An insurance business for the uninsured in South Africa

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Thesis submitted in partial fulfilment for the degree of Master of Business Administration to the Faculty of Commerce, Law, and Managament, University of the Witwaterrand

March 2022

ABSTRACT

Insurance can be defined as a method by which interested members of a society band together and collect funds to pay potential losses that could suffered later by members of the group (Reavis, 2012). The main objective of this study was to determine the feasibility of an insurance scheme for the underprivileged. Following the example of previously conducted research studies in this field, the researcher adopted the mixed methods research approach and employed the case study research design for the purposes of the study. This research targeted a select geographical area, Kriel Town in Mpumalanga, wherein the employees of three ESKOM power stations located in the area were selected to be the population of the study. Questionnaires and interviews were used as data collection instruments for this purpose.

Of the interviewed respondents who were contracted, there was a common challenge of not having permanent contracts, and with the risk of losing their job at any moment, they are not able to make stable decisions regarding their health insurance. Related, the permanently employed individuals noted that they did not earn enough money to allow them the luxury of having enough to join mainstream medical aids. Some common worries that came up centered on the poor services received from public health care centers

On the basis of the findings of this study, the researcher can conclude that the proposed venture, AE Insurance has a good market for penetration, and that its value proposition is good enough to warrant the initiation of such a scheme. While the initial target of the venture would be the low-earning contracted workers of the power industry in Mpumalanga, this can be expanded upon first establishment and make ground towards the rest of South Africa, as this customer profile is prevalent through all provinces and the needs of the people are likely similar across the nation.

DECLARATION

I, Victor Tshamano, declare that this research report is my own work except as indicated in the references and acknowledgements. It is submitted in partial fulfilment of the requirements for the degree of Master of Business Administration in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in this or any other university.

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Victor Tshamano

Signed at Emalahleni (Witbank)

On the 28th of March, 2022

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ACKNOWLEDGEMENT

This work is my dedication to all the people who have supported me through this journey of discovery. I wish to thank my late grandmother, Vho-Matamela Tshamano, whom I never had a chance to meet but whose narrated dedication to community service planted a seed that brought me to this juncture of wanting to use education to serve the people who are in need.

I wish to express my indebtedness to my wife Tembeka, and our two girls, Orifha and Ronewa, for their unwavering support. To my mother, Mashudu Tshamano and my brother, Khumbudzo Tshamano, your support all these years has led me to this point in life and I would like to sincerely thank you.

Lastly, my sincerest appreciation also goes to Lee Larbi, who took on the duty of supervising me throughout this study and provided guidance when I most needed it.

SUPPLEMENTARY INFORMATION

Supervisor	Lee Larbi
DUE DATE	28.03.20221
WORD COUNT	17090
PAGE COUNT	110

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

CBI	Community Based Insurance
CBHI	Community Based Health Insurance
NB	Net Benefit
CMS	Cooperative Medical System

TABLE OF CONTENTS

1. CHAPTER 1. INTRODUCTION

More generally, the aim of this study is to determine the feasibility of an insurance business based on the first principle of risk management and risk readiness, community-based insurance in the health sector. Section 1.1 introduces the history of insurance, considering how this industry has grown over time. Following this, Section 1.2 lays the foundation for community-based insurance, while the context and background for the study are outlined in Section 1.3. The problem statement that underpins this study is detailed in Section 1.4, with the preceding purpose of the study in this context outlined in Section 1.5. The objectives are presented in Section 1.6, followed by the assumptions made during the course of the study. The section is then concluded with a section on the definition of key concepts and a preface to the research report.

1.1. The history of insurance

The existence of insurance can be traced as far back as the 18th century. As noted by the researcher Haueter (2017), at that time, the development of insurance businesses was largely based on the systems of community and the intellectual capacity of those in the business. The calculative work, which in today's times is conducted by actuarial scientists, has proven to be reliable over the years, seeing the industry continually grow on an upward trajectory – leading to it solidifying itself at the center of the world's economy for years (Haueter, 2017). Trade and immigration between countries has also proven to be an influencing factor on the growth of the sector, with travelers insuring their properties to ensure they can recover them in case of any damages incurred in their absence. The industry has

even evolved to the point of people (turned brands) insuring themselves. Some examples to this effect are Michael Flatley, an experienced dancer with the amazing ability of tapping his feet to the delight of his onlookers – he insured those very feet for €20 Million, an equivalent of R320 million in the current economy (Makan, 2019).

There have been many other celebrities who have done body part insurance across various industries and countries, some citing very valid reasons for their choice. For example, upon his arrival in England, Cristiano Ronaldo quickly learned that football in England was different to what he was to in Portugal in that it was very physical. The player immediately expressed frustration at the ease at which one could easily incur an injury, and opted to insure himself in the event that he too was injured to the point of loss of salary (Acuna, 2012). Table 1 below summarizes a few known celebrities who have taken up body insurance, depicting the value of the insurance and the organ(s) insured.

Table 1: Celebrities insuring body parts (Acuna, 2012)

Celebrity	**Body Part**	**Value**
Bette Davis	Waist	$28 000 (equivalent to R251 235,60)
Rihanna	Legs	$1 000 000 (equivalent to R8 972 700)
Daniel Craig	Full body	$9 500 000 (equivalent to R85, 240 650)
David Beckham	Legs	$70 000 000 (equivalent to R628 089 000)
Jennifer Lopez	Bums	$320 000 000 (equivalent to R2871 264 000)

Haueter (2017) has presented that in earlier years, insurance was a frowned upon concept as the general public mostly relied on their spirituality as a medium of

safety. While this still remains true for some communities, prayer was used for protection against any kind of risk ranging from health, accidents, criminal, and even death. This then led to the widely believed notion that all materialized risk was simply '*meant to be'*. The researcher further posits that in those ages, risk was not seen as anything that could be prevented, which then led to the adopted approach of accepting the born consequences and learning to live with them instead of fighting the unseen spiritual realm, which was believed to the source of all that occurred in the physical (Haueter, 2017).

While managing to penetrate a lot of the superstitions, the insurance industry has also suffered through major financial losses at the hands of unforeseen catastrophes (Haueter, 2017). These catastrophes include world wars and terrorist attacks, which all end in large claims being made against insuring houses. The fact that the industry remains standing today is testament to its robust and resilient fabric, which can also be indicative of the human nature to always desire to shift risk where possible.

A Swiss mathematician by the name of Jacob Bernoulli has been lauded as one of the biggest contributors to the field of Actuarial Sciences, having used the Blaise Pascal's triangle of mathematics shown in Figure 1 below to estimate insurance losses. This method, utilizing the Pascal's triangle approach, has remained the foundation with which a majority of insurance houses build their models on to date.


90 ARTIS CONJECTANDI

Fluit ex iis, quæ in præced. cap. de Combinationibus simpliciter spectatis dicta sunt.

11. Termini seriei verticalis cujuslibet ordine divili per terminos collaterales seriei præcedentis (unio vel ab unitate vel à suis respectivè cyphris facto) exhibent quotos Arithmetici proportionales, quorum communis differentia est fractio, cujus numerator est unitas, & denominator ipse numerus sive secundus ab unitate terminus seriei dividentis. Ex. gr.

Non difficulter hæc proprietas, si opus foret, deduci posset ex sequente.

12. Summa terminorum quotcunque seriei verticalis cujuslibet à suis respectivè cyphris incipientis ad summum terminorum eodem ultimo æqualium eam habet rationem, quam habet unitas ad illius seriei numerum, hoc est, Aggregatum numerorum quotcunque lateralium ab unâ cyphrâ seriem suspicientium est ad aggregatum numerorum totidem maximo eorum seu ultimo æqualium, ut 1 ad 1 trigonalium à cyphris duabus, ut 1 ad 3, pyramidalium à tribus, ut 1 ad 4. &c. Idem quoque valet de ratione, quam habet summa terminorum seriei cujuslibet ab unitate incipientis ad summam totidem maximum sequenti termino æqualium. Ex. gr.

Figure 1: Pascal Triangle (Haueter, 2017)

1.2. Community-based insurance

Insurance can be defined as a method by which interested members of a society band together and collect funds to pay potential losses that could suffered later by members of the group (Reavis, 2012). This is the first principle of insurance and is the very definition from which this study was founded. From its inception, insurance was meant to work as a community-based risk management process. To date, a lot of the insurance business models are opportunistic ventures that benefit only one end of the party, exploiting the vulnerable and failing to address the cares of their exposure to identified risks. The World Health Organisation has identified the following key facts associated with Community-Based Health Insurance (CBHI) (World Health Organisation, 2020):

- Community-based insurance schemes are usually voluntary and characterized by community members pooling funds to offset the cost of healthcare.
- Despite much hope in these systems, evidence suggests that the impact of the CBHI on financial protection and the access to needed health care are moderate for those enrolled.
- Most CBHI schemes have low participation levels and the poorest people usually remain excluded.
- Theory and practice show that CBHIs play only a limited role in helping countries move towards Universal Health Care (UHC) targets.
- CBHI have been found to have other positive influences, such as community development and the increased local accountability of health care providers.

1.3. Context of Study

There are a variety of risks that people seek financial protection or financial readiness for. The insurance industry has over the years categorised risks, with different insurance companies choosing to specialise in some of the identified risks

listed: life cover, medical aid, vehicle insurance, household insurance, and so much more. South Africa is home to multiple insurances houses, with each of these focusing one or more of the listed risks, offering coverages at stipulated premiums (StatsSA, 2019).

Based on the survey conducted in 2017 by StatsSA, only 16.4% of South Africans had health care coverage through medical aid, while the black population was reported as having the lowest coverage ratio at 10.1% (Statistcis South Africa, 2017). This has been one of the biggest contributors to the pandemic of overcrowded hospitals and the subsequent lack of service delivery in public health care facilities. Figure 2 shows the full breakdown of health care coverage by ethnic groups.

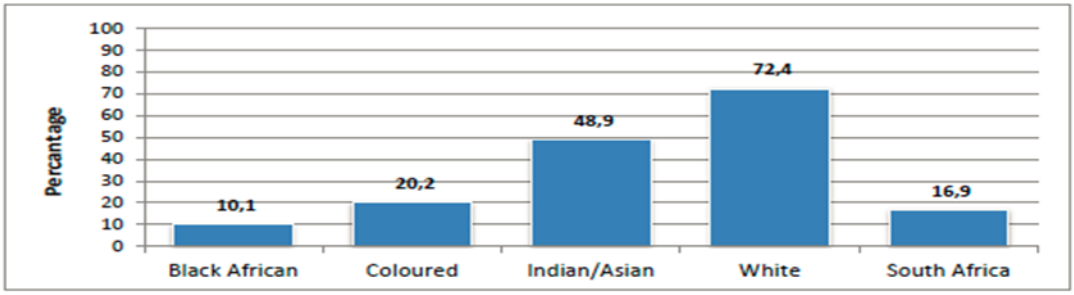

Figure 2: Percentage of ethnic groups with health care insurance (StatsSA, 2017)

Data released by Hippo ZA in 2017 presented that while there are 11.4 million registered vehicles in South Africa, a staggering 65 – 70% of this number is uninsured (Hippo, 2017). These numbers reveal that South Africans experience specific limitations that make carrying the risk incurred from their vehicles on their own backs a more favourable option that enlisting and paying for an insurance package to this regard. Though the study's target population is not only the uninsured in the society, its envisaged outcome will definitely provide relief for both

the uninsured and insured groups; particularly those who find it difficult to keep up with monthly premiums in the health sector.

1.4. The Problem Statement

South Africa continues to face a big health system crisis, wherein a large majority of the country, particularly specific ethnic and economic groups, live outside access to affordable and adequate health care services. Due to affordability limitations, most in this identified group are without health insurance because of the high premiums needed for such programs.

Additional to the personal affordability issues, South African health care facilities have also reached capacity (Rensburg, 2021), and often have to serve more people than they can manage. This overburdening of the health care centers has led to major deterioration of these facilities, inherently lowering their ability to offer quality health care services. This has resulted in notable health care inequalities in the country, with the majority of people living without access to care and awareness of their own medical conditions. This blind living then leads to them only finding out of their conditions when they are critically ill, adding strain to the already stretched medical care facilities. These factors combine to demoralize staff, often leading to poor customer service and general unsatisfactory client tending, a situation that is not good for anyone. On the other end of the spectrum, the country also has a parallel group, that is enjoying the best of health care services due to their ability to afford whatsoever they require. This further increases the divide, making health care more and more expensive, wherein the best services are only accessible to specific privileged groups. As a result, this study seeks to bridge this gap, making private health care affordable by proposing a model for insurance for South Africans.

1.5. Purpose of Study

The purpose of this study is to determine the feasibility of an insurance business based on the first principle of risk management and risk readiness. The

geographical coverage of this insurance business is South Africa. Upon such a determination, the study will further propose a business model to set up such an entity.

This study is motivated by the need to alleviate the national health crisis currently in existence in South Africa. According to Rensburg (2021), South Africa's health care facilities are underfunded while they remain servicing a majority of the population at 71%. The study therefore seeks to address the challenges faced by the majority of people in South Africa who remain uninsured, by proposing an affordable health care insurance that would see them access better health care services to tend to their needs.

1.6. Objectives of the study

On the basis of the purposes outlined above, the main objective of this study is to determine the feasibility of an insurance scheme for the underprivileged. For the purposes of this particular study, the researcher has modeled a customer profile of contracted employees who would not normally afford health insurance premiums on their currently salary, thus making them the target for such a venture. The study aims to uncover the feasibility and durability of such a business model, uncovering the intricacies that would be involved in launching such a product to the stipulated customer group in South Africa.

1.7. Research Question

On the back of the outlined purpose and objective of the study, the primary research question that will govern the direction of the study is as follows:

RQ: Is the underprivileged community in South Africa willing to engage in a CBI scheme to cater for their health?

1.8. Significance of Study

Unaffordability and capacity constraints has led the country's health care system to a place of strain, and all interventions are needed before the country

experiences a collapse in this sector, to the detriment of the vast majority. This study therefore aims to address the issue of unaffordable health care services through the possible provision of affordable health insurance premiums to the underprivileged working force.

1.9. Assumptions

The author of this study has made the following assumptions, which are critical in reaching conclusion to the study:

- Participants of the study will be honest in their responses to survey questionnaire.
- The population covered during the survey will be a fair representation of the total population of the country.
- Data gathered through this research will be relevant to the current means of insurance.
- The targeted survey respondents understand the concept of insurance and therefore their participation will be relevant and useful in determining an outcome.

1.10. Definition of Key Concepts

Community-Based Insurance (CBI)

According to Donfouet and Mahieu (2012), Community-Based Insurance is a system of financial protection put together with the focus of assisting the underprivileged with access to good, quality health care. This specific group makes for people who would otherwise not afford the mainstream insurance premiums often used by the middle-class and the rich.

1.11. Preface to the research report

To this end, the report has six chapters. Following this introductory chapter, Chapter 2 provides a literature review covering the problem, past studies, the explanatory framework and the conceptual framework of the study undertaken. Chapter 3 discusses the research strategy, design, procedures, reliability and validity measures, as well as the limitations of the study. Chapter 4 and 5 respectively present and discusses the findings, to interrogate the research questions, while Chapter 6 summarizes and concludes the research study.

2. CHAPTER 2. LITERATURE REVIEW

This chapter has one main objective, to present the literature findings of similar implementations of community-based insurance schemes in countries identified to have economic or structural similarities to South Africa: Nepal, Senegal, Ethiopia, China, Rwanda, and Ecuador. It focuses on work previously done in this space of community-based insurance, setting a foundation for the feasibility study of the insurance venture detailed in later chapters.

2.1. Introduction

In countries that are generally poor, communities are more and more moving towards community-based insurances (CBI). This is a strategy that has the potential to improve healthcare in poor communities (Gnawali & Pokhrel, 2019).

2.2. Nepal

According to Fadlallah (2018), community-based insurance refers to an insurance option put together by a community of people whose main purpose is to address the risk that may occur in a particular area to those participating in the scheme. This has largely been focused on health-related risk and aimed at developing a scheme that would allow the underprivileged to access quality health care services like the middle class and rich have. Where members of communities are unable to afford premiums that give them access to quality healthcare and where governments do not provide such subsidies sees those in the bottom of the food chain suffer the most (Fadlallah, 2018).

According to Giri, Regmi, and Subedi (2008), over 25% of Nepal's population lived in adverse poverty. The researchers further note that approximately 40% of the health care coverage is paid for by the country's taxpayers, while 60% is catered for through expensive and exclusive medical schemes. The country seems to have given into the poor state of the public health system and have opted to paying

exuberant fees out of their own pockets to access private and quality health care services. As can be expected, some in the country have delayed attending to their health needs due to the lack of funds to this nature. Giri, Regmi, and Subedi (2008) subsequently came to a conclusion that if community-based insurance is implemented with greater diligence, there is great potential to improve the health care system in the country.

2.3. Senegal

In Senegal, researchers Ouimet, Fournier, Diop, and Haddad (2007) conducted a study in order to dissect and understand how CBIs have positive contributions to the community or to the people who signed up for them. The outcomes of the study would be used to interrogate the value of becoming a member of such a scheme. The researchers then indicated that that there is a need to minimise or close the promoter vs subscriber relationship.

2.4. Ethiopia

In Ethiopia, researchers focused their attention on the probability of people joining a CBI initiative in the country. The Ethiopian study revealed that 38% of the health fees being paid in the country were extremely high, a ratio much higher than the rest of the African countries, that averaged at 30% (Haile, Ololo, & Megersa, 2014). These high fees contribute to many people not seeking and getting professional medical care when injured or sick. The researchers came to the conclusion that when these kinds of schemes are adopted at a district level, the community members will most likely be willing to join, with more families and farmers also being willing to join.

2.5. China

The Chinese people's history of CBHI dates bake to the late 1970s. The system in China was implemented as the Cooperative Medical System (CMS). In its form and working principle, the CMS was similar to CBHI, in that the target was

households in poor communities and farmers. The Chinese's version of CBHI has gone through its own cycles of progression. When land policies resulted in land ownership changes, the Chinese farming community was left with no choice but to live their lives without any financial coverage for health eventualities. The change in land policies meant that the farm owners, who previously leased a piece of land together, were required to have individual lease agreements. This then meant that land-use was more expensive. Some farmers found themselves sacrificing the health insurance to be able to continue farming. This saw a dramatic decrease in health insurance uptake in the farming community.

Many farmers and members of the poor rural villages of China eventually lost their valuable means of production due to ill health, wherein they find themselves with an ailing family member who they need to look after. Without health insurance, they resort to selling their seeds which were meant for the next season and some would even sell their properties in order to pay for their medical bills or those of their loved ones. In the 1990s, having seen a major decline in the health of members of these communities, the Chinese government tried to entice the poor farming communities into the use of CBIs. This was done through subsidies for those who would choose to join the CBIs, but the scheme remained voluntary.

In an analysis, Wang (2005) found that regardless of the excessively low monthly premium of the CBI, the under privileged still did not exploit the benefits brought about by the introduction of CBI. This extends to the farmers who the government was hoping will be the greater participants of the scheme. This is regardless of the fact that they remain at risk of receiving poor health care when they fall sick is that much greater. The researcher suggested that in order to encourage participation by the underprivileged, the government needs to move their subsidy to areas where this group was densely populated.

2.6. Rwanda

In Rwanda, a group of scholars conducted a study aimed at determining the factors affecting the low turnout in enrolment of the CBHI. Rwanda followed a system called the "*Ubudehe system".* In this system, the government subsidized the payment for the first category of members. The rest of the category of members were subsidised at a different amount according to their ranking in the category system. The government's involvement in the driving the CBHI has been vital. In Rwanda, the government drives CBHI and it is integrated into the ministry of Rwanda Social Security Board, having been moved in 2005 from the Ministry of Health. Rwanda aims to use the CBHI to provide universal health care to Rwandans.

In their study, Mecthilde and Mukangendo (2018), concluded that the noncompliant nature of the people was due to their frustrations with hospital or medical facilities' long ques. People also find the cost of the system to be too much for them. The method of collecting funds for the whole family also plays a role as one may not be able to afford putting of the people in the family in the scheme. These highlighted factors contribute highly to low adherence to the CBHI scheme. The researchers further recommend that the system be reviewed in the interest of the poor. The premiums should be setup in such a way that the rich get premiums calculated based on their earnings and so will the underprivileged. This is similar to China, wherein the rich, in a way, subsidize the poor.

2.7. Ecuador

An Ecuadorian study was embarked on to determine the feasibility of communities' willingness to join a CBHI/CBI. This study went on to determine if the community understands the CBI system, as well as asses their attitude towards the system. The study focused on a village set-up.

Eckhardt, Forsberg, Wolf, and Crespo-Burgos (2010), concluded that the general population is very much on the same boat when it comes to joining the health insurance. Factors that could win the population's heart are also very similar. Majority of the people are positive towards the CBI and would join with ease if encouraged to. The researchers also presented that policy positions always play a role in determining participation. If reforms are introduced and they work on factors like subsidies for the qualifying, and deal with the possible of exploitation by the rich – this is a system that could potentially work in the country.

2.3. Conclusion

This section considered the different uptakes of CBIs in different African countries. The insurance system of CBIs is one that is being explored in many countries of the world. From the different considerations outlined above, government policies are essential to getting the activity of CBIs going and to promote the uptake from the relevant communities. The following section outlines the study's research methodologies.

3. CHAPTER 3. RESEARCH STRATEGY, DESIGN, PROCEDURE AND METHODs

This chapter aims to identify and describe the research strategy, dimensions and design, the population of the research, the sampling procedure and data collection and analysis methods that will be employed in order to collect, process, and analyse the empirical evidence. This will all build towards the aim of answering the overarching research question presented in section 1.7 above.

3.1. Research strategy

Insurance forms a major part of human financial risk management. In order to fulfil the objectives of the research, this study will develop a method that will allow for the determination of the viability of the venture. Following the example of previously conducted research studies in this field, the researcher will adopt the mixed methods approach, which is a combination of both the quantitative and qualitative approaches for the fulfillment of the research. The quantitative methods will be used to gather the demographic data, while the qualitative approach will be used to uncover themes in line with the objectives in the study.

According to VandenBos (2007), the qualitative research approach is mostly utilized for studies that aim to uncover the participants' understanding of a topic without limiting these themes to predetermined numeric propellants. The opinions of the participants are uncovered through use of one-on-one interviews, group interviews, behavioral observations, and so much more. This approach is also sufficient for highlighting internal attitudes that participants may have toward the subject matter, touching on what people have personally experienced and allows for flexibility in responding to questions. With the ability to get sufficient data with small sample, qualitative research method is particularly cheap, as can be seen on Figure 3 below.

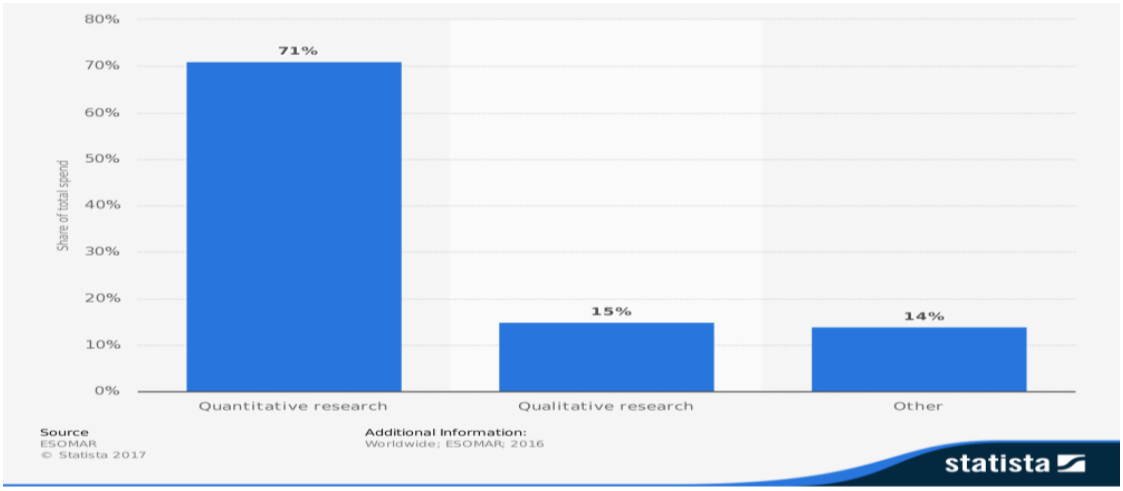

Figure 3: Cost comparison of research methodologies (Gaille, 2018)

On the other hand, quantitative research is defined to be a research strategy more reliant on using predefined figure with predefined variations. It involves the analysis of such data and comparison of the outcomes. For this specific approach, data is often gathered through surveys and experiments.

3.2. Dimension of the research

The research will aim to uncover the following dimensions in the determination of the feasibility of the proposed business venture:

- **Economic:** This dimension focuses on the current expenditure that an individual or household spends on their current risk mitigation risks.
- **Technical:** This focuses primarily on the perceived level of current services received
- **Social:** Willingness to join CBI, this will be trying to establish the community's appetite to joining CBI.

3.3. Research Design

A research design is described as the plan through which the researcher communicates the chosen approach to be applied in the study. Through the

research design, the researcher is able to specify and justify the adoption of a data collection tool and the selection of a sample population for his study (Kumar, 2018).

In his research, Bryman (2012) listed five generic research designs, namely: cross-sectional, longitudinal, case study, comparative and experimental. The researcher chose the case study research design for the sake of this feasibility study. Defined by Yin (1984, p. 23) as "*an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used"*, the case study presented itself as the most relevant choice for the purposes of the research. The researcher will be considering the success of a business venture in context, and will need to investigate this within a real-life context to uncover all the intricacies that could be involved with the running of such a business. This particular approach works best when the researcher aims to closely examine data in a specific closed setting, limiting the geographical area and subjects of the study (Zainal, 2017). This research targeted a select geographical area, Kriel Town in Mpumalanga, wherein the employees of three ESKOM power stations located in the area were selected to be the population of the study.

3.4. Population and Sampling

This research targeted a select geographical area, Kriel Town in Mpumalanga, wherein the contracted employees of three ESKOM power stations located in the area were selected to be the population of the study. The researcher will then sample based on the scope of the study, which is to determine the willingness of the low-earning working class to uptake a health insurance scheme for which they would pay monthly premiums.

The choice of sampling technique depends on whether or not one can obtain a complete list of the population (sampling frame), the research question and objectives (Bryman, 2012). In this study, the strategy will be to pick respondents who are deemed to be the most relevant beneficiaries of a CBI. According to

Solutions (2020), finding a potential participant who has experience with the phenomenon and is willing to share their thoughts is at the heart of a proposed study. As a result, and due to the nature of the study, a homogenous sampling technique will be employed to determine the sample to be used. According to Etikan (2015), homogeneous sampling is form of sampling that focuses on a group of people or phenomena with similar particular characteristics.

The study intends to take a sample of 10% of the un-insured workforce of contracting companies within three Eskom Power stations. The target companies are those with a minimum of three-year contracts. These employees will be contacted through their employers and permissions will be sought and declarations will be made. Together with the questionnaire, an introductory letter will be drawn up which seeks to clarify to the respondents the purpose of the questionnaire. The letter will also provide surety that their personal information will not be used for any purpose other than the study.

3.5. Research Instrument

The first instrument to be utilised is the research questionnaire, and the research interview is the second. The format of the questionnaire will be as follows:

- The research questionnaire will start with an introduction about the researcher.
- Then it will give background into the subject being researched and giving clarity why the respondent has been selected for the research.
- Then it will give background into the importance of the research.
- It will state the expected benefits of the research
- The researcher will then provide surety of confidentiality
- Inform the respondent that they may now carry on to respond to question in the questionnaire.

3.6. Data Collection Procedure

The research data collection process consisted of the following modes: structured surveys, semi-structured one-on-one interviews, document analysis and a literature review. A two-phased interview process was conducted for the data collection, starting with one-on-one interviews with seven parents followed by two focus groups consisting of a minimum of five participants each.

The questionnaire was developed using a structured qualitative research approach. The individual/group data collection process with participants of the research was contacted in the multi-stage approach.

a) Stage 1
    i. The researcher first engaged the targeted company's management to seek approval to conduct research with their employees – this is to get buy-in and support.
    ii. The employer was request to use their tool box talks meetings (morning task distribution/assignment) to share the intended research with the employees

b) Stage 2
    i. Send out, via the employer's email, information sheet and consent form for the employees who are targeted to participate in the process.

c) Stage 3
    i. A series of meetings, with the assistance of an employer was setup to enable one on one and group interview with the research participants.
    ii. Upon informing them, send them a list of questionnaires via SMS or WhatsApp for them to conduct an online survey.
    iii. Conduct the survey and await results.

d) Stage 4
    i. Register with Qualtrics to conduct an online interview to gather information that could be asked to a wider public to determine the view of the public as far as insurance business for the uninsured is concerned.
e) Stage 5
    i. Analyze and interpret the data received.

3.7. Data Analysis and Interpretation

Data from the research was immediately analyzed as it was being received in a meaningful way. The continuous checking of data as it is received will give the researcher a chance to identify areas of improvement in the data collection and such can be promptly dealt with.

3.8. Validity and Reliability

Right at the of offset of the research, Noble (2015) states that evaluating the quality of research is essential if the findings are to be utilised in practice and incorporated into care delivery. The intention of this study is to establish if it feasible to establish a Community Based Insurance. It would be futile if the research is based on falsehood as the outcome should be an implementable proposal based on research conducted.

According to Mohajan (2017), it is of critical importance to ensure reliability and validity of any research work. This is achievable by using reliable research instruments. Validity is defined as a means of determining what instrument is used for research work and the accuracy with which the instrument does the research (Mohajan, 2017). The researcher further defines reliability as the amount of trust one can put on the instrument utilised for the survey. The reliability and validity of research is critical in decision making process. It would a fatal flaw to use data in critical decision-making process while that data is either wrongly obtained. Wrong data can be obtained, not as an intent of the researcher but by an omission to

conduct proper checks and balances when collecting such data. Roberts and Priest (2006), have done an excellent job in assisting researchers to stay away from such risk by determining that, for research to be deemed dependable, a few factors need have been taken into consideration during the research. These includes but are not limited to:

- The research questionnaire
- The way in which data is collected
- People or sector from who/which data is collected from (this deals with relevance)
- The process of analysing collected data
- What conclusions the researcher makes out of the data.

When the above have been thoroughly achieved, the research questionnaire for example may be utilised in determining the accuracy of the data.

3.9. Ethical considerations and unintended consequences of the research

The intention is to have some form of declaration wherein the researcher will state in declaratory terms that the information gathered during the research including personal details of the respondents will be treated with confidentiality. The information gathered during the research will be used for the research purposes and will not be shared with their employers.

In order to receive the Clearance Certificate from the Wits Business School Ethics Committee, constituted under the University Human Research Ethics Committee (Non-Medical), the researcher was required to undergo a rigorous process of checks and balances. This included identifying potential participants to the research, issuing them with an information sheet in order to solicit their consent to participate in the research.

The researcher was subsequently issued with an Ethics Clearance Certificate (WBS/BA567174/794) on the 9th of February 2022. This, in line with the research is a non-medical certificate. See Appendix B for the Ethics Clearance Certificate.

3.10 Limitations of the research

In this section, the researcher looks at the weakness of research. The methodology adopted for this study is a qualitative approach. In line with the methodology, the weaknesses dealt with here will be more in line with qualitative approach. Choy (2014) states that in qualitative approach, the researcher takes an introspection approach and work on determining their past experience from societal view.

3.11. Conclusion

The envisaged outcome of this chapter was for the reader to get understanding of the method used to conduct the research. Though the research method of choice and relevance was qualitative research, it became apparent that a mixed method of both the quantitative and qualitative methods would need to be adopted as a hybrid methodology became necessary to reach a conclusive view of term of the proposed venture initiative. For data or information gathering, the approach was to use interviews in which a sample was selected based on the group of work that they do – low-income contract worker. The reason for this group of employment (low-income contract worker) is that they would normally choose to not have medical insurance or medical aid due to inability to afford.

4. CHAPTER 4. PRESENTATION OF RESEARCH RESULTS

4.1. Introduction

This chapter focuses its attention on laying out the outcome of the conducted research. In this chapter, the findings from the circulated survey and conducted interviews will be presented, uncovering how the participants of this research study responded to the questions and how each of these answer the overarching research question presented in section 1.7, '*Is the underprivileged community in South Africa willing to engage in a CBI scheme to cater for their health and property protection needs*?'

4.2. Demographic profile of the population sample

The following section will detail all the descriptive information collected on the research participants, which could further paint light on the context of their later interview responses.

4.2.1 Interview participants biographical data

The sample population for the interviews consisted of 15 contracted individuals at three different ESKOM power stations, all from the same sector of employment – the heavy steel industry. The interview was conducted in two different formats; wherein the first five respondents were interviewed in a one-on-one set-up. The remainder of the participants were interviewed in two groups of five each. This interview group was made of two females and 13 males. This began to show that the team lacked diversity in terms of gender, race and nationality; as all the interviewed participants were also black and South African. Their academic background was spread between Grade 12 and technical and administration diplomas.

Their type of work in the industry was spread is as below:

Table 2: Work type distribution across research participants

Skill	Quantity
Safety - Fire watcher	2
Store keeper	3
Skilled Trade (Fitter, Welder)	8
Semi-skilled	2

4.4.1 Biographical data from the questionnaire participants

The following biographical data was collected on the participants who participated in the sent-out survey. The survey was developed through a Qualtrics online survey tool and was sent through WhatsApp as the medium of communication to 124 respondents indiscriminately. The respondents were encouraged to send the survey to more respondents where possible. A total of 62 responses were received, and the biographical profile of the respondents is detailed below.

Table 3: Biographical data of the online survey

Gender	***No.***	***Percentage***
Male	29	50%
Female	26	45%
Non-binary/Third gender	0	0%
Prefer not to say	3	5%
Age	***No.***	***Percentage***
20 to 30	7	13%
31 to 45	39	74%
46 to 60	6	11%
+60	1	2%
Ethnicity	***No.***	***Percentage***
African	54	95%
Indian	0	0%
White	1	2%
Coloured	1	2%
Prefer not to say	1	2%
Income	***No.***	***Percentage***
0 to 10 000	9	16%
10 001 to 20 000	15	26%
20 001 to 30 000	5	9%
30 001 to 40 000	5	9%
40 001 to 50 000	9	16%
50 001 to 60 000	4	7%
60 001 to 70 000	4	7%
+70 000	6	11%

Marital Status	***No.***	***Percentage***
Single	25	44%
Married	28	49%
Divorced	3	5%
Widowed	1	2%
Education	***No.***	***Percentage***
No matric	1	2%
Matric	15	27%
Undergraduate	18	32%
Post graduate	22	39%
Children	***No.***	***Percentage***
0	9	16%
1	9	16%
2 to 3	37	65%
4 to 5	1	2%
6+	1	2%

This data is critical in determining the market that will be interested in the product offering. The split between the married and single is very close. Over 70 percent of the survey respondents have a diploma or post graduate study. This may suggest that from the surveyed individuals, there will be a higher expectation of higher quality service. Additionally, according to Dürr (2013), individuals earning between R22 000 to R70 000 make up the South African middle class. That suggests that around 58% of the respondents are in the middle class. This group can join any medical aid. The remaining 42%, should they wish to join, they may go for a low-cost medical aid.

4.3. Structure of the interview

The structure of the interview conducted with the 15 participants is shown below.

Table 4: Structure of the interview

Section	***Questions***	***Probes***	***Rational***
Introduction	- Introduction of the researcher to the interviewee/respondent. - Introduction of the research topic. - Informing researcher of the approval and show them the Ethics Clearance certificate from Wits University Human Research Ethics Committee (Non-Medical) - Ask biographical information from the interviewee(s)	Biographical	- Provide understanding of the topic under research. - Provide a sense of confidentiality.

Personal view of low-cost medical aid	- Establish reasons why they don't have medical aid. - Establish their willingness/desire to join a low-cost medical aid.	Personal views	- Provide opinion on low-cost medical aid.
Opinion of health care	- Personal, family or friend's experience of public health care facilities.	Personal views	- Provide opinion of the health care

4.4. Interview Results

Data for this study was collected in two phases: through the circulated interviews and conducted interview. From the interviews, certain pertains/themes were identified. From the survey, Qualtrics was utilized and respondents independently received questions with their identities not required. The below section will detail the results attained from the interviews in section 4.4.1 and the results from the surveys in section 4.4.2.

4.4.1 Uncovered themes

From the conducted interviews, the following themes were uncovered:

4.4.1.1. Financial constraints

As much as insurance has been available for centuries, there are many who still have no access to this insurance, for various reasons. Of the interviewed respondents who were contracted, there was a common challenge of not having permanent contracts, and with the risk of losing their job at any moment, they are not able to make stable decisions regarding their health insurance. There is also the additional risk of losing the benefits once they fail to pay their premiums. Related, the permanently employed individuals noted that they did not earn

enough money to allow them the luxury of having enough to join mainstream medical aids.

4.4.1.2. Poor medical health services

Of all the interviewed candidates, there was a clear understanding that should they get sick or be injured, they risk receiving delayed medical help at public hospital; a fear they now live with on a daily basis. Some common worries that came up from the interviews are that government ambulances take too long to fetch sick individuals; some have even witnessed friends being left in accident scenes due to not being on medical aid schemes; and lastly, the nurses and doctors at public health facilities do not offer the best of care services. Some of the narrated horrific experiences from the interviews are detailed below.

- Interviewee no.1 narrated a story of a friend who was involved in a motor bike accident. The individual was admitted to a public hospital. There were no doctors to administer critical emergency medical response. By the time the doctors attended to him, his leg was no longer functioning. He had to be amputated.

- Interviewee no.2 narrated a story of an individual was also injured in a road accident. His leg was broken in four places. He was taken by an ambulance to a private hospital. Upon arrival, he was stabilized and the doctors were getting ready to have him transferred to public hospital. He did not want to go to a public hospital. He was asked to make an upfront payment of R90 000 in order to continue being attended to in the private hospital.

- Interviewee no.3 narrated a story of his two sisters (17 years old and 22 years old) who were in an accident. The 17-year old was still in her father's medical aid. The 21-year old was out of medical aid due to age. The younger sister went to private hospital with facial injuries and older sister went to public with similar injuries. The younger sister was fully healed without any facial scars. The older sister lives with severe scars on her face.

4.4.1.3. Key desires regarding health care insurance

The key themes that came under what the participants wanted the most from health care insurance are listed below:

- Access to private health facility accidents.
- Access to private hospitals for child birth/delivery.
- Access to private hospitals when under severe illness and in need for stabilization.

5. CHAPTER 5. BUSINESS VENTURE PROPOSAL

The following chapter outlines the fundamental areas for consideration in the feasibility study of the proposed business venture.

5.1. The vision

In their efforts to illustrate the importance of the mission and vision, Walt and Fourie (2004), indicated that for any business to develop a strategic plan, it is important that these be developed and understood. Their formulation requires time. This is because this foundation lays the direction for how the business will be run and represented.

The business has been given the following name: African Excellence Insurance – AE Insurance (AEI). AEI aims to be known and associated with excellent health services that it provides and a most affordable cost.

Vision: To make quality health care accessible to all

5.2. The mission

AEI provides insurance services for low-income workers, self-employed and anyone else who wishes to take insurance at low cost – after all this is insurance for the uninsured in South Africa. This is meant to be a form of insurance that ensures that all can have access to quality health care at the most critical medical emergency times.

5.3. The values

AEI has a set of values that it endeavors to abide by: caring, reliable, transparent, integrity, and continuous improvement.

5.4. Business objectives

AE Insurance has a set of business objectives that are focused on serving any South African who knows and understands the need for medical insurance but have stayed uninsured due to affordability constraints or the view that conventional

medical insurance is not an option best suited for them. It is from this foundation that the objectives of AEI were derived:

- Make medical insurance accessible to all who need it.
- Create an opportunity for the uninsured to access private health care at low cost at the most critical medical emergency times.
- Avail dignified health care for the currently uninsured/

5.5. Services Rendered by AE Insurance

Upon settling on the above objectives, the key services to be rendered by the business venture are listed below:

- To provides services in the health care sectors aimed at insuring uninsured South Africans.
- To provide guidance to South African on matters of prevention of illnesses.
- To create awareness on the available vaccination programs for emerging illnesses to avoid severe ill-health.
- To provide updates to AE Insurance members on the development of their medical insurance.
- To create online and telephone services for quick guides on matters members may be faced with.

5.6. AE Insurance Market Analysis

In their report, GCIS (2018/19) reported that between the years 2002 and 2019, there was a small increase in the number of individuals covered by medical aid schemes. Of the total population of 45 921 000 in 2002 only 15,9% (i.e. 7,284 mil) were covered by medical aid, and 2.8% percentage increase was witness over 14-year period (increasing to 17.1% in 2016) after which it was followed by a slight decrease to 16.4% in 2018 and to 17.2% in 2019. This is also demonstrated in Statistics South Africa's report which is shown in the table below.

In this same period, over 80% of South Africans were not medically insured. This may mean between 70 and 80% of South Africans were exposed to the possibility of seeking their first medical help at public health facilities. The GCIS (2018/19) report indicated that as of 2019, 71.5% of South African households have presented that they would first visit a public health facility, while 27.1% would visit private health care facilities, and only 0.7% would visit a traditional healer.

Table 5: South Africa Medical Aid Coverage (StatsSA, 2019)

Indicator (Numbers in thousands)	Year											
	2002	2004	2008	2010	2012	2013	2014	2015	2016	2017	2018	2019
Number covered by a medical aid scheme	7 284	7 268	8 057	8 967	9 157	9 608	9 470	9 307	9 447	9 475	9 380	10 069
Number not covered by a medical aid scheme	38 445	39 666	41 266	41 606	42 819	43 300	43 946	45 065	45 646	46 654	47 628	48 262
Subtotal	**45 728**	**46 934**	**49 322**	**50 573**	**51 976**	**52 908**	**53 416**	**54 372**	**55 093**	**56 129**	**57 008**	**58 330**
Percentage covered by a medical aid scheme	**15,9**	**15,5**	**16,3**	**17,7**	**17,6**	**18,2**	**17,7**	**17,1**	**17,1**	**16,9**	**16,4**	**17,2**
Do not know	140	58	101	23	58	36	46	71	53	24	42	99
Unspecified	53	57	56	254	291	161	451	308	474	369	408	0
Total population	**45 921**	**47 049**	**49 479**	**50 850**	**52 325**	**53 104**	**53 912**	**54 750**	**55 620**	**56 522**	**57 458**	**58 429**

The data shows that on average, only 16.98% of South Africans over the period of 2002 to 2020, had medical aid. The percentage difference over the same period shows that there is an average decline of -0.118% (equivalent 0.12%) per annum in medical aid coverage. While 14 million South Africans were employed, only 10 million South Africans had medical aid coverage. When analyzing this data, since the 2020 stats were not obtainable at the time of this analysis, it was necessary to assume that the average growth/decline (-0.118% per annum) in insurance coverage continued to 2020. It is with this assumption that the 2020 medical aid coverage is assumed to have been at 17,08%. This does not take into consideration possibility that there may have been a further decline in medical aid coverage due to possible job losses that occurred at the height of the Covid-19 pandemic.

In their publication of the economic update with a focus on South Africa, The World Bank (2021) concluded that while South Africa saw two quarters of employment growth by the end of 2020, there were a further 1.5 million jobs lost in various sectors in South Africa. This loss in jobs would have most likely affected the number of people who have insurance coverage as a significant number of people rely on their employment income to fund their medical aids. However, for the purposes of this study, the inferred figure of 17.08% coverage in 2020 will be utilized. This will be utilized in conjunction with the 2020 employment figure which averaged at 14.6 million people. According StatsSA (2020), the South African population in 2020 was estimated to be at 59.6 million.

Thus;

Estimated medical aid coverage in 2020 = 59.6x17.08 ÷100

= 10.6 million

With an estimate of 10.6 million covered vs the 14.6 million employed, there remains a gap in the cover of the employed population in South Africa. This balance is therefore the market available for AE Insurance to target. The table below gives the full employment data breakdown in South Africa, showing the exact gaps that AE Insurance can capitalize on to make the venture a success, while Figure 5 below gives all the medical aid data collected and available at this stage.

Table 6: South Africa Employment Data (Statssa, Quarterly Labour Force Survey, 2021)

Province	Jul-Sep 2020	Apr-Jun 2021	Jul-Sep 2021	Qtr-to-qtr change	Year-on-year change	Qtr-to-qtr change	Year-on-year change
	Thousand					Per cent	
South Africa	**14 691**	**14 942**	**14 282**	**-660**	**-409**	**-4,4**	**-2,8**
Western Cape	2 216	2 256	2 225	-31	9	-1,4	0,4
Eastern Cape	1 212	1 235	1 216	-19	4	-1,5	0,3
Northern Cape	287	256	275	19	-11	7,3	-4,0
Free State	723	723	720	-3	-3	-0,4	-0,5
KwaZulu-Natal	2 389	2 421	2 297	-123	-91	-5,1	-3,8
North West	930	979	851	-128	-80	-13,1	-8,6
Gauteng	4 506	4 648	4 448	-200	-58	-4,3	-1,3
Mpumalanga	1 161	1 166	1 104	-62	-57	-5,3	-4,9
Limpopo	1 266	1 257	1 145	-112	-121	-8,9	-9,6

Due to rounding, numbers do not necessarily add up to totals.

The medical aid data is show below:

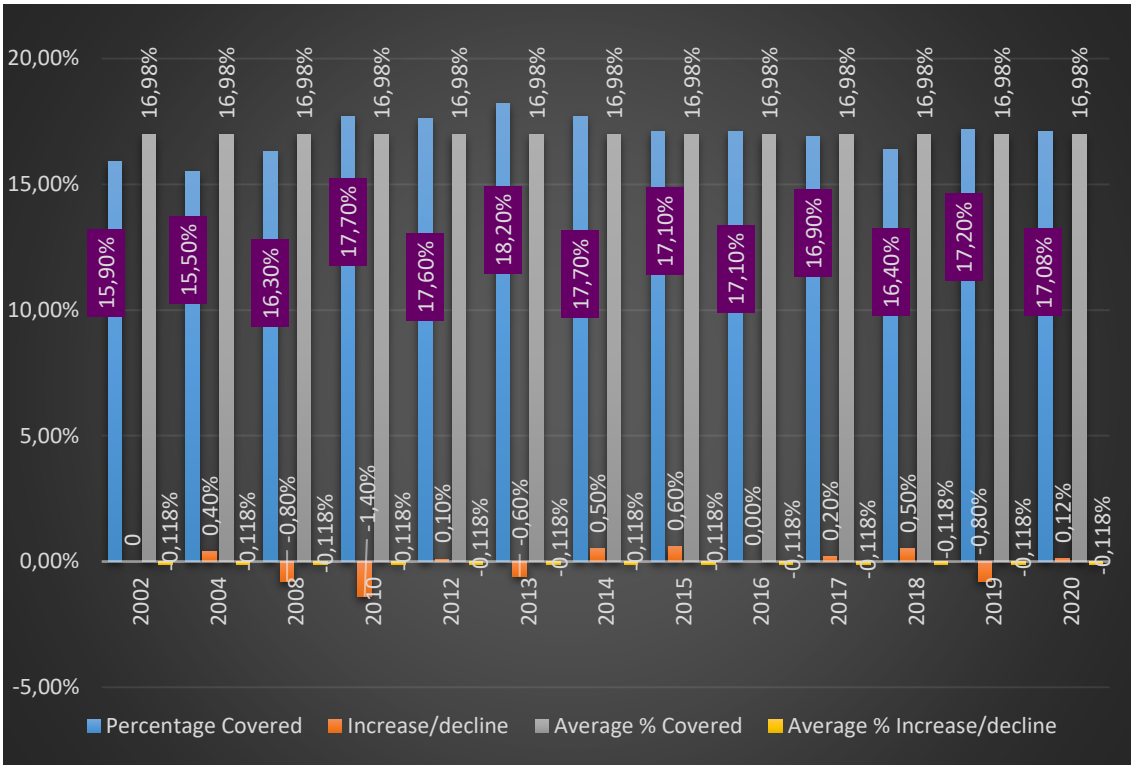

Figure 4: Medical Aid Coverage in South Africa

5.7. AE Insurance Competitive Advantage

AE Insurance intends to provide a unique product(s) to the people living in South Africa that is targeted at those in the population that are unable to afford the main stream medical aid. With this revolutionary product, the business also believes that there are those insured by main stream medical aid schemes that would like to take advantage and enroll with AE Insurance for its affordability ad providing quality health care.

With the current world of technological advancements, AE Insurance will also exploit the use of technology for cost saving initiatives, which will also enable the provision of health care at a low cost.

5.8. AE Insurance Value Proposition

AE Insurance is an initiative that is aimed a servicing a need. The need exists and the need is real.

There is a common occurrence of negligence in the South African health care centers. The interviews conducted with the participants also indicated that this a common worry even in their spaces. Some participants were vividly shaken through the personal experiences in this regard, with one of them later detailing that this is how her mother passed away. Therefore, by providing a low-cost medical aid, AE Insurance intends to reduce such incidents.

The people of South Africa have spoken on various platforms against the poor service delivery they receive at various public institutions. Health care, a very critical need for any human being, has not been spared. The venture’s value proposition is to provide quality health care to all South Africans who are currently uninsured and are willing to take on membership of a low-cost medical insurance to enjoy the use of private health care.

5.9. Environmental Factors Analysis

This section of the study will endeavor to establish and address factors that may affect the implementation of AE Insurance. To make this determination, a PESTEL Analysis has been conducted as seen in the table below. PESTLE stands for Political, Economic, Social, Technological, Legal and Environmental factors.

PESTEL Analysis

Table 7: AE Insurance PESTEL Analysis

OPPORTUNITIES		***THREATS***
Politics have a major role in determining the path a country can follow in terms of Medical aids. It is through political mandates or manifestos that are founded in major political conference that the policy positions are set which lays the way for the country's management systems (including health). In order to create political alignment, it is prudent for AE Insurance to be politically aligned and have a thorough understanding of the major political players. In so doing, AE Insurance will be at an advantage as it would have an understanding of the policy set at conferences by the various political player. With all that, it is also important to have understanding that politics are dynamic and there are no guaranteed winners. There however likely winners and understanding	**Political**	The introduction of National Health Insurance as intended by government may mean those who would normally choose not to join a medical aid due financial difficulties are like not to join an initiative like AE Insurance as the envisaged improvements that may be brought about by the introduction of NHI are precisely what AE Insurance is intending to cater for. Furthermore, political threats do exist withing the democratic South Africa: - Major weaknesses amongst South African politicians in terms integrity that result in major corruption in various spheres of government – from the mere municipal level to the very high political office of the

their policy positions and direction will serve AE Insurance well and avoid major surprises. AE Insurance will perform a thorough analysis of the following factors before starting up their business: - South Africa is politically stable country. The risk of political instabilities is low. The democratic process is alive and well. - Policy changes, though possible as voters may choose exercise their democratic rights to vote for a political party of their choice, are expected to have minor shifts. - Trade regulations & tariffs related to Healthcare - Favoured trading partners - Anti-trust laws related to Health Care Plans - Wage legislation: minimum wage and overtime - Work week regulations in Health Care Plans - Product labelling and other requirements in Health Care Plans		country – including state organs that are tasked with fighting the very corruption. - With the initiative of low-cost medical aid being a rather unfamiliar territory in South Africa, the process of getting approval may face major bureaucratic challenges and maybe even resistance from those who benefit from the current method. - Government may create regulations that stifle this kind of initiatives. - Risks of copy rights if other players in the industry are already having this model. - Regulations intended at controlling pricing that may make this initiative more expensive than intended. - Adherence to consumer protection act - Tax laws may affect pricing for consumers as the taxes are covered for in the members premium. - South Africa's minimum wage law may affect the pricing as the member's premium caters for operational costs of the business.

		- Regulations that may limit the use of affordable medicines which may result in high premium for members.
The Macro environment factors such as – inflation rate, savings rate, interest rate, foreign exchange rate and economic cycle determine the aggregate demand and aggregate investment in an economy. While micro environment factors such as competition norms impact the competitive advantage of the firm. Health Insurance Innovations, Inc. can use the country's economic factors such as the growth rate, inflation and industry's economic indicators such as Health Care Plans industry growth rate, consumer spending and more, to forecast the growth trajectory of not the medical aid and health sector but also that of the organization. Economic factors that Health Insurance Innovations should consider while conducting PESTEL analysis are: - Type of economic system in countries of operation; what type of economic system there is and how stable it is. - The government intervention in the free market and related Healthcare	**Econ**	The economy may not recover quickly enough to see workers who have lost their jobs or part of their income recover financially to join a medical aid scheme regardless of their wish to or the cost of joining one.

- The exchange rates and the stability of host country currency. - Efficiency of financial markets: do Health Insurance Innovations need to raise capital in local market? - Infrastructure quality in Health Care Plans industry - Comparative advantages of host country and Healthcare sector in the particular country. - Skill level of workforce in Health Care Plans industry. - Education level in the economy - Labour costs and productivity in the economy - Business cycle stage (e.g. prosperity, recession, recovery) - Economic growth rate - Discretionary income - Unemployment rate - Inflation rate - Interest rates		
Society's culture and way of doing things impact the culture of an organization in an environment. Shared beliefs and attitudes of the population play a great role in how marketers at Health Insurance Innovations will understand the customers of a given market	**Social**	Risk of targeted member not joining medical aid scheme due to targeted member taking the risk to get health care from public hospital.

and how they design the marketing message for Health Care Plans industry consumers. Social factors that leadership of Health Insurance Innovations, Inc. should analyse for PESTEL analysis are: - Demographics and skill level of the population - Class structure, hierarchy and power structure in the society. - Education level as well as education standard in the Health Insurance Innovations, Inc. 's industry - Culture (gender roles, social conventions etc.) - Entrepreneurial spirit and broader nature of the society. Some societies encourage entrepreneurship while some don't. -Attitudes (health, environmental consciousness, etc.) - Leisure interests		
Technology is fast disrupting various industries across the board. Transportation industry is a good case to illustrate this point. Over the last 5 years the industry has been transforming quickly, not even giving chance to the established players to cope with the	**Tech**	IT Security: Hacking that could result in false claims. Customer information can be stolen by hackers (credit card information, telephone numbers, physical

changes. The taxi industry is now dominated by players like Uber and Lyft. Car industry is fast moving toward automation led by technology firm such as Google and manufacturing is disrupted by Tesla, which has stated an electronic car revolution. A firm should not only do technological analysis of the industry but also the speed at which technology disrupts that industry. Slow speed will give more time while fast speed of technological disruption may give a firm little time to cope and be profitable. Technology analysis involves understanding the following impacts: • Recent technological developments by Health Insurance Innovations, Inc. competitors • Technology's impact on product offering • Impact on cost structure in Health Care Plans industry • Impact on value chain structure in Healthcare sector • Rate of technological diffusion		address, email addresses, personal information, etc.)
Different markets have different norms or environmental standards which can impact	**Env**	

the profitability of an organization in those markets. Even within a country, different states can have different environmental laws and liability laws. For example, in the United States, Texas and Florida have different liability clauses in case of mishaps or environmental disaster. Similarly, a lot of European countries give healthy tax breaks to companies that operate in the renewable sector. Before entering new markets or starting a new business in existing market the firm should carefully evaluate the environmental standards that are required to operate in those markets. Some of the environmental factors that a firm should consider beforehand are: • Weather • Climate change • Laws regulating environment pollution • Air and water pollution regulations in Health Care Plans industry • Recycling • Waste management in Healthcare sector		

• Attitudes toward “green” or ecological products • Endangered species • Attitudes toward and support for renewable energy		
In number of countries, the legal framework and institutions are not robust enough to protect the intellectual property rights of an organization. A firm should carefully evaluate before entering such markets as it can lead to theft of organization’s secret sauce thus the overall competitive edge. Some of the legal factors that Health Insurance Innovations, Inc. leadership should consider while entering a new market are: • Anti-trust law in Health Care Plans industry and in the whole country. • Discrimination law • Copyright, patents / Intellectual property law • Consumer protection and e-commerce • Employment law • Health and safety law • Data Protection	**Legal**	

Given the PEST Analysis above, it's clear that while the threats exist, as they do in any environment, opportunities are great and for AE Insurance can take advantage of these. For AE Insurance to better position itself to acquire a bigger market share, the business needs to market rigorously to their target market. It should be also clear that, though the target is the uninsured, they are not the limit. There are many in the country who have the mainstream medical aid coverage who believe would rather take on the low-cost medical insurance for a number of reasons, amongst them is the fact that they amount they pay and the number of times that they need to use medical aid annually doesn't correspond. Meaning given their normal health status, which may continue to very advanced age, they don't need a medical aid, let alone a very expensive. However, to ensure they are covered for in case of any unforeseen medical emergency, they would rather pay a premium.

5.10. Industry Analysis

Table 8: Industry Analysis

Forces	Strength	Motivation
Threat to entry	Strong	• South Africa encourages entrepreneurship. • Company registration process is properly laid out and possible to follow. • Though the insurance industry is highly regulated, the regulations are aimed at providing a good service to the member of an insurance company.
Bargaining power of Buyers	Strong	• The insurance industry already has a lot of players. AE Insurance will be bringing

		a product that is aimed at the uninsured. These largely the low-income earners. • Opportunities exist for the currently insured who may want to join a low-cost
Bargaining power of suppliers	Weak	• With the product being an intangible product, supplier's influence is limited expect for operational advancements.
Threat of substitute product	Strong	• Current industry players may change strategy in an effort to keep their current clientele by adopting the product that AE Insurance is offering. • Competition laws may be useful in cases where big players start to stifle market entrants.
Rivalry amongst existing competitors	strong	• The target market may still not be convinced of joining a medical insurance. • Other player may make efforts to provide the exact same product taking advantage of the opportunity it provides. With their experience and financial muscle, it may be easy to adopt a new product.

5.11. Customer Analysis

The insurance industry is one that is often taken by people who understand risk and the means to alleviate/mitigate risk. In formal employment, most people are required by their employer to join a medical scheme often with the choices already reduced to a small number as selected by the employer. Employers have a need

to do this in order to reduce the risk of suffering production losses to employees getting sick and unable to get medical help due to issues of affordability.

To analyze the potential customers of this kind of initiative, the behavioral, psychographic, geographic and demographic analysis will be conducted.

5.11.1. Behavioral Analysis

Medical insurance customers, especially ones who join medical insurance by choice can be unpredictable, especially at a young age.

5.11.2. Psychographic Analysis

Insurance clients are looking for risk mitigation to allow themselves to have peace of mind knowing that should they get sick; they will get superior health care. The low-income earners are generally South African and from poor backgrounds.

5.11.3. Geographical Analysis

The clients' geographical setup plays little role in the current digital age as they can access information online with ease.

5.12. SWOT Analysis

Table 9: AE Insurance SWOT Analysis

Strength	Weakness
• There is already a market for a product of this nature. • Most of the people are looking at affordable product that will keep them away from public health facilities.	• Inexperience in the insurance industry space. • New entrant into the market. • The territory is dominated by big player who have a potential to kill competition.
Opportunity	**Threats**
• Accelerated implementation of the product before other player copy the unprotected parts of the idea. • The number of potential clients is significantly higher than the current estimate. • People who are members of the mainstream medical aid may consider joining this initiative as it is cheaper.	• Threat of being squeezed out of the market by industry big players.

5.13. Business Model Canvas

Table 10: AE Insurance Business Model Canvas

<table>
<tr><td colspan="2" rowspan="2">Business Model Canvas</td><td>Designed for:</td><td>Designed by:</td><td>Date:</td><td>Version:</td></tr>
<tr><td>AE Insurance</td><td>Victor Tshamano</td><td>20.03.2022</td><td>00</td></tr>
<tr><td>Key Partners</td><td>Key Activities</td><td>Value Propositions</td><td>Customer Relationships</td><td colspan="2">Customer Segments</td></tr>
<tr><td rowspan="3">• Health Professions Council of South Africa
• Government Health department
• Pharmaceutical industry
• Hospitals</td><td>• Marketing
• Signing in new clientele
• Product information sharing on sign up</td><td rowspan="3">• Clients
• Provision of private health services during medical emergencies
For employees
• Provision of professional services
• Feeling satisfied with service provided
• Job satisfaction</td><td>• Customer satisfaction surveys for members.
• Follow-up with customers if they are satisfied with private health facilities services provided</td><td colspan="2" rowspan="3">• Uninsured people
• Insured South Africans and non-South Africans who may want a low-cost Medical aid.</td></tr>
<tr><td>Key Resources</td><td>Channels</td></tr>
<tr><td>Call center, IT stuff, Management, Legal teams, medical trend analysts</td><td>• Social media feedback
• Customer service quick sheets</td></tr>
</table>

Cost Structure	Revenue Structure
Marketing fees Innovation Staff salaries Electricity bills Internet connectivity	Membership premium
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Table 9: Canvas

5.14. Market strategy

This following section will detail AE Insurance's market strategy, beginning with the market segmentation, target market, positioning, and the marketing 5Ps.

5.14.1. Market segmentation

Market segmentation is the process in which a certain product designed for a particular group of society. This is a strategy in which people with common needs will be grouped together. As (Rogerson, 2013) stated, the concept of market segmentation refers to a situation where businesses would decide to split a market according to its distinct needs based on similarities or commonalities.

The principle of AE Insurance is market segmentation, where an insurance business is created with the low-income earners as the target market. It is worth mention that the responses to the survey questionnaire suggests that not only the low-income earners would be interested in the AE insurance business model.

Geographic	
Area covered	South Africa
Province	All nine provinces
Cities	Entry to market will initially focus on the highly industrialized cities of South Africa. The metros
Demographics	
Age	20 to 30 years old 31 to 45 years old 45 to 60 years old +60 years old

Gender	Male Female Transgender
Income	10 001 to 40 000
Occupation	Working or self employed
Race	All races
Nationality	Any
Psychographic	
Social class	Low-income earners
Lifestyle	Making ends meet, missing middle
Personality	Concerned about their wellbeing
Behavioral	
Occasions	Potential
Benefits	Access to private health care
User status	Instability as not permanently employed
Loyalty stage	Strong loyalty
Attitude toward product	Customer that is in need of the service as they want access to private health care when it is most needed.

Table 10: Market Segment

5.14.2. Target market

As has been outlined on sections above, AE Insurance's target market are uninsured working force of South Africa. Their reasons are inability to afford and for this study, the focus was contracted employees. This is AE Insurance's target. The survey report however suggests that the need for low-cost insurance may cut across.

5.14.3. Positioning

AE Insurance's value proposition is the provision of quality health care at an affordable rate. This will be done by allowing members access to private health care facilities during the time of critical emergencies. A member who has been in a vehicle accident will be receive private health care to the point of stabilization. Once stabilized, critical medical procedures have been performed and out of danger (meaning the member only requires observation), the medical stuff can either refer the member to public hospital for observation or release the member to continue healing from home. The manner in which the services will be provided is a matter of design by medical specialist, i.e., the right time to release a patient and much more of this nature.

5.14.4. Marketing's 5Ps

- *Product*

  Customer value: making quality health care available at a time critical health emergency.

  Provided product: quality health care at an affordable rate/premium.

  Augmented product: each member can select their benefit level.

  Product decision - Benefits and feature:

    - Access to quality health care.
    - Peace of mind knowing there help in time of critical health emergencies.

  Product lifecycle:

- Development – this is a learning point and a lot innovation will be required in order to allow flexibility. The voice of the customer will be critical at this stage.
- Growth – having listened to the customer, AE Insurance can now grow into new heights with products that serve their target market.
- Maturity – at this stage, the company has reached its peak and is consistently running at high level.
- Declining – to protect against losses, the innovation leg of the organisation will always be funded and voice of the customer will be critical.

- *Price*

  The pricing for AE Insurance was determined by the responses from the online survey conducted through Qualtrics. Market entry price will be R500 per member.

- *Promotion*

  Online marketing will be conducted to promote AE Insurance. In these platforms, the benefits of low-cost insurance will be the focus of the market strategy. The business will use the following platforms:

  - Electronic media: convenient, accessible by many in South Africa
  - Social media: available for all to access
  - Adverts (bill boards, flyers)
  - Promotions
  - Targeted campaigns

- *Place*

  The market entry locations are in Mpumalanga. This area has been targeted for its industrialized economy through the mines and power generation plants, petrochemical giant.

- *People*

  AE Insurance will have workers whose focus is on marketing, product development and registering new member.

5.15. Operational Strategy

5.15.1. Key partner

For AE Insurance, key partners are employers of the targeted customers. The banks are also critical in allowing for members to pay their medical insurance on debit orders. Government is critical as they set policy positions.

5.15.1.1. Government

The government of South Africa is in the process of establishing a NHI that is aimed at providing universal health care for all. Policy positions may change the way AE Insurance get operated in this future. The business model may have to change to adapt to the new norm when it happens.

5.15.1.2. Technology companies

For continuous improvement and to stay in touch with the customer, AE Insurance will need to be innovative in the use of technology. Technology can be used to assess hits that potential members are searching for on the internet and use their search history to provide campaigns related to the insurance business.

5.15.1.3. Employers

Employers are critical in allowing for face-to-face marketing of the product. They can allow for mass gatherings of target members for the physical marketing of the product.

5.15.1.4. Banks

A relationship with all South African banks is critical. This will be the means in which monies are paid from members to AE Insurance and vice versa.

5.15.2. Key resources

5.15.2.1. Physical resources

AE Insurance will consist of two types of physical resources:

- **Head office:** this is the physical management center of the company. Strategic decisions about the direction of the company will be made here. This includes marketing, growth, modelling etc.
- **Call center**: this will be an outsourced service but AE Insurance will still be managing. They are responsible for marketing or for the execution of the marketing strategy.

5.15.2.2. Human capital

Head office stuff will form the bulk of permanently employed employees of AE Insurance. Other services will be outsourced. Included in the head office stuff will be: Training and development, Marketing, Strategy development, Executive leadership (CEO, CFO, HR Director etc)

5.15.2.3. Intellectual resources

Management of intellectual property or protection of information of members is a critical matter for AE Insurance to manage.

5.16. Key activities

- Provision of training: all call center employees need to be trained on understanding the product.
- Vetting and validation of members: once a person has decided that they want to join, a process of insuring that they are who they say they are gets under way. This is done through basic security checks.
- Attracting customers: development campaigns targeted at bringing in more customers.

- Innovation and technology improvements: allowing the business to grow through innovation and creating products that customers are asking for.
- Payment of claims: ensure payment of claims is done timeously.

5.17. Organizational Strategy

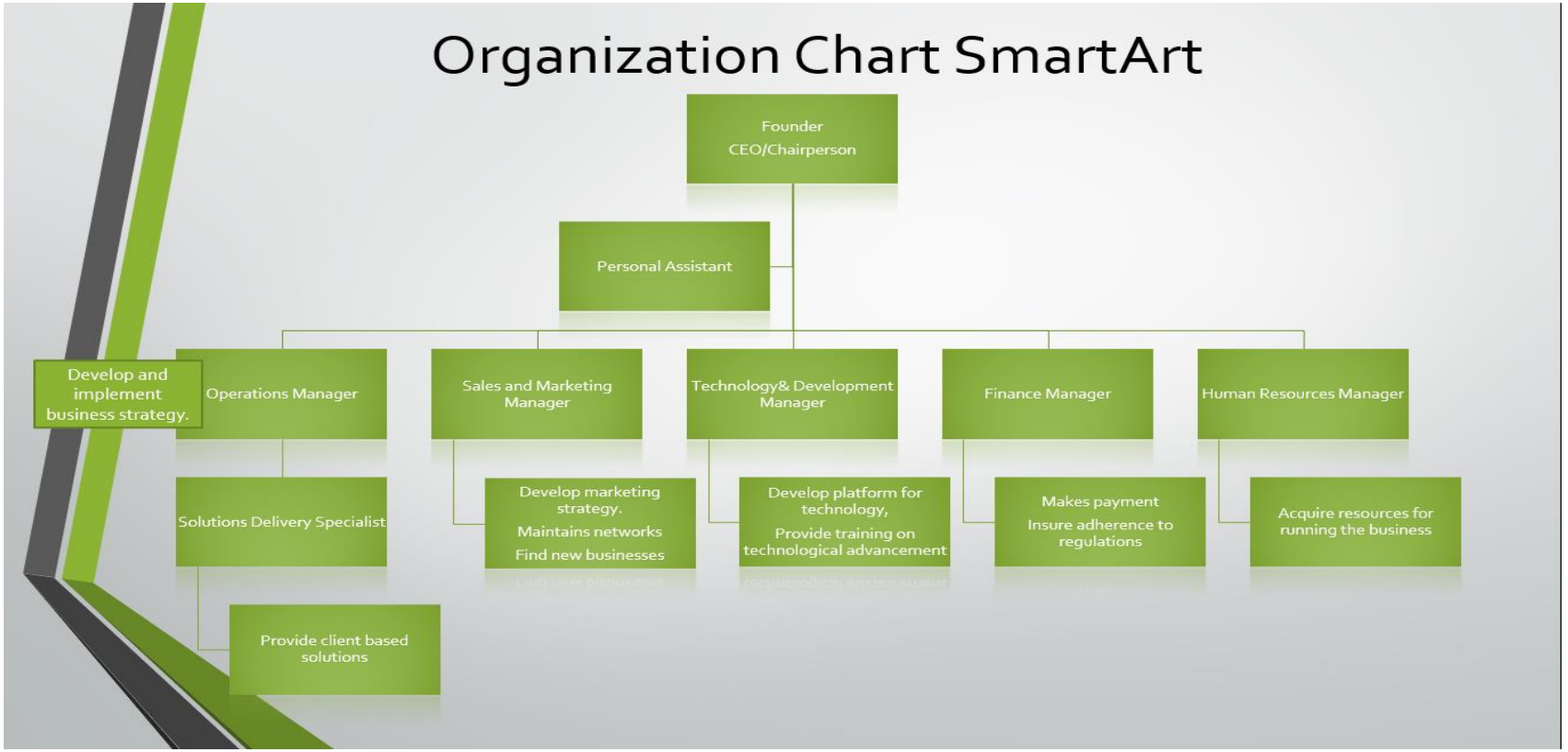

Figure 5: African Excellence Insurance Organizational Structure

5.18. Financial strategy

5.18.1. Revenue stream

AE Insurance's source of revenue will come through its membership. The details of the company's inputs are calculated in the forthcoming session. This will be a month premium paid by members to maintain their membership and ability to claim.

5.18.2. Cost structure

- **Variable cost:** this portion is dependent on claims. Based on behaviors of members, this can be projected on seasonal basis.
- **Fixed cost:** these are overhead costs incurred on regular basis. These includes rentals, utilities, telephones, marketing

5.18.3. Financial projections

This section of the study analyzes the financial viability of an insurance of its kind. Financial projections will be conducted on assumption made.

5.18.3.1. Income statement

Financial information found in the income statement details the business's profitability which a difference between income and cost incurred in the running of the business (operational costs).

5.18.3.2. Sales

At the initial stage of attracting customers, AE Insurance will form partnership with employers of the target employees. Most of the employees are based in major industry that employ the services of contractors. The major provider of this clientele will be the major petrol making company based in Secunda with contracted employee in the region of 10 000 consistently. The next target employer is South Africa's electricity giant that is spread across South Africa with up to 15 power generating asserts and multiple other support businesses in their value chain. The

number of contracted employees per generating assert ranges between 1500 to 2000 per generating unit. This means there are approximately 22000 to 30000 contracted employees in the generating units. Around the same number is spread across other businesses in the value chain. Working with the lower number and result of the survey. It needs to be noted that further studies that are focused estimating potential entrants may arrive at different numbers. For the purposes of this study, the estimated number are based on the following:

- ***Number of contracted employees***: this is an estimate based on actual number of contactors in each of these businesses.
- ***Potential clients***: this is an assumption based on the survey response where 56% of the respondents were certain they would join this kind of a scheme. There is another 37% of the respondents that was on the fence. These have a potential to join but for the purpose of this analysis and in an effort not to be too optimistic, have been left out of potential clients. For this study 18 000 members are going to be assumed to be joining the scheme at its inception period (within the first 36 months to 60 months).

It is also important to note that these numbers are only based on two companies. There is still the airline industry, the food sector, manufacturing sector etc.

Table 11: AE Insurance estimated number of clients

	Responses	**Percentage distribution**	**Estimated number of contracted workers**	**Estimated number of potential clients**
Yes	30	56%	32500	18055
Maybe	20	37%	32500	12037
No	4	7%	32500	2407
	54			

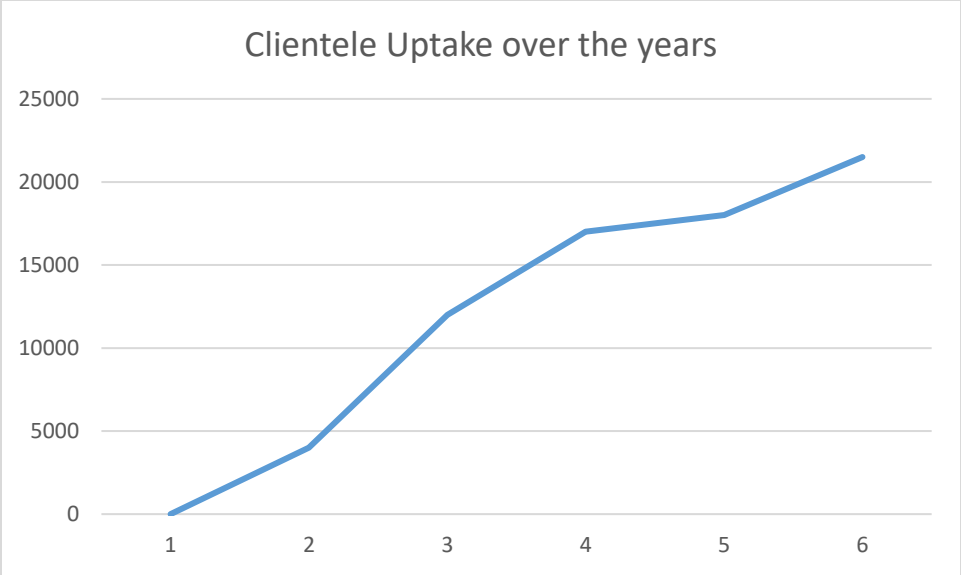

Figure 6: Graph depicting clientele intake

On the question of contributions per months, 45% of the potential clientele chose R250 to R500. For the purpose of this study, R500 will be used as a monthly contribution. See table below for online survey outcome on contribution/

Table 12: Distribution of how much customers are willing to pay

Contribution range	Number of respondents	Percentage distribution
R250-R500	25	45%
R501-R750	17	30%
R751-R1000	4	7%
R1 001-1500	3	5%
R1500+	7	13%
Total	56	

The table below seeks to show estimated contributions based on a combination of factors determined from the online survey.

Table 13: Estimated contributions by clientele

Year	Yr0	Yr1	Yr2	Yr3	Yr4	Yr5
Number of clients	0	4000	12000	17000	18000	21500
Monthly contritributions (@500/member)	R -	R 2 000 000	R 6 000 000	R 8 500 000	R 9 000 000	R 10 750 000
Annual contritributions (@500/member)	R -	R 24 000 000	R 72 000 000	R 102 000 000	R108000 000	R 129 000 000

5.18.3.3. Operating cost

This will be the cost utilized to run the business. This includes fixed and variable costs. Operating cost in this case will consist mainly of the following:

- Wages
- Utilities
- Marketing
- Product improvement etc.

For the purposes of this study, all these costs are estimated to range between 15 and 20% of the total revenue in a period spanning over 5 years.

AE Insurance Operating Statement							
Rand							
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Revenue			24 000 000	72 000 000	102 000 000	108 000 000	129 000 000
Sales and Marketing			**3 240 000**	**4 572 000**	**7 567 320**	**8 018 359**	**8 862 461**
Salaries			2 640 000	2 772 000	5 017 320	5 318 359	5 637 461
Training	2%	of revenue	480 000	1 440 000	2 040 000	2 160 000	2 580 000
Other	0,50 %	of revenue	120 000	360 000	510 000	540 000	645 000
Operating			**4 890 000**	**7 704 000**	**10 885 200**	**15 887 712**	**17 344 375**
Salaries			4 050 000	5 184 000	7 315 200	12 107 712	12 829 375
Training	2,50 %	of revenue	600 000	1 800 000	2 550 000	2 700 000	3 225 000

Other	1%	of revenue	240 000	720 000	1 020 000	1 080 000	1 290 000
Technology			**12 480 000**	**14 640 000**	**16 560 000**	**18 132 000**	**20 149 200**
Salaries			12 000 000	13 200 000	14 520 000	15 972 000	17 569 200
Innovation	1%	of revenue	240 000	720 000	1 020 000	1 080 000	1 290 000
Other	1%	of revenue	240 000	720 000	1 020 000	1 080 000	1 290 000
General			**1 413 000**	**3 358 368**	**4 585 157**	**4 853 445**	**5 723 318**
Accounting	2000	per month	24 000	25 344	26 763	28 262	29 845
Bank charges	150	per month	1 800	1 901	2 007	2 120	2 238
Phone bill	5000	per month	60 000	63 360	66 908	70 655	74 612

Utilities	600	per month	7 200	7 603	8 029	8 479	8 953
IT	5000	per month	60 000	63 360	66 908	70 655	74 612
Lease	10000	per month	120 000	126 720	133 816	141 310	149 223
Salaries			180 000	190 080	200 724	211 965	223 835
Depreciation			720 000	2 160 000	3 060 000	3 240 000	3 870 000
Other	1%	of revenue	240 000	720 000	1 020 000	1 080 000	1 290 000
Total Operating cost			22 023 000	30 274 368	39 597 677	46 891 517	52 079 354
% of revenue			92%	42%	39%	43%	40%

5.18.3.4. Profitability

AE Insurance Income Statement					
Rand					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Revenue	24 000 000	72 000 000	102 000 000	108 000 000	129 000 000
Cost Sale	18 700 521	56 665 017	81 733 476	87 181 612	104 209 607
% of revenue	77,92%	78,70%	80,13%	80,72%	80,78%
Gross Profit	5 299 479	15 334 983	20 266 524	20 818 388	24 790 393
% of revenue	22,08%	21,30%	19,87%	19,28%	19,22%
Operating Expenses	9 783 000	16 354 368	24 057 677	29 839 517	33 220 154
Sales and Marketing	3 240 000	4 572 000	7 567 320	8 018 359	8 862 461
Operations	4 890 000	7 704 000	10 885 200	15 887 712	17 344 375
Innovation	240 000	720 000	1 020 000	1 080 000	1 290 000
General	1 413 000	3 358 368	4 585 157	4 853 445	5 723 318

Earnings from operations	4 483 520,55	1 019 385,41	3 791 152,50	9 021 128,91	8 429 760,93
% of revenue	18,68%	1,42%	3,72%	8,35%	6,53%
Extra-income/expenses	0	0	0	0	0
% of revenue	0%	0%	0%	0%	0%
EBIT	4 483 520,55	1 019 385,41	3 791 152,50	9 021 128,91	8 429 760,93
% of revenue	18,68%	1,42%	3,72%	8,35%	6,53%
Interest income	807 034	251 788	417 027	270 634	64 909
Net Income Before Taxes	5 290 554	1 271 174	4 208 179	9 291 763	8 494 670
Taxes	-2 116 222	-508 469	-1 683 272	-3 716 705	-3 397 868
Net earings	2 367 299	510 916	2 107 881	5 304 424	5 031 893
% of revenue	10%	1%	2%	5%	4%

5.19. Risk Assessment

Risk	Potential	Impact	Mitigation factors
Inability to get investors	Medium	High	The business of insurance is highly profitable. The selling strategy need to demonstrate that.
Inability to attract sufficient customer to make running the business profitable	Medium	high	Survey suggest that people are looking for a product of this nature. Marketing will still be required to place this product at people's faces.
Risk of big player copying the product and modifying their already existing products without incurring new operational costs	High	High	The strategy to deal with completion (big, equal or small player) is to continuously improve the product being offered. The innovation team must remain hard at work.
Higher than expected claims at the beginning which may be detrimental to the business	Low	High	South Africa has already gone through the period where in medical aid member were buying none-medical items using medical aid. The industry

			is well regulated t deal with that. Furthermore, the structure of AE Insurance is such that it caters for medical emergencies.

5.20. Implementation plan

All activities are assumed to be starting on the 1st of March 2023.

Activity	Duration	Estimated completion
Statutory registration	8 weeks	30 April 2023
CIPC Registration		
SARS registration		
Register with insurance bodies		
Obtain office space		
Capital raising	6months	30 Sep 2023
Develop finance request docs		
Source funding from investors		
Product refinement	3 months	30 June 2023
Hire key employees		

Develop relevant platforms		
Business development	2months	30 Sep 2023
Establish key partners		
Refine marketing plans		
Business launch	1.5 month	30 eptember 2023

6. CHAPTER 6. SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATION

6.1. Summary

Insurance can be defined as a method by which interested members of a society band together and collect funds to pay potential losses that could suffered later by members of the group (Reavis, 2012). This is the first principle of insurance and is the very definition from which this study was founded. From its inception, insurance was meant to work as a community-based risk management process. To date, a lot of the insurance business models are opportunistic ventures that benefit only one end of the party, exploiting the vulnerable and failing to address the cares of their exposure to identified risks.

The main objective of this study was to determine the feasibility of an insurance scheme for the underprivileged. For the purposes of this particular study, the researcher modeled a customer profile of contracted employees who would not normally afford health insurance premiums on their currently salary, thus making them the target for such a venture. The study aims to uncover the feasibility and durability of such a business model, uncovering the intricacies that would be involved in launching such a product to the stipulated customer group in South Africa. On the back of the outlined purpose and objective of the study, the primary research question that will govern the direction of the study was as follows: *Is the underprivileged community in South Africa willing to engage in a CBI scheme to cater for their health?*

Following the example of previously conducted research studies in this field, the researcher adopted the mixed methods approach, which is a combination of both the quantitative and qualitative approaches for the fulfillment of the research. The quantitative method was used to gather the demographic data, while the qualitative approach was used to uncover themes in line with the objectives in the study. The study also utilized the cast study research design approach, because the was investigating the success of a business venture in context, and needed to

investigate this within a real-life context to uncover all the intricacies that could be involved with the running of such a business. This particular approach works best when the researcher aims to closely examine data in a specific closed setting, limiting the geographical area and subjects of the study (Zainal, 2017). This research targeted a select geographical area, Kriel Town in Mpumalanga, wherein the employees of three ESKOM power stations located in the area were selected to be the population of the study and homogenous sampling was used for the final selection of the participants.

The sample population for the interviews consisted of 15 contracted individuals at three different ESKOM power stations, all from the same sector of employment – the heavy steel industry. The interview was conducted in two different formats; wherein the first five respondents were interviewed in a one-on-one set-up. The remainder of the participants were interviewed in two groups of five each. Of the interviewed respondents who were contracted, there was a common challenge of not having permanent contracts, and with the risk of losing their job at any moment, they are not able to make stable decisions regarding their health insurance. There is also the additional risk of losing the benefits once they fail to pay their premiums. Related, the permanently employed individuals noted that they did not earn enough money to allow them the luxury of having enough to join mainstream medical aids. Additionally, there was a clear understanding that should they get sick or be injured, they risk receiving delayed medical help at public hospital; a fear they now live with on a daily basis. Some common worries that came up from the interviews are that government ambulances take too long to fetch sick individuals; some have even witnessed friends being left in accident scenes due to not being on medical aid schemes; and lastly, the nurses and doctors at public health facilities do not offer the best of care services. The respondents have shown interest in joining medical aid that comes at low cost. Some of the respondents were part time workers.

Upon understanding the findings of the research, a business proposal was developed with the aim of producing a document that that would serve as a business case for the venture. Risk associated with business startup were dealt with using the very esteemed process of risk identification and mitigation taking advantage of the opportunities presented by the multiple spheres. The following analyses were made to this effect: PESTEL, industry analysis tool(s), business model canvas, risk analysis, and lastly, the implementation plan.

6.2. Conclusions

The main objective of this study was to determine the feasibility of an insurance scheme for the underprivileged. The research has provided insight into the lives of South Africans who are low-income earners. They live in constant fear of getting ill or their children getting and must come face to face with a public health facility. They testify of loved ones they lost to critical medical emergencies because of slow or no responses from the medical stuff in public health facilities. Some have given testimony of loss of life of their loved ones in the hands of public health workers.

On the basis of the findings of this study, the researcher can conclude that the proposed venture, AE Insurance has a good market for penetration, and that its value proposition is good enough to warrant the initiation of such a scheme. While the initial target of the venture would be the low-earning contracted workers of the power industry in Mpumalanga, this can be expanded upon first establishment and make ground towards the rest of South Africa, as this customer profile is prevalent through all provinces and the needs of the people are likely similar across the nation. AE Insurance will benefit significantly from the use of technology and will thus reduce operational costs, allowing the company to provide medical insurance at a low rate.

6.3. Limitations

With most if not every research work, limitations are almost inevitable. Some of the key limitations of the study included time and resource constraints, which prevented the researcher's ability to extend the investigation past Kriel Town in Mpumalanga. Another limitation could be on the data collected, that because of the nature of the discussion, health and finances, participants might have held back their experiences as some would have been deemed 'too personal and embarrassing' to share with external parties.

6.4. Recommendation

The following section details recommendations made by the researcher to the industry under study and for future research on the subject matter.

6.4.1. Industry-related recommendations

As the research data collected via interviews and an online survey will suggest, there is a need to bridge the gap created by a combination of two factors: a poorly run public health care system and expensive medical aid insurance.

- In setting up any business, the team or individual setting up such venture need to be knowledgeable of the acts/laws and regulations of the country, province and/or municipality in order avoid being found in violation of such. This may be tax laws (SARS), labor laws, company registration process (CIPC) etc.
- From the word go, the business must be formed to serve the needs of the customers: creating a good balance between customer service and profitability. With the understanding that customer needs may be dynamic, further improvement of the products offered to the customer needs to be done through surveys aimed at determining what customers need. In fact, it will be best for the customers to design what they want and willing to pay for.

- For any business to survive an entrepreneurial spirit of creativity and innovation needs to kick-in and stay. This is a largely uncharted territory and will require an engine/innovation room that is alive and vibrant in order to have continuous development of the business to flourish. At stated in (Okpara, 2007), innovation is expected to improve company's competitive advantage, revive organisations, redefine businesses and the market/sector in which they perform.

6.4.2. Recommendations for future research

- The topic on provision of quality health care at an affordable premium requires deeper research. A litany of work has been done internationally but in the South African context a lot needs to be done. Countries like China, Senegal, Nepal and others have done work on community-based health insurance. This is an area that this study tried to bring to the fore and is would be a great area to further investigate beyond the findings of this study.
- The researcher uncovered that a lot of the study respondents had bad experiences with the public health care system in South Africa. It would be helpful for the government of the nation to get a good indication of the severity of the problem and the different solutions that can be implemented to eradicate this crisis.

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8. APPENDIX A: Draft Survey Guide

Draft Survey Guide

Introduction:

My name is Victor Tshamano. I am an MBA student at the Wits University's Wits Business School. I am conducting a research on contractors' view of CBI. I would like to request you to participate in the survey to assist the study reach a conclusion.

Draft Survey Question

	What gender are you?	Male	Female	Cross the applicable choice
1.	Please indicate you age			
2.	How many dependents do you have?			
3.	Do you have medical aid?	Yes	No	
4.	Would you like to have medical aid?	Yes	No	
5.	What services would you like a medical aid to cover for you:	(e.g hospitalization):		
6.	How often do you visit a doctor per year?			

7.	How much do you spend on out-of-pocket medical expense per month			
8.	How long do you wait for in the public hospital que?			
9.	Would you be willing to join a low-cost medical aid scheme that is catered for your needs and income?	Yes	No	Please give reasons for your choice :_____ _____ _____

8.4. Appendix B: Ethics Clearance Certificate

Appendix B: Ethics Clearance Certificate

Graduate School of Business Administration
University of the Witwatersrand, Johannesburg

Wits Business School Ethics Committee
Constituted under the University Human Research Ethics Committee (Non-Medical)

Ethics Clearance Certificate

Ethics protocol number: WBS/BA567174/794
This certificate is only valid with a legitimate ethics protocol number and signed by the Researcher (below).

Project title	An insurance business for the uninsured in South Africa
Investigator / Researcher	Mr Victor Tshamano
Nature of Project	MBA (Business Venture Proposal)
Decision of the Committee	Approved, provided stakeholders and participants are guaranteed confidentialty.
Issue Date of Certificate	09/02/2022
Expiry date	Date of submission of the project report
Chairperson	Ms Ayanda Magida ☎ +27 11 717 3953 ✉ ayanda.magida@wits.ac.za

Declaration by Researcher

One copy must be signed by the Researcher and returned to the Chairperson of the Wits Business School Ethics Committee.

I fully understand the conditions under which I am authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I undertake to resubmit the protocol to the Committee.

Signature

16 feb 2022
Date:

8.5. Appendix C: Participants Information Sheet

WITS UNIVERSITY | Wits Business School — Sculpting global leaders

Private bag 3
Wits
2050

Dear Sir / Madam,

My name is Victor Tshamano and I am a Masters student in Masters of Business Administration at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project, and I am investigating feasibility of establishing ***An Insurance Business for the uninsured in South Africa*** under the supervision of Mr Lee Larbi. The aim of this research project is to ***find out how South Africans who would generally not take insurance cover can receive insurance cover at a cost effective and affordable manner.***

As part of this project, I would like to invite you to take part in an interview / answering a questionnaire. This activity will involve filling a questionnaire and will take around 30 minutes. With your permission, I would also like to record the interview using a digital device (optional).

There will be no personal costs to you if you participate in this project, You will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be held securely and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation in my final research report. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time.

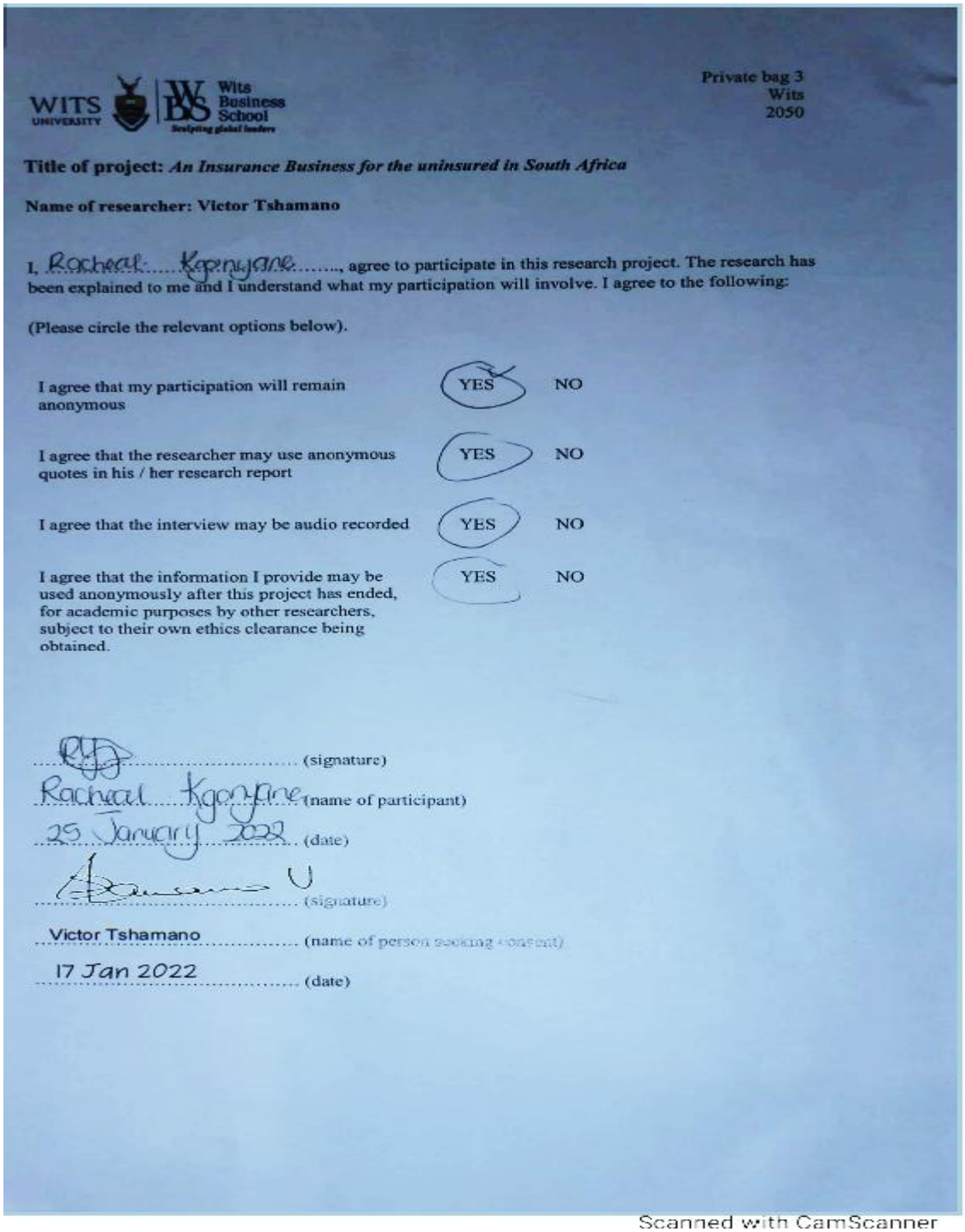
If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report. The data collected from this research project will be stored in Wits and will be kept for 2years. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours sincerely,

Researcher:
Victor Tshamano,
567174@students.wits.ac.za,
0825599018

Supervisor:
Lee Larbi,
lee.larbi@wits.ac.za,
082 826 7207

8.6. Appendix D: Example of a filled consent form



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Private bag 3
Wits
2050

Title of project: ***An Insurance Business for the uninsured in South Africa***

Name of researcher: Victor Tshamano

I, Rachael Kgonyane....., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO
I agree that the researcher may use anonymous quotes in his / her research report	YES	NO
I agree that the interview may be audio recorded	YES	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO

RKJ ..... (signature)

Rachael Kgonyane ..... (name of participant)

25 January 2022 ..... (date)

..... (signature)

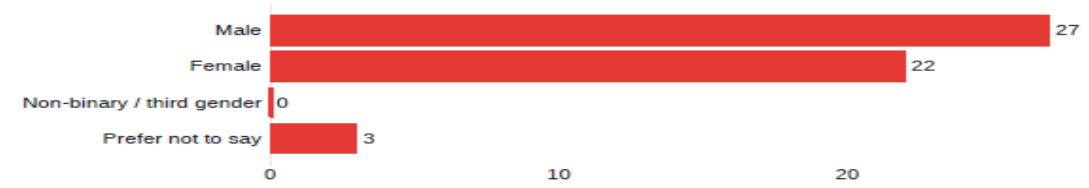
Victor Tshamano ..... (name of person seeking consent)

17 Jan 2022 ..... (date)

Scanned with CamScanner

8.7. Appendix D: Survey Questionnaire and Responses Distribution

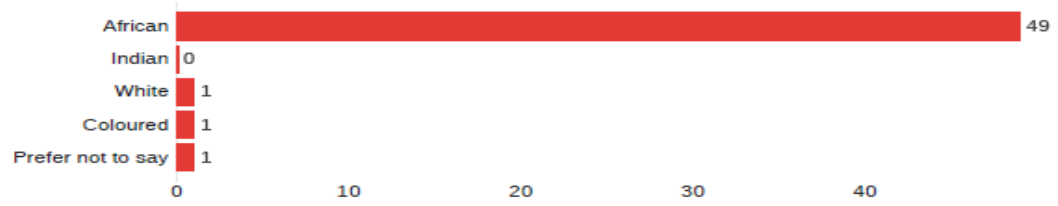
Q1 - What gender do you identify with?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
What gender do you identify with?	1	4	2	1	1	52

Field	Choice Count
Male	27
Female	22
Non-binary / third gender	0
Prefer not to say	3
Total	52

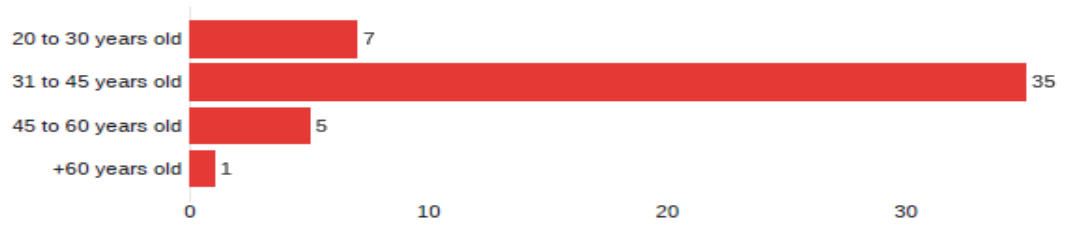
Q2 - Specify your ethnicity



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Specify your ethnicity	1	5	1	1	1	52

Field	Choice Count
African	49
Indian	0
White	1
Coloured	1
Prefer not to say	1
Total	52

Q3 - What is your age?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
What is your age?	1	4	2	1	0	48

Field	Choice Count
20 to 30 years old	7
31 to 45 years old	35
45 to 60 years old	5
+60 years old	1
Total	48

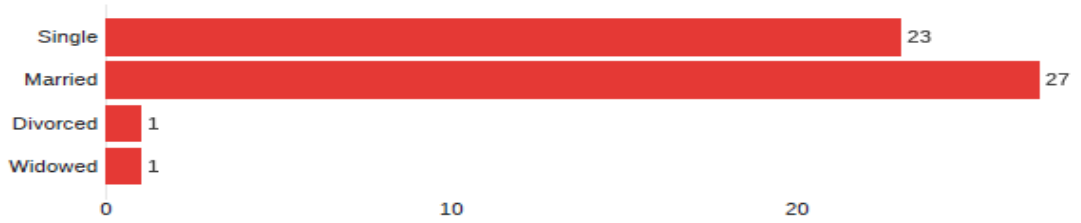
Q4 - Your academic background

51 Responses

Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Your academic background	1	4	3	1	1	51

Field	Choice Count
No Matric	1
Matric	15
Undergrad Degree(Diploma, Bachelor)	16
Postgrad Degree	19
Total	51

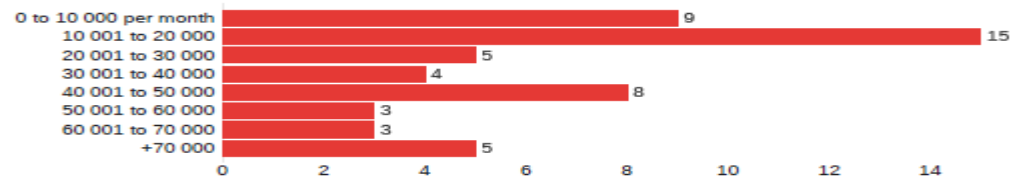
Q5 - Marital status



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Marital status	1	4	2	1	0	52

Field	Choice Count
Single	23
Married	27
Divorced	1
Widowed	1
Total	52

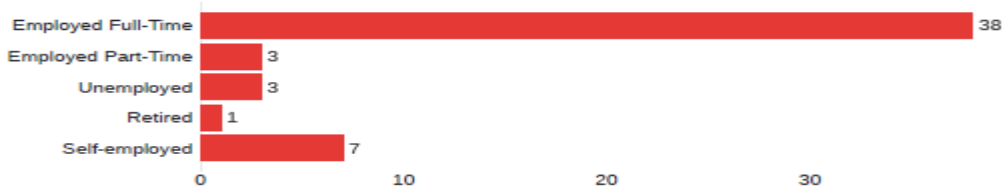
Q7 - Household income(in Rands per month)



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Household income(in Rands per month)	1	8	4	2	5	52

Field	Choice Count
0 to 10 000 per month	9
10 001 to 20 000	15
20 001 to 30 000	5
30 001 to 40 000	4
40 001 to 50 000	8
50 001 to 60 000	3
60 001 to 70 000	3
+70 000	5
Total	52

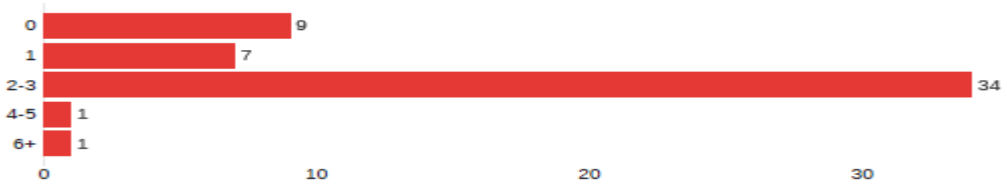
Q8 - What is your employment status?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
What is your employment status?	1	5	2	1	2	52

Field	Choice Count
Employed Full-Time	38
Employed Part-Time	3
Unemployed	3
Retired	1
Self-employed	7
Total	52

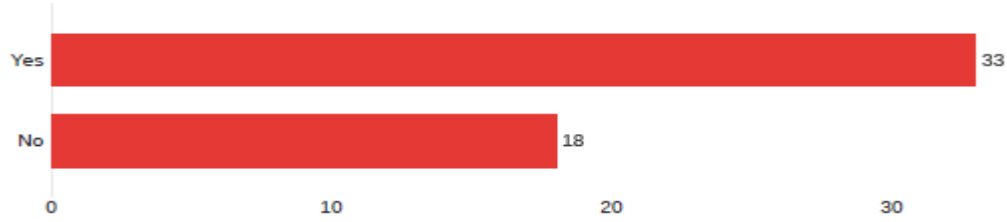
Q9 - How many children do you have?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
How many children do you have?	1	5	3	1	1	52

Field	Choice Count
0	9
1	7
2-3	34
4-5	1
6+	1
Total	52

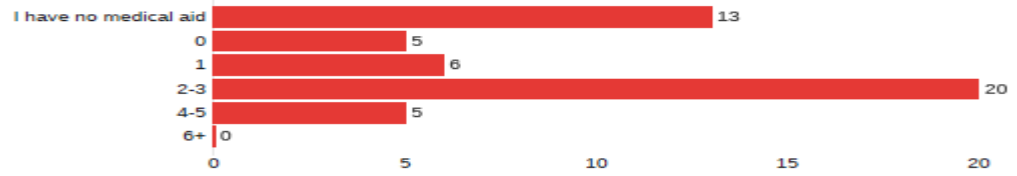
Q10 - Do you have medical aid?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Do you have medical aid?	1	2	1	0	0	51

Field	Choice Count
Yes	33
No	18
Total	51

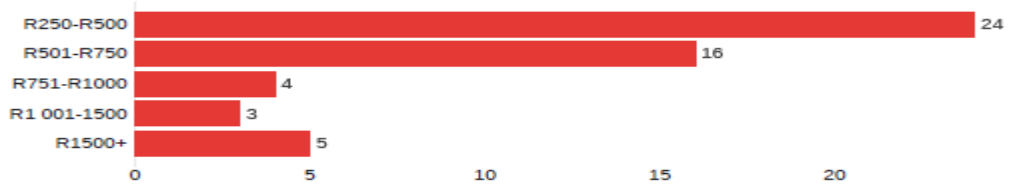
Q11 - If you have medical aid, how many of your dependents are covered?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
If you have medical aid, how many of your dependents are covered?	1	5	3	1	2	49

Field	Choice Count
I have no medical aid	13
0	5
1	6
2-3	20
4-5	5
6+	0
Total	49

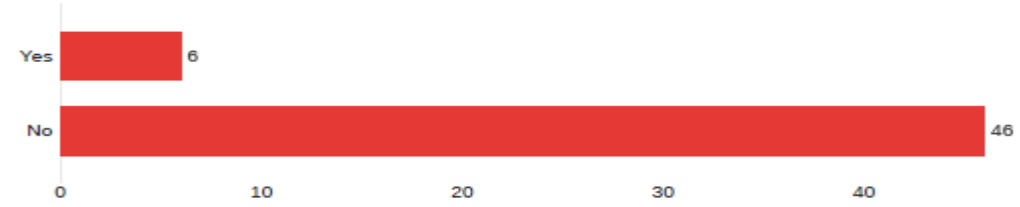
Q12 - On average, how much do you spend on Doctors, Medicines or Medical care per month



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
On average, how much do you spend on Doctors, Medicines or Medical care per month	1	5	2	1	2	52

Field	Choice Count
R250-R500	24
R501-R750	16
R751-R1000	4
R1 001-1500	3
R1500+	5
Total	52

Q13 - Are you using chronic medication?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Are you using chronic medication?	1	2	2	0	0	52

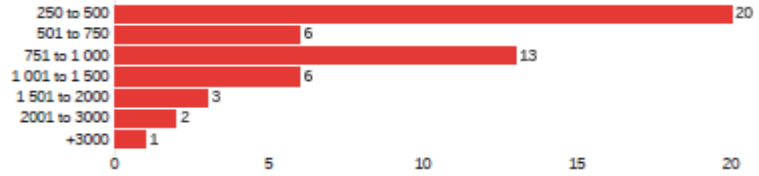
Field	Choice Count
Yes	6
No	46
Total	52

Q14 - Would you support a low cost/club(stokvel) structured medical aid

Field	Min	Max	Mean	Standard Deviation	Variance	Responses
Would you support a low cost/club(stokvel) structured medical aid	1	3	2	1	0	54

Field	Choice Count
Yes	30
Maybe	20
No	4
Total	54

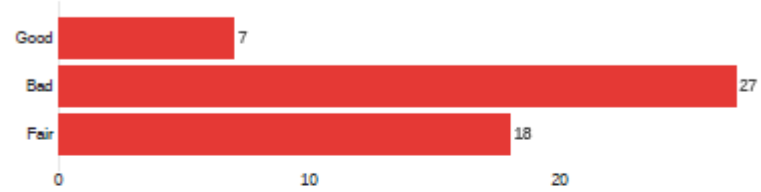
Q15 - How much would you be willing to contribute to a low cost medical aid to cover your dependents?



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
How much would you be willing to contribute to a low cost medical aid to cover your dependents?	1	7	3	2	2	51

Field	Choice Count
250 to 500	20
501 to 750	6
751 to 1 000	13
1 001 to 1 500	6
1 501 to 2000	3
2001 to 3000	2
+3000	1
Total	51

Q16 - What is your experience or perception of public health families(hospitals, clinics etc)



Field	Min	Max	Mean	Standard Deviation	Variance	Responses
What is your experience or perception of public health families(hospitals, clinics etc)	1	3	2	1	0	52

Field	Choice Count
Good	7
Bad	27
Fair	18
Total	52