

**EXPERIENCES OF OLDER BENEFICIARIES  
OF PRIVATE MEDICAL AID SCHEMES  
AND RETIREMENT ANNUITIES  
FOR THE DEVELOPMENT  
OF HEALTHY AGEING MODELS**

**By**

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## ABBREVIATIONS

AARP	American Association of Retired Persons
ADL	Activities of daily living
CAPEX	Capital expenditure
CPI	Consumer Price Index
CPOA	Cape Peninsula Organisation for the Aged
CSR	Corporate social responsibility
ESSM	UCT Exercise Science and Sports Medicine Division
FSB	Financial Services Board
GDP	Gross domestic product
LSM	Living Standards Measure
NCD	Non-communicable diseases
PMB	Prescribed Minimum Benefits
ROI	Return on investment
SDG	Sustainable Development Goals
SSISA	Sports Science Institute of South Africa
U3A	University of the 3 <sup>rd</sup> Age
UN	United Nations
WHO	World Health Organisation

## **GLOSSARY OF TERMS**

<b>Active ageing (WHO)</b>	the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age
<b>Activities of daily living (WHO)</b>	the basic activities necessary for daily life, such as bathing or showering, dressing, eating, getting in or out of bed or chairs, using the toilet, and getting around inside the home
<b>Age-friendly environments (WHO)</b>	environments (such as in the home or community) that foster Healthy and Active Ageing by building and maintaining intrinsic capacity across the life course and enabling greater functional ability in someone with a given level of capacity
<b>Ageism (WHO)</b>	stereotyping and discrimination against individuals or groups on the basis of their age; ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs
<b>Annuities (National Treasury, 2012)</b>	are commonly understood as products which pay an income after retirement
<b>Community-rated (Mcintyre, 2010)</b>	a contribution to health insurance calculated on the basis of the insurance claims profile of the entire community or of the insurance scheme, or on the basis of the average expected cost of health service use of the entire insured group rather than of an individual

<b>Frailty (or frail older person)</b> <b>(WHO)</b>	extreme vulnerability to endogenous and exogenous stressors that exposes an individual to a higher risk of negative health-related outcomes
<b>Gerontology</b> <b>(WHO)</b>	the study of the social, psychological and biological aspects of ageing
<b>Healthy ageing</b> <b>(WHO)</b>	the process of developing and maintaining the functional ability that enables well-being in older age
<b>Health</b> <b>(WHO)</b>	a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity
<b>Healthy life expectancy</b> <b>(Salomon et al., 2012)</b>	the number of years that a person at a given age can expect to live in good health taking into account age-specific mortality, morbidity, and functional health status
<b>Life cycle model</b> <b>(Butler &amp; Van Zyl)</b>	used to describe the accumulation of savings during an individual's working years, to fund their lifestyle when they are unable to earn in their later years
<b>Longevity</b> <b>(WHO)</b>	how long people live

<b>Long-term care (WHO)</b>	the activities undertaken by others to ensure that people with a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity
<b>Non-communicable diseases (WHO)</b>	diseases that are not passed from person to person; the four main types of noncommunicable diseases are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes
<b>Out-of-pocket expenditure (WHO)</b>	payments for goods or services that include (i) direct payments, such as payments for goods or services that are not covered by any form of insurance; (ii) cost sharing – that is a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of the health care received; and (iii) informal payments, such as unofficial payments for goods and services, that should be fully funded from pooled revenue
<b>Shared value (Porter)</b>	creating economic value in a way that also creates value for society by addressing its needs and challenges
<b>Well-being (WHO)</b>	a general term encompassing the total universe of human life domains, including physical, mental and social aspects, that make up what can be called a “good life”
<b>Whealthcare (Global Agenda Council on Ageing, 2016a)</b>	a term which demonstrates linkages between a healthy population and maintaining financial well-being

## ABSTRACT

This study explores the experiences and perceptions of older beneficiaries of private medical aid schemes and retirement annuities. Its main research question is: What motivates, challenges and concerns older research participants when it comes to maintaining their good health and financial well-being? Its research objective is to place these lived experiences within the context of the private health and finance sectors of South Africa in order to develop *healthy ageing* models. It arises out of the increase in longevity and the potential increase of healthcare expenses in old age. The key concepts in this study are ageing frameworks and *whealthcare*: the relationship between the financial services industry and healthcare sector. A qualitative approach is used with semi-structured interviews with professionals in the healthcare and finance sectors and individuals in the retirement phase of their lives. The study is significant as it gives a deeper understanding of the realities of older people who access private sector services and it provides a framework for greater synergy between the finance and health sectors to promote *healthy ageing* and prepare individuals for the financial implications of healthcare costs in later age.

**Keywords:** health, wealth, well-being, retirement, *healthy life expectancy*, *healthy ageing*, *whealthcare*

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# CHAPTER ONE

## INTRODUCTION

### 1. Introduction

#### 1.1 Multifaceted aspects of health and well-being in old age

Health and well-being are subjective terms which are often used interchangeably. The World Health Organisation (WHO) describes *health* as the “the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined”. *Well-being* is “a dynamic state of physical, mental and social wellness; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses” (World Health Organization, 2004, pp. 28 & 56). As we grow older, maintaining a good quality of life requires a more holistic approach to health and well-being. Hence the WHO’s definition of *healthy ageing* as “the process of developing and maintaining the functional ability that enables well-being in older age” adopts a more pragmatic perspective by taking the dynamic and multifaceted aspects of ageing into consideration (World Health Organization, 2015b).

There are various dimensions to ageing and a growing ageing population. Multiple approaches and disciplines are required to address the array of factors influencing ageing in society. The spectrum is extensive, ranging from property management to specialist medical matters. Ageing affects individuals, families, communities, nations and the global community. Many societies are underprepared to meet the challenges presented by a growing older population. Assumptions based on 20<sup>th</sup> century ageing are hampering the adaption of systems and environments to meet the pace of 21<sup>st</sup> century longevity (BlackRock, 2015; World Economic Forum, 2011). In order to understand the bigger picture, it is important to recognise the role of numerous stakeholders and crucially government’s role in addressing the needs of the older members of society.

#### 1.2 Impact of ageing populations on societies and health systems

Government’s role is especially critical in developing nations, as they are facing a growing ageing population without established state health systems, pension and social security entitlement

programmes in place. Compounding this, is that ageing populations in developing regions are increasing at a faster pace than experienced by developed regions. The doubling in the proportion of the population aged 65 years and older from 7% to 14% took the US 68 years, whereas China has taken 26 years to achieve the same increase (Prince et al., 2015, p. 549). However 16.4% of the US gross domestic product (GDP) is attributed to health expenditure compared to 5.6% of China's GDP (OECD, 2015, p. 166). While ageing populations in Organization for Economic Cooperation and Development (OECD) countries have grown old with relatively high levels of personal wealth and adequate state protection, older people in developing nations are likely to lack state provision of healthcare and social security programmes (World Economic Forum, 2011).

In 2011, the over 60 population in South Africa was 4.1million. This is set to increase to 7 million by 2030 (Statistics South Africa, 2014, p. iv). This growing older demographic is particularly vulnerable in a nation which is often viewed as being one of the most unequal societies in the world (as expressed by the Gini coefficient, World Bank, 2017). The South African healthcare system is probably the most reflective of this inequality. The South African public healthcare sector caters to 82% of the population, while the private healthcare sector caters to 18%. South Africa spends 8.8% of GDP on healthcare. The total healthcare expenditure for the public sector was 48.2% and 51.8% attributed to the private sector. In 2008, the per capita expenditure by private and public sector was R10,000 and R1,900 respectively (Ataguba & Akazili, 2010, p. 2). Members of private medical aid schemes exhibit the life and healthy life expectancy of OECD countries shown in table 1 (D. Patel, personal communication, September 8, 2016). However, although the life expectancy of the general population of South Africa is skewed by the HIV/AIDS epidemic, the stark comparison with USA and UK illustrates the inequalities between the public and private sectors. The long-term projection is for South Africa to adopt a universal healthcare system. As financing of public health systems is problematic, the success of a National Health Insurance (NHI) would hinge on a hybrid model between the public and private sectors.

Table 1. *Healthy life expectancy* for South Africa, USA and UK, 1990-2010

	1990				2010			
	Male population		Female population		Male population		Female population	
	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy
South Africa	60.7	52.6	68.7	58.5	57.4	49.1	62.3	52.7
USA	71.7	63.0	78.6	68.1	75.9	66.2	80.5	69.5
UK	72.9	63.4	78.3	67.4	77.8	67.1	81.9	70.1

Source: Healthy life expectancy for 187 countries, 1990-2010: A systematic analysis for the Global Burden Disease Study 2010. (2012). Salomon et al.

The services provided by the private healthcare sector in South Africa are very similar to those of developed nations (Porter, Kramer, & Sesia, 2014). This could explain why the health outcomes of members of medical aid schemes are comparable to those of OECD countries. Discovery Health, South Africa’s largest private healthcare insurer, has bolstered these health outcomes with the Vitality programme. Based on the principles of behaviour economics, the wellness programme encourages healthy lifestyle choices through financial incentives (Porter et al., 2014). Although the Vitality programme and incentive model was designed for a younger market, the innovative model provides a solid foundation on which to develop a programme appropriate to an older demographic.

The South African situation differs to that of OECD nations, in that South Africa has a weak pension and social security framework. Therefore, older members of medical aid schemes have the additional challenge in retirement of ensuring they have sufficient retirement savings to provide an income for life and the potential of covering out-of-pocket payments and long-term care expenses which are not covered by their medical aid scheme.

This research will therefore be looking at this small segment of the 18% of the population who belong to a medical aid scheme. Exploring the lived realities of these older members, challenging assumptions about this seemingly affluent demographic and uncovering the concerns and constraints they experience will lead to innovation. Oliver Wyman best defines social innovation as “the application of innovative, practical, sustainable, market-based approaches to benefit society in general” (Wyman, 2016, p. 5). It is on this basis that it is important to note that the research findings presented in this dissertation pertain to a small demographic who access services from the private sector. The prototype outlined is a private sector solution. These would be inaccessible to

most of the South African population due to affordability issues and socio-economic constraints. As such, they are not models intended to solve the entire South African ageing framework. The emphasis in the development of the research prototype is innovation. Innovation is finding a solution to a problem and creating value. How this value is shared is important for its inclusivity. Thus, this exploratory inquiry contributes to the types of questions that need to be asked in future research for scaling *healthy ageing* programmes and policies within government models.

### 1.3 Older person terminology

Ageing is a dynamic and personal experience. On the biological level, ageing encompasses a wide array of molecular and cellular damage, which is neither linear nor consistent and hence is loosely associated with age as a number (World Health Organization, 2015b, p. 11). However slowing is a hallmark of ageing, resulting in decreased functional capacity which can increase the risk of an older person to environmental challenges (World Economic Forum, 2011; World Health Organization, 2015b). As defined by the WHO, an older person is “a person who has reached a certain age that varies among countries but is often associated with the age of normal retirement”(World Health Organization, 2004, p. 42). However the life course is a social construct, which is being challenged by the perceptions of retirement and shifting roles of older people in their families and communities (World Economic Forum, 2011; World Health Organization, 2015b). For the sake of consistency, the term “older person” was used in this study. With reference to the participants in this study, “older participant” is used. This is in reference to their chronological age of between 65-94 years old and their good functional and health status. (Please refer to appendix 1: Biographical details of older research participants for detailed account of research participants’ characteristics.) However, in other instances in the dissertation, “older person” is used in reference to a demographic which is beyond the research sample and may have decreased functional status. It is recognized that the term “older person” does not capture the diversity of older populations and that there is no such thing as a typical “older person” (World Health Organization, 2015b).

## **2. Research area and problem**

### 2.1 Ageing: A global priority

Ageing is a topical issue affecting societies around the world. The United Nations (UN) estimates that by 2050, the over 60 population is set to double, meaning 1 in 5 people will be over

the age of 60 (United Nations Department of Economic and Social Affairs, 2000). This phenomenon is not a far distant concern. In 2018 for the first time in history, global numbers of older people over 65 years will outnumber children under the age of 5 (He, Goodkind, & Kowal, 2016). Ageing populations in developing regions are growing at three times the rate of developed nations (United Nations Department of Economic and Social Affairs, 2013). By 2050, 79% of older people will live in developing regions (Shetty, 2012; United Nations Department of Economic and Social Affairs, 2001, 2015).

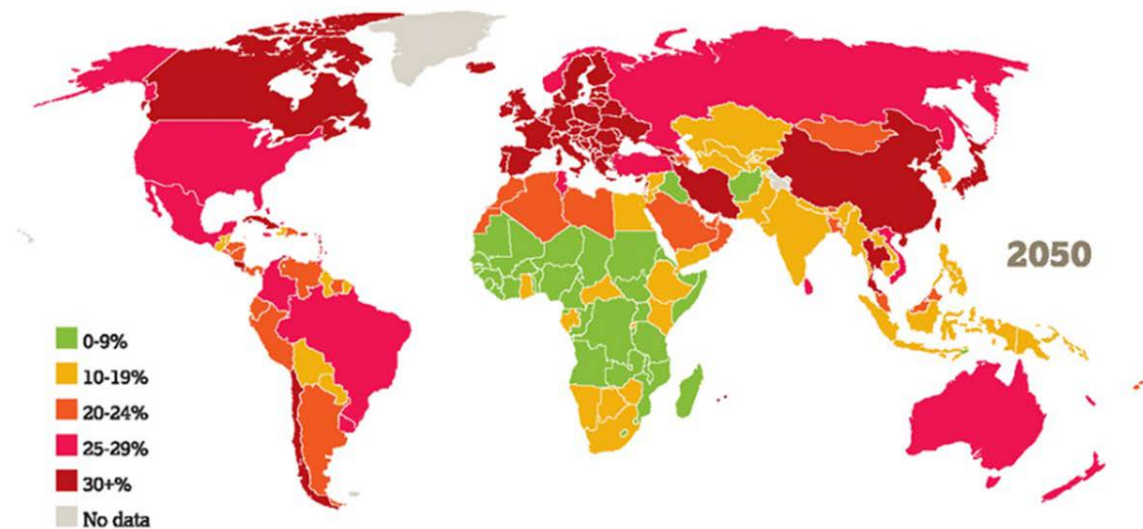


Figure 1. Percentage of older people as part of national population by 2050

Source: HelpAge Global Watch Index. (2015). Available at: <http://www.helpage.org/global-agewatch/population-ageing-data/population-ageing-map/>

As many societies experience a swelling ageing population as shown in figure 1, they will also need to navigate the implications of the longevity of their older demographic. The complexities of caring for a much older population are compounded by the shifts in cultural values and lifestyles due to the increase of the middle class and the changing gender roles which are affecting the forms of care which have traditionally been provided by the females in the family. Helping the ageing provides an opportunity for a diverse array of sectors and industries to research, innovate and collaborate (Porter & Kramer, 2011, p. 67).

The health and finance sectors have an opportunity to be active role players in addressing the needs of older people and promoting a *healthy ageing* culture throughout the life cycle. Fortunately, both sectors have started to realize the interdependencies between the various aspects of an individual's life. This is supported by the increasing trend over the past few decades to focus more on health expectancy and less on life expectancy (Nakajima, 1998; Salomon et al., 2012). It will be shown in this dissertation that the emphasis on health expectancy benefits both the health and finance sectors, but most importantly it has a positive impact on every member of our global community who is growing older.

## 2.2 Health and finance sectors' role in ageing

The following sections detail areas where the health and finance sectors can be instrumental in improving the quality of life for older people and providing a more financially sustainable retirement. Identifying areas where challenges exist in the health and wealth circumstances of older people, provides an opportunity to find solutions to these challenges and through innovation, to create value.

### 2.2.1 Health sector's role in ageing

Non-communicable diseases (NCDs) are lifestyle related conditions such as diabetes, cancer and obesity. Age is the strongest risk factor related to these conditions (World Economic Forum, 2011). There is evidence that 23% of the total global burden of disease is attributable to disorders in people aged 60 years and older (Prince et al., 2015, p. 549). Older people are also more susceptible to multi-morbidity and NCDs are the number one cause of mortality for over 60s as seen in figure 2. The privilege of living longer lives has brought with it the inevitability of chronic disease and disability in later life. A growing ageing population suffering from ill-health adds complexity to health systems and can place additional strain on older people themselves. Older people spend more money on healthcare costs than any other age demographic (Drolet, Schwarz, & Yoon, 2010; Moschis & Friend, 2008). This situation is heightened by the increase in healthcare costs, medical aid scheme increases above standard inflation (Watson, 2016) and the costs of long-term care for geriatric syndromes such as dementia and strokes (Prince et al., 2015). However, many of these conditions can be prevented or delayed, so the emphasis should remain on keeping people healthier for longer (World Health Organization, 2015b).

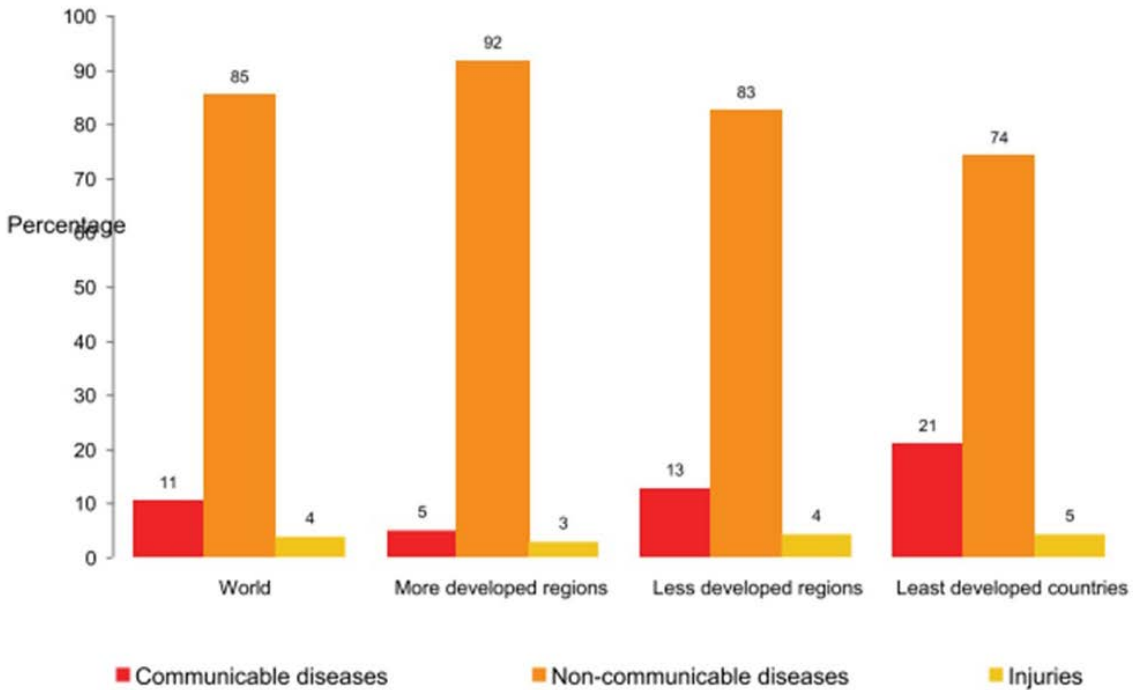


Figure 2. Distribution of death among persons aged 60 years or over by cause, 2008

Source: World Population Ageing. (2013). United Nations, Department of Economic and Social Affairs, Population Division

There is an urgency to maximize the quality of the additional years which have been added to life expectancy. *Healthy life expectancy* is the “number of years that a person at a given age can expect to live in good health taking into account age-specific mortality, morbidity, and functional health status” (Salomon et al., 2012, p. 2144). Figure 3 illustrates that although the average life expectancy in the US is 78.2 years, most individuals will experience health complications in the last 10 years of their life. Those years of ill-health are accompanied by increased healthcare costs, dependency and decreased quality of life. The emphasis should therefore be targeted at promoting an optimal life trajectory, as illustrated in figure 4. Each life trajectory depicted in figure 4 ends at the same age, however the optimal trajectory maximizes intrinsic capacity and compresses the time of disability and dependency (World Health Organization, 2015b).

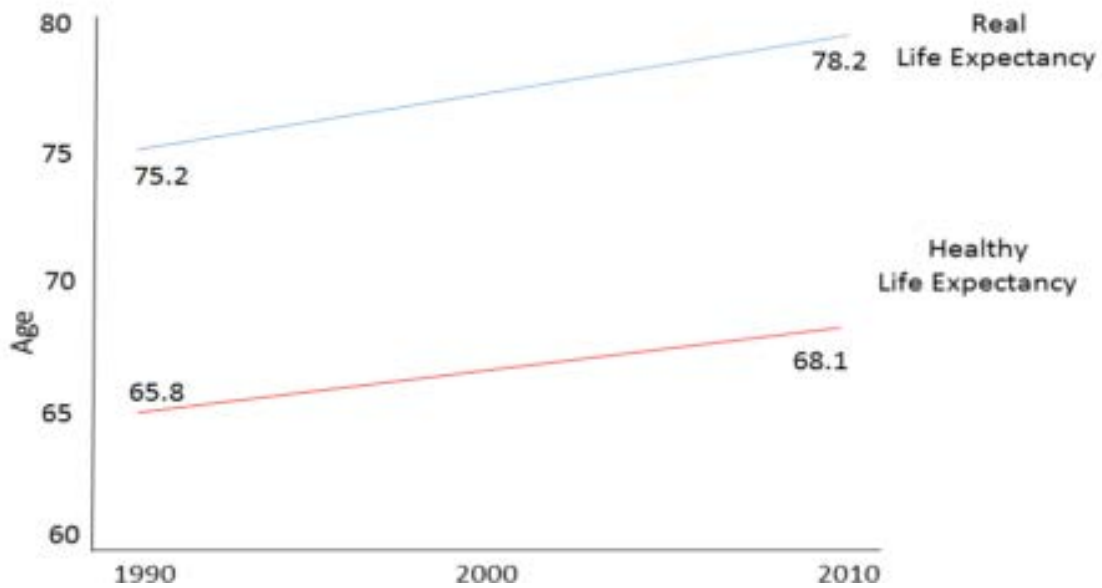


Figure 3. US life expectancy compared to healthy life expectancy 1990 – 2010

Source: Transforming life insurance to promote longevity. (2016). D. Yach [Adapted from Salomon et al. (2012). Healthy life expectancy for 187 countries 1990-2010: A systemic analysis for the Global Burden of Disease Study 2010. The Lancet]

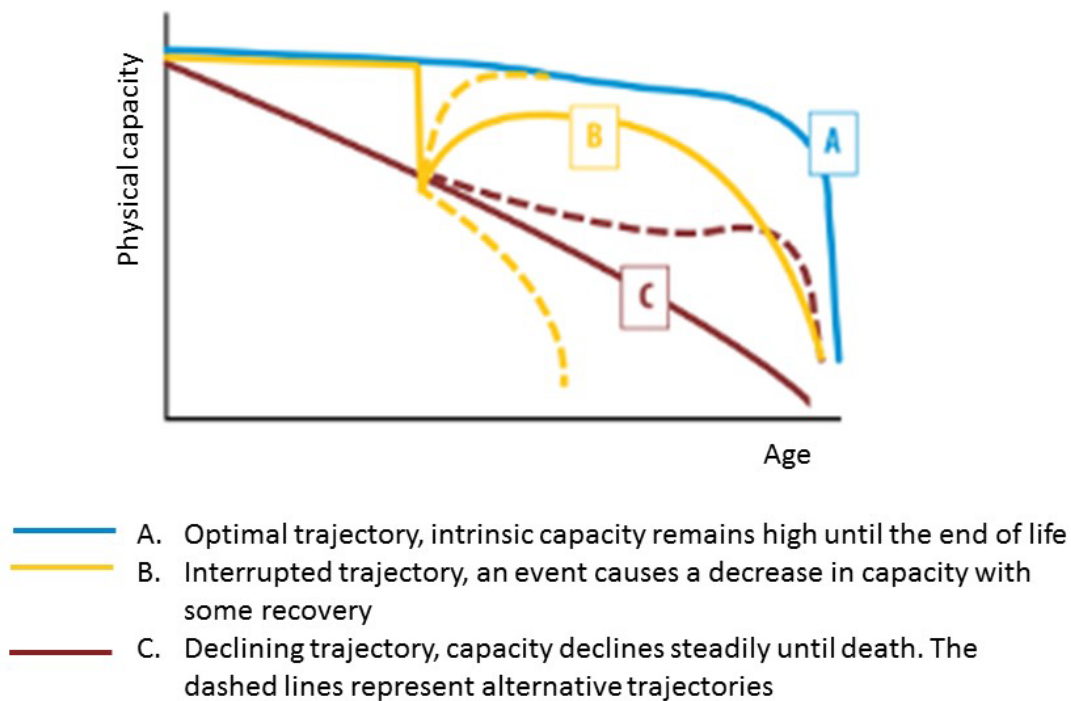


Figure 4. Hypothetical trajectories of physical capacity

Source: The world report on ageing and health. (2015). WHO

The compression of morbidity hypothesis proposes that older people with “healthier lifestyles will live longer yet have less cumulative lifetime disability than those with less healthy lifestyles” (Fries, Bruce, & Chakravarty, 2011, p. 5). In developing solutions which maximize *healthy life expectancy*, physical activity is perhaps the most obvious variable to reduce overall lifetime morbidity (Fries, 1996). Learnings can be made from longitudinal health intervention studies which have shown positive health outcomes in older people. The University of Pennsylvania study (1986 -) tracked alumni yearly. The study showed good health habits led to greatly increased functional ability, decreased lifetime disability, and longer lives (Fries et al., 2011, p. 6; Vita, Terry, Hurbert, & Fries, 1998). The Runners Study (1984- ) showed that regular, vigorous exercise postponed time to disability by 12 years in runners and that runners tended toward fewer knee and hip replacements than controls (Fries et al., 2011, p. 6; Hubert & Fries, 2017).

These studies illustrate that innovation is possible to maximize *healthy life expectancy* by compressing the number of years lived in poor health, supported by health interventions which aim to get as many as possible onto an optimal life trajectory. Refer to figure 5 and figure 6 below.

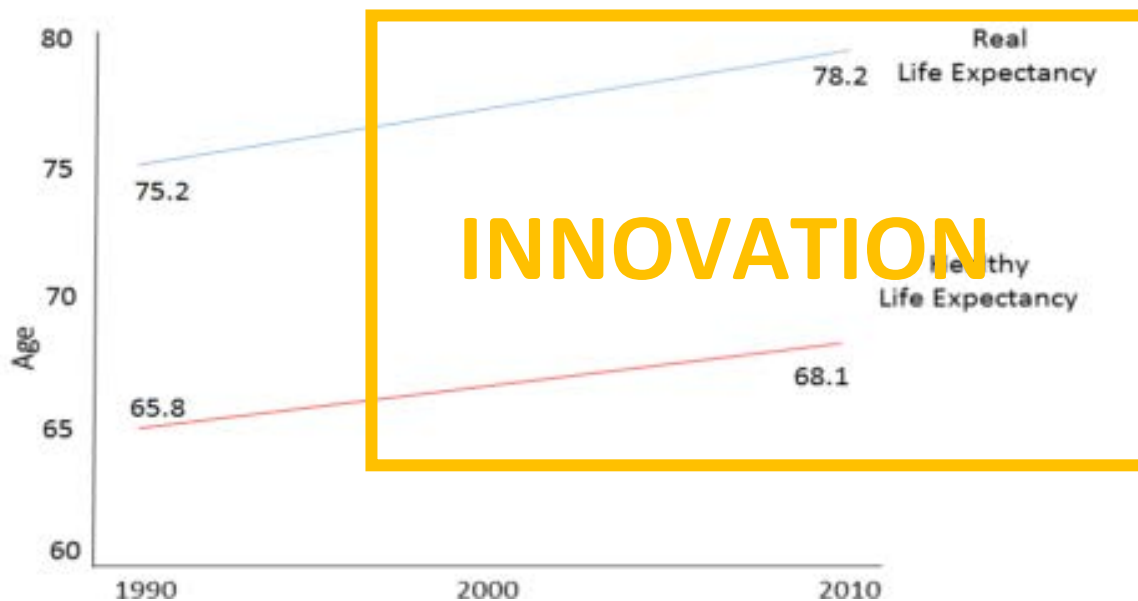


Figure 5. Area of innovation required to maximize health life expectancy

Source: Transforming life insurance to promote longevity. (2016). D. Yach [Adapted from Salomon et al. (2012). Healthy life expectancy for 187 countries 1990-2010: A systemic analysis for the Global Burden of Disease Study 2010. The Lancet]

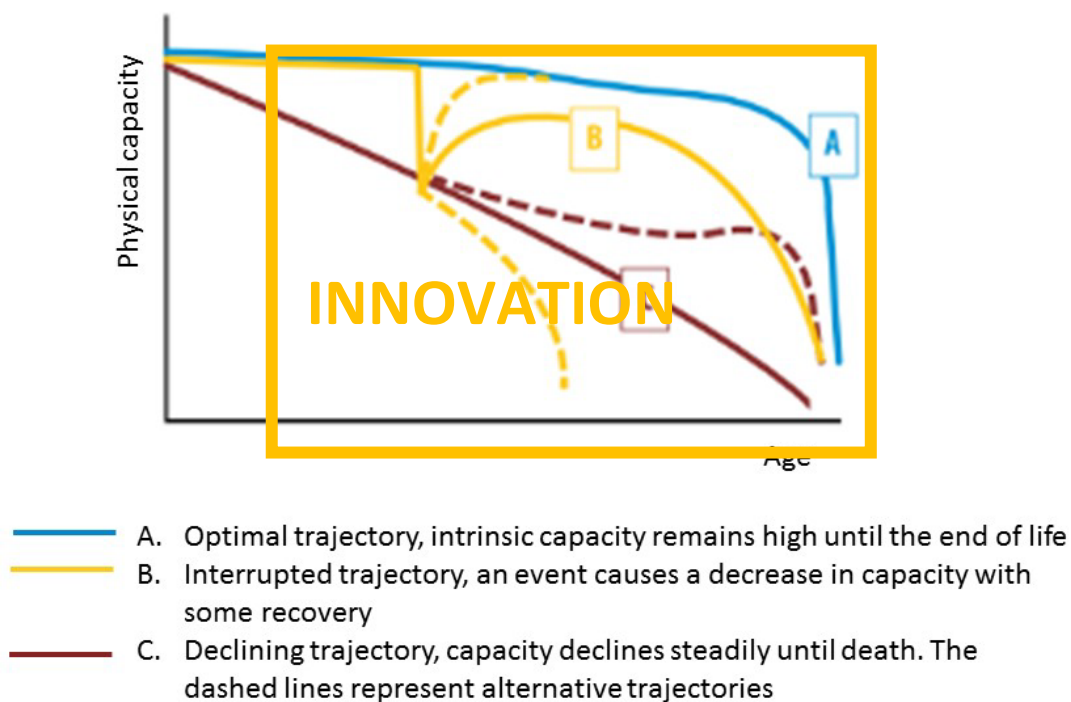


Figure 6. Area of innovation required for optimal life trajectories

Source: The world report on ageing and health. (2015). WHO

It is important to acknowledge that there are conditions related to age per se for which prevention options remain in the future. These include cognitive decline, musculoskeletal disorders and frailty. These conditions therefore require a multi-disciplinary approach of research into advances of prevention and cure, maintaining *healthy ageing* promotion interventions throughout the life course and addressing how society organizes community services and develops payment and insurance systems for long-term care (Knickman & Snell, 2002).

The concept of *healthy ageing*, “the process of developing and maintaining the functional ability that enables well-being in older age” (World Health Organization, 2015b, p. 28), encourages resilience and resourcefulness, and takes into consideration the dynamic relationship older people have with their environments. *Healthy ageing* is underpinned by the WHO’s strategy to promote a human-centric approach which challenges the status quo on how healthcare is funded, managed and delivered.

### 2.2.2 Finance sector’s role in ageing

The finance sector encompasses a broad array of role players, with government acting as umpire and regulator of private finance sector policies. This research has not focused on government’s role, which is an essential aspect of future research. The term finance sector pertains to the non-banking financial services industry. Role players influencing this industry include retirement funds, short-term & long-term insurance, companies, funeral insurance, schemes, collective investment schemes (unit trusts and stock market) and financial advisors and broker (Financial Services Board, 2017).

The *life cycle model* proposes that individuals accumulate savings during their working years, so that they can fund their lifestyle when they are unable to earn in their later years (Butler & van Zyl, 2012a). A pension fund is the most common retirement savings vehicle. Increasingly employers are offering defined contribution pension funds, which means an employee will only be able to draw an income in retirement off their accumulated pension fund contribution. Once in retirement, there has also been a trend for people to invest in living annuities. Defined contribution pension funds and living annuities place pressure on the individual to not outlive their retirement savings. The sustainability of financial security is placed under pressure, due to the combination of increased life expectancy and the probability of higher healthcare costs in later life (World

Economic Forum, 2011). It is from this premise that the finance sector plays a pivotal role in the *healthy ageing* framework.

A person's financial status has been shown to have a bearing on their health outcomes (J. P. Smith, 1999). In retirement, this is most apparent when looking at the relationship between financial and health circumstances in old age. Figure 7 illustrates the accumulation and decumulation phase of a retired individual's savings. Individuals accumulate savings during their working years. Upon retirement, age 65, when individuals stop earning, they enter the decumulation phase of drawing an income off their retirement savings. Figure 8 illustrates the increase in healthcare expenditure from about the age of 75. If these graphs were to be superimposed on top of one another, it would be apparent that as an older persons' retirement savings start to diminish, simultaneously their healthcare costs start to increase. Refer to figure 7 and figure 8 below.

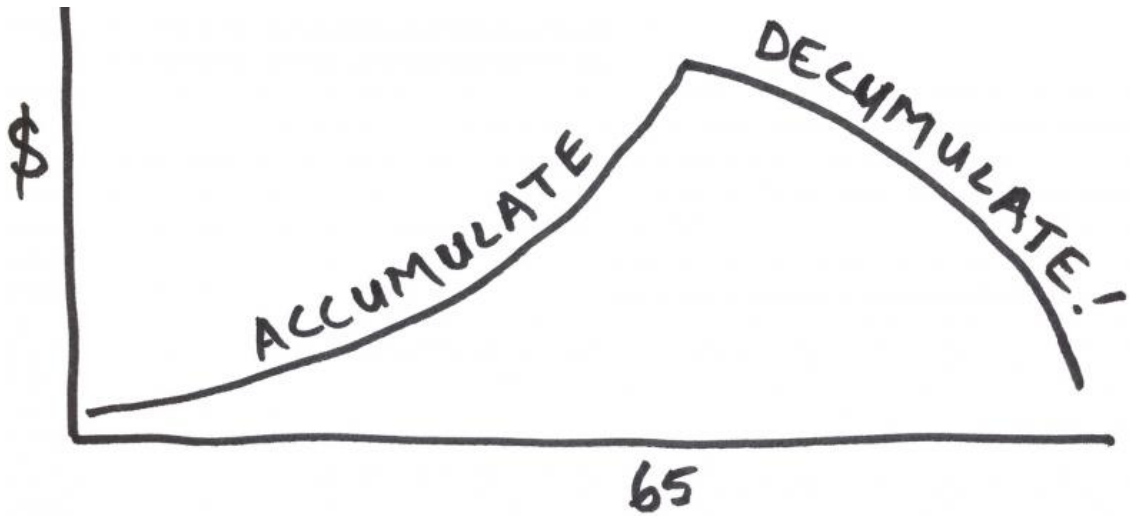


Figure 7. Accumulation/decumulation of retirement savings

Source: Commission for Financial Capacity blog. (2016). T. Hartman. Available at <http://www.cffc.org.nz/reviewretirementincomepolicy/may/op-ed>

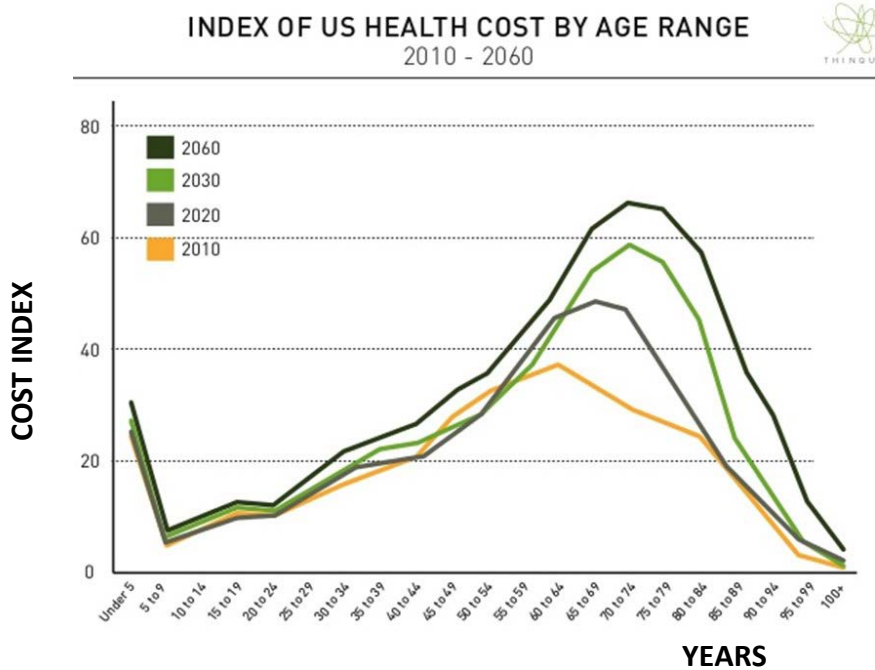


Figure 8. Index of US health cost by age range 2010-2060

Source: EMC Analytics Group. (2014). Available at <http://www.slideshare.net/thinque/future-of-healthcare-anders-sormannilsson>

These two graphs highlight that innovation is needed in two aspects. The first area of innovation is in the retirement model itself (see figure 9). The traditional nest egg model of retirement planning is being placed under pressure by people living longer lives (BlackRock, 2016). The notion that this can be resolved by pushing out the retirement age based on increased life expectancy, is based on the wrong metrics. Although life expectancy has increased due to the reduction of acute diseases, the life extension for over 65s has been relatively low in comparison (Fries et al., 2011). Furthermore, perpetuating this model for younger generations who have adopted different employment and hence pension fund contribution habits to the Baby Boomer generation, places the financial security of future older generations in jeopardy.

The second area of innovation pertains to the increase in healthcare expenses in later age (see figure 10). It is deceptive to think that these expenses tailor off, as most expenses incurred in advanced age are associated with long-term care which is seen as a social welfare expense and not a healthcare expense. These costs are usually out-of-pocket payments which the older person needs to self-fund. However, paradoxically this situation may be inadvertently created by a health promotion intervention. Innovation in health promotion can have complex and unexpected consequences. Giving people the potential to live healthier and longer lives, may result in a healthier but poorer advanced old age. This shifts the discussion to long-term and end-of-life care. This research and the solutions offered are focusing on healthy active ageing. However it is important to recognise that aligned to this, is further research which addresses better living wills, advance directives and related approaches that all lead to people dying with dignity at usually substantially lower costs. Refer to figure 9 and figure 10 below.

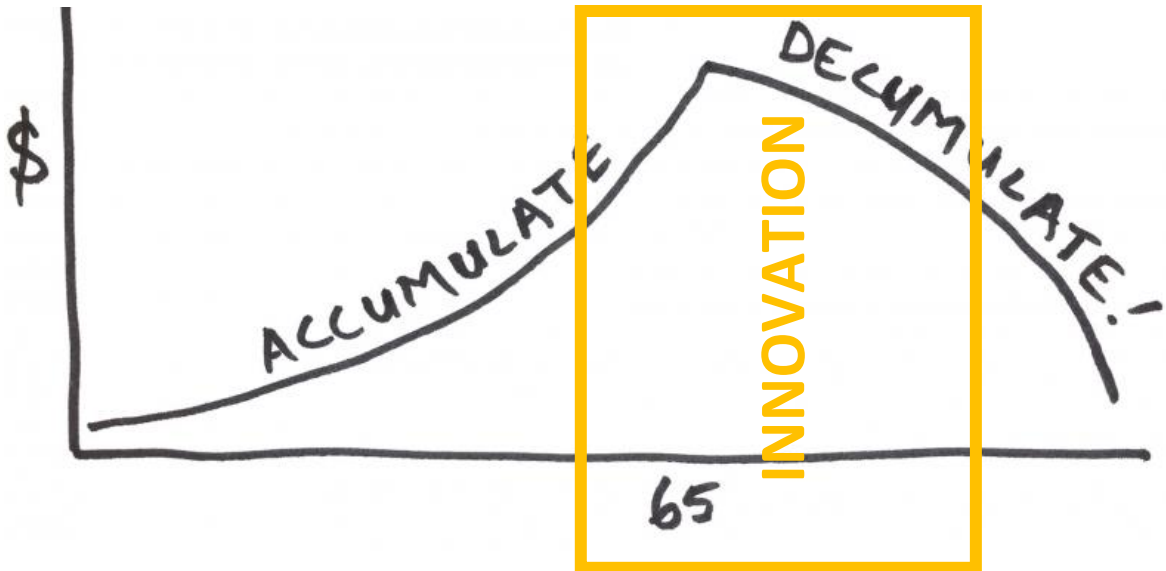


Figure 9. Innovation required in life cycle model of accumulation/decumulation of retirement savings

Source: Commission for Financial Capacity blog. (2016). T. Hartman. Available at <http://www.cffc.org.nz/reviewretirementincomepolicy/may/op-ed>

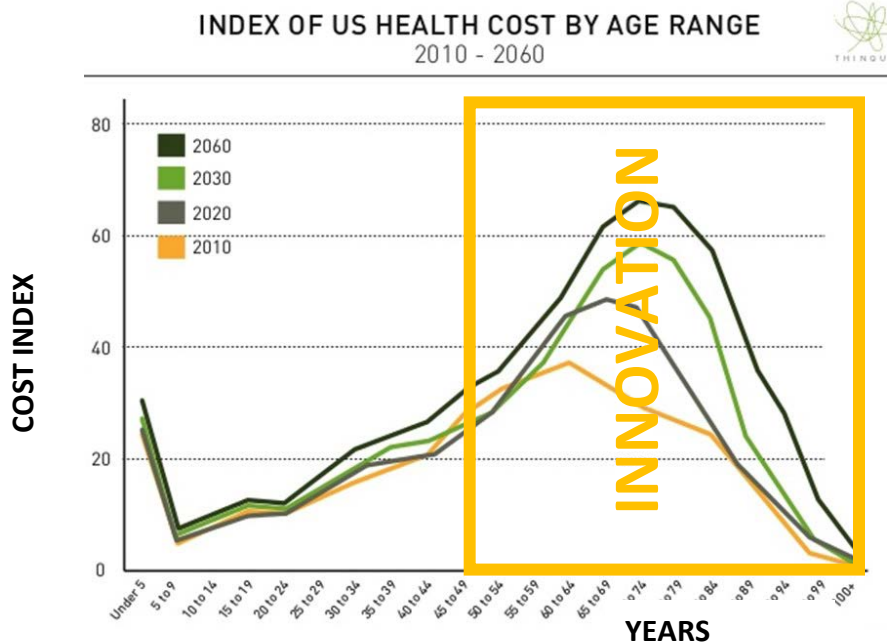


Figure 10. Innovation required in healthcare funding and delivery

Source: EMC Analytics Group. (2014). Available at <http://www.slideshare.net/thinque/future-of-healthcare-anders-sormannilsson>

Within the private sector retirement space, the interdependencies between health and wealth have been illustrated by the graphs representing health outcomes and financial security in old age. In a westernized society where independence is valued, and dependence is deemed to be avoided, becoming a financial and physical burden on one's family can be a cause of anxiety for many older people. This anxiety is compounded as the role of the family caregiver has changed and increasingly the health and finance systems place the responsibility on individuals to be self-sufficient in old age. In addressing the social challenges facing older people, the health and finance sector can create value through innovative solutions.

The health and finance sectors need to establish inclusive business models which target the systemic socio-economic issues which are causing the need in the first place. The association between financial well-being and physical and emotional well-being in retirement years creates the ideal setting for cross-sector collaboration between the health and finance sectors. Public/private partnership is also required as ageing, good health and well-being and financial security pertain to older demographics across socio-economic boundaries. Increased cooperation between the public and private sectors will ensure that legislation and regulation enable innovation and encourage the structuring of more equitable and supportive systems for *healthy ageing*.

### **3. Background to research**

The background to this research covers shifting the paradigm on ageing, promoting active ageing to improve older people's health and well-being, the impact of an ageing membership base on private medical aid schemes, and lastly the researcher's practitioner background in pursuing this study.

#### **3.1 Shifting the paradigm on ageing**

A combination of modern medicine, new knowledge regarding diet and exercise and a sound economic standing, is shifting the mindset of many older people. This societal revolution, is enabling older people to live longer and fuller lives. The entire concept of ageing is being redefined, which is causing a shift in the perceptions of ageing on a societal and individual level (Foddy, 2012; The Consumer Goods Forum, 2013; Williamson, 2008). However, as Dr Hiroshi Nakajima, Director-General of WHO, stated in the 1997 WHO Health Report, "increased longevity without quality of life is an empty prize. Health expectancy is more important than life expectancy"(Lagiewka, 2012; Nakajima, 1998).

The rules regarding ageing are rapidly changing. It's not that our lives are extending at the end, but rather expanding in the middle (Williamson, 2008). With the right interventions, we can stay healthier and feel better for longer. This is important as we could be living 25% of our lives in active retirement (Van Solinge & Henkens, 2010). This whole other adult lifetime is known as the 3<sup>rd</sup> act. Jane Fonda, 78, has lived each of her acts to their full; as an actress; a fitness guru and an activist. Jane Fonda gives an inspiring TEDTalk on the 3<sup>rd</sup> Act. She sees ageing as a staircase: the upward ascension of the human spirit, bringing us into wisdom, wholeness and authenticity (Fonda, 2012). For Jane Fonda, aging is not a pathology. It is potential. Research is showing that those who have positive perceptions towards ageing, not only age better but live seven and half years longer (Levy, Slade, Kunkel, & Kasl, 2002).

### 3.2 Promoting Active Ageing

*Active ageing* is the “process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (World Health Organization, 2002, p. 12). The goal is for 2020 to be the decade of action to foster *healthy ageing* (Maurice, 2016; World Health Organization, 2015b). Numerous studies have shown the positive results of physical activity on the health and well-being of older people at various stages of the life course and levels of functional capacity (Awick et al., 2014; Cadore et al., 2014; Fries et al., 2011; Hamer, Lavoie, & Bacon, 2014; Harris, Selwyn, & Yach, 2015; Lautenschlager, Cox, & Cyarto, 2012; Merom et al., 2014). In addition to the well-being benefits, increased physical activity has also shown a reduction in healthcare expenses (Nguyen et al., 2008; Patel et al., 2010; Portrag, 2016).

### 3.3 Impact of a growing ageing membership base on private medical aid schemes

The chronically ill and the elderly account for 2% of Discovery Health's membership yet access 20% of the scheme's resources, illustrated in figure 11 (L. Holding, personal communication, 2016, 22 May)

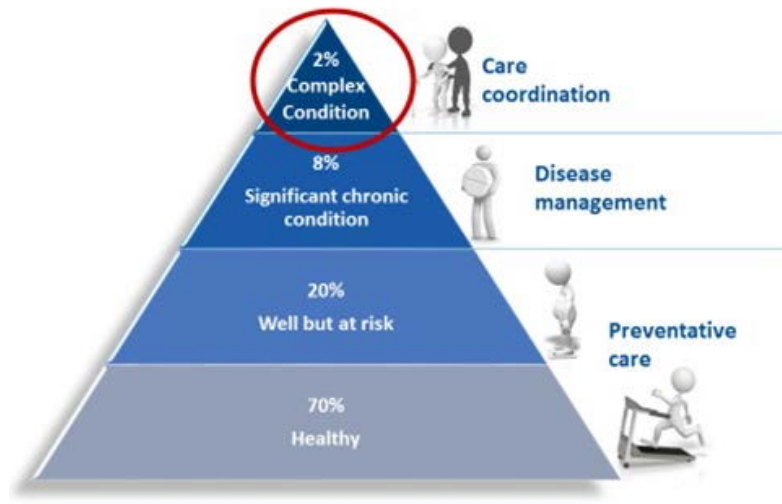


Figure 11. Member segmentation of Discovery Health

Source: Supplied by Linda Holding. (2015). Discovery Health

Discovery has created the Senior Care Coordination Programme (SCCP) in response to the “compelling evidence [that] shows that gaps in care for many patients with multiple chronic illnesses are common because of the fragmented nature of the current healthcare system” (Discovery Health, 2014). The SCCP is a multidisciplinary team comprising of specialist geriatricians, GPs and allied healthcare providers, such as social workers, physiotherapists and occupational therapists. As health systems face an impending crisis, there is an urgent need to reassess their current cost structures and systems. The “value-added” strategy suggested by Porter and Lee suggests that medical aid schemes “need to move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need” (Porter & Lee, 2013a). With regard to the cost structure of healthcare for older members, this is particularly relevant as it is estimated that a person’s healthcare costs in the last five years of their life could be more than the total amount spent during their entire lifetime (Moodley & McLeod, 2001; Ranchod, Abraham, & Bloch, 2015).

### 3.4 Researcher’s background

As a practitioner in senior wellness, I had established relationships with geriatricians, GPs, caregiver agencies and physiotherapists. It was through this network, that I first engaged with

Discovery Health's Senior Care Co-ordination Programme. As a practitioner I was working with clients ranging from their 60s to 90s who were actively managing conditions such as diabetes, osteoporosis, dementia and mobility and balance issues. I became interested in how exercise and wellness services could be integrated into a senior care coordination programme from a preventative and maintenance perspective and not just in response to acute symptoms of chronic geriatric conditions. However, within the current medical aid scheme environment, only registered healthcare professionals' fees are covered. Therefore the problem lay in finding a way to offer the services of a Vitality-type model to older members.

In South Africa 48% of people who are 60 -69 years old and 55% of those 70+ suffer from non-communicable diseases (Statistics South Africa, 2010). This illustrates that senior wellness initiatives are needed on a mass scale to address the health needs of a broader South African population. At the 2015 World Congress of Healthy Ageing, Karen Borochowitz, head of Dementia SA, stated that only 6% of CSR in South Africa caters for society's vulnerable older people (personal communication, July 2015). This is an environment where state provision of health and entitlement programmes are lacking. Based on this and my own experiences as a senior wellness practitioner, it was clear that it is necessary to focus on the financial sustainability of health and well-being models.

The MPhil Inclusive Innovation programme is a multidisciplinary research based degree where "expertise, life experience, passion and innovation converge to support new ideas and possibilities" (Graduate School of Business, 2017). The programme embraces entrepreneurial experience by encouraging candidates to bring their prior knowledge to develop prototypes that will tackle a societal challenge. This format fits within Kolb's experiential learning cycle (Kolb, 2015), which outlines the process of experience, reflection, conceptualization and testing. Having gained practical experience in the field of senior wellness, I realised how significant the issues surrounding the health of an ageing population were. In addition, I had experience in running a senior wellness practice and understood the dynamics and importance of a financially sustainable venture. It is for this reason, that I choose to pursue a Masters degree at the Graduate School of Business. In order to make my practical experience generalizable, I needed to engage with literature and theory around the issues of ageing populations, health and well-being in old age and financial retirement models. Combining practical knowledge, theoretical frameworks and field

work lead to the conceptualization of prototypes. Developing these solutions focused on the complexities of an ageing population within the private health and finance sectors. As innovation cannot occur in isolation, my intention as an engaged scholar is to take my knowledge back into the field of *healthy ageing* and be part of an ecosystem of collaborators, partners and implementers with a shared vision to create a dignified old age.

### **3. Purpose of research**

The purpose of this research was an exploratory inquiry into the lived realities of older beneficiaries of medical aid schemes and retirement annuities, in order to develop solutions which would address the concerns and constraints expressed by the older research participants.

The first aspect of this research was to understand the motivations and challenges the older research participants experienced in maintaining their good health and well-being. This insight was layered with a deeper exploration of their perceptions of their health and wealth circumstances. Gaining a better understanding of their concerns and constraints facilitated the development of solutions which aim to address their needs.

The second aspect of this research was to understand the context of the private healthcare sector and the financial services industry in South Africa, specifically in relation to the ageing consumers these two sectors serve. The purpose of interviewing professionals within the healthcare sector, was to understand the regulatory and organizational structure of the South African healthcare system and what implications this framework has for the health and well-being of older members. As financial well-being is essential to overall well-being in retirement, the purpose of interviewing professionals in the financial services industry was to understand how people entering retirement are guided in their financial management and what role health and well-being play in financial planning. In addition, interviewing professionals from the fitness industry and the wellness engagement models, such as Vitality, provided necessary information for the development of a prototype framework which promotes and incentivizes *healthy ageing*.

### **4. Significance of research**

Research which explores ageing is of benefit to academia, practitioners and policy makers as so many levels of society are influenced and affected by the implications of ageing. This research

is of significance in that it explores the relationship between health and wealth in retirement, an area of great concern for those in the public and private sectors.

The academic area of adult development and health benefits from a multi-disciplinary approach. This is particularly relevant in the health sector, where the multi-disciplinary teams made up of geriatricians, GPs, geriatric psychologists, social workers, physiotherapists, occupational therapists, nurses and caregivers effectively communicate in the continuum of care of the older patient. In the field of gerontology, a diversity of researchers cover areas such as the biopsychosocial and environmental aspects of an older person's overall well-being. As an ageing population increases, there is an ever-pressing need in the movement sciences to develop appropriate exercise guidelines. However, there remains a shortage of qualified experts and specialists in the field of adult development and health. This research has significance as it adds to an area of research which benefits from continual exploration and interrogation. Its contribution crosses academic disciplines, as it addresses the health, physical, social and financial well-being aspects of older people.

For practitioners in the health and finance sectors, this research is of significance in that its findings and proposed prototype offer the basis of future research for programme and policy development. For the private healthcare sector, this research is significant as many medical aid schemes are experiencing an increasing ageing membership base and the complexity of a hybrid of costs incurred by older members. For the financial services industry, this research is significant as it provides insight with regard to integrating health outcomes into financial products and takes into consideration *healthy life expectancy* and not just the standard life expectancy benchmark which has traditionally been used in financial planning. As the ethos of this research is to share the value created by innovation, the findings are relevant in strengthening the bonds between the health and finance sectors. The study's emphasis of greater synergy between these two sectors, provides the basis for future actuarial and quantitative research of health and wealth models for both the private and public sectors.

## **5. Research objectives and scope**

### **5.1 Main objective**

- To explore the experiences of older beneficiaries of medical aid schemes and retirement annuities, so as to design prototypes which address their needs.

## 5.2 Sub-objectives

- To discover what motivates and challenges older research participants to maintain their good health and well-being.
- To understand the context of the private finance and health sectors in South Africa, in order to create cohesive health and wealth frameworks.
- To develop a comprehensive *healthy ageing* promotion prototype.

## 5.3 Research scope

The research was a qualitative study and as such aimed to capture a snapshot of the current private sector retirement environment from the perspective of older people and professionals from the health and finance sectors and the fitness/wellness industry. The parameters of the study were confined to the medical aid scheme environment and the financial services industry. Although these parameters may limit the transferability of the research findings, they did provide clear selection criteria for research participants and ensured that the research was focused and specific. The study does not include any quantitative data from the health and finance sector. However, it does draw on previous qualitative and quantitative studies which have addressed the physical, social and financial well-being circumstances of older people.

## 6. Outline of chapters

### Chapter one: Introduction

Chapter one introduces the broad overview of the research area and problem. It gives the background and context of ageing in society and the role of the health and finance sector in *healthy ageing*. It details the purpose and significance of the research and outlines the research objectives.

### Chapter two: Literature review

Chapter two details the global ageing demographics and explores how societies have responded to the needs of the aged. It reviews age progression studies which help people identify with their future older selves and the influence of behaviour economics and discounting rates with particular reference to health and money. A youth orientated culture inhibits people's perception of their own ageing process and perpetuates ageist attitudes and beliefs. However, the notion of older demographics is being challenged with the 65+ cohort being the fastest growing segment of the global population and becoming a strong market force in the "silvering of the economy". In

turn businesses are aligning their corporate strategies to the ageing and adopting the ‘shared value’ principle to address the social challenges facing older people. In developing the research prototype, ageing frameworks and studies showing the benefit of physical activity and social engagement are reviewed. The chapter concludes with how the health and finance sectors can be more equitable and value driven.

#### Chapter three: Research methodology

Chapter three describes why a qualitative approach was the most suitable methodology for achieving the research objectives. In initial exploratory research, purposeful and snowball sampling techniques provide data which is information rich, but these techniques restrict the generalizability of the research findings. The interview transcripts were analyzed using ground theory type methods. The chapter concludes by discussing the limitations of the research design and researcher.

#### Chapter four: Understanding the research context

Chapter four provides an understanding of the research context. It explains and defines terminology and subject specific content which is discussed by the older and professional research participants. This information pertains purely to the data in the research findings, which are specific to the private health sector and the financial services industry in South Africa. Clarifying terminology before the findings chapters, allays confusion and ensures that the voices of the research participants are the dominant feature in the findings chapters.

#### Chapter five: Perceptions and experiences of the older research participants

Chapter five presents the responses from the older research participants. It portrays their lived experiences as older beneficiaries of medical aid schemes and retirement annuities. The chapter explores their motivations for and challenges in maintaining their health and well-being, their pre-and-post retirement financial planning and the relationship between their healthcare and financial management. The chapter provides insight into the perceptions and concerns the older research participants have with regards to growing older.

## Chapter six: Insights of the professional research participants

Chapter six presents the viewpoint of the professional participants from the financial services industry, the private healthcare sector, the Vitality/engagement model and the fitness industry. The chapter details the context and landscape of the private healthcare sector and the retirement industry and discusses the implications this environment has for an older person accessing these private sector services.

## Chapter seven: Research prototype

Chapter seven presents the research prototype which has been developed by integrating the findings from the industry view and the lived experiences of the older participants. The research prototype comprises elements of a framework which aim to address the issues raised by both the older and professional participants.

## Chapter eight: Conclusion and future research directions

Chapter eight presents a summary of the research findings and prototypes. It continues with a discussion reflecting on the relationship between the themes which emerged from the research findings and outlines areas for future research.

## **7. Conclusion**

Social innovation is interrogating areas of social challenge and developing solutions which address these problems. Sharing the value created from these innovations, expands their inclusivity. In creating solutions for older people, it is important to acknowledge that there is no such thing as a typical older person and the lived reality of an older person in an OECD country may be different to that of an older person living in a developing region. However, older demographics share similarities in the process of ageing and age-related conditions. Therefore, exploring the concerns and challenges experienced by a specific demographic of older people, provides insight into the sort of questions which should be asked for future research. Thus, this exploratory, qualitative research aims to give a voice to underrepresented older beneficiaries of medical aid schemes and retirement annuities and probes the role the health and finance sectors play in promoting and supporting *healthy ageing*.

# CHAPTER TWO

## LITERATURE REVIEW

### 1. Introduction

Catering for the needs of the ageing is an opportunity to meet a key driver in the global economy, specifically health and wellness, as people want to live healthier and more fulfilling lives for longer (Business Lab, 2012; Harris et al., 2015; Kaplan & Porter, 2011; Nakajima, 1998; Van Solinge & Henkens, 2010). As a billion large segment of the market, the 65+ demographic is silvering the economy and creating a paradigm shift in how societies fund, manage and deliver innovative models that promote *healthy ageing* (World Economic Forum, 2015). Addressing the needs of societies' increasingly ageing populations provides the ideal environment for greater synergy between the finance and health sectors. Sustainable *healthy ageing* models that are adapted to the needs of older people and take a systemic approach to the current healthcare and retirement space are needed (Beard & Bloom, 2015; Nidumolu, Prahalad, & Rangaswami, 2009; Tamiya et al., 2011). Embedding *healthy ageing* into the finance and health systems with innovative mechanisms will create more inclusive models which address the inequalities and anxieties that currently exist for many older people.

### 2. Society's response to ageing

The World Health Organization estimates that between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22% (World Health Organization, 2015a). The pace at which ageing populations are increasing, is resulting in a growing recognition that our attitudes towards how we care for our elderly have to improve. In "Being Mortal: Illness, medicine and what matters in the end" (2014), Atul Gawande eloquently describes society's historical response to caring for older people: sterile, medicalized and institutionalized structures designed to ease the burden on family care and hospitals, without the goal of a dignified quality of life for the elderly (Gawande, 2014). The medical profession's tendency has been to focus on the changes of ageing as a pathology to be controlled (Gawande, 2014; Rowe & Kahn, 1997). With longevity now a mainstay, there has been a progressive move towards focusing on health expectancy over life expectancy (Beard & Bloom, 2015; Nakajima, 1998). Sataroniano et al's

review of the practices and policies of ageing propose an ‘ecological model’ where the “patterns of health and well-being in populations are due to a dynamic interplay of biological, behavioural, social and environmental factors that play out over the life course of individuals, families, neighbourhoods and communities” (Satariano, Scharlach, & Lindeman, 2014, p. 1375).

### **3. Encouraging *healthy ageing* behaviour**

#### 3.1 Identifying with future self

Not being able to identify with our future selves in the present, means the actions we take today may be detrimental to our older selves’ ability to meet its needs in the future (Hershfield, 2011; Hershfield et al., 2011; Hershfield, Tess Garton, Ballard, Samanez-Larkin, & Knutson, 2009). This psychological distancing plays the same illusionary tricks as a landscape painting. Objects in the foreground are bright, big and in fine detail, while objects in the background are blurry, faded and in broad strokes (Newcombe, 2015). The human mind perceives its future self in the same manner. It has been shown that individuals who share positive similarities with their future self, are more likely to sacrifice present pleasures for the benefit of their future self (Hershfield, 2011; Hershfield et al., 2009). It therefore stands to reason that older people have a more positive association to their future self, which should influence the decisions they make in retirement. However, psychological distancing can even lead an older person to misjudge the risk involved in addressing how likely or unlikely an event or prospect will occur.

Age progression is a positive step towards facilitating individuals’ ability to connect with their future selves using virtual reality as illustrated in figure 12. The key finding in Hershfield et al’s “Increasing saving behavior through age-progressed renderings of the future self” study (2011) showed that participants who engaged with their future self avatars were more likely to allocate money towards retirement planning. Although the avatar imaging influenced how participants saved financially for their future self, a limitation of the study was not showing participants the realities of not taking care of their future selves physically or emotionally. Further research could potentially show different scenarios of health expectancy and then assess the resultant behaviour changes. With increased longevity, further research would be of interest to age progress individuals in their 50s and 60s as future self avatars in their 80s and 90s. Although the study was useful in showing the effectiveness of age progressed avatars, it stayed within the realm of the financial services industry focusing on individuals up until age 65. Further research would be valuable into

late stage retirement, where the focus is more on health implications which are also directly connected to financial implications. The results of these types of studies could benefit the structuring of wealth, health and well-being policies and programmes.



Figure 12. Age progression procedure of photographed image

Source: Future self-continuity: How conceptions of the future self transform intertemporal choice. (2011). Hal E. Hershfield

### 3.2 Decision theory and behaviour economics

In its simplest form behaviour economics explains how people can act in opposition to what is in their best interests (Camerer, Issacharoff, Loewenstein, O'Donoghue, & Rabin, 2003; Kahneman, 2011; Patel, Nossel, Alexander, & Yach, 2013; Tversky & Kahneman, 1974). How people make decisions is of interest to many disciplines, especially with regard to its influence on health, wealth and well-being (Kahneman & Krueger, 2006; Newcombe, 2015). People often make decisions based on their framing of the subjective measurement of risk or gain relating to that choice (Kahneman & Krueger, 2006). Everyday immediate decisions such as how much to save or lifestyle choices, such as exercising or smoking, are influenced by discounting. Discounted utility theory is the “normative theory for intertemporal choice, or choices between immediate and delayed outcomes” (Gretchen B Chapman, 1996, p. 771). The extent to which a person places value on the trade-off, will be impacted by the value they place on the future outcome of their decision. This value can diminish the further away the perceived outcome may feel (Gretchen B Chapman & Elstein, 1995; Frederick, Loewenstein, & O'Donoghue, 2002).

It is from this premise that health and wealth policies can be structured to encourage people to take positive steps which benefit their future selves without too many constraints on their present-day actions. The optimum implementation of behaviour economics effects behaviour change in subtle ways, without implications on the standard economic model (Loewenstein, Brennan, & Volpp, 2007). Retirement is affected by the accumulative health and financial decisions taken by individuals during their lifetime. These accumulative decisions can be affected by simple issues such as procrastination, “optimistic bias”, or decision-making hesitancy when filling in policy forms. Choice architecture at various stages in the life cycle model can nudge people through incentives, pre-commitment, default options and automatic enrollment to act in the best interests of their future self’s health, wealth and well-being (El, Freitas, & Oliveira, 2014; Newcombe, 2015; Patel et al., 2013; Schwartz et al., 2014; Thaler & Sunstein, 2008).

Easing the decision making process will address the complexities longevity has had on people’s need to make choices with a longer future in mind (Hershfield, 2011). Chapman (1996) and Chapman and Elstein’s (1995) studies are particularly relevant as they address decision makers’ temporal discount rates for health and money. Their experiments showed that although both domains were subject to discounting biases, health received a larger discount rate. This may be due to the fact that future money can be converted into a present day value, whereas health cannot be invested or saved for future consumption (Gretchen B Chapman & Elstein, 1995, p. 374). These studies illustrate the need for a multiple-motives approach to intertemporal choices as proposed by Camerer et al. (2002). In the field of *healthy ageing*, a multiple-motives approach would be beneficial as incorporating insights from psychology, gerontology and economics will provide a better understanding of an individual’s behaviour across domains and what impact this has on their increased life expectancy.

#### **4. Ageism**

Youth-oriented cultures underpin the inability to identify with future older selves and reinforce ageist belief systems (World Economic Forum, 2011). Ageist attitudes are a hurdle to older people gaining access to age-appropriate services and products, equitable and effective medical treatment and autonomy over their life decisions. ‘Ageism’ was first coined by US gerontologist Robert Butler in 1969 to describe the proportions of bias against old people and ageing (Joyce & Loe, 2010). It has been found that 77% of older people experience some form of ageism every day

(Palmore, 2001). How societies move forward without these ageist views will determine the quality of life for this older demographic. The dependency ratio, defined as “dependent” age groups (0-14 and 65+) relative to the population in the working age groups (15-64), reinforces ageism (McMorrow & Roeger, 2000; Sanderson & Scherbov, 2008). By 2050 the dependency ratio in the European Union is expected to deteriorate dramatically to only about two economically active workers for every person over 65 and is an area of concern for heightened ageism in society (McMorrow & Roeger, 2000). McMorrow and Roeger’s analysis of the economic consequences of ageing tends to focus on the burden of ageing to society. The emphasis therefore needs to be on promoting a *healthy ageing* population, as this not only benefits the economy but also increases the productive contribution that older people can make to society (Harris et al., 2015; Rowe & Kahn, 1997; World Health Organization, 2015b).

## **5. Silvering of economy and business strategies**

The 65+ cohort is the fastest growing segment of the world’s population, with the 80+ cohort following closely behind in second place (Business Lab, 2012). As Standard and Poor’s stated, “No other force is likely to shape the future of national economic health, public finances and policy-making as the irreversible rate at which the world’s population is ageing” (as cited in World Economic Forum, 2015, p. 2). In 2015, there were 901 million people worldwide aged 60 years or over (United Nations Department of Economic and Social Affairs, 2015). The older demographic will stimulate economic growth and innovation as businesses respond to this powerful market driver (BlackRock, 2016; World Economic Forum, 2015). Several sectors can implement a strategic framework which can optimize the opportunities surrounding an ageing population. These include supporting older people’s desire to ‘age in place’ by providing products and services that enable an autonomous lifestyle (Satariano et al., 2014), as well as consumer products and services which are customised to the needs and interests of the “silver generation” (World Economic Forum, 2011).

The longevity revolution will impact on people’s savings patterns, as they will be incentivized to save more for the potentially longer span of non-working years. This in turn will have an impact on the economy as increased investment drives economic growth (World Economic Forum, 2011). However financial institutions are recognising that the traditional assumptions which underpinned the retirement model in the 20<sup>th</sup> century will have to be transformed to meet 21<sup>st</sup> century longevity

(BlackRock, 2015; World Economic Forum, 2017). iRetire is BlackRock's initiative to direct their clients' focus from the traditional nest egg planning to a focus on income needs in retirement (BlackRock, 2016). Bank of America Merrill Lynch is adopting a comprehensive approach for their clients' life course by integrating healthy and active ageing into the financial planning process. Bank of America has the industry's first financial gerontologist and is partnering with numerous age-research organisations to roll out longevity training programmes for clients and financial advisors (Bank of America, 2016).

A growing ageing population poses a "longevity risk" to the insurance industry. Swiss Re is adapting their insurance model and practices to address society's demographic change. Traditional insurance practices have been unengaging which has reinforced people's reluctance to have insurance policies. However, digitalisation is transforming the insurance industry's business model by enabling real-time pricing and engagement with policy holders (Global Agenda Council on Ageing, 2016b). A more engaging model may close the protection gap of people who are either uninsured or underinsured for health risks. Swiss Re recognises that as a health and life insurer, they can utilise technology to better protect policy holders whilst promoting a healthy ageing lifestyle (Swiss Re, 2016).

Technology is an effective tool to actively engage with older consumers. Technology enables many industries within the silver economy to improve their services and underpin their value-based care (Porter & Lee, 2013b). Responding to the changing needs of the older market provides opportunities for multi-disciplinary teams to collaborate in gerontechnological research and development (Harris et al., 2015; Joyce & Loe, 2010; Satariano et al., 2014; World Economic Forum, 2016). Delivering new technology in the health, finance and insurance sectors has the potential to change the value-chain relationship with their older client base, especially with regard to monitoring physical activity, observing behaviour and tracking resources accessed (Global Agenda Council on Ageing, 2016b; Nidumolu et al., 2009).

Porter and Kramer's article, "Creating Shared Value", has made a pivotal and influential contribution to the field of business strategy, reflecting the necessary change in ethos within the private sector to create business models that "create economic value by creating societal value" (Porter & Kramer, 2011, p. 67). In the South African context, Discovery Health is the most notable corporate to have adopted the 'shared value' principle (Porter & Kramer, 2015; Porter et al., 2014).

Discovery Health has embedded innovation in projects and products that benefit society. By utilizing new technologies, operating methods and management approaches, productivity increases and they are able to expand their markets (Porter & Kramer, 2011, p. 65). Discovery Health's readiness to roll out innovative products is an illustration of the effectiveness of a 'shared value' business model.

Businesses in the silver economy have an opportunity to align their commercial ageing strategies with their shared value framework (World Economic Forum, 2015). This is especially the case in the health and finance sectors, as social protections, such as pensions and healthcare for older people, have increasingly become dependent on the private sector (Alexander Forbes, 2015). However, to tackle the systemic causes of these societal needs will involve collaboration between governments, non-profits and large donor-funder organisations. Porter's 'shared value' principles have been an influential contribution to the UN's Sustainable Development Goals (SDGs). The 17 SDGs aim to address the challenges the world faces by developing mutually beneficial models and partnerships across sectors (United Nations Global Compact, 2015, 2016a, 2016b). It is a societal investment to collectively design programmes and policies which support and promote *healthy* ageing, as a healthy older population not only brings economic value but will also cultivate a positive perspective towards older people and the role they play in society (World Economic Forum, 2011).

## **6. Ageing frameworks**

### 6.1 Evolution of ageing frameworks

'Successful ageing' was first coined by John Rowe and Robert Kahn in their influential article in the field of gerontology. 'Successful ageing' is defined as "including three main components: low probability of disease and disease-related disability, high cognitive and physical functional capacity and active engagement with life" (Rowe & Kahn, 1997, p. 433). Their conceptual framework is articulated with reference to numerous medical studies within the field of *healthy ageing* and advocates for intervention studies that effect strategies for successful ageing in society's older population.

Stephens et al's (2014) qualitative study gives a comprehensive review of alternative ageing frameworks. The authors criticize Rowe and Kahn's 'successful ageing' framework for viewing the ageing population as a homogeneous group, placing the pressure of perfect ageing on the

individual and not taking the psychosocial model of health into consideration (Stephens et al., 2014). There is increasingly a focus on creating frameworks that emphasize the clustering of the functional capacity of older people. This advocates an approach which promotes resilience and resourcefulness in a fast changing world, despite the challenges of an ageing body (Beard & Bloom, 2015; Bush, 2016; Porter & Lee, 2013b; Stephens et al., 2014; Tamiya et al., 2011; World Health Organization, 2015b). Such an approach combines the elements of the ‘successful ageing’ framework with an emphasis on improving independence and quality of life.

The WHO defines *healthy ageing* as the “process of developing and maintaining the functional ability that enables well-being in older age” (World Health Organization, 2015b, p. 28). The *healthy ageing* concept is essential to the well-being of all nations, regardless of levels of income. As a result of non-communicable diseases, societies are facing the challenge of providing for dependent and disabled older people (Beard & Bloom, 2015; Harris et al., 2015). Many older people struggle with multiple NCDs, with 23% of total global burden of diseases attributable to people over 60 years (Prince et al., 2015, p. 549). The worldwide direct and indirect annual costs of hip fracture in 1990 were estimated at US\$34.8 billion (Harvey, Dennison, & Cooper, 2010), Diabetes mellitus is forecast to increase by 96% from 2004 to 2030 (Prince et al., 2015, p. 555) and musculoskeletal disorders, such as lower back pain and osteoarthritis, are forecast to increase by 70% by 2030 (Prince et al., 2015, p. 557). The 2013 G8 Summit was devoted to setting ambitious goals to prepare for the challenges presented by dementia (Prince et al., 2015). These figures reflect the correlation between the increase in the global burden of disease and the increasing ageing population, demonstrating the urgency for 2020 being “the decade of action to foster *healthy ageing*”. The World Report on Ageing and Health (2015b) outlines the goal to ensure that “countries immediately align their health systems with the needs of older people, that long-term care is available to those who need it, and that everyone can grow old in an age-friendly environment” (John Beard as cited by Maurice, 2016, p. 109).

## 6.2 Benefits of physical activity and social engagement in healthy ageing

There are numerous factors which positively influence *healthy ageing*. However, for the purpose of the research prototype described in chapter seven, physical activity and social engagement have been focused on below.

### *Benefits of physical activity in healthy ageing*

Interventions which promote physical activity have the ability to maximize functional capacity and have also shown positive effects on health and well-being in very advanced years (World Health Organization, 2015b). As many older people exhibit multiple NCDs, physical activity is a cost-effective manner to promote healthy lifestyles. Throughout age-related literature, an emphasis is placed on the benefits of physical activity in ageing. Patel et al (2010), Meisner et al (2010) and Nguyen et al (2008) demonstrate the association between levels of physical activity, the functional ability of older people and the probability of disease or disease-related disability (Meisner, Dogra, Logan, Baker, & Weir, 2010; Nguyen et al., 2008; Patel et al., 2010). Nguyen et al's study is of particular interest as it determined the association between the use of SilverSneakers™ (SilverSneakers, 2014), a private sector fitness programme endorsed by healthcare insurance plans, and the total healthcare costs over a 2 year period. The data showed that regular SilverSneakers™ participants incurred lower medical costs and had fewer hospital admissions (Nguyen et al., 2008, p. 1). Nguyen et al's study could be strengthened by a rigorous cost analysis between the costs of providing an exercise programme for older people, taking into account recruitment and promotion costs, versus the actual savings from reduced medical costs. For the most effective benefit, physical activity programmes need to provide guidance for specific age and functional capacities and promote practical training that incorporates hand, trunk, and lower extremity strengthening movements, with balance and gait exercises (Harris et al., 2015; Rowe & Kahn, 1997; World Health Organization, 2015b). All of these studies showed that increasing and maintaining levels of physical activity of older people resulted in a reduction of medical costs.

Physical inactivity and the resultant limitations and decreased functional capabilities have been shown to lead to feelings of isolation and depression in older people (Harris et al., 2015; Meisner et al., 2010; Rowe & Kahn, 1997). Using archived data from the Canadian Community Health Survey, Meisner et al's study's purpose was to show the association between the different components of Rowe and Kahn's 'successful ageing' framework. Data collected from a large governmental survey and by telephone interviews showed that physically active older people were more likely to be socially engaged and reported greater functional capacity than their inactive counterparts. Meisner et al's conclusions would be strengthened by a pilot study, which Meisner et al do propose.

### *Benefits of social engagement in healthy ageing*

Families, friends and older people themselves, do not consider people “old” if they remain actively involved in their community in a meaningful way (Rowe & Kahn, 1997). AgeWell and Experience Corps are both pilot studies that illustrate the correlation between social engagement and the resultant physical benefits. Experience Corp, in America, is a dual benefit programme designed to improve the well-being of older volunteers and improve academic results of public school children (AARP, 2015; Fried et al., 2004). Tan et al’s study of the Baltimore Experience Corps programme is of particular interest as it explored the impact of a social media campaign on the recruitment and retention of volunteers. The campaign showed that ‘generativity’, the desire from your mid-life to leave a legacy and contribution to the next generation, was a major influencer in signing up as a volunteer (as described by Erikson, Tan et al., 2010, p. 729). Through focus groups, AgeWell (2015), a peer-to-peer support programme in South Africa, showed improved health and well-being for older volunteers and community members (World Health Organization, 2015b). Both pilot projects demonstrated the incentive of stipend or payment for work done within the programme and the positive impact on disadvantaged older people who are at greater risk of poor health. This correlates to research which shows how one’s level of education and financial standing has a direct impact on one’s level of well-being in later years (Rowe & Kahn, 1997).

#### 6.3 Learnings from previous health and well-being studies

Numerous studies have illustrated the benefits and challenges of promoting health and well-being in populations at various stages of the life course. Discovery Health’s Vitality programme, whose most engaged participants are younger, incentivizes members to participate in wellness services and programmes in order to improve their status level and receive discounts (Porter et al., 2014). Patel et al’s extensive cross sectional analysis of the data of 948, 974 Vitality members showed a positive correlation between highly engaged members and a lower in-patient health care costs compared to other members (Patel et al., 2010). The study’s results quantify Discovery’s return on investment. The Vitality programme has successfully promoted healthy lifestyle choices earlier in life, so that their membership base ages in good health with lower healthcare expenses (World Economic Forum, 2011). The Vitality model was implemented in the mid-1990s, when some of their initial members were in their 40s and 50s. It will be of interest to see how Vitality adapts the programme for these members who are now in their 60s and 70s.

A comprehensive approach should include early preventative strategies, as many of the diseases experienced by older people are a result of events which occurred earlier in life, as well as strategies which address the immediate needs of older people. Improving the health of 55- to 70-year-olds is an investment for well-being in very advanced years (World Economic Forum, 2011). This may prove to be a challenge though, as Nguyen et al's (2008) Silver Sneakers™ study showed that only 7% of members actively used their benefit. However better health in early older age has shown lower hospital expenditures during the remaining lifetime, but potential higher expenditures for long-term care (World Health Organization, 2015, p. 98). Ranchod et al's "An actuarial perspective on healthcare expenditure in the last year of life" (2015) echoes these statistics. Ranchod et al's study focused on the cost expenditure for South African health insurers, which showed that members' healthcare costs accrued to the healthcare insurer tail off incrementally from age 70. This phenomenon can be attributed to the exclusion of certain categories of expenditure such as nursing homes and out-of-pocket payments (Scitovsky, 2005). In assessing the above studies, it is noteworthy to add that other studies have shown that overall satisfaction with life actually increases in older age (World Health Organization, 2015). Thus, taking the biopsychosocial aspects into consideration, the integration of these studies may provide insight into the development of a health promotion campaign or programme for older members of medical aid schemes.

## **7. Creating equitable and value-driven health and finance systems**

The societal challenge of ageing is a call for action to the private health and finance sectors to adjust and prepare their systems for a growing older population.

### **7.1 Equitable health system**

Health systems are adept at diagnosing and treating acute conditions in younger populations, but not necessarily attuned to addressing the complexities of an ageing population (Merril Lynch, 2014). Medical aid schemes' risk pooling model focuses on having a large, young and healthy membership base to provide for the "unpredictability of illness and individual's inability to cover healthcare costs without forewarning" (McIntyre & Kutzin, 2012, p. 77). This emphasis is evident by the lack of trained healthcare professionals specializing in geriatrics. In the US, there is one trained pediatrician for every 1,200 patients, compared to one geriatrician for every 9,400 people age 65+ (Merril Lynch, 2014). Thus, older members are vulnerable to receiving inequitable and

poor-quality healthcare. The potential of inequitable healthcare is inconsistent with the consensus that healthcare expenditure rises with age (Butler & van Zyl, 2012a, 2012b; Merrill Lynch, 2014; Petertil, 2005; Skinner, 2007). The increase in healthcare expenditure affects the private medical aid scheme and the older member. Ignoring the quality of geriatric healthcare and the financial implications of ageing could have detrimental effects for the long-term projections of a medical aid scheme (Petertil, 2005).

An ageing population is a heterogeneous entity, influenced by numerous health and lifestyle conditions. It is not possible to impose a simple algorithm or formula to universally describe the effects of the aged on the healthcare system (Petertil, 2005). It is therefore necessary for medical aid schemes to adopt a dynamic approach to the healthcare needs of older members. Porter and Lee's "The strategy that will fix healthcare" (2013b), positioned an overarching 'value agenda' strategy, which provides a practical solution to aged healthcare needs. Just as 'shared value' came in response to the private sector's need to create "value for society by addressing its needs and challenges" (Porter & Kramer, 2011, p. 64), the 'value agenda' addresses how healthcare delivery is organized, measured and reimbursed (Porter & Lee, 2013b). The sustainability of the current healthcare system hinges on the understanding of the cost structure of patient care throughout the duration of their treatment in line with desired outcomes achieved. This is particularly relevant to the treatment of non-communicable diseases, which older people are more susceptible to (Harris et al., 2015; Harvey et al., 2010; Prince et al., 2015; Tamiya et al., 2011). The combination of 'value agenda' and 'shared value' within the healthcare system facilitates models which support a healthy population in a more sustainable way and reduce the long-term health care costs (Patel et al., 2010).

## 7.2 Equitable finance system

Retirement was first conceived by Otto Von Bismarck in 1883, when hardly anyone lived much past their sixties (Weisman, 1999). In the early 19<sup>th</sup> century the average person could expect to live 1.2 years in retirement, whereas nowadays people can expect to live 25% of their lives in retirement (Legutko, 2014; Van Solinge & Henkens, 2010). Despite increased life expectancies, retirement age has generally remained fixed at 60-65 years. The shift to defined contribution pension funds has placed the pressure on individuals to ensure they have adequate income for their lifetime (Sanderson & Scherbov, 2008). The implications of growing old in a modern society have

transformed the perception of retirement from a short period of well-deserved rest and leisure to a potentially extended period of uncertainty (Barrett & Kecmanovic, 2013). How people transition into retirement can have a powerful outcome on their well-being in retirement. The three factors which most affect well-being in retirement are; 1) the reason for retirement (involuntary/forced retirement has been shown to have the most negative effect on life satisfaction), 2) health and 3) either having no pension or a unfavourable pension (Barrett & Kecmanovic, 2013; Bender, 2012; Bender & Jivan, 2005). However, Barret et al's (2013) study found that 60% of older people experience higher levels of happiness post retirement. It is important to understand that there is a diversity in experiences of retirement, which will be different for an older person in their 60s to when they are in their 80s or 90s. However, what will have the most influential impact is the level of health the retired person is in.

The life cycle model proposes that an individual “accumulates savings during their working lives in order to finance consumption in later life when they are unable to earn through working” (Butler & van Zyl, 2012a, p. 2). A person entering retirement needs to ensure that they have adequate income above a minimal level. However, a “Retirement Survey” showed that 40% of individuals reported to receiving less retirement income than they expected (Banks, Blundell, & Tanner, 1998). With the current retirement savings rates in South Africa, most people will be unlikely to afford to retire before 67 (Butler & van Zyl, 2012b). Butler and van Zyl's estimates may be too optimistic as a UNISA study showed that only 6% of South Africans can retire comfortably (Portrag, 2016). This situation is influencing an increasing trend toward part-time work after retirement age, as people attempt to make up the shortfall and accommodate for the potential of increased life expectancy (Kim & DeVaney, 2005).

Unfortunately, many will either experience a forced retirement or the inability to continue working due to their ill-health (Barrett & Kecmanovic, 2013; Bender, 2012; Merrill Lynch, 2014; Skinner, 2007). It is therefore important for pre-retirees to view the investment in their health as a crucial element of their financial security (Merril Lynch, 2014). Ill-health not only creates negative associations entering retirement, but also leads to older people assessing their financial situation as less adequate than those in better health with the same income level (Stoller & Stoller, 2003). Healthcare cost projections are expected to continue to rise. The “Health and Retirement Study” estimates that by 2019, one tenth of older people will be devoting more than half of their income

to out-of-pocket expenses (Skinner, 2007, p. 17). Although an increase in healthcare expenditure occurs irrespective of healthcare insurance coverage, in South Africa the increase is dependent on the type of medical aid scheme membership (Butler & van Zyl, 2012a). This illustrates that regardless of medical aid scheme membership, all people entering or in retirement should expect an increase in healthcare expenditure. However only one in six pre-retirees has ever attempted to estimate how much money they might need for health care and long-term care in old age (Merril Lynch, 2014, p. 13). Thus saving for retirement may be less about overseas holidays and exclusive retirement villages, and more about being able to afford caregivers and quality frail care (Skinner, 2007).

### 7.3 *Whealthcare* for sustainable retirement

It is therefore evident that greater synergy needs to exist between the wealth and healthcare management of retirees. The term *whealthcare* has been coined by Dr Jason Karlawish in response to the early detection of dementia. Irregular or erratic financial transactions can be the first signal of cognitive impairment. As dementia is a public health issue, Dr Karlawish is campaigning for greater communication between the financial services industry and the healthcare sector in the early diagnosis of dementia (Karlawish, 2016; Karlawish & Blazer, 2015; Whealthcare.org, 2016). It is from this launch pad of greater communication, that the term *whealthcare* can be appropriately used for integration of the finance and health sectors in preparing individuals for retirement.

The most sustainable solution for a *healthy ageing* population and the preservation of financial well-being is the linkage of health and wealth; *whealthcare* (Global Agenda Council on Ageing, 2016a). There is increasing awareness of the socio-economic factors and behavioural determinants in how individuals prepare for retirement, influencing health, wealth and well-being in later years (Global Agenda Council on Ageing, 2016a; Newcombe, 2015; R. D. Smith & Hanson, 2012). Clients with a strong financial well-being have a four times lower chronic claims rate (Portrag, 2016). This illustrates that the most efficient and effective programmes should combine health improvement with savings incentives (Gubler & Pierce, 2014). In addressing the challenges of public health problems, clinical health trials should be expanded to include the financial sector (J. P. Smith, 1999; R. D. Smith & Hanson, 2012). Cross sector collaboration pivoting around a culture of *whealthcare* will “spur developments in financial gerontology and related areas that protect the economic security of older people” (Global Agenda Council on Ageing, 2016a, p. 4).

## 7. Conclusion

The 21<sup>st</sup> century will herald unprecedented longevity and top-heavy ageing demographics. Our youth-orientated societies will have to adapt, as this culture will affect how we perceive our own ageing process and how we prepare for the health and wealth needs of our future older selves. It is necessary to be introspective in this regard, as ageism is now a more prolific form of discrimination than racism and sexism (World Health Organization, 2015b). However, it is a misguided belief that older people are a drain and a burden on society. In fact, as the fastest growing demographic in the world, the 65+ cohort is yielding substantial influence over the economy. Businesses in the finance, insurance and health sectors are responding by implementing “ageing” as a key commercial goal. Organisations adhering to a ‘shared value’ principle and the Sustainable Development Goals are aligning their business strategies to address the societal challenges facing ageing populations and using it as an opportunity to promote *healthy ageing*. As the purpose of this research was to develop a *healthy ageing* prototype within the private healthcare sector, initiatives which focused on physical activity and social engagement were highlighted. As well as showing improved benefit to the well-being of older people these initiatives also demonstrated reduced hospitalization expenditure. In promoting *healthy ageing*, it is apparent that the systems which deliver health and finance services need to be adapted to cater to the needs of a growing ageing base. A *whealthcare* framework will ensure greater synergy in the wealth and healthcare management of older people. Thus, the dynamics of *healthy ageing* need to be understood from an older person’s perspective and so too is an understanding needed regarding the perception held by the private health and finance sectors towards their growing ageing client base.

# **CHAPTER THREE**

## **RESEARCH METHODOLOGY**

### **1. Introduction**

This chapter describes the research methodology, sampling strategies and analysis process. It begins by discussing the merits of both quantitative and qualitative methodologies, with an emphasis on using a methodology which is best suited to achieving the research objectives. The chapter continues by outlining how a qualitative approach was employed for this study. The use of purposeful and snowball sampling techniques is explained. A description of the data analysis process using grounded-theory methods is given. The ethical considerations are detailed and the chapter concludes with a discussion on the limitations of the research design and the researcher.

### **2. The relative merits of quantitative and qualitative research methodologies**

Within research, a paradigm is a “loose collection of logically related assumptions, concepts, or propositions that orient thinking and research” (Bogdan and Biklen, as cited by Mackenzie & Knipe, 2006). A paradigm therefore guides the theoretical framework in how knowledge is studied and interpreted. The term paradigm is often used with reference to research methodologies. A quantitative methodology is associated with positivism, with the goal of measuring and analyzing causal relationships between variables. Sample sizes are large to provide numerical data, which is more reliable and objective. As such, a quantitative methodology reduces empirical evidence by use of statistical methods to ensure the study’s sample represents a population at large (Armitage, 2007; Sale, Lohfeld, & Brazil, 2002). In contrast, a qualitative methodology is associated with constructivism, which implies there are a multitude of realities or truths which are socially constructed (A. Bryant & Charmaz, 2007; Charmaz, 2008). Sample sizes are smaller, with the intention of understanding “the world of human experience” (Cohen and Manion, as cited by Mackenzie & Knipe, 2006). Findings from qualitative paradigms are therefore not representative of a large population, but rather provide nuanced interpretation of the phenomena. It is prudent to acknowledge that no single methodological study is going to solve the problems of a multifaceted phenomenon under question. In order for research to have credibility, the challenge for researchers

is to match the methodology to the research question, rather than narrowly following a methodological orthodoxy (Patton, 2002).

In any study, it is important that the methodology is appropriate for the research aims and objectives. The main objective of this exploratory research was to understand the motivations, challenges and constraints experienced by older people within the private medical aid scheme and financial services environment. To discover the perceptions of health, wealth and well-being in retirement, an inductive qualitative approach was employed. Using grounded theory-type methodology, the analysis of semi-structured interviews with sixteen older research participants framed the shared experiences of the private sector retirement space in older people's terms (Charmaz, 2008). The analysis of semi-structured interviews with thirteen professional research participants from the health, wealth and fitness sectors using grounded theory-type methods provided an understanding of the context of the private sector retirement space in South Africa. An inductive qualitative approach with the professional participant interviews was intended to uncover the broader relationships and complexities around the health, wealth and well-being circumstances experienced by older people in the private medical aid scheme environment and the financial services industry. This valuable data was used to contribute to the development of the research prototype. The limitation of this approach is that the findings are not generalizable to a larger population. As such a qualitative approach may not be good for theory testing. However, for this study it was a well-matched methodology for initial exploratory research.

The benefit of integrating the findings from the older and professional research participants is that it exposes assumptions regarding the circumstances of older beneficiaries of private medical aid schemes and retirement annuities. Unearthing such assumptions does not in itself provide solutions but does provide the opportunity to problematize the knowledge upon which health and wealth programmes and policies for retirement are based. Valuable insight can be gained by better understanding the enablers and barriers experienced by older people in maintaining their good health and well-being. These are insights which may not be easily conceptualized in terms of cost or tangible clinical outcomes (Cooper, 2014).

### **3. Sampling methods, recruitment and interview process**

#### 3.1 Sampling strategy

A study's credibility relies on the study's sample. As the interviews with older and professional participants occurred concurrently, the sampling strategy was a combination of snowballing and purposeful sampling. This strategy recognizes that the data often leads the direction of the research. Snowball and purposeful sampling allow for a degree of flexibility and acknowledge that a sample cannot be concretely defined before embarking on the field work (Emmel, 2014). The combination of snowballing and purposeful sampling facilitated flexibility in the field, whilst still adhering to the objectives of the research.

##### *3.1.1 Snowball sampling*

Snowball sampling relies on dynamic social networks. This approach appreciates a social network's fluidity and interactions (Noy, 2008). With snowball sampling participants are identified by a process of "people who know people who know people who know what cases are information rich" (Patton, 2003, p. 5). Snowballing was particularly relevant in terms of referrals from professional research participants either in referring older research participants who matched the research criteria or by introduction to other professionals who could add insight to the research question.

##### *3.1.2 Purposeful sampling*

Purposeful sampling is used to gain information rich, in-depth and detailed case studies. Purposeful sampling's restriction is that it does not generate empirical data that can be generalized from the sample to the population. Its strength lies in its pragmatic approach, which considers the real-world realities of research which is constrained by time, capacity and limited resources. However, Patton insists that there is nothing convenient about purposeful sampling. Rather the focus is on a purposeful strategy which carefully selects case studies which are congruent in answering the research question (Emmel, 2014; Patton, 1999, 2003, 2011).

The strategy of purposeful sampling is to first identify cases with common patterns and shared experiences. Within the sample criteria of this research, older participants were all over the age of 65 (legal retirement age in South Africa) and were beneficiaries of a private medical aid scheme and retirement annuities. Kuzel (1992) advised that "although the rules are not hard and fast, experience has shown that 12-20 (data sources) commonly are needed when looking for

disconfirming evidence or trying to achieve maximum variation” (p. 41). This study recruited sixteen older participants. The sampling strategy was strengthened by purposefully selecting cases which were enlightening or unique (Emmel, 2014). Choosing such cases provided additional insight from their unusual circumstances or specific characteristics within the shared experiences of the sample pool. Within the older participants’ sample pool, participants were chosen to reflect a variation of characteristics. This variation took into consideration age, gender, race, levels of physical activity, health condition, financial circumstances and living arrangements (see appendix 1: Biographical details of older participants).

The variation is illustrated by example of the following participants: Participant #1, aged 65 had recently retired, whereas Participant #2 aged 94 years old, had been over the retirement age for 30 years; Participant #10 was selected as she had macular degeneration and it was hoped that she would provide the perspective of an older person managing a health condition and dealing with increased dependency, whereas Participant #3 was selected as she was very active and in good health; Participant #8, lived in Bishops Court which is an affluent area of Cape Town and had been a successful businessman, whereas Participant #14 lived in Mitchell’s Plain which is a lower socio-economic area of Cape Town and had been a school principal. This strategy placed the judgment on the researcher in choosing cases which could provide the most lessons within the shared experiences of the sample pool. Purposefully selecting specific types and numbers of cases kept the sample size within the capacity of the study confines, provided credibility and reduced bias whilst adhering to the objectives of the research (Patton, 2003).

### 3.2 Older research participant recruitment and interview process

One-on-one semi-structured interviews were conducted with a purposefully selected sample of sixteen independently living older people over the age of 65 years. To obtain maximum variation in perspective and experience, recruitment occurred through advertisement of the study in the University of Third Age South Africa (2016) (a “learning co-operative for third agers” from all walks of life with over 13,000 members nationwide) newsletter, a retirement village and recommendations from professional participants and contacts. Respondents were not selected off a list but were recruited either by direct contact through referrals or through their response to the advert in the U3A newsletter. No one refused participation in the study, as they were aware of research content prior to agreeing to participate. The participants were aware that the interview

would be a discussion of their views and experiences of being a member of a private medical aid scheme and their financial planning for retirement, with a specific focus on health and well-being in their later years. The age of participants ranged from 65-94 years, with a mean age of 75 years. A majority (63%) were women, with most (81%) participants being white (see appendix 1 for biographical details of older participants). The predominance of white older research participants in the study's sample mirrors the race demographics of private medical aid schemes' membership base (see table 2). This is significant in the South African context as it reflects the legacy of apartheid and the long-lasting effect apartheid has had on South Africans' financial means. In terms of the South African Constitution, the government uses race as a measure of progress towards achieving racial equity. The race demographics of private medical aid schemes' membership may demonstrate that little socio-economic change has occurred since the end of apartheid in 1994, particularly for older South Africans.

Table 2. Percentage of Race Demographic of 60+ Medical Aid Scheme Membership

Medical Aid Insurance and Retirement					
Detailed Age		61-65	66-70	71-75	76+
Totals		9.8	7.4	5.2	4.8
		100.0	100.0	100.0	100.0
Race	Black	30.9	11.4	13.8	8.2
	Coloured	9.8	5.6	3.3	6.3
	Indian	6.5	5.4	6.2	5.9
	White	52.7	77.6	76.7	79.7
		100.0	100.0	100.0	100.0

Source: All Media Product Survey. LSM 7-10 Race Demographic 60+ Medical Aid Scheme Membership (January 2015 – December 2015).

Interviews were approximately 1 hour in duration. They took place either at the participant's home or at his/her venue of choice. A predetermined list of questions was outlined, based on factors suggested by the literature and in relation to the development of the research prototype. Interviews

proceeded along the interview outline (see appendix 2). A conversational atmosphere created trust, putting the research participants at ease and allowing for some deviation in the order of discussion. Handwritten notes were taken during the interviews to encourage the participants to share freely under the cloak of anonymity. The older participants appeared to enjoy the opportunity to talk about this stage of their lives and it seemed like a positive experience for them to be able to talk about the motivations and challenges they encountered.

### 3.3 Professional research participant recruitment and interview process

One-on-one semi-structured interviews with thirteen professional participants were procured either through direct contact with the organisation, referrals through professional contacts or snowballing from other professional research participants (see appendix 3: Details of professional participants). In addition to those who were interviewed a further three were contacted but were either unavailable to assist or had professional commitments which put them out of the timeframe of completing this dissertation. Using snowball and purposeful sampling strategy, professional participants were chosen based on the flowchart of the private sector retirement space (see appendix 4) to provide rich, in-depth, and credible cases which would support the emergent findings and the development of the research prototype (Emmel, 2014; Maxwell, 2013). For example, Shivani Ranchod, an actuarial consultant, was selected as she had co-authored a paper on healthcare expenditure in the later years and had an in-depth understanding of the South African private healthcare sector. In addition to this, understanding was gained from the perspective of a private medical aid scheme. Shivani Ranchod recommended speaking to Dr Belinda Richards, who had many years' experience having worked at both Discovery Health and Momentum Health. This illustrates the use of both purposeful and snowball sampling which ensured that the appropriate participants were selected to gain information which would realise the research objectives.

Interviews were approximately 1-2 hours in duration. They took place either at the professional participant's office or his/her venue of choice. The participants were aware that the interview would be a discussion of their views and expertise regarding the wealth, health and well-being needs of older people in retirement. A predetermined list of questions was outlined (see appendix 5: Professional participant interview outline), based on factors suggested by the literature and in relation to the development of the research prototype. However, the interview structure was open

to allow the professional participant to describe the dynamics of their organisation and industry in their own terms and the role their organisation played in the ageing sector (Gioia, Corley, & Hamilton, 2012). The interviews were audio-recorded to capture the fine details of information, jargon or terminology specific to the participant's sector and industry.

#### **4. Data analysis and coding**

##### 4.1 Method of analysis

The data to be analysed, represented on the one hand, the experiences and perceptions of the older participants regarding their wealth, health and well-being and on the other hand the contextualization of the private health sector and financial services retirement space. Taking these two aspects into account, analysis of the interviews entailed immersion into the material by adhering to grounded theory-type methods (Corbin & Strauss, 2008a). Grounded theory-type methods of qualitative analysis entail “a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon” (Strauss & Corbin, as cited by L. L. Bryant, Corbett, & Kutner, 2001, p. 932).

##### 4.2 The process of coding

The initial stages of the coding focused on portraying the participants' own words and meanings (Corbin & Strauss, 2008a; Gioia et al., 2012). Phrases and sections of text were assigned to codes that were connected to either key questions in the interview outline or emergent themes which arose from the data. In some instances, the same text was assigned to more than one theme. This was accompanied by an initial set of broad concepts drawn from the literature and information regarding the South African private healthcare sector and financial services industry. An overview of the private sector health and wealth retirement landscape was created for the emergent findings and themes to be placed. The retirement landscape was represented by using the two graphs discussed in the introductory chapter. The first graph was the accumulation and decumulation in financial planning for retirement and the second illustrated the increase in healthcare costs in old age. Themes were plotted on the graphical representation of retirement in the private health and wealth sectors. This allowed for a systematic coding process, which refined and extended the themes which emerged from the data.

The final themes which arose from the data reflected and incorporated the objectives and purpose of the research. The main objective of the research was an exploratory inquiry into the

experiences of older people. The emergent themes reflected the motivations, challenges and constraints experienced by the older participants in the private retirement space in their own words (see appendix 6: Table summarising older participants' responses). Accompanying this inquiry, was the contextualisation of their "lived realities" in the private healthcare sector and financial services industry for the development of a comprehensive senior wellness programme. The themes which emerged from the interviews with the professional participants illustrated how a comprehensive senior wellness programme is more than the sum of its parts and unearthed the complexities of the private sector retirement environment in South Africa (see appendix 7: Table summarising professional participants' responses). Chapter four provides greater understanding and contextual background to the research themes specifically relating to the South African private sector retirement space.

## **5. Research Ethics**

Ethical considerations were particularly important in this research, due to the sensitive nature regarding health and financial circumstances in later life. Prior to commencing the interviews, ethics clearance was obtained by the Faculty of Commerce at the Graduate School of Business. Research protocols were adhered to by the guidelines provided in the Commerce Faculty Ethics in Research Policy. All research participants were requested to sign a consent form to participate in the research study. All the older research participants were in general good health and of sound mind. Anonymity and confidentiality were assured for the older research participants as they were sharing personal information regarding their health and financial circumstances. The professional research participants agreed to the interviews being audio recorded and their names being cited in the research findings discussion chapter.

## **6. Research limitations**

### **6.1 Overview**

No single method of research would adequately uncover the multifaceted aspects to *healthy ageing* and the complexities surrounding health and wealth in old age. It is important to note that ageing entails a broad range of social, political and environmental issues and stakeholders, which this study was unable to effectively address. The most prominent stakeholder is government and the role of government in addressing the needs of older members of society. There are therefore several limitations to this study, including how the participants were sourced, the sample selection,

the rigor of the qualitative research and the bias of the sole researcher. However, despite the limitations of the study, this initial exploratory research would lead to insights being gained in terms of older people's experiences and perceptions of their wealth, health and well-being and the contextual layout of retirement in the private sector in South Africa. Value would be added to this study's findings with future research which should seek to address scaling solutions to a larger population and expanding the research to incorporate government's role.

## 6.2 Research design limitations

The research had a very specific focus of exploring the experiences of older beneficiaries of private medical aid schemes and retirement annuities. Looking at this very specific demographic within the private sector, gave the study focus but it also contributed to the study's major limitation; generalizability. The study's results are restricted as the findings cannot be applied to the population at large. The study is further limited by various other factors. One of the study's limitations is the situational context of the study. Older research participants all lived in the Cape Town area. This geographical constraint does impact on the generalizability of the findings. The research was part of a Masters project, which expected the research to be completed in a year, with a maximum of two years. This disallowed a longitudinal analysis.

The most noteworthy limitation is the selectivity of the sample. This is particularly the case with a purposeful sampling strategy, where a limited number of cases is chosen in order to produce the most useable amount of information (Emmel, 2014). A balance therefore needed to be set between more or less and depth or breadth (Patton, 2003). As has been stated, the ideal number of cases to achieve maximum variation is between 12-20 (Kuzel, 1992). It was felt that saturation had been achieved after interviewing sixteen older research participants (Corbin & Strauss, 2008b; Gioia et al., 2012; Kovalainen, 2008). The research design also included interviews with thirteen professional participants. In total 29 interviews were conducted to capture the experiences of older people and understand the contextual factors of the private healthcare sector and financial services industry for the development of the research prototype.

Purposeful sampling's major weakness is that the findings cannot be transferred from the sample to the population at large. However, the data from semi-structured interviews with older participants provided rich insights and in-depth detail. This supports transferability as the applicability of the results could be applied to other older beneficiaries of private medical aid

schemes and retirement annuities (Erlandson et al. as cited by L. L. Bryant et al., 2001). Thus, the potential weakness of a small sample size becomes a strength, giving the study credibility to be the basis of future research. The same is applicable to the dependability of the data gained from semi-structured interviews with professional participants. Future policies and programmes should not be based solely on this study's prototype. The purpose of the research's prototype is rather to open up the possibility of future actuarial and quantitative research which was beyond the scope of this research.

### 6.3 Limitations of researcher

Qualitative research will be influenced by the judgments and decisions made by the researcher before, during and after the research design. When adhering to grounded theory methodology, the researcher is the instrument of data collection. This research therefore has limitations as the researcher drafted the interview outlines, conducted the interviews and transcribed the transcripts. The researcher's objectivity may have been comprised due to this immersion. Triangulation of data throughout the research process was essential. The procedure of "cross-checking and cross-validating sources" throughout the data collection process not only enriched the field work but ensured the data collection was rigorous and systematic (Patton, 2002, p. 266). The best strategy for minimizing the bias of a researcher in the collection and analysis of the data is to ensure that there is triangulation of multiple analysts (Patton, 1999). Using multiple coders ensures validity and reliability of the research findings. This is therefore a limitation of the study as it was conducted by a sole researcher. However, during the analysis, the researcher combined the transcripts, literature, observations and memo writing into a cohesive and interactive process.

A purposeful sampling strategy acknowledges that the decisions made by the researcher concerning who to purposefully include in the research will shape the overall design and direction of the research (Emmel, 2014). As the researcher had a background in senior wellness this would have affected the character of the research. The social constructionist method of grounded theory permits the researcher to bring their prior theoretical and practical experience (A. Bryant & Charmaz, 2007; Charmaz, 2008). Charmaz's social constructionist embraces the researcher's subjectivity, as having a practical and theoretical understanding of ageing frameworks brings a deeper understanding of the human dimension (Patton, 2002). As Patton so eloquently states, "the

human factor is the greatest strength and the fundamental weakness of qualitative inquiry and analysis- a scientific two-edged sword” (Patton, 2002, p. 276).

## **7. Conclusion**

The aim of this study was to match the research objectives to the correct methodology and sampling strategy. The main objective of this research, was an initial exploratory inquiry into the experiences of older beneficiaries of private medical aid schemes and retirement annuities. A qualitative inductive approach was best suited as the intention was to gain deep insights and information rich data. The sub-objective of this research was to obtain a better understanding of the context of the private sector retirement space in South Africa. The data gathered from professionals from the private health, wealth and fitness sectors was necessary to provide information rich data for the development of the research prototype. The prototype encompasses a comprehensive senior wellness programme and potential solutions for creating greater synergy between, and incentive models for, the private healthcare sector and the financial services industry.

The sampling strategy for the older and professional research participants was a combination of snowball and purposeful sampling techniques. This pragmatic approach focused on choosing information-rich cases which were congruent with the study’s objectives. The limitation of this sampling strategy is the restriction on the generalizability of the research findings. Due to the research’s qualitative approach and sampling strategy, its findings cannot form the basis of policy or programme development. Rather, the research findings expose the need for future research which includes the role of government in addressing the wealth, health and well-being needs of older members of society and opens the possibility of future mixed methodological approaches, namely qualitative, quantitative and actuarial research that can scale the research prototype to a larger population.

## **CHAPTER FOUR**

### **UNDERSTANDING THE RESEARCH CONTEXT**

#### **1. Introduction**

During the interview process, the older and professional research participants discussed several topics which may be specific to the South African private healthcare sector and financial services industry. This chapter explains the context of the South African private sector retirement environment. It clarifies terminology and defines subject specific content discussed by the participants in chapters five and six. This information pertains purely to the data in the research findings. The information outlined below is also relevant to the prototype presented in chapter seven. The prototype is not intended for implementation in the public sector and hence the role of government is not addressed within this research context.

#### **2. Financial planning**

Below gives background to areas that were discussed by the older and professional research participants:

##### **2.1 Pension funds**

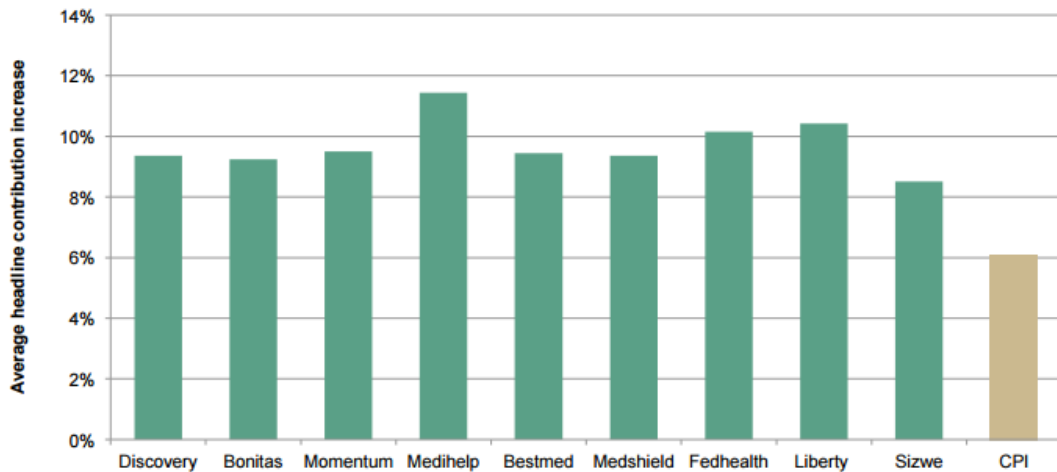
A “pension fund organisation” means any association of persons established with the object of providing annuities or lump sum payments for members or former members of such association upon their reaching their retirement dates (Republic of South Africa, 1956). Most South African companies are obligated to provide their employees with a pension fund, as stipulated by the Pension Fund Act (1956, as amended). There has been an increasing move towards defined contribution schemes over defined benefit schemes. Defined benefit schemes provide the employee an income for life upon retirement, whereas defined contribution schemes only pay out the accumulated balance of the employee’s savings to provide an income in retirement (National Treasury, 2012). This move towards defined contribution places more responsibility on the individual for their retirement planning.

## 2.2 Certified financial planners

Many people choose to seek advice from a professional regarding their financial planning for retirement, as it can feel like a daunting process (Investopedia, 2017). In South Africa, certified financial planners are regulated by the Financial Services Board (FSB). The FSB “oversees the non-banking financial services industry, which includes retirement funds, short-term & long-term insurance, companies, funeral insurance, schemes, collective investment schemes (unit trusts and stock market) and financial advisors and brokers” (Financial Services Board, 2017). The financial services industry is highly regulated to protect the public from unscrupulous professionals. The job of a financial planner is to help you navigate your life by ensuring that your financial affairs are ordered in such a way that your financial resources support the way of life you seek to live (K. Brown, personal communication, September 1, 2016). Financial planning aims to ensure that you have sufficient capital until the end of your life.

## 2.3 Financial planning process

In a typical financial planning process, a financial planner will paint three different scenarios, which allows the client to see when they would be in a position to retire comfortably. In the financial planning exercise, the financial planner will look at budgeting and providing a lifetime monthly income to cover expenses. The “unknowns” such as travelling or buying a new car, will be put in a separate amount known as CAPEX. The two variables affecting financial planning are life expectancy and inflation. A prudent financial planner would base a client’s financial plan on a life expectancy of 90 – 100 years (R. Adshade and K. Brown, personal communication, September, 2016). Inflation, is the other variable which if not accounted for can have adverse implications on a retired person’s income. Inflation is calculated based on the Consumer Price Index (CPI). CPI is calculated based on “current social and economic indicators that are constructed to measure changes over time in the general level of prices of consumer goods and services that households acquire, use, or pay for” (Statistics South Africa, 2013). Medical CPI has historically been above inflation (see figure 13). It is therefore important that medical expense CPI is built into the financial plan. This is not only to account for the above inflation increase of medical aid scheme premiums but also for out-of-pocket medical expenses which will be incurred as the client ages.



Over the last 10 years medical schemes have increased their contributions by significantly more than CPI inflation.

Figure 13. Average annualised contribution increases 2006–2015

Source: Alexander Forbes Diagnosis 2015/2016. Available at [https://contactus.alexanderforbes.co.za/business/Asset Consulting Surveys/2015 Diagnosis.pdf](https://contactus.alexanderforbes.co.za/business/Asset%20Consulting%20Surveys/2015%20Diagnosis.pdf)

#### 2.4 Insurance policies

Most people will have insurance policies as part of their financial management. Short-term insurance policies include car and household insurance and long-term insurance policies include life insurance, dread disease and disability and income protection. It is advantageous for a working individual with dependants to have long-term insurance as it provides assurance that their dependants will be taken care of financially if they were to die. Insurance premiums are often seen as a grudge purchase. When an individual enters retirement or no longer has the responsibility for dependants, life insurance policies are often dropped. Long-term care insurance policies, which are more appropriate for a person in retirement, have struggled to gain traction both in the international and local market (S. Ranchod, personal communication, September 12, 2016).

#### 2.5 Retirement annuities

When a person enters retirement, they will receive a lump sum payout from their pension fund. The South African law compels the individual to invest at least two-thirds of their accumulated

balance and in return the annuity product provides a tax-protected phased-withdrawal income. In 2011, it is estimated that the South African annuities market was R31 billion (National Treasury, 2012, p. 12). For many this is the first time they are being exposed to the open market for investment (National Treasury, 2012). A life insurance company will invest the money on behalf of the individual and in return the individual will receive an income of between 2.5 and 17.5 per cent of the account value (National Treasury, 2012). A person entering retirement has two annuity options. A life annuity is guaranteed to pay you a pre-determined amount for the remainder of your life. A living annuity gives the client the flexibility to choose the level of income each year but it places the individual at risk if they outlive their capital. There has been a move to invest in living annuities. This could be due to short-term considerations and brokers being incentivized by the higher commissions from living annuities (National Treasury, 2012). The aim for the retired individual is to draw an annuity from their investment, which will provide sufficient income for their lifetime without depleting the capital amount.

## 2.6 Property

Having a paid off property when reaching retirement is viewed as advantageous. For most people, buying a property entails borrowing money from a bank in the form of a mortgage, with the aim of paying back the amount borrowed with interest before they reach retirement. A paid-off property provides a dual role for an older person. It allows them the breathing room to continue to “age-in-place” without the additional financial obligation to pay a mortgage. However, if they choose to no longer live in their house, selling their property offers the opportunity of releasing that capital to provide additional income in retirement.

## 3. Private healthcare

It is important to make the distinction between the health sector and the health system, particularly in relation to the health and well-being of older people. As described by Hanson et al, the health sector is made up of actors and activities primarily concerned with the improvement or preservation of health status at an individual or population level, whereas the health system is a broad range of activities which influence health (K. Hanson, 2012). This distinction is relevant in the context of the South African private medical aid scheme environment in terms of what services and care older members receive through their medical aid scheme plan.

### 3.1 South Africa's private healthcare landscape

The private healthcare industry is highly controlled and bound by legislation. Private medical aid schemes are regulated by the Medical Schemes Act (Republic of South Africa, 1998). The act stipulates that a member pays a monthly premium for the provision of health services and in return the scheme aids in settling costs incurred in the provision of health services. Private medical aid schemes are non-profit organisations with a board of trustees. Most schemes appoint a third party to handle the day to day operations. Schemes are either restricted, where membership is specific to an employer or profession or open, with no rules around eligibility (S. Ranchod, personal communication, September 12, 2016). As per the Medical Scheme Act (No 131 of 1998), private medical aid schemes must charge a standard-rate fee to those joining, regardless of the member's age or health. The purpose of a community rated environment is to prevent discrimination against people with health conditions such as HIV or Diabetes (Medicalaid.co.za, 2016). Due to prescribed minimal benefits (PMBs), schemes are obliged to fund in full and without co-payment for 270 conditions (Council for Medical Schemes, 2016). The intention of PMBs is to protect members from running out of benefits for these conditions.

### 3.2 Membership of medical aid scheme

Various plans are available at different premiums. The plans fall under the two categories; comprehensive and hospital plans. A comprehensive plan covers almost all medical expenses and benefits for in-hospital and day-to-day expenses. A hospital plan covers services provided while in-hospital. However the member must pay for day-to-day medical expenses (Medicalaid.co.za, 2016).

### 3.3 Additional products in private healthcare sector

Most medical aid schemes offer a medical savings account. The member contributes a fixed monthly amount to a savings account, allowing the member to access this money in advance to pay for medical expenses incurred during that year. Gap cover is an add-on insurance product to a medical aid scheme membership, to protect members from out-of-pocket (OOP) costs incurred while in hospital (Medicalaid.co.za, 2016).

## **4. Support structures in late stage retirement**

The options outlined below are feasible support structures when considering the possibility of one becoming more dependent in late stage retirement.

#### 4.1 Retirement villages

A retirement village is a secure complex that is restricted to residents over a specified age. The villages are usually uniform in design and managed by a body corporate or home owner's organization. A retirement village provides location-specific social engagement activities. Being a resident at a retirement village offers the day-to-day support which an independent older person may start to lose as the frequency of visits from family and friends diminish. Deciding to move into a retirement village can evoke emotions specific to the older person. It can either signal a positive move towards transitioning to another phase of ageing or a negative association of being removed from their community and being surrounded solely by older people (Goldhaber & Donaldson, 2012). Some retirement villages have a waiting list of 15 years and there are restrictions to putting one's name down before the age of 65 (Woodside Village homepage, 2017). Desirable retirement villages can be expensive and have high monthly levies.

#### 4.2 Frail care

When an older person is no longer able to perform a specified amount of the activities of daily living (ADL), such as dressing or feeding themselves, or is physically and/or cognitively impaired, frail care provides the necessary assistance on a permanent basis (du Preez, 2015). The provision of long-term care is deemed as a social welfare and therefore the cost is rarely covered by medical aid schemes. The estate planning guide on U3A Cape Town's website outlines what older people may expect in terms of the financial commitment of frail care:

Home care usually lasts from 3 – 5 years. Then things start to get really expensive. People migrate to a nursing home. (In South Africa today, this costs around R200 000 a year, and is estimated to be double that in ten years' time!) This lasts on average another 2- 4 years. Finally, there is the hospice. (A stay in a hospice averages 50 days.) All told, you are probably looking at R1-2 million (Clarke & McFarlane, 2016, p. 12).

#### 4.3 Caregivers

For people who choose to remain in their own homes, the role of a caregiver becomes ever more apparent. Caregivers are either paid or unpaid. Historically unpaid caregiving has come from the women in the family unit. However there has been a shift in gender roles in society, as many women seek employment opportunities outside the home (Salomon et al., 2012). Those that do

look after ageing family members often suffer from burnout (World Health Organization, 2004). The interdependencies of caregiving in the broader societal context have implications for the care available to dependent older people. Within the context of this study's sample, most of the participants would use a paid caregiver. There are several caregiving agencies which provide different levels of qualified caregivers. Many older South Africans may also rely on the help of domestic staff.

## **5. 'Shared value' and the Vitality model**

In chapter two, Porter and Kramer's 'shared value' principle was highlighted as showing the necessary change in ethos within the private sector to create business models that "create economic value by creating societal value" (Porter & Kramer, 2011, p. 67). This does not entail businesses acting as charities nor adopting a corporate social responsibility mindset, but rather by aligning consumer demand with social value (World Economic Forum, 2015). Businesses can redefine their corporate strategy to creating shared value, which will drive innovation and productivity and facilitate the business's opportunity to expand into other markets (Porter & Kramer, 2011).

Discovery's Vitality model is the center of its 'shared value' philosophy, aligning to Discovery Health's business model to make people healthier. When it first entered the market, Discovery was a market disruptor offering innovative medical saving accounts and selling their health insurance through life insurance distribution channels (Porter et al., 2014). The Vitality model was introduced by Discovery Health in 1997 before the Medical Aid Scheme Act, when there were no explicit rules disallowing the co-selling of products alongside a medical aid scheme (S. Ranchod, personal communication, September 12, 2016). The Vitality model is based on members paying a premium, which is then used to offset the costs of providing the benefits and discounts from Vitality's affiliated partners. Vitality has recently included discounts on Discovery Life and Insure policy premiums. Vitality incentivizes members to improve their Vitality status by participating in healthy lifestyle activities and preventative health screening in order to benefit from discounts and rewards. By 2014, Discovery Health held 52% of the South African open share market and had begun to expand into international markets (Porter et al., 2014, p. 4).

Vitality is innovatively addressing the global population's health and well-being needs through partnerships and joint ventures with health and life insurers around the world as shown in figure 14. In 2013, the establishment of the Vitality Institute in New York City cemented Discovery's

role as a leader in health promotion and disease prevention research (Porter et al., 2014). The Vitality model offers many lessons in innovative health promotion and does provide learnings for the cohesion of health and wealth.

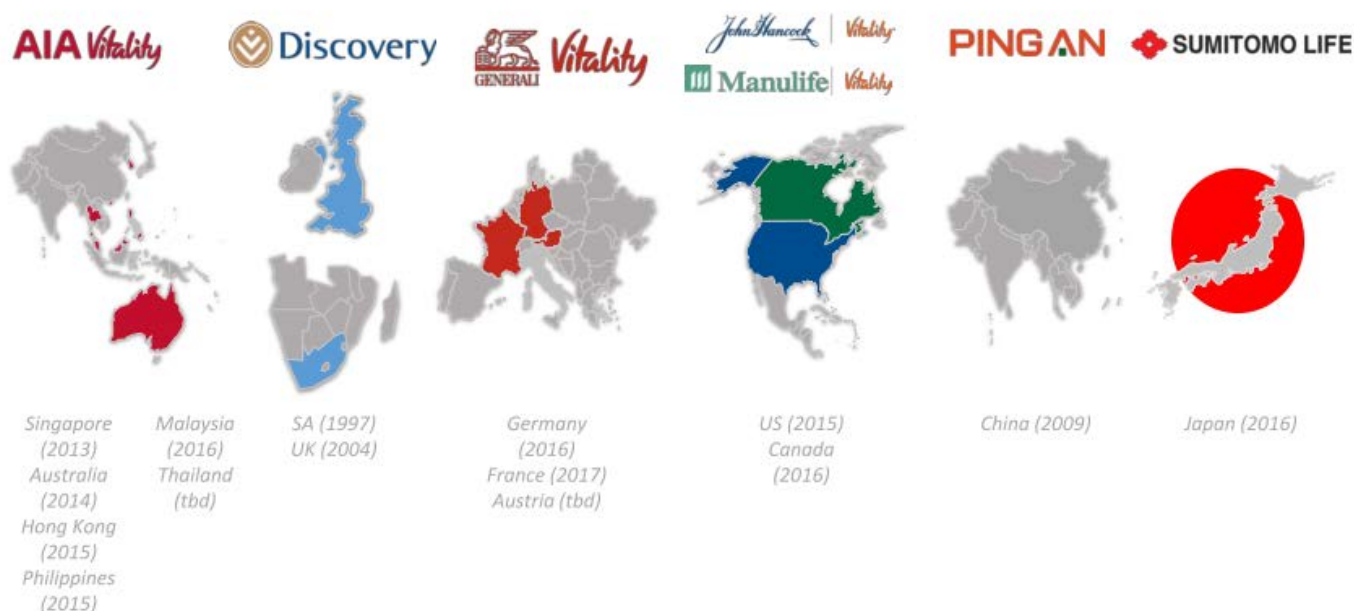


Figure 14. Vitality is working with leading insurers around the world

Source: Transforming life insurance to promote longevity. (2016). D. Yach

## 6. Conclusion

This chapter aimed to clarify and explain the language used and subjects referred to by the participants, which may be specific to the context of the private sector retirement space of South Africa. By giving the background to the financial planning process and explaining the vehicles through which people manage their pre-and post-retirement savings, the terms and phrases the respondents use will be clear. The same is applicable to the terminology surrounding the South African private healthcare sector. Providing definitions and supplementary information before presenting the findings and research prototype, prevents any confusion and ensures that the voices of the participants are the predominant feature.

Chapters five, six and seven present the research findings and the research prototype. Chapter five presents the responses from the older research participants. It portrays the older participants'

lived realities in their own words, describing their motivations, challenges and concerns regarding their social, physical, and financial well-being. The chapter details their experiences and the perceptions they hold as older members of medical aid schemes and beneficiaries of retirement annuities. Chapter six presents the viewpoint of the professional participants from the financial services industry, the private healthcare sector, the Vitality/engagement model and the fitness industry. The chapter details the context and landscape of the private healthcare sector and the retirement industry and discusses the implications of this environment for an older person accessing these private sector services. Chapter seven presents the research prototype based on the research findings presented in chapters five and six. The prototype has been developed by integrating the findings from the industry perspective and the lived experiences of the older participants. The research prototype comprises elements of a framework which aims to address the issues raised by both the older and professional participants.

# CHAPTER FIVE

## PERCEPTIONS AND EXPERIENCES

### OF THE OLDER RESEARCH PARTICIPANTS

#### 1. Introduction

The sixteen older research participants of this study were among the 18% of the seemingly affluent segment of the South African population who belong to a private medical aid scheme. However, the responses from the older participants illuminated not only the diversity in the ageing process but also the diversity of circumstances of individuals accessing these private sector services. The findings from the older participants shed light on the budgetary considerations many older people must make regarding their medical aid scheme membership and the impact out-of-pocket payments can have on their health outcomes. Furthermore, the older participants' responses illuminated the concern many have of outliving their retirement savings and their anxiety about becoming a physical and/or a financial burden. Giving this small segment of the population an opportunity to voice their motivations, concerns and constraints feeds into the type of questions which should be asked in generating solutions which can be scaled to a larger population.

#### 2. *Healthy ageing*

The older participants' responses regarding their health and well-being in their later years were varied and supported the notion that growing older is a personalised experience. As such their responses could not be categorized but rather loosely clustered to portray the individualised perception of the motivations and challenges of maintaining good health and well-being.

##### 2.1 Pros and cons of being in retirement stage of your life

The resounding response concerning the benefits of being at this stage of life was the lower stress levels and reduced responsibilities and the freedom which these bring:

“It’s a great age. I have few responsibilities, I can do what I like and I have a lot of interests that I can pursue.” (Participant #2)

“No more real responsibility.” (Participant #4)

“Definitely far less stress.” (Participant #12)

A few of the participants reiterated the benefit of less stress, but immediately followed on saying that their financial circumstances contributed to their sense of well-being.

“The biggest pro is that I am financially stable and that is entirely thanks to my husband.” (Participant #11)

“Nice to not have commitments. There are no downsides really because I am financially stable. It all goes down to finances.” (Participant #9)

“I have no worries. I consider myself to be exceptionally fortunate, but I have a lot of friends who have financial worry. They are having to downsize, do less social engagements. It’s what you have to do. Cut your cloth to your lifestyle.” (Participant #8)

The responses to the cons of this stage of life were more varied. However, many of the responses followed on from the benefit of more freedom with the downside of having an unstructured lifestyle.

“A pro would be flexibility timewise but linked with that is a con. Which is you can slip into bad habits, waste time, wake up late and be lazy.” (Participant #6)

The downside of an unstructured lifestyle was mentioned by other participants. Participant #3 said that she had to work on being “self-motivated and creating her own structure.” Connected to this was a sense of loneliness. In answering this question, Participant #5 said “Freedom, boredom and health.” As he continued to talk, he asked for “boredom” to be crossed out and replaced it with “loneliness,” saying that “you spend too much time on your own.” Participant #10 gave a big sigh and stated, “There are precious few pros”. Her loneliness was compounded by the fact that her daughter and her family had moved overseas.

Participant #10’s greatest source of despondency was her inability to continue to work due to the macular degeneration of her eyes. “I’ve worked all my life and can’t continue to work. What am I going to do without work?” This stress was also felt by participant #12 saying “What was stressful at first was wondering if I had enough money to see me through.” A few of the participants spoke about the change in mindset needed as they transitioned into retirement. Participant #1 had

recently retired and spoke a lot about being in a “transitional phase.” Participant #8 stated that the pro of this stage was no longer being in a career which was a “pressure cooker” but simultaneously he was experiencing the challenge of changing his mindset now that he was no longer in that environment: “I think it comes down to self-actualization. I had ambitions to be where I am and now I am here” (Participant #8). Participant #9 reinforced this sentiment. “It’s a process. I knew it was coming and planned for it and it’s here and its fine”.

A few of the respondents spoke about declining health as a con. Participant #7 mentioned the “odd ache and pain”, however Participant #4 said;

“It started about five years ago. I’ve lost what used to be considered normal. I get tired, have no strength. This frustrates me. I find things more difficult to do. My kids say; ‘You’re not old Mom.’ But I say; ‘I can’t do this anymore’”.

Whereas Participant #13 was more philosophical, saying “Age is a figure. I’m 88. There are feelings in the body but now we relate this to a number.”

## 2.2 Motivations and challenges for maintaining good health and well-being

Health and well-being were a priority for the participants and many expressed the importance of maintaining good health and well-being at this stage of their lives. They were pragmatic in expressing both their motivations and challenges.

The main motivation for many of the participants was good health in and of itself.

“The motivation is that it is an essential part of life. To be healthy and active. To not decline into a blob and ultimately be a pain for others.” (Participant #6)

“Just because I want to be well and alive...to a large extent I have been influenced by those who have remained fit and well into old age.” (Participant #13)

Participants #3 and #9 described their varied exercise programme of attending gym numerous times a week, entering sporting events and for participant #9, having a personal trainer. Participant #3 said that her main motivation was enjoyment. She enjoyed exercising and spoke about the pain relief she experienced since attending regular Pilates classes. She said it took a long time to convince her husband to go to gym. She was worried about his mental state after being retrenched, but she persuaded him to believe “healthy mind in a healthy body.”

Other participants expressed social engagement as a motivating factor which exercise provides. Participant #11 spoke animatedly about the social aspect of walking:

“We are very routine. Every Monday evening, we meet friends at Keurboom Park. It is lovely chatting to friends. I try never to miss that. Every Tuesday we walk in Kirstenbosch Gardens. Tuesdays are free for seniors.”

Participant #3 reinforced the benefit of having a “group”:

“I am very lucky that I have a good group at Sports Science. If there is no one around then it’s harder. One needs a group to feel that you belong.”

For Participant #4 the motivation for maintaining her good health and well-being was the relationships with her grandchildren:

“My adult children don’t need me anymore but the relationships I have with my grandchildren are really precious to me.”

The older participants articulated numerous challenges. Lack of motivation and applying self-discipline was most commonly cited as one of the biggest challenges in maintaining good health and well-being. Struggling to find and keep a regular routine resulted in low motivation levels.

“My biggest challenge is regular exercise. I need to get back into it, especially as I have put on weight.” (Participant #1)

“Exercise is my challenge. To keep moving, to stay fit and healthy. I still do Run/Walk 4 Life but I really have to be disciplined.” (Participant #4)

“I am an up and down kind of person. I am unmotivated this year. I am feeling depressed. I know that it is a function of the brain.” (Participant #8)

When Participant #8 was probed into what would motivate him out of his low biorhythm, his response was “An event...maybe a shock. A fall. A health scare.”

Other participants cited health issues as a challenge. Participant #6 said she enjoyed walking and attending an aerobics class, but that she had had a “foot op” and this was a challenge now. Both Participants #7 and #10 spoke about “problems” with arthritis. Another challenge was lack

of confidence, either stemming from losing confidence as they have aged or fear due to environmental concerns.

“I admit I can’t do things like I used to. I used to go kloofing but I have lost my ability to hop and so lost confidence as I don’t want to fall. I am hesitant to put myself in danger.” (Participant #9)

“I have a fear of falling too far away from the starting point of Run/Walk 4 Life.” (Participant #4)

“I like cycling. My son brought me a bike, but the roads aren’t safe and I can’t do that alone.” (Participant #6)

Affordability was seen as a challenge for participation in exercise. For Participant #12, the number one challenge was the cost. He could not afford to spend “R700/month on a gym”. Although admitting to not being a fan of exercise, Participant #10 mentioned the benefits she gained from seeing a personal trainer, saying that “exercise did give me increased confidence, agility and coordination.” However, when she stopped working, she could no longer afford to continue with the personal trainer sessions. With an awareness of the depression her situation had caused her, she said, “What would be good is a heart attack to finish me off. But I am too healthy”.

Beyond the challenge of affordability, finances were also a constraint in the maintenance of good health and well-being. For Participant #11, her doctor recommended she go to physiotherapy for the rehabilitation of her broken thumb, but she said with resignation, “Sorry I don’t have the budget.” Holding her thumb up to demonstrate the arthritis she said, “I drop things and it drives me crazy. I am very determined but part of me says, ‘I can’t be bothered.’”

The older research participants’ responses to their *healthy ageing* were varied and reflected each respondent’s personal experience of growing older. However, despite the diversity the common themes were lower stress levels, the effect of financial circumstances on the perceived sense of well-being and the acknowledgement of the realities of an ageing body.

### **3. Financial planning: Pre-and post-retirement**

The strategy of purposeful sampling in selecting a sample with shared experiences is to selectively choose unique or enlightening case studies which could add variation to the shared

experiences held by the sample as a whole. Thus, participants were selected to portray an array of financial circumstances. Although the participants' financial circumstances were not openly discussed before the interview, the researcher used her judgement to select participants who might portray differing financial circumstances.

### 3.1 Pre-retirement financial planning

The participants' responses regarding their pre-retirement planning were varied and may reflect their pre-retirement employment status, gender, marital status and mindset towards financial planning for the years when they would no longer be earning an income.

From the participants' responses regarding their pre-retirement planning, the participants could be divided into three groups which depicted the degrees of the participants' financial preparedness for retirement. The first group, *Poor planners*, had limited or no pre-retirement financial planning. The second group, *Passive planners*, had an emphasis on pension fund contribution and property and the third group, *Active planners* had more interest in their financial management.

*Poor planners:* There were several participants who had limited to no financial preparation for retirement. Participant #6 said that she and her husband had "zero planning." Participant #3 had a similar response, saying "We were the worst – didn't think about financial planning." There was a sentiment of regret and resignation from these participants. "My husband and I did not start and I regret that" (Participant #3).

*Passive planners:* Most of the participants attributed their pre-retirement financial planning to pension fund contributions and the purchase of a property. This was most succinctly stated by participant #1, stating "I had two goals for retirement. First to retire with a fully paid off house and second to have an adequate pension." Participant #1's prudent financial planning meant that he had reached retirement having achieved those goals. He had minimal savings and no investments, but viewed his property as the major source of potential income in the future as it was an asset.

Many of the participants referred to their property as a crucial element of their financial management in their retirement. Participants #3 and #7 who had limited financial planning for retirement, were both keen to point out that their paid-off properties were a positive move to improving their financial position in their old age. For these and other participants who had limited

income from their pension funds and annuities, having a paid off property was seen as surety for future income needs.

For Participant #14 and Participant #16, CPOA Mitchell's Plain retirement village residents, the income they received from their Department of Education pension appeared adequate for now. However, some of the participants expressed the inadequacy of their pension fund income. Participant #13 said her pension was "miserable" and Participant #10 said she did not have a "great pension." However, the discrepancy between the perceived adequacy of pension fund income may more accurately reflect the discrepancies between the participants' lifestyles. Participants #14, #15 and #16 lived in Mitchell's Plain which is a lower socio-economic area compared to the more affluent areas of Cape Town where Participants #10 and #13 reside. These participants may have different demands on their monthly budget and lifestyle expectations, which could explain the perceived adequacy of pension fund income.

*Active planners:* A number of the participants were satisfied with their financial standing in retirement. Some of these participants had been salaried employees and two of the participants had been business owners. For the two self-employed participants, traditional pre-retirement financial planning did not exist. Neither of these participants had contributed to a pension fund. Participant #9 did not have a pension fund as he "didn't want to be subject to rules and legislation" and "I didn't want government making my decisions." Participant #8 always knew he "would extract a 'pension' from entrepreneurship", believing that "anyone who works for a pension fund is crazy." The previously salaried participants highlighted that they had discretionary savings above and beyond their work pension fund contribution.

### 3.2 Post-retirement financial planning

The participants who were satisfied with their financial position in retirement were also the most descriptive regarding their financial management and talkative in general terms about financial management in the retirement space. Participant #9 had many opinions regarding the financial position of retirees. "When people retire, their income reduces but not necessarily their expenses." He continued, "You know the cost of rates etc. keeps going up. So those that own properties are asset rich but cash poor." Participant #12 stated that he was good on the financial planning side. He spoke in detail about living annuities and how he believed "a lot of people are drawing down too much to last them their lifetime."

The role of gender in financial positioning in retirement is an area of growing interest. Participant #12 who voiced many opinions regarding the financial position of retirees, also mentioned numerous times how “clueless” women were regarding money and financial planning. It is interesting to note that the majority of those who stated that they were satisfied with their financial position were men. Participant #11 who was also satisfied with her financial position said, “My husband takes care of all the monthly expenses. He looks after us. There is never a worry and this is huge.” Participant #11 got married for the first time at the age of 57. When she was asked what her situation would have been like if she had not got married, her response was “Then I wouldn’t feel financially secure. I wouldn’t have sold my flat and I would have continued to work.” The discrepancies between the male and female participants are significant, as they illuminate disparities between the participants’ genders regarding financial planning for retirement. It is also important to notice the marital status of the participants. All the men interviewed were married and of the women, five were widowed, three were married and two were divorced. Unfortunately, the sample was not balanced with regards to the marital status of the male and female participants, but this initial inquiry demonstrates a disparity between the genders which could warrant the need for future research.

When a few of the female participants spoke of their post-retirement financial management, they mentioned the pensions they received from their deceased husbands. Participant #2 said that when her husband died his pension was halved and participant #10 said “What I get from my husband’s pension fund only covers the medical aid.” Husband and wife, participants #14 and #15 rely on his Department of Education pension for retirement income. If he dies, she will receive three quarters of the pension fund. For him, it is an “assurance that she won’t be destitute”. These statements shed light on a longer life expectancy for women over their husbands and the vulnerability these female participants experience in living a longer life on a reduced income.

Some of the female participants spoke about the role their adult children play in their post-retirement financial situation. Participant #4’s daughter and son-in-law have been instrumental in securing her current financial situation. They bought her flat and she has invested the money and lives off that. She does not pay rent and must only cover levies and expenses. With resignation she said, “Hopefully I will die before the money runs out.” Participant #10 was particularly authentic in her response:

“I’m trying to hedge my money. To make it last. Sooner or later I will run out of money and then I’ll see what to do. I do have my daughter but I do not want to be a burden. I am fully transparent with her. I have to be. It is difficult in the long run not to be.”

Adult children were seen as an aspect of potential future support, with Participants #4 and #16 saying that they knew they could rely on their adult children if they needed to. However, for some of the participants the reality was that their family members were distant. Participant #3 spoke of the negative effect of emigration, saying “No one is around anymore.” Both Participants #2 and #10’s adult children live in the UK. Although their children are distant, they both spoke of the reassurance that it would be easier for their adult children to give them financial assistance as the British Pound is stronger than the South African Rand.

The response to financial advice was divided amongst participants. The majority of participants had a relationship with a financial advisor. Participant #3 spoke of the benefit of speaking to an advisor who specializes in people of a pensionable age. Although Participant #4 had a long relationship with her financial advisor, she objected to financial advisors, stating “None of the financial planners want to deal with medical aids. It’s too much admin for them.” For some of the participants who did not seek financial advice, they had negative attitudes towards financial advisors. Participants #5, #9 and #12 did not believe in fees and Participant #8 “hated” financial advisors, saying “They are worse than car salesmen.”

The reduction in insurance policies was mentioned by many of the participants as a way of cutting down their expenses. Participant #3 mentioned the value of seeing a financial advisor who assisted them in reducing life policies and getting “special home insurance for over 50s”. Participant #16 said that she had cancelled all her policies, but both she and participant #14 and #15 spoke of maintaining a funeral policy. Participant #8 made a general comment regarding older people and insurance policies, stating that not many over 65s have life insurance and that they are more concerned about their annuity income than their insurance policies.

#### **4. Healthcare management in retirement**

As was explained in more detail in Chapter four: Understanding the Research Context, South African private medical aid schemes offer two types of plans. One is a comprehensive plan which covers in-hospital and day-to-day healthcare expenses and the other a hospital plan which only

covers in-hospital expenses. The table of biographical details of older participants (see Appendix 1) details the older participant's medical aid scheme membership and chosen plan.

#### 4.1 Private medical aid scheme membership

Many of the participants who have elected to be on a comprehensive plan have done so as they believe they need the additional cover and benefits. Participant #3 stated, "When we were younger we were just on a hospital plan and it served us very well. But we realised we needed a more comprehensive plan as we age." This line of thinking was echoed by participant #12 who said he is only willing to pay for a hospital plan. He questions his decision saying, "As you get older, you think are you getting penny wise and pound foolish?" Participant #13 said that she had moved to a medical aid after being advised to by her GP as "it is easier for my GP if I am on a private medical aid." Participant #4 wasn't convinced about being a member of a medical aid. "People say to me, 'you can't *not* have medical aid.' But it costs me so much and what does it give me?" Participant #14 had mixed emotions about being a member of a medical aid. He felt guilty that he was a member and he is wife was not due to affordability. However, he was worried that if he went off medical aid then he would fall ill. "You know what State hospitals are like. You have to wait and hope for the best." Participant #16's story validates why participant #14 believed he should stay on a medical aid:

"When I stopped working, I couldn't afford medical aid anymore. So, I had to go to the day (public healthcare) clinics. They did tests and I had high blood pressure and Diabetes. One day at the day clinic, they found high blood sugar so they sent me to the hospital. When my son found me at the hospital, I hadn't been fed, I wasn't in a bed. After that, my son immediately put me onto his medical aid."

A few of the participants expressed their frustration at understanding their medical aid. Participant #4 said, "I don't understand the jargon of medical aids. It is all on the internet and I can't be bothered to look at a screen." Participant #13 added to this sense of confusion saying, "I don't really know what the hell is going on. You can't talk to the medical aid. They promise you the world and you never hear from them."

Expenses above what was covered by their medical aid were a talking point for participants, whether it be negotiating with specialists to reduce their fees, going to doctors whose rates fall within medical aid scheme rates or the frustrations of depleting medical aid savings accounts.

“There are sublimits. So you are still out of pocket because you need to fund it yourself.” (Participant # 12)

Gap cover was seen as not only beneficial, but also necessary by a number of the participants. “Gap cover is worth it. It pays the difference in costs that are not covered by my medical aid” (Participant #7). Participant #10 had casually heard of gap cover, but apparently “they won’t take over 70s.” However, Participant #12 stressed that he believed more and more people were taking gap cover because they were concerned about increasing healthcare costs but could only afford a hospital plan.

#### 4.2 Participants’ healthcare management

“There is nothing more relevant than looking after your health,” Participant #13 stated when asked about how she managed her healthcare. A number of participants spoke of the importance of preventative screening, particularly the members of Discovery Health. Participants #8 and #1 said their wives spearheaded their preventative screening as part of their Vitality (an incentive based wellness programme available to Discovery Health and Life members) status. Participant #8 was on Diamond status. “I don’t know why Vitality is so complex. The only reason we are on Diamond status is down to my wife’s focusing.” However, he and his wife enjoyed the benefits; 35% off flights, car rentals and cash back on healthy eating. He did appear to be engaged in the programme. “My Vitality age is 71 – but that is mostly down to my weight. Maybe my GP should know my Vitality score.” Other Discovery Health participants were not as engaged. “I don’t like loyalty programmes,” said Participant #1. “I only do the preventative screening as I am encouraged by my wife and daughter for the points gained.” However, he felt that he got no guidance from Vitality for losing weight. Participant # 5 and Participant #4 said that they were not part of Vitality because it cost money.

“I have never had it and it makes me cross. My daughter tells me there is an app where I could get free coffee, but I don’t have a smartphone. I could get the discounts but I can’t figure it out. Vitality isn’t interested in me.” (Participant #4)

Participant #5 said that he was worried as his GP had warned him about being “pre-diabetic.” When asked what advice or referrals his GP had given him, he said that he was advised to lose 5kgs and limit his alcohol intake. However, he said he was stubborn, saying “I don’t see the point

to all of this. Logically I see the point but emotionally I am not sold on it yet. If you are not well, you see the symptoms but there is no obvious *anything*.”

Other participants went into more detail about specific medical events. Participant #6 recounted her foot surgery and several weeks’ recovery. With limited family nearby, she spoke of how humbling it was accepting help from her “church family”. Participant # 7 spoke of her knee surgery. She had a hospital plan, so was only able to have the hospital physiotherapist, which was covered by her medical aid. “I had to do my own rehab when I got home. The only thing I can’t do is kneel. I am just blessed that I am not crippled.”

#### 4.3 Role of financial planning in regard to health and well-being

It is noteworthy that medical expenses and costs were the common thread of discussion amongst participants regarding their healthcare management. However, when the discussion of financial planning in respect of older age healthcare needs was discussed the participants’ mindset around this issue fell into three groups of thinking. The first group, *Aware worriers*, had a heightened awareness of the interdependencies between their health status and their financial position. The second group, *Denialists* struggled to identify with the notion that they might require additional support and care at some stage in their older age and the third group, *Unconcerned*, believed because they were in a sound financial position the relevance of financial planning with regards to future healthcare needs was insignificant. There was one outlier, *Aware and prepared*, who had a detailed preparation for potential healthcare costs.

*Aware worriers*: Some of the participants were conscious of the impact of declining health. “The trouble begins when you fall,” said Participant #2, “The start of the rot is falls.” For some of the participants, financial well-being appeared to be interdependent with their health and well-being. “That’s the whole point. I must keep up exercise and a healthy diet, so I don’t have to incur medical expenses” (Participant #10). For Participant #4 her biggest stresses were health and finances. “What worries me the most is the medical expenses at this stage of my life.” For these participants, the role of finances in their health and well-being played a critical role. For Participant #11, although she considered herself to be in a good financial position, she said that financial planning played a huge role in her healthcare management. “One year we ran out of dentistry (funds in medical aid scheme) and I had to wait until the following year. My husband is so particular about money, even if it relates to health.”

*Denialists:* Other participants were aware of the potential of declining health in older age but struggled to identify that possibility with themselves and their financial situation. Thoughtfully, Participant #5 said, “I would maybe look into healthcare costs in later age, I have heard of the term ‘health span.’” However, he continued by saying, “I have illogical belief in my survival for some time to come.” Participant #6 was also aware that her healthcare costs might increase in older age, saying she had seen others get frail and knew that there was a possibility that she might become dependent at some stage. However, she acknowledged that she did not really think about it, “I’m guilty of that. I am active and healthy but I need to accept that I may not be like that forever.” She was not alone in struggling to recognise the possibility of her much older self’s needs. Participant #7 admitted that she did not give it much thought, saying that she knew she should plan ahead but that she was not a “negative thinker.” When she was probed on this “negative thinker” mindset, she said, “Preparing isn’t negative. It is the right thing to do. I just believe that I won’t be faced with that kind of dependency.”

*Unconcerned:* Others were aware of the importance of planning for healthcare needs but had only accounted for standard medical aid expenses or left it to their financial planners. A few of the participants who considered themselves to be in a sound financial position believed any future health status would have no relevance to their financial position. Participant #9 laughed at this topic, saying “What old people’s things?” He hadn’t sat down and gone through costs as he believed that he had enough capital. Participant #8 also believed that because he was financially stable the relevance of future healthcare costs was marginal.

*Outlier – aware and prepared:* Only Participant #12 had specifically accounted for potential future healthcare expenses in his financial planning. An “engineer” friend had sent him a spreadsheet which worked out the costs of a stroke or other health conditions and the associated costs. “I know I’ve got enough money to last to 91. If I had a stroke for example, I could make it to 86. So, I don’t have anxiety or worry.”

## **5. Anxiety concerning late stage retirement**

Themes which emerged from the data were issues surrounding late stage retirement. These themes were not explicitly drawn up in the interview outline, but rather inductively arose from the older research participants’ responses. These themes relate to the preparedness for older age, such as retirement villages, frail care and caregivers and the anxiety about becoming a burden

### 5.1 Retirement villages

When the discussion of future healthcare needs arose, many of the participants turned the conversation towards retirement villages. Of the sixteen participants, eleven lived independently and five were residents of a retirement village. For many of the independent living participants, there was a negative association towards retirement villages. Phrases such as “you grow old too quickly” (Participant #1), “doesn’t appeal to me” (Participant # 9) and “frek plek” (translation from Afrikaans – dying place) (Participant # 11) were some of the responses. Participant #4 believed that “old age homes in South Africa are pathetic. They are either very expensive or dreadful.” However, some of the participants had put their names down, either for a “just in case” option or out a genuine desire to move into a retirement village. Participants #10 and #11 spoke of the deposits involved and how this had limited the number of their applications to retirement villages. It is unclear if these negative associations are born out of witnessing friends or family having negative experiences in retirement villages or whether it is more out of a desire to maintain their current lifestyles in their independent homes.

### 5.2 Frail care and caregivers

The five retirement village residents all spoke of the frail care facilities available at their retirement villages. All of them stated that this was not their preferred option. Participant #14 said that CPOA did have frail care but that the cost was higher than their pension, so their children would have to pay in the difference. His wife said that she “dreads the thought of having to go to a State home someday.” Participants #2 and #13 mentioned the frail care facilities available at their retirement village but that they would prefer to have a caregiver in their private rooms if they ever needed that additional care. For the independent living participants, most expressed a desire to have a caregiver in their own home if the need ever arose. Participants #6 and #8 had made provision for accommodation in their home for a possible caregiver in the future.

### 5.3 Burden anxiety

All of the participants at one stage or another spoke of their fear or anxiety of becoming a burden. This was verbalised with respect to the loss of independence, being a burden on adult children to becoming a physical or financial burden.

The loss of independence was vocalized by many of the participants. Participant #10, protective over her independence said with a big sigh, ““I do still have self-respect and

independence, so I make sure I maintain my health.” The thought was “scary” for Participant #3 saying “I am extremely independent and don’t want to become a burden.” However, for Participant #13 who considered herself to be independent said it also brought its own loneliness. The ability to drive was associated with maintaining independence for many of the participants. This sentiment was reinforced by Participant #2 who said when she could no longer drive “it was like losing a limb.”

For others, it was the fear of becoming a burden on their adult children. “Nobody wants to be dependent” said Participant #4, expressing the huge stress she believed young couples experience having to care for their growing children and their ageing parents. For Participant #6 this anxiety was expressed in a dichotomous commentary; “I haven’t put my name down at a frail care” and then shortly afterwards saying “I don’t want to be a burden on my adult sons.”

“I have a fear,” said Participant #11 bringing her hands together in a prayer position, “Please God may my health continue to be good.” This fear was echoed by Participant #7 saying “I hope to go in my sleep.” A few of the participants expressed their fear of dementia with comments like “Don’t revive me” (Participant #4) and “Just let me go” (Participant #11). Participant #8 recounted his mother-in-law’s situation. “She had Alzheimer’s and she went to a nice home. But no money would have made a difference.”

The anxiety of becoming a financial burden appeared to be a legitimate fear for some of the participants. For Participant #3, what scared her was how long she would still be able to earn an income. Participant #10 who was no longer able to work due to macular degeneration, was particularly frank:

“My house is paid off, but the rates keep going up. Everything keeps going up. It makes me nervous. I am a little bit in denial. I have made adjustments. I am not living off cat food...but the anxiety is there.”

## **6. Conclusion**

The analysis of the older research participants’ interviews demonstrated the shared experiences among the participants in the retirement stage of their lives. The commonality was particularly prevalent when expressing the benefit of less stress and responsibility but also when expressing the challenges of healthcare expenses and the shared anxiety of the *unknowns* which may

accompany advanced old age. Figure 15 illustrates the four major themes which arose from the analysis of this research data.

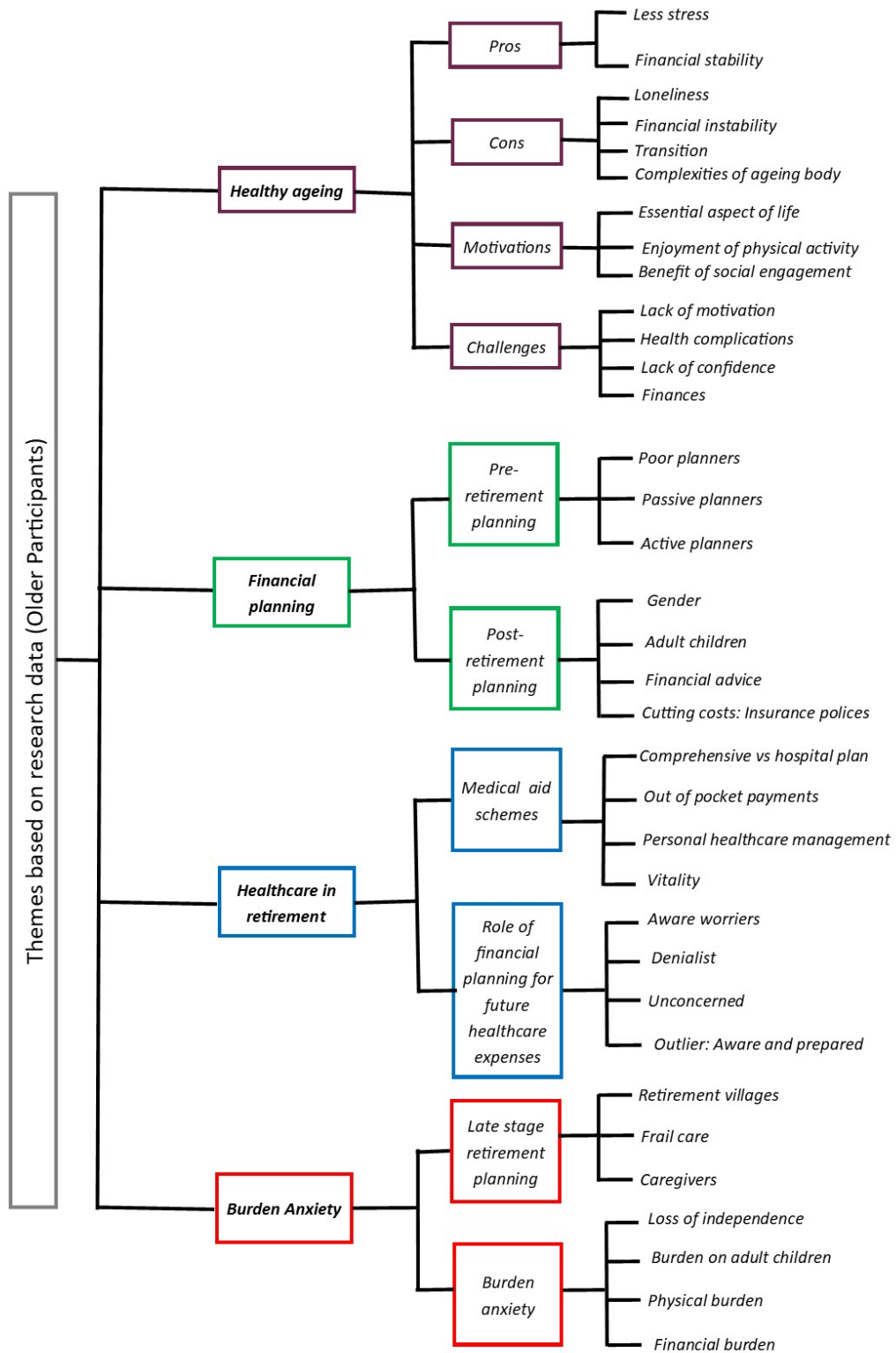


Figure 15. Themes based on research data (Older Participants)

The first theme was *Healthy ageing*. In discussing the realities of *healthy ageing*, participants expressed their struggle with loneliness, the challenge of transitioning into retirement and the complexities of an ageing body. Some participants expressed with a heightened sense of awareness, their gratitude at being in a financially stable position. This was reinforced as other participants stated that their financial instability was a cause of concern. A feature of *healthy ageing*, were the motivations and challenges in maintaining their good health and well-being. The participants were motivated out of a perception that health and well-being were an essential part of life. Other participants expressed their motivation from enjoying the benefits of physical activity, while others benefited from social engagement. Many of the participants found lack of motivation and self-discipline a challenge in maintaining their good health and well-being. The other challenges faced by participants varied from health complications, lack of confidence and finances, either as an affordability issue or a constraint in receiving necessary care or rehabilitation.

The second theme was *Financial planning*. In pre-retirement financial planning, the sample's responses could be categorized into three groups. The first group were *Poor planners* who had little or no pre-retirement financial planning. The second group were *Passive planners*, whose emphasis was on pension fund contributions and property. The third group were *Active planners*, who took an active interest in their financial management and had discretionary savings beyond pension fund contributions. In post-retirement planning data analysis, the role of gender became apparent with regards to financial planning for retirement. Participants also discussed the role of adult children in their financial management, their opinions of financial advice and assessing the necessity of insurance policies as a means to cut costs.

The third theme was *Healthcare in retirement*. As the sample were all members of medical aid schemes, participants spoke about their reasons for choosing either a comprehensive or hospital plan. For some participants, private medical aid membership was a financial constraint. However, it was perceived to be a necessity so a dilemma existed between the vulnerability they felt of being potentially subject to inadequate healthcare services provided by the public health sector or feeling that they were obliged to belong to a medical aid as they were divorced from State healthcare. Most of the participants spoke about their medical aid scheme sublimit and having to self-fund or take additional gap cover insurance to cover the short fall not covered by their medical aid plan. In discussing the management of their healthcare, participants spoke of the importance of

preventative screening, particularly the Discovery Health members who were incentivized by the Vitality programme. When the participants shared their thoughts of future healthcare costs in late stage retirement, the sample fell into three groups. The first group, *Aware worriers*, were very conscious of the interdependencies between their health and well-being and their financial situation. The second group, *Denialists*, struggled to identify with the potential of ever needing additional support and care. The third group, *Unconcerned*, believed that because they were in a financially stable position the potential of future healthcare costs was irrelevant to them. There was one outlier, *Aware and prepared*, who had a spreadsheet detailing the impact a health condition would have on his financial position.

The fourth theme, *Anxiety concerning late stage retirement*, broached issues such as retirement villages, frail care and caregivers. Within this theme, the participants expressed their anxiety about becoming a burden. This was articulated in relation to losing independence, becoming dependent on adult children and becoming either a physical or financial burden.

Analysing the older research participant's interview transcripts created a nuanced and comprehensive viewpoint of the lived realities of older beneficiaries of private medical aid schemes and retirement annuities. Although the older participants' responses reflect their individualised stories, many of concerns and constraints expressed were similar. These similarities may highlight areas of the current private sector retirement landscape where *healthy ageing* is hampered and financial insecurity is heightened.

# **CHAPTER SIX**

## **INSIGHTS OF THE**

### **PROFESSIONAL RESEARCH PARTICIPANTS**

#### **1. Introduction**

This chapter sets out the responses from professionals who understand the small demographic of the South African population which has access to private healthcare services and financial services. Due to this focus, the findings from these interviews cannot be generalized to a population at large. However as this is an exploratory inquiry, the responses from the professional participants place the perceptions and experiences of the older participants in context. The findings outlined in this chapter provide a better understanding of the complexities and incentives of the parties involved in the private sector retirement space of South Africa and how the structure of this environment affects the feasibility of implementing a comprehensive senior wellness programme. Broad inferences cannot be made from these responses nor can they be the basis of policy or programme implementation, however they provided necessary background information for the development of the research prototype and are the foundation for future research.

#### **2. Financial Services Industry**

An exploratory examination provided an understanding of how the financial services industry engages with people entering or in retirement, the financial planning process and how a client's lifetime health and well-being expenses are accounted for by financial advisors. The responses from professional participants working in the financial services industry provided a greater understanding of how they perceive their clients' concerns and constraints in managing their finances for the duration of their lifetime.

##### **2.1 The importance of building relationships**

The importance of values and developing relationships with clients was emphasized by Kate Brown of Fiscal Financial Advisors (2017). Ms Brown believed that being a more fully present listener was a critical skill needed for a financial advisor, as the most powerful benefit of a financial advisor's service is giving people the opportunity to articulate their thoughts, challenges and

aspirations. Ms Brown's "serving the person" approach, which included daily meetings with clients gave her a rich source of growing understanding and knowledge of a retired person's circumstances. Anne Macdonald, Client Wellness Advisor of Personal Trust Financial Advisors (2016), believed financial advisors were becoming increasingly aware of the needs of clients saying, "It is short sighted to think you can advise without taking a holistic picture into consideration" (personal communication, October 14, 2016).

## 2.2 Pre-retirement planning

The process of financial planning was outlined in chapter four, in respect of monthly budgeting, CAPEX allocation and inflation. Ms Brown elaborated on this financial planning process with a human-centric approach. When advising a client preparing for retirement, Ms Brown did an exercise where she got her client to visualise a day in their retirement. "If you wake up on Saturday morning, what would Saturday hold for you?" (personal communication, September 1, 2016). Ms Brown asked her client to visualise opening the curtains, looking out the window and preparing to go for brunch with family or friends. Then she asked her client to write it down and put numbers to it. Robert Adshade of Alchemy Financial Solutions (2017) said that he was increasingly seeing people who were entering the "critical phase" – five years before retirement - and were realizing they couldn't go through this process without advice.

The aim of financial planning is to ensure you have sufficient capital to last your lifetime. Therefore, the most pertinent variable is life expectancy. Mr Adshade believed that he was conservative. "As a default, I never go lower for planning than 90. I am urging more towards 95" (personal communication, September 15, 2016). Ms Brown took a longer view: "We have to assume that you have to manage to 100" (personal communication, September 1, 2016). She acknowledged that not everybody was going to get to 100 but that increasingly people did, so provision should be made to provide up until then. If the person became really ill in their 80s, then the provision of capital made for expenses in their 90s could be "brought to bear on providing the things where financial resources can enhance your quality of life" (K. Brown, personal communication, September 2016). However, for Mr Adshade, life expectancy was something that a lot of his clients were not comfortable talking about. "I have a lot of clients who look at life expectancy of 95...and they kill themselves laughing. But I say rather have it there than not. I am building it in for your protection" (personal communication, September 15, 2016).

### 2.3 Post-retirement planning

The importance of a developed relationship with an attuned financial advisor appeared to be especially relevant after retirement. Articulating the intricacies of post retirement, Ms Brown said, “Of course, there are transitions particularly in the retirement years, which the financial services industry is not interested in, because they don’t involve you suddenly having a big lump of money to invest” (personal communication, September 1, 2016). It is therefore beneficial for a client to have regular reviews with their financial advisor to assess what really matters to them at this stage of their lives. Ms Brown was particularly vocal about her frustrations concerning women’s role in financial planning. She had encountered many women now living as widows, who now needed to solve their issues on their own. “This is a thought that doesn’t strike a lot of people. And it is something that when I speak to men about financial planning, there is often quite a bit of chauvinism out there. Men do the planning, men look after the money...but do they actually take into account that their wives might survive them by 20 years?” (personal communication, September 1, 2016). Ms Brown admitted that she personally got very upset when she spoke to women about organizing their financial affairs. She recounted the following conversations:

“She says ‘My husband looks after it.’ And you say, ‘Ok what will you do when he dies?’ and she says, ‘Well my children will do it.’ And I am thinking are you never going to grow up and take responsibility for your own life? I call this ‘princess syndrome’ – ‘So you are waiting for the prince to come and wake you up?’ Only you don’t actually want him to wake you up. You want him to just be hovering around looking after everything all the time.”

### 2.4 The rise of retirement villages

Retirement villages was a topic brought up by all the professionals in the financial services industry. This may be due to the financial implications and the planning aspect of getting oneself into a retirement village. Ms Brown and Mr Adshade commented that most of their clients said that they wanted to live in their homes for the rest of their lives. However, retirement villages were clearly topical, as Mr Adshade said that over the past few years he had noticed that his role had changed to where he was talking to a lot of people in their 50s and 60s about retirement villages and caregivers.

“I am almost handing out brochures to be honest. I’m educating a lot of people who are quite blinkered towards the concept. Essentially it is going to be an issue that they have to deal with and if their children aren’t going to take it on, then they will have to deal with it” (R. Adshade, personal communication, September 15, 2016).

Ms Brown believed that adult children leaving South Africa to live in other countries had led to the birth of the retirement village, stating “The rise of the retirement village is probably in inverse proportion to the rate of emigration” (personal communication, September 1, 2016). Ms Macdonald was very familiar with retirement villages, having organised the successful Personal Trust talk series at numerous retirement villages across the Cape Town region. Ms Macdonald believed one of the reasons for the popularity of retirement villages in South Africa was the issue with security and the lack of public transport. Retirement villages also provided peace of mind in terms of potential care and support needed in older age, especially if family support was not able to provide this (A. Macdonald, personal communication, October 14, 2016).

## 2.5 Financial planning for healthcare expenses

The topic of clients’ healthcare was introduced into the discussion with the financial advisors in respect of their clients’ medical aid scheme plan membership. Ms Brown believed that often when people had a fixed or lower income in retirement, they looked to cut costs and one of those decisions might be to move to a less expensive hospital plan. However, she added: “Of course in their later years they will at some point almost certainly have a period of very high medical costs” (personal communication, September 1, 2016). Mr Adshade built in the most comprehensive medical aid plan: “It is the one thing we do not compromise on whatsoever” (personal communication, September 15, 2016). Both Ms Brown and Mr Adshade had medical aid contribution as a separate item and escalated this 4% above inflation. For clients over the age of 70, Ms Brown added another item for regular monthly healthcare expenses not covered by the medical aid scheme.

In addition, Ms Brown had a more specific approach for the planning for healthcare related expenses in the late stages of retirement. Within the client’s CAPEX allocation, every three years from the age of 70, a “chunk of money” was assigned for costs that might arise due to compromised health in some way. Ms Brown illustrated the necessity of this by example of a hip replacement:

“The medical aid will pay the bulk of the surgery costs but the other costs might be that they can’t do the shopping for six weeks and they need more help in the home...so suddenly you have a cost that is not a medical expense per se, but it is a cost that arises because you are not in your normal state of health” (personal communication, September 1, 2016).

Ms Brown’s planning multiplied the number of times those “chunks” were needed and then the total amount was removed from the capital available to support the client’s lifestyle. Ms Brown reiterated how carefully this number needed to be looked at, as the total capital amount was presumed to get the client to 100 years old.

Mr Adshade’s approach took a broader overview. When forecasting a client’s monthly income, he was aware that the makeup of a client’s expenses was going to change. “Generally speaking, people in their 80s are spending money very differently to a person who is 60. A lot less for entertainment but a lot more on health-related issues” (personal communication, September 15, 2016). A big part of Mr Adshade’s discussion with clients concerned whether they were going to stay in the same home. The sale of a house would release capital which would give the capacity to pay for “those kind of expenses.” When it came to a “healthcare solution” Mr Adshade believed “whether you age in a retirement village or at home, they are both going to cost money and they are both going to cost about the same amount” (personal communication, September 15, 2016). Mr Adshade acknowledged he “anonymously” placed expenses related to health issues in late stage retirement in the client’s CAPEX allocation.

“I know that it might be used for completely different purposes for a car or an overseas holiday, but at least it is a contingency that is built in. If I had to go into the detail, and it sounds bizarre – ‘that you might be incontinent one day and need nappies’ - this is the answer I regularly get, ‘I would rather die and my children must just let me die’. So, the best way for me to deal with it, is to make sure there is money there” (personal communication, September 15, 2016).

Ms Brown and Mr Adshade’s differences in planning for healthcare expenses in late stage retirement may reflect their clients’ age demographic. Ms Brown has a special interest in late stage retirement planning, and may have more practical experiences with the challenges and costs older clients have faced in dealing with their healthcare solutions and expenses in later old age. There

also seems to be a disconnect between what clients say about wanting to remain in their homes but then also factoring in the release of capital from the sale of their home to cover the cost of healthcare expenses in late stage retirement.

## 2.6 Burden Anxiety

The notion of burden anxiety was expressed by professionals working with older people in retirement. Mr Adshade spoke at length about his clients' concern about becoming a burden.

“They are absolutely determined not to be a burden on their kids. But the sooner they face the reality, and I get myself involved in this quite often, because I can see the writing on the wall. I can see the numbers. They don't want to face where it is going and I don't want them to wake up at the age of 82 and they are caught with their pants down” (personal communication, September 15, 2016).

Ms Macdonald spoke of the “sad situation” of helping clients who were running out of financial resources and were “facing the dread of old age without the necessary support systems.” Dr Richards, Executive Hospital Risk Manager and clinical epidemiologist believed South Africa lacked holistic support for older people. She said that “40% of elderly who were part of a Care Coordination Programme were impacted and affected by emigration” (personal communication, October 17, 2016). In some cases, the distant adult children paid for the medical aid premium, but they did not know the reality of their elderly parents' situation. Dr Richards recounted stories of home visits to elderly members of the medical aid, where the cupboards were bare but the elderly member did not want to admit it to their families.

“There is an assumption that if you can afford medical care, then you are financially resourced and this is not the case” (Dr B Richards, personal communication, October 17, 2016).

Cindy Petrie, who markets Marriot funds to financial advisors, said when you are showing a client a policy, “You have got to show people that you are to be less of a burden. It's that *word* – ‘burden’. It is a big thing. People do not like to be dependent on anyone” (personal communication, September 13, 2016).

### **3. Private healthcare sector and ageing membership base**

Understanding how the private health sector in South Africa is structured is an essential part of an exploratory investigation into the feasibility of implementing a comprehensive senior wellness programme within this environment. The responses from professional participants working in the private health sector provided a greater understanding of the complexities and challenges private medical aid schemes encounter when managing older members and an ageing membership base.

#### **3.1 South Africa's community rated environment**

The concept of “community rated” within the South African private healthcare sector means medical aid schemes need to provide health insurance at the same premium to all members. Shivani Ranchod, an actuarial scientist at Insight Actuaries and Consultants (2017), elaborated:

“Medical aid schemes have to accept everybody and charge everyone the same premium. It is hugely detrimental to attract the old and sick, because you have to charge them the same premium as everybody else but they claim more” (personal communication, September 12, 2016).

Because of this environment, medical aid schemes manage the health of older and/or ill members in a way that would not be visible to the outside world. Dr Belinda Richards outlined a strategy in managing sub-populations (such as members with a chronic disease) within the medical aid scheme environment:

1. Educate members
2. Monitor disease
3. Create programmes for high-risk members
4. Develop social structures
5. Proactively manage (to prevent hospitalization)

Dr Richards emphasized that it was a “tight rope”, with every Rand spent needing to be accounted for. “Everybody’s money is being used and we need to account for everybody’s needs” (Dr B. Richards, personal communication, October 17, 2016). Ms. Ranchod echoed the tension of this “tight rope” environment, saying “There is a strong incentive to not attract the elderly...you do

not want to be seen as the go to scheme for the dying and the elderly” (personal communication, September 12, 2016).

In a private open scheme environment a “business model that attracts the young and healthy, is a financial model that makes sense” (Dr B. Richards, personal communication, October 17, 2016). As private open medical aids schemes have focused on attracting a younger, healthier membership base, as well as historically having a high “turn” of members meant that many schemes “never really took a long-term perspective on the health of their members” (S. Ranchod, personal communication, September 12, 2016).

### *3.2 Complexities of a growing ageing membership base*

Medical aid schemes are experiencing a growing ageing membership base and are having to understand the complexities which that brings to the scheme’s cost structure. Ms Ranchod was able to articulate the nuances, having worked with a medical aid scheme that had a rapidly ageing population. She explained how interesting it was looking at their claims, as there was not “one type of cost” that was driving the high claims. On the one hand, there was the increase of chronic disease prevalence which increases with age and the associated costs of chronic disease medication and care management. The other area was catastrophic events, such as heart attack and cancer which also increase with age. Catastrophic events are “big claims” which make up a big proportion of the scheme’s expenditure. However what Ms Ranchod found particularly interesting was:

“There are a whole lot of small hospital admissions which increase quite dramatically with age. A lot more investigative work. Things that are part of the ageing process. Teeth get more complicated, eyes need cataract operation, skin work, et cetera. It is all relatively cheap compared to a R1million catastrophic event but it’s an accumulative thing. A scheme experiences ageing in this array of different things and I think it is important to recognise that wellness would only help with some of it but not all of it.”

Due to this diversity, the increase in costs by older members as shown in figure 16 cannot be accounted for by a simple formula.

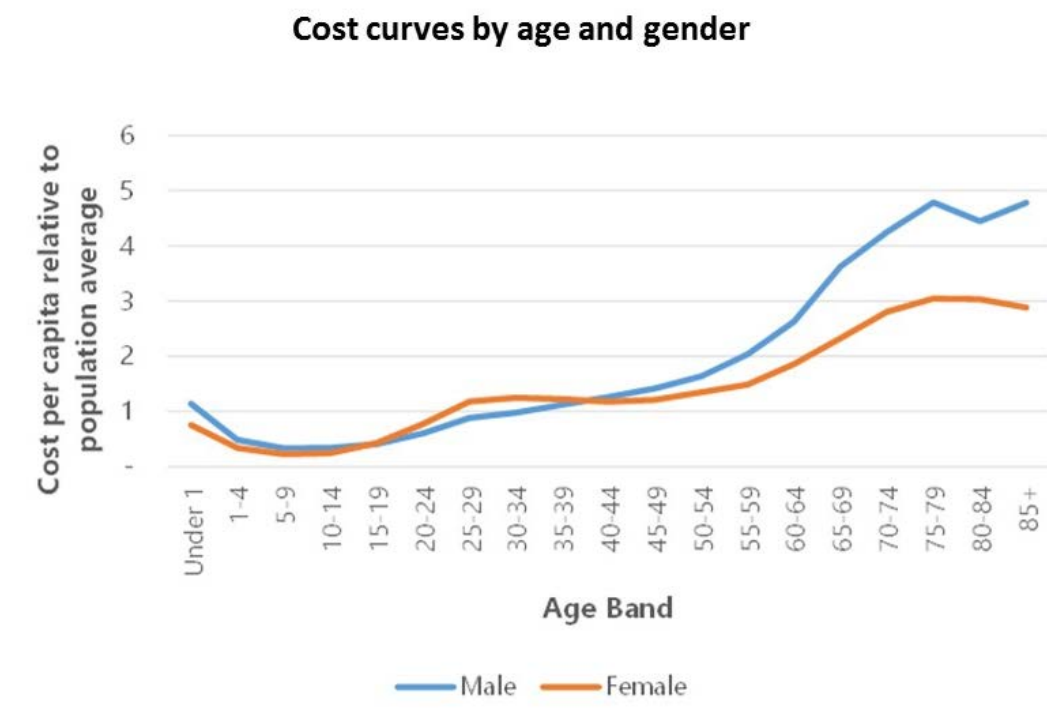


Figure 16. Cost curves by age and gender

Source: Supplied by Shivani Ranchod. (2016). Insight Actuaries and Consultants

### 3.3 Appropriate medical aid plan for older members

The question then needs to be raised on how the complexities experienced by a medical aid scheme impact on the older members themselves. Ms Ranchod pointed out that when a public health system is being designed, all its thinking is around investing heavily in preventative and primary care. However, the medical aid scheme environment is the opposite to this, being very “hospital centric” (S. Ranchod, personal communication, September 12, 2016). In terms of the optimal healthcare needed in old age, Ms Ranchod believed that a “...hospital plan is the worst thing. You are more likely to end up in hospital because you don’t have access to preventative and primary care” (personal communication, September 12, 2016). Despite the affordability constraint of a more expensive comprehensive plan, the age profiles of comprehensive plans show a higher percentage of pensioner members. This is illustrated in table 3, which details Discovery Health’s plans and shows that for example, 20% of Essential Comprehensive plan membership is of

pensionable age. It is because of the age profile that comprehensive plans are more expensive (S. Ranchod, personal communication, September 12, 2016).

Table 3. Detailed financial information per option: registered schemes | for the year ended 31 December 2014

Name of medical scheme	Benefit option name	Members	Beneficiaries	Average age pb	Pensioner ratio (65+ years)
		31/12/14	31/12/14	Years	%
Discovery Health Medical Scheme	Classic Comprehensive	172,180	401,095	38.0	12.6
	Classic Comprehensive Zero MSA	709	1,599	35.7	8.4
	Classic Core	53,854	115,334	36.7	11.3
	Classic Priority	102,694	236,354	34.4	8.4
	Classic Saver	245,478	536,024	30.5	4.9
	Coastal Core	83,786	184,882	35.4	9.3
	Coastal Saver	173,302	396,774	31.7	5.4
	Essential Comprehensive	22,606	46,186	41.9	20.2
	Essential Core	31,763	67,204	33.8	7.7
	Essential Priority	9,383	19,756	33.7	9.0
	Essential Saver	88,124	188,203	28.8	4.1
	Executive	11,678	26,315	40.8	16.6
	KeyCare Access	5,302	7,910	28.8	4.7
	KeyCare Core	14,961	23,745	32.7	8.4
	KeyCare Plus	215,296	383,438	27.5	4.5
	Consolidated	1,231,116	2,634,819	32.6	7.5

Source: Supplied by Shivani Ranchod. (2016). Insight Actuaries and Consultants

#### 4. The Vitality programme

The perceptions and insights of various professionals regarding Discovery Health’s Vitality model, provided a deeper understanding of the Vitality model and its positioning within South Africa’s community rated environment. This was helpful in considering the possible alignment of the incentives of a private medical aid scheme with a comprehensive senior wellness programme.

##### 4.1 Vitality model

When Discovery Health introduced Vitality in the 1990s they were separate products but were sold together. Vitality members were enticed by discounts for gym memberships and movie tickets. These benefits appealed to a younger, healthier market. For the old and sick, paying for an

additional programme above their medical aid scheme premium was unappealing. Ms Ranchod outlined the objectives of the Vitality model:

“I think it is quite important when you look at Vitality, to remember that the programme has a dual purpose. So, the one is the wellness aspect but the other is that it has worked as a powerful selection tool. It has been marketed to the young and healthy. It has never been targeted at older members” (personal communication, September 12, 2016).

From Mr Adshade’s point of view as a financial advisor, Vitality was “an interesting model – highly complex. They have made a product from an actuarial point of view which is incredibly complex and from a marketing perspective it has got a glitzy brochure” (personal communication, September 15, 2016). Ms Ranchod stated that competitors had struggled to copy the Vitality model due to its complexity and the proprietary information relating to costing structures of rewards and discounts with partners.

For Discovery, the Vitality model has become its heartbeat. Dr Deepak Patel, principal clinical specialist and head of research at Vitality South Africa (2016), supported this:

“All our businesses are linked to Vitality. Our ‘shared value’ model hinges on Vitality...If you take care of your health, engage in healthy activities, you benefit but so does Discovery Health and Discovery Life because there are fewer claims. It’s a zero-sum game. Vitality is central to the ‘shared value’ model” (personal communication, September 8, 2016).

#### 4.2 Complexities of Vitality and an older membership base

When discussing the feasibility of implementing a senior wellness programme within the Vitality programme, Ms Ranchod emphasized the role she believed the Vitality programme played for Discovery Health:

“In terms of the benefits offered by Vitality; the tech aspect, the way it is marketed, all of that is targeted to the young and they will never make it attractive to the old, because they will do damage to the scheme if they do. They might not say it, because it is not the right thing to say, but their primary concern is selection. Their

secondary concern is wellness” (S. Ranchod, personal communication, September 12, 2016).

Dr Richards supported this statement saying that “the elderly have no marketing value; there is no return on investment” (personal communication, October 17, 2016). As such, the structure of the incentive wellness programme is aligned to the organisational structure and incentives of the medical aid scheme. Ms Ranchod explained that running a wellness initiative is a “non-healthcare cost and would sit outside of the scheme” (personal communication, September 12, 2016). This line of thinking was reinforced by Dr Richards, saying, “It is not the mandate of a medical aid scheme to pay for wellness. They pay for illness” (personal communication, October 17, 2016). Ms Ranchod summarised as follows: The managed care organisation would be earning a fixed fee. The more intense their engagement with high-risk members and the more effort they expended on the coordination of the health and well-being needs of these high-risk members the more costs they would incur and the lower their profit. If there were any healthcare costs savings incurred by the wellness initiative intervention, they would accrue to the medical aid scheme. Within the Vitality/Discovery Health South African context, there was no incentive for Vitality to increase their costs and there was no incentive for Discovery to be affiliated with a wellness initiative that would attract high-risk members. As Ms Ranchod concluded: “There is a serious mismatch or misalignment of incentives” (personal communication, September 12, 2016).

However, Ms Ranchod’s and Dr Richard’s statements were contradicted by Dr Patel’s explanation of Vitality’s core purpose:

“Vitality’s core purpose is to get people to remain healthy, whether they are young or older. But for the aged, it is to compress the period of morbidity or illness. The main focus of the programme is to prevent or reduce chronic diseases. That means reducing the burden of chronic diseases amongst the population generally but also specifically around the ageing population because they are more affected” (personal communication, September 8, 2016).

Dr Patel acknowledged, however, that there is “a divide that we have to bridge” in terms of older people incurring higher medical costs but also having the lowest engagement with the Vitality programme (personal communication, September 8, 2016).

#### 4.3 Physical activity within Vitality model

Vitality's flagship offering is the gym benefit, with members receiving a 75% discount. (Dr D. Patel, personal communication, September 8, 2016). Although Vitality now has partnerships with various gyms, Virgin Active is the largest gym chain in South Africa and has the longest standing relationship with Vitality. Johann Strauss, Club Manager of Virgin Active, said that the majority of his club's membership base were Vitality members. Mr Strauss believed that Virgin Active had always been a "hip and trendy" brand, with the ethos that "everybody is welcomed at the Virgin Active" (personal communication, September 8, 2016). When he was asked about older club members, he spoke warmly of the "hippos – the tannies" in the pool. He believed that members in retirement age "want to enjoy the facilities" and that it was "more of a lifestyle for them." He stated that there was no specific programme for older members, but that the older women gravitated towards aqua aerobics and low impact classes because participants were in the same age group and that the older men "do their own thing." Virgin Active did not have a pensioner's membership fee, but older people could join as an "off-peak" member if they wished to pay less (J. Strauss, personal communication, November 7, 2016).

The Sports Science Institute of South Africa (SSISA) had a different approach to older members. Claire Cowan, Customer Relations Manager of SSISA, believed that SSISA had a proactive approach to their older members. SSISA offered a "seniors rate" and upon joining, every new member had to undergo a "pre-health screening" assessment. SSISA had recently adopted the American College of Sports Medicine guidelines (2017). Ms Cowan believed that this had the greatest impact on older members as age was no longer a risk factor. The assessment checked whether, firstly, the member led a sedentary lifestyle, secondly, had a chronic disease and/or had experienced a cardiac event and lastly had any symptoms of dizziness, swollen ankles et cetera. If a member answered yes to any of these questions, they needed to go for a medical clearance before starting training. Ms Cowan said that they needed to be careful in communicating this to older members as often the response was "Why? Is it because I am old?" (personal communication, November 8, 2016). If any "red flags" arose during the assessment, members were put into the Prime Time group. Prime Time classes, for these high-risk members included the presence of a biokineticist, an on-site nurse and blood pressure and heart rate monitoring. Ms Cowan believed that SSISA took the "daunting aspect out of it" with a lot of hand holding and sales consultants trained to deal with the "emotional aspect" for some new members. She concluded by saying that

she believed that there it was a “massive problem” as there were “not many facilities where senior citizens feel comfortable to go train” (personal communication, November 8, 2016).

#### 4.4 Possible future programmes for older Vitality members

Physical activity is a big focus of the Vitality model due to the overwhelming evidence of its health promotion. Dr Patel said that there were certain things Vitality was “thinking of, which haven’t been implemented yet” in terms of physical activity which might hold a greater appeal for older members (personal communication, September 8, 2016). These included more low-intensity activities, mind/body activities such as yoga or tai chi and dance classes. Vitality were also “thinking of” having biokineticists in specific classes where blood pressure was measured at the beginning and end of the class. Vitality were also working on a mental well-being programme. Attached to this they were “thinking of” other aspects or proven strategies to combat cognitive ageing. These were connected to continuing learning, the mind/body intervention and mindfulness. How these initiatives were implemented was crucial to their success within the Vitality model. Dr Patel explained the difficulty Vitality had experienced before in partnering with organisations which did not have a central head office, having had their “fingers burned” by dealing with a fragmented franchise organisation. Hence Vitality would most likely introduce these initiatives through the gyms. Dr Patel reiterated that “We are thinking about these things and hopefully we will have some of these things incorporated” (personal communication, September 8, 2016).

#### 4.5 Vitality in international markets

Although Vitality South Africa is “thinking of” programmes which may appeal to older members, Dr Patel recognized that there was greater urgency in some of Vitality’s other markets. He specifically mentioned the US market, where Vitality has partnered with the life company John Hancock. Whereas the general model is to launch the Vitality programme in international markets, the senior programme developed in the US would most likely be adopted by Vitality South Africa. Dr Patel believed that Vitality South Africa’s “demographic might be similar to a Western demographic. Our Discovery Health population is ageing also. So, I think some of the issues that affect many of these Western markets are going to affect us too” (personal communication, September 8, 2016). Ms Ranchod agreed that Vitality had done a very good job of expanding internationally. However she elaborated by saying “They’re in Canada, the UK – all of these markets you can risk rate. You can charge older people more. So, there it is fine – in a risk rated

environment you can offer it. I'd be very surprised if they launched something like that here" (personal communication, September 12, 2016).

## **5. *W*healthcare**

Pragmatic insight was gained from the professional participants working in the retirement space. Their opinions and comments depict their practical experience with regard to paying for morbidity or illness in late stage retirement, the funding of wellness programmes or creating greater synergy between the private health sector and the financial services industry. It is important to note that their suggestions may not be legally or regulatory possible but are merely expressed as "outside of the box" thinking.

### **5.1 Long-term care insurance**

From an "actuarial point of view", Ms Ranchod stated, "Longevity is a tricky thing... you don't know how long they are going to live. How long is that period that they are 'aged'? And it is expensive" (personal communication, September 12, 2016). Across the interviews with professional participants, there was discussion regarding the funding of potential healthcare and support needed in late stage retirement. Dr Richards emphasized that "there is no ways that medical aid schemes can pay for frail care. It is far too expensive" (personal communication, October 17, 2016). However, what this ultimately means, is that these potential costs need to be self-funded by the individual. Mr Adshade referred to these expenses under the same category of "dread disease cover", which is an insurance policy predominantly sold to a much younger market. He elaborated on this saying that when he did a post-retirement planning exercise, the first thing to do was to re-look at the budget and cut down on things that were not a necessity. As dread disease cover is deemed an "emotional buy" many people cancelled the policy as they would rather "save the money." What Mr Adshade believed was necessary was to "ideally create something where dread disease benefit is funded post retirement" (personal communication, September 15, 2016). However, Ms Ranchod said that the argument was that long-term care insurance was not feasible. She said that it was hard enough trying to get people to save for retirement, which was a "positive investment" for their old age. It was therefore seen as impossible in addition to get "people to insure against some of those costs related to old age." She concluded saying that this type of policy would need to be sold in the working years as "you can't sell it once people are already old" (personal communication, September 12, 2016).

Mr Adshade was more pragmatic, speaking specifically about a 62 -year old client who had a Discovery Life insurance policy. Mr Adshade stated “He has been paying a big fat premium for something he doesn’t actually even need” (personal communication, September 15, 2016). Mr Adshade continued saying, “What he actually needs is dread disease cover, because if he had dread disease cover he is only going to be a financial burden on himself. If he is dead, he is dead...so maybe Discovery will create a dread disease benefit for retirement. But the thing is that people don’t want to pay for it. It’s expensive” (personal communication, September 15, 2016).

## 5.2 Health and wealth solutions in retirement

When discussing the potential of structuring health and wealth policies for retirement, Ms Petrie took an “out of the box thinking” approach, such as giving policy holders exclusive access to retirement villages. Ms Petrie’s main brain storming ideas were on how to align the membership to a wellness programme with pension fund contributions and/or an annuity policy. Thinking aloud on how she would market such a product, Ms Petrie said, “We will say to you, if you contribute to this, if you adhere to this, and follow the wellness programme, then at age 70 - when inflation starts to decimate your income – we will guarantee that you will get an increase in income. Big ticket words – people are very motivated by words like that” (personal communication, September 13, 2016). However, she emphasized that all her work was future planning and that the advantage she had was her ability to show clients how their present contribution would affect their future outcome by using the Marriot Investment Planning Tool (2017). She reiterated that any contribution would have to come off at source, have no negative association and that this type of product would be marketed to the middle to high end market. “This is not for the average South African. They do care, but they do not have the luxury of caring. This is a very niche market but it is an up and coming market” (C. Petrie, personal communication, September 13, 2016).

Both Mr Adshade and Ms Petrie were addressing real concerns for older people in retirement, namely end-of-life healthcare costs and income which is vulnerable to inflation. However, it still comes down to when and how policies are marketed and sold. Ms Ranchod mentioned that Discovery were launching their Retirement Solution. She was interested to see “what side (accumulation or decumulation) they are focusing on, because for many years, obviously they have had a very strong focus on the young” (personal communication, September 12, 2016). Mr Adshade was also interested in Discovery’s products, saying “They have got really good products

and they seem to be addressing real concerns...Discovery is the sort of company that is aware of it and doing something about it” (personal communication, September 15, 2016).

### 5.3 Legislation of health and wealth policies

Dr Richards believed innovation was stifled because of the disconnect between legislation which only applies to medical aid schemes but not to insurance and retirement annuity policies (personal communication, October 17, 2016). Ms Ranchod reaffirmed that legally annuity policies and medical aid schemes cannot be tied together. However, she elaborated saying that although it is currently not legally possible there is a need for work to be done in this space:

“What I think people don’t understand is that their healthcare costs are going to climb. Even if your medical aid scheme premium stays level, medical scheme contribution inflation is above normal. So that is going eat into your living annuity over time. But where people can only afford a hospital plan, those other bits are not covered. Your out-of-pocket (OOP) expenditure is going to rise over time. If people understood that, they would be able to plan to start lower with their draw down and know that their draw down was going to have to increase over a period of time. In terms of their pension, you would want to start low and as you get older you can draw more and more to cover all those OOP expenses or a more expensive medical scheme option” (personal communication, September 12, 2016).

Dr Richards believed that assumptions were being made about how people were preparing for health and wealth. She thoughtfully stated, that behaviour change might be incentivized if pension funds and medical aid schemes were linked, but she reiterated that this was not currently possible due to legislation. She felt that ideally investment products should be created for people to pay for frail care costs (personal communication, October 17, 2016). Ms Shivani Ranchod believed that a “wrapper type product” could be creatively developed which tried to manage the draw down on annuity income by linking it to the policy holder’s medical aid premium or healthcare costs in some way (personal communication, September 12, 2016).

## **6. Incentivizing behaviour change**

The insights given by the professional participants with regard to structuring an engagement programme are particularly useful for the development of the research prototype. They lead to gaining a better understanding on how to maximise participation in a wellness programme, by

creating tailored and focused messaging and aligning financial incentives which are appropriate to the participants.

### 6.1 Behaviour change in the healthcare model

“Knowing better is doing better” stated Dr Richards in response to behaviour change. However, she matter-of-factly continued that although people might want to remain healthy the reality was different and there were many reasons why they were not in optimal health (personal communication, October 17, 2016). This was particularly the case in disease management. Both Ms Ranchod and Dr Patel used the example of the management of people living with diabetes. The question of engagement appeared to be the biggest factor. “It is tricky” said Ms Ranchod. “You can run a diabetic management programme but how do you actually get people to change their behaviour and eat differently...the people who are diabetic are the people who are least likely to shift their behaviour” (personal communication, September 12, 2016). Dr Patel referred to a study Vitality had conducted to get greater engagement with diabetic Vitality members who had not registered with the Vitality Healthy Foods programme (2017a). Drawing on behaviour economics, Vitality found that “very tailored but also personalised messaging seems to work.”

Vitality’s “Active Rewards”(2017c), is an app based programme which tracks a member’s weekly fitness goals and adjusts them dynamically based on the member’s activity levels. Dr Patel believed that because the “Active Rewards” programme was a tailored programme, it had seen “the greatest shift in people who were previously unengaged” (personal communication, September 8, 2016). Although Vitality did not specifically target older members, he said “We are trying to cater for people’s different ages but also different levels of fitness and ability. We haven’t got it 100% right, but we will get there slowly” (personal communication, September 8, 2016). Dr Patel said that in the future, Vitality was going to use tailored messaging much more. “We are going to speak to older people much more differently than to younger people, particularly when we want them to adopt certain behaviours” (personal communication, September 8, 2016).

### 6.2 Behaviour change in the insurance model

Dr Avron Urison, medical director of All Life Insurance (2016), believed that “All Life is about changing health not life insurance” (personal communication, September 9, 2016). He spoke in detail about All Life’s Adherence and Control engagement programme which is underpinned by their continuous underwriting insurance model. Although All Life is not a healthcare

management company, nor affiliated to any specific medical aid scheme, they make monthly contact with policy holders either by sms, phone call or email to monitor the policy holder's management of their HIV or diabetes condition. Of the engagement programme, Dr Urison stated, "When you come to us, you are going to commit to doing the right thing...we will monitor indicators of how you manage your life and on that basis we will provide you with insurance" (personal communication, September 9, 2016). Dr Urison believed that All Life's 95% compliance results were due to the financial penalty associated with non-compliance. "People are much more worried about their money than their health," stated Dr Urison. "People don't really care about their health and the reason for that, is it is not something that they can see upfront." Dr Urison believed that the best learning in building an engagement programme was the need to put in financial incentives.

## **7. Conclusion**

The professional participants provided an overview of the wealth, health and well-being circumstances of older people in the private sector retirement space as illustrated in figure 17.

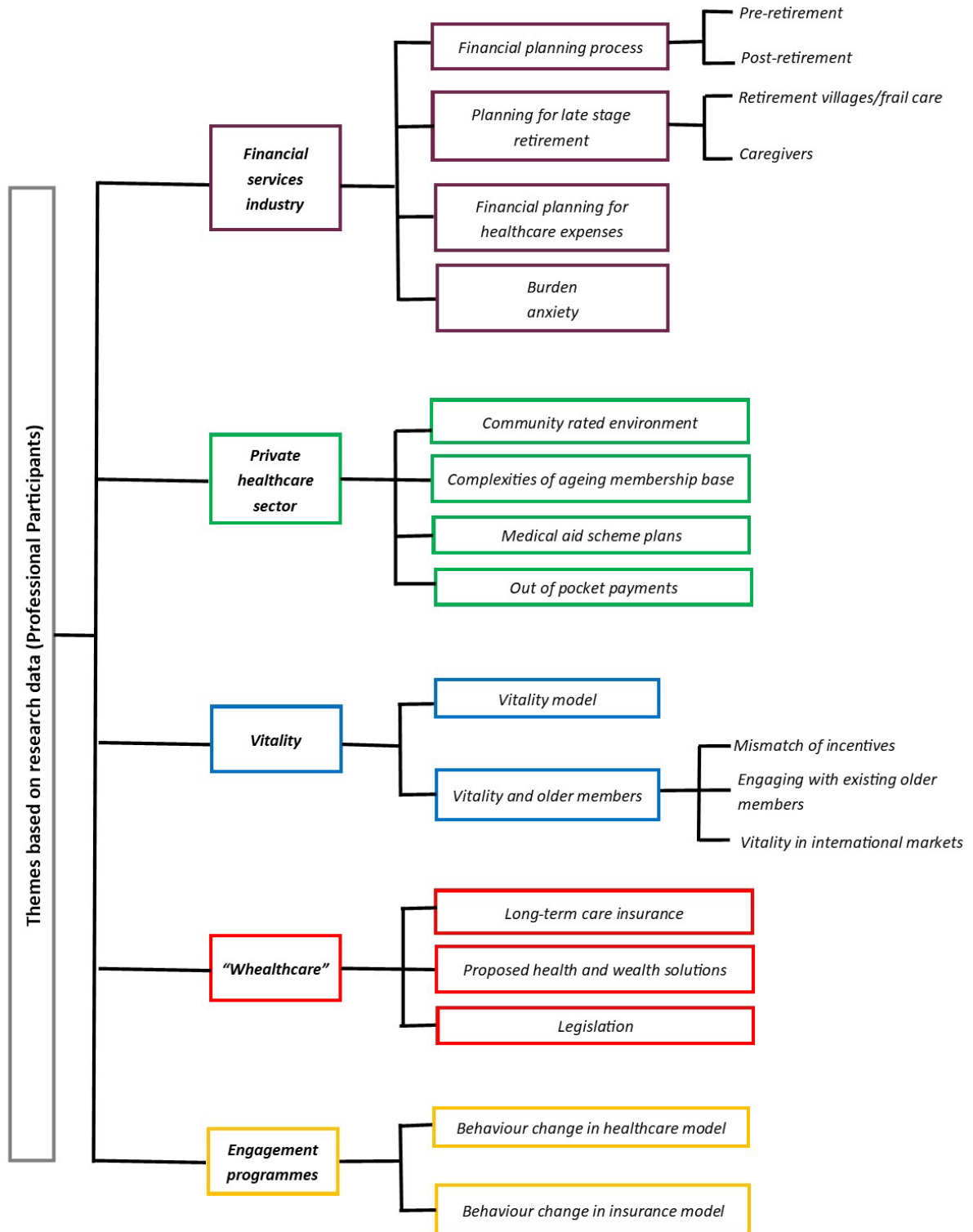


Figure 17. Themes from research data (Professional Participants)

The financial services professionals revealed the real challenges experienced by their ageing clientele. Life expectancy is the most pertinent variable in financial planning. However, it could be argued that the variable of *healthy life expectancy* should be factored more into the financial planning process due to the adverse effect being in poor health can have on one's financial situation and the inevitable increase in healthcare expenses towards end of life. Planning for inevitable healthcare expenses is particularly relevant in the context of South Africa's private healthcare setting, where individuals need to manage out-of-pocket payments and self-fund the costs of care and support which may be needed in late stage retirement.

The healthcare professionals provided much insight regarding the context of the medical aid scheme environment and the complexities of promoting *healthy ageing* in a community rated environment. It appears there is a disconnect between the incentives of private medical aid schemes and needs of older members. Nevertheless, private medical aid schemes are experiencing a growing ageing membership base and are having to come to grips with the hybrid of costs incurred by older members. But as was pointed out, many of these costs would not be affected by the implementation of a senior wellness programme. In fact, it appears that there is a mismatch between the objectives of promoting health and well-being for older members and the danger of being seen as the medical aid scheme for the aged. Vitality, the heartbeat of Discovery's 'shared value' ethos, has been a ground-breaking innovative model which has successfully incentivized members to adopt healthy lifestyle choices. However, the structure and complexity of Vitality underpins Discovery's main objective of attracting young and healthy members. Vitality has nonetheless provided many valuable lessons in how to structure a nation-wide programme and effectively maximise participation with tailored and personalised messaging. All Life Insurance provided insight into maximising adherence in an engagement programme by aligning financial incentives which are appropriate to the member.

The professional participants problematized health and wealth in retirement. It emerged that developing solutions was as complex as the environment in which they arose. This is due to current legislation and the difficulty longevity places on the actuarial modelling of health and wealth policies. The findings from the professional participants created a blueprint of the private sector retirement space for the development of the research prototype but also opened doors to future

research which would address the constraints and concerns expressed by older research participants.

# CHAPTER SEVEN

## RESEARCH PROTOTYPE

### 1. Introduction

This chapter presents the research prototype which has been developed from collating the study's findings. The aim of the prototype is to create a cohesive framework which addresses the health and wealth issues raised by the older and professional research participants. The prototype consists of three elements (see table 4). The first element, Active Age Movement, is a conceptual model for a comprehensive senior wellness programme. The second element is referred to as *Whealthcare* Solutions. These are proposed financial incentive models which aim to maximize participation in the Active Age Movement programme and prepare people for the potential of increased healthcare costs in old age. The third element, the *Whealthcare* Value Agenda model, aims to create more synergy between the private healthcare sector and the financial services industry. The prototype has been developed based on the interdependencies between health and wealth in retirement. In doing so, the prototype aims to promote *healthy ageing* while concurrently addressing the concerns and challenges expressed by many of the older research participants.

Table 4. Elements of research prototype framework

<b>Research Prototype Framework</b>	
<b>Prototype Element</b>	<b>Description</b>
Active Age Movement programme	A comprehensive senior wellness programme which aims to promote <i>healthy ageing</i> behaviour within a Vitality-like model.
<i>Whealthcare</i> solutions	<i>Healthcare Costs Tool</i> : Used to forecast the potential expenses connected to various health conditions in old age.
	<i>Healthcare Silo Fund</i> : Investment fund for the purposes of allocating funds for potential healthcare expenses in old age.
	<i>Well-being dividend</i> : Embedding of well-being into pension fund contributions and pay-outs upon retirement.
	<i>Annuity Integrator</i> : Incentive model which links participation in Active Age Movement programme to annuity income.
	<i>Life transition policy</i> : Incentive model which links participation in Active Age Movement programme to policy premium.
<i>Whealthcare</i> Value Agenda model	An older-person centric framework which aims to create more synergy between the private health and finance sectors by monitoring costs, measuring outcomes and improving service delivery.

## 2. Key points from research findings

The research prototype aims to address the following key points which emerged from the research findings:

- 1) Challenges for maintaining good health and well-being: Many of the older research participants spoke of the negative impact of loneliness and an unstructured lifestyle in retirement. This may affect their motivation levels for remaining active.
  - The Active Age Movement is a holistic programme with a strong emphasis on social engagement. Providing opportunities for participants to be involved in communal projects and volunteer programmes aims to improve social well-being and promote a sense of purpose.
  - Aligning financial incentives to retirement annuity income may be a motivating factor for participation in senior wellness programme.
- 2) Tension between wanting to remain healthy and the concern of outliving retirement savings: Some of the research participants stated that they could ill-afford the potential of increased healthcare expenses and therefore were motivated to maintain their good health and well-being. However, there was also a level of anxiety expressed regarding the potential of outliving retirement savings.
  - The Active Age Movement model provides an exercise and wellness programme appropriate to an older person's needs.
  - Linking participation in an Active Age Movement programme to retirement annuity income incentivizes *healthy ageing* behaviour whilst also alleviating the concern of diminishing retirement income.
  - Linking participation in an Active Age Movement programme to long-term care insurance policy premiums encourages an older person to maintain an insurance policy as a safety net for potential late stage health and care expenses.
- 3) Struggling to identify with future frail-self: Some of the participants believed that they would not be in a position of dependency nor experience adverse health conditions associated with advanced age.
  - The *healthcare costs forecaster tool* assists the financial advisor and client to prepare for financial implications of late stage healthcare expenses. The tool

monetizes health conditions in old age and therefore provides a more accurate picture for the financial planning process.

- The *healthcare silo fund* offers an investment vehicle for saving for potential healthcare expenses and preempts the need for long-term care insurance.
- 4) No marketing value in the elderly: Medical aid schemes are caught between needing to cater to the health and well-being needs of their ageing membership base but simultaneously not wanting to appear to be the go-to scheme for the elderly.
- *Well-being dividend* takes a life course approach by linking participation in a wellness programme to pension fund contributions. In the continuum of the life cycle model, pay-outs can either be invested in a *healthcare silo fund* and/or contribute towards membership fees in the senior wellness programme.
  - The *Whealthcare Value Agenda* model brings the financial services industry and medical aid scheme together as stakeholders in the health and well-being of older members, therefore sharing the responsibility.
- 5) Greater synergy needed between private health and finance sectors: The financial services industry professionals spoke of the implications of poor health on financial planning and the healthcare professionals spoke of the increased healthcare costs in old age.
- The *Whealthcare* solutions and the *Whealthcare Value Agenda* model aim to create a more holistic framework which promotes investing in health and well-being as part of sound financial planning and a more comprehensive financial planning process which factors in *healthy life expectancy* and the challenges longevity brings in terms of long-term care requirements.

For this research, the term “prototype” indicates a preliminary model which is intended to be the starting block for more developed proposals. The models outlined are part of a prototype framework which is in a conceptual stage and would warrant further research to verify their practical application. They are thus models for consideration and not models ready for application. The prototypes have only addressed the structure and implementation potential. In evaluating the merit of the proposed models, it is worth restating the boundaries surrounding their development. They are based on exploratory research findings which cannot be generalized to the population at large. They pertain to the private sector retirement space of South Africa, specifically the private medical aid scheme environment, the Vitality model and annuity and insurance products. As such

the models could only be put into action in partnership with a medical aid scheme and could only be tested when the medical aid scheme applied actuarial data which they hold. The population of interest is older people who are using these private sector health services and financial products.

In introducing these models, it is important to recognize that future research in the following areas is required to verify their feasibility:

*Active Age Movement business plan:* Active Age Movement is a conceptual senior wellness programme and would require a comprehensive business plan. This would be the blueprint for the operational, marketing and financial plan. A thorough analysis of the costs to participants, involved organisations and the wellness programme would ascertain the viability of the programme.

*Return on investment:* a wellness programme aligned to financial incentives needs to demonstrate a return on investment in various areas. To demonstrate the return on investment the research would entail;

- Longitudinal study which shows evidence of impact on health outcomes over a period of several years.
- Evidence of health cost savings accrued due to the wellness intervention.
- Evidence of social impact outcomes not only for health and well-being of older participants but also for beneficiaries of Active Age Movement volunteer programmes.

*Actuarial review:* the proposed *Whealthcare* solutions would require additional research to verify their actuarial dimension. Included in this research would be investigation into the legislation regulating the private health and finance sectors.

*Government's role:* further development of the *Whealthcare* solutions would need to look in detail at the Medical Aid Schemes Act and the Pension Fund Act. This would be essential to address the legislation and regulation parameters affecting the proposed solutions. Critically, future research would have to address the pivotal role government plays as regulator and steward of these private sector initiatives.

*Scaling:* the programme and solutions are targeting a niche market. Future research would need to determine what adaptations the initiatives would need to scale them to a larger population.

### 3. Active Age Movement Model

*Active ageing* is the “process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (World Health Organization, 2002, p. 12). This definition is the foundation of the Active Age Movement programme. The Active Age Movement programme combines physical activity, social engagement and self-development (Beard & Bloom, 2015; Future Learn, 2016; Lagiewka, 2012; World Health Organization, 2015b) as illustrated in figure 18. It proposes a wellness programme which encompasses the multifaceted benefits of keeping an active body and an active mind.

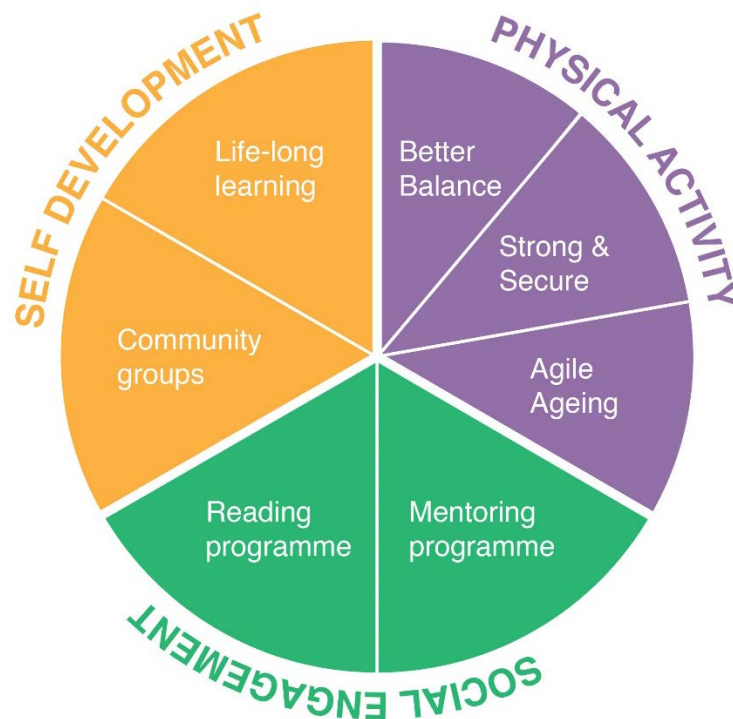


Figure 18. Three core areas of Active Ageing Movement programme

#### 3.1 Overview of Active Age Movement prototype

The Active Age Movement programme is a conceptual model which encompasses the elements of *healthy ageing*. Its implementation strategy is based on the research findings of the private healthcare sector and the existing Vitality model. Learnings from the Vitality model showed that success of the programme would be reliant on partners having a nationwide presence and a central head office. Potential partners with this organizational structure were therefore included in the

Active Age Movement model. Table 5 summarizes the features of the Active Age Movement programme, description of participants and potential partners.

Table 5. Summary of Active Age Movement programme and potential partners

<b>Summary of Active Age Movement Programme</b>		
<b>Essence of the Active Age Movement programme</b>	A comprehensive senior wellness programme encompasses physical activity, social engagement and continuing self development.	
<b>Description of Active Age Movement participants</b>	Older South Africans covered by a private medical aid scheme and able to afford to pay membership fees to belong to a wellness incentive programme. Economically advantaged South Africans and not the greater South African population.	
<b>PHYSICAL ACTIVITY</b>		
<b>Organisation</b>	<b>Role</b>	<b>Description</b>
UCT Exercise Science and Sports Medicine	Research partner	Development of the Active Age Movement exercise programme and guidelines.
Sports Science Institute of South Africa	Research and implementation partner	1. Research partner in development of programme with use of SSISA facilities and staff. 2. Implementation of pilot programme utilizing a control group of SSISA older members.
Virgin Active	Implementation partner	Infrastructure for the rolling out of a nationwide programme.
Care Delivery	Implementation partner	Digital platform for care coordination of Agile Ageing participants and therapists.
<b>SOCIAL ENGAGEMENT</b>		
<b>Organisation</b>	<b>Role</b>	<b>Description</b>
Institute of Ageing	Research partner	Development of the Active Age Movement social engagement programme
Shine Literacy	Implementation partner	Reading programme
Partners for Possibility	Implementation partner	Mentorship programme
<b>SELF DEVELOPMENT</b>		
<b>Organisation</b>	<b>Role</b>	<b>Description</b>
U3A	Implementation partner	Organizational structure for self-development groups.
MOOC (Online learning platforms)	Implementation partner	MOOC courses available on the Active Age Movement website.

## 3.2 Physical activity

It has long been known that exercise is good for your health and well-being. The WHO recommends 150 minutes of physical activity per week (World Health Organization, 2016). As you age, it is optimal to have a varied and consistent exercise programme which promotes functional movement, balance, endurance and mobility. The combination of these elements maximizes capacity and independence for an older person. The importance of maintaining a healthy body is also crucial for maintaining the health of your brain. Physical activity in later life not only keeps individuals stronger, it has also been shown to improve cognition (De La Monte & Wands, 2008; Hamer et al., 2014; Harris et al., 2015; Lautenschlager et al., 2012). Maintaining physical activity is therefore a preventative measure in combatting multi-morbidity in later age (see table of health conditions experienced affecting older demographics in appendix 8).

### *3.2.1 Components of a physical activity programme*

#### *Better Balance*

Barry et al's (2014) study found that approximately 30% of independently living older people over the age of 65 will experience a fall. Attending weekly better balance classes can enable and empower an Active Ageing Movement participant to have confidence to go into public spaces without the fear of falling. Doing regular exercises which focus on improving balance brings the added benefit of increased fluidity of movement and subsequent improved confidence. Joseph Pilates said, "You are only as young as your spine is flexible" (Pilates & Miller, 1945). Spinal movements are essential for mobility. Doing these movements strengthens the core and encourages a good posture. Mindfulness in ankle and foot placement gives an older person the self-assurance to walk in a real-world setting. The classes should include strategies for falling correctly and getting up off the floor. These elements are key to good walking and give an older person the confidence to remain active.

Better balance classes should include:

- Leg strengthening exercises
- Foot and ankle mobility and stability exercises
- Proprioception exercises – knowing where your body is in space
- Cervical, thoracic and lumbar spine movement for increased flexibility and mobility

- Balance exercises for fall prevention and brain health

A fall prevention plan is most effective when adopting a collaborative approach. This entails establishing relationships across sectors. Dr Sebastiana Kalula, director of The Institute of Ageing, has co-authored numerous papers on fall prevention. Her insight and expertise would add much value to an appropriate fall prevention plan in South Africa. Partnerships with occupational therapists would ensure that at risk Active Age Movement participants' homes were "fall proofed". Anne Macdonald, Client Wellness Advisor for Personal Trust Financial Advisors said, "We recognize the negative repercussions of falls on client's lives, so we partnered with an occupational therapist to incorporate a session on fall prevention into the Personal Trust talk series" (personal communication, October 14, 2016). Falls have a detrimental impact not only on an older person's state of mind but also on their wallet (J. P. Smith, 1999). Collaboration across sectors may more effectively reduce the strain on the health system and safe guard the financial well-being of the individual.

### *Strong and secure*

Strength equates to functional capacity. Ideally, we would all enter old age with as much lean muscle mass as we had in our 30s. However, the reality for most people is they start losing 15% of their strength per decade after the age of 50 (Keller & Engelhardt, 2013). Without regular strength training, muscles slowly decay. This natural process of ageing is known as sarcopenia. Regular resistance training can delay this process as shown in figure 19. Furthermore, it is never too late to start strength training. Remarkable results have been shown from doing resistance training with frail nursing homes residents living with dementia (Cadore et al., 2014).

A strong older person is more likely to benefit from increased independence and functional capacity. Having strong limbs will enable getting in and out of a chair by themselves, walking up stairs and carrying their groceries (Sherrington et al., 2008). Doing weight bearing exercises is good for bone health as the resistance positively affects bone density. This is particularly important for the prevention of fractures and broken bones. Having a strong muscular structure around joints relieves the pain from arthritis. However probably the most powerful impact of strength training is the benefit it has on cognitive health (Hamer et al., 2014; Lautenschlager et al., 2012).

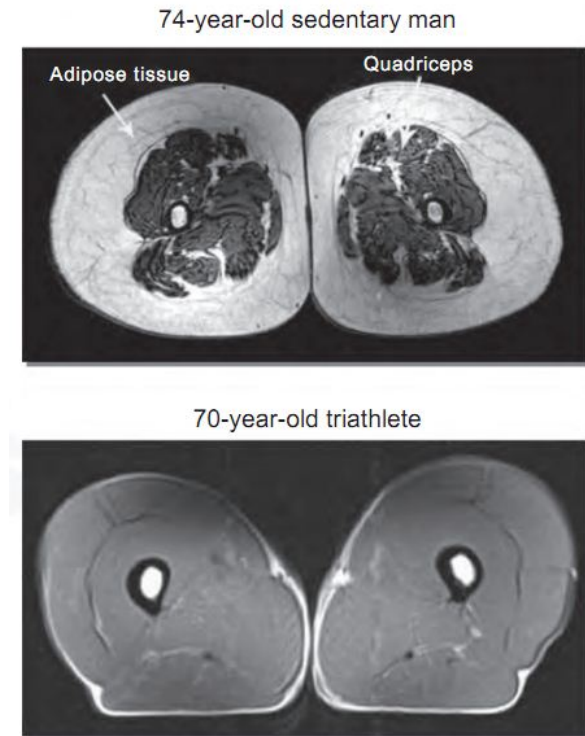


Figure 19. Quadriceps MRI scans of a 74-year-old sedentary man and a 74-year-old male triathlete

Source: This is why you should work out: Ageing muscles in triathletes vs. sedentary people. (2012). B. Rognlin

Strong and Secure classes should include:

- Multi-joint exercises – to strengthen and protect joint structure
- Weight-bearing and resistance exercises – use of weights, resistance bands and body weight
- Standing exercises – for functional movement
- Upper and lower limb strengthening exercises

## *Agile Ageing*

If you are currently 65 and in good health, you have a 70% chance of requiring additional care and support in your later old age (AARP Education and Outreach, 2016). This statistic shows that remaining in good health and well-being does not make you immune to the realities of growing old. Those who experience longevity may also experience frailty. For this reason, functional capacity is the ethos of the Active Ageing Movement, supporting older people in the transition from an active dynamic retirement to a period of immobility and dependency.

As a person becomes more dependent, they start moving less and become more prone to falls. Falls accelerate the decline of a person who may already be in a weak condition. The *Agile Ageing* aspect of the programme would be adapted for older people living with dementia, osteoporosis, diabetes, frailty and a sedentary lifestyle. Exercise sessions ensure that although the older person may not be as active as they used to be, they continue to benefit from the advantages of physical activity and social engagement. Home-based care programmes not only improve well-being but they also promote ageing-in-place (Szanton, Leff, Wolff, Roberts, & Gitlin, 2016).

The Agile Ageing sessions should include the following:



- Massaging lower legs and feet
- Manually mobilizing feet and ankles
- Standing and balance exercises
- Leg and arm strengthening
- Spinal mobility
- Cognitive stimulation

### *3.2.2 Examples of senior exercise programmes*

Exercise programmes which exhibit positive attributes for the development of the Active Ageing Movement exercise programme are shown in the table below.

Table 6. Examples of exercise programmes

Exercise Programme	Description
 <p>The logo for SilverSneakers Fitness, featuring the text 'HEALTHWAYS SilverSneakers FITNESS' and a stylized blue and white winged sneaker icon.</p>	<p><i>SilverSneakers</i><sup>TM</sup> (2014), a well-branded senior exercise programme, has shown participation reduced participants’ healthcare costs (Nguyen et al., 2008).The franchise model partners with health care plans affording members automatic eligibility for SilverSneakers membership.</p>
 <p>The logo for SimpleTherapy, featuring the text 'SimpleTherapy' in a blue and green font with a stylized orange and green swoosh.</p>	<p><i>Simple Therapy</i> (2017) is an online platform offering personalized and adaptive exercise and rehabilitation videos. Simple Therapy was winner of the Swiss Re Foundation’s (2017) “Entrepreneurs for Resilience Award” in 2016, which focused on ageing populations and helping older people live more independently for longer.</p>
 <p>The logo for Oomph!, featuring the word 'Oomph!' in a large, blue, bubbly font with a white outline.</p>	<p><i>Oomph Wellness</i> (2016), Nesta’s (2017) first social investment, exists to better the lives of older people through fun, inclusive health and wellness programmes built around exercise and meaningful activities (Allen, 2014; Oomph Wellness, 2016; Shell LIVEWire, 2012; Spero, 2014).</p>
 <p>The logo for Go4Life, featuring the text 'Go4Life' in a green and blue font with a small graphic of three colorful dots above the '4'.</p>	<p><i>Go4Life</i> (2016) is an exercise and physical activity campaign designed to help older people fit exercise and physical activity into their daily lives.</p>

	<p>Go4Life has an engaging website and an active presence on social media.</p>
	<p><b><i>Vitality Portfolio</i></b> helps older people “plan for lifelong health and independence in the same way you plan for financial security and independence – namely by balancing wellness assets, making regular deposits, and measuring progress” (Van Norman, 2016b). Vitality Portfolio draws parallels between ageing wellness and a diversified investment portfolio.</p>
	<p><b><i>Chronic Disease Intervention Programme</i></b> offers specific, medically supervised rehabilitation for people with chronic diseases of lifestyle, including frailty and ageing (Cape Sports Medicine, 2016). The programme is designed to prepare participants to progress to the <b><i>Prime Time</i></b> (SSISA, 2016) exercise programme, with an on-duty nurse monitoring heart rate and blood pressure.</p>

### 3.2.3 Potential partners for Active Age Movement: Physical activity

Potential partners who could be involved in the development and implementation of the Active Ageing Movement exercise programme and guidelines is described in Table 7.

Table 7. Potential partners for Active Ageing Movement exercise programme

<p><b>Potential partner for Active Age Movement exercise programme</b></p>	<p><b>Description</b></p>
	<p><i>SSISA</i> (2016) and UCT Exercise Science and Sports Medicine Division (ESSM) (2017) is the location of academic sports science research and allied healthcare professional internships. ESSM provides the necessary skillset for the development of the Active Age Movement exercise programme guidelines. Many of SSISA’s programmes monitor and evaluate participants’ heart rate and blood pressure, which should be included in the Active Age Movement exercise programme, to monitor the progress and participation of Active Age Movement participants. This would enable real-time engagement in the <i>Whealthcare</i> model. Learnings can also be taken from SSISA on how they appeal to their older membership base.</p>
	<p><i>Virgin Active</i> (2016) gyms have a nationwide footprint, a central head office and the longest standing relationship of all the Vitality partners. Virgin Active has the infrastructure for rolling out a nationwide programme.</p>
	<p><i>Care Delivery</i> (2016) is an easy to use online platform connecting patients to therapists and caregivers. The platform has potential for the coordinated care of Agile Ageing participants, as well expanding the digital aspect of the Active Ageing Movement programme.</p>

### 3.3 Social Engagement

Social engagement is emphasized in a number of ageing frameworks. Rowe's successful ageing and the WHO's *healthy ageing* frameworks agree on the importance of older people remaining actively engaged in their communities. Symptoms of loneliness and isolation are as detrimental to the health of an older person as smoking and obesity (Shankar, McMunn, Banks, & Steptoe, 2011). Loneliness and isolation are a major cause of concern for ageing members of society as feelings of depression compound symptoms of chronic conditions. Adult development is a multidisciplinary process, which means social prescription should be integrated into a gerontological practice. "Non-medical activities address the concerns of the individual rather than their medical condition" (Drinkwater, 2016). Volunteering projects have shown a positive effect on an older person's physical and emotional well-being, as volunteers' physical activity and social engagement levels increase and a sedentary lifestyle is reduced (AgeWell, 2015; Fried et al., 2004).


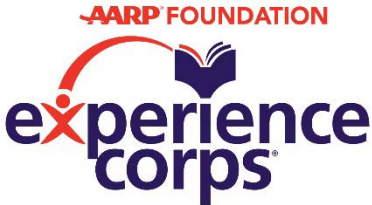
Anderson et al's (2014) study found volunteering is associated with:

- reduced symptoms of depression
- better self-reported health
- fewer functional limitations
- lower mortality

#### 3.3.1 *Examples of social engagement programmes*

Examples of social engagement programmes which have demonstrated a positive impact on the health and well-being of the older volunteers are shown in the table below.

Table 8. Examples of social engagement programmes

Social engagement programme	Description
	<p><i>AgeWell</i> (2015) is a new model of elder care coordination combining peer-based social engagement and mobile technology to improve health outcomes and drive down medical costs.</p>
	<p><i>Experience Corps</i>'s public health campaign recruited volunteers tapping into their desire to "Share your wisdom" (Tan et al., 2010, p. 729). This effective strategy appealed to participants who wouldn't ordinarily be influenced by a health campaign. The volunteers had self-reported feelings of improved health and well-being. The success and innovation of Experience Corps was its development between academia and the American Association of Retired Persons (AARP) (2017). The AARP is a powerful organisation in the US with a strong research and development team.</p>

### 3.3.2 Potential partners for Active Age Movement: Social engagement

A particularly effective campaign for recruiting older persons is tapping into their notion of "generativity". Linda Fried, designer and co-founder of Experience Corps, describes generativity: "As people age, many also want to ensure a better future for generations to follow and to help solve society's needs" (Fried, 2016, p. S168). Table 9 describes potential partners whose purpose is connected into this sense of "generativity", as well as addressing South Africa's broader societal needs.

Table 9. Potential partners for Active Age Movement social engagement programme

<p><b>Potential partner for Active Age Movement social engagement programme</b></p>	<p><b>Description</b></p>
	<p><i>The Albertina and Walter Sisulu Institute of Ageing (IoA)</i> (2016) was established at the University of Cape Town in 2001. It has a multidisciplinary team of researchers and clinicians. A research and development relationship with an academic institution like IoA, would be the basis of monitoring and evaluating health outcomes of volunteers.</p>
	<p><i>Shine Literacy</i> (2016) is a reading programme for schools in resource constrained communities. Shine Literacy has similar characteristics as the acclaimed Experience Corps programme.</p>
	<p><i>Partners for Possibility</i> (2016) pairs business leaders with school principals in resource constrained communities. Partnering with Partners for Possibility would enable the wealth of expertise and wisdom from Active Age Movement participants to be shared with educators.</p>



### 3.4 Self-development

Ageing is a stage of continual growth and development (Eden Alternative, 2013; Thomas, 2016). At any stage of our lives, personal development should be integral to our sense of well-being. Neuroplasticity, our brain's ability to reshape itself, shows that we can continue to learn new skills well into old age. Research shows that one activity per day per week can delay the onset of rapid memory loss for two months (Hall, Lipton, Derby, & Verghese, 2009). Lifelong learning has shown to contribute to cognitive reserve. Cognitive reserve was famously known from the results of the nun study (Snowdon, 2003). The longitudinal study tracked the cognitive health of nuns. The results of autopsied brains revealed that many of the participants' brains showed signs of dementia. However, because the nuns were avid readers and seekers of knowledge they did not exhibit cognitive impairment while alive. Their brains were accessing their cognitive reserve. These studies demonstrate that maintaining a sense of purpose and lifelong learning is good for cognitive health.

### 3.4.1 Examples of self-development programmes

Examples of programmes which encourage a sense of purpose are shown in the table below.

Table 10. Examples of self-development programmes

Self-development programme	Description
	<p><i>HelpAge India</i> (2016) centers organize Active Ageing groups. These initiatives are self-driven by the older people in the community. The programme gives the older people a sense of purpose and keeps them actively involved in the community (B. Mathew, HelpAge India, personal communication, November 2015). The AdvantAge card incentivizes participation in the Active Ageing groups, as members receive discounts at selected retailers who provide products which ageing consumers would need, such as spectacles (HelpAge India, 2016).</p>
	<p><i>Men's Sheds</i> are community based organisations, where all men can gather and/or work on meaningful projects. The objective of the sheds is to improve the health and well-being of the men (Irish Men's Sheds Association, 2017).</p>

### 3.4.2 Potential partners for Active Age Movement: Self-development

The self-development component of the Active Age Movement could include on-the-ground initiatives such as the Active Ageing groups and the Men's Sheds. Table 11 describes potential partners for Active Age Movement self-development programme.



older people. Aspects of the Active Age Movement prototype were based on learnings from initiatives in other parts of the world. It was on this basis that South African organisations which exhibited similar attributes were included in the prototype. Interviewing these organisations was beyond the scope of this research. Therefore establishing relationships with these organisations would be essential to the development of the Active Age Movement programme.

The Active Age Movement programme was developed based on the research findings of the private healthcare sector in South Africa, with a specific focus on the Vitality model. If a senior wellness programme were to be implemented within the Vitality model, additional insight would be gained from focus groups with existing older Vitality members. As the conceptual model was developed for this specific market, a limitation is that it is currently applicable to economically advantaged older members who in addition can afford membership of the Vitality programme. Further research would therefore be required to ascertain how the programme could be expanded beyond this demographic and be more broadly applicable to non-Vitality older members of the scheme.

#### **4. *Whealthcare* solutions**

##### 4.1 Overview of *Whealthcare* solutions

The aim of the proposed *Whealthcare* solutions is to create an engagement programme which promotes *healthy ageing* lifestyle choices and aligns financial incentives which are appropriate to pre-and post-retirement. The *Whealthcare* solutions are designed to strengthen the relationship between the private health sector and financial services industry. Table 12 summarizes the features of the *Whealthcare* solutions and incentive strategies.

Table 12. Summary of proposed Whealthcare solutions

<b>Proposed <i>Whealthcare</i> solutions</b>		
<b>Solutions</b>	<b>Element of <i>Whealthcare</i></b>	<b>Description</b>
Healthcare Costs Tool	Preparation for increased healthcare expenses in old age	Used to forecast the potential expenses connected to various health conditions in old age.
Healthcare Silo Fund	Preparation for increased healthcare expenses in old age	A standalone investment fund for the purposes of allocating funds for potential healthcare expenses in old age.
Well-being dividend	Pension fund contribution	A means of embedding well-being into pension fund contributions and pay-outs upon retirement. Incentivizing contributions to healthcare silo fund by aligning top ups based on health and well-being status.
Annuity Integrator	Post-retirement	Older person's health and well-being status used to positively impact their annuity income. Effective financial incentive to encourage <i>healthy ageing</i> behaviour choices.
Life transition policy	Post-retirement	Life insurance policy which transitions to long-term care insurance. Policy holder receives discounts on premiums based on health and well-being status.

## 4.2 Preparing for healthcare costs in retirement

Financial security in retirement can be dependent on the preparation for potential healthcare expenses associated with old age. It is estimated that a person's healthcare costs in the last five years of their life could be more than the total amount spent during their entire lifetime (Moodley & McLeod, 2001; Ranchod et al., 2015). It is therefore prudent to be financially prepared for these possible high healthcare expenses.

### 4.2.1 *Healthcare costs forecaster tool*

A *healthcare costs forecaster tool* would predict the financial implications connected to various health conditions. For example, conditions such as a stroke, dementia and frailty have costs attached to the treatment and management of these conditions. The tool would forecast the expenses with medical expense inflation built into the algorithm. Some of these costs would be covered by the medical aid scheme but a large portion would be out of pocket payments. A *healthcare costs forecaster tool* would be an engaging mechanism to assist clients prepare for the healthcare expenses that their future self may incur.

### 4.2.2 *Healthcare silo fund*

Knowing what your healthcare expenses may be in the future is only relevant if you are then saving for those potential expenses. A *healthcare silo fund* is a standalone investment fund which is solely for the purpose of allocating funds for potential out-of-pocket healthcare expenses in the later years of your life. These funds can be accessed when you experience an ill-health episode or when long-term care is required. In essence, a *healthcare silo fund* is a self-funded long-term care insurance and would be a component of a client's *healthcare* portfolio.

The *healthcare cost forecast tool* could use similar principles to Marriott's investment planning tool (Marriott, 2017). Marriott's tool allows the client to forecast their investments over their life trajectory, viewing their investment from their present-self perspective and in real-time seeing the impact an adjustment in their savings now would have in their annuity income for their future-self. As part of a *Healthcare* solution, the *healthcare forecaster tool* would make the relevance of investing in a *healthcare silo fund* more tangible for the client. Financial advisors would be able to use the tool in the planning process. It would assist in those uncomfortable conversations with clients regarding their potential health situations in old age.

Connecting a client's health and well-being status to their *healthcare silo fund* would motivate clients to invest in their health and incentivize them to allocate savings to the *healthcare silo fund*. Just as the existing wellness programme status impacts policy premiums, a client's health and well-being status could affect top-up contributions on behalf of the investment company to the client's *healthcare silo fund*. It would be a product which was designed to increase in value the healthier you were. If you died before needing to access the money, the funds would form part of your estate.

#### 4.3 *Whealthcare* in pre-retirement

The proposed solutions below take a life course approach and aim to align incentives which promote healthy lifestyle choices with financial planning for the potential increase in healthcare costs in later age.

##### 4.3.1 *Well-being dividend*

A *well-being dividend* integrated into pension fund contributions entail embedding well-being into financial planning for retirement. Contributions occurring at source would increase the odds of getting more employees investing in their future health and well-being. The use of health and well-being status in pension fund contributions and pay-outs upon retirement, would ensure that both the employer and the employee were *whhealthcare* stakeholders.

Below are examples of the possible application of *well-being dividends*:

*Well-being dividend in employee's pension fund*: when the employee is making their pension fund contribution, a percentage is allocated towards a *healthcare silo fund*. Upon retirement, the employee receives a payback percentage based on the fund's value and the employee's health and well-being status.

*Well-being dividend upon retirement*: an employee is legally allowed to access 1/3 of their pension fund contributions when they retire. The remaining 2/3 must be invested in an annuity product. Based on the employee's health and well-being status, a tax-free percentage of the 1/3 of funds can either be invested in a *healthcare silo fund* and/or contribute towards membership fees in the senior wellness programme. The deduction occurs at source during the retirement transition. A tax incentive monetizes healthy behaviour choices as the employee enters retirement.

Aligning current Vitality-like status with pension fund contributions would promote preparation for healthcare expenses in old age. Well-being dividends would encourage promotion

of healthy lifestyle choices throughout the life cycle model, as the model would transition into post-retirement planning and encourage participation in a senior wellness programme.

#### 4.4 *Whealthcare* in post-retirement

The proposed solutions below aim to address the anxiety of annuity income becoming vulnerable to inflation and being ill-prepared for the out-of-pockets payments associated with additional care and support needed in old age.

##### 4.4.1 *Annuity integrator*

As has been stated, Vitality has evolved to incentivize members to improve their status and in doing so, reduce their insurance premiums. This incentive may be relevant to a younger member who has several insurance policies. Discovery has launched the Retirement Income Investor Integrator (Discovery, 2017b) in response to retirement savings challenges. The need for such a policy is supported by the research findings which show that most retired people drop their life insurance policies and become increasingly concerned about outliving their retirement savings. This illustrates that as much as a wellness programme needs to be adapted to promote *healthy ageing*, so too does the incentive element need to consider the changing needs and motivations of older members.

As part of a *Whealthcare* solution, when the client has their annual review, included in that review could be a health and well-being review. Like a tax return; a health return. This health return could positively impact the percentage of income the older person receives from their annuity. It allows for real-time engagement in the adjustments of annuity income. Linking an older person's annuity income to their health and well-being status may be the most effective incentive to encourage participation on a senior wellness programme.

##### 4.4.2 *Life-transition policies*

The ethos of *whealthcare* is to integrate healthy lifestyle choices through the health and wealth management of clients. However it cannot be ignored that being in excellent health leads to greater longevity which may actually increase the client's life-time health spending (Tacchino, 2016). Longevity brings with it the risk of inadequate preparation to cover the inevitable expenses relating to healthcare and the necessary support required in old age. It is therefore beneficial to develop insurance policies which transition with the policy holder through their ageing stages.

South Africa has a very underdeveloped long-term care insurance market. In fact, internationally long-term care insurance has struggled to gain traction (S. Ranchod, personal communication, December 2016). However just because you may not need the long-term care insurance, does not mean that you shouldn't have a long-term care plan (Gordon & Gordon, 2015). Policies which transition from life insurance policies to long-term care insurance policies may be the most effective instrument to retain policy holders. A life-transition policy may appeal to 'sandwich generation' policy holders, as they are cognisant of their impending retirement and may have witnessed older family members struggling to cope both financially and physically (Gordon & Gordon, 2015). The life-transition policy would be asset-based, thereby giving the policy holder assurance that upon their death, their beneficiaries would receive the contributions either through life insurance or annuity benefit (Gordon & Gordon, 2015; Gresham, 2016).

Similar to the Vitality model, the policy holder could receive discounts on premiums based on health and well-being status.

#### 4.5 Future research to enrich *Whealthcare* solutions

The *Whealthcare* solutions and the Active Age Movement model form an incentive based engagement programme. These models target a niche retirement market within the private sector. Beyond the necessary actuarial research, focus groups with older people accessing these types of financial products would add to our understanding of what the motivators are in terms of aligning financial incentives to a senior wellness programme. Quantitative research and data would support this qualitative research.

### 5. *Whealthcare* Value Agenda model

The Active Age Movement model and *Whealthcare* solutions, were developed through a triangulation of data, which provided the basis of an emergent model which encourages *healthy ageing* through multisector collaboration. In chapter two, the Porter and Lee's 'value agenda' model (2013b) was shown to provide a practical framework for creating a human-centric approach. The *Whealthcare* Value Agenda model (see figure 20) addresses the social, environmental, financial, health and well-being factors of retirement through an integrated network of *whhealthcare* stakeholders who have a shared goal of creating value. Where value is defined as improved health outcomes and financial well-being (Global Agenda Council on Ageing, 2016a; Porter & Lee, 2013b).

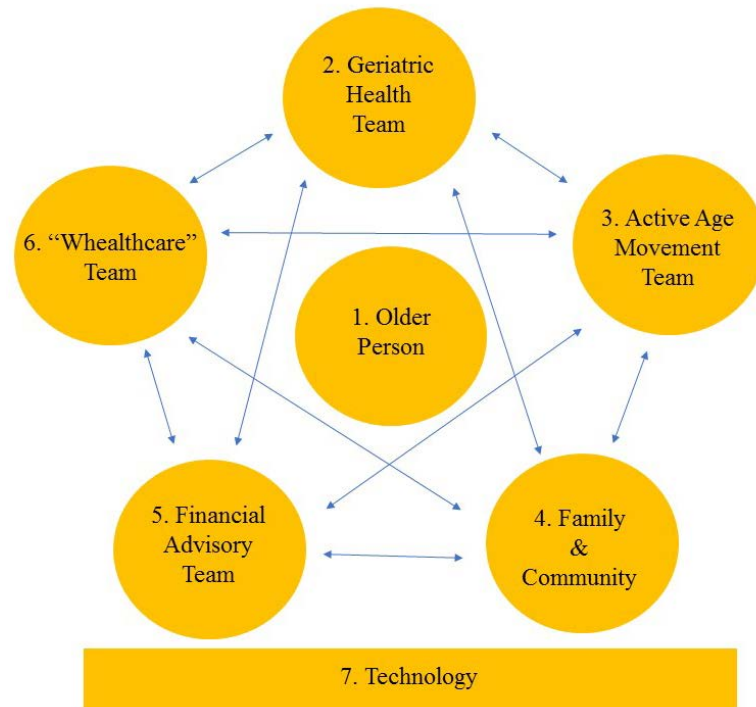


Figure 20. *Whealthcare* Value Agenda model based on Michael E. Porter and Thomas H. Lee’s ‘value agenda’

Source: Adapted from *The strategy that will fix health care: Providers must lead the way in making value the overarching goal.* (2013). M.E. Porter and T.H. Lee

The *Whealthcare* Value Agenda model encompasses:

1. Older person – central to a human-centric designed ‘value agenda’ team
2. Geriatric healthcare team – geriatricians, GPs, social workers and allied healthcare professionals involved in health management of older members
3. Active Age Movement team
4. Family and community – incorporating the social and environmental influences in older person’s health and well-being
5. Financial advisory team – incorporating financial well-being of older member
6. *Whealthcare* team – utilizing data produced from ‘value agenda’ team to develop health and wealth policies

## 7. Technology – facilitating communication between stakeholders and enabling real-time engagement with older person

The use of the *Whealthcare* Value Agenda model in this study has limitations as this research has not addressed the following stakeholders: the geriatric health team, family and community and technology. Further research would be required to understand the role these stakeholders play.

Furthermore, there are two noteworthy areas which would require further research:

### 1) Addressing the current incentives in the market

Within the private healthcare sector, a community rated environment, hospital plans and out-of-pocket payments are current structures which are not supportive of holistic care of older people. It is due to this environment that medical aid schemes are not incentivized to invest in the health and well-being of older members. Within the finance sector, current emphasis on defined contribution schemes and living annuities takes the responsibility off the financial sector and places it on the individual. Thus, the financial sector is not incentivized to innovate in the decumulation phase of financial planning. Further research into the legislation regulating these two sectors is necessary to uncover how incentives can be aligned to create an environment where the older person is securely at the center of the *Whealthcare* Value Agenda model.

### 2) Measuring outcomes

Better measurement of health and wealth throughout the life cycle model will lead to significant improvements in retirement. For the implementation of a senior wellness programme, measuring outcomes is critical for verifying the return on investment and for assessing the impact on health outcomes. These quantitative measurements will determine the viability of scaling a senior wellness programme. The seamless communication between the health and finance sectors is crucial to the success of *Whealthcare* solutions. Integrating health outcomes and potential old age health expenses into financial planning will stimulate more comprehensive *whealthcare* products and provide better guidelines for aligning annuity income draw down to health and well-being management. The effective measurement of human-centric *whealthcare* outcomes would therefore be reliant on qualitative, quantitative and actuarial research.

## 6. Conclusion

This chapter described the research prototype as part of a comprehensive strategy to address the wealth, health and well-being needs of older beneficiaries of private medical aid schemes and retirement annuities.

The Active Age Movement model is a senior wellness programme which promotes *healthy ageing* by encompassing physical activity, social engagement and continual self-development. The prototype looked at initiatives which embody each element and then sought South African organisations which exhibited similar characteristics and had the organizational structure to support the programme's nationwide implementation. The Active Age Movement programme would be enhanced by a multi-disciplinary research team. Its limitations are that it was developed for a small demographic of economically advantaged members of private medical aid schemes. However, the conceptual model was based on implementation within the private health sector, with the intention that future research would demonstrate evidence of improved outcomes for older members and the medical aid scheme. This would be the basis for adapting and scaling the programme for a health system which caters to a larger population.

The proposed *Whealthcare* solutions are aimed at creating an engagement programme which promotes *healthy ageing* lifestyle choices by aligning financial incentives to post-retirement needs. The proposed solutions sought to address how people can better prepare for old age healthcare costs, embed well-being into pension fund contributions and incentivize *healthy ageing* behaviour to annuity income and long-term care insurance policy premiums. The proposed solutions have limitations as they are targeting a niche market, and as conceptual solutions, would require rigorous research to ascertain their actuarial soundness. This would need to be supplemented by an in-depth understanding of the legislation and government's role as regulator of the private health and finance sectors. However, it is based on this necessary research that the intention of these proposed solutions could be expanded into the public-sector pension funds and health systems.

The Active Age Movement programme and the *Whealthcare* solutions are not intended to be stand-alone products but rather form part of a cohesive *Whealthcare* Value Agenda framework connecting the private health and finance sectors. The *Whealthcare* Value Agenda model aims to align the incentives of these sectors to improve health and wealth outcomes, whilst remaining focused on the needs of older people. The *Whealthcare* Value Agenda model has limitations as only some of the stakeholders have been addressed in this study. Future research would be necessary to evaluate each stakeholder's role and the success of the model would rely on mixed

methodological research to monitor costs and measure outcomes for the development of health and wealth programmes and policies.

The research prototype outlined in this chapter has identified areas of challenge pertaining to the health and wealth of older people accessing private sector services, with the ethos of promoting and supporting *healthy ageing*. The research prototype has the potential to improve the health and well-being status of individual older people and through a larger *whealthcare* network, also has the potential to foster an environment where innovation occurs in clusters with collaborators across the health and finance sectors (Prahalad, 2006).

# CHAPTER EIGHT

## CONCLUSION AND FUTURE RESEARCH DIRECTIONS

### 1. Introduction

This study was an exploratory inquiry into the lived realities of older beneficiaries of private medical aid schemes and retirement annuities in South Africa. Employing a qualitative methodology, the research design was based on semi-structured interviews with a purposefully selected sample of older members of medical aid schemes and professionals from the private health sector, the financial services industry and the fitness industry. The aim of the interviews with older research participants was to gain a deeper understanding of their motivations, challenges and concerns regarding their wealth, health and well-being. The aim of the interviews with the professional participants was to understand the context and constraints of the private sector retirement space. In gaining this insight, a prototype containing three elements was designed for implementation within the private sector retirement space which would not only promote *healthy ageing* but also address the concerns expressed by the older research participants. The prototype aimed to create a cohesive strategy which placed the older person at the center of an interconnected *whhealthcare* framework.

### 2. Summary

#### 2.1 Context

A growing ageing population and increased life spans are impacting societies around the world. By 2050, the over 60 population is set to double (United Nations Department of Economic and Social Affairs, 2000) However many western societies remain focused on a youth culture, which inadvertently endorses ageist attitudes (World Economic Forum, 2011). This is compounded by many people's inability to identify with their future older self (Hershfield, 2011). This has repercussions on people's ability to prepare for the health and wealth needs of their future older self.

The 65+ and the 80+ cohorts are the fastest growing global demographic (Business Lab, 2012). Businesses are implementing ageing as a key commercial strategic driver in response to this billion

large consumer base (World Economic Forum, 2015). The silvering of the economy is transforming the retirement model and how services and products are being designed to meet the needs of these ageing consumers (Bank of America, 2016; BlackRock, 2015). Businesses also have the opportunity to align their commercial strategy to societal need by creating a ‘shared value’ framework which promotes *healthy ageing*. A population which is ageing in good health, not only brings economic value but also reduces the adverse effects of non-communicable diseases.

There are various factors which influence *healthy ageing*; however campaigns which promote physical activity and social engagement have shown to be beneficial in the health and well-being of older people. In order to address the health and well-being needs of older people, a comprehensive strategy is needed to create equitable health and finance systems. Current health systems remain focused on acute care and there is a lack of qualified geriatric healthcare providers (Merril Lynch, 2014). This is compounded in a risk pooling model with an emphasis on a large, young and healthy membership base (McIntyre & Kutzin, 2012). The current finance system has progressively transferred the responsibility and risk onto the individual through defined contribution pension funds and living annuities (Sanderson & Scherbov, 2008). This traditional accumulation/decumulation life cycle model creates anxiety for retirees facing the potential of longer lifespan and increased out-of-pocket healthcare expenses in later life (Barrett & Kecmanovic, 2013). The combination of a silvering economy and longevity will stimulate greater integration of the health and finance systems across public and private sectors to prepare and support people for a healthier and more dignified old age.

## 2.2 Perceptions and experiences of the older research participants

The older research participants interviewed in this study are part of the 18% of the South African population that belong to a private medical aid scheme. When the participants spoke about the factors influencing their health and well-being, there was a shared consensus regarding the benefits of less stress and more flexibility. Accompanying this was the downside of a less structured routine and loneliness. Most were motivated to maintain their good health and well-being as it was viewed as an essential part of life. Several mentioned the enjoyment of physical activity and the benefit of social engagement. The challenges spoken of were lack of motivation, health issues, less confidence and financial constraints.

“A pro would be flexibility timewise but linked with that is a con – which is you can slip into habits, waste time, wake up late, be lazy. But retirement doesn’t have to be about achievement” Participant #6.

A stratification of responses became evident when financial planning was discussed. Responses concerning pre-retirement planning fell into the categories of *Poor planners*, *Passive planners* and *Active planners*. For post-retirement planning the responses were again varied. Participants spoke of the role of adult children in financial security, and gave opinions about the value of financial advice and the reduction of cover by insurance policies.

“My husband and I were the worst. We didn’t think about financial planning. My husband and I didn’t start and we regret that. I am scared to touch capital now. We have become very frugal.” (Participant #3 - *Poor planner*)

“I had two goals for retirement. One, retire with a fully paid off house and two, have an adequate pension. I had minimal savings and no investments. I see my property as the major source of potential income in the future because it is an asset.” (Participant #1 - *Passive planner*)

“I have always been very concerned with saving money. In addition to my pension at work, I made contributions to annuities above and beyond my pension fund. Nobody cares about my money as much as I do. I had a financial planner but now I do it myself.” (Participant #5 - *Active planner*)

“I am trying to hedge my money. To make it last. Sooner or later I will run out of money and then I’ll see what to do. But I do have my daughter but I do not want to be a burden. I am fully transparent with her. I have to be. It’s difficult in the long run not to be.” (Participant #10)

All participants were members of medical aid schemes; however some chose to be on a comprehensive plan and others on a hospital plan. For some, being on a hospital plan was either out of choice or out of financial necessity. Many of the participants spoke of the necessity of gap cover and frustrations of out-of-pocket payments.

“I am only willing to pay for a hospital plan. As you get older, you think are you getting pennywise and pound foolish?” (Participant #12)

Participants who were members of Discovery Health spoke of Vitality in regard to the incentive for preventative screening. When participants were asked about the role of financial planning with regard to their health and well-being, they again could be categorised into three groups: *Aware worriers*, *Denialists* and *Unconcerned*. There was one outlier, *Aware and prepared*, who had a spreadsheet detailing the financial implications of a health condition on his financial situation. Irrespective of health or financial circumstances, all the participants spoke about their anxiety of becoming a burden. This was either with respect to the loss of independence or becoming a financial or physical burden.

“My major worry is health – how am I going to cover it and how long am I going to live? Health and finances are my biggest stresses. Health is an expense I can ill afford.” (Participant #4 - *Aware worrier*)

“I don’t give it much thought. Because I know I should plan ahead but I’m not a negative thinker. I pray that I will be looked after and believe that I won’t be faced with that kind of dependency.” (Participant #7 - *Denialist*)

“I don’t think about it because there will always be enough.” (Participant #13 - *Unconcerned*)

“I know I have got enough to last to 91. So if I had a stroke or something, I could make it to 86. So I don’t have anxiety and worry.” (Participant #12 - *Aware and prepared*)

### 2.3 Insights of the professional research participants

The purpose of interviewing the professional participants from the financial services industry, the private healthcare sector and the fitness industry was to gain a better understanding of the complexities and incentives of the parties involved in the private sector retirement space of South Africa.

### *Financial services industry*

The financial advisors interviewed spoke of the different variables influencing pre-retirement planning with life expectancy being the most pertinent, yet least predictable, variable. Property and retirement villages were topical conversation points, particularly as property assets were viewed as potential sources of income in later years. However, many clients in their 50s and 60s expressed a desire to remain in their homes for their old age. Financial planning for healthcare expenses in later life was described by Robert Adshade in a broad sense:

“Generally speaking, people in their 80s are spending money very differently to a person who is 60. A lot less for entertainment but a lot more on health-related issues... I factor all sorts of things into CAPEX. Because it is almost like anonymous thing. I know that it might be used for a completely different purpose such as a car or an overseas holiday, but at least it is a contingency that is built in” (R. Adshade, personal communication, September 15, 2016).

Kate Brown took a more detailed approach to healthcare expenses in late retirement with a separate allocation within CAPEX to account for the potential of out-of-pocket payments relating to ill-health episodes:

“The medical aid will pay the bulk of the [hip] surgery costs but the other costs might be that they can’t do the shopping for six weeks and they need more help in the home...so suddenly you have a cost that is not a medical expense per se, but it is a cost that arises because you are not in your normal state of health” (K. Brown, personal communication, September 1, 2016).

The notion of burden anxiety was also present through the financial planning process, with clients expressing their fear of becoming a burden on adult children.

“If I can single out the biggest thing retired people say to me, is that they never want to be a burden upon their children. It’s a funny thing – in how western and eastern societies are so different from each other. In eastern cultures it is not an indignant thing to be financially dependent. But in our society, they would rather kill themselves than be a financial burden on their children. And when I look at their money, I can see that they are absolutely going to be a financial burden on

their kids – it is only a matter of time. I only try approach the topic and get their kids involved so there is not this reaction” (R. Adshade, personal communication, September 15, 2016).

### *Medical aid scheme environment*

Professionals from the private healthcare sector spoke of the effect a community rated environment (health insurers obliged to offer policy at same price to all persons) has on medical aid schemes in South Africa. Since all members irrespective of health or age pay the same premium, medical aid schemes do not wish to appear attractive to older members as they incur more costs. However, there is also complexity in an ageing membership base, as the hybrid of costs incurred by older members does not follow a simple formula. Adding to this complexity is that the medical aid scheme environment is very hospital centric and does not adequately provide for the primary healthcare services needed to support *healthy ageing*, particularly for hospital plan members.

“Medical aid schemes have to accept everybody and charge everyone the same premium. It is hugely detrimental to attract the old and sick, because you have to charge them the same premium as everybody else but they claim more” (S. Ranchod, personal communication, September 12, 2016).

“There is an assumption that if you can afford medical care, then financially resourced and this is not the case” (B. Richards, personal communication, October 17, 2016).

### *Vitality*

Vitality is an innovative model which incentivizes Discovery clients to participate in wellness services and programmes in order to improve their status level and receive discounts.

“All our businesses are linked to Vitality. Our ‘shared value’ model hinges on Vitality...If you take care of your health, engage in healthy activities, you benefit but so does Discovery Health and Discovery Life because there are fewer claims. It’s a zero-sum game. Vitality is central to the ‘shared value’ model” (D. Patel, personal communication, September 8, 2016).

However, the Vitality programme does have a return on investment for Discovery Health, as it attracts young and healthy members.

“I think it is quite important when you look at Vitality, to remember that the programme has a dual purpose. So, the one is the wellness aspect but the other is that it has worked as a powerful selection tool. It has been marketed to the young and healthy. It has never been targeted at older members” (S. Ranchod, personal communication, September 12, 2016).

As outlined in chapter four, the Vitality Institute is a leader in health promotion and disease prevention research (Porter et al., 2014). As such, Vitality South Africa would not likely develop a senior wellness programme, but would most likely adopt initiatives based on research from the Vitality Institute in the US.

“There is a greater urgency in some of other markets. To some extent we are catering for our seniors, not ideally, but we are in our market. But Vitality has a presence everywhere in the world. And some of our other markets particularly the US, where we partnered with a life company called John Hancock, they are looking at an older age programme. So some of those initiatives may come from our other markets and we will adopt them” (D. Patel, personal communication, September 8, 2016).

“Vitality has done a very good job of expanding internationally. They’re in Canada, the UK – all of those markets you can risk rate. You can charge older people more. So there it is fine – in a risk rated environment – you can offer it. I’d be very surprised if they launched something like that here” (S. Ranchod, personal communication, September 12, 2016).

### *Whealthcare*

It appeared that there was a need to develop solutions which addressed the financing of healthcare expenses in later life and the anxiety of becoming a financial burden. However, the current private health and finance sectors conform to different legislation. The opinion of some the participants was that innovation is stifled within the health and wealth environment due to the regulatory parameters.

“Insurance and retirement funds are not subject to the same legislation as medical aids. There is a disconnect...legislation only applies to medical aids but not to retirement space” (B. Richards, personal communication, October 17, 2016).

“What I think that people don’t understand is that their healthcare costs are going to climb. But even if your medical scheme premium stays level, medical scheme contribution inflation is above normal level. So just that is going to eat into your living annuity over time. But where people can only afford a hospital plan, those other bits are not covered. Your out-of-pocket expenditure is going to rise over time. If people understood that, they would be able to plan to start lower with their draw down, and know that their draw down is going to have to increase over a period of time. So legally it can’t be tied together, but you could have a wrapper type product that ties to manage the two together” (S. Ranchod, personal communication, September 12, 2016).

### *Engagement programme*

Two effective strategies were outlined in building a successful engagement programme. The first was tailored and personalised messaging and the second was aligning participation to financial incentives and penalties.

“We found there is a greater response to that tailored and personalized messaging. And I think in the future, we are going to tailor our messaging much more. We are going to speak to older people much more differently than to younger people, in some instances. Particularly when we want them to adopt certain behaviours” (D. Patel, personal communication, September 8, 2016).

“People are much more worried about their finances than their health and therefore the best learning out of all of this, which may be of interest to you, is that if you are going to build an engagement programme you need to put in financial incentives. People don’t really care about their health and the reason for that is, it is not

something that you can see up front” (A. Urison, personal communication, September 9, 2016).

## 2.4 Prototype

The prototype that was developed from this research is composed of three elements which, together form part of a comprehensive strategy to address the issues that had been identified through the combination of the literature review, the overview of current practices and the in-depth interviews.

### *Active Age Movement model*

The Active Age Movement model promotes *healthy ageing* by focusing on physical activity, social engagement and self-development. It proposes the structure of the programme and potential partners who could be involved in the implementation of the programme within an existing Vitality-like framework.

### *Whealthcare solutions*

The *Whealthcare* solutions form part of the engagement model of the Active Age Movement model and aim to align financial incentives which are appropriate for the retirement market. The first aspect is preparing people for healthcare costs in later life. The *healthcare costs forecaster tool* is a prediction of the financial implications connected to various health conditions. Connected to this is the *healthcare silo fund*, which is a standalone investment fund for the purposes of allocating funds for potential out-of-pocket healthcare expenses in the later years of your life. The second aspect is the *well-being dividend* in pre-retirement. This aims to embed well-being into pension fund contributions by aligning Vitality-like status to pension fund contributions and incentivizing investment into a *healthcare silo fund*. The third aspect looks at post-retirement space. The *annuity integrator* aims to align Vitality-like status to annuity income pay-outs and the *life transition policy* proposes transitioning life insurance into long-term care insurance policies. Vitality-like status would affect discounts on policy premiums.

### *Whealthcare Value Agenda framework*

The *Whealthcare* Value Agenda framework is an emergent model which encourages *healthy ageing* through multisector collaboration. It proposes an older-person centric *whealthcare*

approach which aligns the motivations and incentives of the wealth, health and well-being players into a cohesive framework.

### **3. Discussion**

The qualitative approach followed in this research offered a glimpse into the lived realities of older members of medical aid schemes. Listening to older people speak in their own words problematized ageing in the private sector space of South Africa: the challenges of being in poor-health and the motivation for remaining physically active; the anxiety of having the financial means to pay for healthcare expenses; the awareness and gratitude expressed at being in a financially stable position.

These motivations, challenges and concerns articulated by the older participants put a face and a name to the graphic representation of the traditional accumulation and decumulation life cycle model and the inevitable increase in healthcare expenses in later life. Their cases provided learnings for the development of the research prototype. Analyzing the older participants' data and processing the insights gained from them, supported the notion that promoting *healthy ageing* involves a life course approach that, on the one hand, addresses the immediate needs of older people and, on the other hand, prepares the future generation of older people for a more sustainable and healthy old age. Being able to personalize an older person's experience assisted in making the research prototype a more human-centric model.

The main objective of the research was to understand older participants' motivations and challenges for maintaining good health and well-being and to use these insights to aid the development of the Active Age Movement model. Interestingly, only two older participants spoke about physical activity in detail but many spoke of the benefits of social engagement and lifelong learning. This may demonstrate that there is a need to create a comprehensive wellness promotion campaign, where physical activity is integrated into the programme but is not necessarily the main focus.

*Healthy ageing* was initially the central theme of the study. However, as the research unfolded it became apparent from many of the older participants that financial well-being had a substantial influence in respect of their health and well-being. Interviewing financial advisors was valuable for understanding this dynamic. The financial advisors' perspective on financial planning for healthcare expenses in later life shed light on the role the financial services industry plays in this

respect. There seems to be a lack of understanding, or an underestimation, of the potential extent of these expenses and of how to effectively allocate these funds for when they may be needed.

From this initial inquiry it appeared that there is a lot of scope for developing the healthcare aspect of the financial planning process. However there also appears to be an area of tension between the client and the financial advisor in openly discussing this topic. Financial advisors described the delicate balance between going into the detail of geriatric health conditions and the accompanying realities and costs associated. In describing these awkward conversations, it appears people are unable or unwilling to identify with their much older, and potentially frail, older self. This illustrates Chapman's (1996; 1995) studies which showed that health received a larger discount bias than money. Value would be added to this research by interviewing a larger sample of financial advisors on how they incorporate holistic planning for their clients. Initiatives such as Merrill Lynch's illustrate that there is a growing awareness of this need (Bank of America, 2016). This is supported by the professional participant responses across the sectors, where financial advisors broached health issues and healthcare professionals broached the financial issues of out-of-pocket payments and long-term care.

Life expectancy is an important and unpredictable variable in financial planning. However, based on the above insight, *healthy life expectancy* is a variable which can be integrated into the financial planning process alongside life expectancy. Scenarios can be painted for pre-retirement clients for when they can comfortably retire based on their assets, investments and a proposed life expectancy variable. However, a more genuine scenario picture focusing on the variable of *healthy life expectancy* could be incorporated into this scenario setting, as being in poor health and dependency can have adverse implications for the financial situation of the client. Furthermore, it would be interesting to see if *healthy life expectancy* scenario projection would affect a client's lifestyle choices and financial planning decisions.

Some of the participants said that they could ill-afford healthcare expenses and that this was a motivating factor for maintaining their good health and well-being. It is noteworthy that these participants were expressing these sentiments from a viewpoint of financial instability. This raises a dilemma. If these participants' motivations to stay healthy arise out of financial instability, is their financial instability being compounded by the transference of these expenses to long-term care which will have to be funded by themselves? Studies have shown that healthy early retirees

incur less hospitalization expenses yet do incur higher long-term care expenses (World Health Organization, 2015b). These results come from the Netherlands which has well established state provision of long-term care. The concern then arises in the private sector retirement sector in South Africa, where long-term care expenses are deemed to be social welfare expenses and therefore not covered by private medical aid schemes. It is in these circumstances that the involvement of both government and the private finance sector is imperative.

Those participants who voiced their anxiety of outliving their retirement savings and of having inadequate funds for healthcare needs, represent a 'shadow group' that has the potential to fall through the cracks of both private and public sector support. They have become accustomed to the quality of health care provided by the private sector and view the public health sector services as inferior. Because of this, they are divorced from the services and provisions offered by the State. They are also divorced from the provision of government state pensions. In 2017, the old age grant was R1600 per month (Department of Social Development, 2017), which is an inadequate amount for a decent standard of living. Not one of the participants who expressed their concern of outliving their retirement savings mentioned the possibility of relying on a government old age grant. Although undesirable, the participants spoke of relying financially on adult children if need be. Even though unspoken, there was a sense that their adult children would not provide the necessary day-to-day care themselves. If the older person became frail and physically dependent, this would be provided for by paid-for caregivers, which would have financial implications for the adult child. The level of anxiety expressed by older participants and by some financial advisors was noticeable. It is not clear if this level of anxiety is unique to this demographic of older people because their welfare is so dependent on the private sector's provisions of health services and the inadequate social security provided by the State.

To adhere to the ethical considerations of this research, the older participants were in good health and sound mind and still within the parameters of a *healthy life expectancy*. However, it would be of interest to better understand the experiences of older people who were beyond their *healthy life expectancy*, were in a declining trajectory of physical capacity and were at the tail end of the decumulation projectory. Participant #10 was selected, as she was living with macular degeneration and experiencing increased levels of dependency. She also expressed a heightened concern about financial stability and not having family structures in place for support. She had the

greatest perceived level of vulnerability and despondency. The following statements revealed her sentiments:

“When my eyes went, I thought oh God what am I going to do? I feel healthy which is upsetting as I don’t want to get to 90 odd”

“I have paid my way all my life. I don’t want to be a financial and physical burden”

“I am trying to rely on myself. I hate to be dependent”

Although her situation provided valuable insights, the majority of the participants in this study were not yet in these circumstances. The research participants provided valuable information for the formulation of the prototype which addresses the needs at this stage of their lives. Research which looks at older people who were already in that grey area of financial instability and heightened health care expenses would provide even greater insight.

There were a few areas where pre-existing views were challenged in this research. Within the realm of “inclusive innovation” research there was a perception that it was more pressing and relevant to address the needs of disadvantaged older people in South Africa. Although there is merit to this opinion and there is agreement that much needs to be done in the public health sector, this research exposed an assumption that if a person belonged to a private medical aid then they were financially resourced. Responses from both older and professional participants illustrated that, although these participants were not living on the poverty line, they were vulnerable to receiving inadequate healthcare services and lived with the anxiety of outliving their retirement savings. This research demonstrated that there is slice of the population who belong to private medical aid schemes who are vulnerable; in particular, single women who receive a reduced pension from their deceased husband, or have a greater life expectancy than their deceased husband’s financial planning might have made provision for.

Another pre-existing view which has been challenged is the perception that there is not a return on investment for the medical aid scheme to invest in senior wellness programmes. It has been demonstrated that healthy early retirees incur less hospital expenditure. It must be acknowledged that a senior wellness programme would not influence costs associated to the ageing process irrespective of health. However, analysis of this costing structure would most likely show that the costs of catastrophic events and the management of non-communicable diseases are probably

higher than these standard age-related expenses. Studies of healthy early retirees showed that healthcare expenses are not eradicated but are rather transferred to long-term care expenses. Long-term expenses are not covered by medical aid schemes. If a senior wellness programme is looked at from this perspective, inadvertently there may be a return on investment for the medical aid scheme as they are transferring the expenses from themselves to the individual.

It is within this context that a *whealthcare* framework could be best implemented in an organisation such as Discovery which is also focused on insurance and investment models. The senior wellness programme could therefore be available to investment clients as part of a holistic *whealthcare* planning process. It is from this perspective that understanding the actuarial implications is imperative, especially in relation to the following questions: to what extent do lifetime health costs remain the same? Is it just the timing of those costs which is affected? How does transferring these lifetime health costs impact the funding model and the funder? Attempting to answer these questions makes *healthy ageing* a dynamic and complex subject.

The benefit of prototype development is that it encourages “out the box thinking”. As has been stated, *healthy ageing* is a dynamic and complex topic which could benefit from a multi-perspective approach. The prototype not only aimed to address the real needs expressed by the older research participants and reflected in the literature; its goal was also to create a cohesive strategy which encourages innovation and facilitates collaboration and communication between the *whealthcare* stakeholders.

The Active Age Movement model proposes an all-inclusive programme which gives older people access to participating in activities which will benefit their health and social well-being, and gives them a sense of purpose. The Active Age Movement model provides a framework for a feasibility study, where the calculated cost savings can be compared between a group with the wellness intervention and a group without. However, the Active Age Movement model is more than just a cost containment strategy. Many real-world initiatives were referred to in the literature which promoted aspects of *healthy ageing* and the Active Age Movement model provides all of these aspects under one umbrella. Many retirees say that they struggle to find opportunities to volunteer and get involved in their communities (World Economic Forum, 2011). The Active Age Movement model is a programme which facilitates this for them. The Active Age Movement model not only benefits older people, but as part of a ‘shared value’ framework it also addresses

broader societal needs in resourced constrained communities. This provides the basis for further research into various areas of social impact.

In addressing the concerns expressed by older participants, *Whealthcare* solutions aim to create an engagement programme which not only encourages participation in the Active Age Movement programme, but is also relevant to the financial concerns of retirees, aligning incentives which aim to resolve the concerns of a diminishing retirement income and providing the safety net of long-term care insurance. A qualitative approach enabled these concerns to be voiced and provided the validation for the further actuarial research. Although the Active Age Movement model and *Whealthcare* solutions are currently theoretical frameworks, the intention is for them to be the starting point on which future programmes and policies can be developed based on additional research which proves their feasibility. The aim of the *Whealthcare* Value Agenda framework is to support this action-based research. Strengthening the connections between the health and finance sectors will ensure that mutually beneficial outcomes can be monitored and measured and a culture is developed which nurtures quick-learnings from prototyping.

#### **4. Future research**

The research prototype presented in this dissertation is a theoretical framework and would require additional research to ascertain the feasibility of various elements. However, this study has also demonstrated that there is scope for future research in scaling the research prototype within the private sector retirement space and furthermore provides the basis for future research beyond the boundaries of the private sector retirement space.

##### **4.1 Scaling *whealthcare* prototypes within the private sector retirement space**

As has been stated, research would be required to address the feasibility of the prototype, such as a business plan for the Active Age Movement model. However future research also has the capacity to address the systemic causes and constraints which currently infringe on the scaling on the prototype within the private sector retirement sector. The first area of research should address the delivery of wellness initiatives within the existing medical aid scheme environment in terms of analyzing the cost cycle of health services provided to members. Porter and Lee's value agenda model's emphasis is on how to deliver improved outcomes at a reduced total cost (Porter & Lee, 2013b, p. 50). This supports evidence that healthcare services which address the multi-dimensional needs of older people are more effective than services which independently address

individual diseases or conditions (World Health Organization, 2015b). It is on this basis that wellness interventions should not be deemed an external cost to healthcare provision, but rather an integral component of the primary healthcare services offered to members of medical aid schemes. Therefore research which addresses provision and funding of preventative wellness services needs to be incorporated into the Active Age Movement model so that the benefits are not only felt by those who can afford membership of the Vitality programme.

It could be reasoned that addressing the health and well-being needs of older people is not just the responsibility of medical aid schemes. This is particularly the case as increased longevity and the unpredictability of healthcare expenses place pressure on individuals. Education is needed in the post-retirement sector to address income requirements in the decumulation phase and a detailed approach to financial preparedness for health expenses beyond mere monthly medical aid scheme contributions. In addition to *whealthcare* education, the finance sector is a key player in developing funding models to scale *whealthcare* prototypes. In 2011, R1trillion was invested in the South African retirement market (National Treasury, 2012, p. 14). *Healthy ageing* should be an integral investment in this asset allocation. Aligning the Active Age Movement model and *Whealthcare* solutions to pension funds and retirement annuities provides a unique opportunity to scale the *whealthcare* ethos to a larger audience.

#### 4.2 Government's role

This study specifically looked at implementing strategies for ageing consumers who are accessing services provided by the private healthcare sector and financial services industry. However, the older demographic of the 18% belonging to medical aid schemes is not a unified group. Along the spectrum there are those who are adequately prepared and then there is a 'shadow group' who are not. Currently the state is absent in dealing with the needs of this 'shadow group'. In the development of a national health insurance, well-meaning strategies face the danger of oppressing this small but vulnerable demographic (Cooper, 2014). Hence future research which addresses government's role with regards to private sector initiatives, health systems and social security, needs to be inclusive of economically disadvantaged older people within the private healthcare sector.

It is crucial that future research also addresses government's role as regulator and steward of the proposed private sector *whealthcare* initiatives. This research would need to investigate the

Older Persons Act (Republic of South Africa, 2006), the Medical Aid Scheme Act (Republic of South Africa, 1998) and the Pension Fund Act (Republic of South Africa, 1956). Having a better understanding of this legislation would impact the feasibility of the proposed initiatives, would open possibilities for greater synergy between these government departments and stimulate private/public sector dialogue.

The awareness of the vulnerabilities of a growing ageing populations in low- and middle-income countries should signal the need for further research (Lloyd-Sherlock, 2000; World Health Organization, 2015b), especially as there is insufficient data on the health of older populations accessing the public health sector (S. Ranchod, personal communication, September 12, 2016). Factoring in the aspects of the *wealthcare* framework, future research would have to address the public health system and the public pension fund and social security systems.

A move toward universal healthcare coverage would be the first step in addressing the inequalities between the public and private sector. South Africa's *healthy life expectancy* is far below that of developed countries (Salomon et al., 2012), as it shown in table 13. The *healthy life expectancy* of older members of private medical aid schemes mirrors that of the US and UK, whereas the remaining population is in stark comparison. Thus building an equitable health system needs to take a top down and bottom up approach. Health inequalities create a cumulative disadvantage in the health outcomes of poorer older people (World Health Organization, 2015b). Likewise taking a life course approach means that ensuring better health for older people will result in better health for all (World Economic Forum, 2011). In creating an age-friendly public health sector, government will need to address infrastructure, safety and accessibility. It has been shown that 60% of economically disadvantaged older people do not access healthcare services because of the cost of transport (World Health Organization, 2015b). A weak health system is not able to adequately deal with emerging health problems among older people (Nabalamba & Chikoko, 2011).

Table 13. Healthy life expectancy for South Africa, USA and UK, 1990-2010

	1990				2010			
	Male population		Female population		Male population		Female population	
	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy	Life expectancy	Healthy life expectancy
South Africa	60.7	52.6	68.7	58.5	57.4	49.1	62.3	52.7
USA	71.7	63.0	78.6	68.1	75.9	66.2	80.5	69.5
UK	72.9	63.4	78.3	67.4	77.8	67.1	81.9	70.1

Source: Healthy life expectancy for 187 countries, 1990-2010: A systematic analysis for the Global Burden Disease Study 2010. (2012). Salomon et al.

In addressing the health and well-being of older members of society, it is essential that policies are developed which ensure financial security (World Health Organization, 2015b). Progressive and flexible policies need to replace outmoded public policies which limit the economic opportunities of older people. Education on financial management for pre-and post-retirement is needed, as well as investment in social security for financially vulnerable older people. Government's response to the challenges faced by older people may be slow due to other pressing issues. Yet South Africa has witnessed one of the greatest increases in population ageing in Africa (Nabalamba & Chikoko, 2011). Therefore there is a need to co-ordinate research between health, economics, innovation and the public and private sectors in response to the growing ageing demographic (G20, 2015).

#### 4.3 Public/private partnerships

Despite South Africa's extreme inequality, it is apparent that growing old can be a struggle for older people living in both wealth and in poverty (Dr Richards, personal communication, October 17, 2016). This signals the urgency to address the needs of the ageing through increased public/private partnership and collaborations across sectors. Systems have traditionally been developed in professional or sector silos; however the Sustainable Development Goals (SDG) signal a shift in how the public and private sectors tackle the challenges facing society (United Nations Development Programme, 2017; United Nations Global Compact, 2015; World Health Organization, 2015b). However, because older people are not referred to as a specific group, unlike women and children, they are less likely to be targeted for development support (Nabalamba & Chikoko, 2011). SDG 3: Good health and well-being is viewed as one of the most pressing issues

facing sustainable development (see figure 21). The challenges faced by older people align to SDG 3, as it affects the retirement model, health system and long-term care models. Within the framework of public/private partnerships societies benefit from big corporates making ageing a key strategic driver and small businesses aligning their business models to the needs of older people (World Economic Forum, 2015). There is especially a lot of scope for public/private partnerships within the long-term care model. As there is often insufficient public sector provision, the financial responsibility is transferred to the older person and the burden of care is left to families.

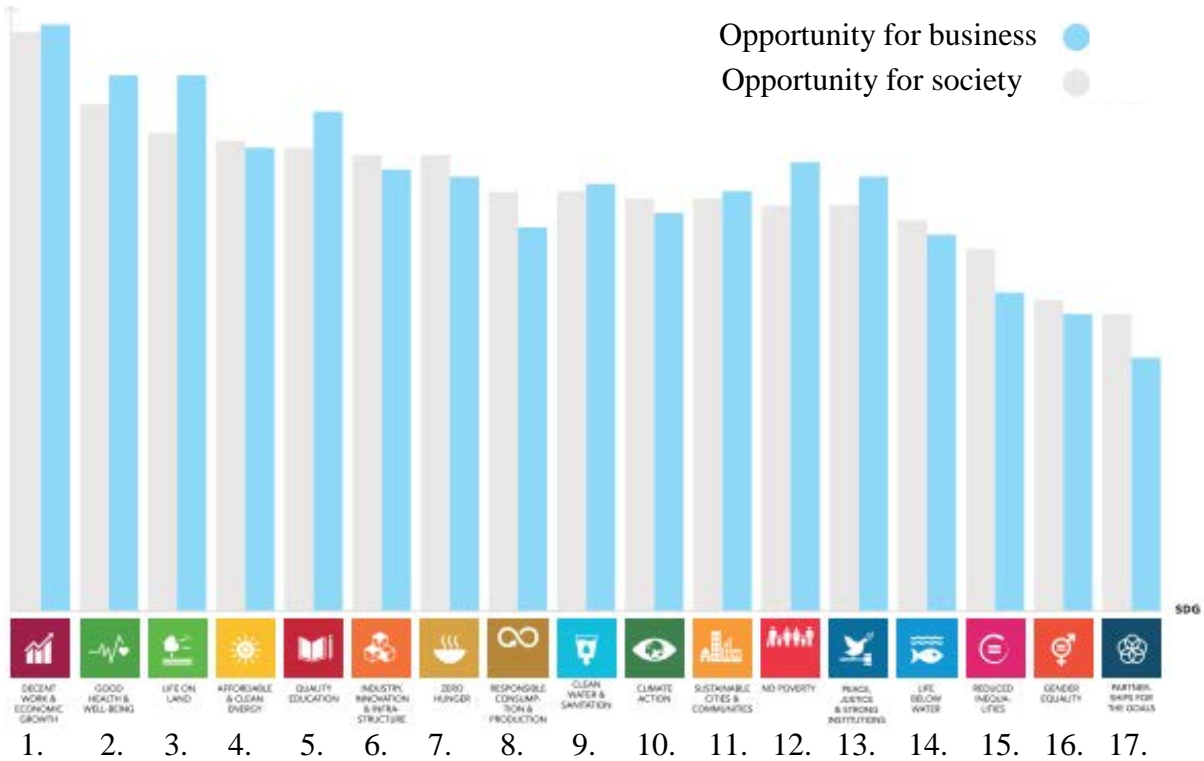


Figure 21. How respondents find the SDGs to impact on sustainable development and new business opportunities - bars indicate percentage of respondents who have selected the SDG

1. Decent work and economic growth
2. Good health and well-being
3. Life on land

4. Affordable and clean energy
5. Quality education
6. Industry, innovation & infrastructure
7. Zero hunger
8. Responsible consumption and production
9. Clean water and sanitation
10. Climate action
11. Sustainable cities & communities
12. No poverty
13. Peace and justice strong institutions
14. Life below water
15. Reduced inequalities
16. Gender equality
17. Partnerships for the goals

Source: Global opportunity report. (2016). United Nations Global Compact

However there remains a paradigm debate regarding the over emphasis by decision-makers to base decisions on scientific evidence, hard data and the reduction of costs. It has been contended that policy-makers can make more informed decisions, not solely by focusing on minimalizing costs but rather on how societies can benefit from the investment in *healthy ageing*. This shifts the economic rationale from burden and dependency of an ageing population to a proactive campaign of increasing the longevity dividend (World Health Organization, 2015b). This outlook encourages social impact investors, as it rewards metrics which prove positive effects on social challenges (OECD, 2014).

To shift the focus to investment for social benefit also opens the possibility of rethinking the role of public/private partnerships. Health and wealth innovation has traditionally been driven by policy innovation which is then converted into services and policies. However, using this study as an example, a qualitative inquiry could be the basis of exploratory action-based research. Prototypes which are developed based on the real, lived and individualised experiences of the older people offer an opportunity for public/private partnerships to not solely be a mechanism for service delivery but also to be viewed as a platform for learning and innovation. In doing so, systems are

designed which better meet the needs of older people and through iteration, the older person remains in the centre of service delivery. This model encourages the cooperation between academic research and business sectors and stimulates greater dialogue between the public and private sectors (G20, 2015).

## **5. Conclusion**

*Healthy ageing* is a multi-faceted and dynamic interaction between an older person, their family, community and support structures. As such the concept of *healthy ageing* cannot be blanketly applied to all older people across different regions and socio-economic boundaries; in part because public policies and environmental issues are contributory factors, but also because there is no such a thing as a typical older person. Many older people experience their later years with an increased perception of well-being. However due to longevity and the traditional retirement model and health systems, many older people will also experience feelings of anxiety concerning outliving retirement savings and the potential of increased healthcare costs in their later years. It is therefore crucial that an on-going exploration occurs to understand what motivates older people to remain active, which structures hamper their pursuit of good health and well-being and what concerns them as they look forward towards their advanced old age.

Exploratory inquiry fits into a body of knowledge which informs policy-makers' decisions. In order to make breakthroughs in *healthy ageing* programmes and policy development, a continuous, reflexive and interactive learning process needs to occur (Johnson & Andersen, 2012). This nurtures an ecosystem for rapid learning between many collaborators and partners (Prahalad, 2006). Innovation and research should not and cannot occur in isolation. As such exploratory research lays the foundation for action-based research initiatives in which prototyping forms the basis of public/private partnerships and informs policy development. Key to this prototyping approach is working with quantitative and actuarial researchers to develop practical, sustainable and market-based initiatives which keep the focus on the older person whilst maximizing the opportunity to expand the societal dividend from the promotion of *healthy ageing* (OECD, 2014; Wyman, 2016).

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# APPENDICES

## Appendix 1: Biographical details of older research participants

Participant	Age	Gender	Race	Marriage Status	Medical Aid	Plan	Financial Planning for Retirement	Physical Activity	Living Arrangements
Participant #1	65	Male	White	Married	Discovery	Comprehensive	Pension fund, paid off property, no discretionary savings. No financial planner.	None. Hobby – stamp collection.	Paid off - original family home
Participant #2	94	Female	White	Widowed	Scheme through Rhodes University	Comprehensive	Husband's pension. Long relationship with financial planner. Adequate but not wealthy.	None. Hobby - bridge	Retirement Village
Participant #3	68	Female	White	Married	FedHealth	Comprehensive	Inadequate financial planning. Still working	Very active. Gym, Pilates and running	Paid off - flat
Participant #4	73	Female	White	Widowed	Discovery	Hospital	Not much thought given. Long relationship with financial planner. Sold flat to daughter. Lives in flat and lives off	Walks. Involved with grandchildren	Paid off - flat

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Race</b>	<b>Marriage Status</b>	<b>Medical Aid</b>	<b>Plan</b>	<b>Financial Planning for Retirement</b>	<b>Physical Activity</b>	<b>Living Arrangements</b>
							income from sale of flat.		
Participant #5	75	Male	White	Married	Discovery	Comprehensive	Well prepared. Pension fund, discretionary savings.	None	Paid off house
Participant #6	68	Female	White	Widowed	GEMS	Comprehensive	“Zero financial planning”. Pension fund. Inheritance.	Weekly aerobics class. Involved in church.	Paid off house
Participant #7	83	Female	White	Divorced	Genesis	Hospital	Took out retirement annuity at 38. Some discretionary savings.	Walks. Hobby – bridge.	Paid off flat
Participant #8	69	Male	White	Married	Discovery	Comprehensive	Well prepared. No pension fund. Entrepreneur – capital growth. Dividend income motivator.	Pilates, golf	Paid off house
Participant #9	74	Male	White	Married	BestMed	Hospital	Well prepared. No pension fund..	Personal trainer twice	Paid off house

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Race</b>	<b>Marriage Status</b>	<b>Medical Aid</b>	<b>Plan</b>	<b>Financial Planning for Retirement</b>	<b>Physical Activity</b>	<b>Living Arrangements</b>
							Entrepreneur. Dividend income. Manage own finances.	a week. Cycles.	
Participant #10	71	Female	White	Widowed	Resolution Health	Comprehensive	Pension fund. Half of deceased husband's. Not adequately prepared	None	Paid off house
Participant #11	70	Female	White	Married	Engen	Comprehensive	Pension fund. Discretionary savings. Bought property.	Walks with friends. Social	Paid off house
Participant #12	80	Male	White	Married	Oxygen	Hospital	Well prepared. Different silos of savings. Very knowledgeable on financial management & fees	Finds exercise tedious. Gyms expensive. Enjoys hiking	Paid off house
Participant #13	88	Female	White	Divorced	GEMS	Comprehensive	Well prepared. Long relationship with financial advisor	Aqua aerobics	Retirement village

<b>Participant</b>	<b>Age</b>	<b>Gender</b>	<b>Race</b>	<b>Marriage Status</b>	<b>Medical Aid</b>	<b>Plan</b>	<b>Financial Planning for Retirement</b>	<b>Physical Activity</b>	<b>Living Arrangements</b>
Participant #14	80	Male	Coloured	Married	GEMS	Hospital	Pension fund. No discretionary savings.	None – involved in church & community	Retirement Village
Participant #15 (married to #14 – not on medical aid but was involved in interview)	77	Female	Coloured	Married	NONE	NONE	NONE	None – involved in church & community	Retirement Village
Participant #16	78	Female	Coloured	Widowed	GEMS	Comprehensive	Pension fund. No discretionary savings.	None	Retirement Village

## **Appendix 2: Older research participant one-on-one interview outline**

1. What are the pros and cons of being in this stage of your life?
2. What are the motivations and challenges in maintaining your good health and wellbeing?
3. Tell me more about your financial planning – pre-retirement and post retirement.
4. Describe your health care management.
5. What medical aid scheme are you a member of? What plan?
6. Describe the role of financial planning with regards to your health and wellbeing.
  - a. What impact would illness have on your financial situation?
  - b. Have you done any research regarding health related costs in later age?
7. Who do you seek advice from with regards to your financial and health decisions?
8. What digital/technology/media do you engage with the most?
9. What support do you feel you will or currently need to maintain your independence and keep a good quality of life?
10. What have you done in your life that has made this stage of your life more enjoyable?
11. In closing, what would you say is the most pertinent thing to remember from our conversation?

### Appendix 3: Professional research participants' details

Name	Organisation	Role	Industry	Contact	Reason for inclusion in research
Kate Brown	Fiscal Financial Advisors	Independent financial advisor, partner in Fiscal Financial Advisors	Financial Services Industry	Professional contact while working in senior wellness. Curator of Living Long, Living Well lecture series at UCT Summer School.	Ms Brown has a special interest in late stage retirement and longevity. Wished to gain Ms Brown's insight into late retirement financial management and development of proposed research prototype solutions
Simon Spurr	CareDelivery	Owner	Health sector – digital innovation	Professional contact while working in senior wellness. Met at the World Congress on Healthy Ageing in 2015.	CareDelivery is an easy to use digital platform which connects patient to caregiver/therapist. Insight would be used for the development of the prototype.
Dr Deepak Patel	Vitality	Principal clinical specialist and head of research at Vitality South Africa	Health sector – innovation	Contact made via referral with fellow MPhil student to Vitality tech team.	Vitality is an innovative health promotion programme. Patel's insight would provide information regarding the Vitality model and

Name	Organisation	Role	Industry	Contact	Reason for inclusion in research
					add value to the development of research prototype.
Dr Avron Urison	All Life	Medical Director & Co-founder	Health sector – innovation and insurance	Referral through Tom Gardner – Operations Director of All Life and guest lecturer on MPhil programme	All Life offers insurance to individuals living with HIV and Diabetes. Wished to learn from Dr Urison’s insight into focusing on specific demographic/target market and effective incentivization of an engagement model. Specifically, All Life’s continuous ongoing level of engagement with clients’ health management which makes All Life an interactive insurance model
Shivani Ranchod	Insights Actuary	Actuarial scientist specialising in health sector	Health sector - actuarial consultancy	Professional contact while working in senior wellness. Ms Ranchod gave talk at St Luke’s Hospice on her co-	Ms Ranchod would provide insight into the regulation and organisational structure of the private healthcare insurance of South Africa, which was the

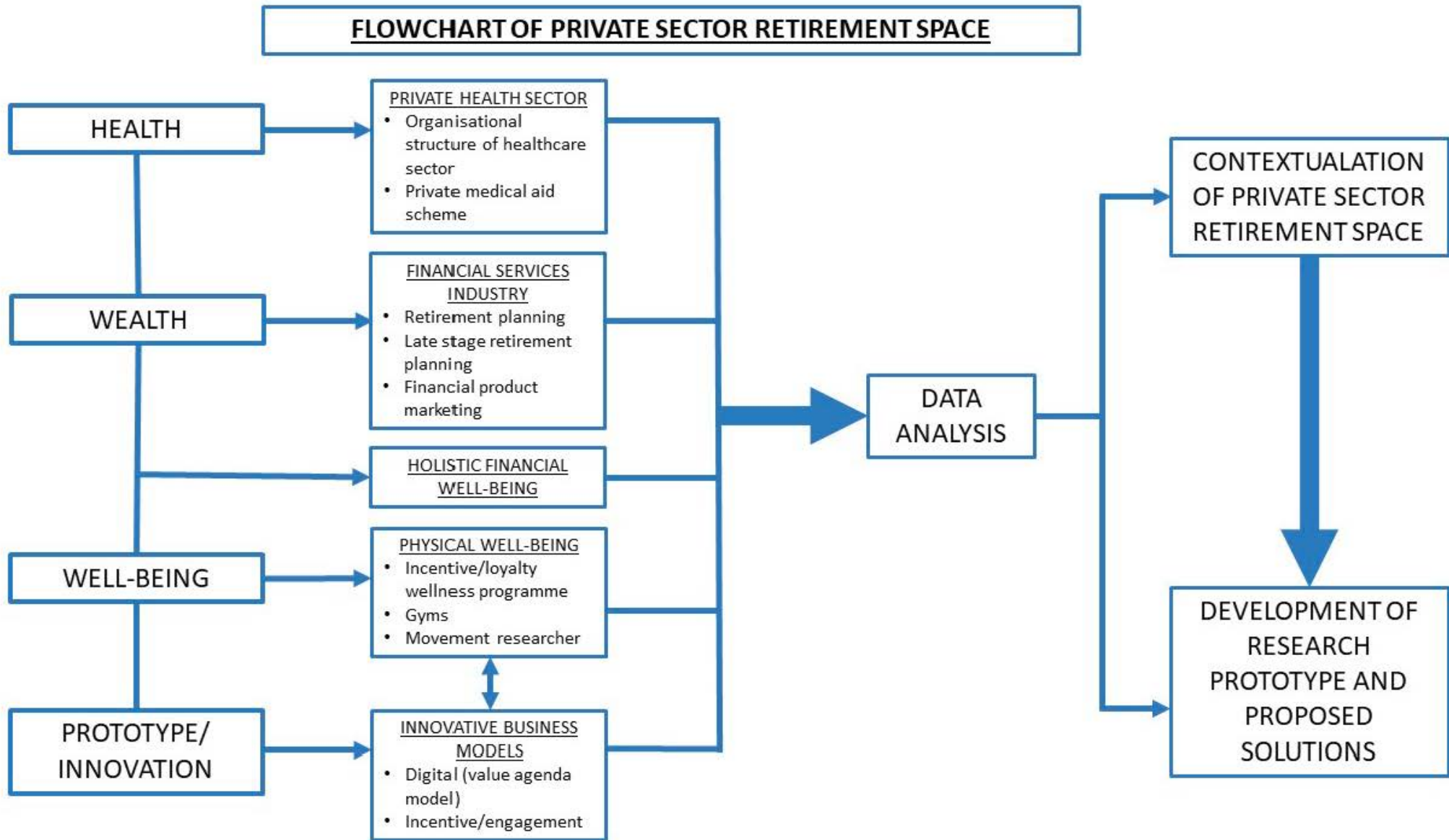
Name	Organisation	Role	Industry	Contact	Reason for inclusion in research
				authored paper - <i>An actuarial perspective on healthcare expenditure in the last year of life</i>	specific area of focus for the research and pertained to the constraints of implementing a senior wellness programme in the current private healthcare sector.
Cindy Petrie	Marriott Investments	Senior Investment Consultant	Financial Services Industry	Referral through professional contact in the financial services industry.	Marriott markets itself as: "The Income Specialists [who] aim to reduce financial anxiety of retired investors by offering Solutions for Retirement, using an Income Focused Investment Style which produces reliable and consistent monthly income". Ms Petrie would provide pragmatic insight into the retirement fund market.
Robert Adshade	Alchemy Financial Advisors	Independent financial advisor, co-founder of Alchemy Financial Advisors	Financial Services Industry	Referral through Alchemy Financial Advisors' client	Alchemy Financial Advisors assists clients to prepare financially for retirement. Mr Adshade would provide insight into how to guide clients through

<b>Name</b>	<b>Organisation</b>	<b>Role</b>	<b>Industry</b>	<b>Contact</b>	<b>Reason for inclusion in research</b>
					their financial management and planning.
Dr Laurie Rauch	UCT – Exercise Science and Sports Medicine	Researcher	Health sector – sports science	Referral via professional contact at the Institute of Ageing	The development of a senior wellness programme would entail collaboration with exercise and sports medicine researchers. Dr Rauch’s insight would add value to the development of the research prototype.
Anne Macdonald	Personal Trust Financial Advisors	Client Wellness Advisor	Financial Services Industry – special interest in client’s health and well-being	Professional contact while working in senior wellness.	Personal Trust Financial Advisors recognise the importance of their clients’ health and well-being and the implications of this on their financial planning. Ms Macdonald’s insight would benefit the value agenda model and the implementation of the prototype.
Dr Belinda Richards	Metropolitan Health Group	Executive hospital risk manager and	Health sector – private healthcare insurer	Referral from Shivani Ranchod.	Dr Richards has had many years’ experience in the private healthcare insurance industry in

<b>Name</b>	<b>Organisation</b>	<b>Role</b>	<b>Industry</b>	<b>Contact</b>	<b>Reason for inclusion in research</b>
		clinical epidemiologist			South Africa. Dr Richards would provide insight from the point of view of the healthcare insurer which would add value to the implementation of the prototype. Views held by Dr Richards and not Metropolitan Health Group.
Hilary Henderson	Independently employed	Retirement life coach and author	Retirement arena	Referral from Anne Macdonald, Personal Trust.	Ms Henderson assists clients transitioning into retirement. Ms Henderson would provide insight into the nuances of retirement.
Johann Strauss	Virgin Active	Club General Manager	Fitness Industry	Virgin Active contacted directly.	Virgin Active has an established relationship with Discovery and the Vitality model. As one of the largest partners of Vitality and it is a major player in the fitness aspect of Vitality. Mr Strauss's insights would be valuable for the development and implementation of the research prototype.

<b>Name</b>	<b>Organisation</b>	<b>Role</b>	<b>Industry</b>	<b>Contact</b>	<b>Reason for inclusion in research</b>
Claire Cowan	Sports Science Institute of South Africa (SSISA)	Customer Relations Manager	Fitness Industry	SSISA contacted directly.	SSISA offers tailor made exercise programmes to older members and members with chronic conditions. Ms Cowan would provide insight which would benefit the design and implementation of the research prototype.

**Appendix 4: Flowchart of private sector retirement space in South Africa**



## **Appendix 5: Professional research participant one-on-one interview outline**

1. Describe your organisation's vision, mission and purpose.
2. What are the origins of your organisation? (How did it start?)
3. What is your background?
4. What role do you feel your organisation fills in the ageing sector?
5. Describe how your organisation engages/supports older clients in maintaining their good health and wellbeing as they age.
6. What market research does your organisation do in the development of services and products for older consumers?
7. What marketing tools do you find most effective in communicating with older clients?
8. What have been your notable successes and why?
9. What have been your notable failures/challenges and why?
10. What partnerships and/or collaborations has your organisation currently or has been part of?
  - a. What were the successes and why?
  - b. What were the challenges and why?
11. What research & design and innovation do you feel is going to have the greatest impact on the ageing sector in the future?
12. In closing, what would you say is the most pertinent thing to remember from our conversation?

## Appendix 6: Summary of older research participants' responses

Question	Response	Participant
<b>1. What are the pros and cons of being in this stage of your life?</b>	<ul style="list-style-type: none"> <li>Pros: great age – few responsibilities, can do what I like, a lot of interests that I can pursue</li> <li>Cons: car was stolen but probably should have stopped driving by then anyway. Not driving is like “losing a limb”</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>Pros: Very happy to be at this stage of my life</li> <li>Cons: To be self-motivated, have to create own structure</li> <li>Loneliness -&gt; have to plan for retirement -&gt; travel or volunteer</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Pros - no more real responsibility</li> <li>Cons: started about 5 years ago - lose what used to be considered normal – get tired, no strength =&gt; frustrated, find things more difficult to do. My kids say...” you’re not old Mom” but I say I can’t do this anymore</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>Freedom, boredom and health</li> <li>Loneliness – aspect of spending too much time on your own</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>“A pro would be flexibility timewise BUT linked with that is a con – which is you can slip into bad habits, waste time, wake up late, be lazy – but retirement doesn’t have to be about achievement.”</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>I have no worries – consider myself to be exceptionally fortunate but I have a lot of friends who have financial worry</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>Nice to not have the commitment</li> <li>No downsides really because I am financially stable – it all goes down to finances</li> <li>All goes down to money – biggest fear</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li><i>{big sigh}</i>... ”Precious few pros”</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>Cons: energy levels are lower and body doesn’t do what it used to do.</li> <li>Pros: “The biggest pro is that I am financially stable and that is entirely thanks to my husband”</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>Pros: definitely far less stress. “What was stressful at first was wondering if I had enough money to see me through”</li> </ul>	#12 (80-year-old, white, male)
<ul style="list-style-type: none"> <li>Pro: Enjoy seniors group that they run</li> <li>Con: Immediate family doesn’t visit much</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)	

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Cons: more sick than healthy</li> </ul>	# 16 (78-year-old, coloured, female)
<b>2. What are challenges and motivations for maintaining good health and wellbeing?</b>	<ul style="list-style-type: none"> <li>• Motivations: enjoy it, started at 40, keep bones strong – had back surgery, Pilates - spoke of pain that she experienced but gone since Pilates class</li> <li>• Challenges: Need a group to feel that belong.</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Motivations: Grandchildren</li> <li>• Challenge: To exercise, to keep moving, to keep fit &amp; healthy. Still does Run/Walk 4 Life – try to be disciplined. She has a fear of falling too far away from starting point of Run/Walk 4 Life</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Motivations: Well-being comes from mixing with other people. I don't get enough of that. At this age – friends die.</li> <li>• Challenges: Apply self-discipline</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Motivations: The benefits – it's an essential part of life. To be healthy and active. To not decline into a blob and ultimately be a pain for others.</li> <li>• Challenges: Like cycling – my son brought me a bike – but the roads aren't safe and I can't do that alone. I like walking and aerobics class, but I had a foot op.</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• I am an up and down kind of person – unmotivated this year...<i>AB ask what would motivate you to get out of low biorhythm?</i> “An event.... Maybe a shock, a fall. “a health scare”</li> <li>• The object is to live as long as possible in the right frame of mind</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Motivations: Health – I go to gym twice a week with personal trainer. Cycle every weekend.</li> <li>• No challenges because I am very healthy</li> <li>• “I admit I can't do the things like I used to – I used to go kloofing but I have lost my ability to hop and so lost confidence as I don't want to fall. Hesitant to put myself in danger”</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Challenge: Problem with osteoarthritis in both knees and shoulders</li> <li>• Problem is living alone – boredom.</li> <li>• “What would be good is a heart attack to finish me off. But I am too healthy.”</li> <li>• “I do still have self-respect and independence – so make sure I maintain my health.”</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Challenges: going to the dentist way too much. Doctor recommended she go to physio for broken thumb but “sorry I don't have the budget”</li> <li>• “Can't gripe” -&gt; arthritis {<i>shows AB her fingers</i>} – “I drop things and it drives me crazy”. I am very determined but part of me says “I can't be bothered”</li> <li>• Very conscious about money – so won't go for physio</li> </ul>	#11 (70-year-old, white, female)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Motivations: Very routine. Every Monday evening – meet friends in Keurboom Park – lovely chatting to friends, try never miss it. Every Tuesday walk in Kirstenbosch – free for seniors. <i>{spoke a lot about enjoyment of walking and social aspect}</i></li> </ul>	
	<ul style="list-style-type: none"> <li>• Challenges: 1) costs of gyms – R700/month 2) devoted time to exercise is tedious</li> <li>• challenge is discipline</li> <li>• Motivations: want to remain reasonably healthy</li> <li>• “If people want to live longer they need to have interests”</li> <li>• “Having a faith – don’t knock it for wellbeing” Meditation is also very good.</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>• “Just because I want to be well and alive...to a large extent I have been influenced by those who have remained fit and well into old age.”</li> <li>• <i>{spoke a lot about friendships/relationships connected to gym &amp; aqua aerobics class}</i></li> </ul>	#13 (88-year-old, white, female)
<b>3. Tell me more about your financial planning: pre-retirement and post retirement.</b>	<ul style="list-style-type: none"> <li>• 2 goals 1) retire with fully paid off house &amp; 2) adequate pension</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Minimal savings</li> <li>• No investments</li> <li>• <b>** property**</b> - seen as the major source potential income in future because of asset</li> </ul>	
	<ul style="list-style-type: none"> <li>• When husband died – pension was halved.</li> <li>• “Terribly bad at finances”</li> </ul>	#2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Worst – didn’t think about financial planning. My husband and I didn’t start and regret that</li> <li>• Bought first property at 50 – struggle.</li> <li>• Scared to touch capital, became more frugal</li> </ul>	#3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Sold flat to daughter and son-in-law – she has invested that money and lives off that. “Hopefully I will die before the money runs out”</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Always been very concerned with saving money. In addition to pension at work – made contribution to annuity above and beyond pension fund.</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>• “Zero planning” – retired off teacher’s pension</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Divorced at 38 – one year later took out an Retirement Annuity. Not the biggest saver</li> <li>• “I have my flat – probably get R1.6million – but if I sold it where would I go?”</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Always knew I would extract “pension” from entrepreneurship</li> <li>• “Anyone who works for pension fund is crazy”</li> <li>• Life insurance – not over age 65</li> </ul>	#8 (69-year-old, white, male)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Did own investments</li> <li>• Didn't have a pension fund – didn't want to be subject to rules and legislation -&gt; didn't want government making my decisions</li> <li>• “When people retire – their income reduces but not necessarily expenses”</li> <li>• He says of other older people... “Cost of rates etc keep going up – asset rich and cash poor”</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Had to take early retirement – not great pension fund</li> <li>• Deceased husband's pension fund pays for medical aid</li> <li>• She has cut down insurance expenses</li> <li>• House is paid off – but rates keep going up etc -&gt; everything gone up – makes me nervous</li> <li>○ A little bit in denial</li> <li>• I have made adjustments – I'm not living off cat food – but the anxiety is there</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>• HUGE! Pre –saved as much as I could</li> <li>• Husband takes care of all monthly expenses -&gt; he looks after us, there is never a worry and this is huge</li> <li>○ <i>{#11 got married at 57 for first time}</i> “If not married – then wouldn't feel financially secure. Wouldn't have sold flat and would have kept working”</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Good on financial planning side - &gt; creating silos of money</li> <li>• “I think there are a lot of people who are drawing down too much to last them their lifetime”</li> <li>• “Financial planning – most people – especially women don't have a clue” Mentioned a few times how “clueless” women are about money <i>{#12 spoke a lot about IFA fees, withdrawal down on capital – very interested in the financial aspect of retirement}</i></li> <li>• “1<sup>st</sup> year of retirement – big panic – jeez got 35 years to live!”</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Pension was miserable – R20k/month</li> <li>• Investments came out of salary</li> <li>• Didn't have vast expenses – not like today</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Got dept. of education pension. was optional – you have to agree to sign up.</li> <li>• No regular savings account</li> <li>• When working – no savings only contributed to pension fund. If he dies – then his wife will get ¾ of pension fund. “An assurance that she won't be destitute”</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
	<ul style="list-style-type: none"> <li>• Living off pension fund through dept of education</li> <li>• Had few policies – but cancelled</li> <li>• Have a funeral policy – Momentum – pay out of pf for policy</li> </ul>	# 16 (78-year-old, coloured, female)

Question	Response	Participant
4. Describe your health care management.	<ul style="list-style-type: none"> <li>Key issues – major hospital costs</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>When younger – just hospital plan – served us very well</li> <li>Realised needed a more comprehensive plan as age</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>What worries me the most is the medical expenses at this stage of my life.</li> <li>My major worry is how can I afford it – you need to be extremely rich.</li> <li>I’m not convinced – never understood – people say to me, you can’t <i>not</i> have medical aid – but it costs me so much and what does it give me?</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>Worried about “pre-diabetic” been warned by GP - “didn’t see point of all of this” -&gt; logically he sees the point but emotionally not sold on it yet. <b>tell me more about this emotionally?</b> If not well, you see the symptoms but there is no obvious “anything”</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>Foot surgery - hard to ask people for help – humbling to have to accept. Doesn’t have a lot of family but largely church based friends or neighbours.</li> <li>“Church family”</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>With hospital plan – only cover care in hospital – so only used hospital physio – had to do own rehab – only thing I can’t do is kneel – just blessed I am not crippled</li> <li>Have got to talk to specialist and negotiate. I have learnt – advantage of age – not frightened to ask question or voice an opinion.</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>Does do preventative screening – is part of vitality</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>Did analysis of it and decided on a hospital plan</li> <li>Have sufficient funds to cover small expenses</li> <li>Savings plan – no benefit (<i>he felt very strongly about this – he described how you get less money back on payments and it’s your own money</i>)</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>Had a low bone density. Luckily no falls – Personal trainer taught me how to fall.</li> <li>“Exercises did give me increased confidence, agility and coordination”</li> <li>“I feel healthy which is upsetting as I don’t want to get to 90 odd”</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>Concerned about dementia, healthcare costs increasing – a lot of people are taking gap cover because only afford hospital plan</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>Obsessed with keeping well – very concerned...“there is nothing more relevant than looking after your health”</li> </ul>	# 13 (88-year-old, white, female)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• He is a member of medical aid. They can't afford to have her on</li> <li>• He is guilty that he is on medical aid and his wife is not, but worried that if he goes off medical aid then he will fall ill</li> <li>• "You know what state hospitals are like. You have to wait and hope for the best".</li> <li>• Most people who I speak to say "Don't stop medical aid. You must keep medical aid."</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
	<ul style="list-style-type: none"> <li>• When stopped working – couldn't afford medical aid – had to go to day clinics – did tests – had high BP and Diabetes.</li> <li>• At day clinic – found high blood sugar – went to hospital – son come to hospital – found mother in hospital – hadn't been fed etc – son put her immediately on medical aid</li> </ul>	# 16 (78-year-old, coloured, female)
<b>5. What medical aid scheme are you a member of? What plan?</b>	<ul style="list-style-type: none"> <li>• Discovery, Essential Comprehensive. Would never be on just a hospital plan</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Rhodes University – own medical scheme</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>• FedHealth – full comprehensive with added bit of extra cover</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Discovery. Basic plan – coastal plan – just a hospital plan – cheapest – based on cost.</li> <li>• I don't understand jargon of medical aid – it is all on the internet</li> <li>• Can't be bothered to look at screen and don't get around to printing it off and reading it</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>• AdMed (Guardian) – medical gap insurance <ul style="list-style-type: none"> <li>▪ Pay for hospital related costs not covered by medical aid</li> </ul> </li> <li>• Discovery Coastal Saver</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>• 2<sup>nd</sup> highest plan – Emerald for benefits. Hospital plan, dental</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Genesis – hospital plan</li> <li>• Has gap cover with Liberty Life</li> <li>• Gap cover is worth it, pay difference in MA cover costs</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Discovery – Classic Comprehensive</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>• BetOne Network Best Med – R1800/month</li> <li>• Did analysis and chose BestMed</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Resolution Health – Millennium Plan – middle</li> <li>• "The trouble is, they argue about everything"</li> </ul>	#10 (71-year-old, white, female)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>MA give you annual sum (<i>savings account</i>) and then that's depleted it's gone - "bloody swines"</li> <li>"I've heard of gap cover – casually heard of it – but apparently they won't take over 70s"</li> </ul>	
	<ul style="list-style-type: none"> <li>Engen – fully comprehensive</li> <li>AdMed – gap cover – often needs it – top up</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>"A lot of Doctors charge more than MA rates"... {<i>Speaks about increase of medical aid costs – "up to 18%"</i>} Stratum – gap cover</li> <li>OM no longer covering costs of joint replacements</li> <li>OM – hospital plan – only willing to afford</li> <li>"As you get older – are you getting penny wise and pound foolish?"</li> <li>Sublimit eg: dentistry – "still out of pocket because need to fund yourself"</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>GP advised that she move to private medical aid..."easier for my GP if I am on a private medical aid"</li> <li>GEMS – "<i>don't really know what the hell is going on</i>"</li> <li>"Can't talk to MA – they promise you the world and you never hear from them"</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>GEMS – Hospital plan</li> <li>"It's only peace of mind – because still healthy"</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
	<ul style="list-style-type: none"> <li>On son's medical aid – GEMS Emerald option</li> </ul>	# 16 (78-year-old, coloured, female)
<b>Vitality...</b>	<ul style="list-style-type: none"> <li>Don't like loyalty programmes</li> <li>Preventative screening – encouraged by wife &amp; daughter because of points</li> <li>Vitality screening – said lose weight &amp; GP said lose weight. Vitality give no guidance</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>Too complicated to figure out. It's a computer thing. It makes me cross because I could get the discounts but I can't figure it out</li> <li>"Vitality isn't interested in me"</li> <li>"Why? It's going to cost me so much more money – it comes down to cost"</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>Doesn't use Vitality because it costs money</li> </ul>	#5 (75-year-old, white, female)
	<ul style="list-style-type: none"> <li>Diamond status – only through focusing. My wife has spearheaded it.</li> <li>Don't know why – it's too complex</li> <li>Does do preventative screening – is part of vitality</li> </ul>	#8 (69-year-old, white, male)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• My Vitality age is 71 – but that is mostly down to weight</li> <li>• Maybe my GP should know about my Vitality score</li> <li>• No incentive from money – rather pride – are you proud of yourself?</li> </ul>	
<b>6. Describe the role of financial planning with regards to your health and wellbeing?</b>	<ul style="list-style-type: none"> <li>• They should – but procrastinate. Has taken into account standard medical expenses</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Don't think about it too much. left it to financial planner</li> <li>• Trouble starts when you fall. The start of the rot is falls.</li> <li>•</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Not enough financial planning – only their medical aid.</li> <li>• Spending money on going to gym and trail run races</li> <li>• Very important to healthy eating and exercise</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• “Major worry is health – how am I going to cover it and how am I going to live?”. Health and finances are biggest stress.</li> <li>• “Expense that I can ill afford”</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Have sufficient capital to not have to worry</li> <li>• “I have illogical belief in my survival for some time to come”</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Don't think about it to be honest – sounds irresponsible</li> <li>• “I'm guilty of that, I am active, healthy but need to accept that I may not be like that forever”</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• If stopped working – would have to give up Genesis (medical aid)</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>• “This is the whole point – must keep up exercise and healthy diet – so I don't have to occur medical expenses”</li> <li>• “From financial point of view – I have got to keep a healthy as possible”</li> <li>• “It all costs money” eg: uber because can't drive <i>{getting lifts to Helen Keller support group}</i></li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>• HUGE! Husband is so particular about money – even if it relates to health.</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>• “A friend of mine is an engineer. He sent me the spreadsheet which figures out costs of stroke and related costs” <ul style="list-style-type: none"> <li>• Input data page and anticipated inflation plus expected rate of return</li> </ul> </li> <li>• “Financial sector and healthcare sector should communicate more, but big companies don't do radical thinking and change”</li> </ul>	#12 (80-year-old, white, male)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>Valuable thing to do. I haven't planned in advance. Afraid I didn't allocate specifically</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>Luckily son and daughter have good jobs – so son pays for medical aid</li> </ul>	# 16 (78-year-old, coloured, female)
<b>6a. What impact would illness have on your financial situation?</b>	<ul style="list-style-type: none"> <li>House is an asset – so would use the proceeds of sale to cover necessary costs</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>Play havoc – wouldn't be able to live on own.</li> <li>Don't give it much thought – because I know I should plan ahead but I'm not a negative thinker</li> <li>I believe I won't be faced with that kind of dependency.</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>"I know I've got enough to last to 91 – so if I had a stroke etc make it to 86. So don't have anxiety and worry"</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>I don't think about it because there will always be enough</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>"It's sounds ludicrous that I pay R982/month for peace of mind and chronic medication"</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
<b>6b. Have you done any research regarding health related costs in later age?</b>	<ul style="list-style-type: none"> <li>I have heard term "health span"</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>Never researched – just know that I had to have enough</li> <li>It's relevant to correlation between financial planning – if financially secure -&gt; can afford it so its relevance is marginal</li> <li>Our new house has a flat for a caregiver if need be – so yes, we have made provision for that</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>laughs – "old people's things" – haven't sat down and done the sums – but get a feeling that I have enough capital</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>"No, no. I do it adhoc basis</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>No not really – but have practical experience from friends</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>Not really – take it one day at a time</li> <li>CPOA – supply frail care centre – part of contract</li> </ul>	# 16 (78-year-old, coloured, female)

Question	Response	Participant
<b>Retirement villages</b>	<ul style="list-style-type: none"> <li>RV - just old people {<i>made a funny face</i>}</li> <li>Grow old too quickly – spoke of friends who are the same age but have aged so rapidly since living in RV</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>“Old age homes in RSA are pathetic. They are either very expensive or dreadful”</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>Don’t want to go to RV. Just carry on as I am - if I get crippled then make a plan</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>“I will leave my flat with my feet first”</li> <li></li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>Doesn’t appeal to me but applied for “just in case”</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>Had name down at PineWood before I turned 70 but cancelled that because of R2k deposit.</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>Put name down at Woodside</li> <li>So proactive – absolute necessity of caring for self in last years</li> <li>Approx. R2k for deposit at Woodside but can’t afford deposit at another place</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>Lots of frail care places with CPOA – so Berghof moves residents to frail care</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>CPOA frail care higher than pension, so children have to pay in</li> <li>State homes...” dread if I must go there someday” – (#15 wife)</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
<b>7. Who do you seek advice from with regards to your financial and health decisions?</b>	<ul style="list-style-type: none"> <li>Financial: not sought advice</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>Long relationship with IFA</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>Spoke to IFA who special in people of pensionable age. Helped reduce life policies. Warrick – special home insurance for over 50s.</li> <li>Very beneficial to work with advisors who specialized in retirement</li> </ul>	# 3 (68-year-old, white, female)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Objects to financial planners – none of the financial planners want to deal with medical aids, it’s too much admin for them - IFAs are not interested.</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Have medical broker - need to have a good broker</li> <li>• Financial: Read press, subscribe service</li> <li>• Fees – doesn’t believe in fees.</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>• IFA at Liberty</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Financial: spoke to a broker for policies.</li> <li>•</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>• IFA – hate them, worse than car salesmen</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Finance: Investments I do on my own – reading, listening</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>• Finance: husband deals with finance side. Goes to IFA. Get info from friends, radio, talks</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>• Finance: seek “confirmation” from friends – talk generally. One friend very clued up -&gt; says don’t change. Article in Allan Gray – negative impact of switching.</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>• “What financial advice? Just be wise” (#14-husband)</li> <li>• “When we’re debt free, I would like to have a little capital to cover my healthcare expenses that may occur.” (#15 – wife)</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
<b>8. What digital/technology/media do you engage with the most?</b>	<ul style="list-style-type: none"> <li>• Majority of participants prefer email as form of communication.</li> <li>• A few have smartphones.</li> <li>• Four participants use no technology at all</li> <li>• Two participants spoke about really enjoying technology</li> <li>• Three participants spoke of enjoying social media (mostly Facebook for keeping in contact with friends and family.) However most of the other participants were scathing of social media)</li> </ul>	

Question	Response	Participant
<b>9. What support do you feel you will or currently need to maintain your independence and keep a good quality of life?</b>	<ul style="list-style-type: none"> <li>Allowed to have a carer at her retirement village, has a frail care – but don't want to go there.</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>What scares me is how long will I be able to earn</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Spoke of experience of looking after elderly clients with Dementia in UK</li> <li>“Don't revive me”- let me go – especially if I have dementia</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>Assume you can get around – I have a little car, so for now it's easy</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>QoL – good relationship with son – very important</li> <li>Being able to drive is good.</li> </ul>	#7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>Mother-in-law got Alzheimers – she went into a nice home – but no money would have made a difference.</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>{big sigh} “Trying to rely on myself hate to be dependent”</li> <li>Live on own, because of eye sight daughter employed a helper once/week – she is a driver and has training as a caregiver – she is “part of family” really wonderful – she drives for her.</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>A vehicle. Pray to have wisdom to know when to stop - &gt; everyone fights to maintain your independence</li> <li>Health – if I lose my memory “let me go”</li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>“What happens when I can't drive anymore??? Wonderful thing of freedom ...gives you independence. Hard to conceive for me not to be independent.”</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>“In coloured communities – don't have much support from adult children”- #14 – husband</li> <li>#15 (wife) talks about State homes – “dread if I must go there someday”</li> </ul>	# 14 (80-year-old, coloured, male) & # 15 (77-year-old, coloured, female)
<b>10. What have you done in your life that has made this stage of your life more enjoyable?</b>	<ul style="list-style-type: none"> <li>Important for young people to know that what they do when they're young can colour their old age</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>Raise my children – loved them and been there for them</li> </ul>	#4 (73-year-old, white, female)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>Lifelong learning – why U3A is good.</li> <li>Big fan of MOOC.</li> </ul>	#5 (75-year-old, white, male)
	<ul style="list-style-type: none"> <li>Having a wide range of interests</li> <li>Valuing friendships</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Got an education and daughter and granddaughter – they are the great joys in my life</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>I am independent but brings with it its own loneliness</li> </ul>	# 13 (88-year-old, white, female)
	<ul style="list-style-type: none"> <li>Giving to other people – that is what I like to do.</li> </ul>	# 16 (78-year-old, coloured, female)
<b>11. In closing, what would you say is the most pertinent thing to remember from our conversation?</b>	<ul style="list-style-type: none"> <li>First year into retirement, so it is a year of transition – not putting pressure on myself</li> </ul>	#1 (65-year-old, white, male)
	<ul style="list-style-type: none"> <li>Younger people – start thinking of your retirement the minute you start working</li> <li>Need money to do what you want to do – biggest stumbling block – can’t socialize</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Fear of dementia</li> <li>Question of health and finance is a big concern</li> <li>Independence – ability to drive</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>“No planning just blessing” don’t know how people cope without it</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Very important is the support of your family</li> </ul>	# 7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>Too late to do financial planning in old age- but young people should plan early</li> <li>Keep active – physically and mentally</li> </ul>	# 9 (74-year-old, white, male)
	<ul style="list-style-type: none"> <li>Important for people to take responsibility for themselves – both older and younger generation</li> <li>Value independence – don’t be a burden on anyone</li> </ul>	#10 (71-year-old, white, female)
<b>Loneliness</b>	<ul style="list-style-type: none"> <li>Biggest thing is loneliness -&gt; need to plan to busy (when asked about technology)</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>On principle, I walk to the shops -&gt; make a point of going to Cavendish (mall) Otherwise I can stay in my PJs all day – sometimes I could be bothered.</li> <li>Don’t have many friends – most left RSA</li> <li>Haven’t made new friends – it’s my fault I know.</li> </ul>	#4 (73-year-old, white, female)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>Loneliness – aspect of spending too much time on your own</li> </ul>	#5 (75-year-old, white, female)
	<ul style="list-style-type: none"> <li>Loneliness – there are times, when people are busy -&gt; eg: love to go to Stellenbosch – then would need to find people who are available – then loneliness does creep in</li> <li>Learnt to play scrabble alone – but it’s not the same</li> </ul>	#6 (68-year-old, white, female)
<b>Burden Anxiety</b>	<ul style="list-style-type: none"> <li>Is a little bit scary. Extremely independent and don’t want to become a burden</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>It’s how life works now – your children caring for their own children and their parents – huge stress on a young couple. Nobody wants to be dependent</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>“I haven’t put my name down at frail care.” “I don’t want to burden my adult sons”</li> </ul>	#6 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Son is 61. I would hate to be a burden on him</li> <li>“Hope to go in my sleep”</li> </ul>	# 7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>Not going to be a physical burden</li> <li>Our new house has a flat for a caregiver if need be – so yes we have made provision for that</li> </ul>	#8 (69-year-old, white, male)
	<ul style="list-style-type: none"> <li>“Paid my way all my life – I don’t want to be a financial and physical burden.”</li> </ul>	#10 (71-year-old, white, female)
	<ul style="list-style-type: none"> <li>“I have a fear...please God my may health continue to be good”</li> </ul>	#11 (70-year-old, white, female)
<b>Social Engagement</b>	<ul style="list-style-type: none"> <li>Friendships through playing bridge three times per week</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>Gym – also a source of social engagement.</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>U3A - “thought it was a jolly good idea” -&gt; like being educated, looked into U3A for educated peers</li> <li>U3A – thinks it’s more about social.</li> </ul>	#5 (75-year-old, white, female)
	<ul style="list-style-type: none"> <li>Has regular bridge friends</li> </ul>	# 7 (83-year-old, white, female)
	<ul style="list-style-type: none"> <li>Keep physically and mentally active</li> <li>I like talks at U3A, hiking groups. “U3A people feel old” – he laughs</li> </ul>	# 9 (74-year-old, white, male)

Question	Response	Participant
	<ul style="list-style-type: none"> <li>Motivations: Very routine. Every Monday evening – meet friends in Keurboom Park – lovely chatting to friends, try never miss it. Every Tuesday walk in Kirstenbosch – free for seniors. <i>{spoke a lot about enjoyment of walking and social aspect}</i></li> </ul>	#11 (70-year-old, white, female)
	<ul style="list-style-type: none"> <li>No problem with loneliness now – twice week hiking, volunteer for Meals on Wheels</li> </ul>	#12 (80-year-old, white, male)
	<ul style="list-style-type: none"> <li>Close friends – when you are young you are included. I still have a very social programme at this stage of life but the fact is as you get older your friends start having their own problems.</li> </ul>	# 13 (88-year-old, white, female)
<b>Immigration</b>	<ul style="list-style-type: none"> <li>Impact of older children living outside of RSA -&gt; children in UK – could send pounds if need be – more for the pound</li> </ul>	# 2 (94-year-old, white, female)
	<ul style="list-style-type: none"> <li>Negative effect. No one is around anymore. No family</li> </ul>	# 3 (68-year-old, white, female)
	<ul style="list-style-type: none"> <li>Dread to think of the thought of children not being around. RSA is complex – “live in paradise but pay for it”.</li> </ul>	#4 (73-year-old, white, female)
	<ul style="list-style-type: none"> <li>Great that adult children are nearby</li> <li>Those who can't afford to visit overseas children =&gt; stressful</li> </ul>	#8 (69-year-old, white, male)

## Appendix 7: Summary of professional research participants' responses

Question	Response	Participant
<u>Financial Services Industry</u>		
Values, vision and mission of organisation?	<ul style="list-style-type: none"> <li>You can't do things for people. You can only help them to see things for themselves.</li> <li>Powerful benefit in our service, is that we give people the opportunity to articulate</li> <li>The more fully present the planner/listener is the more helpful the process can be.</li> <li>Many women find that male advisors talk down to them or this person is waiting to for a chance to sell something</li> <li>Meaningful exploration about what the rest of your life holds for you and given your hopes, your dreams, even your aspirations your intentions your personal value system.</li> <li>In fact we do an exercise with clients where we encourage them to imagine how their life would be perfect. Where they are about to retire and what does this retirement look like? If you wake up on Saturday morning, what would Saturday hold for you, what would Sunday hold for you? What would Monday to Friday hold for you as a retired person? And we actually ask them to write it down and put numbers to it. – gives an example of imaging waking up on a Saturday morning and going for brunch with friends or family</li> </ul>	Kate Brown
	<ul style="list-style-type: none"> <li>Mutually respectable relationship.</li> <li>Importance of values – as long as I am being honest and treating their money as I would treat my own</li> </ul>	Robert Adshade
	<ul style="list-style-type: none"> <li>Short sighted to think you can advise without taking holistic picture into consideration</li> </ul>	Anne Macdonald
The role of the financial planner	<ul style="list-style-type: none"> <li>The job of a financial planner is to help you navigate your life and ensure that your financial affairs are ordered in such a way that your financial resources support the way of life that you seek to live and where through financial measures you don't fly in the face of your personal value system.</li> </ul>	Kate Brown
	<ul style="list-style-type: none"> <li>I do tend to get quite a bit of work with people entering retirement - can't go through this process without advice.</li> <li>Make sure he goes through this retirement process correctly and needs some scenarios planned for him.</li> <li>"Critical phase"? Where would you say that critical phase is? 5 years before, early 50s, late 40s</li> </ul>	Robert Adshade
	<ul style="list-style-type: none"> <li>But a lot of advisors are being the go between family and clients</li> <li>Many families are distant</li> </ul>	Anne Macdonald

Question	Response	Participant
How do you feel financial advisors speak with their clients about their health and well-being as they age?	<ul style="list-style-type: none"> <li>• KB gives an example of needing to buy a hearing aid - “More important to have a better hearing aid than to drive a more expensive car.”</li> <li>• Constant renewal and review of what really matters at this stage of my life.</li> <li>• “Serving the person” sort of approach is beginning to get some traction... boils down to in any financial planning firm at a crude level is the client the client or is the money the client?</li> </ul>	Kate Brown
	<ul style="list-style-type: none"> <li>• Since 2015 - been giving seminars on pertinent health issues at retirement villages</li> <li>• Huge positive response, interest &amp; follow up (positive feedback)</li> <li>• Has translated into getting new clients</li> </ul>	Anne Macdonald
Retirement Villages	<ul style="list-style-type: none"> <li>• Immigration...led to the birth of the retirement village. The rise of the retirement village is probably in inverse proportion to the rate of immigration.</li> <li>• Property - scale down - release enough capital from the sale of their home to help them to afford all of these other things which we know they may need if they live until they are old.</li> </ul>	Kate Brown
	<ul style="list-style-type: none"> <li>• I found that over the last 5 years my role has changed a lot where I found that I am talking a lot to people in their 50s &amp; 60s about retirement villages and caregiving.</li> <li>• What I have found myself doing is almost handing out brochures to be honest. In educating a lot of people are quite blinkered towards the concept. Essentially it is going to be an issue that they have to deal with it and if their children aren't going to take it on, then they will have to deal with it. And we live in a society where we are gung-ho on being independent, financially independent, and that is an issue they need to take care of.</li> <li>• It's not my mandate. My mandate is not to put their names down at a retirement village, but I can help them with the financial implications.</li> </ul>	Robert Adshade
	<ul style="list-style-type: none"> <li>• Talking about policies and incentives...What happens if it gives you exclusive access to a retirement village?... I'm just thinking out of the box here...</li> </ul>	Cindy Petrie
	<ul style="list-style-type: none"> <li>• Seeing increasingly people looking at live-in care</li> <li>• Defiant – not wanting to leave home</li> <li>• Not putting names down in RV and have no option</li> <li>• RSA has issue of security and lack of transport</li> </ul>	Anne Macdonald
Gender	<ul style="list-style-type: none"> <li>• Many women living on their own as widows... now need to solve their issue on their own. This is a thought that doesn't strike a lot of people.</li> <li>• There is often quite a bit of chauvinism out there. Men do the planning... but do they actually take into account that their wives might survive them by 20 years?</li> <li>• I personally get very upset when I ask a woman, how do you organize your financial affairs and she says my husband looks after it. And you say ok what will you do when he dies and she says,</li> </ul>	Kate Brown

Question	Response	Participant
	<p>well my children will do it. And I am thinking, are you never going to grow up and take responsibility for your own life? And that is what I call “<i>princess syndrome</i>” so you are waiting for the prince to come and wake you up. Only you don’t actually want him to wake you up. You want him to just be hovering around looking after everything all the time.</p>	
<p>Financial Services – pre-and-post-retirement</p>	<ul style="list-style-type: none"> <li>• Of course there transitions particularly in the retirement years, which the financial service industry is not interested in because they don’t involve you suddenly having a big lump of money to invest.</li> <li>• Very importantly if something very serious happens in the client’s life you have developed a relationship</li> <li>• We listen to what has happened and then we can see, does that have financial implications that we need now as financial planners to help you resolve.</li> <li>• Transition: all the dignity that comes from work and all the sense of status, self-worth and purpose that gives momentum and structure to your week. The minute you lose that and you are suddenly faced with the day and the week and the year, and particularly in this case, whatever you have accumulated financially, that’s it. You now have to make that last.</li> </ul>	<p>Kate Brown</p>
	<ul style="list-style-type: none"> <li>• Typical first meeting; discussing his needs, objectives, circumstances, retirement objectives</li> <li>• cashflow requirements.</li> <li>• I will paint 3 different scenarios for him – retire at age 60, 63, 65</li> <li>• One of the biggest assumption is that all of his debts are paid off</li> <li>• Monthly expenses what is he is going to have and how that might change going forward.</li> <li>• Unknown capex items - travelling and changing your car.</li> <li>• I don’t factor that it all the way to 95. To 85. Because it is unlikely that they are going on skiing trips at 86, or buying a new car.</li> <li>• Capital growth - relates with inflation.</li> <li>• I work with 8% inflation, 10% growth, a life expectancy of 95.</li> <li>• Property the vast majority of A+ income group would get to a point – somewhere in their 70s usually - want to downsize- release capital which I will take into account for planning.</li> </ul>	<p>Robert Adshade</p>
	<ul style="list-style-type: none"> <li>• With pension/provident funds – once you hit retirement age you are no longer their problem anymore. Then you are living off the capital.</li> </ul>	<p>Cindy Petrie</p>
<p>Medical Aids</p>	<ul style="list-style-type: none"> <li>• We’re not licensed to advice on them on individual medical aids - majority of our clients are in a medical aid by virtue of an employee relationship that has existed at some stage.</li> </ul>	<p>Kate Brown</p>
<p>Healthcare Plans</p>	<ul style="list-style-type: none"> <li>• People have a lower income and so they tend to be looking to cut costs...of course in their later years they will at some point almost certainly have a period of very high medical costs.</li> </ul>	<p>Kate Brown</p>

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• People have a period of being well and because of improved life expectancy that span of being well is longer, but there is still a span at the end of most people’s lives where their health is compromised and failing. Or they have become frail and infirm and need help and all those things.</li> <li>• Medical aid, as an assumption, we build in the most comprehensive medical aid possible. It is one thing we do not compromise on whatsoever. Sure, they might have a hospital plan, but we have to factor in that they might need to upgrade to a comprehensive.</li> </ul>	Robert Adshade
Financial Planning for healthcare expenses	<ul style="list-style-type: none"> <li>• We would highlight their medical aid contribution as a separate item and whereas their normal monthly expenses would escalate with either inflation of CPI or possibly CPI +, their medical aid contribution would be calculated at CPI +4.</li> <li>• Then for older clients, we generally have another item in the regular monthly expenses for medical expenses not covered by medical aid and so that should cover what we know they have got now, what pills and potions they’re taking and that those should be escalated to cover medical inflation being higher than average inflation.</li> <li>• Lifetime capital expenditure - expense as a chunk of money usually every three years from the age of 70. Which is for costs that may arise because your health is compromised in some way. Gives example of hip replacement</li> <li>• So that chunk of money, which we have allocated every 3 years. All of that and possibly more, might be used in the time of post-operative care.</li> <li>• So suddenly you have a cost that is not a medical expense per se but it is a cost that arises because you are not in your normal state of health.</li> <li>• You multiply the number of times you take out those chunks you find that for many people anywhere between R25k-R500k has been removed from the capital available to support their lifestyle.</li> <li>• We need to look at that quite carefully because of course that total sum is presumed to get to 100.</li> <li>• We don’t bring it up in conversation, it will cover the cost of nappies. So we don’t specifically have the conversation about nappies but there is additional provision made for those extra things you need as you age.</li> <li>• You are also giving me the idea that are we putting enough into that number where we provide for the extra things you need as you age in order to age well.</li> </ul>	Kate Brown
	<ul style="list-style-type: none"> <li>• Now medical inflation is obviously one of the items in CPI but it is not a big item.</li> </ul>	Robert Adshade

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Average client we have, in their baskets of expenses, medical aid will be an above average % to what CPI is. But I feel that I am covering that base by have a bigger % in there to cover that.</li> <li>• The makeup of the expenses is going to change. Generally speaking people in their 80s are spending money very differently to a person who is 60. A lot less for entertainment but a lot more health related issues.</li> <li>• A big part of the discussion is are you going to keep the same home - can release capital and that could be injected to up your income at that point.</li> <li>• I don't go into depth of the caregiver, but I do know that it is a R15k/month figure. ...So I will say do you see yourself getting your own private caregiver in? Do you see yourself going into a retirement village?</li> <li>• Release a R1million through changing of homes and it gives the capacity to pay for those kind of expenses.</li> <li>• I don't think the majority of people are aware or pay much attention to their cash flow requirements in their retirement and how it may change.</li> <li>• When it comes to healthcare solution – whether you age in a retirement village or at home – they are both going to cost money and they both cost about the same amount.</li> </ul>	
Life Expectancy & Healthy Life Expectancy	<ul style="list-style-type: none"> <li>• We assume 100.</li> <li>• The point is that if you have made provision for these things to be able to live to 100</li> <li>• If you get really ill in your early 80s - that provision you have made for all those expenses in your 90s. That capital can now be brought to bear on providing the things where financial resources can enhance your quality of life.</li> </ul>	Kate Brown
	<ul style="list-style-type: none"> <li>• As a default, I never go lower for planning than 90. I am urging more towards 95.</li> <li>• For a lot of clients, it is not something that they are comfortable talking about, so I have to use my intuition and I always err on the conservative.</li> <li>• I have a lot of clients who look at life expectancy of 95 which is built into my variables and they kill themselves laughing but I say rather have them there than not. I am building it in for your protection.</li> </ul>	Robert Adshade
Role of organisation in ageing sector	<ul style="list-style-type: none"> <li>• Perfect research opportunity because every day in this office a client comes for a review...we listen to clients...how they see the challenges they face or they talk about how a friend has coped with a particular situation...rich source of growing understanding and knowledge.</li> </ul>	Kate Brown
Burden Anxiety	<ul style="list-style-type: none"> <li>• What is a reality of our generation ...is more and more of our parents are becoming dependent on us.</li> </ul>	Robert Adshade

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Our parent’s generation, is that they are absolutely determined not to be a burden on their kids. But the sooner they face the reality, and I get myself involved in this quite often, because I can see the writing on the wall, I can see the numbers, they don’t want to face where it is going and I don’t want them to wake up at the age of 82 and they’re caught with their pants down. It’s also about dignity...need to be smart about these kinds of things rather than being reactive. I see that they don’t want to face it, they bury their problems</li> </ul> <p>Financial planning for prevention of “becoming a burden”</p> <ul style="list-style-type: none"> <li>• People think that they are bullet proof...I have factor capex and all sorts of things in. because it is almost like anonymous thing. I know that it might be used for a completely different purpose such as a car or an overseas holiday, but at least it is a contingency that is built in. but if I had to get into the detail, and it sounds bizarre – that you might be incontinent one day and need nappies – and this is a regular answer I have by the way, is “I would rather die and my children must just let me die.” And that is a regular answer that I will get. Not wanting to face the reality. So the best way for me to deal with it, is to make sure there is money there and there is a name next to it.</li> <li>• If I can single out the biggest thing retired people say to me, is that they never want to be a burden upon their children...And when I look at their money, I can see that they are absolutely going to be a financial burden on their kids – it is only a matter of time.</li> </ul>	
	<ul style="list-style-type: none"> <li>• You have got to show people that you are going to be less of a burden. It’s that word “burden”.</li> <li>• So with this policy – and if you follow these things, we will make sure that you are self-sufficient. You are not going to be dependent. And that’s a big thing as well, people do not like to be dependent on anyone.</li> </ul>	Cindy Petrie
	<ul style="list-style-type: none"> <li>• “Sad situation”- clients running out of financial resources or have no family</li> <li>• Facing dread of old age without necessarily support systems</li> </ul>	Anne Macdonald
Insurance/policies/ whealthcare	<ul style="list-style-type: none"> <li>• “Dread disease cover is sold ...to a much younger market.”</li> <li>• It’s an expense... when you look at your retirement planning exercise, you have to re-look at your budget. You have to cut down on those things that aren’t necessities. And one of those things is dread disease cover, which is an emotional buy. And a lot of people say, rather save that money and put it away and draw less income.</li> <li>• Ideally need to create something where dread disease benefit is funded post retirement.</li> <li>• By co-incidence this 62-year-old client has a discovery life policy...He has been paying a fat premium for something that he doesn’t actually even need... He actually needs dread disease cover, because if he had dread disease cover he is going only to be a financial burden on</li> </ul>	Robert Adshade

Question	Response	Participant
	<p>himself. If he is dead he is dead...that exact same benefit that he has got should be wrapped up by other companies but for dread disease.</p> <ul style="list-style-type: none"> <li>• There are financial burdens that some people might encounter, and some people might not encounter. So maybe it is Discovery who will create a dread disease benefit for retirement. But the thing is that people don't want to pay for it, it's expensive.</li> </ul>	
	<ul style="list-style-type: none"> <li>• At the age of 70, they are going to give you this this this and this. Things that are invaluable...are there things that are incentives at age 70? Everyone is so happy to sell me things at 50 – which is great. But what happens when I am really really old and I can't do any of the stuff for myself anymore? Is there going to be a safety net? And I know, that if I paid an additional X, and I know that I have got that that triggers automatically at 70 – then I will probably go for that policy.</li> <li>• What happens if it gives you exclusive access to a retirement village?... I'm just thinking out of the box here...</li> <li>• This is what Marriott does. We put in your capital amount. But if at the age of 70, (this is what Discovery is very good at – and if anyone is going to go for this it will be them) we will give you an out bonus. We will give you a payout – because at 70, you might have unforeseen things and you really might need it. So will guarantee you that you will get, I don't know 5% of your capital value.</li> <li>• The reason why you contribute to a pension fund is to get an income when you retire. So you sacrifice now to accumulate sufficient capital, so when you retire you will have adequate income for life. So what happens if you incentivize a product where by contributing to this you get a payout bonus at the age of 70 by adhering to all these things. So that would be one part – so your income would be boosted. This is what happens to people – when they get to the age of 70, inflation starts to decimate their income.</li> <li>• If you contribute to this, if you adhere to this, and follow the programme – then at age 70, when people really start stressing about income because they have retired and let's say someone retires on an income stream of R20k/month it might not always hedge inflation so we will guarantee that you will get an increase in your income. Big ticket words – people are very motivated by words like that.</li> <li>• This is like a tax thing. It's a grudge purchase.</li> <li>• You are never going to get someone to voluntarily contribute to this. It has to be something that is done at source, it has to be on my pay slip – going off with my UIF, with everything else - &amp; it needs to be in there with that column... There couldn't be any negative association with this.</li> </ul>	Cindy Petrie

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• This is just part of our package - so we are going to make it part and parcel of your 17% or 22% contribution that 3% goes towards this. Whealthcare solution</li> <li>• Everything I do is future planning. Nothing is tangible now.</li> <li>• Marriott has got an amazing tool. And on that tool, you can put in your current contribution and what your future outcome will look like. You have got to give somebody a future outcome. You have got to show it to them. You have got to proof it to them. Healthcare forecaster tool</li> <li>• This is going to be, same as me, selling Marriot products for people who are more middle to high end. This is not for the average South African. They do care, but they don't have the luxury of caring. They will work until their last breath. This is a very niche market but it is an up and coming market.</li> <li>• It's like asset management – people don't care if its equity or whatever – they just want to know that they are going to be safe, that they are going to be held.</li> <li>• You have got to start at source. 25 + up and running... Do you want to be a burden to your children – it's the same people that I am marketing to. Fees, tax. How do you come out at 65 better off here? And I have to prove it. And unfortunately, stats is the only thing – you have to show it, you have got to prove it.</li> <li>• Go speak to govt pension fund – they are the ones who have got to carry the brunt of it at the end of the day. Marriott is now part of govt pension fund. We see the big picture. I mean if you went to speak to govt pension – think of the obesity in our country. It's a huge scratch – it's the beginning of something.</li> </ul>	
	<ul style="list-style-type: none"> <li>• Long-term care insurance: the argument is that it isn't feasible...to get people to insure against some of those costs related to old age is almost impossible.</li> <li>• You need to sell it in the working years – you can't sell it once people are already old.</li> </ul>	Shivani Ranchod
Retirement Identity	<ul style="list-style-type: none"> <li>• “If you have a purpose when you retire you'll retire happier and adjust more easily”</li> <li>• That's what work gives you – structure. Suddenly you need structure in place</li> </ul>	Hilary Henderson
Closing	<ul style="list-style-type: none"> <li>• I don't know how you put a monetary value on the type of relationship we have with the vast majority of our clients.</li> </ul>	Kate Brown
<u>Incentive/Loyalty/Wellness Programmes</u>		
Discovery/Vitality	<ul style="list-style-type: none"> <li>• They are trying to make it attractive to young people</li> <li>• Vitality is the heart beat.</li> <li>• Affect the premium you pay for life insurance.</li> <li>• Highly complex product. They made a product which from an actuarial point of view is incredibly complex and from a marketing perspective has got a glitzy brochure.</li> </ul>	Robert Adshade

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• They have got really good products. And they seem to be addressing real concerns.</li> <li>• Vitality has been their way of navigating through the medical aid scheme act. Started with gym memberships</li> </ul>	
	<ul style="list-style-type: none"> <li>• a dual purpose. So the one is the wellness aspect but the other is that it has worked as a powerful selection tool... marketed to the young and healthy, it's never really been targeted at older members.</li> <li>• Because medical schemes have to accept everybody and charge everyone the same premium, it's hugely detrimental to attract the old and sick. Because you have to charge them the same premium as everybody else but they claim more.</li> <li>• So vitality ITO the benefits offered, the tech aspect, the way it's marketed. All of that is targeted to the young and they will never make it attractive to the old. Because they will do damage to the scheme if they do. They might say it, because it is the right thing to say but their primary concern is selection, their secondary concern is wellness.</li> <li>• The beginning of Vitality –</li> <li>• Vitality was created before the medical aid schemes act.</li> <li>• Vitality was a separate product but they sold them together.</li> <li>• If you were old and sick and you didn't want this extra thing.</li> <li>• It was this compulsory programme.</li> <li>• You only sign up for it if you figure you are going to get more money out of it than you are going to put in.</li> <li>• In the early days it was a very much a way of attracting the young and the healthy. So the gym, and the movies – which are not attractive to older members.</li> <li>• Vitality business model...</li> <li>• You pay a premium and they use that to offset the costs of providing benefits.</li> <li>• Vitality links it all together. You also get discounts on life insurance etc. and the only reason why they can do that is because it is separate to the scheme.</li> <li>• Managing existing older members of Vitality?... find a way to manage that but not in a way that is visible to the outside world. It has to be behind the scenes. It is an important dynamic to understand. It is something that they won't ever talk about, obviously as it doesn't have a nice social flavour. But it is a very real. And it's not just them. It is every loyalty programme with every scheme.</li> <li>• Retirement space - apparently they are launching their retirement solution. It will be interesting to see where their solution is in that space. It will be interesting to see if they are only interested</li> </ul>	Shivani Ranchod

Question	Response	Participant
	<p>in the accumulation phase...It would be interesting to see what side they are focusing on, because for many years, obviously they have had a very strong focus on the young. Although on the palliative side, they have definitely come to the party in terms of engaging with that stuff. So yes, maybe it is shifting.</p> <p>Implementing a senior wellness programme in Vitality type model?</p> <ul style="list-style-type: none"> <li>• An intervention like a wellness programme, is that ideally you should have a control group. Be able to say the same risk profile. Someone with the intervention and without the intervention.</li> <li>• ITO working out the numbers, to actually calculate the cost saving, ideally you need those two groups to be able to estimate what the cost difference is. A control group with the intervention and a control group without the intervention. So the other way of looking at it, just theoretically right, before some intervention, is to look at the differences between the costs. So you could take the Diabetic population for example, and you could look at, try split them into a population that is well controlled and a population that is not and look at the differences in the costs patterns between the two. And then if you could hypothesise that the wellness programme would mean that people are well controlled.</li> <li>• So if you ran a wellness initiative, the actual initiative would be a non-healthcare cost and would probably sit outside of the scheme.</li> <li>• Difficulty is, when you look at the structure from an incentives programme point of view, if you have the managed care organisation earning a fixed fee...so the more effort you expend, the more costs the managed care company incurs and the lower their profit will be because they are earning this fixed fee. And all the savings of their interventions accrue to the scheme. So there is quite a serious mismatch/misalignment of incentives.</li> </ul>	
	<ul style="list-style-type: none"> <li>• Virtually all our businesses are linked by Vitality. Our ‘shared value’ model hinges on Vitality. The basic concept is that, if you take care of your health, engage in healthy activities, you benefit but so does Discovery Health, Discovery Life because there are less claims. It’s a non-zero sum game. Vitality is central to the shared value model.</li> </ul>	Deepak Patel
	<ul style="list-style-type: none"> <li>• Vitality model – “naturally pre-selects people that are healthy”</li> </ul>	Laurie Rauch
	<ul style="list-style-type: none"> <li>• Elderly – no marketing value – no ROI</li> </ul>	Belinda Richards
Partnerships	<ul style="list-style-type: none"> <li>• Flagship offering is the gym benefit. Discount 75% - hugely appealing to young and some older members</li> <li>• We have to deal with each branch and that has not been the best kind of commercial set up.</li> <li>• What we might do, even to use the gyms, to get the gyms to introduce programmes which are more suitable for older people.</li> </ul>	Deepak Patel

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• We have burnt our fingers. Trying to have these one on one partnerships with cross fit and sweat 1000 hasn't worked out.</li> </ul>	
	<ul style="list-style-type: none"> <li>• We don't form alliances and we are not linked to any healthcare network. - insurance space</li> </ul>	Avron Urison
Active Rewards	<ul style="list-style-type: none"> <li>• "Active rewards" - we have seen the greatest shift in people who were previously unengaged. We have also seen big shifts in older people.</li> <li>• Huge success... very tailored programme.</li> <li>• Doesn't have stats of over 60s who have signed up. I'm sure we have got that somewhere.</li> <li>• If you have CC again, the target is lower.</li> <li>• Trying to cater for people's different ages but also different levels of fitness and ability. We haven't got it 100% right, but we will get there slowly I guess.</li> <li>• Need a smart phone. So that might be an impediment for many older people.</li> </ul>	Deepak Patel
Vitality +/- Vitality's role in the ageing sector?	<ul style="list-style-type: none"> <li>• Discovery the listed company would want to charge an extra fee for that to run the programme. And then you would have to convince the scheme that they would save more on claims. That they would save more than the fee that Discovery would charge for that programme. The most convincing way to do it would be through a clinical trial. It would be useful to know how Discovery pilot a new programme and you could pilot something on a small group and track them and see what the impact is.</li> <li>• Every extra person you add here (past a certain age or condition) going to cost scheme more than they add in contribution and gradually your contribution will level will have to rise.</li> <li>• Vitality has done a very good job of expanding internationally. They're in Canada, the UK – all of those markets you can risk rate – you can charge older people more. So there it is fine – in a risk rated environment – you can offer it. I'd be very surprised if they launched something like that here.</li> </ul>	Shivani Ranchod
	<ul style="list-style-type: none"> <li>• There are certain things we are thinking of, which we haven't implemented yet ITO PA particularly for older adults</li> <li>• mind/body kind of activities, yoga, tai chi</li> <li>• things like dance classes which may a greater appeal for older members.</li> <li>• We have done a study on how we can get greater engagement, again drawing on behaviour economics, and we message people. (engaging with Diabetic members in healthy foods programme)</li> <li>• Screening in important – many screening tests are recommended for older people.</li> <li>• We are working on a mental well-being programme.</li> </ul>	Deepak Patel

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• will address cognitive ageing... good evidence that physical activity helps with cognitive ageing.</li> <li>• haven't implemented some of the other aspects or proven strategies to combat cognitive ageing that is being connected to continued learning, the mind/body intervention, mindfulness. So we are thinking about these things and hopefully we will have some of these things incorporated.</li> </ul> <p>Ageing populations in other markets</p> <ul style="list-style-type: none"> <li>• Greater urgency in some of other markets</li> <li>• US, where we partnered with a life company called John Hannock, they are looking at an older age programme. So some of those initiatives may come from our other markets and we will adopt them.</li> <li>• I think our demographic, might be similar to a Western demographic. Our Discovery Health population is ageing also. So I think some of the issues that affect many of these Western markets are going to affect us too.</li> </ul> <p>Older people higher medical costs but low engagement in Vitality</p> <ul style="list-style-type: none"> <li>• Divide that we have to bridge. Need to make it very specific to older people. And we are beginning to do that.</li> <li>• Would probably promote Run/Walk for Life, but we would want Run/Walk for Life to be available in a place that is also appealing. {not in a school hall}.</li> <li>• Thinking about bios perhaps being available for specific kind of classes – you know where blood pressure is measured at beginning or end of the class.</li> </ul> <p>Challenges</p> <ul style="list-style-type: none"> <li>• Technology - many of our programmes rely on technology to a greater or lesser extent. Key problems which may prevent older people from engaging.</li> <li>• A bit of complexity with Vitality.</li> </ul>	
	<ul style="list-style-type: none"> <li>• Started Care Coordination Programme at Discovery – social isolation score...</li> <li>• Importance of touch</li> <li>• Wellness programmes are not set up for elderly</li> </ul>	Belinda Richards
Target Group	<ul style="list-style-type: none"> <li>• Continuous underwriting - when you come to us, you are going to commit to doing the right thing... monitor indicators of how you manage your life and on that basis we will provide you with insurance.</li> </ul>	Avron Urison
Marketing/Communication	<p>Market research - development of services and products for older members?</p> <ul style="list-style-type: none"> <li>• None</li> <li>• We don't really segment our members into different age groups.</li> </ul>	Deepak Patel

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• We have done some research on how to message to those with CC – if it was Diabetes – many of them are older and we found that very tailored but also personalized messaging seems to work.</li> <li>• In the future we are going to tailor our messaging much more... speak to older people much more differently than to younger people Particularly when we want them to adopt certain behaviours.</li> <li>• It's not very specific to older people, but we are aware that we need to talk to people differently.</li> </ul>	
	<ul style="list-style-type: none"> <li>• Main engagement is adherence and control programmes. - at least once per month have an engagement whether it is a sms/phone call/email.</li> <li>• How are you managing your health?</li> <li>• We are not a health care management, so we won't manage people's health. We give a level of advice,</li> <li>• Continuous ongoing level of engagement which makes it interactive insurance model. Ongoing</li> <li>• We're very into our market and understanding who we are speaking to — difficulty in specific targeting</li> <li>• It is quite interesting. Our first ad was all about healthy eating and living for Diabetes. And then we switched to testimonial type ads and we get a better response on testimonials. People will say they have been with All Life. People will say they have been with All Life etc etc, rather than an ad talking about a healthy lifestyle.</li> </ul>	Avron Urison
Health Sector		
Value proposition	<ul style="list-style-type: none"> <li>• Get people to be more engaged in changing their lifestyle. Our core purpose to get people to remain healthy, whether they are young or older, but for the aged to compress the period of mobility or illness.</li> <li>• Main focus of the programme is to prevent, reduce or prevent chronic diseases.</li> <li>• Reducing the burden of chronic diseases amongst population generally but also specifically around the ageing population because they are more affected.</li> </ul>	Deepak Patel
	<ul style="list-style-type: none"> <li>• All Life at the end of the day is about changing health. It is not about life insurance.</li> </ul>	Avron Urison
	<ul style="list-style-type: none"> <li>• Patient centered approach to healthcare</li> <li>• Health care consumer – freedom, choice</li> <li>• Digital tool</li> </ul>	Simon Spurr
Views on the health sector	<ul style="list-style-type: none"> <li>• “Not health system it's a sick system”</li> <li>• People look at bottom line</li> <li>• “Don't make them healthy, keeps them in the system”</li> </ul>	Laurie Rauch

Question	Response	Participant
Preventative measures for chronic diseases	<ul style="list-style-type: none"> <li>• Scope of the programme and where people can actually modify their lifestyle. One of our biggest focus is PA and there is overwhelming evidence that it is health promoting. That is wards off chronic diseases, but also improvement of health. There are many many benefits of PA.</li> </ul>	Deepak Patel
	<ul style="list-style-type: none"> <li>• Education</li> <li>• Monitor disease</li> <li>• High risk programmes</li> <li>• Develop social structure (eg: church knows that this elderly person is living alone)</li> <li>• Proactively manage -&gt; prevent hospitalization</li> <li>• Preventative screening -&gt; \$ taken away from those who need it <ul style="list-style-type: none"> <li>▪ BR speaks of preventative screening of mammograms – may not need annual screening – but wellness and preventative screening costs money which may be better used for high risk</li> </ul> </li> <li>• “Wellness wave” – not only good</li> </ul>	Belinda Richards
Research into exercise/wellness programmes for older people	<ul style="list-style-type: none"> <li>• SSISA research - high intensity and diet</li> </ul>	Laurie Rauch
	<ul style="list-style-type: none"> <li>• study to what extent can cover wellness - there needs to be savings on illness side</li> <li>• “every rand spent needs to be accounted for. Can’t pay for wellness/”feel good” stuff – using everybody’s money and need to account for everybody’s needs <ul style="list-style-type: none"> <li>• Comes down to Rands and Sense</li> <li>• “it is a tight rope”</li> </ul> </li> <li>• Evaluate, create programmes, implement and monitor</li> <li>• Have to measure outcomes</li> <li>• Innovation and collaborations in environment – spending in lieu of money.</li> </ul>	Belinda Richards
How medical aids address needs of ageing members	<ul style="list-style-type: none"> <li>• They wouldn’t manage costs of older members through Vitality. They would have other ways of doing it that doesn’t have a marketing aspect to it. So, there is difference between managing who you are already have and been seen as a place that is attractive for people to join.</li> <li>• Look at ways of managing those members, through their disease management programmes or their high risk beneficiary management programmes or those sort of things, but anything that has got a marketing flavor that is visible to the world outside of who is currently in Discovery, would be aimed at the young and healthy.</li> <li>• It is a very strong incentive to not attract the elderly. For example, on the palliative benefits side, one of the reasons why schemes are only starting now to be clearer about what they offer in that space despite the fact that it is cheaper alternative and better quality alternative is the same reason. You don’t want to be seen as the go to scheme for the dying and the elderly.</li> </ul>	Shivani Ranchod

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Not the mandate of medical scheme to pay for wellness – they pay for illness</li> <li>• RSA – societal environment not support holistic wellbeing of elderly</li> <li>• Eg: Pilates in UK for example that would be paid for by the state OECD nations</li> </ul>	Belinda Richards
Membership of plans	<ul style="list-style-type: none"> <li>• So I think that it is useful to understand that historically schemes used to experience what is call turn. So you set price and benefits for a year but membership is essentially month to month. You have more brokers in the market than you have doctors. You would see a lot of movement between schemes. So schemes never really took a long term perspective on the health of their members and that has shifted over a period of time. So Discovery has been very effective because of Vitality ITO the loyalty aspect in reducing their “turn” levels. So their “turn” or “churn” levels are very low. I think that it is 4%. It is very low. From a business point of view the big perks of Vitality, so remember they will now benefit from the wellness (Vitality) on the life insurance side, but they didn’t benefit from wellness on the medical scheme side. The scheme benefitted. The benefit for them has been around the marketing power, the loyalty, the reduction of “churn”. All that kind of stuff. When you reduce the “turn” then you can start to think of the longer-term perspective. Things like medical aid savings accounts, not a great idea. So, when you design a public health system, all its thinking is around investing heavily in preventative and primary care. You have got people taking care of the basics so they don’t end up in hospital. The medical scheme environment is the opposite. It is very hospital centric, with very little focus on the primary stuff. So for an ageing population, you need access to all that. So hospital plan is the worst thing. You are more likely to end up in hospital because you don’t have access to all that. Impact you see is the age profiles tend to be different on different options within a scheme. So you effectively pay more for more benefits on a comprehensive plan because the profile will tend to be older.</li> <li>• But even though there is an affordability constraint – the pensioners do seem to be more likely to be on a comprehensive.</li> </ul>	Shivani Ranchod
	<ul style="list-style-type: none"> <li>• Private open scheme environment – business model attract young and health – it is a financial model that makes sense</li> <li>• However with PMB legislation and reality of members becoming older</li> <li>• Discovery started 22 years ago – their membership base is now 22 years older</li> <li>• Mid 90s medical scheme package – retained members for life but in 90s this disappeared</li> </ul>	Belinda Richards
Medical savings accounts	<ul style="list-style-type: none"> <li>• Ignores that people don’t invest in preventative care. What is going to motivate you to go to the dentist, have your pap smear. And actually, the scheme has an interest in you doing all that kind</li> </ul>	Shivani Ranchod

Question	Response	Participant
	<p>of stuff because if you don't go have the pap smear, they might have to pay for you to have chemo.</p> <ul style="list-style-type: none"> <li>• But the thinking in the 90's was classical insurance kind of thinking. As opposed to health thinking.</li> <li>• Again, it is trying to cater more towards the young instead of the whole population. Medical aid savings accounts are a disaster if you are old. They have fallen out of favour a little bit but I would say the majority are in savings account plans. But interestingly, even schemes with medical savings accounts have inserted more preventative and primary care stuff into the main scheme anyway over and above. So Discovery, there is a preventative care benefit. All your screenings and immunizations.'</li> </ul>	
Benefits to subpopulation	<ul style="list-style-type: none"> <li>• Hospitalization benefits – where there is access to physio after hospital, or packages of care. Diabetics get a visit to podiatrist. But they only access that if they are members of the diabetics programme. So, they have found ways of working in some of those things but it is only subpopulation based condition, diagnosis or population base. You have got to be part of programme to access it.</li> </ul>	Shivani Ranchod
Homebased programmes	<ul style="list-style-type: none"> <li>• Wellness Consultants - either dieticians, bios or nurses who go out to various corporates. Vitality check. Some of them might go out to clients and do a wellness check at their homes.</li> <li>• It's not available to everyone - Discovery Health. It's not available through Vitality.</li> </ul>	Deepak Patel
	<ul style="list-style-type: none"> <li>• No programme for elderly per se</li> <li>• Programme for high risk population</li> <li>• Education to patient, coaching to family</li> <li>• Physio and social workers</li> <li>• Using social and health infrastructure – putting web in place</li> </ul>	Belinda Richards
Complexities of ageing membership base for schemes	<ul style="list-style-type: none"> <li>• Gives a sense of scale. What sort of quantum of costs are you talking about. We were dealing with a scheme last year who had quite a rapidly ageing population. A very generous, almost like a blank cheque type scheme that was getting more and more expensive because it was getting older and as it was getting older the young people were leaving because we don't need a blank cheque and we are paying a fortune for these benefits. But the old people were using these benefits benefitting from the blank cheque they stayed. It is was ageing exponentially. So it was very interesting looking at their claims experience because they're are a bunch of different things going on. This high cost –it's not a one type of cost that is driving that. So on the one hand, you have got increasing chronic prevalence. So the prevalence of the diseases increases with age. And that means just to manage people well, they are on chronic medication. So it</li> </ul>	

Question	Response	Participant
	<p>means your chronic medication costs are going to increase with age. Then you have got the catastrophic type stuff and that increases with age. So the heart attack, the cancer – so those big claims make up a big proportion of the scheme’s expenditure. But the other thing that we found which is really interesting is that there is a whole lot of small hospital admissions that increase quite dramatically with age. So a lot more investigative work, a lot more scopes, things like skin things taken off – don’t know clinical word. But you have basically got, as part of the ageing process, all these little things. Teeth get more complicated, eyes need a cataract operation – is relatively cheap compared to a million rand catastrophic event but it’s accumulative thing. So the scheme experiences ageing in this array of different things and I think it is important to recognize that the wellness would only help with some of it but not all of it. You can’t stop the cataract or the dental stuff, skin stuff and to some extent you can only delay the catastrophic stuff. So that’s why it’s a difficult trade off. The thing we were asked a lot when we presented the end of life paper, is the life time costs. And to what extent do interventions keep your life time costs the same; it’s just the timing of those costs that is different. That is what makes it a difficult sell. It is not obvious what those dynamics are.</p>	
	<ul style="list-style-type: none"> <li>• Population who can afford medical aid stays the same – only intake is from newly employed members – small amount – however current membership base continues to increase</li> <li>• No change in society where people can afford medical aid =&gt; so existing members are getting older</li> </ul>	Belinda Richards
Whealthcare	<ul style="list-style-type: none"> <li>• Link medical aids to pension funds? Legally it can’t be tied together. But yes, it is a very good question. You could have a wrapper type product that ties to manage the two together. Can’t legally do it?... well you could be creative about it. You have these things called living annuities. Which are very controversial as well. The idea is that you draw down. The old fashioned idea is that you bought a fixed annuity and the insurance company would carry the longevity risk. So they would guarantee you, let’s say here’s your lump sum and we can give you R20k/month with an inflation escalator. And we will pay it out until you die. That was the old fashioned way. Then what developed in South African market was these living annuities, where you can basically draw down and you can vary the rates at which you draw down. But if you run out of money you run out of money. So the longevity risk has been transferred back to the policy holder. The attractive idea, is that you reach the retirement age of 65 but you continue to do some part time work, so you don’t actually want to draw down your pension because you are still generating R10k/month doing part time work. So instead of drawing it down you can contribute to it and allow it to continue growing and you have a higher pension fund that starts at 75 or 80, which reflects more of how people actually live. So that is the attractiveness of a</li> </ul>	Shivani Ranchod

Question	Response	Participant
	<p>living annuity, but it's got the risk that you draw too much and you run out of money. So it puts the responsibility of the policy holder. Which raises all sorts of questions around advice etc. but you could have system where your draw down is linked to your medical aid premium or your healthcare costs in some way.</p> <ul style="list-style-type: none"> <li>• What I think that people don't understand is that their healthcare costs are going to climb. But even if your medical scheme premium stays level, medical scheme contribution inflation is above normal level. So just that is going to eat into your living annuity over time. But where people can only afford a hospital plan, those other bits are not covered. Your OOP expenditure is going to rise over time. If people understood that, they would be able to plan to start lower with their draw down, and know that their draw down is going to have to increase over a period of time. ITO their pension fund. So you would want to start low and as you get older you can draw more and more to cover all those OOP expenses or a more expensive medical scheme option.</li> <li>• From an actuarial point of view – the thing about longevity is so tricky – because with technological change and medical advancements it is very hard to know. If you sold policies to younger people, you don't know how long they are going to live. How long is that period that you are “aged”? Because it is expensive</li> </ul>	
	<ul style="list-style-type: none"> <li>• Can't innovate because of legislation</li> <li>• PMB – can't penalize member</li> <li>• “If you could link pf &amp; ma – incentive behavior change” - can't make change because of legislation</li> <li>• Wealth and health – should have product to pay for frail care</li> <li>• Assumptions are made of how people prepare for health and wealth</li> <li>• Redistribute of wealth to support frail care –</li> <li>• There is no way that medical schemes can pay for frail care – far too expensive – so ideally create products which people could invest in. However – if person dies at 68 before needing it, then what?</li> </ul> <p>Behaviour Change</p> <ul style="list-style-type: none"> <li>• Insurance and retirement funds not subjected to the same legislation as medical aids</li> <li>• There is a disconnect...legislation only applies to medical aids but not to retirement space</li> </ul>	Belinda Richards
Public Sector	<ul style="list-style-type: none"> <li>• Huge disparities. I mean we are talking about our private sector population. If you had to think about ageing in the public sector, nobody is even engaging with that stuff.</li> </ul>	Shivani Ranchod

Question	Response	Participant
	<ul style="list-style-type: none"> <li>The implications for public sector are huge because they are not doing a very good job of picking people up early. When you talk to people at Grootte Schuur – they feel like they are seeing an explosion of hypertension and diabetes. But it is at the tertiary level – when people are incredibly ill and how do you on a mass scale – how do you do stuff earlier?</li> </ul>	
Behaviour Change	<ul style="list-style-type: none"> <li>Question of engagement is a huge one – so even in disease management programmes and all those sort of things – it is tricky right – you can run a diabetic management programme but how do you actually get people to change their behaviour and eat differently. Programmes like Vitality have limited capability in that space right. The people who are diabetic are the people who are least likely to shift their behaviour. So what do you do to in those sort of spaces.</li> </ul>	Shivani Ranchod
	<ul style="list-style-type: none"> <li>Not so much with ageing population, but I would assume that many of them were aged, diabetic members who hadn't registered with our health food programme. We have done a study on how we can get greater engagement, again drawing on behaviour economics, and we message people.</li> <li>Done some research on how to message those with CC – if it was Diabetes – many of them are older and we found that very tailored but also personalized messaging seems to work.</li> <li>in the future, we are going to tailor our messaging much more. We are going to speak to older people much more differently than to younger people, in some instances. Particularly when we want them to adopt certain behaviours.</li> </ul>	Deepak Patel
	<ul style="list-style-type: none"> <li>“Knowing better is doing better”</li> <li>Earlier you teach people to do right thing</li> <li>Remain healthy BUT reality is different</li> <li>Many reasons why not in optimum health</li> </ul> <p>Whealthcare</p> <ul style="list-style-type: none"> <li>Insurance and retirement funds not subjected to the same legislation as medical aids</li> <li>There is a disconnect...legislation only apply to medical aids but not to retirement space</li> </ul>	Belinda Richards
	<ul style="list-style-type: none"> <li>It is quite interesting. Our first ad was all about healthy eating and living for Diabetes. And then we switched to testimonial type ads and we get a better response on testimonials. People will say they have been with All Life. People will say they have been with All Life etc. etc., rather than an ad talking about a healthy lifestyle. It is quite interesting. I'm not sure what it says.</li> <li>I will tell you how to really get people to engage, and it's one of the things we learnt at All Life.</li> </ul> <p>Whealthcare</p> <ul style="list-style-type: none"> <li>Our best compliance results are at 95%. Why is that? Because if they don't comply, they get a financial penalty. So what we have learnt, which is probably what Discovery has also latched</li> </ul>	Avron Urison

Question	Response	Participant
	<p>onto, is that people are more worried about their money than their health. Which may initially be surprising, but when you think about it, it's not surprising because it's true. People are much more worried about their money than their health. So in other words, if I say to you go do a blood pressure test because it's going to keep you healthy, they're not so worried. Go do a blood pressure test because I am going to give you a free coffee or a free trip to Cape Town, people are a lot more incentivized to do that. And from our perspective, if you do that you are able to keep your policy or your premium at a reduction. So people are much more worried about their finances than their health and therefore the best learning out of all of this, which may be of interest to you, is that if you are going to build an engagement programme you need to put in financial incentives. People don't really care about their health and the reason for that is it is not something that you can see up front. So if I stop smoking because it is going to give you cancer in 30 years, well that means nothing to me and you don't believe. But if I say stop smoking and I will give you R100 here, you may be more incentivized.</p> <ul style="list-style-type: none"> <li>• Diabetes on the other hand, we are very excited about, we are looking to launch that into international first world markets. There we can operate. Overseas is interesting, you think SA doesn't export much, but the fact that you have your insurance which is linked to your wellbeing going forward is quite uniquely SA</li> </ul>	
Immigrations	<ul style="list-style-type: none"> <li>• 40% of elderly impacted and affected by immigration</li> <li>• Some don't see adult children – kids pay for medical aid premium – but they don't know the reality of the elderly parents' situation</li> <li>• Also some adult children are not earning a lot of money, so they cannot afford to visit elderly parents</li> </ul>	Belinda Richards
Burden Anxiety	<ul style="list-style-type: none"> <li>• When did home visit in CCP- people cupboards are bare, but they don't want to admit it to family</li> <li>• There is an assumption that if you can afford medical care, then you are financially resourced and this is not the case</li> </ul>	Belinda Richards
Closing	<ul style="list-style-type: none"> <li>• I think one of the big questions you will have to address is the incentives in the market currently, in the medical scheme space – how do you – given that schemes are so averse to the elderly – how do you convince them, that there are actually ways of managing to get those costs down. You have to see it in the context of this community rated environment – where you have to charge everybody the same price. That is the complicating factor.</li> <li>• From actuarial point of view, aren't you deferring some of these costs? Similar argument to HIV – bizarre to think, but those were some of the questions surrounding funding HIV. Would it cost less to fund ARVs or let people die. And the question was – don't ARVs just delay the</li> </ul>	Shivani Ranchod

Question	Response	Participant
	<p>inevitable? And you still incur those costs, just a few years down the line. One of the answers to that question, is there is an obligation – is why do you really buy medical scheme cover. You really buy it because you want better healthcare outcomes. At the end of the day, it is the quality of care you receive for that price that you are paying. So there is some kind of obligation on behalf of the scheme to be able to – even if you are just deferring it. There is a value to that, to the consumer. I would want more years of active healthy life and I am willing to pay for that.</p>	
	<ul style="list-style-type: none"> <li>• Different for team-based clinic care- benefits of multidisciplinary team <ul style="list-style-type: none"> <li>• No incentive for HCP to collaborate – paid per time</li> </ul> </li> <li>• “That older person belonging to medical scheme, that they can have access to healthcare” <ul style="list-style-type: none"> <li>• In RSA – inability is sad for wealthy and poor</li> <li>• Lack of societal support is very sad affair</li> </ul> </li> <li>• CCP – findings <ul style="list-style-type: none"> <li>▪ Disadvantaged communities more likely to take care of their elderly</li> <li>▪ Wealthy – family aren’t interested – BR give example of Dad that has an affair – then has a stroke – girlfriend not interested, and neither are children</li> </ul> </li> </ul>	Belinda Richards
	<ul style="list-style-type: none"> <li>• No doubt that digital is playing a big role. There has got to be a lot more done in the digital space. Your wearable devices</li> <li>• Will be interesting for you in monitoring people’s health as they get older, is that people are learning more about their health and how they age, and their question is how do they interact, how do they take that information and share it with various providers to give them services in the broader sense.</li> <li>• We are going to see in the digital age, and it is starting to happen, there is going to be a lot more personalized for the individual to help them understand their health. Insurance is going to be very different in the next 10 years, to how we see it now.</li> <li>• People don’t necessarily have the motivation to actually change their health and their behaviour.</li> </ul>	Avron Urison
	<ul style="list-style-type: none"> <li>• Technological aspect has got to be focal point</li> <li>• Industry needs to drive engagement</li> <li>• Make things easier for HC consumer</li> </ul>	Simon Spurr
<u>Fitness Industry</u>		
Virgin Active	<ul style="list-style-type: none"> <li>• Big concept regarding wellness aspect – a lot of partnerships with medical institutions (Discovery, Momemtum)</li> <li>• A lot will join to have fitness benefit on medical aid</li> <li>• Discovery/Vitality</li> </ul>	Johann Strauss

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• VA caters for a high variety – so very popular</li> <li>• 85-100 group exercise classes/week</li> <li>• Instructors - Mostly from eta – fitness instructors</li> <li>○ Franchise model</li> <li>• Personal trainer would specialize more than fitness instructors</li> <li>• JS – “hippos”- the tannies</li> <li>○ “They’re the best”</li> <li>○ They are the loyal ones</li> <li>○ Get to retirement age – want to enjoy the facilities</li> <li>○ They will tell you if something is wrong with the club – they have the time</li> <li>○ It is more of a lifestyle for them</li> <li>○ Once every ¼ - buy a cake, sit down with them</li> <li>○ JS – tells AB a story about having tea with older members – he recounts fondly</li> <li>• We’ve got a great product – but we’re in the sales industry – we sell a lifestyle</li> <li>• Strategy for older members?</li> <li>• JS – everybody is welcome at VA <ul style="list-style-type: none"> <li>○ Slogan – young, old, fit or unfit – all welcome – have this up on the walls of new clubs</li> <li>○ Doors are open to everybody</li> </ul> </li> <li>• A lot of older people come in saying that their doctors have told them they need to go exercise</li> <li>○ It is never too late to be active</li> <li>• Aqua is so popular because it is the same age group</li> <li>• Low impact is popular</li> <li>• Still have step classes – because it was started 20-30 years ago and those older members still enjoy it</li> <li>• No pensioner’s membership fee – they can join ‘off peak’ membership</li> <li>• Challenges?</li> <li>• JS – getting policies right -&gt; a lot of members think that it is VA – but guidelines in place by Vitality</li> <li>• Tells about getting free smoothie at Kauai – the older members enjoy that</li> <li>• Marketing? <ul style="list-style-type: none"> <li>○ VA brand has always been hip and trendy</li> </ul> </li> <li>• Older men do their own thing</li> </ul>	
SSISA	<ul style="list-style-type: none"> <li>• “Senior citizen” rate</li> </ul>	Claire Cowan

Question	Response	Participant
	<ul style="list-style-type: none"> <li>• Pre-health screening – most important question is; are you sedentary? (PPHS – pre-health participation screening)</li> <li>• Based on ACSM – most impacted on senior citizen group as age no longer risk factor - &gt; sedentary lifestyle</li> <li>• #1 – sedentary lifestyle # 2 chronic diseases and cardiac events #3 symptoms – dizziness, swollen ankles</li> <li>• If answered yes to any questions -&gt; sent to doctor. If seniors under care of specialist/doctor – need medical clearance</li> <li>• Challenges - don't take medical clearance very well – “Why, am I old?” – need to be careful in communication – face to face best</li> <li>• Any issue then “red flag” – join Prime Time – higher risk group <ul style="list-style-type: none"> <li>• Have an assessment by 2 bios</li> <li>• No extra charge</li> <li>• Blood pressure monitoring – log book</li> <li>• On-site nurse</li> </ul> </li> <li>• Increase in retirement talks – routine, psycho/emotional side/lifestyle, nutrition, exercise</li> <li>• SSISA – takes daunting aspect out of it, a lot of hand holding – sales consultants trained to deal with emotional aspect</li> </ul> <p>Marketing</p> <ul style="list-style-type: none"> <li>• Word of mouth – predominantly</li> <li>• Involved in retirement talks at UCT</li> <li>• VA sales team very young – SSISA – sales diverse, especially ages</li> </ul> <p>Scale</p> <ul style="list-style-type: none"> <li>• It is tricky, not easy. We won't be able to compete with VA</li> <li>• Difficult to control branches remotely</li> <li>• Not closed off to opening new branches but not a priority</li> <li>• “Vitality + is critical – not many facilities where senior citizens feel comfortable to go train.” – CC thinks that access is a massive problem</li> <li>• Relationship with Discovery – did research for step test for Vitality - 1 or 2 projects but predominantly membership subsidy</li> <li>• Technology – introduced new app, most queries from older members – but most have smart phones</li> <li>• Vitality subsidy higher at VA</li> </ul>	

Question	Response	Participant
	<ul style="list-style-type: none"> <li>R&amp;D – constantly up to date, looking at research</li> </ul>	
<u>Prototype</u>		
<p>What role do you feel your organisation fills in the ageing sector?</p>	<ul style="list-style-type: none"> <li>Huge huge huge</li> <li>Substantial proportion of calls come from adult children for elderly parents</li> <li>Elderly model increasing <ul style="list-style-type: none"> <li>Daily tasks - &gt; care worker provides this service</li> </ul> </li> <li>Never built with intention of dealing with insurance</li> <li></li> </ul>	Simon Spurr
<p>Engagement with ageing consumer</p>	<ul style="list-style-type: none"> <li>Fundamentally build platform that is easy to use</li> <li>Compared to uber</li> <li>Simple</li> <li>Creating a care co-ordination platform for Donald Gordon -&gt; stream lining process</li> <li>Health Cloud – create better end to end -&gt; agnostic =&gt; not aligned to any MA or insurer</li> </ul>	Simon Spurr
<p>Success</p>	<ul style="list-style-type: none"> <li>Lots of interest from B2B – insurer {pushed to spend less}, MA, wellness companies</li> </ul>	Simon Spurr

## Appendix 8: Health conditions affecting older demographics

Health conditions affecting older demographics
<p><b>Frailty</b> is a medical condition (Cesari et al., 2016; Fried, 2016). As frailty is associated with old age, there is a perception that it is a natural ageing process. However just because something is predictable does not make it normal (Van Norman, 2016a). Like a disabled person, a frail person has the right to care and therapy to help them cope with their condition.</p>
<p><b>Osteoporosis</b> is like leaving cane furniture out in the elements. Over time it will decay. Large honeycomb-like pockets make the bone brittle and more susceptible to fractures and breaks. A woman between the ages of 65-69 is five times more likely to die within the year of breaking her hip than a woman who has not (LeBlanc et al., 2011). Those who experience a fall are also prone to a post- fall syndrome which includes “dependence, loss of autonomy, confusion, immobilization and depression” (World Health Organization, 2007, p. 7). Weight-bearing and balance exercises should be part of a fall prevention plan.</p>
<p><b>Diabetes</b> if poorly managed can result in festering sores, normally on the legs and feet. Diabetes is the number one cause of amputation of the limb to prevent gangrene (Diabetes.co.uk, 2017). Blindness can also occur. Diabetes can cause death as people can go into a diabetic coma. Diabetes is treated with exercise, diet, biguanide, or sulphonylurea drugs or insulin (Prince et al., 2015, p. 555). Cardiovascular exercise is particularly beneficial, as is good foot care, including podiatric pedicure and lower limb massage.</p>
<p><b>Dementia</b> is now the most feared disease to contract (Merril Lynch, 2014). The slow progression of memory loss is compounded by the decreased physical capacity at varies levels. An older person with a low muscle mass will most likely have the disease progress more quickly. Frontal lobe gait can affect how the person walks. Although this is neurological, exercises which encourage good walking will benefit the older person. There is immense benefit in facilitating mindful movement for an individual living with dementia.</p>
<p><b>Stroke</b> is when blood flow is cut off to an area of the brain causing cells in that area to die. When this occurs, abilities controlled by that area of the brain such as memory or muscle control are lost. Being physically active will help with stroke recovery and may help prevent a second one.</p>
<p><b>Sedentary lifestyle</b> can compound the symptoms of chronic diseases. Having our bodies in a prolonged seated position damages the myofascial structure of the body and is associated with falls, loneliness and depression which has a detrimental effect on an older person’s wellness (Singh, 2009).</p>