‘Joining Late’: Exploring the impact of the Late Joiner Penalty (LJP) imposed by South African Medical Aid Schemes

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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It is my belief that even though my name is attached to this research, each person who I have interacted with, had spirited debates with, grown, laughed and cried with has led me here. This work is equally yours. Thank you!

Contents

Acronyms

BIG	Basic Income Grant
CHW	Community Health Worker
CMS	Council for Medical Schemes
CPUT	Cape Peninsula University of Technology
CSG	Child Support Grant
DHMS	Discovery Health Medical Scheme
DSP	Designated service provider
DtD	Day-to-day
GP	General Practitioner
HMI	Health Market Inquiry
LJP	Late Joiner Penalty
LMIC	Lower and Middle Income Countries
MSA	Medical Schemes Act
NDP	National Development Plan
NPC	National Planning Commission
NEET	Not in Employment, Education or Training
NGO	Non-governmental organisation
NHI	National Health Insurance
NYP	National Youth Policy
OOP	Out of pocket
PHC	Primary Health Care
PMB	Prescribed Minimum Benefit
PSP	Preferred Service Provider
RDP	Reconstruction and Development Plan
SAHRC	South African Human Rights Commission
sPHC	selective Primary Health Care
SRDG	Social Relief of Distress Grant
UHC	Universal Health Care
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Abstract

This study explores how black women in paid employment experience the Late Joiner Penalty (LJP) that has been imposed on them by the Medical Schemes Act of 1998. Using various theories of citizenship, this research explores ways in which women are still excluded from obtaining full citizenship rights. The researcher applied a qualitative approach and conducted one-on-one in-depth interviews to generate meaningful data.

The findings of the study reveal that women experience work precarity in various forms, which has been heightened by the COVID-19 pandemic. Women are subject to periods of "waithood" with delays that may impact their economic stability and growth. In addition, strong themes of control exerted by medical aids, healthcare practitioners and male partners reinforce the ways in which women are denied full access to citizenship. Furthermore, medical aid is gendered and forces women to organise their productive lives around their reproductive obligations. The LJP revealed no risk for the scheme but appears only to endeavour to exploit those who have been historically marginalised. Moreover, the lack of knowledge of the LJP, the finer details and the long-term implications of joining a medical aid scheme for poorer working-class families are problematic and consistent with current hegemonic practices that reward citizens for fitting into the ideal mould. These findings were then discussed within the theoretical framework of citizenship using Barchiesi's (2007) Theory of Social Citizenship and Brown's (2016) Theory of Sacrificial Citizenship as analytical tools.

The research demonstrates that neoliberal policies and legislation punish the poor through a form of poverty tax (LJP) and decrease the ability to generate financial and health security through medical aid scheme subscription. Additionally, the LJP undermines the constitutional promise of equal citizenship by effectively discriminating against citizens on the basis of age, gender and historical disadvantage.

Chapter 1: Introduction

This chapter presents a brief overview of the background and rationale for the study, including the research question, aims and objectives as well as an overview of the methodology that was employed during the study.

1.1 Background and rationale

The overall purpose of the legislature is to create laws that are in line with the South African Constitution (Republic of South Africa, 2021). Enshrined in the South African Constitution is the right to equality and that "equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures **must be** designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination [emphasis added]" (Republic of South Africa, 1996, pp. 5-6). In addition, the Constitutional Mission of the World Health Organization (WHO) (2006, p 1) reaffirms "the right to health to all people irrespective of race, religion, political belief, economic or social condition". It also asserts that peace and security is at the core of quality health for all. As such, member countries are obligated to fulfil the right of all to receive health care.

In 1998, the Medical Schemes Act (MSA) 131 was ratified, its intention being to provide control and oversight over certain medical scheme activities and protect the interest of members of medical schemes amongst other matters (Republic of South Africa, 1998). However, the act also includes a clause in the Medical Schemes Amendment Act, No. 55 of 2001, chapter 5, clause 29A that states medical aid schemes may apply conditional specific waiting periods to members for up to twelve months and general waiting periods for members who have not been a member of a medical aid for a minimum of 90 days prior to application (Republic of South Africa, 2004b). Additionally, section 13 of the MSA stipulates that "A medical scheme **may** apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependent who qualifies for late joiner penalties [emphasis added]" (Republic of South Africa, 1998, p.11). These penalties range between 5% and 75% of the premium for members who join a medical aid scheme after the age of 35 years and form part of their contribution for the rest of their membership term[1].

[1] People are able to avoid this penalty by ensuring that they have credible medical aid cover prior to the age of 35 years. One of the biggest medical aid schemes in South Africa, Discovery Health Medical Scheme (DHMS), (2018) would waive these penalties if one of the following criteria is met:

1. Through Late Joiner Penalty amnesty that was granted until April 1st, 2001.
2. Expatriates returning to South Africa who had previously been on DHMS.
3. Members younger than 46 years, who have no pre-existing medical conditions and whose late joiner penalty percentage less than 25%.

The government granted an amnesty period to allow people the opportunity to join medical aid schemes without penalties prior to March 31st, 2001 in an effort to boost medical aid membership among the broader public (Appasamy, 2012; McLeod & Ramjee, 2007).

While the South African government and various other global institutions have created policies to ensure health care for all, many of these policies fall short due to the unequal distribution of power between patients based on their structural position in society, in both the private and public healthcare sectors. The LJP technically guarantees increased penalties for those who are excluded from accessing medical scheme benefits prior to the age of 35 years without taking into account their socio-political, economic or historical background. The aim of this minor dissertation is to show how the values that are espoused by the LJP contradict those of the Constitution of South Africa.

Currently, not much is understood about the ways in which people are navigating, accessing and negotiating health care within the context of these policies. The recent Health Market Inquiry (HMI) report produced by the Competition Commission of South Africa (hereafter, "Competition Commission"), makes little mention of the LJP in relation to the lived realities of ordinary South Africans (Competition Commission of South Africa, 2019). The style of the report relies on quantitative data to present its findings, despite the fact that the evidence collection process included public hearings and first-person accounts. This can be contrasted with the South African Human Rights Commission (SAHRC) report on Access to Health Care Services which does include these voices (South African Human Rights Commission, 2007). However, even in this report, no mention is made of the LJP. A brief search on Google Scholar in February 2021 using the key phrases "late joiner penalty" and "South Africa" without any time frame generated only 16 results. Therefore, this research will add to this field of knowledge. It is important to note this study is exploratory in nature as it aims at generating lines of inquiry that can be pursued in the future. The study focuses specifically on women, given their double burden of productive and reproductive work, and in this instance specifically care work or social reproduction work within the household. In this minor dissertation, experiences of women – specifically black women in paid employment – will be documented in relation to the LJP of the Medical Schemes Act 131 of 1998, chapter 4, section 13. These experiences will be analysed through the concept of citizenship, specifically Franco Barchiesi's (2007) work on Social Citizenship and Wendy Brown's (2016) concept of Sacrificial

4. Members joining Key Care Plans who are younger than 50 years and earn less than R11 551 [per month].

Citizenship. I also draw on Fakier and Cock's (2009) critique of the gendered nature of social reproduction work in South Africa. In the conclusion of this minor dissertation, I reflect on some of the policy implications of the analysis I undertake below and make recommendations about how the MSA could be amended to ensure that the LJP creates less of a regressive effect on the Constitution's promise of equal citizenship.

The researcher defined "black" in relation to Biko's (1978) idea of a collective black identity which includes Coloured, Indian and black African people according to apartheid classification. The term black refers to a political identity reflecting a shared experience that these racially divided groups had under the apartheid regime.

This research journey started with a personal experience related to the LJP. In 2018, a close friend's mother passed away on the morning she was scheduled to have surgery. She had been in pain for over a year but due to the high demand on the public healthcare system she was unable to secure an earlier theatre date. My friend, who was 32 years old at the time, had planned on putting his 55-year-old mother on a medical aid scheme but was unable to afford the high costs and the associated penalties. As a single black mother, during the time of the amnesty period she was unable to afford the cost of private medical aid and when she desperately needed to access health care services in her later years, it became virtually impossible.

Similarly, my partner and I felt it important to have health care options for our parents. Ensuring that their health and wellbeing is taken care of meant that they would have access to health care without the challenges that my friends' mother had experienced. In addition, we reside in different cities, which means our mother needs to use public transport to travel to and from a healthcare facility. Medical aid scheme membership gives her access to her local general practitioner (GP) and provides the option of calling a private ambulance in the event of an emergency. When we initially could afford the added cost of health care, we added our mother to our medical aid scheme. She was 50 years old at the time and as a result we were subjected to a 50% penalty that we had to pay in perpetuity, this was the equivalent of R621 per month in 2020 (Momentum Health, 2020). The total cost of medical aid membership for the main member and two adult dependents was R4 747 per month, excluding savings. My partner's mother – a single black parent who had worked as a domestic worker when work was available – was unable to access private medical aid prior to 2001. Now, the added burden of care has been imposed on us by the LJP due to structural inequalities imposed by the law. While completing our income tax returns last year, we realised that in addition to the more than

R50 000 spent on medical aid subscriptions, we had additional out of pocket (OOP) medical expenses. This was despite having hardly utilised the medical aid benefits.

In June 2020, at the height of the COVID-19 pandemic in South Africa, I was hospitalised. I spent two nights in hospital and the next six months on chronic treatment. My medical aid scheme would not cover the cost of my medication as it was not on the Prescribed Minimum Benefit (PMB) list, and co-payments for every doctor and specialist visit including in-hospital blood tests and imaging soon added up. This became our personal responsibility to pay as the medical aid savings were depleted. When we really needed the medical aid scheme to "aid" us with our health care finance, they failed to do so. Instead, the added stress of my wellbeing was then compounded by concerns about our financial health. These personal experiences have allowed me to engage with the LJP which extends beyond just a piece of legislation.

As an advocate of Universal Health Care (UHC), this research aims not to minimise the efforts of realising National Health Insurance (NHI) in South Africa but to shine a light on current discrepancies within private medical aid schemes. This minor dissertation has been written in the hope that the experiences recorded here will encourage further, more robust debates regarding policies and laws and those they truly serve, as well as to challenge or influence policies and laws, where justified.

1.2 Research Question and Objectives

The research question is: What are women's responses to the LJP of the Medical Schemes Act 131 of 1998, chapter 4, section 13 and their perception of its effects?

The question aims to gain an understanding of how women respond to the LJP and its perceived effects with a view to the findings possibly influencing policy changes regarding the LJP of the Medical Schemes Act

The specific objectives for this research study were to:

1. Establish working black women's knowledge of the LJP,
2. Explore working black women's responses to being subjected to the LJP and
3. Understand working black women's strategies for living with the LJP.

1.3 Research Methodology

This study was guided by an interpretive paradigm. This paradigm acknowledges the subjective viewpoint of the participants in order to understand a particular context, but it is also guided by the context of the participants (Bertram & Christensen, 2014). There is a deep

understanding that the larger social, cultural and political context impacts the ways in which people behave. As the theoretical framework was citizenship, the researcher found the interpretive framework appropriate and valid for the current study. The data were therefore interpreted through the framework of citizenship using the social, cultural and political contexts of the participants as the foundation rather than hypothesis testing. Through continuous self-reflexivity and journaling, the researcher endeavoured to observe their own positionality and to analyse and interpret the data (Babbie & Mouton, 2001; Creswell, 2015).

Six one-on-one telephonic interviews were conducted with black women who were in paid employment. These participants were recruited via social media, five of whom were from the greater Cape Town area and one from Pietermartizburg. The data were coded using NVivo 12 software (QSR International, n.d.). This was an iterative process, where each transcript was read repeatedly in order to delineate particular themes and subthemes. The process of analysis was not linear in nature but allowed the researcher to sift through relevant facts and allowed time to construct a framework to capture the analysis. Data interpretation and analysis were closely linked; the interpretation of the data took place at the same time as the data analysis. These processes were iterative and happened concurrently.

1.4 Chapter Summary

Chapter One introduces the research topic with a brief background and provides the rationale for the study. It also introduces the research questions, objectives and a brief overview of the methodology for the study. The next chapter presents the literature review, which includes the theoretical framework of citizenship.

Chapter 2: Literature review

2.1 Introduction

More than 25 years post-apartheid, South Africa still suffers from huge socio-economic inequality, and a lack of universal access to health care, affordable housing and good quality education (Bongani & Solomon, 2014; Buhlungu, 2007; Burger & Christian, 2018; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Mayosi et al., 2012). These inequalities, which can still be defined by race, also intersect with class, gender, ability as well as geography even though the country has one of the most progressive constitutions in the world (Ross, 2010). Notions of citizenship, access to human rights and dignity are embedded in the ethos of the Constitution. However, in this minor dissertation I argue that the LJP clause in the Medical Schemes Act No. 131 of 1998 infringes upon these rights.

Since very little research has been done in this area, the study explored the ways in which working class black women experience the LJP and its effects on their lives. Theories of citizenship are used to critically analyse the ways in which citizenship is constructed in post-apartheid South Africa and how these are enacted on women through this specific piece of legislature. Pateman's (1998) Sexual Contract Theory, Barchiesi's (2007) Theory of Social Citizenship and Brown's (2016) Theory of Sacrificial Citizenship are used as an analytical tools to expand on this phenomenon. In addition, Fakier and Cock's (2009) analysis of social reproduction is used to highlight the gendered nature of the research question: What are women's responses to the LJP of the Medical Schemes Act 131 of 1998, chapter 4, section 13 and their perception of its effects?

2.2 The Constitutional promise and the Medical Schemes Act

The South African Constitution is the founding document upon which the country is governed (Republic of South Africa, 1996). Laws that are found in contravention of the South African Constitution by a court would therefore be found to be unconstitutional and would be declared invalid (Republic of South Africa, 1996). Each Act of parliament should therefore abide by and enforce the rules that are set out by the South African Constitution (Republic of South Africa, 2021). The values of the South African constitution include; "(a) Human dignity, the achievement of equality and the advancement of human rights and freedoms; (b) Non-racialism and non-sexism; (c) Supremacy of the constitution and the rule of law; [and] (d) Universal adult suffrage, a national common voters' roll, regular elections and a multi-party system of democratic government, to ensure accountability, responsiveness and openness" (Republic of South Africa, 1996, p. 3). If the Constitution is the foundation of South African law, then the Bill of Rights is the cornerstone and it follows that it is also applicable to all laws.

It is therefore the responsibility of the legislature to ensure that the rules and values that are enshrined within the Constitution inform the laws that are passed and improve the lives of the citizens they serve.

On November 20th, 1998 the Medical Schemes Act No. 121 of 1998 was assented to (Republic of South Africa, 1998). The purpose of the Act was, "to consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes (CMS) as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the co-ordination of medical schemes; and to provide for incidental matters" (Republic of South Africa, 1998, p. 101). On paper the purpose of the Act seems to be in line with that of the Constitution as well as the Bill of Rights. However, a closer look at the regulations could reveal some flaws (Republic of South Africa, 2004a).

In this section, I identify specific aspects of the Medical Schemes Act that appear to serve to undermine the right of equal access to health care services, particularly in the context of the ongoing structural inequalities generated by apartheid and patriarchy.

Within the Medical Schemes Act No. 121 of 1998, the Act makes provision for a penalty for individuals who join a medical scheme after the age of 35 years, i.e.

> **Premium penalties for persons joining late in life**.—(1) A medical scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties (p. 11)

The use of the term "may be applied" suggests that the medical schemes have a choice as to whether or not they will apply this penalty. It seems that the legislature had intended that a measure of discretion would be used when applying this penalty. However, an ethnographic study conducted by Golomski (2018) between November 2014 and March 2015 specifically related to white insurance brokers and healthcare administrators showed that the opposite is true: "Older adults were penalized in this fee, and having not been employed in the past or not making enough to join a scheme did not matter" (p. 321). While the participants in this study showed growing concern for their own health care and that of their parents, they continued to sell and to subscribe to medical schemes as, in their view, they still provided better access to and quality of health care than the public healthcare system.

The penalties that have been approved by the MSA range between 5% and 75% of a member's premium for the rest of their life, which makes it much more difficult to access private medical aid – particularly if a person have been unemployed, or engaged in part-time, informal or contract employment.

As I show in the analysis that follows and by drawing on the experiences of interviewees, this law overtly contradicts the promises outlined in the preamble of the South African Constitution (Republic of South Africa, 1996, pp 1-18)[emphasis added] of:

1. a **recognition of the injustices of the past**
2. belief that **South Africa belongs to all who live in it**, united in our diversity
3. heal[ing] the divisions of the past and establish a society based on **democratic values, social justice and fundamental human rights**;
4. lay[ing] the foundations for a democratic and open society in which government is based on the will of the people and **every citizen is equally protected by law**;
5. **[the means to] improve the quality of life of all citizens** and free the potential of each person

Chapter one notes the founding provisions:

3. (1) There is a **common** South African citizenship.
   (2) All citizens are— (a) **equally entitled to the rights, privileges and benefits of citizenship**; and (b) equally subject to the duties and responsibilities of citizenship.
   (3) **National legislation must provide for the acquisition, loss and restoration of** citizenship

Chapter two, outlined in the Bill of Rights, includes the following:

7. (1) It enshrines the rights of all people in our country and **affirms the democratic values of human dignity, equality and freedom**
   (2) The **state must respect, protect, promote and fulfil the rights in the Bill of Rights**
9. (1) **Everyone is equal before the law** and has the right to equal protection and benefit of the law.
   (2) Equality includes **the full and equal enjoyment of all rights and freedoms**. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
   (3) The **state may not unfairly discriminate directly or indirectly against anyone** on one or more grounds, including **race**, **gender**, sex, pregnancy, marital status, ethnic

or social origin, colour, sexual orientation, **age, disability**, religion, conscience, belief, culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

10. Everyone has **inherent dignity** and the right to have their dignity respected and protected.

11. Everyone has the **right to life.**

13. No one may be **subjected to slavery, servitude or forced labour**.

20. No citizen may be **deprived of citizenship**.

24. Everyone has the right—

(a) to **an environment that is not harmful to their health or wellbeing**; …

27. (1) Everyone has the **right to have access to**—

(a) **health care services**, including reproductive health care;

(b) **sufficient food and water**; and

(c) **social security**, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The **state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights**.

(3) **No one may be refused emergency medical treatment**.

The limitations of these rights are only permissible when:

36. (1) The rights in the Bill of Rights may be limited only in terms of **law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom**, taking into account all relevant factors, including—

(a) the nature of the right;

(b) the importance of the purpose of the limitation;

(c) the nature and extent of the limitation;

(d) the relation between the limitation and its purpose; and

(e) less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, **no law may limit any right entrenched in the Bill of Rights**.

The right to human dignity and the right to life are non-derogable rights — rights that in theory cannot be taken way and are fully protected by the Constitution. The right to equality is protected on the grounds of race, colour, ethnic or social origin, sex, religion or language.

Given the current legislation and the way it is being imposed in relation to the constitutional assurance, it calls into question the idea of who is deemed fit to be called a citizen and to receive full benefits of the promise of equal citizenship? The Constitution overtly states that; "No citizen should be deprived of citizenship" (Republic of South Africa, 1996, p. 12). So, it begs the question, what does it mean to be a citizen of this country?

2.3 The citizenship debate

Boatcă (2015) contends that citizenship and citizenship rights are extended through various avenues. Some can obtain citizenship through *jus sanguinis* (children inherit the citizenship rights of their parents), *jus soli* (birth right citizenship), or citizenship through investment where one may be able to purchase the rights to citizenship. Citizenship was meant as an equalising mechanism to mark universal equality of political and social rights (Boatcă, 2015). However, in the case of the poor, we see that many rights abuses are enacted without any recourse. Poni (2009) argues that different rules apply to the poor. In the case of South Africa, the state can evade its responsibilities and abuse the power that it holds by intimidating the poor through physical violence, the threat of exclusion from services and the use of legal recourse that they are not able to afford (Poni, 2009). By this definition, one can see how the Constitutional promise and the lived realities find themselves contradicting each other. In addition, in South Africa more black people find themselves in conditions of impoverishment compared to their white compatriots (Delobelle, 2013). The socio-political and historical context of colonialism, the dispossession of land and livestock as well as the overt exclusionary apartheid policies that rated blacks as second class citizens have left a legacy of inequality that has been difficult to overcome (Coovadia et al., 2009).

While Boatcă's argument is compelling, she is silent on the gendered dimensions of citizenship. Pateman (1988) contends that the social contract cannot and should not be understood without acknowledging the sexual contract. The original exclusion of women from the social contract through the disguise of women's work as "natural" and apolitical is one of the key mechanisms which prohibited women from participating in the political sphere. Pateman asserts that women were excluded from the social contract and the paternalistic model of oppressive power was only replaced by the "fraternity", as espoused by the celebration of men during the French revolution. She argues that the exclusion of women in the social contract allows institutions, such as marriage, employment and the state to function

as mechanisms for oppressing women. Through the exclusion of women from the political sphere and by relegating women's work to the private sphere, Pateman argues that the idea of equal citizenship has been flawed for women from the start. Given this innate flaw within the social contract it matters not how many strides are made within society by including women in politics, voting or economic activities if we do not acknowledge the underlying structural exclusion of women from the "social pact" and the political importance of their reproductive work. The exclusion of women through patriarchal structures which relegates reproductive work to the private sphere adds to the larger debate around care work and its true value. Both Boatcă and Pateman's analyses has merit.

However, Barchiesi (2007) turns our attention to how these dynamics play out in the context of the post-apartheid government's embrace of neoliberalism. He argues that the overarching neoliberal message that has been touted by the South African government has been one of social inclusion or citizenship vis-à-vis wage labour. By this, he means that the government has argued that one would best be able to access full citizenship rights if they are in paid employment. He argues that by using wage labour as a device of social discipline, or as a way to control people's behaviour, citizens are able to claim their access to citizenship. Yet with the increase in unemployment and the precarious nature of wage labour in contemporary South Africa, it is impossible for all citizens to access wage work and they are by default punished for not being 'the perfect citizen' as the state provides no welfare assistance for able-bodied, working aged adults who cannot find paid work. The popular discourse therefore is that individuals who are unable to secure jobs, are seen as lazy and unproductive members of society who should not receive full access to citizenship and social relief assistance, thereby absolving the state of their responsibility to protect human dignity.

Similarly, Brown (2016) argues that neoliberal policies and the decentralisation of responsibility for social welfare from the state onto the individual, forces the individual to be held accountable for their socio-economic situation regardless of their class, race or context. These discourses, like those of wage labour are problematic in a society with existing inequalities and only serve those who are already in power. Furthermore, she asserts that the law is used as a tool which further empowers the state, finance and corporate capital while delegitimising the causes of workers, consumers and citizens. This decentralisation of power, coupled with the responsiblisation of citizens place a dual burden on individuals. Individuals are both "expected to fend for themselves (and blamed for their failure to thrive) and for the well-being of the economy (and blamed for its failure to thrive)" (Brown, 2016, p10). Brown asserts that the sacrificial nature of this citizenship is found in the ways in which religion and collective solidarity is used to protect the growth of the country/economy at the expense of

individual wellbeing. For individuals, precarious work or unemployment along with the commodification of state services becomes the sacrifice they have to bear for the "greater good".

2.4 Paid and unpaid work

Globally the concept of social reproductive work refers to unpaid work that is mainly performed in the private sphere (the household) (Fakier & Cock, 2009). Benya (2016) and Fakier and Cock (2009) argue that this labour, which is predominantly carried out by women within the private sphere, is essential to the productive sphere. Both Dalla Costa (1996) and Federici (2012) agree that capitalism benefits from the reproductive work that is largely done by women. The current state of social reproduction is in a state of crisis and this is exacerbated in the Global South, where mostly women are employed in the precarious informal labour market to provide domestic services (Fakier & Cock, 2009). Social reproductive work, which includes physical work such as cooking and cleaning as well as emotional work such as care work, forms the foundation of what happens within the public productive sphere. However, women are not compensated for this and it is seen largely as a "labour of love" (Andrews, Timm, & Paremoer, 2020; Fakier & Cock, 2009).

In dual income households, women continue to bear the burden of reproductive work (Fakier & Cock, 2009). Fakier and Cock (2009) argue that the state of reproductive work both globally but particularly in the South should be regarded as one that is in a state of crisis. In a case study done in KwaZulu-Natal Province, South Africa, the authors argue that the state of crisis is heightened by the increase in poverty, unemployment, an increase in gender based violence, the HIV/AIDS pandemic and the resultant number of orphaned children, the feminisation of labour, the inadequate provision of social grants and poor access to food and water (Fakier & Cock, 2009). Women are then immersed in these conditions to not only provide care for children and the elderly but also to make do with the meagre provisions in order to secure food and water. Women therefore serve as "shock absorbers" to mitigate the worst effects of the reproductive crisis. This not only benefits capital and patriarchal notions of reproduction but also absolves the state from providing adequate social support to its citizens, particularly women. They contend that the multifaceted ways in which women who largely do reproductive work are exploited and the conditions that perpetuate this should be re-examined as a matter of urgency.

This was exacerbated by the COVID-19 pandemic where women were effectively excluded from accessing the Social Relief of Distress Grant (SRDG), as one of the prerequisites for receiving the SRDG is not being a recipient of another grant (Casale & Shepherd, 2021).

Caregivers who receive a Child Support Grant (CSG) on behalf of a minor were excluded from receiving the SRDG. Because of the gendered nature of care work, this revealed the state's inability to see the value of caregivers or to recognise women outside this caregiving role and make sufficient accommodations for their social wellbeing as well. Moore (2020) argues that the state's inability to recognise women as more than caregivers, is a failure to recognise them as citizens. In addition to the lack of financial support by the state, lockdown restrictions placed an added burden of care on women and resulted in a decrease in their income as well as the number of hours worked in the paid economy (Casale & Shepherd, 2021; Moore, 2020). The crisis of social reproductive work is not only exacerbated in the South but is heightened by added crises such as the global COVID-19 pandemic, to which none of us are naturally immune.

To mitigate the human resource crisis within the public health sector, the state has employed a cadre of Community Health Workers (CHWs) through NGOs (Hlatshwayo, 2018). The CHWs are mostly black women and are regularly hailed as "unsung heroes" (Vale, 2020) but find themselves burdened by the dual care work of looking after their own families as well as those in their communities, without adequate compensation (Hlatshwayo, 2018). Andrews, Timm and Paremoer (2020) contend that CHWs' double burden of work is associated with healthcare as well as social development. This would therefore translate into a triple burden of work as they care for their families, their communities through the healthcare work as well as undertake social development work. However, the state, through the mechanism of volunteerism and underemployment has exploited this particular type of worker and has regarded the reproductive work that they do as unskilled (Andrews et al., 2020). While precarious work is defined by the underemployment, casualisation, lack of unionisation and benefits, one could argue that social reproductive work is seated at the heart of all precarious work given the ways in which it is devalued in society.

2.5 Black women

For the purpose of this minor dissertation, the researcher felt that, given the way in which citizenship status intersects with poverty, wage labour and gender, it would be important to examine the ways in which these intersections impact black women in South Africa. According to the 2019 mid-year population estimates, South Africa's population was approximately 59 million (Statistics South Africa, 2019b). The majority of the population is black African representing approximately 80%, while coloureds and Indians make up approximately 11% and whites represent approximately 8% of the population. Approximately 49% of the population is male. The SAHRC equality report argues that South Africa is one of the most unequal countries in the world (South African Human Rights Commission, 2018). Income and

wealth inequalities persist; while poverty has increased, 90% of the country's wealth is owned by only 10% of the population. Land is still unequally distributed with only 4% of rural land being owned by black South Africans and of this a mere 13% is owned by women.

Women, both black and white, have been subjected to patriarchal systems both in the pre-colonial era as well as the era of settler societies (Salverda, Krus, & Van Niekerk, 2008). Women and women's bodies were subjected to male domination and used specifically for reproductive labour. When compared to men, South African women from all population groups spend more time on unpaid reproductive labour (Statistics South Africa, 2013). However, white women spend the least amount of time on reproductive labour while black women spend a disproportionately greater time caring for others. Due to the inequitable health system, women also have the added burden of more time caring for relatives and children who are ill (Amollo, 2012). Health inequalities are also exacerbated, and considerable differences are seen in each population group (Statistics South Africa, 2019a). Access to medical aid cover and private healthcare facilities is substantially lower for black African people when compared to other population groups. For women in particular, poverty contributes to higher rates of gender inequality specifically for those who reside within rural areas (South African Human Rights Commission, 2017).

The experiences of men and women in the public healthcare system in South Africa are profoundly different (Mbali & Mthembu, 2012). The physiological and anatomical differences in men and women are heightened in a health care system that focuses on the biomedical approach which used the white, male, cisgendered, heterosexual, able-bodied subject as a normative measure (Mbali & Mthembu, 2012). In addition, gender socialisation, gender-based violence, HIV/AIDS, maternal mortality rates and unpaid care work increase inequalities between men and women (Mbali & Mthembu, 2012).

Women are not only subject to abuse by their partners but studies have shown that individuals reinforce patterns of violence that exploit the already marginalised (Lucas d'Oliveira Pires Lucas, Grilo Diniz, & Blima Schraiber, 2002). Lucas et al. argue that violence in the form of neglect, verbal and physical violence and to a lesser extent sexual abuse are all forms of abuse perpetrated by healthcare workers. These workers are socialised into patterns of abuse within the teaching and training environment and continue to reinforce their power and control over patients. Kim and Motsei's (2002) eerily entitled article, "Women enjoy punishment" contend that nurses whose primary work is to give care are firstly individuals before they are care workers. Individual attitudes and beliefs that are reinforced by society through socialisation, including patriarchal norms, are thus reinforced within the workplace.

2.6 South Africa's healthcare system

The long history of private health insurance in South Africa was founded on an ethos of providing health insurance for whites only. This was the foundation of the dual healthcare system we experience today. Over 80% of South African citizens access health care through the public health system, while less than 20% use privately funded medical aid schemes (McLeod, 2011; The National Planning Commission, 2011). However, more than 50% of the total health care expenditure is represented by the private health sector while only 16% of the population has access to it (Goudge et al., 2018). This inequality is further evident in the ways in which human resources have been allocated, showing a larger number of healthcare workers employed in the private sector (Coovadia et al., 2009; Mayosi et al., 2012), which disproportionately privileges those who have access to health care through medical schemes and entrenches the public/private sector divide in the health system.

With the advent of democracy in the early 1990s and government policies that promoted privatisation, the number of for-profit general hospitals, private GPs and medical specialists increased exponentially. The SAHRC has argued that various policies and legislation do not align with the constitutional objectives and as a result new patterns of inequality and segregation are forming (South African Human Rights Commission, 2018). Gilson and McIntyre (2007) contend that not enough is known and understood around the impact of health policies and argue that, "In order to address health system inequalities, policymakers and analysts need to pay closer attention to the comprehensive regulation of the private sector and the achievement of a more equitable public-private mix" (Gilson & Mcintyre, 2007, p. 3).

In 2019, the Competition Commission (2019) released a report that highlighted the excessive cost of private health care and the need for additional regulation from the state. While the report had explicitly highlighted the use of penalties to dissuade members from anti-selection practices[2], it failed to recognise the complexities of South Africa's history and that many South Africans are completely unable to afford the exorbitant cost of private medical aid. In addition, McLeod and Ramjee (2007) argue that these penalties place people who could not afford access to medical aid schemes in the past in a position of unfair disadvantage.

Abadía-Barrero and Bugbee (2019) argue that a new critical agenda needs to be at the forefront of research. They contend that the primary health care (PHC) agenda has been

[2] "Anti-selection includes a broad range of behaviours, including 105.1. individuals join medical schemes when in need of care, i.e. when they expect healthcare expenses and leave the scheme once treatment has been completed; and 105.2. people not joining medical schemes (or leaving if they are already members) when they believe they will not need access to care." (Competition Commission of South Africa, 2019, pp. 119-120)

assimilated by neoliberal agendas and large intergovernmental organisations such as the WHO and the United Nations Children's Fund (UNICEF) have adopted selective primary health care (sPHC). The sPHC looks at the efficient allocation of resources while disregarding the comprehensive PHC plan that was expressed in the 1978 Declaration of Alma-Ata, which comprised holistic ideas of health that included socio-politico-economic conditions. Cairncross, Peries, and Cutts (1997) contend that vertical health programmes are much easier to measure and evaluate than the myriad social determinants of health, and this could be another reason why sPHC programmes were implemented.

While policies might be implemented to make monitoring and evaluation of health outcomes easier, there might be adverse effects on the ground. Golomski's (2018) work highlights how disconnected bureaucratic policies are in relation to ordinary people, while Sanz (2017) asserts that there is a disjuncture between "bureaucratic time" and illness. His work shows how bureaucratic processes that are implemented at the level of the insurance scheme are in tension with the sometimes-urgent health care needs of the patient, thus causing the patient further harm. For South Africans, many of the medical aid schemes are contracted to specific network service providers. Members can no longer freely access services at a preferred healthcare facility or practitioner as they are bound by scheme rules to choose from the Designated Service Provider (DSP) list (Kaplan & Ranchod, 2014). In addition, various other bureaucratic processes are in place, certain procedures require authorisation from the medical aid scheme before they may be undertaken, while a specific formulary is given for each illness and the way it should be treated. This could be inconsistent with what the healthcare practitioner has prescribed. The possibility of accessing private healthcare could generate reflexive calculations and choices that might be as simple as avoiding long service-user waiting times within a public health system over shorter times within the private healthcare sector, despite the fact that decision-making over health care provision within the private sector is highly regulated by medical aid schemes and not solely or even primarily a matter of "patient preference" or "doctor knows best".

"Quality health care for all" which is part of the National Development Plan 2030 (NDP) of South Africa has not yet been achieved (The National Planning Commission, 2011). While the state would like to focus specifically on the public healthcare system, they acknowledge the need for access to private health care and how it could work in tandem with the public healthcare system in not only reducing the excessive cost of privately funded health care, but also to narrow the gap of quality care for all (The National Planning Commission, 2011b). However, Mthiyane (2012) argues that access to private health care does not guarantee quality of service. Her study, which focused on decision-making in women who had

undergone a hysterectomy, showed that private health services did not guarantee adequate counselling and support services. In the study, all of the women interviewed received treatment at a private healthcare facility and six of the seven women expressed their dissatisfaction with the lack of information about their options and the post-operative side effects of a hysterectomy.

Golomski's (2018) study highlights other disadvantages related to the high cost of private health insurance. While medical schemes innately have an in-built equalising model, where members are not penalised by paying more in premiums for pre-existing conditions, it does not make any concessions for lower socio-economic class members who pay larger proportions of their incomes to medical aid schemes as all members pay the same premium. "Most formal sector employers require their staff to take out medical scheme cover even though there is no legislation requiring membership" (Ataguba & Mcintyre, 2012, p. 36). In addition, members pay large out of pocket (OOP) amounts to cover co-payments, day-to-day (DtD) benefits, pharmaceuticals and other assistive devices such as wheelchairs and crutches that are supplied freely through the public healthcare system (Ataguba & Mcintyre, 2012; Mcintyre & van den Heever, 2011). Furthermore, Ataguba and Mcintyre (2012) contend that the administrators of medical schemes are ultimately for-profit organisations and as such their mandate is in opposition to the 'not-for-profit' mandate of medical aid schemes which brings into question the ways in which the LJP is implemented.

When analysing benefit design for medical schemes, all schemes offer in-hospital cover while New Generation, Hybrid and Traditional schemes offer DtD benefits at varying rates (Kaplan & Ranchod, 2014). Payments are almost always guaranteed when the cost is associated with in-hospital care, which has biased spending in favour of tertiary care (Competition Commission of South Africa, 2019). However, research shows that public health is most effectively promoted by investing in comprehensive primary health care and improving the social determinants of health by "tackling the inequitable distribution of power, money, and resources" (WHO Commission on Social Determinants of Health, 2008) that shape unequal health outcomes.

The Competition Commission also reports that "overutilization is prevalent in the private healthcare sector, without stakeholders having been able to demonstrate associated improvements in health outcomes" (Competition Commission of South Africa, 2019, p. 30). In 2010, the president appointed the National Planning Commission (NPC) to develop a long-term development strategy for South Africa (National Planning Commission, 2010). Their responsibilities include the monitoring and evaluation of developmental policies aligned with

the NDP through a multi-disciplinary approach and providing solutions that would develop the growth of South Africa as a country. The NPC's Diagnostic Report released in 2011, stated that "private healthcare is not a solution, as in South Africa it has proved costly and inefficient" (The National Planning Commission, 2011c, p. 32). However, In 2005, the post-apartheid government introduced the Government Employees' Medical Scheme (GEMS) for civil servants (Goudge et al., 2018). Goudge et al. argue that by providing a closed option scheme to civil servants, the state had effectively prioritised quality health care for civil servants in the private sector at the expense of the broader population, which relies on public sector facilities.

Opponents of the current NHI Bill (2019) would argue that the existing health coverage that is offered by medical schemes should continue, and that the NHI should only cover those who do not have private healthcare coverage (van den Heever, 2019). Others contend that this line of thinking would only perpetuate the existing lines of inequality already seen, given our two-tiered healthcare system (Reynolds, 2017). Additionally, van den Heever (2019) asserts that the health care challenges in both the public and private sectors are due to the lack of action and an inability on the part of government to create meaningful change within these systems. He therefore contends that if government is not able to fix these systems prior to the implementation of the NHI, then both healthcare systems would fall into a state of disrepair. However, the discussion here has shown that the private sector, if left unregulated, does not necessarily provide patients with better value-for-money than the public sector, better information about their medical conditions, more efficient use of resources, or more freedom of choice with respect to service providers and treatment or procedures.

2.7 Chapter Summary

This chapter highlighted the key promises of the Constitution as well as the LJP, as outlined in the MSA Act of 1998. In addition, concepts of citizenship by Barchiesi (2007b) and Brown (2016) were discussed as well as Fakier and Cock's (2009) study that highlights the crisis of social reproductive work. These will be used as analytical tools in Chapter 4. It also foregrounded the reasons why black women were used as the study population followed by a short overview of the healthcare systems in South Africa.

Chapter 3: Methodology and Results of Data Analysis

3.1 Introduction

This chapter outlines the methodology and results of data analysis employed during the study. The qualitative data were analysed by generating themes which will be described in detail below. The findings will be discussed at length in the following chapter and linked to the scholarly literature on citizenship.

3.2 Research approach, paradigm and strategy

A qualitative research approach was adopted as the objective of the study was to explore working women's responses to the LJP and its perceived effects on their lives (Bertram & Christensen, 2014; Punch, 2014). Epistemologically, the research is grounded within the interpretivist and critical paradigm, which acknowledges the subjective nature of knowing, contextual realities and how other factors such as socio-political status, class, economics, gender and history shape realities (Bertram & Christensen, 2014).

The current literature on the topic of the LJP is limited, framed from a positivist perspective and data is largely reflected quantitatively. In addition, the focus of existing literature responds to the economic question of risk mitigation for medical aid schemes and lacks deeper awareness of how these impact members of society at large. In Golomski's (2018) paper, entitled *Elder Care and Private Health Insurance in South Africa: The Pathos of Race-Class*, he asserts that research that specifically focuses on the impact of medical scheme plans on providers, specifically in lower and middle income countries (LMIC), have not been explored. His paper focuses specifically on white healthcare providers and insurance brokers and is the first which explores the impact of the MSA that shows a more nuanced reflection of the implications.

Due to the current global COVID-19 pandemic, one-on-one in-depth qualitative telephonic interviews were conducted using a topic guide with a semi-structured, opened-ended question format (Appendix 1) (Punch, 2014). Topic guides provide assistance while the interview is being conducted, combining structure and flexibility (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2013). The participants had the freedom to explore their ideas and suggest new topics which were of importance to them. All the interviews were conducted in English and transcribed verbatim. Where participants code-switched, the researcher was able to translate these expressions into English and capture the essence of the intended meaning.

3.3 Sample approach

When selecting the sample population, the researcher took into consideration the age restrictions imposed by the LJP. The inclusion criteria comprised of those with knowledge of the LJP and women in the formal or informal sector work ages raging between 30 and 60 years. A purposeful sampling method was deliberately employed in order to meet the inclusion criterion (Ritchie et al., 2013). In addition, snowball sampling techniques were applied where existing participants referred respondents from their social group of acquaintances who had knowledge of, and experience related to the LJP. Participants who had no knowledge of the LJP were automatically excluded.

3.4 Recruitment

Six participants were interviewed. Two of the participants worked in private medical practices (full-time permanent), two worked for non-government organisations (NGOs) (both full-time, however one participant was on a contract), one was self-employed and the other participant worked for a private company (on a contract post). The researcher received ethics approval during the height of heavy lockdown restrictions (please see ethics confirmation in Appendix 4). Movement was limited for essential travel and as such a social media strategy was employed to recruit participants. A poster was prepared and circulated via Facebook and WhatsApp (please see Appendix 5). Direct messages were later sent to potential participants who met the inclusion criteria. The researcher had set out to interview a diverse group of women represented by age, ethnicity and employment type. However, this was unfortunately not achieved in terms of age and ethnicity. The participants were all employed women between the ages of 35 and 43 years and none of them were black African. Only one black African responded to the interview call; however, she declined to participate as she felt uncomfortable with being interviewed. Three participants dropped out of the study after contracting COVID-19 and being hospitalised. One participant contracted COVID-19 and a follow-up call was difficult to arrange as she was suffering from long COVID. The researcher tried to respect the convalescence period and time of each participant.

Participation was on a purely voluntary basis and interviews were audio-recorded, transcribed verbatim and anonymised with the verbal consent of the participants as soon as possible after the interview. Post-interview field notes were transcribed as well. The informed consent form can be found in Appendix 2. In addition, all participants were given verbal and written information regarding the nature of the research and the research process, with the written information sent electronically by email or WhatsApp message (please see Appendix 3). Participants were able to ask clarifying questions and were made aware of the voluntary basis

of their participation. All the interviews were conducted in English, which was the participants' first language.

Interviews were conducted via telephone (Skype for Business) or Zoom, depending on which medium worked best for each participant. This, in itself, had posed various other challenges for the research. Some recordings were dotted with intermittent static silences as there were various network issues. Additionally, some interviews were arranged telephonically and meeting requests were thus not sent out. This meant that some interviews had to be postponed as the participants forgot about them. Some interruptions disrupted the flow of the interview and the lack of face-to-face interaction meant that communication and cues from body language and facial expressions were lost. The researcher had to constantly assure their presence to the participants with verbal responses. Some of the participants were unknown to the researcher and various techniques were employed both before and after the interviews to ensure that a comfortable, non-threatening space was created. The researcher took time to ease the participants into the conversation by discussing issues such as their wellbeing, their state of mind and coping methods and strategies during COVID lockdowns, prior to actively recording and commencing with the interview process. Participants were surprisingly open and shared very intimate details with the researcher. Again, the lack of face-to-face contact posed a dilemma as responses which were limited to spoken words alone may not have been sufficient for the researcher during these moments.

Participants were offered an opportunity to read the transcribed data for informant validation purposes and were able to provide feedback where any inaccuracies had been identified. In addition, participants were given the opportunity to discuss important themes that arose from the interview in an effort to co-create knowledge (Moletsane, 2015). These conversations were also transcribed verbatim and used as part of the dataset. Furthermore, each participant was given the opportunity to choose their own pseudonym; this allowed them the opportunity to see themselves within the research without compromising their anonymity or their confidence.

3.5 Data storage and management

The research objectives required qualitative analysis of in-depth interviews. The researcher conducted six semi-structured interviews. All consent forms, participant names and contact details were stored separately. Electronic data were stored on the researcher's personal laptop which is password protected. The interviews were recorded using a digital recorder stored electronically in MP3 format. After transcription all identifiable information was

removed. The transcribed data were stored on the NVivo 12 software where all files are user access protected.

3.6 Quality assurance

The researcher was responsible for overall quality assurance. Participants were offered an opportunity to read the transcribed data for informant validation purposes and provide feedback where any inaccuracies were identified. Transcribed and anonymised manuscripts were also checked by the supervisor.

3.7 Profiles of research participants

Participant I: Mia

Mia is a 35-year-old, Indian female who responded to my research poster on Facebook. She lives in Pietermaritzburg with her parents and sibling. She is a university graduate who currently works remotely for an international company. She currently subscribes to a medical aid as a dependent on her mother's medical aid scheme. She has not experienced a LJP but is concerned about how this may impact her in the future. Mia has worked abroad in South Korea and Spain where she had access to NHI through a small monthly contribution (Participant interview I, June 2020).

Participant II: Deesha

Deesha is a 40-year-old, divorced Indian female who works in for an NGO in Cape Town. Deesha was not penalised for joining a medical scheme late. However, even though she had medical aid membership through her ex-husband's insurance a condition-specific waiting period was imposed on her, for her pre-existing medical conditions (Participant interview II, June 2020).

Participant III: Celia

Celia is a 42-year-old, married coloured female with two children. She works in the Southern Suburbs of Cape Town for a private specialist and her cost of employment package does not include any additional benefits such as a retirement fund or medical aid contribution. She initially accessed medical aid through her husband's work benefit in her early twenties while he was working for the City of Cape Town. However, in 2008 he lost his job and their medical aid benefits were subsequently suspended. In October of 2009 Celia applied to be on a medical aid again, this time for herself and her first-born child. In December, she found out that she was expecting her second child. When the medical aid scheme was notified of this, they implied that she had known about the pregnancy when applying for cover, and there were

questions about whether the scheme would cover her antenatal care. She thus delivered her second born child at a state facility and only discovered later that her medical aid scheme would have covered the cost of care associated with her pregnancy. Celia had suspended her medical aid membership due to unaffordability as she was the sole breadwinner at the time as her husband had started studying full time. In 2017, Celia was able to subscribe to a medical aid scheme again and was fortunately not penalised with the LJP as they had proof that they were members of a medical aid scheme during their twenties. She and her partners' salaries were affected by the global pandemic in 2020 and they have been unable to afford their medical aid payments. Should they wish to subscribe again they might be forced to pay the LJP (Participant interview III, August 2020).

Participant IV: Zaida

Zaida is a 43-year-old coloured female who grew up on the Cape Flats. She currently works as a secretary for a private specialist and does not contribute to a pension or medical aid scheme. Zaida worked abroad for several years and upon returning to South Africa, she completed a National Diploma in Human Resources. She has been an active member of a medical aid scheme for three periods of her life. Firstly, during her twenties when she joined a medical aid as part of her overall benefits package and then later on two occasions in her thirties, once in her private capacity after returning to South Africa and the second time was through the company that she worked for. However, this was short lived as she was retrenched and has since not been able to afford medical aid insurance.

Participant V: Naomi

Naomi is a 37-year-old coloured female, married with three children (Participant interview V, October 2020). She has a degree in finance and is self-employed. After graduating she worked for an international financial organisation where she subscribed to a medical aid scheme as part of the overall benefit package. When she first started working, she wanted both her parents to have access to medical aid funding as it meant that they could access private health care, however they both declined. When she resigned, this benefit was no longer available to her and she subsequently decided not to purchase medical aid again as she believed she would receive better financial benefits from investing an amount equivalent to the premiums in an investment account for medical emergencies. She has not been affected by the LJP, but should she join a medical scheme in the future she might be (Participant interview IV, October 2020).

Participant VI: Ameera

Ameera is a divorced 38-year-old coloured female. She has a 17-year-old daughter from her marriage who is currently in Grade 11 and has full custody of her. Ameera does not have access to a medical aid scheme, nor can she afford one. Her daughter had access to medical aid benefits through her ex-husband's scheme, however, this was only for a short period of time. At the time of the interview, she was working for an NGO and was unsure of whether she would have a job after December 2020 (Participant interview VI, October 2020). Fortunately, the organisation she works for received funding for another project and she is currently still employed (Participant follow-up call VI, April 2021).

3.8 Data Analysis

In order to generate themes, each transcript was read carefully to gain an overall understanding of the context of each participant. Transcriptions were also done by the researcher, which helped to immerse herself in the data. While transcription took place, the researcher found herself identifying patterns and themes. The initial repeated reading of the transcripts left room for open coding. The data revealed recurring themes that were common amongst some of the participants' narratives. However, this thematic analysis also showed how some participant views diverged from others.

Using NVivo 12 software, data were coded systematically after close reading of the transcripts and follow-up transcripts using transcendental realism (Punch, 2014). Data reduction, data display and the drawing of conclusions were informed by this approach. First level codes were used to reduce and summarise data. Sub-themes within the broader codes were used to help reduce codes further and to provide more understanding than the first level codes. In addition, field notes and memos were used as part of the analysis to highlight certain thoughts and ideas that became apparent during the process (Bernard, 2006). The use of diagrams and flow charts allowed for ideas to be clarified and verified throughout the process (Punch, 2014). The process of analysis was not linear in nature but allowed the researcher to sift through relevant facts and allowed time to construct a framework to capture the analysis. Data interpretation and analysis were closely linked; the interpretation of the data took place at the same time as the data analysis. These processes were iterative and happened concurrently.

Thematic analysis of the data from the interviews generated the following themes, which form the framework in which the results are presented and are later discussed:

- Autonomy and control
- Precarious work and waithood
- Women's reproductive work subsidises the productive economy

- Lack of knowledge regarding the LJP

3.8.1 Autonomy and control

Themes of autonomy and control were dispersed throughout the interviews. Participants actively shared experiences where they were able to gain control over their lives through making decisions that would benefit them and their families. Some of these decisions and actions were made in the face of strong social, judicial, economic and cultural opposition while other decisions felt more neutral. Ameera was married to her partner under Islamic law and found him to be abusive, herself threatening violence in order to get the divorce she wanted. According to South African law, marriages under Islamic or Shari'ah law are not recognised (Gabru, 2004). This means that the gap in the legislative framework leaves little to no options for women who are trapped in abusive relationships. Under Islamic law, women who are in abusive partnerships cannot access divorce privileges unless the husband requests dissolution of the marriage. As such, men are reluctant to divorce their wives. By threatening her husband, Ameera was able to receive full divorce rights which typically include maintenance of the woman and an inability for the husband to reclaim any of the gifts her husband had bestowed on her during their marriage. Ameera's decision to take control of her life in opposition to the dominant patriarchal system embedded in both Islam and the South African judiciary is testament to her agency.

Ameera found herself in a space where society, the law and her religion would continue to hold her hostage to a partner who was abusive. She was socialised into believing that as a Muslim woman there were certain abuses that she had to tolerate from her husband. However, getting out of an abusive marriage was a matter of survival and with a child to take care of there was no doubt that she would do whatever it took to free herself from this oppressive relationship. It was crucial for her to act and use whatever resources she had at her disposal to remove herself and her daughter from that dangerous environment. She was able to overcome strong societal narratives of what a good Muslim wife should be and act in the best interest of herself and her daughter. This phenomenon that positively reinforces the behaviour of men through culture, religion and law and negatively reinforces women's desire to leave abusive marriages is Harro (2013) refers to as institutional and cultural socialisation. Ameera was able to liberate herself from this cycle by speaking out and using the tools available to her (such as threatening violence) in order to break free from this oppressive relationship. At the same time, she was also able to break the cycle for her daughter.

However, due to her actions, Ameera no longer has access to the health care benefits that she would have received as a beneficiary of her husband's medical aid and as a 38-year-old

woman she would now be subject to LJP. While their daughter was able to access medical aid benefits, Ameera lamented the various restrictions the medical aid had placed on accessing care and relayed a story about how she needed to make two separate dentists visits a week apart when her daughter needed two fillings. Even though Ameera has been able to enact her agency through securing a divorce with full rights, this has left her vulnerable to being penalised for joining a medical aid scheme late. Additionally, she has added concerns of approaching the age of forty without any financial security for retirement.

Ameera: I think my biggest focus and concern now is reaching 40. The reality of that and saving for retirement. So, so that would take priority over medical aid at the moment, to be honest. Erhm, it's like a double-edged sword… (Participant interview VI, October 2020).

Given this study's focus on medical aid scheme access and health care, it was interesting to observe that one of the participants had chosen not to purchase medical aid. When Naomi was 35, she decided to leave her full-time job at an international financial institution and consequently, her medical scheme benefit was terminated. During the first few months after this change, she had been exploring medical aid options and eventually opted not to purchase medical aid. For her it seemed more reasonable to take the contribution she would have made on a monthly basis and transfer that into an investment fund that she could access if she or her family needed emergency medical care. Her interim plan was and is to access the freely available care within the public health sector, to which she has access as a citizen. During the course of our conversation, she relayed a story about a friend of hers who had additional bills due to a shortfall that the medical aid did not cover. The following is an extract of her reflection:

*Naomi: You get what I'm saying? And I mean, I've had a baby in the last two years and that's huge for medical aid. That's almost why you have to have medical aid. You know? And kids in and out day to day. So, when she said that, I**, I inwardly smiled and I said, I definitely made the right choice. Because that would've been me. I would've been paying monthly and then I'd still be stuck with bills thereafter because that's the reality. It doesn't matter how awesome your plan is. It doesn't matter how awesome the medical aid is.** [emphasis added]* (Participant interview V, October 2020)

Naomi, who has a finance degree and who has been working within the finance industry for years feels that she had made the best decision for herself and her family. The financial benefits for her far outweigh the possible benefits she might receive from a medical aid scheme subscription. She used the knowledge that she gained within the finance industry to re-evaluate these ideas regarding medical aid membership, which largely go uncontested.

In an article published by the CMS (2009), *How and why people join medical schemes,* it is noted that there are four reasons why someone would opt to join a medical scheme: (1) as an option through their employer, (2) a perception that they would be able to access higher quality of care within the private sector, (3) members would prefer to avert risk given the high cost of private health care, and (4) affordability (Maphanga et al., 2009). Noami's decision not to opt-in to private medical aid goes against the dominant discourse but she has an alternative plan should things go awry. She is able to control her financial and health-related wellbeing through alternative financial solutions and the use of public healthcare services. She is also able to pay for DtD medical expenses like over-the-counter medications OOP, while planning for more costly events like dental check-ups on an annual basis, using funds she would have spent on insurance premiums. She also has the flexibility of working from home, which frees up her time to visit the public sector clinic should any of her children require a clinic visit – which is free. Her behaviour challenges beliefs about anti-selection and opens other possibilities for opting out of medical aid subscription. While the dominant messages around public versus private health care still prevail, Naomi's personal experience and that of her parents have allowed her to make a more informed decision regarding her own and her family's health and wellbeing and she was able to take control of this aspect of their lives. However, Naomi is uniquely positioned to do so as someone who is now self-employed as a financial advisor. She is in control of how she spends her time and is able to decide on the best health care and financial options available to her and her family.

In addition to making financial decisions, participants shared their experiences with asserting a sense of autonomy in relation to healthcare professionals. In some instances, a form of complacency settled in as they learned over time what decisions and prescriptions healthcare professionals were likely to make in relation to their conditions. However, with knowledge came a renewed sense of power. Mia revealed that her family doctor always prescribed antibiotics even though she constantly had adverse side effects to this medication. She eventually stopped taking the medication prescribed by her doctor, would identify the illness she had and decide how she would treat it. Furthermore, restrictions of labour law required her to have a medical certificate if she was on sick leave for two or more days. If she required this, she would still visit her family doctor and use the sick note to negotiate her time off from work but would administer a course of treatment that she felt would be most suitable for her. In the following extract, Mia reveals how a GP had misdiagnosed her and only responded to her request for further tests because it was required. She had subsequently sought care from a homeopathic practitioner who was able to treat her accordingly.

Mia: ...and then, my GP retired and then I started going to another GP and that GP was just ridiculous. I mean, I went to him with a shoulder ache and he started diagnosing me with uhm, a degenerative disorder and telling me that I had all of these other things, you know. Like a long list of things and that I needed to have tests for them and one test that I did request which I already had suspicions about was the only thing he followed up on because it required further testing. So, and then I went to a homeopath and adjusted my lifestyle to accommodate the results of the test that I had received. Uhm, so it's like you are paying someone you know that you already don't trust and then you are not taking their advice because you don't trust them, and you are still doing your own thing. But you have to have the advice because they have a degree and because they have the power of signing for medicine and signing medical reports. So even now I am looking for a new GP and I haven't been to a GP in over a year because I haven't had need. (Participant interview I, June 2020)

While Mia acknowledges the power that certain healthcare professionals have and that the system contributes to it, she has found ways of mitigating these to suit her lifestyle. This is similar to Deesha's situation. She prefers making use of natural homeopathic medicines and to consult with alternative healers. While she is currently on a medical aid, she still chooses the way in which she receives health care even if it is at an additional cost to her since her medical aid only covers allopathic medical care. Deesha spoke about experiencing a similar loss of autonomy or choice in relation to her medical aid cover, which also does not fully reimburse the costs of "alternative" medical treatment.

Deesha: Oh health care, erhm, I think because of being ill last year and because I two-years ago went to a nutritionist, but I was so desperate to stop my problem with my inflammation I went again to an alternative nutritionist, which again medical aid does not pay for. So, they did give me, reimburse me a certain amount like. Erh, the alternative nutritionist charged me erhm just before lockdown I went to her for two sessions altogether and vitamins, she charged erhm R2 950 or so, and the medical aid paid me back R950 [or] something like that. So they don't fully pay it and they claim because she charges much higher rates, but I also would not go to another nutritionist erhm, like a typical average nutritionist, because I've been to the one especially the one who came to me in hospital…
Researcher: Mmmh
Deesha: …And they tend to advise me and tell me stuff that does not make sense to me. (Participant interview II, June 2020)

Like Mia, Deesha has found that the allopathic treatments are not always the best for their health and have found ways of acting in their own best interest. However, her narrative also highlights the ways in which medical aid schemes enact control over their members. Medical aid schemes are designed in such a way that they can dictate to members where they should get care, the type of care they should receive, by whom and when. Both Mia and Deesha had shared their experiences with their medical scheme that would only pay a limited portion towards homeopathic care. This type of care, which is largely preventative, stands in opposition to biomedical approaches which are given more weight within the South African healthcare context. Medical aid plans focus largely on in-hospital care, and chronic medical benefits with an option of additional day-to-day, out of hospital benefits (Kaplan & Ranchod,

2014). In addition, medical aid schemes are typically contracted to DSPs and members are subject to receive care only at facilities or from healthcare practitioners who are contracted into the scheme. This restriction has become a criterion for medical scheme choice when deciding which medical aid to subscribe to.

Celia recalls how she would spend time researching the best medical aid scheme and options. While affordability was a big decision-making factor, the ability to find a scheme that would allow her the capacity to choose where to receive care was important.

Celia: …the criteria that we looked at for joining a medical aid was [were] cost, and what benefits they were offering for the amount of money that they were offering [expecting]. The things that were important to us were ***not being limited to going to a specific hospital*** *or just having a service at a state facility, but that we would be able to go to a private facility. Erhm, and with our previous medical aid and this is years back when we [were] with, when Jacob [pseudonym] still worked for the City of Cape Town we were never limited to the facility that we had to go to. We could go to any service provider and any hospital that was closest to us, for want of a better word. And these days, what I find or what I found in my homework to get medical aid was that* ***no matter which medical aid we were going to join, we would be limited by the doctor, by going to see a preferred provider for a particular medical aid and a preferred hospital service provider as well****. Erhm, and based on where I worked, and where our home was, that basically factored in who we would choose as a designated service provider. So that's all the things that went into deciding that and then cost is a huge, huge factor. [emphasis added]* (Participant interview III, August 2020)

Mia's experience of control by the medical aid scheme takes on a different form. She is currently a member of a medical aid scheme but even at the age of 35 she is not allowed to be a "main member" due to the precarious nature of her work. She is a university graduate, who has spent a few years working abroad due to her inability to find work in South Africa. Upon her return, she has worked in various jobs but with limited contracts. While she is able to afford medical scheme membership, the medical aid does not recognise her as a full member:

Mia: …So, when I was working over… when I left South Africa, I didn't have any… I was still dependant on my parents for medical aid and uhm, because I hadn't been employed full-time since graduation, because of the state of affairs in the country. And then I finally went overseas, was able to earn a living wage overseas that was tax deductible? Or tax free? And uhm did that for three years and then when I returned, I was not working straight away and living off of my savings and then… I started working part-time, but still below a taxable amount and was considered a dependent because I wasn't full-time employed. So…, I hadn't joined my own medical aid and I was paying cash for anything that the medical aid wouldn't provide.
Researcher: So, you were a dependent on your parents' medical aid? And…
Mia: Yes.
Researcher: ...but you are still a dependent on your parents' medical aid?
Mia: Yes, because I went overseas and when I returned, I couldn't afford my own medical aid and I was considered a dependant because I wasn't full-time employed.
Researcher: And you still not full-time employed?

Mia: Uhm, at the moment I'm [employed] on a contract basis and that is also still not considered full-time employed. (Participant interview I, June 2020)

While Mia is willing to subscribe to a medical scheme as a main member, the medical scheme has rejected her application due to her contractual work status. However, she is able to subscribe to a medical scheme through her parent's benefit but only as a dependent. This reveals an interesting resistance between autonomy (which she has gained as an income-earner) and control (exercised over her by the medical aid scheme which does not recognise her as the "right" type of worker), but still leaves Mia concerned about her future regarding a LJP due to her inability to access private medical aid, which is through no fault of her own.

After her divorce, Deesha was desperately seeking to sever all ties with her ex-husband and her the access to his medical aid scheme was the last link between them. She thus needed to find a new scheme. Even though she had been on a medical aid and had no periods of uninterrupted cover, her new scheme still excluded her from accessing benefits for her pre-existing medical conditions.

Deesha: Erhm, so, erhm, they said that they explained to me that I would not be able to use my medical aid for three months erhm, because ya of pre-existing conditions.
Researcher: Okay.
Deesha: Mmmh.
Researcher: Now, your, so sorry but you were…
Deesha: They said that…
Researcher: No, but you were on your ex's medical aid, why did they not want to pay for it?
Deesha: So, they ya, I don't know? I don't know [with] these guys. And so, the first three months I couldn't use it and I actually did not get off my ex's medical aid. He kept threatening to and this is such a typical woman issue. He kept threatening to… He would encourage me to use it, erhm after the divorce and then he would erh kind of threaten to… or insult me to get off his medical aid and don't use it. (Participant interview II, June 2020)

Deesha found herself trapped between control exerted over her through arbitrary implementation of scheme rules and her abusive ex-husband, while at the same time having to make the best decision for her physical, mental and emotional wellbeing. She had managed to get through this period in her life but not without increased stress levels.

Medical aid schemes are also finding other ways, such as reward programmes, of exerting control over their members and encouraging members to self-regulate. Discovery, Momentum and Fedhealth all have reward programmes attached to scheme membership (Compare Guru, 2017). Incentives are tiered and based on members' abilities to reach specific health goals. Medical aids have partnered with certain companies to offer their members discounted rates and added rewards for living a healthy lifestyle, including discounts on gym membership and rewarding healthy eating. However, this comes at an additional cost. The popular Discovery

Vitality membership for a single member is R290 per month, over and above the medical aid subscription (Discovery Health Medical Scheme, 2020). As Deesha explains, it is not financially viable to opt for the Vitality package as she would not be able to recoup the money she spends in discounted savings and therefore opted not to join their reward programme. Adrian Gore, the founder and CEO of Discovery Health argued that as a financial institution they needed to be innovative in order to survive in the South African market, "Our gut instinct was that if you can make people healthier, you can offer more sustainable insurance" (Gore, 2015). A cross-sectional study done in 2006 showed that members had decreased health care costs as participant in the Vitality programme through Discovery Health. The challenge with the Vitality programme is that it once again excludes those who cannot afford the associated costs but also ignores other forms of promoting health and wellbeing such as Mia and Deesha's practices. However, these women are still able to act autonomously in the face of control enacted over them by their medical aids, healthcare practitioners, employers, partners and the state.

With the unapologetic way in which medical aid schemes and administrators apply the LJP, members are forced to subscribe to medical aid as soon as possible or find themselves paying a higher penalty at a later date. This could even be at the cost of their own financial and psychological wellbeing, should they not be able to meet their budgetary requirements.

3.8.2 Precarious work and waithood

Since the 1970s there has been an increase in "flexible employment" (Benach et al., 2014). Work precarity can be identified by the casualisation of jobs, lack of unionisation and bargaining power, decreased employer incentives such as medical aid and retirement benefits, low wages and employment insecurity. The participants of this study shared their experiences in this regard and with the global COVID-19 pandemic, their job precarity had only increased. Zaida is deemed an essential worker. She works in a private specialist practice and is part of the front-line staff who has face-to-face contact with patients. She does not belong to a private medical aid scheme due to its lack of affordability and also does not belong to a union. In addition, she has no other employee benefits, i.e. pension or provident fund. When asked around contingency measures her employer had put in place should she contract COVID-19, this was her response:

Zaida: So, we never did discuss what would happen if we needed to be hospitalised. I suppose it is. It might be some kind of risk involved because of the job that I do. ***The actual cover of that medical treatment is a personal responsibility. Anyway, apart from… I'm thinking of if I needed to be hospitalised at any point that would be done in my own capacity****. What has happened in this COVID time is that if at any point any of the staff exhibit symptoms… Firstly, if we were exposed to anybody, erh who has become known to be positive*

erh, our doctors would question us about, just to confirm whether we have had an exposure that is unsafe. As in, like erhm, within the social distancing [protocols], without a mask, etc. [emphasis added] (Participant interview IV, October 2020)

Even though Zaida is permanently employed, she cannot afford the high costs of joining a medical aid scheme and while her employer is a healthcare practitioner, she had deemed it the responsibility of her employees to secure their own health insurance. To add insult to injury, Zaida occupies a job that is not in line with her tertiary qualification. She currently works as a secretary (she does not have a formal contract or a letter of employment), despite the fact that she completed her National Diploma in Human Resource Management at the Cape Town University of Technology (CPUT) in 2013. The precarity in her employment is not only seen in the lack of contract and medical benefits but additionally, she is underemployed and does not belong to a union.

Similarly, Celia has worked within her private medical practice for more than ten years and has opted to buy into medical aids at different times during the course of her employment as her employers had usually not offered this benefit.

Celia: Private medical practices, they do not offer any other compensation or perk, for want of a better... or any other benefit apart from your salary. So, your medical aid, your provident or pension fund or retirement annuity comes out of your pocket, and in general they don't contribute toward that… (Participant interview III, August 2020)

During the pandemic, even though she was also seen as an essential worker, she too experienced a pay-cut. Coupled with the fact that her partner was self-employed, this left her with no choice but to accept the decreased salary in order to keep the lights on at home. During this time, her medical aid cover had also lapsed. She confessed to feelings of insecurity and fear owing to the pandemic, should her or her loved ones fall ill and need hospitalisation.

I interviewed Ameera in October of 2020. At that time, she confirmed that while she had a long-term contract in place with her employers, she had no way of ensuring her long-term employment in the organisation as funding had not yet been secured.

Researcher: …But now you also mention that you work in the NGO field, which is a very precarious field in terms of funding and…
Ameera: Exactly, like even now we've got salaries until December. After December, moet ek met my bek in die wind staan vir Jan [I must stand with my mouth open against the wind in January – meaning the wind must fill my stomach] (laughter).
Researcher: Are you kidding me?
Ameera: I just hope for the best. Ya, and – and my directors are very chilled, shame.

Researcher: You don't have… and – and – and I ask this, so we and I understand NGO sectors to a certain extent. ***So, you've got funding until December month and nothing's been firmed up [confirmed] for (laughter) 2021 which is around the corner, erhm...***
Ameera: ***Yes, definitely promises, but I also know from my experience that funders are very fickle, that promises doesn't, unless it goes 'ka-ching' in the- your bank, in your organisational bank account, it really means nothing****. [emphasis added]*
Researcher: Absolutely. So, you don't have a contract, a long-term contract or a…
Ameera: We do, but long-term contracts do nothing if you have no money. You can't even sue people that has [have] no money. You can't even take them… because what are they gonna do.? They're gonna be like no, we don't have money. What do you want us to do? So, erhm, we're waiting and hoping for the best. Erhm, I've started a… I'm also such a loyal... I've started looking at NGO Pulse and things and I'm thinking but my directors are going to be so sore if I send in my resignation letter, how are they going to live without me? (laughter).
(Participant interview VI, October 2020)

Ameera laughed nervously during this part of the interview. Her reality of job insecurity, being a single parent with little to no support from the father of her child during a global pandemic, only heightens the uncertainty and the short-term sustainability of her and her daughter's livelihood.

A graduate, thirty-five, unmarried, with no dependents and still living with her parents, Mia has also not been able to find job security. Her story is a story of many young graduates who find themselves stuck in what Honwana (2014) would argue is "waithood". Waithood is referred to as the period where one is "waiting for adulthood". The National Youth Policy (NYP) 2020 defines a youth as someone who is between the ages of 14–35 which is in line with the African Youth Charter, where a youth is defined as being aged 15–35 years (Government of the Republic of South Africa, 2015). In 2014, approximately 36% of young people in this age group in South Africa were unemployed, with the rate of unemployment higher for women than men (Cassim & Oosthuizen, 2014). The *Fact Sheet on "NEETs"* published in 2017, showed the highest rate of persons (46%) who are not in employment, education or training (NEET) are between the aged 25 – 34 years (Department of Higher Education and Training, 2017). This definition of not being in employment, education or training is problematic, as it overtly refuses to account for instances like Mia's or Zaida's where they are underemployed. Although Mia has made every effort to be an economically active member of society, the precarious nature of her work has left her in a void, suspended by the practicalities that do not allow her the full freedoms she has worked for. This is not only the case for Mia, as Zaida, Ameera and Celia have shared similar experiences of waithood. This state of waithood is camouflaged by underemployment and other forms of job precarity. The definition of NEETs as unemployed also draws attention away from the work they are actually doing, i.e. unpaid social reproduction work is not counted as "real work" by the NEET framework. Failing to

account for and value the social reproduction that the participants do is something that is more fully discussed below.

Celia expressed a similar concern with her families' growth trajectory, after her partner went back to study full-time. According to her hypothetical analysis, their family might only achieve some level of financial freedom when they are both in their fifties due to the delay in achieving adulthood. Within the South African context adulthood would then be seen as someone who is financially and emotionally independent, someone who is able to provide for themselves through wage labour and its attached benefits.

Celia: It… to some extent yes [has changed the way I think about medical aid]. It made both Jacob [pseudonym] and I realise that this is something that we need to get going sooner rather than later, ***because hypothetically if we were in an ideal financial position only at the age of 50, which is closer to our retirement age and closer to the time that our kids are grown up and we maybe have more financial stability – and the reason why I say only 50 financial stability is because Jacob was about 34 when he started studying and he started practising really late so the practice took x-amount of years to grow versus erhm a practice that he started in his 20s or early 30s. Erhm, so say hypothetically we would be more stable at the age of 50 and then we decide to join, then we are looking at all other possible comorbidities that we may have and then be really fined or penalised for joining that late. But that would be the only time that we could possibly afford [to join a medical aid scheme]****. So, we made the decision to join when we did and although there were a lot of months where things were really really tight, one of the things that we made sure we paid was the medical aid. [emphasis added]* (Participant interview III, August 2020)

If they had waited to achieve financial freedom the cost of medical aid care would increase exponentially not only due to the LJP but due to possible comorbidities they might suffer as a result of the natural aging process. Precarious work and waithood, which is an ever-increasing phenomenon, were not considered when the LJP was written into law. The assumption that the larger population would be able to access medical aid scheme benefits by the age of 35 years is dependent on job security, which the South African government is not able to guarantee, given the high unemployment and underemployment rates in the country.

3.8.3 Women's reproductive work subsidises the productive economy

The unseen and unpaid reproductive work done largely by women subsidises the productive economy. It is estimated that approximately US$10.8 trillion per annum should be spent on those who do reproductive work and yet we find that those who are doing the work are undervalued and underpaid (Lawson et al., 2020). In addition, the current pandemic has only further blurred the lines between public and private spaces, and this has exacerbated the issue. Mia has been working remotely from home during lockdown while her sister, who is an essential health worker, has had to work on site. She confesses that while she does work in

a tracksuit as part of the "productive economy", her sister is absolved from doing reproductive work as her work is seen as more important because it is done in public, rather than in the privacy of the home. In the quote below Mia reflects on how she assists her mother and fellow household members with everyday chores.

Mia: ...so obviously that [referring to her mother being a pensioner] comes with a certain reduced capacity to do what she is used to doing. Uhm, basic things like you know, helping with the everyday chores, uhm taking care of meals, and tending to the yard, tending to the house, going on errands for her and taking her on errands, emotional support, things like that you know, just being able to be present, that is there, an extra pair of hands which does go further than you'd expect but it does help because now that I am working more regularly and am unable to offer that time, there is a strain… because… I'm, I noticed that okay, for me it was a case of because I'm not working as regularly let me do other things to make life easier... (Participant interview I, June 2020)

When Mia initially arrived home after working abroad, and with her contract jobs, she was able to assist her mother with the social reproductive work. Now that she is in full-time employment but working from home, she is struggling to balance the two. This confirms what Valodia (2000) notes as the "double load" that women bear (Cited in Fakier & Cock, 2009). While her sister also benefits from Mia's social reproduction work, she does not actively participate in ensuring that the reproductive work is done. Mia believes that there is a certain value placed on reproductive work (which is different for everyone) and some people are therefore able to contribute to this even if they are part of the productive economy. Mia sees the importance of reproductive work and therefore actively contributes to this type of work within their home, while her sister does not.

Celia had gone to extra-ordinary lengths after delivering her second child in order not to be penalised financially during her maternity leave:

Researcher: So, I want to highlight the fact that having a new baby is not just about, you know, taking care of the baby but it also probably meant there was a decrease in your salary while you were on maternity leave. Erhm, am I right?
Celia: No, I'm... I'ma say no, because I ended up working from home during my maternity leave, so that I didn't get a cut in my salary. My employer at the time had offered me 80% salary for being on maternity leave. Lord knows why I convinced him to let... I convinced him to [let me] come back to work sooner, but I started working from home when he [the employer] got back from leave which was about 6 weeks after I had my... my baby. So, I went back to work. (Participant interview III, August 2020)

Although Celia had negotiated a way around her reduced income, she found herself trying to balance her productive employment, a new born baby and his older sister who needed to go to school, in addition to the other reproductive tasks she was responsible for. Her husband was studying full-time during this period, so she was the sole wage-earner in the household.

She recalled how starkly different this was for her in relation to the birth of her first child when these reproductive tasks were assumed by her mother and she was able to focus solely on the care of her new born baby and her own recovery. Sadly, her second birth was a bit more traumatic. While she gave birth naturally, she suffered a perineal tear, urinary retention and she was constipated. In addition, the baby had to be re-admitted to hospital as he had jaundice. What is apparent from her story is that the financial benefits of going to work early had placed added strain on her to continue to produce within the private sphere at 120% even though she was working on diminished capacity due to her recent birthing experience.

Mia and Celia's experiences both confirm the importance of unpaid, unseen reproductive labour, whether it is done by themselves or others, like Celia's mother. These are important for the ongoing production of productive labour. What the LJP therefore does is create an added barrier for women to access care that might be available to them either by them having to (1) meet the financial burden of the penalty should they be subjected to it or by (2) maintaining contributions to avoid being penalised. This places added pressure on women in order to make ends meet as in the case of Zaida, who already has challenges with trying to stretch her salary just for basic needs, and Celia who has already expressed concern around the care needs of her family now that she is no longer covered by a medical aid scheme. The LJP assumes therefore that both men and women have already achieved equality when accessing work opportunities but moreover totally ignores the reproductive labour burden that many women face. In doing so, the reflexive calculations that women have to make around care; the 'how', 'when', 'where' and 'which' care can create further anxiety that could result in adverse health outcomes for them.

3.8.4 Lack of knowledge regarding the Late Joiner Penalty

While there was some broad understanding around the LJP, most participants were not aware of the intricacies of the penalty and how it was implemented. This uncertainty had led Ameera to believe that the penalty was a once-off lump sum payment that would be paid to the medical aid scheme for joining late.

Ameera: So, I think it shed light on the whole penalty thing. ***Cause like I said I thought it was a once off thing, it's not, it gets added into your monthly thing*** *which again, I think capitalism is a bitch. [emphasis added]* (Participant interview VI, October 2020)

The knowledge that she would now have to fork over an additional percentage in monthly contributions in perpetuity has left her with more questions than answers, as it makes her feel that medical aid affordability and benefits are skewed in favour of the medical schemes. Zaida also expressed that on learning about the LJP that she was "scared off" from joining

(Participant interview IV, October 2020). She, like Celia and Naomi had expressed a desire to apply for medical aid membership on behalf of their parents.

Zaida: Where I needed to make like calculations and the way the people that were explaining it to me, I'm assuming it was correct. I'm just not sure if my memory is remembering it properly, but it was… ***and I don't know actually what the amount would've been. I just know it was… it scared me off. It scared you off having to…*** *You already know what medical aid costs, now you've got this late joiner penalty that is going to be added onto that amount every month for the rest of this person's life, that is wanting to go onto medical aid.*
Researcher: Mmmhhh
Zaida: That was just obviously something I wouldn't have been able to afford. And that is when I also erhm, was educated I am going to say about erhm if you are joining a bigger company, they get to actually erhm apply for you for medical aid without that late joiner penalty….[emphasis added] (Participant interview IV, October 2020)

While she was unsure of the ways in which the penalty was structured, she had realised that joining a large company would negate this penalty. However, when applying for posts within her field of study she was unable to find jobs that would allow her to maintain her lifestyle as all the posts that she qualified for were junior, entry-level positions.

Deesha's understanding of the LJP was also sketchy. She was unsure whether the rules of the LJP applied to her, if the three-month exclusion was due to the LJP or if this was due to her having a pre-existing condition. She also conveyed feeling of being pressured into subscribing to a medical aid and not fully understanding the fine print when signing up.

Deesha: So, they asked, have you been on medical aid and I feel that was the main question and now I realise you know? Reading my policies and stuff (cough) sorry. So, erhm, the one I think the main question that is linked to the late [joiner] penalty I would say is the extra cost on your medical aid or where you would start three months later and with some people even twelve months later. How hectic is that? So, one question I think was erhm, were you on any other medical aid er and how long ago did you get off the medical aid?
Researcher: Mmmh,
Deesha: So, I told them that I still am on my ex's medical aid. I still am on a medical aid. I just don't want to use it. So, they said "okay". Erhm and then the other then of course I got [have] diabetes and hypothyroidism so those two, those two really, I think counted and erhm. So, they were not going to pay. And I mean end of last year I also read in the policy that especially if you are 35 years and older, they could add that penalty. (Participant interview II, June 2020)

Mia shared a similar lack of knowledge around the details of the LJP and had more questions than answers. Since she is currently still in a state of waithood, she is unable to actively engage with this law as it technically does not apply to her yet. Lund (2008) warns us in her reflection on writing the report which aimed to explain the CSG to South Africans, about the lack of communication and miscommunication that emanated post submission. The mixed messages that were communicated to the public were seen as a way of the state trying to deceive them and failed to capture the true essence of the recommendations that were put

forward. The LJP, which has already been ratified leaves little room for the larger population to contest it given their lack of knowledge. Freire (1970) would argue that the lack of knowledge that surrounds these laws aims to hold people within a state of oppression or dehumanisation. The state would overtly control the information and narratives that are available to the larger public in order to keep them submissive. The lack of knowledge surrounding the LJP and medical aid schemes in general is concerning as this information could determine whether a family would fall into a state of debt as described by Naomi (Participant interview V, October 2020) or have increased OOP healthcare costs even though they are subscribed to a medical scheme (Ataguba & Goudge, 2012). In addition, the Competition Commission (2019) acknowledges that benefit options are not standardised and are therefore confusing. As a result, many people are unable to adequately plan for their health care.

3.9 Chapter Summary

In this chapter, the researcher presented the methodology and an analysis of the data collected for the study. Data were collected using one-on-one in-depth interviews. The data were coded using NVivo 12 software, where the following themes emerged: (1) autonomy and control; (2) precarious work and waithood; (3) women's work subsidises the productive economy and; (4) lack of knowledge regarding the LJP. The findings in this chapter will be discussed at length in relation to the literature review in the next chapter.

Chapter 4: Discussion

4.1 Introduction

In this chapter, the themes that emerged in the previous chapter will be discussed in greater detail. These themes are: (1) autonomy and control; (2) precarious work and waithood; (3) women's social reproductive work subsidises the productive economy; and (4) lack of knowledge regarding the LJP. These themes highlight the paradox of the LJP in relation to citizenship. The institution of citizenship is generally seen as one that provides everyone with access to equal rights, thus eliminating or mitigating class, race and other hierarchies (Boatcă, 2015). In addition to citizenship also being an equalising force, it historically included the decommodification of social income, health insurance and retirement benefits provided by the state (Barchiesi, 2007b). The following analysis will show that while the ultimate goal of the institution of citizenship, as described in the South African Constitution is to promote substantive and formal equality, legislation such as the LJP is written in a manner that supports neoliberal ideals that ultimately only benefit those who are already regarded as full citizens. By this, I mean that the LJP was written with people in mind who would be able to achieve active citizenry by the age of 35 years. That is, to be able to actively participate in wage labour as the primary mechanism for financing their household's social reproduction needs, including accessing private medical aid either through their status as an employee or as a result of being able to afford private health care themselves.

4.2 The inadequacies of wage labour

At the cornerstone of our Constitution is the realisation of social justice and human rights which would recognise our history of colonialism and apartheid as an economic barrier. Given that South Africa is only 25 years post democracy, the hundreds of years of oppression still have an impact on the country and its people and would need active reforms to transform the status quo. Redistributive policies and the institutionalisation of social rights are embedded in the Reconstruction and Development Plan (RDP) of 1994 and the Constitution of 1996 (Barchiesi, 2007a). However, the RDP policy document also spoke of wage labour as a central theme which would reduce the dependence of its citizenry on state welfare (Barchiesi, 2007b). Barchiesi contends that there is a disjuncture between policy discourses and the expectations of wage labour. In his paper entitled, "*Wage labor and social citizenship in the making of post-apartheid South Africa"*, he argues that there has been an increase in the commodification of public services such as health care, retirement, municipal and transport subsidisation along with an increase in the discourses that idealise the working citizen and shame those who are dependant on social welfare. This focus on wage labour as a key to access social rights comes at a time of increased unemployment numbers, increased casualisation of jobs and a

decrease in state funded social benefits, which is worsened by macro-economic policies that absolve the state from providing social assistance to its citizens. COVID-19 has heightened the crisis we see in the job market with women suffering disproportionately in terms of loss of wages in both the formal and informal sectors (Casale & Shepherd, 2021).

Zaida had reflected on this in her interview when she spoke about sourcing a job at a large company or within the public sector which seemed to be a solution to getting past the LJP. "*So, that's when I started… Okay, now I need to really find a big company to work for which is mostly government jobs cause then you don't need to pay that penalty. That's one of the reasons maybe, why I've been looking for a government job."* (Participant Interview IV, October 2020). Zaida's awareness of the limitations of the job market, coupled with a reluctance to incur a LJP had her seeking employment within the public sector. However, entry-level positions would not cover her cost of living.

The South African Constitution overtly states that there needs to be a recognition of the injustices of the past as well as an acknowledgement that the country belongs to all who live in it. Zaida, Naomi and Celia had all wanted to improve their parents' wellbeing and to this end wanted them to subscribe to a medical aid scheme. However, South African medical schemes' implementation of the LJP effectively discriminates against black South Africans. When implementing the LJP, medical schemes do not appear to take into account the historical exclusion of black South Africans from higher education and formal wage labour. The structural legacies of racially discriminatory education and labour policies effectively make medical aid unaffordable to most black South Africans. Patriarchal gender relations and their limiting effect on women's access to education and wage work compound this dynamic for black South African women. Ideally, the recognition of the nation's diversity and differences should be recognised within the laws and policies that are drawn up and should focus on those who have been disenfranchised in order to fast track the equality journey. However, the LJP is implemented in exactly the opposite manner.

The mandate for improved quality of the life of citizens is embedded within the constitutional promise, particularly the socio-economic rights contained in Chapter 2 of the Constitution. This promise extends beyond physical welfare and includes a broader promise to "free the potential of each person". Zaida, Naomi and Celia would have been able to access this better quality of life through the peace of mind that would come with having their parents access private medical aid as well as the quality of care their parents would have been able to access. However, the LJP places a structural barrier on them that only reinforces already entrenched oppressive practices.

Barchiesi (2007b) argues that atypical types of wage work have grown exponentially, post-apartheid. There has been a stark increase in the number of temporary, contract and outsourced jobs combined with a decrease in employee benefit packages. All of the participants in this study have been affected by work precarity in one or more forms. All of them are responsible for their own retirement and health insurance contributions. Deesha and Ameera both work for NPOs and their job security is dependent on donor funding while Ameera is in the unfortunate position of having a contract but being unable to exercise any contractual rights should funding be depleted. Mia has been stuck in a state of waithood to find permanent work and do away with the limited contracts while Celia has been affected by COVID-19 and is only receiving 80% of her salary, even though she is considered an essential worker. Zaida is also underemployed, doing secretarial work while she has a National Diploma in Human Resource Management, and Mia reports that she had taken other jobs including working abroad even though she has a university degree. All of the participants, despite having secured wage work, feel that private medical aid is unaffordable in relation to their current earnings, and are sceptical of their ability to pay medical aid contributions later in life, given the costs associated with the LJP.

What the LJP does is that it assumes that people who are actively engaged in wage labour are able to firstly, afford the cost of medical aid and secondly that they would be able to make these contributions by the age of 35. Given the precarious nature of work, casualisation, contract work, waithood and underemployment in this cohort, it is evident that this legislation did not have in mind citizens experiencing waithood as a permanent condition. Statistics show that more than 50% of women between the ages of 15 and 34 year are NEET (Maharaj, 2019). These citizens thus find themselves in a position where they are suspended in a form of waithood. Mia's case is particularly insightful as it is actual medical aid schemes which deem her unfit to subscribe to a medical aid as a main member due to her precarious contract work.

Narratives that paint wage work as morally and ethically good and condemn those who are unable to provide for themselves have been at the forefront of the ANC's policy discourse post-1994. This can be seen in various policy documents. For example, the National Youth Policy (2015) is subtitled "*We are generation 2020. We don't want a hand-out, we want a hand up!"* Its vision talks about creating a South Africa *"that moves away from passive citizenry towards a socially and economically included society in which people are active champions of their own development, supported by an effective government"* (Government of the Republic of South Africa, 2015, p. 2). The NDP outlines a plan that is focused largely on economic growth through increasing employment and also has a 12-page vision statement that places the responsibility of this vision onto the citizens of the country (The National Planning

Commission, 2011a). The 2003 State of the Nation address by former President Mbeki reaffirmed the desire to decrease the number of citizens dependant on social grants, while Joel Netshitenzhe argued that **dignified work** is the best hope for **social inclusion** for South Africans [emphasis added] (Barchiesi, 2007b). Barchiesi argues that the state has tried to use wage labour as a mechanism of social discipline. This form of socialisation forces individuals to see their ability to access work as an individual problem even though both unemployment and underemployment are at an all-time high and are structural in nature.

Within the confines of accessing health care too, there seemed to be a sense of accountability placed squarely on participants. Zaida expressed the desire to decrease her monthly expenditure on essentials to try to afford medical aid benefits. However, this was a futile exercise as she was barely able to meet her and her family's needs. Celia was constantly reworking her personal finances to barely make medical aid contributions. Nevertheless, despite all the months of sacrifice she has lost the benefits of her medical aid scheme as her membership has now lapsed due to non-payment.

Section 3 of the South African Constitution proclaims that there is a "common South African citizenship". However, this commonality is negated when those who have been historically disenfranchised – i.e. black South Africans – are charged more than others for the same services, through the imposition of the LJP. The LJP also covertly reinforces otherness through framing the ability to pay for a human rights service, a legitimate barrier to accessing health care. Ameera, for example, spoke about being denied medical care from a private GP for her daughter's heart defect, in an emergency situation, under the guise of her not having made an appointment. Yet the Constitution also claims that no one should be turned away in a medical emergency.

In *Discipline and Punish,* Foucault (1995) argues that power is central to and present in all human relationships and that while power could be seen as overt through violence, it is also found in the covert ways in which society normalises and disciplines us through socialisation. Discipline is therefore a tool that is used by the state in order to control large populations and could be likened to the ways in which the state vilifies those who are in need of social assistance and praises those who are able to achieve full citizenry without the state's assistance. This type of discipline or self-regulation therefore pervades other spheres of life, not only access to wage employment. Brown's (2016) argument extends beyond this as she notes how neoliberal practices decentralise power and displace the responsibility of specific actions onto the individual through "responsibilisation" in order to create an individual "self-investing" citizen. This individualisation creates weakness within the collective (where

previously workers were unionised and had a collective consciousness) as well as collective sacrifice (where full citizenship requires you to work collectively towards national growth, even when this comes at great personal expense) and vilifies ground-up action or mobilisation against the state. This devolution of power through responsibilisation is used as a means of control and power over the people.

Brown contends that the law is also used to decentralise power through responsibilisation. In the case of the LJP, members are individualised, and their collective problem is minimised to a question of economic ability to access the private market. In addition, the LJP overtly harms citizens, particularly those who have historically been disenfranchised due to colonialism and apartheid and enforces a form of poverty tax on them. Karger (2007) defines poverty tax as the "hidden tax paid by the poor because they are poor" (p.413). The LJP then legitimises medical aid schemes' actions that enforce this law and protects large companies through doing so while depriving individuals, particularly those who are poor, of the full promise of equal citizenship. The law therefore then legalises and legitimises the actions of medical aid schemes over and above the lives of its citizens, even though its true purpose should be to ensure that citizenship rights are acquired and restored. Poor people are not given the full privilege of citizenship which includes the right to access health care, and the acquisition and restoration of equal citizenship cannot be fulfilled as long as the LJP is being applied in its current format.

4.3 Women's social reproductive work subsidises the productive economy

Throughout history, women have been burdened with responsibilities of social reproductive work. This work, though undervalued and usually unpaid for, subsidises the working economy. Benya (2016) puts the spotlight on the women that do the reproductive work in mining communities in the North West Province of South Africa. Not only do we see how everyday reproductive work aids the mining sector, a keystone of the South African economy, but she highlights how women's work is affected by the working economy. In parts of the Wonderkop township in Marikana, where access to water was limited, women would wake up in the early hours of the morning to fetch water for the functioning of the household. At times when the mine shafts were not operational, women would have to do additional laundry or cook additional meals for their partners.

As detailed in section 2.4, CHWs share similar challenges in that their work is extremely important to maintain the reproductive aspects of society that fuel the productive economy (Andrews et al., 2020).The CHWs, who are largely black working-class women, do the "work that contributes to producing and reproducing people, specifically the labour force" (p. 23.)

This work is additionally invisibilised through a nationalised volunteering programme which reinforces the notion that care and reproductive work is unskilled and minimises the value that it adds to society. The state's failure to recognise care work as important reinforces patriarchal notions of work and relegates the work that is being done by millions of women to a place of insignificance.

During the pandemic, the responsibility of reproductive work had seen huge shifts with hard lockdowns, school closures and by default an increase in reproductive responsibilities (Vale, 2020). Prior to my interview with Naomi, she had to ensure that her children were occupied in order for her to fully engage with me. Celia's employer initially gave her a handset to answer calls and respond to emails from home while ensuring that her children were also actively engaged in their schoolwork. For South Africans and many around the world the global pandemic has blurred the lines of reproductive and productive workspaces and compounded the responsibilities of these two spheres without fully acknowledging the indispensable nature of reproductive work.

Moore (2020) contends that the South African government has failed to recognise womxn[3] as full citizens by not considering that womxn do most of the care work. As mentioned in section 2.4, during 2020, South Africa's government responded to the COVID-19 pandemic by establishing the SRDG for its citizens. However, as noted, those who already receive social grants through the state are ineligible to receive this financial relief. The CSG, which is meant to support the child, is paid to the caregiver which automatically excludes the caregiver from receiving the COVID-19 grant. Moore argues that because womxn are mainly the primary caregivers, only one third of womxn were recipients of the SRDG. The state's inability to acknowledge the importance of care work while calling on all of us to care more (Vale, 2020) is as Moore puts it, "adding insult to injury". The inability to appreciate and add value in the form of monetary compensation perpetuates the belief that care work does not have the same economic value as productive work.

The participants in this study are no different, Celia revealed that the balance between reproductive work and the working economy was something she had to manage. When reflecting on how she balanced work, childcare and other responsibilities she commented; "you make it work" (Participant interview III, August 2020). While in this study, for example,

[3] Moore uses the term womxn in her article which is used by intersectional feminism to avoid the perceived sexism innate in the original term wo-'man' or wo-'men'.

Mia's reflections showed that her sister benefited from the reproductive work that Mia still had to do even though she too was part of the working economy.

Just as Benya (2016) and Andrews et al's (2020) work highlights the importance of reproductive work, so too do the participants in this study reflect on how they must also ensure that their reproductive responsibilities support the productive sphere. While Mia does everything that she can within her ability to ensure that she assists her aging mother with the reproductive work responsibilities, this allows her sister to continue to produce within the public sphere. So too does Celia's case highlight the importance of ensuring that paid work and reproductive responsibilities are met. Unlike the participants in Benya's (2016) study, who largely do reproductive work, all the participants in this study, like the CHWs in the report cited above, are burdened with the "double load" of both productive and reproductive work, complicated by the precarious nature of their productive work. They are then coerced like Celia, to accept a 20% reduction in their salary during the COVID-19 pandemic and to find time to balance the added care and educational needs of her children while also needing to make the household books balance, due to her partner's loss of work as well. In this context, the possibility of having to pay a LJP when joining a medical aid scheme later in life feels like an unfair, additional burden to bear.

Most of the participants in this study pointed out the many strategies they employ – at their own expense – to remain healthy enough to avoid depleting their medical aid benefits. This social reproductive work subsidises the medical aid schemes, which benefit from having members who are healthy and averse to claiming benefits, while nonetheless keeping their policies paid up to date, in order to avoid incurring a LJP later in life. Deesha and Mia are both avid supporters of homeopathic remedies and are always seeking the least invasive holistic medications, diet information and follow specific lifestyles in order to improve their health. However, the medical aid system which largely focuses on biomedicine only supports a portion of these activities. Mia reports that her medical aid only covers R1 000 per annum for homeopathic care and even though she pays the full adult dependent premium monthly, that is the only benefit she ever uses. Medical aid schemes like Discovery Health only tend to give members discounted benefits when they subscribe to additional products like Vitality, where they would then get discounts on healthy consumption choices like purchasing gym memberships or healthy foods (see section 3.5.1). In contrast, the everyday social reproduction work that women are constantly doing, which is also health promotion work, is negated, unseen, unappreciated and profitless.

What these examples illustrate is that the women who participated in this study find themselves in positions where they are unable to 'dig themselves out of poverty', due to the strong structural inequalities that they still face. It suggests that the LJP is one element of a much larger problem of structural exclusion, one that cannot only be addressed by mitigating the impact of the LJP or continuing to rely on the promise of "job creation". Scholars like Barchiesi (2007a) and McKay (2001) would argue for a Basic Income Grant (BIG) on a non-means tested basis as a mechanism for mitigating structural exclusion, given the inadequacies of the current social grants and the lack of wage labour. McKay (2001) would further argue that traditional arguments in favour of a BIG have not examined the practicalities of the BIG through a gender equity perspective and is important to note how a BIG could change the way we value reproductive work in relation to income. In Mia's household where all the members are women, this reproductive work burden falls on the shoulders of the person who works from home. A BIG could promote equality between the sexes, acknowledgement of the value of social reproductive work and possibly improve work incentives (McKay, 2001). For women, it could change social relationships between men and women and by default the structural power dynamics that reinforce the oppression of women by men. In addition, it could also change the double burden of work that has been imposed on women specifically with the feminisation of the labour force. However, the initial proposed BIG contribution in South Africa was set at R100 per month (Barchiesi, 2007a), which would be an improvement on the current situation and would give women more resources. However, the amount would be insufficient to create structural change, necessary for long-term change.

As detailed in section 2.2, the Constitution promises that the "The **state may not unfairly discriminate directly or indirectly against anyone** on one or more grounds, including **race**, **gender**, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, **age, disability**, religion, conscience, belief, culture, language and birth" (Republic of South Africa, 1996). At first glance the state had protected itself against being accused of discrimination by writing into the MSA that a medical aid scheme **"may"** impose a late joiner penalty [emphasis added]. However, given that this penalty has been imposed on most members, the law may need to be amended. It could be argued that the state itself has sanctioned this form of discrimination without adequately making provisions for those who have been previously discriminated against through disenfranchisement due to apartheid and its structural legacies. In addition, given the nature of social reproductive work, one could argue that the state is unfairly discriminates against women through their policies and the laws that prevent them from accessing private health insurance, while at the same time relying on their unpaid reproductive labour to protect public health. Furthermore, while not touched on in this

research study, the link between advancing age and natural physical decline with the need for additional care leaves this piece of legislation open to further scrutiny.

The reproductive work which is largely done by women not only supports but is the cornerstone of the productive economy. Wage work is becoming more precarious (Barchiesi, 2007b; Benach et al., 2014; Federici, 2012), political discourses seem only to seek to reduce the state's fiscal responsibilities (Barchiesi, 2007a; Brown, 2016), and it is becoming harder to find a space in which one is able to activate their citizenship (Brown, 2016). Subsequently, as raised in section 2.4, women find themselves carrying the burden of this dysfunctional patriarchal and capitalist system which uses women, as Fakier and Cock (2009) contend, as "shock absorbers" of the larger structural crisis we currently face. An increased responsibility on individuals to be the perfect citizen has seen a decrease in the ability to activate social networks and claim full rights from the state, while leaving those who have been excluded historically, particularly black women, on the margins. The current political discourse in conjunction with the LJP forces individuals to access medical aid insurance even if it becomes unaffordable, while holding people in a state of "uneducation" in order to sustain and maintain the states' innocence.

4.4 Uneducation: the gendered financial consequences of not understanding the LJP

Naomi shared her story of initially wanting to add her parents to her medical aid when she first started working. The idea that medical aid and private access to health care is automatically a "better" option than the public healthcare system is pervasive. However, Naomi's own experiences accessing health care through the public system along with her parent's experiences have taught her otherwise. Naomi's initial socialisation led her to accept the popular discourse regarding the desirability of private rather than public health care and for years she utilised private sector care. It was only when she was actively engaging in calculating the value that medical aid schemes provide after resigning from her full-time job that she was able to apply her existing knowledge of the finance world and to interrogate these internalised belief systems. Naomi's active engagement with the subject matter gave her a better understanding of what she was purchasing and why, and this led her to believe that she had made the best decision for her family by investing the equivalent of the monthly medical aid contribution in an interest-bearing account. Day-to-day expenses are paid for OOP such as over-the-counter medications as well as doctor's visits if needed, and her children are all able to access the local public clinics free of charge. The only additional medical expenses that she has are the annual dental check-ups for the entire family which she then draws from her investment fund, free of any penalty or additional costs. She also confirms that when she did have a medical emergency, she was able to afford the cost of the private emergency

medical facility and paid the R1 800 upfront. However, she added that the funds to cover the cost of care were not needed immediately as the service provider would invoice her and send the bill by post, which arrived a week later. One might argue that in this instance, Naomi is able to hold the state accountable to provide healthcare services for herself and her family. However, she is also privileged because she has other options, and is not only dependant on the state for care. Nevertheless, Naomi's actions, which go against the current hegemonic discourse regarding public versus private health care, are ones that she was able to achieve through her own lived experience and with the application of her financial knowledge she is able to make sound financial and health care decisions for herself and her family.

In contrast, other participants found themselves in a state of uncertainty and some in a state of anxiety as their choices were limited. Throughout Ameera's interview, there was an oscillation between needing or wanting health insurance and having to plan for retirement. As we concluded the interview, there was a sense of uncertainty as she was left to decide on the best course of action for herself. The interview highlighted challenges she was unaware of in relation to the medical aid scheme membership as well as in retirement planning. There is a deeper understanding that deciding between health care and retirement benefits now becomes her responsibility and that access to private health care and retirement benefits seems unattainable given her precarious work.

Lack of knowledge regarding private medical aid scheme options and the long-term implications thereof, could have people buying into private health insurance with the hopes of using it in their old age, without realising that premiums would still need to be paid even post retirement. This one piece of information should be a game changer. However, Celia, Naomi and Zaida had all expressed the desire to add their parents to a medical aid scheme so that they too could access private health care. It seems only logical that their own premiums would have to be considered in the long-term, but no mention was made of this. If currently the participants are already struggling to 'make ends meet' and all their benefits are their responsibility, it follows that their retirement savings would be impacted by private medical aid premiums as well. Given the continued commodification of state services, this important information would have a huge impact in deciding whether or not it is beneficial to subscribe to a medical aid scheme. At this point it seems that people are then left to choose between purchasing health care or purchasing retirement benefits, with either choice appearing equally distressing.

Popular discourses only seem to perpetuate the lack of knowledge that surrounds this subject matter. There seems to be an unwritten rule that "you've made it" once you have a job with

medical benefits. Should these benefits be subsidised by the employer, then the benefit truly becomes a benefit. However, in recent years these benefits have increasingly been added as a total cost to company where employer contributions have decreased or even disappeared and the full cost of membership becomes the sole responsibility of the employee (Barchiesi, 2007b). In such instances, if the benefit does not continue post retirement, the cost of maintaining medical aid membership becomes burdensome. Ameera's grandfather and Celia's father currently enjoy the post-retirement medical benefits at no extra cost to themselves but for Celia and Deesha, who currently pay their own medical aid subscriptions from their own pockets, this will not be the case[4].

Deesha's experience subscribing to the medical aid scheme for the first time had left her confused; she was unsure of the fine print until after she signed up to the scheme. She was also in a state of crisis within her personal life. She had been harassed telephonically by sales staff after making initial inquiries into medical aid cover and when asked for more time to think about her options they would continue to pressure her and ask if she had other questions. The sales staff were unfortunately unhelpful in answering her questions. She also felt that if she had more time to think, research and discuss her options, she would have been able to make a more informed decision. Decisions around financial health, health care and wellbeing are all important and yet not much education and thought goes into the process. This appears to be something that has been left to chance, in some instances a person is employed by an organisation that equips them with benefits such as medical aid or retirement annuity contributions but in most instances, these decisions become the individual's responsibility to make.

Naomi's experience is particularly enlightening as it has brought her to a different conclusion regarding health care, access and financial aid than what she had when she initially graduated. These decisions were informed by personal experiences, knowledge that she gained in her professional environment and anecdotes from friends and family members which are in total opposition to the current hegemonic discourse. Her choice not to subscribe to a medical aid scheme also contradicts notions of anti-selection practices and pushes us to think more critically about the way we engage with financial and health decisions. The challenges that Zaida faces regarding care for her aging mother with the dual responsibility of social reproductive work, and productive work is an issue that most women face with the feminisation

[4] Ameera's grandfather worked for Telkom and receives medical aid scheme benefits through Bonitas which he no longer makes contributions towards, while Celia's father enjoys the benefits afforded to him through the Government Employees' Medical Scheme (GEMS).

of the workforce (Fakier & Cock, 2009). However, care work and social reproduction responsibilities will only increase as we see in the case of Mia and her mother.

4.5 Chapter Summary

This chapter highlighted the inadequacies of wage labour in trying to achieve active citizenship, emphasised the ways in which women's social reproductive work subsidises the productive economy as well as the consequences of financial uneducation in relation to the LJP. Furthermore, these challenges underscore that the LJP benefits medical aid schemes and punishes those who have not achieved full citizenship. The next chapter provides the main findings, conclusions and recommendations.

Chapter 5: Conclusion

5.1 Overview

This study explored women's responses to the LJP of the Medical Schemes Act 131 of 1998 chapter 4, section 13 and their perception of its effects. It sought to meet three specific objectives. This chapter provides a brief summary of this research by revising the previous chapters. It also integrates the study's main findings and provides recommendations based on research findings.

5.2 Chapter summaries

The study was introduced in Chapter One. It outlined the background and rationale for the study. Details of the research question aims and objectives, methodology including sample approach, data storage and management were also covered.

Chapter Two focused on the literature review which discussed the South African Constitutional chapters relevant to this study, as well as the MSA. Debates around citizenship by Barchiesi (2007b) and Brown (2016) as well as social reproductive work by Fakier and Cock (2009) were highlighted and used as analytical tools. This was concluded by a discussion of as the South African Health Care system, as experienced by black women.

The research design and methodology utilised to generate data were discussed in detail in Chapter Three. The study participants were introduced and the main themes, namely (1) autonomy and control; (2) precarious work and waithood; (3) women's social reproductive work subsidises the productive economy; and (4) lack of knowledge regarding the LJP were thematically analysed.

Chapter Four presented a discussion of the themes that emerged in the previous chapter, with the main findings outlined below.

5.3 Main findings

There is a lack of knowledge around financial wellbeing, medical aid schemes in general and particularly the LJP. All of the participants expressed an uncertainty around the specific details of the LJP, a lack of understanding in the way the LJP is applied and the long-term cost implications when signing up for medical aid membership as an individual. The LJP by default punishes the poor and, in particular, women through a poverty tax that decreases their ability to achieve financial and health security. This particular piece of legislation does not serve all citizens and continues to exclude women, particularly those who have been historically excluded from achieving full citizenship.

Women are more likely to be subject to the LJP due to their structural location in society. The research found that women experience work precarity in various forms. All of the participants experienced work precarity. This was seen through their underemployment, their lack of employee benefits, lack of unionisation, and with the added burden of the COVID-19 pandemic one participant experienced a decrease in wages with an increase in reproductive work due to national lockdowns.

Most of the participants experienced forms of waithood. This is partly a function of their insecure access to waged work, and of their perceived social status, within a patriarchal society, as "dependents" of men or their parents. This reflects a delay in their transition from childhood to adulthood and an extension beyond the globally defined norm of persons who are not in employment, education or training (NEET). The inability for policy and law makers to recognise this reality that many endure leaves the policy making process somewhat irrelevant as it fails to identify and acknowledge the bigger challenges that are faced by its citizens. This inability to acknowledge reality only perpetuates the national dialogue that praises wage labour over social grants.

All the participants reflected on the double burden of the workload they carry due to the gendered nature of reproductive work. These ranged from taking care of their children to ensuring that the health care needs of their parents or parents in-law were met in addition to the responsibilities of their paid employment. This required additional sacrifices from women and as stated by Celia, "you make it work". Women are therefore sacrificing much more than men in order to ensure that the productive labour outcomes are met. These findings suggest that the state is able to maximise the value they receive from women citizens while not giving them full access to full citizenship.

The sample size is small and research findings are not generalisable, the researcher recognises the relative privilege of this cohort. They have not experienced the worst in terms of access to education, jobs, housing and other resources as a result of apartheid and colonial oppression. This raises the questions of how the insights discussed here would change had the voices of women who are even more marginalised been included.

5.4 Recommendations

The Constitution of South Africa has been lauded as one of the most progressive in the world and yet we have laws that contravene its human rights principles. The covert ways in which the LJP and possibly other laws have disregarded the citizenship rights of historically disadvantaged groups should be examined and steps need to be taken to rectify these

injustices. The researcher acknowledges the importance of the proposed NHI but recognises that it may be years before it is fully implemented. In the light of this, it is also important to urgently evaluate existing laws and policies that govern the private healthcare sectors in order to create a more equitable society.

Laws and policies should be made with a "people first" approach in mind. In this instance, the LJP was made with the medical aid schemes in mind and focused on maximising profits and reducing losses due to the possibility of anti-selection. The study has highlighted that only one participant has opted to not purchase medical aid even when she could "afford" to do so. In this instance, her decision not to re-join a medical aid scheme was taken as it was more beneficial to invest that money in other investment accounts, rather than pay monthly premiums for a service that will not meet her families' needs.

Laws that are ratified should be evaluated and examined to see the effects that they have on all South African citizens. Regular monitoring of new and existing laws will highlight any inequalities that they might pervade or uphold.

The CMS should be at the forefront of evaluating the Medical Aid Scheme Act of 1998. This is at the core of their mandate. However, the topics that are being evaluated by the CMS and the questions that are used to monitor and evaluate the legislation should not only benefit existing medical aid members but should include the rest of the population.

Laws should be made easier to read. While there were several newspaper articles that had focused on the LJP post-ratification, this served only a small portion of the population. Lund (2008) reflects on how important it was to communicate a new policy, in her case the CSG, to the broader public. However, a combination of an understaffed communications department and an inability to translate policy documents into layman's terms led to public confusion and mistrust in the process.

Policy and law makers need to actively ensure that the constitutional mandate is met, along with an active seeking out of underrepresented groups within these processes. Many scholars argue that when looking at certain policies through a gendered lens we are able to increase the scope of a particular subject matter (Benya, 2016; Fakier & Cock, 2009; Lund, 2008; McKay, 2001). This is especially true with the pervasion of neoliberal policies that aim to minimise the social responsibility of the state. The state should acknowledge the unfair favouritism of private medical aid administrators in administering medical aid membership for profit over basic human rights and should take measures to reverse this injustice.

Valuable lessons learnt from the development of the CSG is the need for (1) adequate research; (2) an interdisciplinary team with experts in various fields; as well as (3) sufficient time that allows for adequate input prior to its implementation (Lund, 2008).

“Education is the most powerful weapon you can use to change the world”, words spoken by the late President Nelson Mandela. His words echo as this process of research has shed light on the multiple factors that dictate the ways in which a lack of knowledge could keep you in a state of oppression. For many of the participants and for myself, knowledge around finances, medical aids and retirement benefits are as important as knowing where to go in a medical emergency. This therefore becomes an important key to empowering South Africans from the bottom up.

Throughout the research journey, many interesting challenges were highlighted but were unfortunately not captured within this study as they fell outside of its scope. During recruitment many males approached me with the hopes that their voices could also be heard, some were healthcare professionals, who did not even know that the LJP existed. The ongoing challenges around spatial apartheid and where private healthcare providers are concentrated given the propensity for medical aid schemes to use DSPs would add a nuance to the topic that has not been addressed. In a recent article, Wolpert (2021) laments that the use of Discovery Health Medical Scheme (DHMS) specialist referral networks, which should be part of the Preferred Service Provider (PSP) network, are pitiful. While Wolpert resides in Johannesburg, he was referred to specialists as far away as Cape Town. In addition, the costs that were covered by the medical aid were a fraction of what the specialist had charged. This highlights the unaffordability of private health care within South Africa, the huge bargaining power that medical aids have, and the high costs of co-payments that members still have to ‘fork out’. The good news is that the CMS will be publishing new guidelines for DSPs and co-payments within the next 180 days (Business Tech, 2021; Council for Medical Schemes, 2021), hopefully this would mitigate some of challenges medical aid members currently face. The Minister of Health, Zweli Mkhize’s 2021 budget speech highlights other challenges that we still face and which are compounded by the COVID-19 pandemic (Felix, 2021).

While some of these concerns that are raised are not a direct result of the LJP the unaffordability of the medical aid makes it more likely for people to experience exclusion due to not having access to a medical aid scheme. This minor dissertation focuses on the way in which one aspect of private medical aid schemes function and as such other issues fall outside the scope of this research. In this minor dissertation, I have shown how the state has

successfully imposed a poverty tax on its citizens through the LJP. In addition, the promise of equal citizenship has been compromised by discriminating against citizens based on their age, gender and historical disadvantage. Moreover, recommendations to amend the LJP have been proposed in the hopes of realising the Constitutions' promise of equal citizenship for all.

5.5 Chapter Conclusion

This chapter has summarised the main findings of the study as well as proposing recommendations that could be used at various levels of society. Existing lessons around policy and law making should be utilised in conjunction with the constitutional mandate to create a more just society for all who live in it. Addressing these structural challenges at a macrolevel would allow for a better understanding of what is happening on the ground. This is in conjunction with empowering citizens with the knowledge and tools to ensure that they are able to make decisions that benefit them and not reinforce the structural oppression that already affects them.

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Interviews

Participant I: Mia, 2020. Scottsville via Skype for Business, 6 June.

Participant II: Deesha, 2020. Muizenburg via Skype for Business, 17 June.

Participant III: Celia, 2020. Mitchells Plain via Skype for Business, 25 August.

Participant IV: Zaida, 2020. Mitchells Plain via Skype for Business, 13 October.

Participant V: Naomi, 2020. Mitchells Plain via Zoom, 20 October.

Participant VI: Ameera, 2020. Observatory via Zoom, 21 October.

Participant VI: Ameera, 2021. Follow-up call via WhatsApp, 7 April 2021

Appendices

Appendix 1: Semi-structured interview

Establishing knowledge of the LPJ

- When did you first hear about the LPJ?

- Were you affected by it? (If no, why not?)

Establishing response to being subjected to a LJP:

- How did you feel after being told you'd have to pay a LJP?

- What strategies, if any, did you use to challenge this penalty?

Strategies for living with the LPJ?

- How did you choose who you should register on the medical aid?

- Would you say being subject to the LPJ has impacted your relationships with family members?

- How do you ensure that you manage your budget so you can pay for medical aid at this higher rate?

- Has learning about the LPJ changed the way you think about medical aid?

Appendix 2: Consent form

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

Faculty of Humanities
Department of Political Studies

Name of researcher:

Natasha Moodaley

Title of research project:

"Joining Late": Exploring the impact of the late joiner penalty imposed by South African Medical Aid Schemes

By filling out this questionnaire / answering the questions put to me:

- I agree to participate in this research project.
- I have read this consent form and the information it contains and had the opportunity to ask questions about them.
- I agree to my responses being used for education and research on condition my privacy is respected, subject to the following: - *(tick as appropriate)*

	Yes	No
My name may be used in the published research		
My personal details (e.g. age, occupation, position) may be included in the published research		
My responses can only be used in a way that I cannot be personally identifiable		

- I understand that I am under no obligation to take part in this project.
- I understand I have the right to withdraw from this project at any stage.
- I understand that this research might be published in a research journal or book. In the case of dissertation research, the document will be available to readers in a university library in printed form, and possibly in electronic form as well.

Name of Participant : _____

Signature of Participant : _____

Date : _____

The researcher must supply you with an ***Information sheet*** which provides his / her contact details, outlines the nature of the research and how the information will be used and explains what your participation in the research involves (e.g. how long it will take, participants' roles and rights (including the right to skip questions or withdraw without penalty at any time), any anticipated risks/benefits

which may arise as a result of participating, any costs or payment involved (even if none, these should be stated))				
Has this been provided?	**Yes**		**No**	
Have your received verbal confirmation/explanations where needed?	**Yes**		**No**	

Appendix 3: Information Sheet for Research Participants

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

Faculty of Humanities
Department of Political Studies

Information Sheet for Research Participants

Title of research project:

'Joining Late': Exploring the impact of the late joiner penalty imposed by South African Medical Aid Schemes.

Nature of the research:

The research is designed to explore women's responses to the "Late Joiner Penalty" of the Medical Schemes Act 131 of 1998 – chapter 4 section 13. In addition, it would also like to understand the perception of the effects of the Late Joiner Penalty on women. We want to understand the problems and concerns regarding how women manage their health, their financial resources as well as the implications this has on their relationships.

Name of researcher:

Natasha Moodaley			
Telephone	083 321 8087	**Email**	Natasha.moodaley@uct.ac.za

Name of researcher's thesis supervisor:

Dr Lauren Paremoer			
Telephone	021 650 3388	**Email**	Lauren.paremoer@uct.ac.za

Department address details:

Room 5.33, Leslie Social Science Building, Upper Campus, Rondebosch, Cape Town, 7701	
Telephone	(021) 6503381 / 3916

What are the implications of your involvement in this interview / project?
*** The researcher may explain these to you verbally in more detail, if needed ***

If you decide to participate in this study, you will be required to do an interview with the me, in which you will be asked about your experiences relating to accessing medical aid and health services. The interview process should take approximately 60 minutes. These interviews will be conducted at a location that is suitable for you. A follow-up interview between 7 and 14 days after the interview will be required to verify the original transcript which shouldn't take more than 30 minutes. Sensitive topics such as health and finances may cause emotional distress, therefore the researcher will design the questions as sensitively as possible. However, apart from

that, there are no risks involved in the study and you may withdraw from the study and stop the interview without any consequences or penalties.

Information obtained about you for the purposes of this study will be kept strictly confidential. You will be given a pseudonym to ensure that your responses are anonymous, and only accessible by the researchers involved with the study.

This is an unpaid study and you will not receive any incentive or compensation for participating in this study.

Should you feel that I have behaved unethically or abused during our interaction, you can contact my supervisor, Dr Lauren Paremoer, who will address your complaints.

Appendix 4: Ethics approval

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To: Dr Lauren Paremoer

From: Dr Vinothan Naidoo

Subject: Ethics Clearance

Research: 'Joining Late': Exploring the impact of the late joiner penalty imposed by South African Medical Insurance Schemes

Date: 21st May 2020

This letter confirms that the student researcher, Ms Natasha Moodaley's Ethics Project Title: 'Joining Late': Exploring the impact of the late joiner penalty imposed by South African Medical Insurance Schemes, has been approved by the Political Studies Ethics Committee on the 21st of May 2020.

Yours sincerely

Dr Vinothan Naidoo

Ethics Committee

Department of Political Studies

Appendix 5: Recruitment Poster