the USA, in 1880, Dalton introduced "use and occupancy" insurance, as a form of business interruption insurance. The policy would pay, upon a loss, a per diem which is different for different periods of the year. These policies limited the payment to the "actual loss sustained".

The great breakthrough

The great breakthrough came in 1899. It therefore took more than a century to design a workable consequential loss policy, and five decades after the courts had made it clear that property insurance does not cover consequential losses.

Credit is given to Ludovic MacLellan Mann (1869-1955), a broker from Glasgow, Scotland, for the development of the currently used consequential loss policy.



LOSS POLICY

This policy was used for four decades before being formally adopted, in 1939, by the British insurance market, as the loss of profits policy. This new form of cover was marketed by the Western Assurance Company. Unlike earlier policies, it used turnover as the basis for the calculation of cover. This covered loss of profits, standing charges and the increase in the cost of working. And thus, the modern consequential loss policy was born.

The contribution of MacLellan Mann, to society, was recently re-discovered, and there is now even a society established in his honour. One would think he would be remembered for the insurance policy he designed, which is still in use today, but this is not even listed in his achievements. He is remembered for other things.

The development of the BI policy

In 1910, the regulatory authority in Germany, following machinery breakdown, approved business interruption insurance. This was followed in 1938, by the Gross Earning Policy, introduced in the USA. This was a form of business interruption insurance, which covered an insured's loss of gross earnings suffered, because of a disruption caused by physical damage. This still did not provide an adequate solution to the financial loss suffered, as a result of the operations of the business being interrupted.

In 1939, in addition to formally adopting the modern BI policy, the additions method was introduced, as an alternative to the original 'difference method' for calculating the insured gross profit. Business interruption insurance was further developed at Lloyd's, by Cuthbert Heath. He designed a product that would bridge the gap between traditional fire insurance and business interruption insurance. His product was criticised, on the basis that the policy was opening up an avenue for fraud, as the loss suffered by the insured could not be quantified with certainty.

Different names have been used to describe this form of cover, including Consequential Loss Insurance, Gross Profits, Business Interruption Cover, Gross Earnings, or Business Income. These policies are indemnity policies and are aimed at compensating the insured for actual financial loss. However, what is important to note, is that all of these policies responded to financial losses originating from actual physical loss to the insured property. The demand for more comprehensive and broader cover grew, as the basic cover was widened, by introducing extensions which will be discussed separately.

In order to provide a workable form of cover, standardised, accurate and reliable books of account needed to be maintained by the insured business. These necessary standards were only introduced by accounting and business bodies in the early 20th century. International standards ensuring accurate and transparent reporting are still continuously being developed.

Cover for 'pure' pandemic risk

It should be clear that the basic BI policy covers consequential losses, which arise out of physical damage to property. This is not what happened with COVID-19. Insurance properties were not damaged. The business losses occurred because the economy was shut down; losses unrelated to physical damage are referred to as pure financial losses. Consequential loss policies are not pure financial loss policies. Thus, a generally usable 'pure' pandemic risk policy has not yet been developed. The main reason for this is that the pandemic risk violates the fundamental principle of insurability.

There have been some attempts to create a pandemic policy. After the Ebola outbreak of 2014-2016, in 2018, Marsh LLC, in association with Munich Re and Metabiotica, marketed a product called PathogenRX, which is the best-known example of a product designed to cover pure pandemic risk. Only one policy of this type was sold pre-COVID-19. The policy was originally designed to cover epidemics but was further developed to cover the pandemic risk. The initial target client base for this cover was the travel or hospitality industry.

Originally, the policy was modelled on morbidity and mortality tables, and aimed to cover events which would not result in death, but which would probably impact on a person's ability to travel between areas, or which would result in international borders being closed. New triggers involved restrictions and regulations by governments involving lockdowns, supported by evidence that loss was suffered by the insured. The policy can be tailored to individual requirements, to provide cover for various geographical areas, specific expenses, types of diseases or specific periods of time.

In the next part of this series (February 2022 edition), we will look at how the fundamental principles are captured by the policy wording.

Prof Robert W Vivian
Finance & Insurance
University of the Witwatersrand

Penny Spentzouris
University of the Witwatersrand

Dawn Taylor
(Retired)
University of the Witwatersrand

CPD article

Cyber awareness crucial AMID RISING CYBERCRIME

October was International Cyber Security Awareness month, aimed at raising awareness of cyber risks for businesses of all sizes. And for good reason, a study by US cybersecurity firm, Varonis, found that global data breaches exposed 36 billion records in the first half of 2020. The same study found that over a fifth of cyber breaches were caused by phishing attacks and that 95% of cybersecurity breaches are caused by human error.

According to Accenture, South Africa has the third-highest number of cybercrime victims worldwide and loses around R2.2 billion to cyberattacks every year.

The biggest flaw

The human element has always been the biggest flaw within any organisation's computer system or cyber security controls.

Phishing attacks are specifically designed to take advantage of human nature and employee mistakes. Cyber security control mechanisms will always do what they are configured to do, it is the misconfigurations by humans that bring about vulnerabilities. Furthermore, suspicious emails with download instructions and phone calls aimed at getting vital information from employees are still very effective gateways for cyber criminals to gain access to companies' data.

This is why, over and above a cyber insurance policy, risk management measures such as taking out a professional indemnity policy for professional services and educating employees and contractors on cyber security risks and preventative measures, as well as their role in protecting the organisations assets and information assets, is crucial.

Cyber risks to consider

One of the most significant cyber risks to consider, is ransomware. This is once again something that is affected by the human element. It encompasses elements of data exfiltration and data encryption, and how those seem to play out within the market.

Furthermore, South African businesses have definitely seen an uptick in such cases over the past 12 to 18 months.

SHA's Annual Risk Review, found that 19% of respondents suffered some kind of a ransomware attack, and on average, each ransom was about R50 000. Most of the respondents in this survey were SMEs, hence the fairy low ransom amount, but multiple high-value ransom cases have been well documented in the media in recent months.

Adapt to the risk landscape

Regarding what businesses should be doing to adapt to the changing risk landscape, the answer lies in better technological solutions.

With companies starting to move systems and applications into the cloud and going ever more digital and technological, cyber security is bound to become a critical business risk, more so than it is now. But even more important, businesses have to ensure that their workforce is sufficiently skilled to handle potential cyber threats.

It is recommended that companies begin by looking closely at their basic cyber security measures. This includes doing regular backups, performing regular security patching, data encryption, anti-virus software, and use of firewalls. Focusing on the human element, ensure that proper passwords are used, and that all employees clearly understand what to do in any situation where they suspect they may be targeted by a phishing attack.

The cyber risk landscape is only gaining momentum. The one thing that we know for sure is that no company is immune to cybercrime anymore, no matter how big or small, or how much they invest in their IT systems. However, making sure that the human side of your operation is unassailable, can go a long way towards preventing an attack. That's why it's vitally important for businesses to educate their employees on the most common risks and how to avoid them.

Sizwe Cakwebe
Cyber Risk Manager
SHA Risk Specialists

SHA°
risk specialists

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ARE YOU RESPONSIBLE FOR EMPLOYEE WELLBEING?

Arguably, there's another insidious epidemic running concurrently to the pandemic right now. That of burnout. Many are exhausted, afraid, depleted and depressed.

An *Oracle and Workplace Intelligence* study found that 2020 was the most stressful year people reported ever experiencing in their working lives. Eighty five percent said newfound work-related stress was impacting their home environments. Seventy eight percent reported the pandemic has negatively impacted their mental health. And 76% said they thought their companies should be doing more to protect their mental health. Which begs an interesting question. How responsible should employers be for their employees' wellbeing?

Employee value proposition

Workplace wellness is not a new concept. The global workplace wellness market was valued at USD $52.8 billion in 2020 and has a compound annual growth rate (CAGR) of 7.1% forecast from 2021 to 2028. It should hit $66.2 billion by 2027. Thousands of varying sector verticals have sprung up to assist employers in providing Employee Assistance Programmes (EAPs) to employees. And COVID-19 may have accelerated this.

COVID-19 has highlighted the shortcomings of not including holistic wellbeing as part of the employee value proposition. Increasingly, employers are recognising the link between wellness and productivity in the workplace. People are a company's greatest asset, and the best people are becoming a scarce commodity. Having a holistic employee value proposition (EVP) is key from a retention and talent attraction perspective.

Employee wellness

Before COVID-19, it was estimated that one-third of South Africans will experience a common mental disorder in their lifetime. Now Netcare is planning to add mental-health facilities to its hospitals, as mental health volumes surge. Widespread retrenchments, layoffs, remote working and ongoing concern for oneself and one's loved ones are all taking a toll. Boundaries have blurred between work and home life, leading to digital presenteeism - the burden of needing to feel connected and available around the clock.

Then there's the question of money. Many are struggling to make it through the month, leaning on loans to replace net income lost. Sanlam has seen members having to pause, cancel or cut down retirement contributions in the wake of retrenchments, furlough or being laid off. This has significant implications for people's futures - which is extremely concerning in a country where just 6% of South Africans can retire comfortably.

Employees are ultimately responsible for their own financial, mental and physical wellbeing. But there's no getting around the fact that happier, less stressed people are likely to be better, more productive performers. It's in employers' best interests to build on people's personal resilience by providing work environments that are conducive to learning, growth and general happiness.

What can employers do?

Right now, employers are dabbling in several services - from offering gym memberships and virtual yoga, to meditation app subscriptions, take-out vouchers, and even small stipends to allow team members to rent hot desks in co-working spaces.

But one of the best ways to empower employees to be confident and secure is to look ahead.

Helping people to know they are financially provided for post-retirement is one of the greatest gifts an employer can provide, especially amid the pandemic.

Sanlam research has shown that financial wellness is as - if not more - important as physical wellness, given the effect financial 'unwellness' has on a person.

An umbrella fund removes these concerns, providing a simple, cost-effective solution that bolsters an employee value proposition. Not surprising then, that the Sanlam Umbrella Fund has seen increased interest over this period.

Employees get the peace of mind that they're providing for their future selves. They get access to educational material, free proactive benefit counselling and the chance to choose a solution that really works for them. Many umbrella funds have also branched into ecosystems built to facilitate success and confidence for members, by offering general wellness services in addition to the financial focus.

Going forward, the global competition for top talent - especially those with scarce skills - will continue to escalate. Employers may not be responsible for their employees' wellbeing. But those that take holistic employee value propositions seriously will be the ones to 'win' and retain high performers.

Avishal Seeth
Head:
Sanlam Umbrella Solutions
Sanlam

The impact of a growing direct insurance market AND THE VALUE OF ADVICE

The Small, Medium and Micro-Enterprises (SMME) segment, which includes complex and dynamic risks that have traditionally used the intermediated market when buying insurance, is seeing increased competition from direct insurers.

Advancing tech such as artificial intelligence (AI), insurtech and advanced data analysis will significantly increase the attention that direct insurers pay to this segment and has the potential to radically change the intermediated commercial insurance sector.

With the increased cost of regulation impacting insurers and intermediaries alike, it is becoming more difficult to service the low-end of the commercial market as the premiums to support it is limited.

The challenge

There has been a hardening in the market, as larger more complex risks with more volatile loss ratios and reinsurance restrictions impact both the underwriting and pricing of these policies. Typically, this scenario would have seen a hardening of rates across all commercial policies but that is not the case. The SMME market is experiencing a significant softening of rates as competition in this space increases.

As competition for the SMME segment has dramatically increased and cross-subsidisation within large portfolios is under attack, we are creating a new world that presents a lot of uncertainty for brokers and insurers alike.

It is foolish to assume that SMMEs would stay intermediated, as products and pricing is made more attractive in the direct market – these businesses will not remain intermediated for the benefit of intermediaries and insurers.

The reality is that the disintermediation of the SMME market would be catastrophic for all players in the intermediated insurance ecosystem because SMMEs are a critical segment within all intermediated insurers and the vast majority of intermediaries. As an industry, we need to treat the SMME segment with the care and respect it deserves and not take it for granted.

The solution

The solution is in insurers and intermediaries collectively harnessing data to better align service and costs.

Anybody not embracing the benefit of data, which is driving advances in insurer algorithms and digital engagement, is going to lose the battle to maintain their portfolio of SMME clients.

As many insurers and intermediaries look toward embracing data and the effect that it has on our tried and tested business processes, the key to our success will be the combined effort to achieve symbiotic improvements in key processes that involve all aspects of client service, from advice to policy servicing. Insurers will have to share the intellectual property and IT platforms that they have developed with the intermediaries, and likewise, intermediaries will need to embrace the need for clean and accurate data which almost always originates in the broker's office.

System providers need to be engaged with a common objective of achieving improved outcomes for customers at every leg of the insurance life cycle.

SMMEs still need broker advice but receiving it in a different accessible and digitally delivered format can better align the costs with the servicing of these clients.

The bottom-line

Through the right use of technology, the role of advice in commercial insurance is preserved, as brokers are enabled to deliver value to business customers and keep their costs down. If your insurance partner is not looking at the world like this, you will struggle to maintain your SMME client in a changing world.

Insurers who are embracing data and technology need to make sure that they take the intermediated market on the journey with them. The role of an intermediary has always been important to customers in commercial insurance and there is no reason that should not be the case in a digitised world.

David Pedra
Executive: Outsourced Business Solutions
Old Mutual Insure

ESG AND ITS IMPACT ON THE INSURANCE SECTOR

Climate change is recognised as a real and potentially destabilising threat to economies, as well as to the well-being of all citizens. It is also usually those that are the most economically vulnerable that suffer the higher risk.

Addressing key risks

If climate risk is not adequately managed the result will be that either insurers will no longer offer cover for it, or they will ultimately not be able to pay out any claims relating to catastrophic natural losses. This is relevant to both the non-life and life sector. Environmental, Social and Governance (ESG) issues are coming to the forefront, particularly in the financial sector. Businesses are increasingly taking ESG matters into consideration.

These include:

- **Environmental issues**: Businesses are being asked to minimise their impact on nature. This means physically minimising carbon emissions and deforestation, but also incorporates positive contributions such as the financing of environmental improvements.
- **Social**: There is increasing pressure on businesses to contribute to fairness in society. This considers aspects such as improving labour rights and diversity and inclusion within a company's workforce, and product safety for customers.
- **Governance**: Governance processes designed to improve decision making, reporting and ethical behaviour are becoming more important. This includes enhanced reporting, independent audits, consideration of board structures, the inclusion of independent directors, and transparency in relation to executive compensation.

A global framework

Insurers across the world came together to create the UN Principles for Sustainable Insurance (UNP), under the auspices of the UN Environment Programme's Finance Initiative. This is a global framework for addressing key risks in the insurance sector.

The principles, which have been endorsed by the South African Insurance Association (SAIA) but have not been widely adopted, include:

■ **Principle 1:** We will embed ESG issues that are relevant to our insurance business into our decision-making process. This can be achieved by:

- Establishing a company strategy at Board level to monitor and identify ESG risk.
- Establishing risk management programmes for ESG.
- Integrating ESG risks into underwriting.
- Developing products that consider ESG risks and contribute positively to reducing such risks.
- Incorporating ESG issues into repairs, replacements, and other claims services.
- Educating staff on the risks of ESG.
- Adopting an investment policy that considers Principles for Responsible Investment.

■ **Principle 2:** We will work with our clients and business partners to raise awareness of ESG issues, manage risk and develop solutions.

■ **Principle 3:** We will work with governments, regulators, and other key stakeholders to promote widespread action across our society

on ESG issues. This means that the insurance sector should support prudential policy, regulatory and legal frameworks that enable risk reduction, innovation, and better management of ESG issues.

■ **Principle 4:** We will demonstrate accountability and transparency in regularly disclosing publicly our progress in implementing the principles.

On 15 October 2021, National Treasury issued a technical paper on Financing a Sustainable Economy. It considers defining sustainable finance for all parts of the South African financial sector, which includes banking, retirement funds, insurance, asset management and capital markets.

The following definition is proposed for the purposes of South African policy making:
'Sustainable finance contributes to the delivery of the sustainable development goals, and a just transition to a low carbon and climate resilient economy and financial stability. Sustainable finance encompasses financial models, services, products, markets and ethical practices to deliver resilience and long-term value in each of the economic, environmental, social and governance aspects. This is achieved when the financial sector: evaluates portfolio and transaction-level environmental and social risk exposure and opportunities, using science-based methodologies and best practice norms; discloses and mitigates these risks and links these to products, activities and capital allocations.'

Responsible insurance approach

Sustainable finance, therefore, requires a collective approach in terms of regulations, as well as goods and services offered, for sustainable development goals to be achieved. Thus, a 'responsible insurance approach' requires the UNP principles to be incorporated into the business model of all insurers. The management, identification, and assessment of ESGs is a collective effort within the entire financial sector.

The Prudential Authority, as the prudential regulator of insurers, is required to ensure that the insurance sector promotes safe and sound insurers and that policyholders are provided with protection when dealing with such companies. Our law has shifted to a risk-based model, which also requires insurers to consider emerging risks and how these will be managed through an insurers own risk and solvency assessment (ORSA) report.

ESG risks can, therefore, be incorporated into an insurer's ORSA. Given the recognition of the importance of ESG risks, no doubt we will in due course find South Africa's legal framework will be further enhanced to provide guidance and standards in terms of ESG risks. Insurers should not see this as another regulatory compliance hurdle but rather as a step to ensure the survival of the insurance sector.

Christine Rodrigues
Partner
Bowmans South Africa

NEW PROPOSALS TO AMEND PPRS HAVE MAJOR IMPACT

At the beginning of August this year, the Financial Sector Conduct Authority (FSCA) released amendments to both the life and non-life Policyholder Protection Rules (PPRs) which, if implemented, will have a major impact on insurers from a compliance and operational point of view.

If one just looks at the tracked changes it may come across as innocuous, however, if one takes a closer look, one will see that there are fundamental changes which, if implemented, will change the way certain business has always been done.

It is important we are aware of these potential changes, and if comment has not already been provided to the regulator, even though the deadline has passed, an attempt is made to communicate with the FSCA to provide comment.

Key changes to be aware of

The key change is the definition of policies, which form part of the PPR's new jurisdiction. Up until now, when the extended PPR was brought in in 2018, only personal lines policies and small commercial policies (policyholders with turnover or net asset value of R2 million a year or under) were included.

In practice, insurers would have implemented the new regulations for those policies only, most of which are centred on protecting the customer and making sure the customer is treated fairly.

The basis of the PPR was always to protect personal lines clients, primarily as they do not have access to the same level of legal advice as a company would, and companies would in all likelihood have employees more suited to protecting and understanding their rights than an individual. Also, the products for commercial products are normally expressed in a more legal manner, specifically the more corporate products such as marine, engineering and mining type risks. It would be very difficult to express the policies in plain language, even though the PPR regulations do make the point that plain language should take the intended market to whom the policy is being sold into account.

The real issue is the PPR regulations were designed specifically for personal lines policies, and this is indicative in the strict disclosure requirements, the requirement for plain language, that the underwriter only deals with the complaint and that the broker fees being charged by the broker be properly disclosed and accepted by the client and polices by the insurer, where the insurer facilitates the

collection of the premium. A commercial entity would be more equipped to negotiate a broker fee and understand the needs of the commercial policy that they were procuring.

It is clear the regulator has always expressed the view that 'treat the customer fairly' does not only apply to natural persons, but commercial entities as well, but if one looks at the trends in the market, the focus of protection is the vulnerable – the 'man in the street', so to speak.

The proposed amendments

The proposed transitional period was only six months, and if one takes into account that if the proposed amendments go through as they are, the disclosures at inception would need to be amended to fit the disclosure requirements, which may include systems changes given that the products are different, the requirement for policyholders to sign off broker fees would need to be complied with, which may take considerably more than six months as the requirement would need to be implemented on the renewal of the policy, and the policy wordings in certain circumstances may need to be amended to be more plain language. Also, where niche corporate underwriting managers are concerned, the insurer would need to deal with all insurance complaints directly, specifically with regards to claims, which will take some time to implement.

Two more important changes

The final two important changes are with regards to personal lines policies only, are that an excess payable by a client should not be above R10 000 per any one event. If the policy allows for a higher excess, an affordability assessment will need to be carried out so the insurer can satisfy itself that the policyholder will be able to pay it, should a claim be submitted. There are cases, specifically with high-net-worth policies, and where the policyholder chooses to take a higher excess for a lower premium that the excess is above R10 000 per event. These issues will need to be rectified by insurers if this regulation is finally enacted. It may impact rating engines and IT systems as well.

Finally, there are amendments with regards to no claims reward schemes, both in the way the scheme is communicated and how its dealt with, specifically if terminated. Again, wordings and systems may be impacted. It does appear because the Conduct of Financial Institutions (COFI) Act has not yet been passed as expected, the regulator is using the PPR to enact Treating Customers Fairly (TCF), in respect of commercial policies. It is hoped though that not all the provisions of the PPR are to apply equally to commercial (specifically corporate) policies, and that where appropriate, certain provisions can be relaxed for the more corporate policyholders. It is also expected that a longer transition period may be necessary.

Danny Joffe
Head of Legal
Hollard Insure

CPD article

THE UNTOLD TRUTH ABOUT intermediary agreements

'A wise person builds a house on a rock, while a foolish person builds a house on sand.' Or, 'A chain is only as strong as its weakest link.' These common age-old proverbs still hold truth in the modern commercial climate of Financial Services Providers (FSPs).

FSPs eagerly embark on the road to growth and success without realising that the intermediary agreement signed with the insurer, forms part of the foundation of its business. This bureaucratic step is hastily completed because FSPs believe that the insurer will only cancel their agreement in the event of fraud or dishonesty. However, this is not always the case.

First-hand experience

Let me put this into perspective from first-hand experience.

CASE 1

A prominent FSP signed an intermediary agreement with a recognised long-term insurer, in March 2010. In July 2021, the FSP received a Cancellation of Broker agreement which stated, "We hereby give 30 days' written notice of cancellation in terms of clause 3.2 of the agreement."

No reasons were provided, and no breach of contract was cited. The adviser stated that he no longer placed new business with this insurer, however, the FSP still receives recurring commission on the 30 000 funeral policies which were placed over the last 11 years. The intermediary agreement stated that, if the broker advises or entices any policyholder to cancel or replace a policy after the said termination, the broker shall immediately cease to be entitled to any further commission.

CASE 2

An established FSP concluded an intermediary agreement with a reputable life insurer in September 2011. In January 2020, the FSP received a Notice of Termination letter shortly after the licence holder's wife had a disagreement with the nurses who were contracted to obtain blood samples from the prospective policyholders.

It was then realised that the termination clause in the intermediary agreement was not subject to a breach of contract. The FSP itself did not breach any of the terms of the agreement. In fact, the termination clause allowed the insurer to terminate the agreement without providing any reasons. After having engaged with various Head of Departments at the insurer, a complaint was lodged with the Financial Sector Conduct Authority (FSCA).

In July 2021, the FSCA responded stating, "After our analysis of the facts pertaining to this matter, it has been established that we cannot intervene as this is a contractual dispute. Kindly note that our Office will be closing this case." During 2020, the insurer proceeded to re-intermediate the policyholders to another FSP, despite the policyholders' request to remain with their trusted adviser.

Both the above cases raise the issue on whether the customer is treated fairly when he or she is compelled to choose between the insurer or their long-standing adviser.

Terms and conditions

It is imperative that FSPs understand the terms and conditions relating to termination and the consequences of termination. Intermediary agreements are governed under Rule 12 of the Policyholder Protection Rules (PPRs) in terms of the Long-Term and Short-Term Insurance Acts, however, the Rule does not provide for minimum standards relating to the terms and conditions. This means that the agreement may be drafted on whatever terms the insurer deems suitable.

The essential elements of a valid contract are capacity, consensus, legality, possibility of performance and formalities. These elements are contained in the intermediary agreement, therefore, the FSP enters into a legally binding contract upon signature. It will be difficult to dispute termination where the FSP consented to unilateral termination without reasons or a breach. The FSP will be forced to seek expensive legal recourse.

More consideration

More should be done in the industry to force insurers to draft intermediary agreements based on minimum standards, which are fair and reasonable, taking into account the effect of termination on the policyholder and the broker.

Alida Ganesen (Govender)
Compliance Officer,
Attorney
FAIS Compliance and
Licensing CC

Ever-increasing competition and digital disruptions in the insurance market are putting margins under pressure and making it ever more difficult for established insurers to maintain profitability levels.

Many insurers are having to drop their margins to attract new customers, yet customer acquisition can be a costly process; both in terms of physical costs and the administrative time and effort it requires. At the same time, the insurance market in South Africa is not growing at a rapid rate, so insurers have to compete for each other's market share to grow their customer base.

UPSELL INTELLIGENTLY WITH DATA MINING

Harnessing customer insights

In light of this, insurers should rather look at extracting additional profitability by relying strongly on upselling more services and products to existing and new customers and increasing the spend of these customers with the insurer.

However, the modern customer has become largely immune to general sales messages. Instead, they expect an increasing level of personalisation and will choose to buy from the brands that offer services and products that are not only of interest to them but have been tailored to their specific needs.

Successful insurers are harnessing customer insights to create messaging that is highly customised, very targeted and crafted specifically around the needs, wants, fears and desires of individuals to break through to these customers.

Two critical components

To do this at scale, insurers need two critical components – insights from data and the ability to dynamically apply those insights to guide their sales agents in their conversations with the customers.

Insurers with powerful data analytics have the ability to deliver much-needed individual targeting and are, therefore, better positioned than their competitors. When offering personalised insurance products and services, companies need to focus on core growth areas such customer experience, product development and improved online services.

Modern contact centre and customer relationship management (CRM) systems have come a long way to delivering the raw technology capability. In addition, deploying omnichannel and multichannel cloud-based communication platforms will ensure that insurers can enable a deeper engagement with their customers, across the channels that their customers prefer to use.

A multichannel/omnichannel approach will also ensure that companies can collect data across all touchpoints, with which the customer interacts, and build an improved customer journey by leveraging this data to create meaningful and valuable interactions.

Thus, the secret sauce to creating deeper customers relationships and successfully upselling products and services lies in the cross-referencing of customer data, crafting relevant scripts and adequately training agents.

Modern customer expectations

Stock-standard introductory scripts no longer resonate with modern customers. The modern customer wants to feel like his or her insurer knows who they are, what they are interested in and additional products they might be interested in.

Personalisation, which depends on static information, such as demographics or transactional data like the customer's name, gender, age, occupation and purchase history, can be harnessed for promotional campaigns for products similar to a customer's previous purchases.

However, hyper-personalisation, or hyper-segmentation of the customer base, goes a step further. It allows companies to interact with customers in real-time, with unique, timely and contextual suggestions or experiences based on users' location, time or behaviour. This can be done by gaining insight into customers by analysing data collected by artificial intelligence and machine learning technologies, as well as Internet of Things (IoT)-enabled devices.

Considering the current market dynamics, the case for personalised marketing is a compelling one for insurers, as it is an effective strategy to leverage during the current wave of digital disruption.

Personalisation enables insurers to compete with disruptors and reap the financial benefits of retaining customers they would have otherwise lost. Additionally, it provides an enhanced experience for customers in the form of tailored messaging, customised offers and targeted pricing at just the right time.

André Schoeman
Head of Product Management
Jasco

A CATALYST FOR ENABLING INSURANCE INNOVATION

Data has become the most valuable asset that a modern enterprise can possess, yet this is still a mindset that many companies in the South African insurance industry need to wrap their heads around.

Increasingly, numerous factors are making it a critical imperative for insurers to harness the data assets within their organisations today, including product commoditisation, shrinking margins and disruptive start-ups, as well as aging technology and processes, changing customer expectations and regulatory uncertainty.

Predictions are that data will continue to grow exponentially, with Statista revealing that the total amount of data created, captured, copied and consumed globally reached 64.2 zettabytes in 2020. By 2025, global data creation is projected to grow to more than 180 zettabytes.

Failing to create new business

Like many other industries, the insurance sector has traditionally generated and collected massive volumes of data. However, in comparison with many other service industries, insurers have been slow to monetise their data, often failing to create new business lines or models to capture the value of data and analytics.

Prior to the outbreak of the COVID-19 pandemic, many insurers faced organisational challenges to becoming data-driven entities, while others were waiting for business opportunities to emerge before enhancing their data analytics capabilities. As such, insurers typically lagged behind other industries in terms of investment in and adoption of analytics.

The value of becoming data-driven

However, with the pandemic accelerating digital transformation significantly in most industry sectors, insurers are increasingly recognising that those wishing to stay ahead of the pack need to evolve to comprehensive, agile service providers with innovative product and service offerings, that are ultimately data-driven.

The value of becoming data-driven should not be underestimated. Findings from an EY industry survey show that large commercial insurance markets are in line to experience $600 billion in revenue growth by 2030, and a combined operating ratio drop of 25%-30%, provided the industry becomes more agile, increases connectivity between market participants and intelligently applies the use of data.

However, the opportunity for growth and profitability gains will only be significant if organisations are able to overcome the technological hurdles that are stifling operational efficiency and underwriting excellence.

Global innovation service provider Zühlke Technology Group argues that two of the most important trends that are driving the digitalisation of the insurance sector are the customer experience and the evolution of product and service offerings.

Ultimately, the pandemic has served as a catalyst for enabling insurance innovation in South Africa and the rest of the continent. The global response to COVID-19 has underscored the new approaches that insurers should be considering, which include customer-centric digital tools and other technological innovations that are able to respond to stakeholders' needs.

Giving rise to new business models

The customer experience has increasingly been a disruptive force, as the interaction between customers and insurers has been changing dramatically over the last decade. The modern customer wants targeted information quickly, expects fast reactions and wants personalised and scalable offers.

These expectations can be addressed with the proper implementation of machine learning and AI technologies, with systems based on Natural Language Processing to automate enquiries in contact centres that incorporate an omnichannel communication approach.

ML algorithms are effectively laying the foundation for solutions and programs, with the ultimate aim of increasing profits, reducing risks and faster identification of systematic errors.

This results in claims processing times being reduced to a few minutes, significantly improving the customer experience. Each interaction can be used to collect data on individual customer needs and to further personalise offers and information.

Aside from the customer journey, the range of products and services offered by insurers is also changing fundamentally. The move is away from standardised insurance products for claims settlement, towards a holistic portfolio of services and modular, flexible products and smart services that are primarily aimed at loss prevention.

The explosion of data volumes is giving rise to new business models, revenue streams and huge opportunities to increase value. However, monetising this data requires insurers to rethink their approach to building and managing data and analytics assets, while also developing go-to-market capabilities to bring data-centric offerings to clients.

Thokozile Mahlangu
CEO
Insurance Institute of South Africa

UNLOCKING AFRICA'S INSURANCE MARKETS

Africa is one of the most dynamic and exciting insurance markets in the world and has the potential to benefit significantly from what Insurtech has to offer.

But despite a real appetite amongst governments, regulators and companies to work closely with the (re) insurance industry, success is not guaranteed, and there are particular issues that will need to be addressed to unlock Africa's potential.

The potential of the African market

The mood for change was very apparent at this year's AIO conference in Lagos, in September. The theme of the conference was the contribution the insurance industry can make in rebuilding Africa's economy, and there is no doubt that our industry has a huge role to play.

The potential of the African market is undeniable. Prior to the pandemic, it was expected to grow 7% annually between 2020 and 2025, faster than North America and Europe, and even faster than Asia.

But if leaders and regulators are serious about achieving these ambitions, they must focus on the major benefits that will come from embracing technological innovation. For Africa, that means supporting more collaboration between the growing, but fragmented, Insurtech sector and the established brokers and insurers who can provide the necessary platforms to help them scale their products and services.

South African authorities are beginning to understand the potential that Insurtech can have. The Intergovernmental Fintech Working Group recently set out a vision for the countries Fintech sector, in which the Group highlighted the role Fintech partnerships can play in providing accessible and appropriate financial products, especially insurance, at scale. With Insurtech start-up *Naked* recently raising $11 million in a Naspers-led round, and Old Mutual announcing its partnership with a venture capital firm with the explicit focus of deploying capital on Insurtech companies, there is clear confidence amongst private investors of the potential these partnerships have.

Kenya, too, is seeing increasing amounts of investments in its Insurtech start-ups. The country's Insurance Regulatory Authority has been giving firms cash awards in recognition for their ability to increase access to insurance in underserved markets.

A unified African approach

It is important to treat the Insurtechs we work with not simply as 'tech support', but instead as valued and strategic partners that are integral in helping us to deliver for African clients as we work with them in developing new risk solutions.

The overwhelming focus in Africa has been on the process to quote, bind and issue, and we know from the experience within the London market, where PPL has revolutionised the quote and bind process in just eighteen months, that this can make a real difference to client/broker/insurer/reinsurer collaboration, no matter the size of the risk.

What we need is a unified African approach and the game changer could be the African Continental Free Trade Agreement (AfCFTA). Much of the discussion at the AIO conference was on the importance of the AfCFTA, which has ambitions to create a single African market.

The AfCFTA emphasis on regulatory harmonisation, uniform tariffs and the impetus it gives to the SME sector could make it easier for Insurtech start-ups and tech entrepreneurs to do business across member states. This will be key to easing the flow of business and to enabling the transfer of investment, capital, and knowledge across different countries which can support new and vibrant insurance markets within Africa.

A win-win situation

Our own experience in Africa has proved to us the value of specialist partnerships and local knowledge, combined with global technological and insurance expertise.

Embracing disruptive technologies and embedding them in our business has not only enhanced our offerings, but also delivered real benefits to our clients. For Africa, it can only be a win-win situation.

Manoj Kumar
Chief Executive
MNK Re Group

5 ways for IFAs to transform their client experience

Financial advisers, you are needed. You support, guide, inspire and reassure.

Demands on your time, money and resources make it harder to do more of what makes you brilliant.

WHILE bigger financial advice networks benefit from data-driven decision-making and automation, how can smaller financial advice practices without deep pockets and marketing departments retain competitive advantage and thrive? Through delivering a seamless, personalised and exceptional client experience.

Here are five ways to be brilliant at it:

1 Never forget another birthday

The little personal touches are just one of the things you do that make you rock. Making the time to engage with clients outside of your mandatory meetings is easier said, than done, when there is so much other stuff to stay on top of.

The best financial advice firms do it using their CRMs and you can too. With the right system, you can do a quick click Zoom and set up a flow of automated yet beautifully personalised emails and reminders in minutes. You won't forget another birthday, and they won't forget you. And no one needs to know how you're doing it.

2 Have uncomfortable conversations

If you genuinely want to be the best you can be, then you're going to have to find out where you're stopping short. Your technology system can help identify problems getting in the way of delivering awesome advice and superstar service. Lots of feedback on the same issue? Houston, you have a problem.

To get to the bottom of what clients think, why not ask them? Luckily, having those uncomfortable conversations is easier if your CRM can do it. The best systems make it easy to whip up and send a quick online survey to your client base. Just make sure you turn any negative comments into positive action and there'll be no stopping you.

3 Keep it simple, superstar

No one can explain the intricacies of financial advice quite like you. Those real-world examples and funny analogies are part of what makes you unique. But what about the clients that need a picture or those Millennials who want everything in a video?

Before you Google how to become a top YouTuber or Graphic Design whizz, just let technology do it for you. Knock their socks off, with digital statements of advice, that use interactive graphics and animations to bring your conversation to life. There are even tools that offer an easier way to demonstrate cashflow modelling, which will be a relief to everyone.

4 Be more Netflix

Make no mistake, Baby Boomers, Generation X, Xennials and Millennials and every other kind of person in between are all looking for a fast, frictionless digital experience.

Even small financial advice firms can be more Netflix. The trick here is to use an out-of-the-box Client Portal. Already bursting with all the right tools for an effortless 24/7 service and experience your clients will love, a Client Portal will open up a whole world of potential, enabling you to become the data-driven business you always imagined.

5 Do your best, automate the rest

Having the time to do your best, means automating the rest. All that unnecessary admin, data entry, MORE data entry, manual revenue reconciliation and reporting is best left to technology. The right financial advice software has your back; silently taking care of it all, while you take care of your clients.

Small practice. Big demands

It's not easy running a financial advice business. Every day there are more demands on your time and money. We can help. With affordable IFA software, that has everything you need to work in a smarter and more automated way. So, you can do more of what makes you brilliant.

Barrie van Zyl
Head of Account Management
Iress

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Artificial intelligence (AI) and machine learning (ML) have the potential to revolutionise call centres for the better, but only if insurers (and others) know what they are trying to achieve.

Call centres have become a fact of business life, but they have never been perfect. However, significant technology developments over the past few years look set to overturn a status quo that has never really satisfied anybody. But, as always, companies need to be clear about what they want to achieve.

IT'S ALL ABOUT IMPROVING THE CUSTOMER EXPERIENCE

Key drivers for investment

A small hint: the traditional focus on cost which has ruled call centre technology implementations in the past is not going to cut it. The emergence of affordable smartphones and the migration of business and social life onto mobile platforms with well-designed, user-friendly mobile apps has radically changed customer expectations.

In this new age in which customer experience is paramount, the traditional call centre with its clumsy IVR (interactive voice response) system seems positively antediluvian: too time-consuming, too impersonal.

Alongside the mobile revolution and all its consequences, another important technological development has been the emergence of the cloud. In this context, the cloud has made it possible to access the powerful data processing and storage capabilities that AI and ML need without the massive capital and operational investments that traditional, on-premises data centres would require.

In short, AI and ML are now able to be deployed at scale. The question is how they can help improve the customer experience while also making the call centre itself operate more smoothly. Recent research shows that while hard benefits like cost reduction remain critical, softer benefits like improved customer experience and loyalty are now key drivers for investment in AI.

Several avenues to explore

There are several avenues that companies should be exploring in their bid to improve their ability to compete for customer loyalty and a better bottom line:

- **Better enabled human agents.** AI and ML capabilities are advancing fast and are now being used to feed human agents with information and insights in real time to help them service customers better and faster. For example, a type of AI called sentiment analysis can analyse customer's requests and recommend a bouquet of solutions to the agent, who can then use his or her human judgement to decide which ones to offer. AI can also be used to help in areas like customer retention by identifying trigger phrases like "I'm closing my account" and rapidly serving up special offers designed to prevent customer churn. An important corollary is that agents will need suitable training to enable them to wield these sophisticated tools successfully in the heat of a customer call.

- **Increasingly intelligent customer assistants/bots.** Talkbots or chatbots can be infuriating if they are not properly designed, but when used intelligently they can improve the customer experience by providing basic information rapidly. Customers don't want to wait for an agent for answers to basic questions, such as "What is my excess?" or "Is water damage covered by my policy?" and so on. The AI has to be able to discern quickly when it cannot help and redirect the customer to a human agent.

- **Predictive call routing.** Call centres have always tried to get the customer to an agent with the right skills, but the criteria and mechanisms used have been, frankly, rather primitive. Using AI, it is increasingly possible to identify customer personality types and route their calls to the most appropriate agent for a better, more productive customer experience.

Undoubted promise

AI and ML are not silver bullets, but if used wisely they have undoubted promise in the quest to improve the customer experience and optimise the call centre.

Interactions, "Study reveals hidden drivers of AI adoption", GlobeNewsWire (27 February 2020), available at https://www.globenewswire.com/news-release/2020/02/27/1991835/0/en/Study-Reveals-Hidden-Drivers-of-AI-Adoption.html.

Morné Stoltz
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TOP TRENDS SHAPING THE INSURANCE INDUSTRY

For the past two years, the impact of the pandemic has driven most of the conversation around the insurance sector – where its headed, how it will shift and change, the role of digital and the changing demands on both the industry and the stakeholders it engages.

Where we are headed as a sector

And while those discussions are far from over, there seems to be more stability around where we are headed as a sector, and technology remains the core determining factor.

According to a recent KPMG survey, there are a few key areas that businesses will be considering into the near future – all of which are pivoted around technology. If we consider these elements, they are all crucial to business success and meeting consumer demands and as such, technology into 2022 and beyond will continue to dominate boardroom decisions.

The shift in technologies

Let's look at the shift in technologies and what this means for the changed consumer.

1 **Automating workflows and Artificial Intelligence (AI)** - History has proven to us that the automation of workflows within the insurance environment is critical to reducing turnaround and ensuring solid customer experiences. In fact, research shows that such automations can reduce paperwork by almost 80% and increase claims processing by around 50%.

However, it is not just about claims processing but also about intelligent underwriting, especially for the adviser building up in a tough competitive environment. AI has transformed the way the sector works in this regard and intelligent underwriting, built within the policy engine, ensures that the insurance application process is convenient, and uniquely aligned to the needs of the client. This generates a premium suited to the client's affordability and life stage, while providing real, personalised policies and financial protection. It is becoming ever more critical to meet consumer expectations around price, personalisation and immediacy.

2 **Machine learning** - Optimising processes and reducing redundancy is critical in the insurance space, and therefore, technologies such as robotic process automation, and machine learning are crucial to the mix. Such technology is enabling consultants to focus on servicing customers' immediate needs, instead of tasks that can be easily automated and processed.

Machine learning that happens over time when implementing such technologies also means that insurers are creating scope in the advice, fraud prevention, risk management and sales environments. This gives them not only a competitive edge but, importantly for the business, optimises processes, productivity and essentially profitability. And, for those that service the adviser market, it is offering them a unique edge in providing real time policies to their clients and optimising the customer experience.

3 **Remote acceptance and self-servicing platforms** - Consumers are demanding quicker turnaround and the opportunity for full transparency of the process – and they want all this securely. Therefore, being able to offer a secure process for clients signing up a new policy, for example, in the comfort of their own home through a One-Time-Pin (OTP) verification, is the norm. Financial institutions have been doing this for years, and insurers must do the same. The personal interaction with the client must remain however – financial advisers should make use of remote interaction processes to bring both technology and the human touch into collaboration for the best, most efficient outcome.

This transition from purely human to a hybrid of both has also enabled consumers to access self-servicing platforms and update their own details and add/remove existing products quickly and safely. It also enables insurers to provide a communication and education platform, especially for clients without an adviser.

If we don't adapt, we will be left behind

These are just a few of the many technologies driving the insurance sector forward. If we, as insurers and advisers, are not creating opportunity for quicker, easier insurance that offers transparency, personalisation and efficacy with the backing of the right advice and technological support, we will certainly be left behind.

Kobus Wentzel
Head of Distribution
& 1Life Vantage
1Life

Within the insurance industry the claims process plays a significant role in determining the insurer's competitiveness.

Nearly eighty percent of premiums collected represent the payment of claims and processing costs. Claims are the moment of truth for insurers - it is where they are tested in terms of their ability to delight or disappoint clients.

Insurers cannot achieve high performance by pursuing isolated, quick-fix systems and improvements of their claims operations. Instead, they must take a holistic view of claims personnel, processes, and technologies, deep-rooted in enterprise data management and executed across the company. Insurance providers must adopt precise processes supported by meaningful systems of measurement and enabled by effective digital platforms and evolving technologies to adapt to change.

specific responsibility and contribution to the ultimate outcome.

These traditional measures will need to give way to a balanced scorecard or automated measures that are reflective of everyone's impact and efficiency on the claim's outcome.

Data driven claims to fast track cycles

The speed, efficiency and transparency in the claims process depends upon the

The game has changed

Personalisation is the name of the game. Digital personalisation capabilities are the new competitive edge when it comes to acquiring, managing claims and keeping customers in 2022 and beyond.

Policyholders understand digital communications mean that their insurer collects their personal data — anything from behavioural data to their location or any information they have submitted. They expect an insurer to use this information collected, to improve and personalise their experience. Today's consumers are fundamentally different from their parents. Their needs, knowledge and digital expectations expanded rapidly over the past decade. The amalgamation of technology with everyday life has created a new kind of consumer- a digital native.

These digital natives are fast becoming the disruptive force in the insurance industry. With access to comparison sites, ratings, and testimonials just a click away. Policyholders don't look at every single interaction with their insurer in isolation. They treat any communication or interaction, no matter the channel, as a part of the whole. So, focus on a holistic view of the claims operating models and how that fits into the overall business strategy.

Reinvent the role

The claims professional performs a role that is 80 percent clerical and 20 percent professional. This ratio needs to be reviewed and reversed.

The future claims facilitator will be at the centre of a service offering, channelled through the customers' preferred means of interaction and powered by real-time access to relevant data and information. A future claims facilitator, equipped with effective digital claim tools and with the support of a strong back-office, will bring claims to a faster and satisfactory resolution for both the policyholder and the insurer.

The claims professional of the future must also be less focused on processing and more oriented, with access to intelligent data and protocols, on decision making.

Changes in the claims operating model and the roles of who processes what will require a new set of thinking and measurement, to ensure that performance objectives are aligned. In essence, today's common claims metrics focusing primarily on "inventory" such as file counts, closure rates and average pending are becoming increasingly less relevant in a world where a claim may be touched by several people, each with a

insurer's ability to capitalise on rich claims information, make it readily available to internal and external users, and leverage it for continuous improvement. Next to the new business and underwriting process, the claims transaction is where insurers learn the most about their individual policyholders and, in the aggregate, about their businesses. This wealth of information creates new opportunities for insurers to not only improve the efficiency and effectiveness of the claims process itself, but also to improve their underwriting, pricing, risk selection and reserving.

Breaking away from the pack is not a question of tactical steps, but to a true claims transformation to be the best in connecting products and claim services with the needs of customers.

Wimpie Van Der Merwe
CEO
Global Choices & Director of Claim Central Africa

digitalpath

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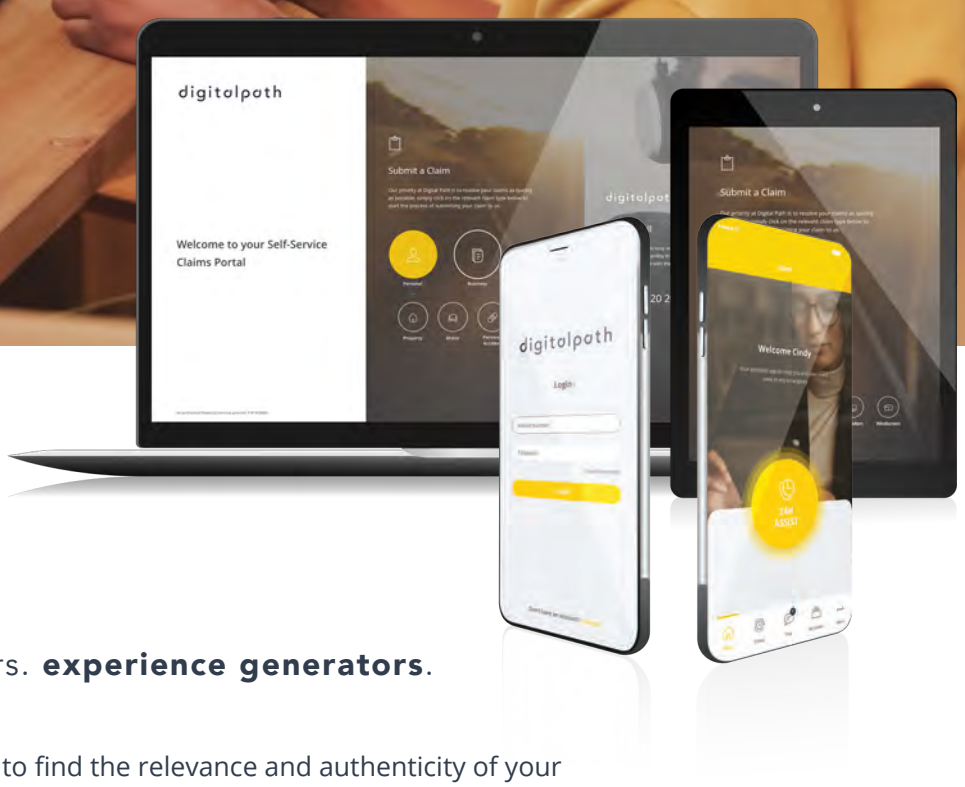

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CPD article

D&O LIABILITY TRENDS driving claims and premium increases

There is no question that conditions for organisations have substantially changed in the past two years of the global pandemic.

Conditions have evolved

Since Directors and Officers (D&O) liability is directly linked to business performance and insurance requirements, it follows that conditions in this underwriting arena have also evolved.

After a good decade of minimal claims, among the most prominent trends emerging is an acceleration of years of reductions in premium income, now coupled with a sharp increase in claims. The net effect comes down to a single concept fundamental to the provision of insurance services: sustainability.

In short, insurers today must be careful of the risks they take on, while pricing premiums appropriately. Terms and conditions are becoming tighter, with more exclusions.

Prominent trends emerging

These headline trends broadly underpin the mood of the industry:

1 **Increased regulatory requirements** - Following the impact of the pandemic on businesses, we have seen a heightened focus on regulatory requirements and customer outcomes. Some regulations affect all organisations, while others are industry specific. Regardless, compliance comes at a cost, non-compliance, arguably more so. Directors could see an increase in regulatory scrutiny to ensure compliancy with the specific industry framework they are operating in.

2 **Insolvency** - Even prior to the pandemic, insolvency rates were high, and with the now unprecedented business conditions in South Africa (and globally), insolvency proceedings are on the up. This is traditionally among the biggest sources of claims in the D&O industry, with an inevitable increase surrounding economic uncertainty. When companies fail, directors are held accountable for their actions and decisions; shareholders are increasingly litigious, not only in cases of insolvency, but also when it comes to the trends which follow: cybersecurity breaches, climate impacts, unmitigated adverse events, and bribery and corruption.

3 **Cyber incidents** - Cybersecurity is a board-level risk. Ever-present, it demands mitigation from every business today, not only in terms of appropriate technology and processes, but also from an insurance perspective. As mentioned above, directors can be held accountable from a regulatory perspective or by their shareholders who may seek to recoup losses following data breaches or service outages. From a governance perspective, directors have a duty to manage and ensure proper security controls or backups are in place.

4 **Climate change** - Directors are confronted with growing environmental awareness and climate-specific regulation, and highly active groups targeting companies for perceived or actual environmental impacts. In short, this is accelerating related D&O claims. Directors must consider climate change and the environment-related risks and take necessary mitigatory steps. Directors can expect social and regulatory pressure, which can result in costly investigations and litigation. Failure to adapt to environmental risk factors by directors can also lead to breaches of statutory or fiduciary duties.

5 **Event driven litigation** - Event-based litigation can and does occur for a variety of other reasons, including catastrophic loss or reputational damage. While more closely associated with the United States and Europe, South Africa isn't immune to class action suits, particularly with a growing propensity towards litigiousness. Defending these claims is a lengthy and very costly process, underscoring the value of appropriate insurance. At the same time, and as mentioned previously, insurers must price these policies appropriately in the interests of sustainability.

6 **Bribery and corruption** - King IV brings with it increased transparency, and with that, companies will be expected to adapt their practices accordingly. Directors are liable for corrupt actions and are responsible for creating and maintaining controls that guide operations. Already a major source of D&O claims, and again with the premise that everyone is presumed innocent until proven guilty, cover is both necessary but increasingly costly as insurers balance premium income against the cost of claims.

The importance of D&O insurance

The increase in risk exposure, coupled with the steady rise in claims, brings into focus the importance of having D&O insurance.

Javesh Ramcharan
Senior Underwriter
– D&O/Crime/FI
AIG South Africa

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RECENT CASE LAW ON DISCLAIMERS

The reliance on disclaimers is like a revolving Mobius strip of people who think they have worded and displayed the perfect disclaimer, with courts that tell them they have not.

Here is an example of *Osman Tyres and Spares CC & Another versus ADT Security (Pty) Ltd,* which related to failed security services.

Gross negligence is different

In terms of the Private Security Industry Regulation Act of 2001, a security service provider is not entitled to contract out of "any malicious, intentional, fraudulent, reckless or grossly negligent act or omission".

The courts now accept that gross negligence is different and separate, and distinct from negligence. Whether an act or omission is negligent or grossly negligent, is a question of fact.

A court will not decide on the issue of gross negligence until all the evidence is revealed. In this case, an alarm had been activated repeatedly, on at least four separate and distinct times within a short period of 18 minutes, without any reaction to the activations by the security service provider.

Where a party like the defendant wants to be absolved from an obligation or liability that would otherwise arise, it is for that party to ensure that the extent to which they are to be absolved is plainly spelt out.

Despite this, the court found that the exclusionary clauses were not ambiguous. They clearly stated that, whilst the security service provider would exercise reasonable care, it gave no guarantee. The contract provided that was not an alternative to insurance and that the security service provider was not liable to the customer for any damage or loss incurred. As the claimant had failed to prove gross negligence, no liability was found.

A disclaimer notice

In the *Stearns versus Robispec (Pty) Ltd* case, a retail store tried to rely on a disclaimer notice at the entry to the store, to escape liability for injury to a shopper caused by their negligence.

The disclaimer notice at the entrance made it plain that the defendant was not liable for any loss, damage or injury sustained by anyone on its premises.

CPD article

The claimant denied having seen the notice, although he conceded that such notices in stores are common. The onus was on the defendant shop owner to show that the claimant was bound. Although the notice was prominently displayed, the court found that the notice did not make it obvious that it was a disclaimer.

There were two headings in larger script on the notice containing the disclaimer, one stating 'trading hours' and the other heading stating 'right of admission reserved'. The disclaimer was not distinguished by a heading which would have drawn attention to it, and the script was smaller than the rest of script. A disclaimer should be pertinently brought to the attention of a customer, and not by way of an inconspicuous clause. The court refused to allow the shop owner to rely on the disclaimer and granted damages to the claimant.

In the absence of any warning

Similarly, a disclaimer should not be tucked away in a document, which deals with other things. In an October 2021 judgment, *UPS SCS South Africa (Pty) Ltd versus van Wyk t/a Skydive Mossel Bay*, the exemption from liability for loss or damage was contained in a credit application.

The credit application was signed by the claimant, not because he wanted credit, but to be allocated an account number which he was told was required for cross-border shipments. The disclaimer in the standard trading conditions in the credit application was not binding on the claimant, because the clauses appeared in fine print and were not conspicuously legible. They appeared on the second and third pages of the credit application, which could only be read with extreme difficulty and concentrated effort. The courier company had not explained to the customer that the credit application included an exclusion of liability for loss or damage.

Conditions in a contract which undermine the very essence of the contract must be clearly and pertinently brought to the attention of the customer who signs a standard form. The claimant succeeded.

In another October 2021 judgment, *Pick 'n Pay Retailers versus Pillay,* the plaintiff successfully claimed for personal injury sustained when the vehicle boom at the car park operated and descended on her, causing injury while she was walking through the motor exit with her trolley. The shop owner conceded that shoppers with trolleys usually walked on the same section of the road where the boom was in operation. A sign which read "caution boom overhead" was not erected at the time the claimant was injured. It had been erected because of another incident prior to the event, for which damages were claimed. In the absence of any warning at all, despite knowledge of the risk of the boom hitting shoppers, liability was found.

In the *Cooper versus Shamwari Hospitality (Pty) Limited* case, the owners of a game reserve escaped liability for an injury suffered by a guest who, upon returning from a game drive after dark and walking to the restaurant, stepped into the swimming pool and fractured her right leg. The claimant relied on Section 48 of the Consumer Protection Act, which states that a term or condition of a transaction or agreement is unfair, unreasonable or unjust if it is excessively one-sided or the terms are so adverse as to be inequitable. In this case, the claimant was bound by the standard form of guest indemnity which exempted the owners from liability for injuries. The court held that the indemnity was neither ambiguous nor unreasonable and the claimant had signed it voluntarily.

In this case, the claimant had prior knowledge of the position of the swimming pool adjacent to the deck. The pool was not a risk of unusual character that obliged the owners to provide a special warning as required by the Consumer Protection Act.

Disclaimer of liability

To sum up it up, an unambiguous disclaimer of liability, even for gross negligence, will be upheld if the disclaimer is clearly brought to the attention of the customer in a situation where the customer has a choice whether or not to contract on the basis of the exemption from liability. Where the notice excludes negligence but not specifically gross negligence, it may be difficult to prove that there was gross negligence or recklessness on the part of the service provider.

Patrick Bracher
Director
Norton Rose Fulbright
South Africa Inc

MICROINSURANCE HURDLES

The Insurance Act No. 19 of 2017 introduced Microinsurance, and after four years of teaching, it started to bother me… I questioned where it is? Why are insurers not jumping at the opportunity? What is the hold up? Why are there only a few micro insurers registered in South Africa? Why have we not heard of them yet?

Ideal way to expand footprints

The products that one can offer are only limited by one's imagination. The socio-economic good it can do is endless. Microinsurance needs to be inexpensive, accessible and easily understood, and it can positively impact so many people's lives. With microinsurance one can offer products of up to R100 000 in the life sector, R300 000 in the non-life market and even reinsurance.

In South Africa and Africa for that matter, there is such a low insurance penetration that this is the ideal way to expand footprints.

So, what is the hold up?

After a few discussions with various stakeholders, the answers became apparent:

1 **The unknown** - As with all new insurance products being introduced, there is always the risk of the unknown. How will the product be priced? The actuaries have no historical data to work off of in combination with other regulation which limits the excess payable to a maximum of R1000. And if priced too high, then point two will not become a reality.

2 **Critical mass needed** - Since we are talking about microinsurance, the premiums will also be relatively small. The next consideration would then be on how to get the premiums collected. There are various options like cellphone bill collections, partnering with retail outlets or even payroll deductions from employees' salaries. The only way to ensure profits are made is to ensure critical mass, as one claim can have a huge impact on the insurer's balance sheet, which brings us to point three.

3 **Capital outlay** - There will have to be huge capital outlay to start off with, not only the minimum of R4 million capital required, as per the regulations, but also a huge marketing expense - mostly the Insurtech and human capital that will be needed to adhere to some of the other requirements that will be discussed in point four.

4 **Claim payments** - Microinsurance regulations state that claims need to be finalised within two business days, after all the required documents have been received. This will require a highly advanced system, impeccable processes and a large human capital compliment.

5 **Reinsurance** - There are also strict regulations regarding the reinsurance placed on a microinsurance portfolio that state that a micro insurer may not reinsure more than 75% of premiums to one insurer or reinsurer. They may also not retrocede, or in other words arrange a second reinsurance for incoming reinsurance for microinsurance of more than 75% of premiums.

6 **Economy at large** - With the dismal state of South Africa's economy, however, if you can get all of the above in place, with inflation, high petrol prices, poverty and high unemployment, will it truly be economically viable?

The answer to a lot of problems

I do believe that if sufficient research, cooperation, time and a lot of capital is brought together, that microinsurance can be the answer, and in time, even profit. It will be able to assist with unemployment, and more importantly, youth unemployment as commission is uncapped (except for credit life microinsurance).

As one of my interviewees noted, I am a social capitalist because I truly believe that if we overcome all the drawbacks and bond together for the common good, microinsurance might just be the answer to a lot of problems, except maybe the high petrol price.

Marisa Grundling
Programme Coordinator:
Short Term Insurance
Milpark Education

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CPD article

THE ETHICAL COMPASS

for evolving policy wording

At its core, insurance exists to support the financial resilience of the insured through risk transfer. It aims to return customers to the position they were in, prior to the insured event taking place - providing much-needed peace of mind.

However, such protection will always depend on various factors, and the reality is that any policy agreement cannot cover every eventuality.

The narrative

While the narrative around "fine print" is something that largely enjoys shared cynicism, it has been fuelled since the onset of the pandemic – particularly for insurance.

Considering the legal requirements in terms of the policy wording, these have obvious historical reasons – many informed by legal precedents. However, for the insured, what can breed discontent is misinterpretations stemming from a lack of understanding of the:

- Types of risks they may or may not have covers for;
- Limit of cover for such risks; and
- Prevailing conditions applicable for such covers to be triggered.

Legal (un)certainty

The unprecedented, evolving nature of both the pandemic and the responses of global governments became a publicly played out a litmus test for the policy wording. Could this have been avoided with clarity presented more simply?

The short answer is, no.

There are numerous lessons but, more so, critical and empowering practices that have been reaffirmed. These include:

1 **Plain language** - While specific legal terminology is required in any contract, what's been hugely empowering for customers is the accelerated shift towards "plain language". This remains imperative in facilitating ease of understanding to provide greater certainty for contracting parties and deliver fair outcomes. The increased importance of clearly articulating agreements, highlighting key information, terms and conditions, providing a complete view of specific covers, and ensuring effective understanding of exclusions - before customers sign on the dotted line - has been cemented. Ultimately, ensuring that all stakeholders are of the same understanding will only help reduce the scope for ambiguities or misinterpretations at claims stage and nurture the relationship of trust.

2 **Regular reviews** - The importance of insurers and intermediaries regularly engaging with policyholders to establish changes to their risk profiles; ensure necessary policy reviews and adjustments are being made; and create awareness of new risk management solutions that better address customer needs; has just been strengthened by the pandemic.

3 **Responsive risk management offerings** - While the pandemic and its effects could not have been anticipated, it has prompted the more robust and responsive development of products, services and solutions to address foreseeable threats and pre-empt changes to customer risk profiles. It also facilitates a more sustainable, relevant value proposition that fosters relationships between the insured, insurer and the intermediary.

Staying true to purpose

The insurance industry exists to serve a critical social and economic need - a purpose that must remain the foundation that informs all decision-making. With emphasis on building enduring partnerships, nurturing relationships of trust and ensuring continued transparency.

Accordingly, all changes must aim to offer clarity to all parties and serve the best interests of the collective. As insurers and intermediaries, our emphasis on fairness, transparency and customer service excellence must be unwavering. We also have a responsibility to ensure full alignment to the principles of Treating Customers Fairly (TCF), maintaining the highest ethical standards. By doing so, any question around fairness becomes irrelevant.

Sedick Isaacs
Head of Business Support Services
Bryte Insurance


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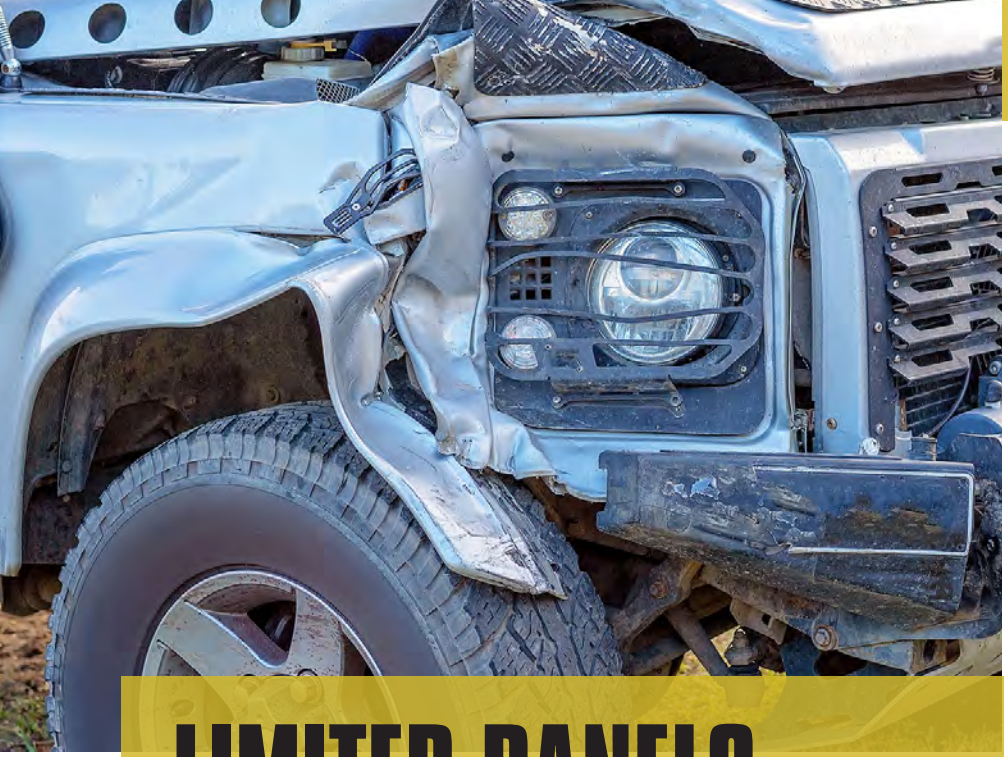

LIMITED PANELS... frustrating for brokers and loss adjusters?

Many insurers have preferred suppliers of repair and services; some are very restrictive, and some insurers give brokers and loss adjusters free reign to use whomever they want. With panels being historic and limited, some brokers and loss adjusters have voiced that this is "frustrating".

FAnews spoke to **Duma Nongauza, Head of Corporate Procurement at Old Mutual Insure** and **Anton Ossip, Chief Executive Officer of Discovery Insure** about this.

The concept of panels is evolving

"The guidelines for competition in the South African Automotive After-market were introduced by the Competition Commission as of June this year, aimed at transforming evergreen contracts in the insurance industry so that panels are more diverse, affording more opportunities to historically disadvantaged individuals," said Ossip.

Nongauza added that, "With the rapid development of technology, especially of Big Data and Artificial Intelligence (AI), the concept of panels is evolving."

"We are continuously trying to leverage technology to improve our spend direction tools to ensure that artificial barriers for entry are removed and work allocation is based on actual data and performance. In this regard, we always champion suppliers that provide superior service, cost effectiveness to customers and those with strong BEE credentials to enable transformation in our value chain," continued Nongauza.

Service providers and costs

"There is various criteria that needs to be considered when selecting a repairer for an accident damaged vehicle, for example does the repairer have the appropriate tools and machinery coupled with the skill sets to ensure the vehicle is repaired according to the required standards. What type of warranties will be given to the insured post repair? By using that service provider contracted to an insurance house this ensures that the risk to the insured is limited, if not eliminated completely," emphasised Nongauza.

"Ultimately, with any insurance claim, the insured remains the most important party. Customer satisfaction remains and needs to remain the focus in any claims process We have to acknowledge that the freedom to select any service provider may have a dual effect; while it can create ease of use, it can also impact the final cost to the claim and ultimately the insured via their premiums. With the introduction of spend direction and data analysis findings by OMI, a balance between ease of use and final cost is becoming easier," added Nongauza.

Ossip said, "Due to negotiations with our service providers, insurers like ourselves can manage the costs of repairs through rebates and negotiated rates, which provide savings to our clients. These help us to keep premiums as low as possible, as well as ensuring the uniformity, consistency, and excellence of the service we provide."

"As a responsible business, we certainly would advocate for our customers to have a choice in terms of supplier selection. At the same time, we have a responsibility to ensure the selected supplier has the right tools, kit and equipment to ensure that the repair is completed to the standards and levels that we would like in order to ensure that the process is fair to the customer. In this regard, if we can ascertain the standard of repairs that the service provider can deliver, OMI would ensure that these service providers are also included into our value chain," emphasised Nongauza.

Mutually beneficial outcomes

"The strict use of the panel system by some insurers might create barriers for entry. As OMI, we believe that direction of spend should be based on the service providers performance aligned with our strategy and legislative requirements," said Nongauza.

"The insurance market is a market that is dependent on all stakeholders in the value chain and ensuring concerns are addressed strengthens the value proposition ultimately to the insured and the future insured. We are working hard to ensure that as we build and deliver new solutions into the market that we test and engage with our brokers to ensure we achieve mutually beneficial outcomes for all," concluded Nongauza.

Myra Knoesen
FAnews Journalist

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Sustainable investing, depicted by some as a trade-off between profit and worldly ideals, is increasingly demonstrating that the profit part of the equation is becoming the more convincing of the two competing arguments.

SUSTAINABLE STOCKS gain positive sentiment

This is not to say that investing in a sustainable stock will always yield higher returns, but it does suggest that there is less of a trade-off between maximising yield and investing in sustainable stocks.

Responsible investing

According to a report by investment bank Morgan Stanley, during the market volatility brought on by the onset of the Coronavirus pandemic, companies that focused on Environmental, Social and Governance (ESG) factors weathered the year better than their non-ESG peers.

In the report, more than 3 000 US mutual and exchange-traded funds showed that sustainable equity funds outperformed their traditional peers by a median total return of 4.3 percent in 2020.

A longer time horizon shows similar findings according to the report. For the full year of 2019, sustainable equity funds outpaced traditional peer funds by a median of 2.8 percentage points.

A number of factors

"There are an increasing number of studies in the market proving that the performance of investments using an ESG framework are on par and sometimes better than traditional agnostic investing," said Famida Singh, Liberty's Divisional Executive for Retail Investment Propositions.

"A number of factors influence this. The consideration of ESG and the desire for long-term sustainability are at the forefront of many quality businesses globally. These companies have adopted and invested in sustainability drives to contribute to positive socio-economic benefits and positive impacts on climate. These companies have aligned their business models and sustainable investment philosophies and are delivering quality returns to shareholders," she added.

"This rise in awareness has been driven by a number of factors including increased legislation and the ongoing heightening of awareness and action from investors, asset owners and managers, industry bodies and other stakeholders. And the worldwide need to address climate change is obviously another factor," added Jeanne Fourie, Liberty Lead Specialist for Sustainability.

"Screening of investments for exposure to specific factors such as child labour or illegal practices may lead to the exclusion of certain investments and many fund managers will now include a list of exclusions as part of their process. Some funds will go as far as explicitly outlining these exclusions in the fund mandate or objective," said Fourie.

Guide investors through complexity

Singh believes investors should look at ESG with a long-term lens. "We think the companies of the future are the ones that are taking care to protect the future."
An example of this is one insurer's Structured Global Performer ESG V1 portfolio that tracks the MSCI Global Diversified ESG 100 Decrement 5% Index for local investors who feel that companies which adhere to sustainable environmental, social and governance principles make a worthy investment opportunity.

It is a structured portfolio where if the change in the value of the basket is positive at maturity date (after adjusting for tax), but less than 12%* p.a., the client will receive the full 12% p.a. nett of tax and fees. If the change in the basket at maturity date is more than 12%* p.a, then the client receives the full growth (adjusted for tax) of the basket.

If there is no change or where the basket of underlying indices drops by less than 30% at the maturity date, then the client receives their full invested amount invested in the structured portfolio back. If the return drops by more than 30% at the maturity date, then the capital protection falls away and the client receives the return on the basket. All returns are net of fees and taxes and are denominated in Rands.

Investors are currently faced with many complex solutions in the market, and in some cases, it is difficult to make an assessment of what the right choice is. It is critical that financial advisers guide investors through this complexity.

Famida Singh
Divisional Executive
Retail Investment
Propositions
Liberty

Jeanne Fourie
Lead Specialist for
Sustainability
Liberty

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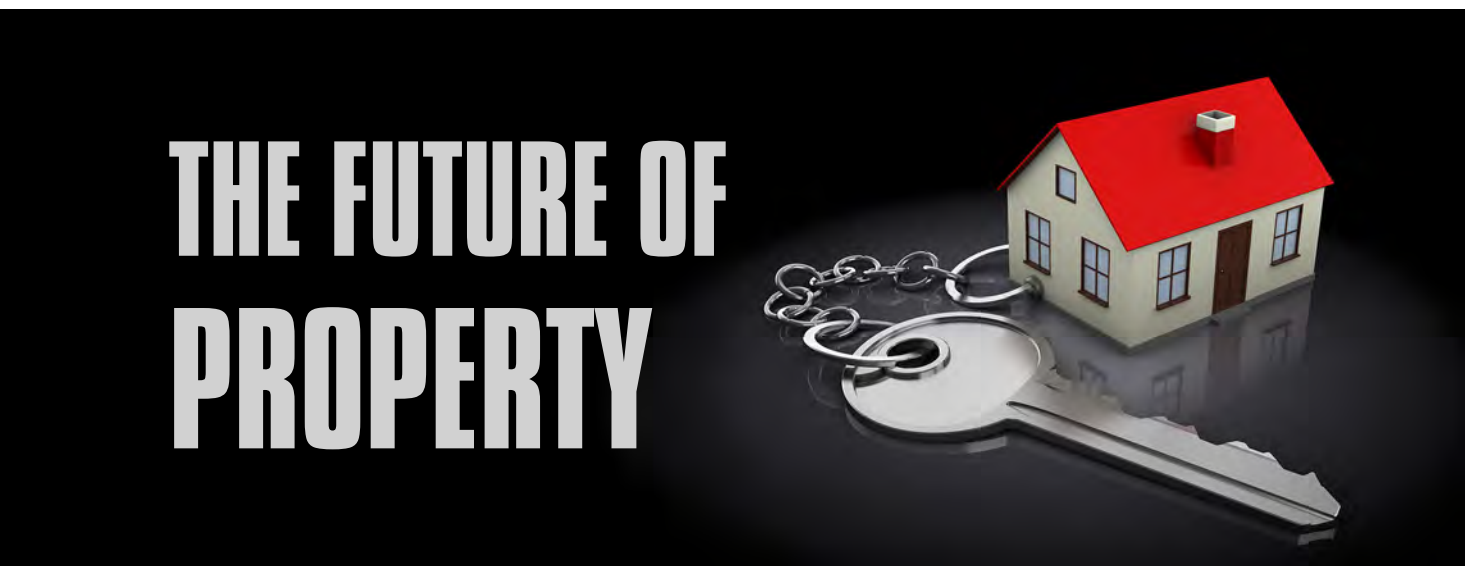

From equity investments to fixed-income solutions, the pandemic has impacted almost every asset class.

But even with the world having been turned upside down over the last 18 months, the fundamentals of property and its overall value proposition remain unmoved.

Significant future growth

The disappointing returns of REITs (Real Estate Investment Trusts) and listed property over this period has arguably had the biggest impact on the perception of property investments. But this is just one type of solution within this asset class, and their current returns aren't uncharacteristic as they have always played puppet to a variety of factors that affect their performance.

The real issue with these types of investments is the influence of market sentiment diverging from the fundamental cash generation valuation of the underlying properties. There is no denying the pandemic's impact on the property sector, but this period has also revealed the robust nature of property and bolstered the track record and credibility of certain vehicles. And now, there is the expectation amongst property experts that the market will recover and investing at a low point has the potential for significant future growth.

There are always learnings from the past that can help us navigate the present. These historic events, if analysed correctly, can reveal comparative reasons behind market movements, including the speed of recovery, and can help us forecast returns as well as strategically position investment portfolios. Much like other notorious events, COVID-19 will see a recovery curve with an array of opportunities for those who understand the market.

Inflation beating income yields

Financial providers with the requisite property experience can offer investors sustainable inflation-beating income yields and capital preservation. The full spectrum of property-related services offers a myriad of investment opportunities, from financial services to non-financial needs fulfilment. It greatly benefits investors and the value of these assets when a provider can effectively leverage the entire landscape.

Debt instruments, for example, have the potential to offer a secure yet promising return. Unlike direct property investments, the various layers of property finance, from senior and subordinated debt to preference share investments, make returns more tangible, predictable, and secure, suiting most investors' risk appetite.

The fundamentals of property, being location, long and strong tenant relationships, expert property management, and the opportunities presented by development projects, will remain relevant in a post COVID world. Debt instruments have offered investors viable returns during this period, while property trends like that of convenience retail have only been accelerated in this new normal. Commercial property has been affected by the remote working reality; however, these investments still have the potential to offer a space for productivity, collaboration, short-term leases, or even residential redevelopment.

Lucrative investments to clients

An in-depth understanding of the trends affecting this industry, the nuances, and opportunities within the various sub-sectors of the market will ensure that providers continue to bring lucrative property investments to their clients.

Adding value in this environment will mean building capabilities across the entire value chain, from utilities management to solar solutions, in a country bedevilled by load shedding, to understanding and utilising the data provided by tenants and investing in an innovative agile approach. A cohesive ecosystem of property-related capabilities has the potential to create unique opportunities for property investors while ensuring property owners bolster the value of their assets.

It is true that the property industry can be complex, with its own particular risks. Now it is even more important for investors to access appropriate professional financial advice to help them get the most out of this asset class. Financial advisers should be looking to partner with property investment providers who are able to unlock this value.

Property is an age-old asset that has been around for millennia, and with the right expertise, partnerships, and mindset its robust and tangible nature will continue to add value in investment portfolios for years to come.

Sheldon Friedericksen
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GLOBAL INVESTING in the time of increased risk

As tempting as it may be to take a more aggressive stance in China, at today's valuations, we are increasingly mindful of the risks. We don't have the luxury of investing in a vacuum.

However, our job is to rationally assess – and seek out – attractive risk based on research and to remain disciplined during uncomfortable periods. This sounds easy on paper, but never feels that way at the time.

Compelling long-term value

Leaving political risk aside, the Chinese equities look extremely compelling and are trading well below our assessment of their intrinsic value.

At 9% of the Orbis Global Equity Fund (the Fund), as of 30 September, which includes Naspers, we believe our position sizing in China is appropriate in light of the risks. We remain enthusiastic about our selected holdings in the area, the largest of which is NetEase. As painful as the escalating geopolitical and regulatory developments have been, it is worth remembering that leaning into political risk has also worked in our favour: on the eve of the 2020 US presidential election, our holdings in managed care organisations (MCOs) such as UnitedHealth Group and Anthem were uniquely sensitive to political risk.

We first bought into the MCOs in 2008, amid fears about "Obamacare", and were presented with another opportunity when Bernie Sanders proposed "Medicare for All" in the 2020 presidential campaign. The doomsday scenario is always the same – that the MCOs will be put out of business by a nationalised healthcare model – but the pandemic also brought fresh fears of a surge in COVID-19-related claims.

Since President Biden took office, he has not made any notable moves in healthcare. We continue to believe that the services of UnitedHealth and Anthem will be in even greater demand in the future, as the US tries to provide better healthcare to an ageing and growing population at a manageable cost. We fully expect their share prices to remain volatile, but we continue to believe that they offer compelling long-term value.

Performance in the future

Importantly, UnitedHealth and Anthem have nothing to fear from Chinese regulators, just as NetEase will never need to care about US healthcare policy. From a fundamental perspective, these businesses are completely uncorrelated. When we assemble a whole portfolio of opportunities like this, we end up with a collection that is truly differentiated.

Historically, our analysis shows that less than half of the fund's long-term relative performance can be attributable to its factor exposures. Trying to mimic the factor exposures of the fund would have beaten the World Index – an impressive feat – but you would have been unable to replicate the performance of the fund over its history. Only time will tell if our current selections can repeat this performance in the future. We are optimistic.

For better or worse

We focus on the risk/reward proposition of each individual investment opportunity, and for better or worse, we expect this approach to produce a pattern of relative returns that is uniquely our own. Some of the biggest winners in the history of the Orbis Funds – XPO Logistics, NetEase, and Samsung Electronics to name a few – made us look foolish on more than a few occasions before ultimately living up to their fundamentals. We can't help feeling the same way about a lot of our holdings today.

When compared to the averages of their World Index peers, the companies held in the Fund are growing faster and yet trade at significantly lower valuations. That's pretty exciting – especially at a time when one can easily pay more than 50 times revenue for an unproven software business or US$1 million for a digital picture of a rock.

John Christy
Orbis

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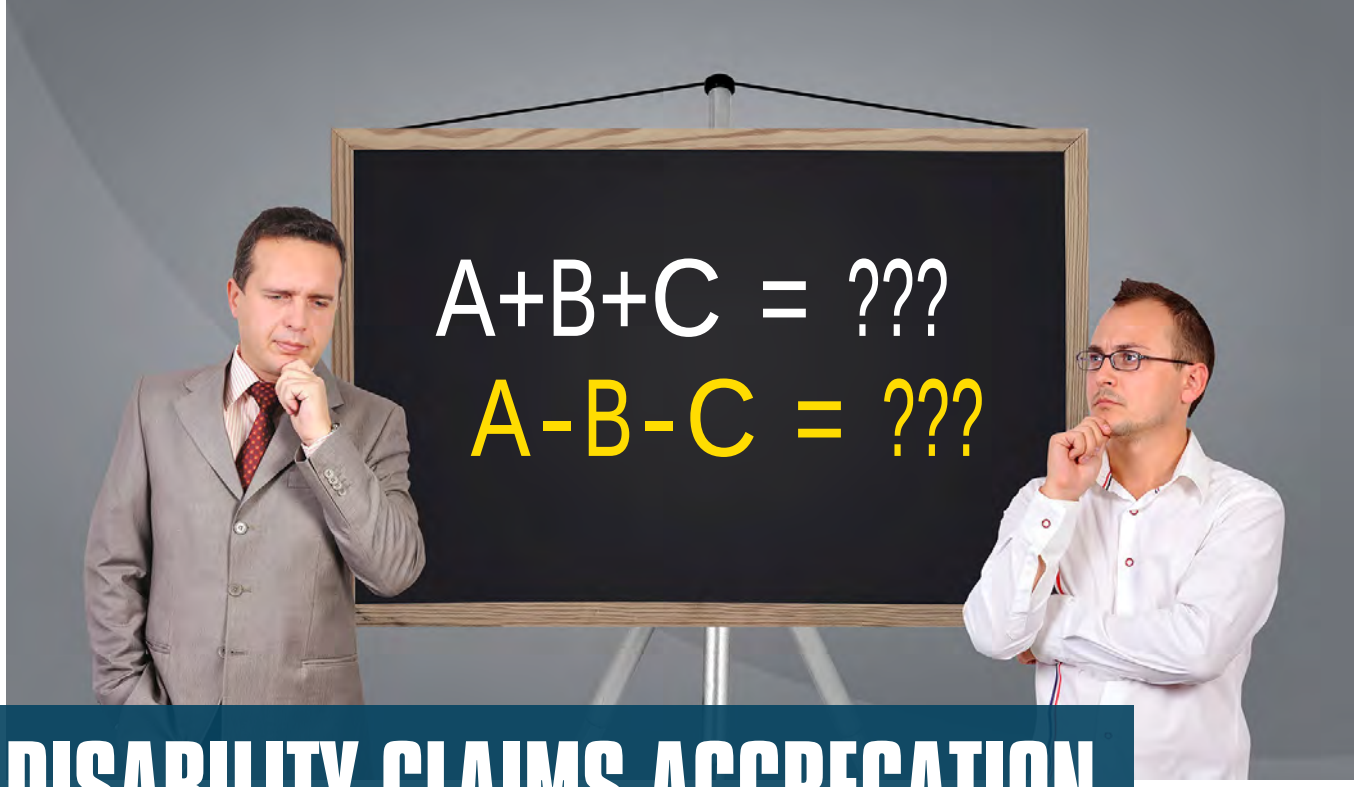


DISABILITY CLAIMS AGGREGATION

In part one of this series (published in the October edition), I discussed the purpose of disability insurance, disability limits and practices for aggregation of benefits, and the position of major insurers on aggregation.

In this article, I attempt to provide practical examples and more clarity on the major insurers' approach to aggregation.

Taking aggregation into account

Important note: Net (after tax) active income (income the client is working for) should be insured. Net income is used because claims payments on income protection are no longer taxable. Passive income should continue, irrespective of the client's ability to work, and should not be insured.

There are different scenarios where aggregation (limitation) of Disability Lump Sum and/ or Income Protection may occur:

1. At application and underwriting stage;
2. When a benefit/s is increased; or
3. At claims stage.

Most (not all) insurers will aggregate against benefits the client may have with other insurers.

Most (not all) will aggregate against active income the client may still receive whilst in claim.

The prudent financial planner should exercise due care, skill, and diligence when it comes to taking aggregation into account and advise his / her clients accordingly.

Increasingly, clients are engaging in more than one active income generating activity. Advisers should consider and recommend disability benefits which are not aggregated against active income the client may still receive whilst in claim.

Some practical examples

Here are some practical examples and more clarity on the major insurers' approach to aggregation.

PPS:

A client, for example, has RX cover with company A, and RY cover with PPS (Lump Sum and/or Income Protection).

1. PPS will not aggregate (reduce the claim) against any active income the client still generates during temporary illness or permanent disability.
2. If the client first claims from company A, PPS will not aggregate, but company A will possibly aggregate against PPS.
3. If the client first claims from PPS, PPS will not aggregate against company A's cover.

BrightRock:

BrightRock will not aggregate against active income. For example, if a client is insured for R30 000 Income Protection per month and he/she still earns a total of R10 000 active income during a claim, BrightRock will pay the full sum insured of R30 000 and not R30 000 minus R10 000 = R20 000.

Furthermore, if proof of income was submitted at underwriting stage, BrightRock will not call for it again. To place this in context, this is very relevant to the COVID period we are facing, where a lot of clients have lost a portion of their income. If a client submitted proof of income at underwriting stage and, for example, lost half of their income during this pandemic, Brightrock will still pay out the proof of income that was submitted at underwriting stage.

Momentum:

Momentum will pay the actual loss of income, up to the maximum of the benefit amount. Actual loss of income is calculated as being the difference between the client's pre-disability income and any income that the client earns during disability. However, if the disability is total and permanent, and a Permanent Disability Enhancer Benefit was added to their Complete Income Protector Benefit, the client will qualify for a Permanent Disability Enhancer Benefit pay-out. This means that they can elect to have a part, or all the income, commuted as a lump sum pay-out. If the client decides to rather keep on receiving an income (full or partial), the future income will not be aggregated against other income after a claim was admitted.

At new business application stage, the client must state what existing insurance he/she has. Momentum's underwriting then provides the lump sum and or income protector, considering that he/she already has cover elsewhere (financial underwriting) and may limit benefits.

If the client now takes out cover from another company after this and doesn't disclose to that company that he/she already has cover with Momentum (and elsewhere), that company can repudiate or limit a claim payment.

In other words, it's not about where the client first claims. The principle is that a client should never be in a better position during disability than pre disability. Disability cover should put the client in the same position he / she would be in if he / she was not disabled. This is a long-term insurance principle which applies to all companies.

Old Mutual:

Claim aggregation is done on income benefits, not lump sum amount benefits. Lump sum benefit aggregation is only done at underwriting stage.

For income protection claims one of the steps is to determine whether the client also has other Income Protection benefits with other companies. If so, it becomes a conversation with the other companies. Different factors are then considered:

1. Waiting periods of other benefits.
2. Cover amounts at other companies, and what the total is, compared to the client's average before disability income.
3. Average income before the customer became disabled.

Should the client's cover between all the companies be less than his /her average before disability income, all the companies where he/she holds benefits should pay out in full, according to the product's definition and requirements.

Should the client's cover be more than his/her pre-disability income, then the companies will agree to each pay pro-rata to prevent enrichment.

So, the companies try to bear the burden together if a client is insured with more than one company.

The same process applies if the client has products with different waiting periods. It may, therefore, happen that the company with the shortest waiting period reduces its payment when the other products with longer waiting periods start paying. Again, a conversation between the companies will take place. However, not all companies always adhere to the above "agreement" between companies.

Hollard:

For the most part, they aggregate against active income unless any passive income was a main source of income prior to incapacity. Hollard will aggregate against other companies' cover.

Sanlam:

When calculating the amount to pay for a claim, the client's other forms of income will be considered. The total claim payment one can get will let a client have the same income he/she earned before the claim, but not more than what he/she earned. In other words, Sanlam will aggregate against active income during the claim and other companies' cover the client may have.

Liberty:

Aggregation against active income and other insurers' benefits applies. In other words, Liberty will reduce (aggregate) claim benefits against active income whilst in claim and against cover with other companies.

FMI:

Claim payments may be reduced by:

1. Payments from other income benefits that pay out when the life insured is unable to perform their own occupation due to illness or injury. In other words, FMI will aggregate against other companies' benefits.
2. Compensation schemes (whether for loss of income or not).
3. If the life insured is claiming under the Occupational Disability criterion, any income derived through the life insured's participation in income generating activities. This includes income that was generated before the claim, which the life insured receives during the Extended Income Claim Protector claim period (in other words, FMI does aggregate against active income).
4. Sick leave payments.

Discovery:

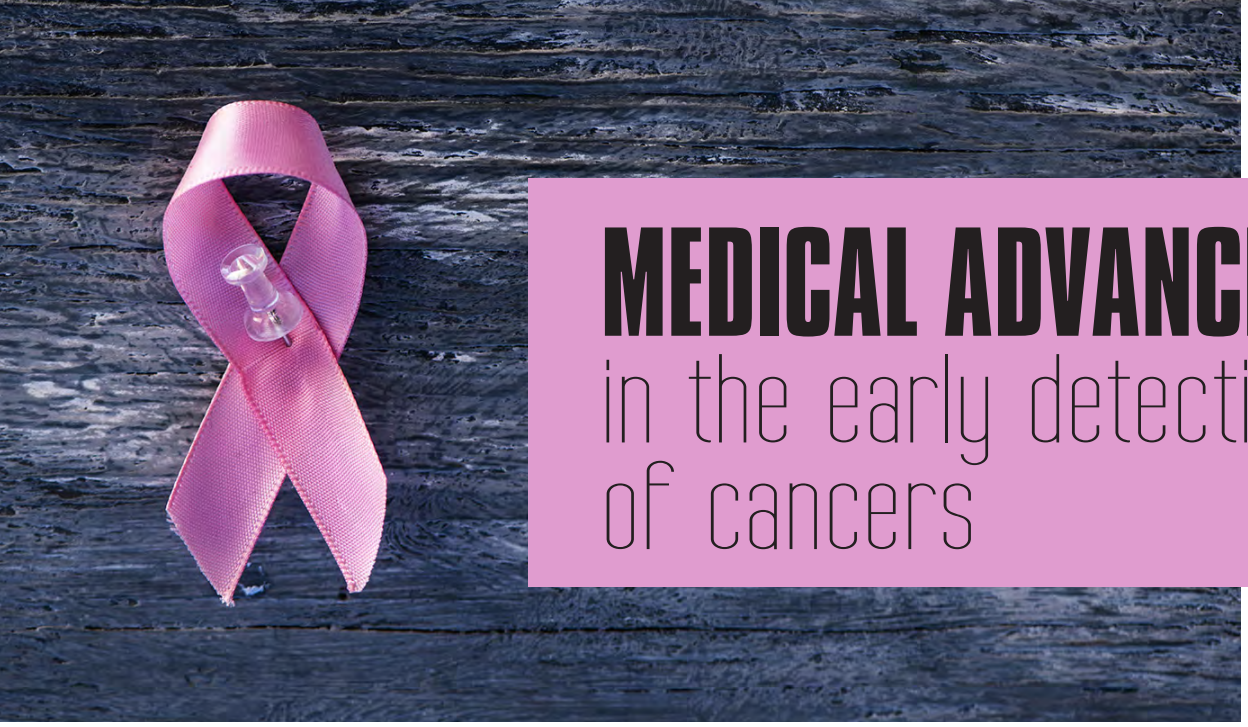
Discovery Life will not aggregate against income still generated while disabled (active income), unless the client qualified for a claim under the loss of income underpin or Category D (occupational disability) underpin. On the Essential ICB, however, both Category A and D claims will be aggregated against income. Discovery will aggregate against cover with other companies.

A side note

Please note that the author took every care in researching and requesting from each insurer their position on aggregation of disability benefits, which proved to be cumbersome. However, errors and omissions are excepted.

Anton Schutte
General Manager and Financial Planner
PWG Group

For insight into Income Protection, Critical Illness and Disability products, download our digital edition where we tackle the complexities surrounding this by scanning the QR code above.



MEDICAL ADVANCES in the early detection of cancers

National Breast Cancer Awareness month (October) once again highlighted the importance of early cancer diagnosis and treatment.

According to the International Agency for Research on Cancer, this disease remains the leading cause of death worldwide, with an estimated 19.3 million new cancer cases and almost 10 million cancer deaths during 2020.

Diagnosing cancer in late stages, and the inability to provide treatment, condemns many people to unnecessary suffering and early death. This is why early detection and treatment of cancer continues to be a high priority in the global medical research community.

Slowly winning ground

When a suspicious lump or relative symptoms are experienced by a patient, a doctor may perform a tissue biopsy, where cells are collected for closer examination. The next step involves examining the cells, to determine if cancer is in fact present and to identify the type of cancer and the subsequent prognosis of the patient.

The National Cancer Institute (NCI) states that although this approach is important for patient care, it can be invasive, very painful, risky and very costly. Also, some patients may not be able to undergo this procedure due to the inaccessibility of their tumors. Therefore, researchers have been exploring a new approach that could possibly serve as an alternative to tissue biopsies.

This is called a liquid biopsy, which relies on analysing samples of tumor material; molecules as well as whole cells that are found in the body fluids such as blood or urine.

Alternative to tissue biopsies

According to the NCI, scientists discovered more than 100 years ago that tumors shed molecules and cells into the body fluids. More recently, researchers were able to demonstrate that analysing these molecules and cells, by way of a liquid biopsy, have the potential to reveal some of the same information that tissue biopsies provide.

Industry researchers and academics from various specialised areas are working on many fronts to develop and refine clinical uses of liquid biopsy tests. Therefore, different liquid biopsy tests can analyse different kinds of tumor material which could include DNA (provides the code for the cell's activities) and RNA (converts that code into proteins to carry out cellular functions) and entire cells.

The positive aspect of this is the fact that bodily fluids are usually easier to access and, in most cases, the procedure to collect the samples is much less invasive and can be repeated more easily than a tissue biopsy. This opens up the possibility to use liquid biopsies for several important applications.

According to Miguel Ossandon, Programme Manager for the Cancer Diagnosis Programme at the NCI, "Liquid biopsies could be used to monitor cancer development, track a patient's response to treatment, or as a 'surveillance' method for people who have completed treatment but are at high risk of their disease returning." Other experts note that although liquid biopsies have tremendous potential to diagnose cancer in early stages, there is still a long way to go with regard to refining the science and application of the procedure. Looking forward, they envisage that liquid biopsy tests may be used to screen for early-stage cancers in high-risk individuals, such as those with hereditary cancer syndromes.

Smart choices

Rapid advances on the medical and technological front make it possible to treat and cure previously 'life-threatening' diseases such as cancer.

We have seen the treatments for cancer evolve from a 'one-size-fits-all' approach to a highly sophisticated personalised approach that aims to target the characteristics of each tumor and get the best possible outcome for each individual. However, this can only happen if clients have access to cutting-edge treatments.

In our experience, there are two things that clients are looking for when it comes to Critical Illness cover. Firstly, access to the most comprehensive cover and, secondly, an affordable price tag. Affordable, comprehensive Critical Illness cover is available and should therefore be a non-negotiable for your clients.

George Kolbe
Head of Marketing for Life Insurance
Momentum

https://pubmed.ncbi.nlm.nih.gov/33538338/
https://www.cancer.gov/news-events/cancer-currents-blog/2017/liquid-biopsy-detects-treats-cancer

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The state of mental health or the lack thereof

"We have all endured some level of loss or trauma in our lives, especially during the COVID-19 pandemic. Therefore, we need to actively 'check in' on our mental state and continuously move our mental health to a positive "mind space", states Jenny Ingram, head of product development for Momentum Retail Life Insurance.

She highlights that "The absence of sickness does not imply wellness and people might be shocked to learn the extent to which mental health claims manifest in Momentum Myriad's claim experience."

She further explains that, "12% of the total amount paid during 2021 for income protection claims have been for conditions related to mental health, or one could say the lack thereof." In some of the more extreme years we have observed that suicides represented as much as 11% of the total death claim payouts."

The invisible disease

The World Health Organisation (WHO) recognises the importance of mental health and defines health as 'a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity'. The fact that World Mental Health Day is observed annually on 10 October clearly indicates the seriousness and scale of mental illness. The global theme for this year's World Mental Health Day was 'Mental health in an unequal world', which depicts South Africa's situation extremely well. According to the South African Depression and Anxiety Group their pre-COVID-19 statistics indicated that one in three citizens will or already suffers from a mental health problem and only one in 10 South Africans who suffer from mental illness actually reach out for help.

According to the WHO, during 2018, 10.7% of the global population suffered from a form of mental illness, which could include drug or alcohol dependency, schizophrenia and/or depression. The Mental Health Foundation in the United Kingdom also notes that untreated mental health problems already account for 13% of the total global burden of disease. They estimate that mental health problems (particularly depression) will be the leading cause of morbidity (number of specific illnesses) and mortality (the number of deaths related to the specific illnesses) in the world by 2030.

Zero gender preference

Jenny states that, "By the time that a mental illness claim meets the claim criteria for an insurance payout, it is already on an extreme scale of illness. This is why it is so important to manage our mental state in order to avoid reaching these extreme stages of illness."

She adds that, "Our claim statistics also indicate that men and women face different challenges when it comes to managing their mental health. In most cases, genders react differently to mental health due to societal norms, stigma and pressure. Women are generally more prone to complete burnout but they are more likely to seek treatment. In contrast, men are very hesitant to seek treatment and more likely to remain silent, which could lead to more extreme outcomes such as suicide."

In a recent media article, the CEO and founder of the MediSpace Lifestyle Institute, Dr. Tshidi Gule remarked that, "There is mounting evidence that the economic impact of the COVID-19 pandemic is affecting women's mental state much more compared to men." She added that this could be due to women facing more child-care responsibilities, economic uncertainty in unequal paying jobs and gender violence; all being amplified throughout the pandemic. Gule supported this argument by saying that, "Women's jobs are estimated to be 1.8 times more vulnerable during the COVID-19 pandemic than men's, and though women make up 39% of global employment, they account for 54% of overall job losses, mostly in the accommodation and food services industries."

Long-term implications

Jenny remarks that challenging times could have the opposite effect from what Dr. Gule described. According to her, "An extremely challenging period, such as the current pandemic, could result in people actually displaying a lot of resilience and solidarity, which could be the reason why Momentum has not observed an increase in mental health related claims yet."

During 2019 Momentum recorded an extreme year for suicide claims in their individual life insured book but has not observed such extreme levels of suicide claims since then. Jenny adds by saying that "In January 2019, 11% of our income protection claims, which was deemed permanent at the time, were due to psychiatric reasons and during September 2021 that percentage stood at 10%, which means that we have not observed an increase in these types of claims for permanent or long-term claims during, or as a result of, lockdown. A similar trend was visible with our lump sum disability benefit claims where admitted claims as a result of psychiatric problems declined over the last couple of years.

She concludes by saying that, "We are perhaps more worried about the long-term economic impact of COVID-19 and the effects of lockdowns, as we have very clear evidence over the years that economic hardships in the long-term, and a drop in socio-economic status leads to an increase in mental illness diagnoses and therefore to an increase in claims."

PRE-EMPTIVELY managing cancer risks

The big four illnesses (cancer, heart attacks, strokes and coronary artery bypass grafts) contributed to 70% of the illness claims Old Mutual paid in 2020, and cancer was the biggest culprit. The Cancer Association of South Africa says as many as one in every 17 men has a lifetime risk of prostate cancer.

The costs are high, with a 2020 study showing that the average care cost per breast cancer patient in the public sector (Groote Schuur hospital) was R15 774. That excluded the non-medical costs, which could include fuel and transport costs to access medical care, special diets or eating programmes, mental health support and increased household costs.

Stages, cost and risk

Typically, there are four stages when it comes to a severe illness - with different cost implications and different risk cover at different stages.

- **Diagnosis**: This stage is typically covered by medical schemes. This stage includes costly treatment such as Magnetic Resonance Imaging (MRI) scans, angiograms, and electrocardiogram (ECG) tests.
- **Treatment**: A medical scheme plays an even more significant role at this stage, and there is usually a bigger out-of-pocket aspect, which can be addressed with Gap cover. Treatment could typically include bypass surgery, chemotherapy, radiation, and pathway ablation.
- **Recovery**: This is when Severe Illness cover comes to the fore. During the recovery phase, a patient may need to make lifestyle adjustments such as arranging for fulltime childcare, potentially start using a cleaning service, payment towards costs for recovery at home and covering loss of income where long recovery periods are required. It is common for clients to underestimate these expenses and typically, while medical schemes cover clients adequately during diagnosis and treatment, it is at the tail end of the process where Severe Illness cover comes to the fore.

Caregiver

According to Handy Helpers, a full-time caregiver will cost about R4 500 to R7 500 a month, while a part-time caregiver will cost R250 to R400 a day. A housekeeper is likely to cost between R3 000 to R5 500 a month. Remember that post-treatment, it is quite common to need time off work to recuperate fully, and this could translate to lost income.

Peace of mind

COVID-19 has left the world whirling on the brink of uncertainty and change when it comes to the economy, healthcare and even business models.

Taking the time to have a cancer screening can give your clients peace of mind, or an early diagnosis, so they are able to manage their critical illness optimally.

Encourage clients to get checked

Here are ways for advisers to start the conversation with clients about the importance of cancer screenings:

- Medical schemes are keen to reduce their costs, so they cover cancer screenings for patients at risk, or past a certain age.

- According to the National Cancer Registry (NCR), one in four South Africans are affected by cancer. This highlights the importance of having cancer screenings as early and as regularly as possible. Dr Louis Kathan, Head of Life Healthcare Oncology, says the medical industry is anticipating increased cases going forward, as more South Africans postponed their regular mammograms, pap smears and prostate cancer checks on the back of COVID-19 fears.

- Cancer screenings are typically recommended as follows:
  - Breast cancer – annual mammograms for women aged 40 and older.
  - Cervical cancer – pap smears every three years for women aged 21 and older.
  - Prostate cancer – screenings from the age of 40 if there is a family history or annually from the age of 55.
  - Colorectal screenings – annually from the age of 45.
  - Lung cancer – annual screenings from the age of 50 to 80.

John Kotze
Retail Protection
Product Management
Head
Old Mutual

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TO DIVERSIFY OR SPECIALISE?

The world of work has changed, and employees' needs are evolving. Employers need to re-evaluate their employee value proposition, which includes employee benefits, and there is a huge opportunity for financial advisers to tap into employee benefits (EB).

You need to wear many hats

A good place to start is by looking at who of your clients are executives or decision makers around EB, in their companies, and starting a conversation with them around EB. Momentum Corporate's recent research shows that these are usually the Chief Financial Officers and Human Resource Directors.

What worked in the past doesn't necessarily work in this evolving landscape.

Many companies are still offering employee value propositions that worked for previous generations of employees, but no longer work for a modern workforce.

Traditional EB remains core to the employee value proposition, but there's a growing need for a more holistic approach that addresses the needs or stressors that impact not only work engagement levels, but overall wellness for employees.

Also, with businesses fighting to keep going in the current economic climate, leaders are looking at ways to reduce costs, while supporting their employees in ways that will keep them engaged and productive. They don't always think of how EB, which is a component of the employee value proposition, can help them achieve this.

Where to start

By offering to evaluate the evolved needs of a client's business, you can compare that with their existing offering. The employee value proposition and EB mix needs to be more integrated and holistic, taking the whole person needs of employees and their families into account. It's no longer simply about offering a competitive remuneration and benefits package, but rather a proposition that considers work-life balance, work-life fusion, and the health and well-being of employees and their families.

As an example: a business has 50 employees. The average salary is R175 000 a year. The employer contributes 7.5% and the employee contributes 7.5% to retirement savings.

They become part of an umbrella fund - with two lumpsums of death cover and two lumpsums of disability cover. The financial adviser's earning potential is around R49 500 a year, in commission, and about R8 600 in the first year (including VAT).

Licensing requirements and EB providers

The EB industry is highly regulated, with specific licensing requirements. You can just about enter the industry immediately with the licences you already have.

With your existing Long-Term Insurance licence and Short-Term Personal Lines licence, you can automatically sell insurance products to employers who only want to offer their employees insurance benefits, as well as Gap cover products. For retirement benefits or other group benefits such as health solutions, you will need the appropriate additional Pension Funds Benefits and Health Services Benefits licences.

Where you do need specific licences, it is important to partner with a thought-leading provider who can take hands with you to offer appropriate solutions. Some insurers have specialists who can support you to manage the advice requirements. They also provide insights around human needs derived from real data; engagement-rich, evidence-based solutions that combine these insights with innovation and technology to enable you to bring your best advice to life for each unique client; and tailored, flexible solutions.

Recurring income

For as long as the group scheme contract you have with an employer remains in place, you have potential business for life. Once they have the group business, further opportunities arise with the employees as individuals, providing a continuous pipeline of individual leads. Many employees with basic benefits might want to add to their insurance and retirement benefits. This means you can create a full circle of business by turning your individual book into an EB/group book, ultimately attracting more individual business.

In the current economic environment, there is no debate between diversification or specialisation. To grow and sustain your business, the answer is easy – diversify with employee benefits.

Nashalin Portrag
Head of FundsAtWork
Momentum Corporate

momentum
corporate

It's not only about taking care of billions of rands.

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The success of your clients and their employees is our business. That's why we work with you to offer a suite of benefits that best suits the unique needs of your clients' employees. That's also why we make our solutions as flexible as possible, so that when life changes, employees can change their plans along with it.

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CPD article

A TWO-WAY STREET

Employers and employees both need to understand their obligations when it comes to retirement funding – and intermediaries have a crucial role to play.

Looming retirement-funding crisis

South Africa has a looming retirement-funding crisis. Only one in every three South African adults (including retirees) have some form of pension, according to the Federation of Unions of South Africa, while 61% of pensioners cannot meet their expenses, according to Sanlam.[1] The lack of retirement saving is clearly the major problem we face, but as important is the fact that even those lucky enough to have a job with retirement benefits are not realising them to the full.

The reason, I believe, is that both employees and employers do not fully understand their obligations to make the system work. Forbes says that 80% of companies reported that their employees do not open or read benefit materials.[2]

Retirement benefits are one of the main tools for attracting and retaining staff. When employees get the most out of their retirement benefits, they are likely to be better motivated. If the members of the fund are well informed and active, the fund will perform better and become more of a drawcard.

Employer obligations

An essential obligation for employers is to ensure that their employees are aware of their retirement objectives. This means putting structures in place to help them to formulate their retirement goals. Some questions that need to be in the foreground include: how much do they want or need at retirement as a percentage of final salary? What are their post-retirement expectations? Are they on track? What is their projected savings at retirement?

A related issue that employers need to bring to employees' attention is whether their contributions and those of the employer will be adequate to meet their retirement funding objectives. Is there any flexibility? What is the investment strategy? What are the risk/return objectives of the chosen investment portfolios? What are the longer-term investment performances of these portfolios versus peers, and at what cost?

While a company's retirement funding arrangements are the core retirement investment vehicle for most employed people, a much smaller number of affluent employees would have other personal investments. Employers should be urging all their employees to harmonise their personal and corporate retirement funding arrangements into a focused strategy to avoid dilution of either.

Another vital employee obligation is to ensure that the employer has a practical and adequately constituted management committee - with at least 50% of its members elected by the members. The committee should meet regularly to discuss the business of the fund and, crucially, act as a communication channel with the members. Unfortunately, many funds still lack this effective and direct communication channel, which also provides valuable governance.

Employee benefits consultants play an essential role in facilitation here, and can provide expert guidance, advice and reporting. They can also monitor the service-level agreements of the various providers like the fund administrator, asset manager and risk underwriter.

Employee obligations

Employers have an obligation to encourage and enable employees to get the most out of their fund, but employees have a massive responsibility to take control of their retirement planning. Ultimately, it is their responsibility to use the tools the employer makes available to make informed decisions.

A very important employee obligation is to understand the importance of nominating beneficiaries for both the retirement benefit, as well as the unapproved death and funeral benefits. Many members may not be aware that insurers today require a valid nomination-of-beneficiary form to avoid the funeral benefit being paid to the estate of the late member.

Employer and employee obligations are primarily mirroring images of each other, but, in the end, employees must realise that their futures are in their own hands.

Gus Roome
Senior Consultant
GCI Employee Benefits

[1] *"Shock retirement numbers for South Africa", BusinessTech (19 May 2021), available at https://businesstech.co.za/news/finance/491907/shock-retirement-numbers-for-south-africa/.*

[2] *Chris Renz, "Only half of employees understand their benefits. Here's what HR leaders can do about it", Forbes (2 July 2019), available at https://www.forbes.com/sites/forbeshumanresourcescouncil/2019/07/02/only-half-of-employees-understand-their-benefits-heres-what-hr-leaders-can-do-about-it/?sh=3b7d08f37813.*

TIK-TOK: THE CLOCK IS TICKING on SA's R45 billion unclaimed benefits bomb

What if the Financial Sector Conduct Authority (FSCA) shoots a Tik-Tok video featuring an over-enthusiastic social media influencer, to try and reunite R42 billion in unclaimed pension benefits with the intended beneficiaries? asked a concerned FAnews reader. What indeed, we responded. This would be no worse than the countless attempts at tracking and tracing made to date.

Lambasting retirement funds

Each year, journalists have a field day reporting on the retirement fund industry's unclaimed benefits dilemma. We latch onto the biggest number mentioned during the regulator's update sessions and proceed to lambaste the 'greedy' retirement funds industry for keeping the money. But the truth is that most of these unclaimed funds will never find their way home.

An unclaimed benefit is a benefit owing to a retirement fund beneficiary or member that remains unclaimed 24 months after it falls due. And by year-end 2019 the industry was sitting on almost R45 billion belonging to 4.5 million untraced beneficiaries, held in 1 286 retirement funds. How, you ask, have so many beneficiaries remained unpaid for so long?

It turns out that the migratory nature of SA's work force, especially during the 1980s and 1990s, as well as inaccurate member data, outdated or missing contact details and poor recordkeeping by fund administrators make track, trace and repay incredibly difficult. Another issue, is that the investment return on unclaimed benefits are keeping pace with repayments. This explains why Olano Makhubela, Divisional Executive: Retirement Funds at the Financial Sector Conduct Authority (FSCA), recently told us that the assets held in the unclaimed benefits space show little sign of year-on-year decline.

Too little data to track or trace

"My personal view is that a sizeable 40% of these unclaimed benefits will never get back to beneficiaries because they are either deceased or there is simply not enough member data to identify and trace them," said Makhubela. And many of the orphaned accounts are of such low value that tracing becomes uneconomical. We learned that approximately 17% of unclaimed benefits are in accounts worth R100 or less, with another 10% of the total in accounts holding between R100 and R250.

Viral Tik-Tok campaign or not, very few beneficiaries will make a trip to town to pick up R100. Likewise, it makes no sense for a retirement fund to spend R1 000 or more on tracing beneficiaries of such small balances. Consumer journalists are typically horrified by these low values. How could a member account have accumulated less than R250 after compounding for three or four decades? they growl.

Fortunately, the issue relates to administrative complexities and the low compounding effect on small values rather than exploitation. By way of example, a low-income worker in the early 1980s may have been earning around R200 per month with only 5% of that, or R10, going to retirement savings. Assuming they hopped jobs after two months and could not be traced, the R20 in unclaimed benefits would hardly have grown over the ensuing decades: R20 compounding at 8% monthly over 30 years is only worth R218,71.

Chasing an unlikely outcome

It also frequently happened that a fund member would withdraw his or her benefits when leaving a job prior to the final period's interest being paid, because there was no unit pricing at the time. Small values relating to the division of administrative surpluses could also land in a member's account post resignation.

Rather than spending millions chasing an unlikely outcome, the industry must rethink how we use this multi-billion rand fund. One proposal, offered up by National Treasury, is to consolidate all of the funds into a single, centralised fund that would remove the conflict inherent in retirement funds keeping unclaimed benefits on their balance sheets, and address the near impossibility of finalising low value accounts. A centralised fund, said Makhubela, offers an easier, more streamlined approach to managing and processing unclaimed benefits on an ongoing basis.

Gareth Stokes
Stokes Media

KEY INSIGHTS ON SAVING AND INVESTMENT HABITS

Since 2009, the annual Old Mutual Savings & Investment Monitor (OMSIM) has tracked and probed the savings and investment habits of working metropolitan households in South Africa.

This year, in light of the global COVID-19 pandemic, Old Mutual conducted their research survey with a particular focus on the attitudinal and behavioural shifts of households, as a result of the COVID-19 pandemic.

FAnews joined Old Mutual as they unpacked the 2021 OMSIM research findings.

Financial needs of customers

"In today's market, companies must find new ways to connect with customers in a meaningful way and meet their diverse range of financial needs. That means understanding their needs, creating the propositions that will meet those needs, and remaining relevant. The research findings enable us to understand and find innovative ways to respond to the changing financial needs of our customers," said **Iain Williamson, CEO at Old Mutual.**

"The research plays an important role in providing valuable and practical tips and tools to improve the financial wellbeing of our people," added Williamson.

Macro-economic perspective

From an economic perspective, "The year 2020 saw the worst global recession since the 1930s. 2021 is seeing record recovery that should extend to 2022 as the major economies put the pandemic behind them. The recovery has benefited greatly from policy support. Those countries whose governments lack the means to support their economies fiscally and vaccinate their populations will recover slowly," said **Izak Odendaal, Investment Strategist at Old Mutual Wealth.**

"In macroeconomic terms, savings is the difference between spending and income. Across the world, spending fell during lockdowns. In the rich countries, households benefited from government income support. This pushed savings rates to record levels. Time will tell whether there is a permanent change in saving behaviour," added Odendaal.

"Workers' total incomes have recovered, despite the large number of job losses. This is good news, but also a stark reminder of the k-shaped nature of the recovery and the increased inequality and that probably contributed to the recent unrest. Lower interest rates also support the consumer spending recovery by lowering interest payments," he continued.

"The local economy is greatly helped by global recovery. Commodity prices have surged over the past year, and this has pushed SA export values to record level. On the other hand, the tourism and leisure sectors have borne the brunt of the pandemic, and are likely only to recover with widespread vaccination," said Odendaal. "Investment returns of a typical SA balanced portfolio are not only much better than they might have been a year ago, but also somewhat better than pre-pandemic (SA equity in particular). Many people invest "through the rear-view mirror" by looking at past performance. Improved returns should therefore boost the confidence of investors and could make them more inclined to save," he added.

"The global economic recovery is going better than expected, but the virus still poses a risk. The impact on households globally and in SA has been very uneven. Time will tell if there has been a permanent change in savings behaviour here and abroad," concluded Odendaal.

Research findings

To build on the 2021 OMSIM findings, Old Mutual conducted an additional 'rapid results' survey in July to assess whether the recent unrest had further eroded people's sense of wellbeing.

This July survey revealed that people's confidence in the South African economy dropped a further 3%, from 34% to 31%, the lowest level recorded in the history of OMSIM. The percentage of respondents who made emergency funds a priority also went up - from 37% to 40% - over this short period of time.

An interesting statistic revealed in the July report showed that 23% of the working metropolitan population say they are checking/have checked that they have enough insurance protection in place.

Lynette Nicholson, Head of Research at Old Mutual believes this year's main OMSIM results are surprisingly encouraging, considering the very challenging backdrop. "The COVID-19 pandemic seems to have jolted many of us into facing up to financial realities that we may have been in denial about in the past. For example, 87% of South Africa's working metropolitan householders claim that the pandemic has changed the way they think about and manage their finances."

The research also indicates that although job and income security remain the top financial priority for 65% of working metropolitans surveyed, they are also prioritising the way they manage their money. Around 62% of households are cutting expenses where they can, 50% (up 10% from 2020) are prioritising paying off their debts and 37% are now making sure they have enough emergency funds, up from 33% in 2020.

The survey also found that:

- 39% of respondents have switched to cheaper supermarket brands;
- 25% moved to a cheaper cell phone or data options;
- 31% replaced gym subscriptions with exercising on their own/ at home;
- 18% moved in with family members and 16% had family members move in with them to reduce living expenses; and
- 69%, are taking advantage of rewards and loyalty programmes that offer opportunities to pay less for everything, from fuel to food and other household products. This is up from 54% in 2020.

A leading trend identified by the research has been the growth of multi-earners, or "Poly-Jobbers", a term Old Mutual coined for those working metropolitan individuals who have more than one job and more than one source of income. Currently, 44% of the metro working population claim they are learning something new or upskilling.

Indebtedness is likely to continue rising, considering that 54% have dipped into savings to make ends meet, 34% have fallen behind on household bills, 34% have borrowed from family and friends, 31% have cashed in savings/investment policies, 28% have fallen behind on store card payments, 32% have fallen behind on credit card payments, and 19% have fallen behind on rent or home loan payments.

Furthermore, the OMSIM 2021 research shows that one in three (34%) respondents do not have enough savings to last more than a month (at most) if they lost their income/jobs.

More than half (51%) of respondents have adult dependents, one in three (31%) say they are giving support to more people since the start of COVID, and 43% are firmly wedged in the sandwich generation, meaning they are breadwinners who financially support ageing parents and/or grandparents, as well as their own children and/or grandchildren and other relatives.

Financial empowerment

"Poor financial habits are the root of poor savings habits. You can see, however, that people are making adjustments… but as much as people know what they should do, they lack the motivation to save consistently," said **John Manyike, Head of Financial Education at Old Mutual.**

"From the statistics, 87% of the respondents claim that COVID has made them change the way they think about and manage their finances. Thirty eight percent are earning less than they were before COVID. Although COVID potentially forced shifts in behaviour, many people have chosen to shift their financial priorities. These are good signs that people are adjusting their lifestyles and spending habits (62%). Thirty seven percent are planning ahead and building a financial buffer to make sure they have emergency funds. And, being aware of the dangers of bad debt, 50% say they are paying down or paid off debt," continued Manyike.

"What we know is that applied knowledge is power. People who set clear goals and have a plan to achieve them, are more likely to succeed. The action of saving is behaviour-based and once you get into the swing of it and repeat the behaviour continuously, it will become a habit. The more you do it, the better you become at it," concluded Manyike.

Myra Knoesen
FAnews Journalist

CPD article

CASTING A WIDER NET ON UNCLAIMED BENEFITS

For those of us in the financial services sector in South Africa, unclaimed benefits are a persistent challenge. For more than a decade, financial institutions have been trying to solve this conundrum: how to return the total of R42 billion in unclaimed pension fund benefits owed to an estimated 4.5 million South Africans.

Financial advisers and brokers know that a pension fund is the pillar upon which a client's future is built. As a result, the idea that so many people in South Africa spent years, even decades, paying into their pension funds without ultimately receiving those benefits is a great cause for concern.

Since 2018, one insurer has successfully traced and paid over R380 million in assets to thousands of members and beneficiaries – and continues in its efforts to trace the remainder, who are owed a share of a pooled R2.3 billion.

Tracing the beneficiaries

The government has challenged us as an industry to cast the net wider in tracing the beneficiaries, particularly the ones who aren't even aware that they have money waiting to be claimed by themselves or their families.

We, for example, are working around the clock to trace beneficiaries and have been experiencing some hurdles such as beneficiary apathy which has been a surprising trend.

In certain cases, the benefits owed to individual members are small, and certain members simply don't believe it's worth their while to go through the administrative process required for them to claim a few hundred Rand. However, in these tough economic times no amount is too small. We have managed to trace some members, who are reluctant to provide their details and follow through on their claim, suspecting that they could be the victim of a scam.

We have tried to ensure that the claims process isn't overly demanding, by simplifying the requirements for claiming - while also retaining some security checks, to protect our members' funds from fraudulent claims.

It has become evident that the main challenge that leads to the prevalence of unclaimed benefits is a lack of knowledge about pension payouts and how they work among the public in general.

Advisers can contribute

With wide networks and clients across the country, advisers can contribute to the tracing process by educating people on unclaimed benefits and how they can claim their share if they are eligible.

It's ultimately a win-win situation as people with unclaimed pension money would undoubtedly benefit from advice as your future clients - in the event of a payout.

So, who is eligible to claim for unclaimed benefits? This would generally be employees of companies who contributed as members of retirement funds during their employment and did not claim or receive their benefit upon terminating employment.

Another major category are the children or surviving spouses of deceased former members of retirement funds, who might not be aware that their departed loved one left an unclaimed pension benefit.

It is difficult to find some of these beneficiaries because a sizeable portion of former fund members live in remote rural areas, which means matching names to addresses is not always simple. Many others were registered with their respective pension funds using incorrect or incomplete details, making them difficult to trace.

This is an industry-wide issue that can only be tackled if we all work together. For example, you could encourage a client to visit his or her insurer's unclaimed benefits page, which could have a built-in search engine to check if he or she is owed any benefits with the insurer or pension fund administrators.

If it is confirmed that a person or client has unclaimed money, they will be required to provide a completed claim form from the institution holding the money.

Let's all work together

Whether benefits owed are R500 or R500 000, in a time where South Africans are financially stretched due to the tough economic landscape, every bit goes a long way.

Linda Mateza
Liberty Strategic Executive
for Retirement Funds

CPD article

IT'S TIME FOR BENEFICIARY FUND PROVIDERS TO STEP UP

As beneficiary fund administrators, our focus should always be on the beneficiaries, because after all, the funds are there to protect their best interest.

Although Section 37C of the Pension Funds Act describes how death benefits should be distributed, administering beneficiary funds should not merely be a transactional relationship.

A fiduciary responsibility

We cannot, and should not, view beneficiary funds the same way we view pension or provident funds. This offering requires a far more personalised touch that could change lives. Is the industry facilitating that?

A prudent approach to the management of beneficiary funds could not only change lives but could have a more far-reaching positive impact on society as a whole. Administrators are in a uniquely powerful position to help build the foundation upon which beneficiaries can build a responsible, sustainable future and with this power comes, as the cliché goes, great responsibility.

Beneficiary fund administrators have a fiduciary responsibility to ensure the wellbeing of the beneficiaries in their charge. This includes their day-to-day needs, their educational needs, and their future needs.

Balance and engagement

Merely making payments for the sake of ticking boxes simply won't do. Neither will an overly extensive capital preservation approach. The keys to a well-managed beneficiary fund are balance and engagement.

Balancing a capital preservation strategy with one that offers enough liquidity and flexibility to allow for ad-hoc payments, when necessary, enables administrators to see to both the daily needs of beneficiaries, as well as unexpected medical or schooling expenses. A fair fee structure ensures that the funds are managed and invested wisely, opening possibilities to beneficiaries once they reach the age of majority without eroding the fund.

However, the relationship doesn't need to end there. And it shouldn't. Through constant engagement with the guardian and, in some cases the beneficiary, administrators can work with their clients to help them reach their goals. Whether this goal is to further their education, invest, or buy a car to get to work or university, nobody is better positioned to help them make this a reality than those tasked with managing the fund.

By taking an active interest in the lives, needs, and desires of beneficiaries, administrators have an opportunity to improve the lives of our nation's most vulnerable. And, if they are innovative in their approach, this need not even impact the beneficiary's capital. Offering supplementary services can assist beneficiaries in ways that truly add value to their lives, help them further their education, or build valuable skills. In a country where youth unemployment and skill shortages are at an all-time high, administrators should be jumping at the opportunity to make a lasting difference.

The best possible outcome

There are, of course, administrators who take their fiduciary responsibility very seriously, but the reality is that, as an industry, we're simply not doing enough. Administrators need to make decisions that will deliver the best possible outcome for the beneficiaries. Rather than simply paying out a lump sum when the beneficiary reaches the age of majority, they should engage in discussions to assess the need at that moment and determine whether the money could be put to better use and strengthen the foundation they built over the years.

Trustees have an equally big responsibility when it comes to placing the fund with an administrator. Rather than simply weighing up the fees and promised returns, they need to determine whether the administrator's processes, and the level of care they offer beneficiaries and guardians, will help beneficiaries succeed in their lives after school.

Considering the size of beneficiary funds in our country and the number of children dependent on these funds, beneficiary fund providers can make an immense difference if they adopt a holistic approach to fund management.

It's not rocket science; it just requires some effort on our part.

Muhammad Jogee
Group Products Operations Manager
Fedgroup

MEDICAL SCHEMES' AVERAGE INCREASES

COVID-19 has put pressure on the South African healthcare environment. More importantly, wallets are tight as consumers continue to face financial pressure.

This year, for the first time, it seems likely that medical schemes will announce contribution increases which are in line with recommendations suggested by the Council for Medical Schemes (CMS). This is according to Jill Larkan, Head: Healthcare Consulting at GTC.

The CMS guidelines are based on a review of national and global macro-economic outlooks and, this year, the significant effects of the coronavirus pandemic on medical scheme reserves and member hospitalisation trends.

A balancing act

The CMS has recommended that contribution increases for the 2022 benefit year be limited to 4.2%, in line with the National Treasury's projected CPI figure. Larkan expects medical schemes to align very closely with this recommended contribution increase for next year.

According to Larkan, "The lower-than-anticipated increases are due to the financial constraints that South African consumers are facing on the one hand, and record reserves held by the medical schemes on the other. Lower-than-usual usage of medical scheme benefits amongst members who have generally been fearful of doctor visits and hospitalisation, have resulted in combined medical scheme reserves growing to a record R73.29 billion."

"This behavioural pattern, could, however, reverse if vaccinations and infections combine to confer herd immunity on the population. In that case, members could flock back to doctors to catch up on delayed procedures, and some conditions which could have been worsened after a year of delayed care. Medical schemes thus have a precarious balancing act ahead of them so as not to overburden struggling members on the one hand and ensure adequate reserves for their future care on the other."

For consumers and companies alike, we have to get the balance of products, services and premiums right, so that we can ensure the sustainability of our industry.

Average increases for 2022

A few schemes have shared their 2022 increases with us so that you can get a clear idea of what 2022 holds for your client.

BESTMED MEDICAL SCHEME

	Gross Contribution Amount in Rands		
Plan	Principal Member	Adult Dependant	Child Dependant
Beat 1	R 1 746	R 1 354	R 734
Beat 1 Network	R 1 570	R 1 220	R 661
Beat 2	R 2 133	R 1 656	R 898
Beat 2 Network	R 1 919	R 1 491	R 807
Beat 3	R 3 239	R 2 301	R 1 250
Beat 3 Network	R 2 914	R 2 073	R 1 127
Beat 4	R 5 062	R 4 181	R 1 251
Pace 1	R 4 242	R 2 980	R 1 071
Pace 2	R 6 026	R 5 909	R 1 329
Pace 3	R 6 918	R 5 569	R 1 190
Pace 4	R 8 642	R 8 642	R 2 025
Pulse 1 (R5 500 p.m)	R 1 760	R 1 673	R 1 059
Pulse 1 (R5 501 – R8 500 p.m)	R 2 114	R 2 009	R 1 269
Pulse 1 (>R8 501.00 p.m)	R 2 537	R 2 284	R 1 269
Average Contribution Increase - 3.9%			

BONITAS MEDICAL FUND

	Gross Contribution Amount in Rands		
Plan	Principal member	Adult dependant	Child Dependant
BonComprehensive	R8 217	R7 749	R1 672
BonClassic	R5 677	R4 874	R1 401
BonComplete	R4 570	R3 660	R1 241
BonSave	R2 950	R2 284	R883
BonFit Select	R2 230	R1 727	R669
BonStart	R1 338	R1 338	R1 338
BonStart Plus (New)	R1 670	R1 587	R735
Standard	R4 230	R3 667	R1 241
Standard Select	R3 822	R3 307	R1 119
Primary	R2 654	R2 076	R844
Primary Select	R2 322	R1 816	R738
Hospital Standard	R2 592	R2 184	R986
BonEssential	R2 033	R1 555	R596
BonEssential Select	R1 784	R1 364	R523
BonCap (based on Income)			
R0 - R700	R780	R780	R780
R701 to R9 430	R1 274	R1 274	R600
R9 431 to R15 320	R1 507	R1 507	R693
R15 321 to R19 930	R2 429	R2 429	R919
R19 931	R2 982	R2 982	R1 131
Average Contribution Increase - 4.8%			

FOR 2022

COMPCARE MEDICAL SCHEME				
	Gross Contribution Amount in Rands			
Plan	Income Band	Principal Member	Adult Dependant	Child Dependant
Pinnacle	All	R 7 818	R 6 086	R 2 165
Pinnacle ED	All	R 6 535	R 5 085	R 1 820
Dynamix	All	R 5 894	R 4 604	R 1 643
Dynamix ED	All	R 4 851	R 3 785	R 1 371
Symmetry	All	R 4 681	R 3 650	R 1 321
Symmetry ED	All	R 3 946	R 3 071	R 1 107
Selfsure	All	R 3 880	R 3 880	R 971
Mumed	All	R 3 721	R 2 901	R 1 046
Mumed ED	All	R 3 021	R 2 351	R 838
Unisave	All	R 2 870	R 2 397	R 860
MedX	All	R 2 596	R 2 402	R 838
MedX ED	All	R 1 899	R 1 899	R 594
NetworX	0-500	R 464	R 464	R 464
NetworX	501-4000	R 1 218	R 1 158	R 427
NetworX	4001-5001	R 1 218	R 1 158	R 427
NetworX	5001-6000	R 1 218	R 1 158	R 427
NetworX	61-8000	R 1 281	R 1 218	R 450
NetworX	81-90	R 1 499	R 1 426	R 527
NetworX	91-100	R 1 499	R 1 426	R 527
NetworX	101 - 120	R 1 669	R 1 584	R 587
NetworX	121-140	R 1 835	R 1 744	R 647
NetworX	141-160	R 2 019	R 1 918	R 711
NetworX	161-180	R 2 262	R 2 148	R 796
NetworX	181-200	R 2 533	R 2 405	R 892
NetworX	200+	R 2 842	R 2 554	R 994
NetworX ED	0-500	R 405	R 396	R 217
NetworX ED	501-4000	R 583	R 575	R 287
NetworX ED	4001-5001	R 745	R 715	R 357
NetworX ED	5001-6000	R 745	R 715	R 357
NetworX ED	61-8000	R 892	R 847	R 427
NetworX ED	81-90	R 892	R 847	R 427
NetworX ED	91-100	R 948	R 901	R 450
NetworX ED	101 - 120	R 1 023	R 973	R 485
NetworX ED	121-140	R 1 125	R 1 071	R 535
NetworX ED	141-160	R 1 237	R 1 177	R 588
NetworX ED	161-180	R 1 385	R 1 318	R 658
NetworX ED	181-200	R 1 552	R 1 477	R 737
NetworX ED	200+	R 1 864	R 1 678	R 831
Selfnet	All	R 1 799	R 1 799	R 636
Average Contribution Increase - 5.75%				

DISCOVERY HEALTH MEDICAL SCHEME (DHMS)			
	Gross Contribution Amount in Rands		
Plan	Principal Member	Adult Dependent	Child Dependent
Executive plan	R 7 688	R 7 688	R 1 468
Classic Comprehensive	R 6 309	R 5 966	R 1 258
Classic Delta Comprehensive	R 5 681	R 5 378	R 1 132
Essential Comprehensive	R 5 301	R 5 010	R 1 069
Essential Delta Comprehensive	R 4 775	R 4 510	R 957
Classic Comprehensive Zero MSA / Classic Smart Comprehensive	R 4 585	R 4 230	R 1 459
Classic Priority	R 4 041	R 3 186	R 1 617
Essential Priority	R 3 472	R 2 731	R 1 388
Classic Saver	R 3 485	R 2 750	R 1 397
Classic Delta Saver	R 2 784	R 2 200	R 1 118
Essential Saver	R 2 770	R 2 078	R 1 110
Essential Delta Saver	R 2 209	R 1 668	R 887
Coastal Saver	R 2 763	R 2 078	R 1 116
Classic Smart	R 2 070	R 1 634	R 827
Essential Smart	R 1 483	R 1 483	R 1 483
Classic Core	R 2 594	R 2 046	R 1 038
Classic Delta Core	R 2 076	R 1 637	R 830
Essential Core	R 2 229	R 1 671	R 896
Essential Delta Core	R 1 781	R 1 340	R 715
Coastal Core	R 2 062	R 1 548	R 820
KeyCare Plus - R0-8550	R 1 279	R 1 279	R 464
KeyCare Plus - R8551-13800	R 1 758	R 1 758	R 495
KeyCare Plus - R13801+	R 2 595	R 2 595	R 695
KeyCare Core - R0-8550	R 1 005	R 1 005	R 260
KeyCare Core - R8551-13800	R 1 253	R 1 253	R 310
KeyCare Core - R13801+	R 1 916	R 1 916	R 435
KeyCare Start - R0-9150	R 968	R 968	R 583
KeyCare Start - R9151-13800	R 1 629	R 1 629	R 637
KeyCare Start - R13801+	R 2 536	R 2 536	R 688
Average Contribution Increase (based on adult contributions) - Discovery Health has announced a contribution freeze for the first 4 months of 2022, meaning that all medical scheme premiums on Discovery plans remain the same as 2021, for the first 4 months of 2022 (January, February, March and April), until 1 May 2022. The Average Annualised Increase across all options from 1 May 2022 is 7.9%.			

MEDICAL SCHEMES' AVERAGE INCREASES

FEDHEALTH MEDICAL SCHEME

	Gross Contribution Amount in Rands		
Plan	Principal Member (effective from 01/04/2022)	Adult Dependent (effective from 01/04/2022)	Child Dependent (effective from 01/04/2022)
myFED (< R6 251)	R 1 275	R 1 275	R 543
myFED (R6 252 - R8 550)	R 1 301	R 1 301	R 601
myFED (R8 551 - R10 219)	R 1 552	R 1 348	R 759
myFED (R10 220 - R12 622)	R 2 176	R 1 899	R 835
myFED (R12 623 - R14 426)	R 2 765	R 2 279	R 1 081
myFED (> R14 427)	R 3 750	R 3 416	R 1 429
flexiFED 1	R 1 901	R 1 489	R 695
flexiFED 1Elect	R 1 481	R 1 158	R 539
flexiFED 2	R 2 670	R 2 376	R 788
flexiFED 2GRID	R 2 373	R 2 116	R 701
flexiFED 2Elect	R 1 998	R 1 786	R 593
flexiFED 3	R 3 045	R 2 790	R 1 079
flexiFED 3GRID	R 2 707	R 2 483	R 960
flexiFED 3Elect	R 2 282	R 2 092	R 810
flexiFED 4	R 4 076	R 3 720	R 1 226
flexiFED 4GRID	R 3 619	R 3 311	R 1 091
flexiFED 4Elect	R 3 053	R 2 844	R 936
maxima EXEC	R 7 460	R 6 476	R 2 305
maxim PLUS	R 11 790	R 10 176	R 3 642

Average Contribution Increase - Fedhealth has announced a contribution freeze for the first 3 months of 2022, meaning that all medical scheme premiums on Fedhealth plans remain the same as 2021, for the first 3 months of 2022 (January, February, March), until 1 April 2022. MediVault amounts, threshold levels and all benefit changes and limits will, however, be effective from 1 January 2022. The average annualised increase across all options from 1 April 2022 is 5.5%.

GENESIS MEDICAL SCHEME

	Gross Contribution Amount in Rands		
Plan	Principal Member	Adult Dependant	Child Dependant
Private Choice	R 1 390	R 1 390	R 455
Private	R 1 925	R 1 925	R 550
Private Comprehensive	R 2 715	R 2 715	R 550

Average Contribution Increase - 3.50%

HEALTH SQUARED MEDICAL SCHEME

	Gross Contribution Amount in Rands		
Plan	Principal Member	Adult Dependant	Child Dependant
Aspire Prime (*Rise replaced by Aspire Prime)	R 2 207	R 1 784	R 788
Aspire	R 2 494	R 2 016	R 890
Flex (*Changed from traditional to hybrid benefit structure)	R 3 556	R 3 195	R 1 106
Prosper	R 4 383	R 4 080	R 1 533
Optimum	R 6 100	R 5 086	R 2 087
Millennium	R 7 247	R 6 205	R 1 688
Ultimate	R 8 395	R 7 650	R 2 080
Cobalt	R 10 009	R 9 690	R 3 569

Average Contribution Increase - 12%

MEDIHELP MEDICAL SCHEME

	Gross Contribution Amount in Rands		
Plan	Principal Member	Adult Dependant	Child Dependant
MedPlus (previously Plus)	R10 122	R10 122	R2 526
MedElite (previously Elite)	R5 832	R5 454	R1 584
MedVital (previously Prime1)	R2 100	R1 602	R690
MedVital Elect (previously Prime 1 Network)	R1 650	R1 200	R648
MedAdd (previously Prime 2)	R2 598	R2 202	R882
MedAdd Elect (previously Prime 2 Network)	R2 148	R1 602	R750
MedPrime (previously Prime 3)	R3 906	R3 306	R1 140
MedPrime Elect (previously Prime 3 Network)	R3 198	R2 706	R930
MedElect (new) (R0 - R800)	R702	R702	R702
MedElect (new) (R801+)	R2 226	R1 740	R720
MedSaver (previously Unify)	R2 814	R2 310	R846
MedMove! (new)	R1 452	R1 452	R1 452

Average Contribution Reduction - 0.45%

FOR 2022

MOMENTUM MEDICAL SCHEME			
	Gross Contribution Amount in Rands		
Plan	Principal Member (effective from 01/09/2022)	Adult Dependant (effective from 01/09/2022)	Child Dependant (effective from 01/09/2022)
Ingwe State (<= R775)	R482	R482	R415
Ingwe Network	R482	R482	R434
Ingwe Any	R482	R482	R482
Ingwe State (R776 - R7 750)	R792	R792	R427
Ingwe Network	R996	R996	R456
Ingwe Any	R1 294	R1 294	R513
Ingwe State (R7 751 - R10 250)	R907	R907	R438
Ingwe Network	R1 268	R1 268	R474
Ingwe Any	R1 810	R1 810	R547
Ingwe State (R10 251 - R14 600)	R1 059	R1 059	R458
Ingwe Network	R1 752	R1 752	R515
Ingwe Any	R2 465	R2 465	R575
Ingwe State (R14 601 +)	R1 829	R1 829	R550
Ingwe Network	R2 499	R2 499	R736
Ingwe Any	R3 163	R3 163	R918
Evolve Option	R1 424	R1 424	R1 424
Custom Any in-hospital Any chronic provider	R3 078	R2 470	R1 099
Custom Any in-hospital Associated chronic provider	R2 762	R2 158	R1 004
Custom Any in-hospital State chronic provider	R2 303	R1 738	R844
Custom Associated in-hospital Any chronic provider	R2 580	R2 036	R910
Custom Associated in-hospital Associated chronic provider	R2 330	R1 806	R823
Custom Associated in-hospital State chronic provider	R1 808	R1 368	R641
Incentive Any in-hospital Any chronic provider	R4 151	R3 373	R1 619
Incentive Any in-hospital Associated chronic provider	R3 598	R2 886	R1 413
Incentive Any in-hospital State chronic provider	R2 924	R2 304	R1 157
Incentive Associated in-hospital Any chronic provider	R3 672	R2 954	R1 372
Incentive Associated in-hospital Associated chronic provider	R3 307	R2 630	R1 256
Incentive Associated in-hospital State chronic provider	R2 354	R1 858	R903
Extender Any in-hospital Any chronic provider	R7 899	R6 361	R2 265
Extender Any in-hospital Associated chronic provider	R7 035	R5 665	R2 024
Extender Any in-hospital State chronic provider	R6 297	R5 169	R1 849
Extender Associated in-hospital Any chronic provider	R6 945	R5 595	R1 965
Extender Associated in-hospital Associated chronic provider	R6 339	R5 103	R1 824
Extender Associated in-hospital State chronic provider	R5 544	R4 204	R1 629
Summit	R11 331	R9 062	R2 603

Average Contribution Increase - Momentum Medical Scheme's contribution increases have been deferred to 1 September 2022. Meaning that contributions on all Momentum Medical Scheme plans will remain the same as 2021 - for the first 8 months of 2022 (January to August 2022), until 1 September 2022. Savings, threshold levels and all benefits changes and limits will, however, be effective from 1 January 2022. The average annualised weighted increase (based on family contribution) from September 2022 is 2%.

MEDSHIELD MEDICAL SCHEME			
	Gross Contribution Amount in Rands		
Plan	Principal Member	Adult Dependant	Child Dependant
PremiumPlus	R 6 747	R 6 183	R 1 290
MediBonus	R 6 528	R 4 587	R 1 359
MediSaver	R 3 894	R 3 225	R 948
MediPlus Prime	R 3 885	R 2 772	R 873
MediPlus Compact	R 3 531	R 2 520	R 792
MediCore	R 2 961	R 2 505	R 684
MediValue Prime	R 2 364	R 2 064	R 666
MediValue Compact	R 2 139	R 1 869	R 603
MediPhila	R 1 593	R 1 593	R 411
MediCurve	R 1 485	R 1 485	R 1 485

*Contribution rate is applicable to the members first, second and third biological or legally adopted children only, excluding students. Average Contribution Increase - 6.3%

PROFMED MEDICAL SCHEME			
	Gross Contribution Amount in Rands		
Plan	Principal Member (effective from 01/01/2022 - 31/03/2022)	Adult Dependant (effective from 01/01/2022 - 31/03/2022)	Child Dependant (effective from 01/01/2022 - 31/03/2022)
PREMIUM OPTIONS			
ProActive	R 1 923	R 1 777	R 749
ProActive Plus	R 2 283	R 2 123	R 890
ProSecure	R 4 079	R 3 777	R 1 594
ProSecure Plus	R 4 980	R 4 607	R 1 940
ProPinnacle	R 8 741	R 8 108	R 2 622
SAVVY OPTIONS			
ProActive Savvy (< R7 000)	R 717	R 860	R 576
(R7 001 - R11 000)	R 1 290	R 1 290	R 577
(> R11 000)	R 1 730	R 1 599	R 674
ProActive Plus Savvy (> R7 000)	R 2 055	R 1 910	R 802
ProSecure Savvy (R7 001 - R11 000)	R 2 641	R 2 641	R 1 197
(> R11 000)	R 3 672	R 3 399	R 1 434
ProSecure Plus Savvy (> R11 000)	R 4 481	R 4 147	R 1 747
ProPinnacle Savvy (> R11 000)	R 7 867	R 7 298	R 2 360

Average Contribution Increase - Profmed's contribution increases have been deferred to 1 April 2022. There will therefore be no increase on 1 January 2022. Increases effective. 1 April 2022 will be announced closer to the time.

REDEFINING HEALTHCARE IN 2022

The 2022 product line up from Bonitas Medical Fund includes the use of reserves to keep contribution increases lower, a Benefit Booster to stretch day-to-day benefits, a revised international travel benefit with payment for COVID tests and a contribution towards quarantine costs. There is also a renewed focus on preventative care, virtual consultations and plans that enable affordable, quality healthcare.

The Scheme performed well in a volatile market. A positive offshoot of the pandemic was an increased appreciation of the importance of medical scheme cover, that resulted in better-than-expected member retention and a 2.3% membership growth since January.

CONTRIBUTION CHANGES

We have taken a strategic decision to utilise approximately R600 million of reserves to ensure that 82% of members receive a below CPI contribution increase for the 2022 benefit year. The innovative Benefit Booster equates to an increase in day-to-day benefits for members ranging from 16% to 32%, depending on the members' plan. We believe it is the largest increase in benefits ever seen in the medical scheme industry, as the Scheme is providing members with R446 million worth of additional day-to-day benefits that can be used to fund acute medication, specialist consultations or even non-surgical procedures.

The average weighted contribution increase across all plans is 4.8% with the BonStart premium decreasing by 7.9%, which can be attributed to the low cost versus benefits ratio and the younger membership profile on the plan. The decrease in contribution is an industry first – as was the decision to offer BonFit Select at a 0% increase in 2020.

There will be a total of 15 plans for the year ahead comprising traditional, savings, hospital, edge (virtual), network and income-based plans, each carefully crafted with a specific mix of benefits.

Increases range from minus -7.9% to 6.5%. Bonitas has opted to increase its options which are currently in a growth phase – BonSave, BonFit and BonEssential – by only 3.6%.

SUSTAINABILITY AND AFFORDABILITY

The Council for Medical Schemes (CMS) recommended increases in line with CPI of 4.2%. We feel that the use of part of our reserves to cushion members against increasing costs is an appropriate strategy.

TOP LINE CHANGES

- An additional virtual plan, BonStart Plus, aimed at attracting a new profile of member through this diversified distribution channel and attractive pricing. Virtual care has proven a sound and reliable solution for improving access to quality healthcare and is now offered across all 15 Bonitas plans.
- The introduction of a new Oncology Management Programme that utilises a partnership between Medscheme Managed Healthcare and the South African Oncology Consortium (SAOC), to improve the coordination of care of oncology patients.
- Offering the back and neck programme – which has a 93% success rate – on a digital platform. The eDBC app is a technology-driven channel offering digital coaching solutions and home-based care to help improve pain and mobility. It includes a self-assessment, baseline progress checks and outcomes' evaluation.
- Enhancements on the existing international travel benefit which includes a COVID-19 PCR test pre- and post-travel as well as a contribution of up to R1 000 per day for enforced quarantine.
- A new personalised wellness and lifestyle programme AMP is now available on the new Bonitas app. It allows members to access their health information. Biometric data, claims and wearable data are used to regularly update their health score, while an avatar nudges them on the best steps to boost their health. In addition, through a partnership with Avo by Nedbank members can do life differently with great deals across groceries, tech, professional home services, takeaways, prepaids and so much more.

THE WAY FORWARD

We have two interdependent priorities as a Scheme: to make quality healthcare more accessible and affordable, while ensuring the financial sustainability and longevity of the Scheme. Our members remain at the heart of our interactions and we actively strive to find ways to amplify value and drive business development.

Our core focus is on three key principles- namely care, capability and reliability which helps us redefine healthcare for a new world.

Lee Callakoppen
Principal Officer
Bonitas Medical Fund

Bonitas

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Bonitas

Dr Ryan Noach
CEO
Discovery Health

The trends shaping the future of healthcare

New technologies and cutting-edge digital platforms are having meaningful impact on healthcare systems.

The topic of digital healthcare and its applications spans a wide range of services. I would like to focus on three technologies that I believe have truly come to the fore over the course of the COVID-19 pandemic, proving the value of digital healthcare offerings.

Virtual healthcare technologies

Prior to COVID-19, we had access to a growing array of digital healthcare solutions. However, with natural human resistance to change, and regulatory hurdles, the healthcare system remained a laggard in its adoption of digitisation.

Telemedicine consultations, for example, had been available to healthcare consumers for some time. Yet, pre-COVID, they represented a very small proportion of total healthcare consultations.

Over the past two years, this has changed rapidly. The COVID-19 pandemic has accelerated the adoption of digital healthcare technologies which have met patient and provider needs for safe ways to continue to access healthcare despite the pandemic's broader impacts - such as social distancing measures put in place to limit the spread of COVID-19. Management Consulting firm McKinsey reported that in April 2020, the overall telehealth utilisation for office visits and outpatient care was 78 times higher than in February 2020.

And, for many people, access to virtual doctors' consultations became a "gateway experience" into a world of connected care, extending from professional advice to diagnostics, and even to digital therapeutics. Although these big increases are promising, virtual consultations still represent a small proportion of total consultations. Considering that they are easily accessed, cheaper than in-person consultations and have been shown to be safe – we expect continued growth in the proportion of virtual consultations.

Wearable sensing technologies

The use of remote sensing technologies has played a significant role in supporting the treatment of patients recovering from COVID-19 at home. The streamlining of patient care facilitated through this option is especially relevant during peaks of COVID-19 infection when hospitals and ICUs are under strain.

In September this year, for example, the South African Medical Journal published Discovery Health's findings which demonstrate the impact of providing almost 40 000 high-risk scheme members with pulse oximeters to use while recovering from COVID-19 at home. Members shared readings from these devices with their doctors to ensure early detection of a decline in blood oxygen levels. All in all, home monitoring using a pulse oximeter was found to be linked to 48% lower likelihood of death in this cohort.

Continuous glucose monitoring technologies also enable value-based healthcare. Value-based healthcare is a critical element in healthcare transformation as it aligns reimbursement of healthcare professionals to patients' clinical outcomes.

Continuous Glucose Monitoring (CGM) sensors, for example, provide important feedback about glycaemic trends in response to meals, exercise, and medication - allowing for actions to be taken by the member and provider to improve overall glycaemic control. In addition, this tool enables ongoing monitoring of patients by their healthcare providers for improved patient care.

When patient deterioration is detected, actionable notifications enable caregivers to deliver real-time clinical interventions.

These elements are fundamental to optimising the management of diabetes and empowering patients to understand and control their condition far better.

Remote monitoring of a patient's vital signs is a critical component of delivering safe and efficient healthcare in a home setting. Going forward, we will see increased use of devices such as biosensor patches that enable a real-time view of a member's health status with up to 22 physiological metrics to track. What is remarkable is that this form of technology processes data in real-time, allowing for

(Continued on p.80)

> Remote monitoring of a patient's vital signs is a critical component of delivering safe and efficient healthcare in a home setting.

The trends shaping the future of healthcare

(Continued from p.78)

early detection of deterioration compared to traditional nurse led monitoring which is often done every two to six hours. How might this play out?

Globally, there has been a proliferation of hospital at home programmes with increasing evidence to support the treatment of medically appropriate conditions in a patient's home.

The ability to stay at home with family or friends and still access the right care was a welcome option during the pandemic and this is likely to continue to be a favoured route for patients with other conditions going forward.

Biotechnologies and genetics

The need for safe and effective solutions to COVID-19 has driven advances in cutting edge healthcare technologies. Vaccine development and rollout has typically taken many years to achieve. Yet, here we are, 19 months into the global COVID-19 pandemic, with several countries having vaccinated a large proportion of their population and introducing COVID-19 vaccine booster shots for individuals considered at high risk of serious COVID-19 illness.

Based on the extensive data and studies available on COVID-19 vaccines, COVID-19 vaccines are safe and effective and have a profound impact on reducing the risk of both morbidity and mortality (with a precipitous drop in severe COVID-19 disease in population groups that have been vaccinated).

The advent of the mRNA vaccines, now manufactured and commercially available through both Pfizer-BioNTech and Moderna, represents the culmination of 10 years of research into medicine production. The successes realised in the COVID-19 vaccine development process mean that in future, vaccine development will be faster and more efficient.

This progress also offers high hopes for improved prevention and cure of serious diseases. mRNA technology has promising potential to impact the top six causes of death accounting for 50% of mortality in Discovery Health's population over the past 10 years, prolonging average life expectancies.

Genetic sequencing also takes personalisation of care to a deeper level. The ability to sequence the human genome quickly and cheaply, opens up a new world of possibilities for personalised risk-mitigation and treatment plans, particular to personal makeup and needs.

Next Generation Sequencing (NGS) promises to accelerate precision medicine especially when it relates to cancer treatment. Sequencing of tumour DNA, allows oncologists to determine tailored treatment plans for cancer patients, allowing for a personalised and precise approach to cancer treatment and an improved clinical response to treatment. This approach is referred to as Precision Oncology, and consequently, the most likely response to treatment.

Even in the absence of genetic profiling, highly personalised approaches are made possible through Big Data analytics. The Data Science Laboratory, for example, uses Big Data analytics to accurately predict who, in the near future, is most likely to develop chronic conditions such as diabetes. The team is also working on pinpointing behaviours most likely to change the course of an individual's health trajectory, in order to prevent the onset of diabetes as far as possible, including the downstream costs relating to diabetes complications.

“Next Generation Sequencing (NGS) promises to accelerate precision medicine especially when it relates to cancer treatment.”

Patient-centric care

There's no doubt that going forward, digital health technology will play a vital role in meeting the needs of ever-more engaged, informed and connected patients who want faster, safer, more affordable, real-time access to care. Discovery Health will continue to investigate and invest in this landscape.

The integration of digital technologies is integral to creating platforms and support systems that allow us to focus on patient-centric, ever more personalised pathways. All these innovations and developments inspire our drive to enhance access to affordable, efficient, on-demand, cutting edge healthcare across the continuum. ●


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Myra Knoesen
FAnews Journalist

Has COVID upped customer expectations?

COVID-19 has thrown the spotlight on medical schemes and private healthcare.

Lee Callakoppen, Principal Officer of Bonitas Medical Fund says, "Consumers are becoming savvier and are wanting more from their healthcare provider. They are starting to interrogate the various medical scheme options available to them, and weighing up the cost versus benefits, to ensure they find a plan that not only delivers on their healthcare needs but also suits their budget.

FAnews spoke to a few industry experts about the medical scheme environment and changing customer expectations.

Customer satisfaction trends

"The annual South African Customer Satisfaction Index (SA-csi) survey for medical schemes showed a 3.2% increase in the overall member satisfaction average from 72.9% in 2020, to 76.1% in 2021, according to an article published on the IFC website titled 'Best Medical Aids for 2021'," said **Mark Bayley, Managing Director of Universal Healthcare.**

However, according to Bayley, more recent overall findings show that while healthcare consumers have clung to their medical scheme membership over the past year, it continues to be viewed as a grudge purchase, which does not always reflect the actual value received in return.

"Perceived value is largely related to how a medical scheme is used. There are those members who rely on their healthcare benefits for bigger medical expenses, such as chronic healthcare needs or hospitalisation, however, there are also those who use it for smaller claims including GP visits, optometry and dentistry visits. The co-payments on such day-to-day benefits can impact the member's experience in terms of the perceived value of medical scheme membership," he said.

"The survey shows that areas of concern to members include out-of-hospital costs and co-payments on primary healthcare and chronic medicine, which are a result of healthcare inflation costs. The purchase decision environment has become complex due to the wide range of benefit options now available, which may assist in providing more affordable choices but may well complicate the advice and decision-making process," added Bayley.

"The expectations gap amongst members is largely due to a lack of understanding around the actual cover afforded and of the regulatory environment in which medical schemes operate. Customer complaints were mostly made in relation to the detail and performance of their cover, the related fees and costs, additional out-of-pocket co-payments when claims are not covered, and their chronic medication not being covered as they expected," continued Bayley.

The industry average of complaints incidence, according to Bayley, is 16 out of every 100 interactions, and complaints successfully handled is at a low 57.6%. "This needs to be addressed with clear, simple communication and member education before it becomes necessary to complain. The findings of the survey indicate that the perceived value for money is a powerful predictor of future usage and company sustainability and growth."

Customer expectations

"The pandemic placed a bright spotlight on health, wellbeing and the importance of quality cover. We also saw significant shifts in consumer expectations where value for money, affordability, and overall quality became increasingly important factors in decision making processes. We have also seen a definite shift from 'comparing benefits and premiums' to members questioning the tangible value they get for every Rand spent. Members want to see exactly what they pay for, what benefits they have access to, and importantly, how their medical scheme actively enables and supports their health and wellbeing.

The pandemic also saw more members move online than ever before and customer satisfaction is now inextricably linked with customer

> The expectations gap amongst members is largely due to a lack of understanding around the actual cover afforded and of the regulatory environment in which medical schemes operate.

service capabilities and platforms. This also means that members now have a very different customer journey expectation when compared to a pre-pandemic world," said **Bianca Viljoen, Spokesperson of Health Squared Medical Scheme.**

Bayley said, "Schemes have been required to adapt by keeping contribution rates as low as possible and, in cases where members have struggled to afford their membership, special payment arrangements have been made. Medical schemes, in turn, are expecting more from their administrators," he added.

"With the need for quality healthcare during the pandemic, schemes had to be flexible, adaptable and above all else – innovative. Our priority was to ensure members had continued access to safe, quality healthcare, service and advice, as what they were accustomed to, pre-Covid," said Callakoppen.

Influencers of satisfaction

"As a general rule, we know that a major influencer of medical scheme member satisfaction is the level and quality of direct interaction with a scheme. This includes driving factors such as first call resolution, the provision of accurate and helpful information during queries and ensuring that members are recognised as individuals throughout all client interactions, including calls and correspondence," continued Bayley.

"Furthermore, a strong emphasis has been placed on taking an empathetic and caring approach towards members. This has been particularly important for medical schemes in the COVID-19 environment. It has been found that medical schemes that emphasise emotional intelligence and ongoing training in call centre teams are better equipped to meet members' emotional needs. This is in addition to excellent product knowledge, which all medical scheme agents must have as a basis," said Bayley.

"Finally, on a COVID-specific level, members may have felt reassured by the willingness of medical schemes to cover most COVID-related medical costs, as well as to fully fund the cost of the COVID-19 vaccine for all members," added Bayley.

"A combination of the above factors may have contributed to the upward trend in customer satisfaction," emphasised Bayley.

Justifying value and quality

"A strong benefit offering, balanced with value for money, has always been top of mind for the healthcare consumer, however, it is true that this is now more important than ever," said **Josua Joubert, CEO and Principal Officer of CompCare Medical Scheme.**

"A scheme that can realistically address this must provide value-based healthcare at each step of the clinical decision-making process. The merits and unique clinical circumstances involved in each case must be evaluated against international, evidence-based best healthcare outcomes and results. This type of value proposition focuses on quality of care per Rand spent, and not only on lowering the cost of healthcare," continued Joubert.

Brokers going in to 2022

"The financial adviser's role is becoming more vital than ever before. We are seeing a definite shift towards members seeking expert guidance on their health and wellbeing portfolios. From a financial adviser perspective, this means a far bigger focus on holistic advice spanning medical scheme, primary care, gap and co-pay cover, and even disability and critical illness from a life assurance perspective," said Viljoen.

"The pandemic has also led to a far bigger focus on mental wellbeing with corporate and individual clients enquiring about a more holistic approach. These types of benefits will soon trickle into the must-have category," she added.

"Businesses and consumers will continue to face highly dynamic and often challenging economic conditions, further highlighting the important role of a financial adviser to ensure quality, appropriate and sufficient cover within a client's budgetary constraints," she concluded.

"There is a great deal of opportunity for innovative solutions and forming meaningful partnerships. Now is the time to align with reliable partners who have the capability to meet the demand for good value," concluded Joubert.

"Members need to be empowered to make the right choices around healthcare and understand the implications of their purchase. Members have service expectations and plans and benefits need to be explicit about these, while meeting regulatory requirements," said Callakoppen.

"Brokers are pivotal to ensuring customer satisfaction amongst our members. They assist consumers by making informed recommendations that take into account the consumer's specific needs. They also play a vital role in education around the offerings, how to maximise benefits, how to benefit from managed care, both financially and in terms of quality of life, various healthcare terminology and assisting members with claims," concluded Callakoppen. ●

> "As a general rule, we know that a major influencer of medical scheme member satisfaction is the level and quality of direct interaction with a scheme."

Myra Knoesen
FAnews Journalist

Insights on vaccine developments

The target of vaccinating millions of South Africans before the end of 2021 has put into question whether this timeline is achievable or not. Amongst this, we have Long COVID-19 and fourth wave concerns.

FAnews spoke to **Damian McHugh, Executive Head of Marketing at Momentum Health Solutions** and **Dr Ronald Whelan, Chief Commercial Officer at Discovery Health** for some insights on the latest vaccination developments.

The target of vaccinating millions of South Africans before the end of 2021 has put into question whether this timeline is achievable or not.

Vaccine statistics

"The Government vaccination target is 28 million people, or 70% of the adult population, by December 2021. For us, the cost of people remaining unvaccinated and the impact that they will have on the health sector, far outweighs the cost of the vaccine," said McHugh.

"As of 4 October, we have vaccinated over 230 000 South Africans since 19 July 2021. As a reliable vaccination centre provider, we encourage people to see the COVID-19 vaccine as an 'Injection of Life' that gives hope to a pandemic free world," added McHugh.

Whelan said, "As of 27 September, 2.2 million vaccination doses have been delivered across the Discovery adult population to-date, 1.5 million Discovery Health members have been vaccinated to-date (i.e., 56% of Discovery Health's 2.7 million members vaccinated to-date), 78% of members over the age of 60 years vaccinated to-date (350 000 fully vaccinated and 50 000 partially vaccinated)."

Vaccine procurement

"The National Department of Health (NDOH) is the sole procurer of vaccines for South Africa and has appointed specialised distribution partners to coordinate the distribution of vaccines to provincial medical stores and private facilities. There is no indication at this stage whether private procurement of vaccines will be permissible in South Africa," emphasised Whelan.

"Private providers buy vaccines from the NDOH. Where vaccines are administered to members of a medical scheme, providers are reimbursed by medical schemes for the administration of the vaccine and the vaccine itself. Where vaccines are administered to people without medical scheme cover, providers are funded by the State. The cost of funding vaccines and vaccination is very reasonable and affordable for medical schemes – particularly when accounting for the benefits of reduced infection, severe disease and hospitalisation," Whelan continued.

McHugh said this model makes absolute sense. "With Government being the sole purchaser and funders helping to pay for those who belong to medical schemes, Government is able to vaccinate and ensure a good pipeline of vaccines in order to continuously inoculate more South Africans."

Those who refuse to get vaccinated

"While we encourage South Africans to vaccinate and get the 'injection of life', we have seen in the past month that the country is experiencing significant vaccination hesitancy. This is mostly instigated by false reports surrounding the vaccine," emphasised McHugh.

Whelan said, "The COVID-19 vaccination not only reduces risk of infection (60-70% reduction in infection risk against the Delta variant), but it also reduces severe disease and death (95% reduction in risk of death as a result of COVID-19). Furthermore, vaccination reduces the risk of transmitting COVID-19 to others by 50-80%".

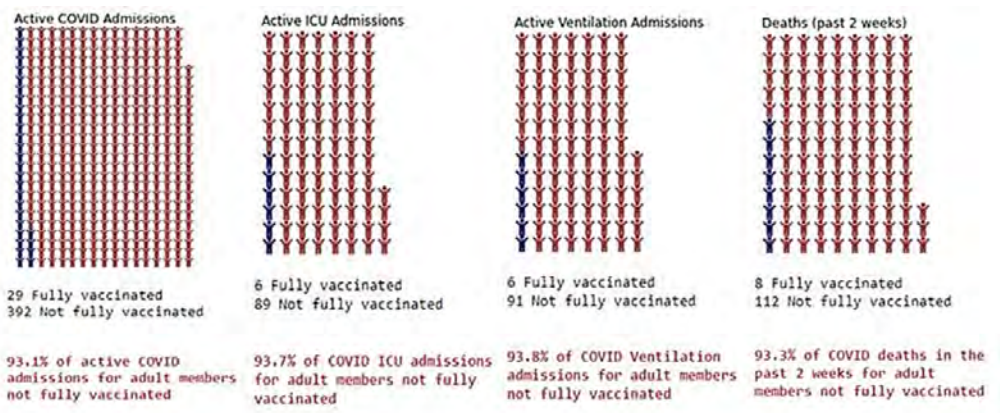
The figure on the next page illustrates current active Discovery Health admissions to hospital for COVID-19, comparing vaccinated members to unvaccinated members.

Other concerns

"There is also emerging evidence that vaccination reduces the incidence and severity of long-COVID, in the unlikely event of a breakthrough infection post-vaccination. Based on our analy-

sis and modelling, more than 25 000 additional deaths can be averted if we are able to vaccinate over 60% of South Africa's adult population before December 2021," said Whelan.

McHugh concluded by saying, "As we move past the third wave, we know that based on our previous trajectories, the onset of the fourth wave is projected for November/December this year. This will once again coincide with the festive holiday season and given the current 'Covid fatigue' we are seeing, could prove to have a major impact on the country. For us, it is simple, to return to any kind of normality and to prevent further negative medical and economic impacts, we must reach the targeted 70% of eligible South Africans vaccinated as soon as possible." •



> While we encourage South Africans to vaccinate and get the 'injection of life', we have seen in the past month that the country is experiencing significant vaccination hesitancy.

Josua Joubert
Chief Executive and Principal Officer
CompCare Medical Scheme

Resetting for medical scheme members

'In survival mode' is no way to live. Yet looking back over the past 18 months and longer, our industry has perhaps settled into a reactive state. Yes, we are all part of a system that is not without challenges.

However, it is our own proactive behaviour that will determine our survival.

A total reset is already upon us, with dramatic changes in not only the expectations of consumers, but also their real life experiences.

Back to the drawing board

Going back to the drawing board means reassessing what matters most. In the medical schemes context, value equates to meaningful benefits that provide support, without members dipping their hands into their own pockets.

Realistically, so many healthcare consumers avoid getting the care they need purely because of the financial implications.

Take mental health, for example. We know that this is one of the most underfunded areas in global healthcare and, at a local level, the average medical scheme has poor psychosocial benefits. This simply can no longer be the case.

Mental health matters

Before COVID-19, the South African Depression and Anxiety Group reported taking around 600 calls for help per day. By September of this year, that number sharply increased to 2 200 calls daily.

Equally alarming are the figures released by UNICEF in their 2021 report* on the mental health of children, adolescents and their caregivers. The report refers to a survey, which found that one out of every five people aged 15 – 24 expressed regular feelings of depression.

Whether purchasing medical scheme membership as a family or as an individual, tangible mental health benefits such as unlimited access to a 24/7 professional helpline with referrals for one-on-one counselling when required, should not be restricted to certain options only. Taking things one step further still, applying a child rate on all options until the age of 27 for students and those who are financially dependent, can provide a much needed lifeline.

Support in preventative care

It would be difficult not to mention the impending wave of devastating late diagnoses that will likely be the result of so many people having delayed preventative check-ups, in an effort to avoid the doctor's office during COVID, as well as to reduce expenses.

With a global cancer prevalence of one in five people, according to the International Agency for Research on Cancer, this is deeply worrying. An unlimited oncology programme is essential but simply not enough – it is the scheme that pays for preventative checks from risk rather than day-to-day benefits that is giving members real support in the here and now.

Family benefits

Wellness benefits and kids health benefits are no longer 'nice-to-haves'. Active support in regaining and maintaining physical health with access to a fitness and nutritional programme, an assessment from a biokineticist and registered dietitian, exercise prescription, healthy eating plan and regular monitoring can go a long way to helping the stressed and strained individual to restore balance.

Kids benefits that include an additional emergency room visit and unlimited GP visits for those under the age of six can offer some welcome financial assistance, while the option of an occupational therapy assessment, exercise prescription programme and healthy eating plan for children can provide just the boost that a tired young family needs.

Financial stability

And of course, the money matters. Yes, one can choose to implement contribution increases gradually each year or to defer them to later in the cycle. Kicking the can down the road is a strategy. The question is whether it's the right one for the medical scheme member.

Ultimately, it is first and foremost the job of the medical scheme to ensure that all members have access to the care they need whenever they may need it – medical schemes need to be prepared. We need to be ready to show up. ●

> Ultimately, it is first and foremost the job of the medical scheme to ensure that all members have access to the care they need whenever they may need it – medical schemes need to be prepared.

* https://www.unicef.org/reports/state-worlds-children-2021?utm_source=referral&utm_medium=media&utm_campaign=sowc-web

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Contribution increases aren't on time

Medical scheme increases are not just happening in January anymore; some medical schemes are increasing contributions at different times in the year.

An overview of 2020 and 2021

Discovery Health Medical Scheme (DHMS) started this trend for their 2020 benefit year, and other medical schemes have followed suit this year, including Momentum Health, Profmed, Fedhealth and Platinum Health.

The years 2020 and 2021 saw increased claims for COVID-19 related expenditure, especially pathology and hospitalisation claims, but significantly lower claims for other healthcare, including elective surgery and other discretionary care such as preventative screening.

Overall, medical schemes had far lower claims over 2020 and 2021, which boosts surpluses and reserves but presents a conundrum for setting contributions. Even when medical schemes achieve annual surpluses and increased reserves, contributions cannot automatically be lowered or granted low contributions to offset these gains in reserves.

Conundrum for setting contributions

Contributions are set based on expected claims for the following year. To the extent healthcare claims are expected to resume to normal or near normal (say pre COVID-19 levels), contributions would need to reflect those expected costs. This is for two reasons;

1. The Council for Medical Schemes (CMS) requires medical schemes, indeed each option on each medical scheme, to be priced at break-even, which can cause some pricing distortions.
2. Contributions priced below expected claims to reduce any perceived excess accumulated surplus cannot be sustained. They would need to be caught up to expected claims at some point in the future.

One possible alternative would be to distribute excess reserves to medical scheme members since medical schemes are essentially not-for-profit trusts 'owned' by their members. While there may be some technical methodological difficulties with this approach, the CMS has so far not entertained the possibility.

> One possible alternative would be to distribute excess reserves to medical scheme members since medical schemes are essentially not-for-profit trusts 'owned' by their members.

Deferring annual contribution increases to later than 1 January is an interesting balance of both options. The delayed increase essentially gives back the increase percentage to all active members over the period of delay without compromising the sustainable level of medical scheme contributions.

There are some administrative difficulties to overcome for company payrolls being out of sync, and companies with split risk books may find it more difficult to manage reconciliations and other administrative functions. Option change timing, usually limited to November and December each year, also needs to be more flexible. The question of benefits is entitled to be linked to options and contributions. Schemes should allow option changes at the point of contribution change and the usual January selection window. This marginally increases the risk of anti-selective option changes, but the risk is not deemed significant.

The effect on advice

It's unclear whether this pattern of different contribution increase timing will remain in place or also get back to the normal annual cycle at some point. For financial advisers, the challenge is the effect on advice regarding medical scheme and option choice. It has always been complex to compare benefits between medical schemes, even the options within a medical scheme. Now it is also more difficult to compare contributions. Should one look at the contributions in January? Or only the contributions to be increased later in the year to make an effective comparison?

Changing between medical schemes is a lot more difficult than switching household or car insurance coverage. So, the advice that's given, and the member's decision is more of a medium to long-term decision, even though strictly speaking, medical scheme coverage is short-term in nature. Therefore, we would propose a longer-term consideration of contributions for advising, so as not to be taken in by temporarily low contributions that will unavoidably increase at some later point. It is better to compare where things will end up over the medium term.

In the shorter term, within a scheme with delayed timing on an increase, members and advisers may play for some time in making the right option selection. ●

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CPD article

Dr Katlego Mothudi
Managing Director
Board of Healthcare Funders (BHF)

Telemedicine and telehealth hold immense potential

Too many, telehealth and telemedicine may seem like a new phenomenon in South Africa, yet it is not. At the peak of the COVID-19 pandemic, the usage of largely dormant telemedicine solutions in South Africa were significantly ramped up as close physical medical interactions were minimised in compliance with COVID-19 protocols.

The outbreak of the COVID-19 pandemic sparked renewed interest in telehealth and telemedicine solutions and accelerated their adoption, with some administrators reporting a surge of over 1 000% in their usage at the peak of the pandemic.

What are telemedicine and telehealth?

However, what are telemedicine and telehealth and how can these smart solutions be leveraged to help to plug the capacity gaps in the healthcare system? What are the important lessons we have learnt about the adoption of telemedicine during the COVID-19 pandemic? And what are the regulatory barriers that constrain a broader application of telemedicine?

> “Telemedicine refers to clinical care that is administered remotely via telecommunications technology to a patient, either the diagnosis or treatment of such patients.”

Telemedicine refers to clinical care that is administered remotely via telecommunications technology to a patient, either the diagnosis or treatment of such patients. Telehealth is much broader and refers to the administration and advancement of healthcare via technology platforms, including the collection of information, virtual training of healthcare professionals and through hosting of webinars.

Despite advances in technology and the increasing penetration of broadband internet coverage, there is little doubt that telemedicine will not totally replace the conventional face-to-face interaction between patients and health practitioners. However, we live on a continent that is characterised by a chronic shortage of medical professionals, and solutions such as telemedicine can play an important role in facilitating access to medical services, particularly for people in remote and rural areas.

The ratio of healthcare professionals to patients in South Africa stands at 40.7 doctors – both general practitioners and specialists – per 100 000 people. This is one doctor for 2 457 people in the public healthcare sector. And this is a moving target in the sense that adding more practitioners will not be proportionate to the rate of a rapidly growing population.

Telehealth and telemedicine solutions allow us to be innovative and to stretch the limited resources to cover as many people as possible.

A cost-effective alternative

We witnessed the efficacy of telehealth in dealing with the HIV/Aids pandemic 20 to 30 years ago, in many countries in Africa. Governments and entities that were looking after HIV-infected populations relied a lot on mobile health technologies to communicate with patients, send them reminders for patient check-ups and arrange for focus group engagements.

Access to mobile devices will always avail a cost-effective alternative that will enable us to improve access to primary healthcare. Telehealth and telemedicine can also help to offset the shortage of healthcare infrastructure such as hospital beds, which were in short supply at the peak of the COVID-19 pandemic.

For example, we have technology that enables patients to be monitored remotely through solutions, such as oxygen saturation monitors that are linked to a centrally located smart device that collects data and informs healthcare professionals of the condition of the patient.

This augmentation of physical contact has been a safe and cost-effective alternative to managing healthcare, and it has in turn played a crucial role in addressing some of the healthcare challenges presented by our strained healthcare system.

There are devices that can be used by patients wherever they are, and those devices can then upload data into a central database that can be

accessed by other healthcare practitioners for cross-refencing and to monitor compliance.

While face-to-face consultations will remain the primary and preferred method of medical care for millions of patients and healthcare practitioners, there is an opportunity to deploy elements of telehealth in the ecosystem in areas such as data management, reviews, and post-surgical consultations.

Blockchain

To that end, it is critical that the healthcare industry should agree on how to harmonise the growing number of online healthcare systems and ensure that they are aligned. Telehealth solutions currently have the unintended consequence of fragmenting data management in the healthcare system, as data hosted by one healthcare practitioner or administrator is often inaccessible to others in the system.

It would, therefore, be futile and self-serving for one administrator to have its own system that cannot be accessed by other healthcare providers who are not linked to the administrator in question. Blockchain technology may be a solution that allows for multiple operators to store their data in a central database that can be securely accessible to all, but above all, empowering the patients or health citizens to manage access to their healthcare data.

Currently the data is kept and controlled largely by those who fund the healthcare sector, and this is not a sustainable model as it still perpetuates fragmentation of the ecosystem. The industry must find a way to bring the healthcare providers along to enable them to store and retrieve the data from these and other databases.

There is no doubt that telemedicine and telehealth can go a long way towards facilitating access to healthcare services in rural areas, reduce costs, prevent the spread of illness, and enable easy follow ups. These interventions are convenient, save time, and can potentially reach more patients. The downside is that the systems are internet enabled, require data and the right devices to function effectively. This can be prohibitive for communities that have no compatible smart devices and where internet connection is poor or not available.

A virtual health roadmap

However, a hybrid healthcare system that caters for both traditional one-on-one consultations and techno-based platforms seems to present a plausible solution to address some of these challenges.

Funders need to define a value-backed virtual health roadmap, optimise provider networks, and accelerate value-based contracting to incentivise telehealth development and implementation. They also need to build virtual health into new product designs to meet changing consumer preferences and demand for lower-cost plans, and to integrate virtual health into the care delivery approach. In addition, it is advisable that they should also reinforce the technology and analytics foundation that will be required to achieve the full potential of virtual health through sound Health Technology Assessment (HTA) principles and policies.

Policymakers can come to the party by accelerating the development of an overall consumer-integrated "front door" and to segment the patient populations and specialties whose remote interactions could be scaled with home-based diagnostics and equipment. The segmentation can be designed to be disease-based or geographical.

There is also a need to build the capabilities of the provider workforce and to provide incentives for them to support virtual care. In addition, ways of measuring the value of virtual care by quantifying clinical outcomes must be considered. This will help in further considerations of strategies for growth in new areas of healthcare.

Accelerating access to healthcare

While telemedicine and telehealth hold immense potential for accelerating access to primary healthcare, these platforms are constrained by limitations such as limited physical examination, lack of access to data and devices, potential for abuse and the potential risk of losing human touch and interaction.

Telemedicine and telehealth may have their inherent limitations, but their ability to complement healthcare provision is immense. The COVID-19 pandemic has seen healthcare practitioners investing more in telemedicine and telehealth platforms and the trend is set this way as the important lessons learnt from the usage of these technologies cannot be unlearnt, and neither will the investment in this infrastructure go to waste.

Ultimately, healthcare providers will have to determine the part of their work that needs to be generated from online platforms, and the percentage to be derived from traditional consultations. ●

The industry must find a way to bring the healthcare providers along to enable them to store and retrieve the data from these and other databases.

Gareth Stokes
Stokes Media

Red light green light: Government shrugs off growing NHI concerns

The South African government is pushing ahead with its National Health Insurance (NHI) implementation despite growing concerns about the solution's affordability and government's capacity to manage it.

The proposal has drawn widespread criticism from healthcare policy journalists and NGOs, spearheaded by the likes of author, Dr Anthea Jeffery, and the Free Market Foundation (FMF). And it has caused rumblings of concern at medical schemes and among healthcare intermediaries too.

> The issue presently, and probably in the future, is that government has a poor record of maintaining and managing its public healthcare infrastructure.

Universal healthcare for all

One of the challenges facing critics of NHI policy, is that providing access to universal healthcare for all South Africans is a noble pursuit, and a right that is enshrined in our constitution. "While it remains a laudable goal that there should be better quality and more readily accessible healthcare, we do not believe that the NHI proposal represents a reasonable option to achieve it, or that a sufficient level of technical analysis has been performed by government in fully understanding the complex dynamics of either the public or private sector," writes the Health Policy Unit of the FMF, in their May 2021 research paper on the healthcare landscape."

"Government argues that NHI is the only means of meeting its healthcare obligations, despite citizens already having access to an array of healthcare services on offer in both the public and private sector. "Much confusion has been sewn into the policy process [in] arguing that the NHI is necessary for South Africa to achieve universal health coverage; yet South Africa does currently achieve near-universal health coverage," writes the FMF.

The issue presently, and probably in the future, is that government has a poor record of maintaining and managing its public healthcare infrastructure. Per the FMF: "What afflicts the public health sector is poor quality of care, not a lack of universal access".

Feeding the patronage network

In an opinion piece published on Biznews.com, Michael Settas, Chairman of the FMF Health Policy Unit, warns that the NHI's design has more to do with feeding patronage networks than improving healthcare outcomes. "The policy proposes to centralise vast sums of money within a single NHI Fund," he writes.

Furthermore, the NHI Bill "seeks to monopolise the management of all healthcare services in the country, private and public, while dramatically increasing arbitrary and discretionary powers of the Minister of Health, thus enabling even greater levels of corruption". There are also growing concerns that that the recent R150 million Digital Vibes tender, and the many PPE procurement scandals that occurred in 2020, will become commonplace in a monopolistic, politically-dominated NHI.

John Kane-Berman, writing on politicsweb.co.za, took issue with the Acting DG of Health's response to questions about the impact of the Digital Vibes scandal on the NHI. Dr Nicholas Crisp was reported as saying: "It may impact on the debate in Parliament, and may influence how they may want to reformulate what is in the Bill; but from an implementation perspective, we think [NHI] is still a good idea and the best way to get [healthcare] services to people". We enjoyed Kane-Berman's retort: "Anyone who has any understanding of the ANC knows that Dr Crisp is wrong in claiming that NHI is the best way of getting services to people; but unfortunately, he is undoubtedly correct in stating that the ANC will press ahead anyway".

Rubber stamping through Parliament

Dr Crisp also recently commented that most outstanding NHI processes would be completed by the end of 2021. "The Chairperson of the Portfolio Committee has indicated that he would like the process of hearings to be completed before the end of this year, and that the rest of the process of evaluating the NHI Bill should be finished by the end of this year too," he said. Of course, there are many issues that could push

the enactment of the legislation further down the road; but it seems there is enough political backing for NHI, and enough ANC support in Parliament, to limit delays.

Even so, the reasons offered by government to rush through NHI can be countered. The FMF research paper dismisses government's claims of inadequate funding in the public sector, pointing out that public health expenditure has grown substantially over the past two decades, both in per capita and in real terms.

Government's ongoing criticism of the private sector for inflation-plus price hikes is also flimsy… "The Health Market Inquiry's six-year long assessment of the private sector found that much of the sector's failings were a result of an incomplete regulatory framework and inadequate regulatory oversight from government and regulators," notes the FMF.

The FMF is concerned about flaws in the policy design process. They suggest that work on the NHI Bill was undertaken with a specific solution in mind, with each subsequent discussion or policy document closely aligned with this predetermined outcome. In the context of a predetermined outcome, it hardly matters that the technical detail is absent or that solutions are not properly tested or costed. This fixation on a centralised NHI Fund may also explain why the abject failure of the NHI test projects has simply been ignored.

Lessons from the vaccine procurement bungle

If government's performance through pandemic is indicative of the future under NHI, we should be very concerned indeed. The Department of Health leaned heavily on medical schemes and private healthcare infrastructure throughout the pandemic, and were quite happy for medical scheme member's to pay for vaccinations, and schemes to assist with vaccine distribution, while preventing medical schemes' from participating in critical areas, including procurement.

Dr Jeffery, in an article published on the Institute of Race Relations' Daily Friend newsletter, went as far as to blame the country's halting vaccine procurement process on "the opportunity the ruling party saw to pilot the vital single-buyer element in its proposed NHI scheme".

Overnight, claims Jeffery, we found ourselves unwilling participants in a healthcare system that was beholden to a political ideology that favours China and Russia over the West. "Ideology further requires that the entire vaccination procurement and distribution process be controlled by the government," she wrote. Under the future NHI system, government will not only choose the vaccine manufacturer and negotiate for the purchase of vaccines, but also decide which private sector firm may administer these vaccines.

The very existence of medical schemes and healthcare intermediaries could be under threat too, because section 33 of the NHI Bill is written to prevent medical schemes from offering cover for any services already covered by the NHI. Sadly, there is little clarity to date on the specific services the NHI will cover, making meaningful debate on this issue quite difficult.

One Minister to oversee it all

The NHI, as proposed, will see as much as R450 billion per annum allocated to healthcare product and service providers from a single centralised NHI Fund. Some of these funds will come from the national budget and some from dedicated taxes on personal income, with alarming hints that the NHI Fund is also eyeing the billions of rand in accumulated capital reserves held by the medical schemes industry.

The NHI Fund will be 100% controlled by the Minister of Health, who will also enjoy sole discretion to appoint critical personnel to the NHI Fund and its various governance structures. "The conjuring up of this NHI Bill is the starkest example you will find of immutable cravings for the Marxist and statist ideologies of central planning, unfettered access to public monies and the dissolution of free market enterprise," concludes Settas.

"Even a neutral observer to this proposal would pose critical questions as to why it is being implemented when the 10 NHI pilot projects were failures; when no in-depth technical assessment, comprehensive costing or institutional feasibility studies of the proposals have been undertaken during the 12-year policy process; and why it is necessary to sweep aside two substantial assets, the private and public health sectors, to be replaced with an untested and unworkable policy".

The bottom line: citizens should think twice before they applaud a system that will put every aspect of their healthcare provision in government's hands. And before pledging blind loyalty to NHI, ask: What would the 2020 healthcare experience have been without the private sector? ●

Even a neutral observer to this proposal would pose critical questions as to why it is being implemented when the 10 NHI pilot projects were failures.

Antony Brown MBE
Head of Africa
Aetna International

The pandemic's impact on workplace health and wellness

The unprecedented spotlight on public health, over the last 12-18 months, has emphasised the need for effective health and well-being initiatives in the workplace like never before.

One of the most significant changes for businesses and their employees has been the mass shift to remote working. Research we've conducted, with employees and HR Directors, suggests that this shift has had a significant impact on staff's physical and mental health, as well as productivity.

For those responsible for corporate health and wellness strategies, understanding the short and long-term health trends created or accelerated by the pandemic will be critical.

Mental health, a priority

Several studies conducted over the past year have shown an increase in mental health issues since the start of the pandemic. For instance, the World Economic Forum (WEF) found a particularly strong link between loneliness during the pandemic and a high risk of mental health problems such as anxiety, depression and sleep disruption.

While the easing of restrictions may offer some respite, the effects of the pandemic will not simply vanish. Employers will not only need to contend with the long-term impact the crisis has had on people generally — including higher levels of anxiety and forms of post-traumatic stress disorder (PTSD), what the industry is now calling 'long-COVID' — but will need to plan how they can support employees as they adjust back to a more normal pace of life.

Long-term health trends

The indirect health impacts of COVID-19 are likely to become clearer as time goes on, but we know that access to in-person consultations has been limited over the last 18 months. This, coupled with a widespread fear of becoming infected with the virus, means many have delayed check-ups and preventative care such as mammograms.

Monitoring the delayed impact of these and other factors will allow decision makers to guide the right elements of their corporate wellness programme. Enabling access to consultations, whether by virtual or physical means, will be crucial to ensure employees are getting the care they need when they need it.

The effects of sedentary behaviour

For many employees across Africa, working from home has eliminated any form of commute. Additionally, without the opportunity to socialise with colleagues - for example at lunch, or over a mid-morning tea/coffee - many of us are moving less. This increase in sedentary lifestyles can increase the risk of a number of physical health issues, such as muscular skeletal conditions (MSK) and obesity.

Companies must help to promote physical activity and well-being, if we are to begin to tackle the health impacts of sedentary behaviour. Investment in proper ergonomic equipment (both for those working from home as well as in the office) will be key, as will physical health initiatives including access to virtual and physical gym memberships, physiotherapy and other forms of physical care.

Technology finds its place

The pandemic has helped to establish telemedicine as a practical and convenient health care solution, which has had a huge impact on providers and patients alike. Consumers now expect digital access to information, appointments and advice, and this is being reflected in the wants and needs of global employees.

This appetite for digital health solutions means technology will play a fundamental role in our new approach to workplace health. Now is the perfect time to reassess how technology such as apps and devices can empower employees to better manage their physical and mental health.

The needs of employees around the world have changed drastically during the past year, and the return to normal working life will lead to even more change. Businesses must be willing to adapt to these ever-evolving circumstances and, wherever possible, maintain a working structure and culture designed to prevent these health problems from occurring in the first place. ●

"This increase in sedentary lifestyles can increase the risk of a number of physical health issues, such as muscular skeletal conditions (MSK) and obesity."

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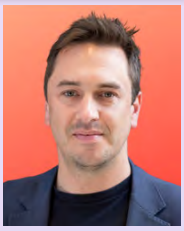
DIGI THIS, DIGI THAT...
the future of insurance is 'digital everything'

Delving into the future of insurance, FAnews hosted a live webinar, sponsored by Genasys, where esteemed speakers spoke about the future of insurance, how Insurtech is no longer a value add, but a given and how digital is changing everything.

Clutching onto the ways of the past



On the topic of the future of insurance, **Andre Symes, Co-CEO of Genasys** pointed out that the insurance industry has been notorious for clutching onto the ways of the past. Looking at where insurance is going, he said… partnership, collaboration and choice have become very important.

Symes used dinosaurs, cell chargers and paint palettes as an example of why adaption and adoption of/to technology is so critical. "What do dinosaurs, cell chargers and paint palettes have to do with technology eco systems? It's not the strongest of the species that survives, nor the most intelligent that survives. It's the one that's most adaptable to change," he said.

"When we speak of eco systems and partners, we must ask ourselves, why have partnerships and collaboration become so important? That's where dinosaurs come in. Charles is often misquoted. But its still super valid. Dinosaurs were evolving, but when a major event like an asteroid hits, simple evolution is not quick enough. In more recent times and in business, we can obviously reference COVID, and step changes are needed," he added.

"When COVID hit, nobody had the luxury of taking their time to evolve their monolithic core systems into the next thing, the ones who could act fast, leapfrogged their competitor. So, why has the partnership and ecosystem approach become so important? Technology options give us the ability to adapt or pivot quickly. Technology eco-systems give us choice, choice gives us options to adapt or pivot quickly and being able to adapt quickly, future proofs us," he emphasised.

"Why have partnerships and collaboration become so important? Because we simply cannot build solutions for the unforeseen, but we certainly can architect for it. The more we future proof our businesses, and the more we engineer in agility, the more we reduce the risk to our businesses for future changes," he stated.

"So, how do you ensure that your business can adapt and be able to play in this new collaborative environment? Let us look at an example. There was a phase, for example, when we used adapters, often referred to as middleware in tech, but only when we started adopting universal standards like USB, Bluetooth, Wi-Fi etc., did it make plugging in new devices more feasible and convenient," said Symes.

So, how do we cater for this?

"You need Application Programming Interfaces, a clear vision of your roadmap and internal change management. This is where the art of choosing the right partner comes in," he said.

When choosing eco-system partners, Symes said you need to ask the following questions:

- Are they going to help your customer?
- Are they solving a business problem?
- Are they going to collaborate?
- Who else is in the eco system?
- Is there a technical fit?
- Is it financially viable?

"With the right core and partners, you have options! So, back to dinosaurs, cell chargers and paint palettes… don't be a dinosaur and become extinct but adapt. Like the USB cable and chargers (adopt – so you become more feasible and convenient), and lastly, have a vision and paint your unique offering," he concluded.

No longer a value add, but a given

Mutoda Mahamba, CEO and Founder of Solvency Insurance then emphasised that Insurtech is no longer a value add, but a given.

"History has shown us that the "too big to fail" of the past, have indeed failed. We put a spotlight on why companies that are grappling with artificial intelligence, the "internet of things," and implementing digital platforms, will ultimately fail," he said.

"Looking at Artificial Intelligence trends shaping the insurance industry, firstly, we have the explosion of data from connected devices (existing devices joined by new, growing categories and new data created, allowing insurers to understand their clients more deeply). Secondly, there are open source and data eco-systems (data can be shared and used across industries and public and private entities will come together to create ecosystems), and thirdly, there are advances in cognitive technologies ("active" insurance products tied to an individual's behaviour and activities, new product categories and engagement techniques)," said Mahamba.

Insurtech, no longer a value add but a given has an effect on distribution (purchasing insurance is faster, usage-based insurance (UBI) products proliferation and agents transition to process facilitators and product educators), underwriting and pricing (automated underwriting, supported by a combination of machine and deep learning models, usage and a dynamic, data-rich assessment of risk, and enables consumers to make decisions about how their actions influence coverage, insurability, and pricing) and claims (more than half of claims activities have been replaced by automation, IoT sensors and an array of data-capture technologies, human claims management focuses on a few areas: complex and unusual claims, contested claims).

In terms of adaption to Insurtech, Mahamba said, "get smart on AI-related technologies and trends - the Board and Senior Leadership Team should in building a deep understanding of AI-related technologies, with pilots and proof-of-concept (POC) designed to test not just how a technology works but also how successful the insurer might be operating in a particular role within a data- or IoT-based ecosystem. Develop and begin implementation of a coherent strategic plan that touches operations, talent, and technology and outlines a road map of AI-based pilots and POCs. Detail which parts of the organization will require investments in skill building or focused change management. And lastly, create the right talent and technology infrastructure - insurers must make measured but sustained investments in people, with a unique mix of being technologically adept, creative, and willing to work at something that will not be a static process. Identify external resources and partners to augment in-house capabilities that will help carriers secure the needed support for business evolution and execution," he concluded.

DIGI THIS, DIGI THAT...
the future of insurance is 'digital everything'

How digital is changing everything

In her keynote, **Shelley Walters, CEO of The Sales Counsel,** addressed how the move from office work to remote and hybrid work has brought massive challenges and, along with it, opportunities for differentiation. While this change has meant an enormous change in insurance and insurtech, we should not underestimate the impact that the modernisation of the workforce has on our client engagement.

According to McKinsey, 75% of B2B buyers now prefer remote, human to human engagement, and according to Gartner, one extraordinary experience can raise your customers' expectations of your competitors.

Shelley emphasised that in a highly regulated and commoditised environment, how you sell is more important than what you sell, or the price you sell it at. This is important to bear in mind when you consider that client expectations are a rising.

Looking at the 2020 research conducted by Landmark; the pressing questions for the financial services sector were/are as follows:

1. How do brokers, advisers and planners keep up with the volume of enquiries and communications;
2. How can they protect their base from an economic recession or competitors;
3. How can they effectively conduct technical, financial and emotional conversations on the phone or a video call; and
4. How can they establish relationships with new clients, many of whom they have never met.

What are the challenges of engaging with the connected client? Walters said, "It is different... technology enables remote face to face meetings, but it alters the dynamics. We sit in different regions, it can feel artificial, time moves differently online, there are fewer opportunities for casual connection, keeping the conversation on track can be a significant challenge and technical issues can derail your meeting at a moment's notice."

Engagement is also more challenging. "There is lower engagement, higher levels of distraction, key decision makers may delegate remote sales calls to junior contacts, people are more impatient, more disagreeable, less likely to share scepticism and challenge viewpoints. It is harder to facilitate consensus. It is less collaborative, less conversational and customers' drop off'," she said.

There are eight ways to elevate your remote client engagement, according to Walters. These include:

1. A professional set-up;
2. Meeting management;
3. Tools of the trade;
4. Stakeholder engagement;
5. Improving your pitching skills;
6. Delivering data driven engagements;
7. Social engagements online; and
8. Doing more of what brings in revenue.

Here is how to elevate your online client engagement, according to Walters:

- **STEP 1 Appreciate** – "I appreciate you taking the time to join this call."
- **STEP 2 Agree on time** – "We are scheduled for 60 minutes; does that still work for you?"
- **STEP 3 - Align to the end goal** – "By the end of today's call, I would like to know more about your requirements and what you would see as the next step for your organisation."
- **STEP 4 - Agenda** - Communicate a narrowly scoped agenda with few (er) defined objectives, to ensure that everyone is getting the impact they expect from the call.
- **STEP 5 - Summarise** - Revisit what was discussed in the previous meeting, so everyone can connect the dots.
- **STEP 6 - Connect the wagons** - At the end of the call, summarise the discussion, confirm that the end goal agreed at the onset of the meeting has been achieved and leave a positive last impression.

"Prepare engagement for all participants. Be interested rather than interesting. Uncover opportunities to relate and connect. Weave acknowledgement into your engagement and invest in relating efforts outside of the meeting. Command the virtual room. Maintain structure, adapt to client needs, be clear and specific, keep dialogue short and keep the dialogue interactive. Use nonverbal behaviours to energise and engage. Be mindful of your facial expressions and smile. Take ownership of the engagement and practice and dry run your important meetings. Finish strong... don't run overtime, clarify and align, gain commitment, confirm the next steps and follow up with selected, relevant buyer enablement content. And lastly, optimise virtual engagements, test your technology and other equipment, plan engagement for all attendees and manage your remote environment," she concluded.

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GWII hosts annual Golf Day

Gauteng Women in Insurance (GWII) hosted their prestigious annual golf day at the magnificent Steyn City Golf Club in Midrand with main sponsor Auto & General, co-sponsors Camargue, Clyde & Co, F&I Insurance, F&I Reinsurance and Emerald Risk Transfer.

Starting play

On arrival players were supplied with golf shirts, sponsored by Clyde & Co and caps and visors sponsored by Everinghams. The funky socks were sponsored by F&I Insurance & F&I Reinsurance. Players were supplied with masks and buffs, sponsored by Yard Insurance.

Thank you to the additional sponsors for the goody bags, Digicall and Genasys.

The event, open only to experienced golfers, was played over 18 holes.

For the first time ever at the GWII Golf Day there was a hole in one competition where someone stood a chance to win R100 000, sponsored by SHA Risk Specialists. Unfortunately, no one won it.

As players came off the field, players and guests then enjoyed a gin from the gin bar, sponsored by Emerald, while indulging in sushi. The day ended off with a sit-down dinner and prize giving session.

Awarded efforts

Category winners included all the 4-ball groups. Prizes were also given for nearest the pin and the longest drive. Thank you to all of our prize sponsors:

- The first four ball won Nespresso coffee machines, sponsored by GWII;
- The second four ball won Pro Shop gift vouchers, sponsored Chubb; and
- The third fourball won Carrol Boyes hampers, sponsored by Discovery.

Nearest the pin won a Woodlands Spa voucher, sponsored by FAnews and the longest drive won a Le Creuset Boutique Store gift voucher, sponsored by Paton Personnel. For the lucky draw, winners walked away with wine and chocolate hampers, sponsored by Digicall.

Thank you sponsors

GWII would like to thank all the sponsors, and all the 4-ball sponsors – Leppard Underwriting, Horizon Underwriting Managers, King Price Insurance, SHA Risk Specialists and Straightthrough, and the supporting sponsors Everinghams, iTOO and Yard Insurance.

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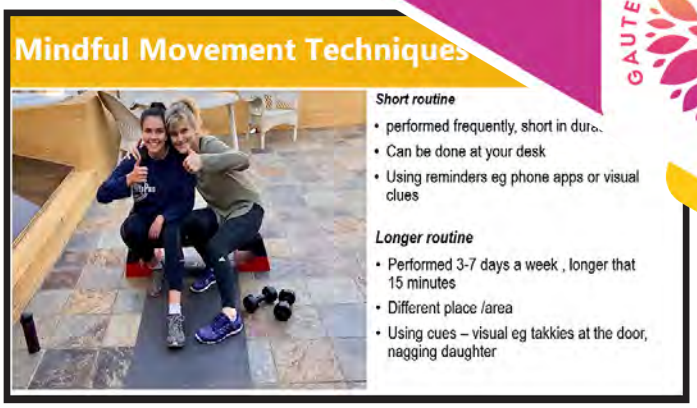
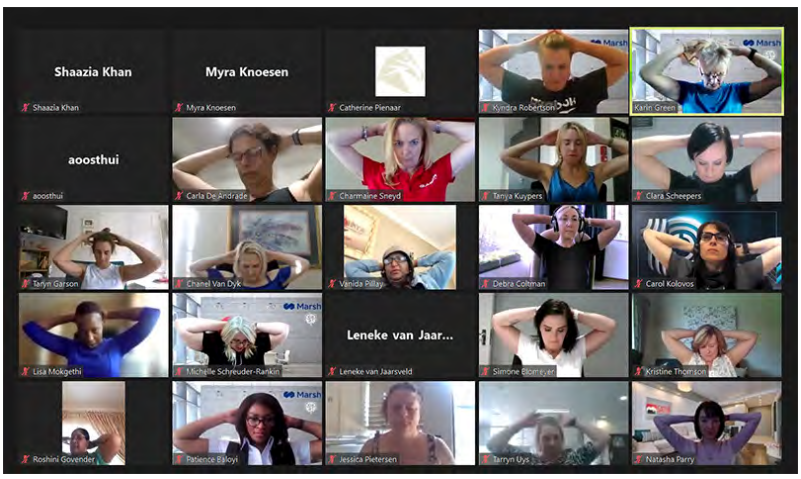
Mindful Movement

Gauteng Women in Insurance (GWII) hosted a motivational event, on Thursday 14 October, with main sponsor Marsh.

Themed Mindful Movement, guest speaker Karin Green, from The Networking Company and one of South Africa's leading Bio-kineticists, spoke to the ladies about the importance of movement, in part three of the Resilience Masterclasses.





A "do-able" gentle approach

Green discussed five elements of fitness, the importance of posture in maintaining energy and vitality, and how interval training is a key factor in developing a fitness programme.

The key elements that Green discussed include:

1. The importance of creating a proper workspace;
2. The dangers of sitting too much;
3. The fundamentals of human movement;
4. The importance of moving; and
5. Movement trends in 2021.

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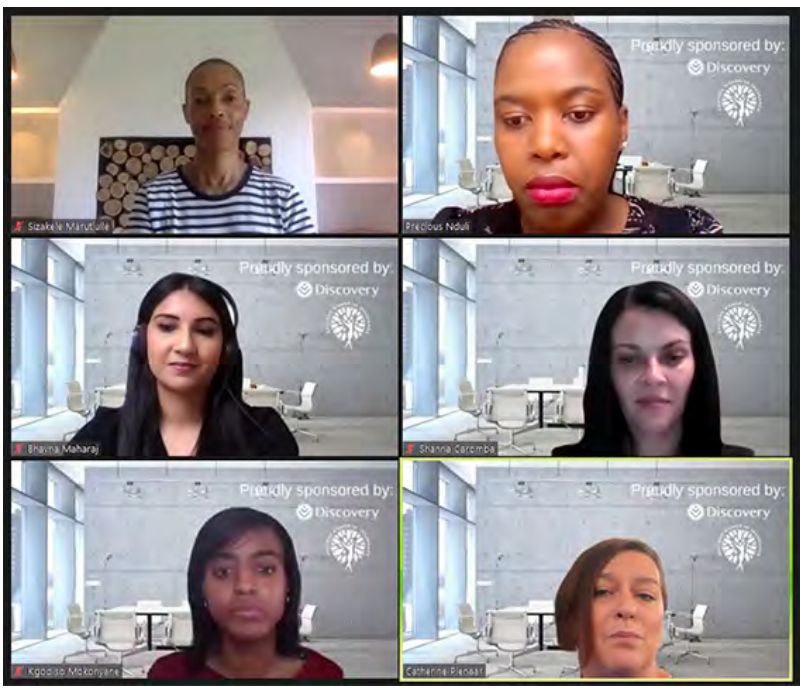
GWII CPD Session - Celebrating Diversity

Gauteng Women In Insurance (GWII) hosted an inspiring Continuous Professional Development (CPD) session themed 'Celebrating Diversity' on 27 October, proudly sponsored by Discovery.



The powerhouse session to engage and celebrate women saw keynote speaker, Dr. Sizakele Marutlulle, a creative problem solver, intersectional strategist, brand-building expert and global speaker blow attendees minds away with her personal journey, insights and experience of diversity.

A panel discussion

This, followed by a panel discussion, led by Precious Nduli, Head of Technical Marketing and Marketing at Discovery Insure, whereby the inspiring women of Discovery - Bhavna Maharaj, Head of Product Development, Kgodiso Mokonyane, Head of Strategy and Ancillary Products and Shanna Caromba, COO of Personal Lines at Discovery Insure shared their stories and insights into celebrating diversity, their roles and positive affirmations.

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