



Personal Medical, Dental and Allied Health Cover as an Asset Rather Than an Expense or Liability: A Narrative Review with a South African Perspective

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ABSTRACT :

Background: Health insurance contributions are commonly framed by households as a recurring expense or liability, particularly in years when few claims are made. This framing may contribute to under-insurance, downgrading of cover and deferral of preventive medical, dental and allied health care. Objective: To review whether personal medical, dental and allied health cover is better conceptualised as an asset that protects health capital, earning capacity and household wealth than as a pure expense. Methods: A narrative review was undertaken of peer-reviewed literature in health economics, dental public health and health-systems research, supplemented by South African statutory instruments, regulator reports and fiscal documents. An illustrative household model, based on explicit hypothetical assumptions, compared net contribution outlay with exposure to uninsured events. Results and discussion: Health functions as human capital whose loss carries large economic costs; insurance reduces catastrophic out-of-pocket spending; and coverage improves access to care and, in some settings, health outcomes and financial security. Oral diseases are highly prevalent, largely preventable and linked to systemic disease, yet benefit designs often restrict dental cover. In South Africa, the medical scheme fees tax credit partly offsets contributions, while legal uncertainty around National Health Insurance complicates long-term planning. In expected-value terms contributions usually exceed average claims, so the asset argument rests on risk transfer, access and protection of health capital rather than financial return. Conclusion: Reframing cover as a health-capital protection asset is analytically defensible and may support better decisions, provided affordability, benefit design and evidence limitations are acknowledged.

Keywords: Medical aid; health insurance; dental care; allied health; health capital; South Africa

1. Introduction

In South Africa, private health cover is delivered mainly through medical schemes regulated under the Medical Schemes Act. In 2024 the Council for Medical Schemes regulated 71 schemes serving more than 9.1 million beneficiaries [1]. The industry covered 9.17 million beneficiaries, roughly one in seven South Africans, and the average beneficiary age rose from 32 to 34.2 years [2]. The regulator has also described a year of economic volatility, rising unemployment and household financial pressure that reduced disposable income and strained scheme membership [1]. Contributions are therefore under constant scrutiny by the households that pay them.

For many households the monthly contribution is one of the largest fixed commitments in the budget and is experienced as an expense: money that leaves the household and, in a year of good health, appears to return nothing. In accounting terms a contribution is indeed expenditure. Economically, however, the relevant question is what the payment purchases. Grossman's seminal model treats health as a durable capital stock that depreciates with age and can be maintained through investment in medical care [3]. Cross-country evidence shows that population health is a significant determinant of economic output [4]. Medical care is also unlike ordinary goods because of uncertainty over when illness will occur and information asymmetry between patients and providers, features that make insurance institutions necessary [5]. Behavioural economics adds a further consideration: people weigh losses more heavily than equivalent gains [6], so a certain monthly outflow may loom larger than a probabilistic, deferred protective benefit.

Oral health illustrates the tension well. Oral diseases affect an estimated 3.5 billion people worldwide [7,8], and untreated caries of permanent teeth has been ranked among the most prevalent conditions in the global burden of disease [9]. Nevertheless, dental care is often treated as discretionary and, in

many benefit designs, is subject to annual limits or funded from savings accounts or out-of-pocket payments. A Lancet series argued that oral health has been neglected within global health policy and that prevailing models of dental care are costly and poorly integrated with universal health coverage [10]. The same pattern applies to allied health services such as physiotherapy, optometry, dietetics, psychology and audiology.

The research problem addressed here is that a purely expense-based framing of health cover may lead individuals and households to under-value protection, to downgrade or drop cover, and to defer preventive care. The objective of this review is to examine whether personal medical, dental and allied health cover is better conceptualised as an asset (specifically, an instrument that protects health capital, access to care, earning capacity and household wealth) than as an expense or liability. The working hypothesis is that this reframing is supported by economic and clinical evidence, provided its limits are stated openly.

2. Materials and Methods

2.1 Study design

This is a narrative review combined with an illustrative quantitative model. It is not a systematic review and no formal protocol was registered. The narrative design was chosen because the question spans several disciplines (health economics, insurance theory, dental public health, rehabilitation and health law) whose evidence is not amenable to a single pooled estimate.

2.2 Sources and selection

Targeted searches were conducted in September 2026 for peer-reviewed articles, regulator reports, statutes, fiscal documents and reputable legal and news commentary. Search concepts included health capital, health insurance and access to care, catastrophic health expenditure, oral disease burden, dental benefits and utilisation, rehabilitation need, workplace health and productivity, South African medical schemes, the medical scheme fees tax credit and National Health Insurance. Priority was given to landmark theoretical papers, systematic reviews and global burden estimates, randomised or quasi-experimental studies, official statistics, and primary legal and regulatory documents. Sources were included when they directly informed one of the review themes and were excluded when they were duplicative, promotional or unsupported by verifiable data.

2.3 Synthesis

Findings were grouped thematically and synthesised narratively. No meta-analysis or formal risk-of-bias scoring was undertaken; instead, the weight given to each source reflected its study design and its transferability to the South African setting. Where evidence originates from high-income settings, particularly the United States, this is stated.

2.4 Illustrative household model

To make the asset-versus-expense distinction concrete, a hypothetical South African household of four (two adults and two children) was modelled. The assumed monthly contribution (R5,000) and the scenario costs are hypothetical, are expressed in constant 2026 rand without discounting or medical inflation, and are not derived from claims data. The statutory medical scheme fees tax credit was calculated using the rates published by National Treasury for the 2026/27 tax cycle [11]. The model is intended only to illustrate reasoning, not to estimate outcomes for any real household.

2.5 Ethical approval and regulatory requirements

This review used only published literature, public documents and hypothetical data. It involved no human participants, patient records or identifiable personal information. Ethical approval and informed consent were therefore not required.

3. Results and Discussion

3.1 Two ways of seeing a contribution

The literature supports two distinct framings of cover, summarised in Table 1. Under the expense lens, a contribution is a recurring outflow judged against claims made in the same year, and unused cover is regarded as wasted. Under the asset lens, the contribution purchases a bundle of protections (financial risk transfer, timely access to care and preservation of earning capacity) whose value is received whether or not a claim arises, in the same way that the value of a fire policy or of a stable bridge is not measured only on the day of the fire or the flood.

It is important to be precise about what is being claimed. In bookkeeping terms, contributions remain expenditure and do not appear as an asset on a household balance sheet. The asset lens is an economic and decision-making frame. It relocates the object of the asset from the policy itself to the health capital, financial security and access that the policy protects.

Table 1. Expense (liability) lens versus asset (health-capital protection) lens

Dimension	Expense / liability lens	Asset lens
Framing	Recurring outflow with no visible return in healthy years	Purchase of protection for health capital, access to care and household wealth
Time horizon	Monthly or annual budget	Life-course horizon covering dependants and ageing
Unused cover	Wasted money	Value of risk transfer received regardless of claims
Health status	A cost driver	A capital stock that depreciates and can be maintained
Oral and allied health	Discretionary extras	Early-intervention services that may avert costly downstream disease
Response to price increases	Cancel or downgrade across the board	Re-optimize cover to protect core benefits (hospital, chronic, emergency)

Source: conceptual synthesis by the author.

3.2 Health as capital

Grossman's model implies that individuals demand health because it yields both consumption benefits (feeling well) and investment benefits (more healthy time available for work and other activities) [3]. Health capital depreciates, and medical care is one of the inputs that offsets depreciation. At the macroeconomic level, the production-function analysis of Bloom and colleagues estimated that a one-year increase in life expectancy is associated with an increase in aggregate output of roughly 4% [4]. At the household level the parallel is straightforward: illness reduces the capacity to earn, and cover that preserves timely access to diagnosis and treatment protects the stream of future income on which every other household asset depends. On this reading, insurance is not the asset itself but a mechanism that safeguards the most important asset most households own.

3.3 Financial risk protection

Arrow's classic analysis explains why insurance is central to medical care: the timing and cost of illness are unpredictable, and risk-averse individuals gain from pooling [5]. Empirically, catastrophic health spending (out-of-pocket payments that exceed a defined share of a household's capacity to pay) is a recognised route into financial hardship, and Xu and colleagues showed that prepayment and risk pooling reduce that exposure [12]. Wagstaff and colleagues found that catastrophic health spending remains a substantial problem across 133 countries [13]. In South Africa, analyses of health financing indicate that private prepayment, and the benefits it purchases, are concentrated among higher-income households [14]. Cover therefore protects those who hold it, but its unequal distribution is also a reminder that the asset argument applies only to households that can sustain contributions.

3.4 Access and outcomes: what the evidence shows and does not show

Evidence that insurance improves health is real but mixed, and the asset case should not overstate it. The RAND Health Insurance Experiment found that cost sharing reduced the use of both effective and less effective care [15], and that free care improved some outcomes, chiefly among the poor and the sick, rather than producing across-the-board gains [16]. The Oregon randomised lottery found that Medicaid coverage increased health-care use and reduced depression and financial strain, but did not produce significant improvements in measured physical health such as blood pressure or glycaemic control over two years [17]. Quasi-experimental analyses of state Medicaid expansions, in contrast, associated coverage with improved access and lower all-cause mortality [18].

Taken together, these studies suggest that the most robust benefits of cover are improved access, reduced financial strain and better mental health outcomes, with mortality and physical health effects appearing over longer horizons and in populations with greater unmet need. All of these studies come from the United States and should be transferred to South Africa with caution. The implication for the asset argument is that the protection of financial security and access is well supported, whereas claims of guaranteed health improvement are not.

3.5 Dental care as a distinct case

Dental diseases carry large economic consequences. Listl and colleagues estimated that they cost about US\$298 billion annually in direct treatment and a further US\$144 billion in indirect costs, largely productivity losses, giving a total of roughly US\$442 billion [19]. The disease burden is heavily concentrated in untreated conditions [9], and oral diseases share risk factors with major non-communicable diseases [7]. Periodontitis has an independent association with cardiovascular disease [20], and the relationship between periodontitis and diabetes is bidirectional [21]. These links do not mean that dental cover prevents systemic disease, but they do support the view that oral health is part of, rather than separate from, general health capital.

Access is the weak point. United States data document strong gradients in dental utilisation by insurance status and income [22], and the WHO has called for oral health to be integrated into universal health coverage [8]. South African accounts describe an uneven distribution of oral health services and resources [23]. Where scheme benefits for dentistry are capped or drawn from limited savings accounts, households effectively self-fund much of their dental care, and many defer treatment until it is symptomatic and costlier. It is plausible, and consistent with the principles of preventive dentistry, that regular examination, scaling and early restoration are lower-cost than late-stage extraction, endodontic or surgical care. Local cost-effectiveness studies in the South African private sector are needed to confirm the size of this effect.

3.6 Allied health services

Allied health professions, including physiotherapy, occupational therapy, optometry, audiology, dietetics and psychology, maintain function, participation and work capacity. Cieza and colleagues estimated that about 2.4 billion people worldwide live with a health condition that would benefit from rehabilitation [24]. Because these services often sit in limited day-to-day benefits, they are among the first to be dropped when contributions are trimmed. The asset lens would treat them as maintenance of functional capacity, with priority determined by an individual's clinical needs rather than by the convenience of a benefit category.

3.7 Productivity and the employer perspective

Health-related lost productivity, including absenteeism and reduced performance while at work, can rival or exceed direct medical spending. A multi-employer study found that health-related productivity costs were substantial relative to medical and pharmacy costs [25]. A meta-analysis of employer wellness programmes estimated favourable returns from reduced medical spending and absenteeism [26], although such findings are specific to programme type and setting and should be interpreted cautiously. For self-employed professionals and small-business owners, whose income depends directly on personal capacity to work, the link between health protection and income continuity is especially direct.

3.8 The South African regulatory and fiscal context

The Medical Schemes Act establishes the framework within which schemes operate, including requirements that open schemes accept applicants, restrictions on risk-rating by health status and a mandated set of Prescribed Minimum Benefits [27]. These features make cover more valuable as protection against the unexpected: the person who develops a serious condition after joining is not repriced out of the pool on the basis of that diagnosis, subject to the Act's provisions on waiting periods.

The state also recognises cover fiscally. Under the medical scheme fees tax credit for the 2026/27 cycle, a taxpayer may claim R376 per month for each of the first two persons covered and R254 for each additional dependant [11]. Because the credit is a fixed monetary amount rather than a percentage of income, it offsets a larger share of contributions for lower-contribution members than for higher-contribution ones, but it is a partial offset in all cases.

Long-term planning is complicated by legislative uncertainty. The National Health Insurance Act was enacted in 2024 to pursue universal access through a single purchasing fund [28]. Its implementation has been suspended pending Constitutional Court proceedings; in May 2026 the Court heard challenges to the public participation process and reserved judgment [29], and it confirmed the invalidity of the certificate-of-need provisions of the National Health Act [30]. Because this situation is evolving, readers should verify its current status. For the argument of this review, the practical point is that until the legal and policy position is settled, medical schemes remain lawful, regulated and relevant, and neither wholesale cancellation nor complacency is well-founded.

3.9 Illustrative household model

Table 2 sets out the hypothetical household's net annual outlay after the statutory credit. Table 3 compares that outlay with the potential uninsured cost of three levels of health event.

Table 2. Hypothetical household: net annual contribution outlay

Item	Amount (constant 2026 rand)
Monthly contribution (assumed)	R5,000
Annual contributions	R60,000
Medical scheme fees tax credit: $(2 \times R376 + 2 \times R254) \times 12$	R15,120
Net annual outlay after credit	R44,880 (R3,740 per month)

Source: author's calculation; contribution level is hypothetical; credit rates from National Treasury (2026).

Table 3. Hypothetical uninsured exposure compared with net annual outlay

Scenario (hypothetical uninsured cost)	Cost	Multiple of net annual outlay
Routine primary care and preventive dental care for the family	R12,000	0.27
Emergency surgery with a short private hospital stay	R120,000	2.7
Major event (for example ICU admission, cardiac surgery or a cancer treatment programme)	R600,000	13.4

Source: author's calculation; scenario costs are illustrative assumptions and not claims data.

Over twenty years the household's net outlay would be R897,600 in constant rand, or about 1.5 times the single major-event scenario. Under the expense lens this appears large, because in a healthy household most of it produces no visible claim. Under the asset lens the comparison is different: a household that wished to self-insure against the major-event scenario alone would need to hold a liquid reserve of about R600,000. At an assumed real return of 3%, the annual opportunity cost of that reserve would be R18,000, lower than the net outlay, but the reserve would be exhausted by one event, could not respond to several events across four family members, and would tie up capital that most households do not have.

The model also exposes an honest limitation. Schemes incur administrative costs and cross-subsidise sicker members, so in expected-value terms a healthy household will usually pay more in contributions than it receives in claims. The asset case is therefore not that cover yields a positive financial return on average. It is that the household buys protection against a low-probability, high-severity loss that it could not readily absorb, together with access and continuity of care.

3.10 Counter-arguments and limitations

Several counter-arguments deserve emphasis. First, affordability: membership growth has lagged behind population growth and the beneficiary base is ageing [2], and for many households the choice is between cover and other essentials rather than between cover and discretionary spending. The asset lens cannot remove that constraint. Second, benefit design and medical inflation matter; an asset that is priced beyond the household's means, or that excludes the services most often needed (such as dentistry), is less valuable than the framing implies. Third, the evidence on health outcomes is mixed and largely non-South African, as discussed above. Fourth, this is a narrative rather than systematic review and is therefore susceptible to selection bias, and the household model rests on hypothetical inputs. Finally, the author is a dentist in private practice, and this professional position may have shaped emphasis, as disclosed below.

3.11 Practical implications

- Individuals and households: evaluate cover by the risks it removes (catastrophic hospital costs, chronic disease and emergencies) and by the access it secures, rather than by the claims-to-contribution ratio in a single year.
- Cost pressure: when contributions become unaffordable, consider restructuring to protect core hospital and chronic benefits before abandoning cover, and keep preventive dental and allied health care within the budget where feasible.
- Clinicians and practices: communicate preventive care as protection of long-term health capital, and be transparent about scheme benefit limits and expected out-of-pocket costs.
- Employers and policymakers: recognise that the productivity and financial-protection value of cover is broader than the claims it pays, and that benefit design should not systematically exclude oral and allied health care.
- Researchers: local studies of the cost-effectiveness of preventive dental and allied health benefits in the South African private sector are a priority.

4. Conclusion

Personal medical, dental and allied health cover can be defended as a health-capital protection asset. The strongest support comes from the theory of health capital, the role of insurance in reducing catastrophic spending, and evidence that coverage improves access and financial security. Oral health illustrates both the promise and the difficulty: oral diseases are prevalent and largely preventable, yet dental cover is often the first casualty of budget pressure. The asset lens should not be read as a claim of financial return, as an accounting treatment or as a substitute for addressing affordability. Properly bounded, however, it offers a more accurate account of what households purchase, and may support more considered decisions about which benefits to protect, retain and use. Future work should test the framing with South African claims and utilisation data.

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7. Conflict of Interest

The author is a dentist in private practice in South Africa. Dental services may be reimbursed through medical schemes and insurers, and this professional context is disclosed as a potential interest. The author declares no other financial, professional, institutional or personal interests that could have influenced this work or its interpretation.

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