Promoting health citizenship and multilingualism in the health insurance industry

By

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Keywords

Health

Health communication

Health literacy

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Citizen-consumer

Consumerism

Multimodality

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Participation

Abstract

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PhD thesis, Department of Linguistics, University of the Western Cape

The thesis explores the role of semiotic structuring of health information in relation to language, multimodality and health literacy and the affordances for agentive participation among consumers of two leading South African medical schemes – Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS).

The focus is on who has access to health information, how this information is constructed and what the semiotic health habitat looks like for citizen-consumers. Through a virtual ethnographic approach the thesis explores the design of genres of health information artefacts: application forms, application guides, a comic book, and a variety of website images.

The choice to study the commercial package of a private health industry is aimed at finding and defining codes of practice in health communication that could be replicable in the public health sector. A new perspective emerging out of the thesis is how semiotic structuring of style, stance-taking, and choice of registers affects reading positions, and how these determine with what voice citizen-consumers can engage with this information.

This analysis is supported by data collected through an online questionnaire that was completed by 80 participants. The quantitative data were analysed qualitatively to respond to the research that framed the thesis in understanding the processes of language use and communication.

Another significant development is that the thesis finds that Discovery Health's commercial package fits in with the postmodern constructs of health, beauty, lifestyle and even happiness. Related to these

factors are notions of English, white, middle-class aesthetics, which dominate this package. GEMS, in contrast, follows a more conventional focus on health access and medical care, and is less racially and linguistically specific.

The thesis also finds that more accessible health information and better designed artefacts are required for health subjectivity, a finding which was found to apply to both Discovery Health and GEMS.

Declaration

I declare that ***Promoting health citizenship and multilingualism in the health insurance industry*** is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Alfred Mautšane Thutloa

July 2018

Signed....  .....

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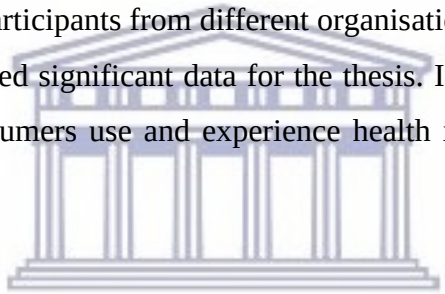
Prof. thanks for your continued leadership and insight. This has been an enriching experience for me in so many ways and I am honoured for the privilege.

I would also like to thank my late mother, Rosinah Thutloa, whose values I continue to live by today.

A special thank you to all the participants from different organisations who took part in the study. Your contributions have provided significant data for the thesis. I hope this thesis adds value to the understanding of how consumers use and experience health information in a dynamic and complex health industry.



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AIDS: Acquired immunodeficiency syndrome

Discovery Health: Discovery Health Medical Scheme

GEMS: Government Employees Medical Scheme

HIV: Human immunodeficiency virus

IOM: Institute of Medicine

MDR-TB: Multidrug-resistant tuberculosis

NGO: Non-Government Organisation

WHO: World Health Organization

XDR-TB: Extensively drug-resistant tuberculosis

Chapter 1: Introduction

1.1 Background

The thesis focuses on the construction and distribution of health information across multimodal artefacts and multi-semiotic contexts, and how consumers use and experience this information. It specifically explores multimodality and the affordances that semiotic structuring, particularly across websites, offers for agentive participation and health citizenship, among consumers in the health insurance industry. According to Nanda and Pramanik (2008: 5) health communication is about promoting personal and public health and can contribute to "all aspects of disease prevention and health promotion."

Health citizenship in this study is about how consumers take health information, navigate through different artefacts, such as websites, to find health-related information. Health communication is also largely concerned with the powerful role of human communication in the health care delivery system (Kreps et al 1998, 2007). This is an interdisciplinary field that includes important theories and concepts and different aspects of communication, such as linguistics and behaviour, interpersonal communication, cross cultural communication and new technologies in communication.

In essentials, the thesis is an exercise in the study of health communication. Although the term 'health communication' has only been around since the 1970s, communication researchers have been studying this field for decades (Sparks 2013). Health communication is a significant research area with a long history, as a concept "health communication" has evolved over time. The field of health communication was influenced by the social sciences such as psychology and sociology, and while the field of communication had for years borrowed from theories in the social sciences, the shift to health care as a research area was a natural one (Kreps et al 1998: 3).

Publications on health communication in the USA began in the 1980s when, for example, Kreps and Thornton (1984) began contributing to scholarly publications into the field of health communication with *Health Communication: Theory and Practice*. There was much interest among communication scholars in researching the health care context. By 1985 a Commission for Health Communication and a Speech Communication Association were established in the USA. Conferences soon followed and in 1989, the first scientific quarterly journal called *Health Communication* was launched that assessed the state of the field of health communication and the way forward. This was followed by a second quarterly journal, the *Journal of Health Communication*, which had a more international approach.

Health communication as a research area has developed as an exciting applied behavioural science looking at human and mediated communication in the health care system, with emphasis on problems and resolving a wide range of health issues (Kreps et al in Jackson and Duffy 1998). In the field of health communication, communication is regarded as the process where information is shared for health care delivery and for promoting health (Kreps et al 1998). Like several other research areas, health communication draws from a vast list of research literature and other research disciplines, such as health professions, nursing, medicine and social work (Kreps et al 2007).

Health communication is an important aspect of inquiry for an understanding of how health information is constructed, distributed and assimilated in the health care setting. As a field of inquiry health communication has a long-established history, but how it was understood then to what it means today is vastly different. In the health context health promotion, education and communication are significant for energising citizens to take charge and engage for policy change. Still there are certain health discourses that influence how citizen-consumers think about health and act in a certain way based on the information they receive.

The thesis looks at the perceptions and practices of consumers who use health information constructed and disseminated by two leading South African medical schemes – Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS).

Another related aspect of the thesis is to look at the role of technology in the distribution of health information, an area of research that focuses on enhancing communication between health providers and patients (Sparks 2013). The thesis aims to contribute to this area, and to explore how the construction and distribution of commercially shaped notions of health, language and citizenship beyond the patient-doctor research theme, which is layered into technologies of communication and impact the uptake of heath information.

Health communication should also be understood in the context of the changing notions of health. The concept of health is widely defined as "a state of complete physical, social and mental well-being, and not merely absence of disease or infirmity," (World Health Organization 1998: 1). Health is also regarded as a resource for enabling people to lead individually, socially, and economically productive lives (World Health Organization 1998). Health has also become an achievement for people to work towards, a form of investment to avoid future chronic illness and premature death (Cockerham 2005).

Much has been achieved in the field of health communication, with recent research showing the powerful role of communication in health. Today there is more focus on community participation, and how to empower citizens relating to their health concerns (Kreps et al 1998). Citizens are better educated and more informed than before and health care providers should respond to the issues that matter to them, namely health care access, relations with physicians, meaningful and clear information and participation in health care and treatment decisions (Wadhwa 2002).[1] This means that Discovery

[1] The Internet Journal of Health ISSN: 1528-8315 [Accessed on 08 July 2012]

Health and GEMS should ideally provide health information in ways that enable citizen-consumers to use information for positive health outcomes.

In recent years, the framing of health discourses and health management has become increasingly commercialised (Gilman 1999, Feathersone 2001, Kickbusch 2004, Porter 2011) and health has become something people can do and buy (Cockerham 2005). Modern notions of health citizenship are about an ideal body and youthfulness (Feathersone in Johnston 2001), and health communication is increasingly about individual beauty. According to Porter (2011) the ideal body is a commodity for sexual attractiveness and social mobility.[2] This has led to the transformation of bodies to fit culturally mediated appearance ideals. Nevertheless, Feathersone in Johnston (2001: 79) argues that the *"*construction of body parts around youth and appearance*, however*, demands *increasing* personal investment as individuals consciously attempt to reach the ideal. In the new liberal postmodern context, increasing responsibility is put on the consumer to take care of their own health.

The commercialisation of health is part of globalisation and modernity. In his own words Giddens (1990: 175) explains that "[globalisation] is a process of uneven development that fragments as it coordinates - introduces new forms of world interdependence, in which, once again, there are no 'others'." This raises the question of what agency means in a new health structure, specifically around the choices consumers make relating to nutrition, exercise, dieting and not smoking. To what extent are the choices people make a matter of personal choice or shaped by external factors at a global scale (Cockerham 2005).

[2] Porter's perspective on health perhaps indicates a westernised and first world view of health in modern times. Although these commercial notions of health do indeed exist in the private health sector in South Africa, which the thesis focuses on, it should be mentioned that there are other notions of health that are about 'bread and butter' issues where these commercial constructs of beauty and attractiveness are non-existent or even insignificant because people have to deal with widespread disease outbreaks, poor sanitation and the associated health challenges and lack of health care in resource constrained settings.

The question of agency and participation is thus central to this thesis. As the thesis is a human sciences research project grounded in the linguistic field, health communication will be studied by looking at notions of *linguistic citizenship*, that is, how language allows for different means of agency and participation. Agency and participation in health are important as they are the pathways towards fostering health citizenship, by enabling consumers to become involved in the choices that affect their health. Citing Ferguson (1999: 7), Gaventa (2002) says that people should exercise their democratic rights in the decision-making processes relating to health care provision. Participation is also fundamental to citizenship as it emphasises "agency of citizens as 'makers and shapers' rather than as 'users and choosers' of interventions or services designed by others," (Gaventa 2002: 4).

Health literacy is a key component for health communication efforts to be successful in fostering agency and participation in questions of health, and for encouraging behaviour change among consumers. Health literacy has become one of the most vital literacies for accessing knowledge and information around health-related issues in modern society (Kickbusch 2004). In addition, the health system is becoming even more complex to understand; treatment decisions need to be taken, complex drug regimens must be followed, and healthy lifestyle choices are essential – therefore living with health or a chronic illness both demand high health literacy (Kickbusch 2004). In the context of this research, health literacy is about how medical schemes through information, create specific audiences and different structures of health literacy.

Literacy is not a neutral, single dimensional technology but a set of lived experiences that varies from community to community (cf. e.g. Ahearn, 2004). Therefore, people with different types and levels of literacy would experience and have different views and attitudes towards the health information presented. The thesis looks at a specific group of people, a community of consumers, who have access to *private* health care services in South Africa, and how they navigate through genres of health information across various multimodal artefacts.

Kress (2010) describes multimodality as a way of communicating a message by using a variety of mediums such as text, images and colour. There is a lack of studies into multimodality in health, particularly in South Africa. However, there are examples of researchers elsewhere that are specifically exploring multimodal health communication; for example, Harvey (2013) has conducted a critical multimodal discourse analysis of hair loss websites; and Harvey (2012) has also dealt with health communication and psychological distress: exploring the language of self-harm. The way consumers navigate through different health-related information using different modes is important to understand how information is consumed for health citizenship.

There are several concepts that are important in the structure of the thesis, mainly health communication, health citizenship, health literacy, multimodality, citizen agency and participation. All these concepts link three important focus areas, namely language, health, and communication and the interrelationship of these areas will be discussed further in the next section.

1.2 Language, health and communication

Language, health and communication have been studied across disciplines, specifically in the context of patient-doctor communication (Molina Health care and California Academy of Family Physicians 2004, Seed Orff et al 2013, Zeng and Tse 2006). Norton and Mutonyi (2010) state that most applied linguistic research that looked at the relationship between language and health was conducted in the industrialised world. According to the authors, this research focused on four main areas:

1. The study of discourse in health care settings
2. Problems faced by non-native speakers in the health sector
3. How virulent ‘superbugs’ were represented in the media, and

4. Sociolinguistic research on HIV/AIDS in resource rich countries.

Research into the health insurance industry in South Africa has generally focused on identifying client satisfaction among health management organisations (Coovodia 2008) and determining the importance of client relationship management for administrators of medical schemes (Calmeyer 2012). Research that focuses on how consumers in the health insurance industry use health information has not been extensively studied in South Africa. The thesis therefore is an attempt to look at health communication outside of the clinical setting appropriately by introducing a different perspective on, how the design of information affects agentive participation and health decision-making among this specific community of consumers in the South African context.

In the health setting, issues of language are an important consideration as language is the foundation to social development and democracy. Djite (2008) agrees, stating that the scales have generally been tipped in favour of the more powerful languages, the so-called 'majority' languages to the detriment of local languages and other forms of communication, and that this has resulted in language exclusion and in the exclusion of speakers. Tollefson (1991) explains that institutional limitations created by dominant groups have prevented linguistic minorities from receiving access to social and political structures; as a result, this has reinforced inequalities between the majority and minority groups. Therefore, the linguistic distribution of health resources is important for the democratic participation of consumers. However, commenting on the role that multilingualism plays for agency and participation, Stroud (2002) notes that merely acknowledging and giving recognition and rights to languages does not ensure that the voices of speakers of these languages will be audible in contexts and on arenas that matter.

Stroud (2002:67) explains that linguistic citizenship *is* about giving voice to citizens. Linguistic citizenship in the context of this study should be understood not just in terms of access to multilingual information but about the ability for citizen-consumers to express voice through the affordances to which this access to information, through different modes, provide for democratic participation. Stroud's (2006) linguistic citizenship model offers a powerful tool that expresses how speakers agentively choose to contextualise what language means to them. What makes this model significant in the context of the present study, where health communication is mostly in English, is the emphasis of linguistic citizenship on a broad repertoire of semiotic means, including multimodal, non/verbal registers. Although the respondents in this instance received the bulk of information in English, they nevertheless navigate, understand and act on this information despite not being native speakers of the language, and do so using the multimodal affordances provided by the technologies used. Semiotic structuring creates different reader positions, literacies, and opportunities or barriers to use health information for health care decision making, and it is one of the ambitions of this study to probe how this is managed. The distribution of information has become increasingly multimodal allowing consumers multiple ways to access and use health information. In this environment this is how the diversity of consumers is catered for through different modes such as websites, SMS communication, letters, and other communication artefacts.

According to Iedema (2003:30) "multimodal analysis considers the complexity of texts or representations as they are, and less frequently how it is that such constructs come about, or how it is that they transmogrify as (part of a larger) dynamic process." Multimodality was introduced to show the significance of semiotics outside of 'language in use', such as imagery, gesture and so on, this means that language is not the only factor important for communication (Iedema 2003).

Iedema (2003) also introduces the notion of resemiotization to refer to how the encodings (and materializations) of messages shift over time and across space. An example of this is seen in a review

of 44 international versions of Cosmopolitan magazine's November 2001 issue conducted by Machin and Thornborrow (2003). These authors explore how discourses are globally marketed through a specific print media product. The researchers focused on two areas of female agency: women in the work context and women's sexuality and these were compared across various magazines. The authors were able to show that although the 44 versions of Cosmopolitan magazine were adapted to fit their local environment, there were observable similarities between all versions. The authors investigated through multimodal discourse analysis the distribution of this magazine's global brand. According to the authors the images across the magazines depicted women in abstract and generic settings that were not tied to a geographic territory. They explain this further when they refer to Kress and van Leeuwen (1996) who suggest that generic settings lowers modality by shifting images from representing natural to more schematic, idealised and abstract symbols. Still the mobility of such discourses also depends on how easily they could be adapted to the local context.

Jones (2009) also explains that computer and television screens have made it possible for information to be accessed through various modes with different functionalities and different kinds of social meanings. By using a range of multimodal features, websites have become important tools for medical schemes to share health information. According to McMullan (2006) health information has become one of the most frequently sought-after topics over the Internet. Wyatt et al (2005) agree that although there has been little social science research about how people incorporate information from the Internet, quantitative data shows that health information is extremely popular with Internet users. This makes the design and content of websites holding this information significant for the uptake of health information. The thesis offers analyses of the websites by Discovery Health and GEMS, in chapter 6, to demonstrate what sort of space citizen-consumers, from a semiotic point of view, inhabit.

By looking at the design of the medical schemes' websites, it is possible to glean information on the ideals about health, consumption and even their target audiences that these medical schemes hold.

Through these websites, the medical schemes not only construct health standards but they influence and craft who should consume this information and how it should be consumed. This means different consumers with diverse health literacies would experience the information on the websites differently. In fact, Norman and Skinner (2006) comment that electronic health tools are ineffective if the people who should access this information lack the literacy to access it. The thesis will argue that Discovery Health and GEMS allow for different levels of participation among consumers and that the medical schemes establish certain health ideals.

The research methodology to be followed is structured mainly in two parts: a virtual ethnographic evaluation and discussion of website images and the analysis of genres of health information artefacts, as well as an electronic questionnaire administered to 80 participants. The virtual ethnographic approach is based on Halliday's (1994) trifunctional model on Reading Images (in Kress and van Leeuwen 2006), to interrogate and discuss the construction, distribution and uptake of information by members of Discovery Health and GEMS. Along with other useful analysis tools, the thesis will show how semiotic structuring and reader positions are shaped across digital and print media.

The electronic questionnaire supports the genres of multimodal artefacts by gathering data on the participants' home language, the languages in which they received information, the communication channels they followed for information, how this information was constructed, and their perceptions about the construction and distribution of this information for their health knowledge and subjectivity.

There is limited research on how health citizenship is shaped through carefully constructed health information. This thesis thus seeks to contribute to the understanding of the role of health information through the research questions that follow.

1.3 Research questions

The research questions shape the discussions presented in the thesis around issues of access to health information, what sort of health citizens are constructed, who has access to what information and how it is presented, and what semiotic environments do the health citizens navigate for agentive participation. The research questions are:

1. Who has access to health information and how is this structured?
2. What does the semiotic health habit look like for the health citizen-consumer?

The first research question focuses on the construction of health information, while the second question delves into those perceptions and practices of the health citizen-consumers who access information from Discovery Health and GEMS. Thus, the linguistic in linguistic citizenship for health is in the semiotic forms and use of language, styles, and other forms of semiotic linguistic structuring.

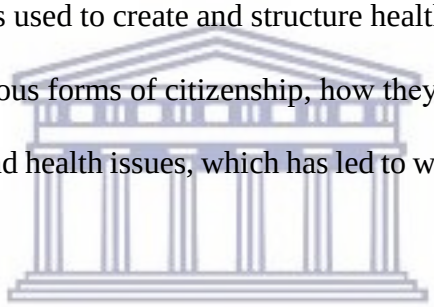
Academic research that involves a process of data collection and analysis can among others involve the collection and review of quantitative and qualitative data. Each research method offers different opportunities for analysis. In this study the genres of artefacts and quantitative questionnaire data are analysed qualitatively.

There are certain research themes applicable to the thesis particularly the concept of citizenship, how health citizenship has been defined and shaped in modern times. Also, how language and aspects of communication such as register, stance, and style affect how consumers make use and experience

health information and the artefacts holding this information. The thesis is multi-layered and has been divided into a structure that would show the links between different concepts to respond to the research questions.

1.4 Thesis outline

Chapter 2 offers a discussion of the main concepts of the thesis, mainly health, how it is constructed in modern times, the shift in notions of health to governmentalities of bodies. The chapter also looks at health citizenship as an offshoot of health, and how it should be understood in the context of the thesis, as to how information is used to create and structure health citizenship. Another key concept is that of citizenship and the various forms of citizenship, how they have shaped health and the citizens' interaction with information and health issues, which has led to what is described as citizen-consumers in the thesis.



Chapter 3 follows with a look at language, multilingualism, and health literacy. This chapter discusses issues of linguistic access to information and its impact to health outcomes. Translation services are also discussed as a possible intervention to bridge the language gap to make health information more accessible.

Chapter 4 looks at research design, the concept of virtual ethnography, which formed the framework for the analysis of the various multimodal artefacts, mainly websites. Virtual/online ethnography allowed for the reading and analysis of artefacts: application forms, guides, website information, as well as how the researcher negotiated access with gatekeepers at Discovery Health and GEMS. The challenges faced in getting access to members is discussed as well as steps followed to collect data via an online questionnaire. As a follow-on to the previous chapter, Chapter 5 provides a far wider analysis

of the multimodal artefacts above, in relation to language choice, style, how style is a form of identity or branding, stance and register.

The analysis of different types of website images contained on the home (landing) page, health section and application web pages are then analysed in Chapter 6. Through Halliday's (1994) trifunctional model on Reading Images (in Kress and van Leeuwen 2006), along with other useful analysis models, the thesis discusses how information is constructed and how meaning making occurs across print and digital media. Data from the questionnaire punctuates the different discussions around health information structuring, access, notions of language, health and health citizenship.

As Discovery Health offers the most vibrant model through its commercial package of health citizenship, Chapter 7 continues to discuss the idea of a Vitality citizen. This discussion sets to show how citizen-consumers are initiated and socialised into a 'health career'- where Discovery Health becomes an ally in guiding people on this career. This fits in with the main thrust of the thesis on the evolution of health – where the health care for all model is no longer, health risk management in now the responsibility of citizen-consumers, as architects and masters of their own health and happiness.

Chapter 8 offers an interpretation of the responses to the research questions, the data collected, and arguments made in relation to the research questions. This chapter will return to the core pillars that shape the study, how information is structured and who has access to it and what the semiotic environment looks like for citizen-consumers.

Chapter 1 provided the background to the thesis for discussions on health communication, pointing to the importance of considering how health discourses are shaped - globally and locally - what affordances are provided to consumers through health information and what notions of health are produced and widely distributed to craft modern health citizenship.

Chapter 2: Health citizenship in times of the citizen-consumer

2.1 Introduction

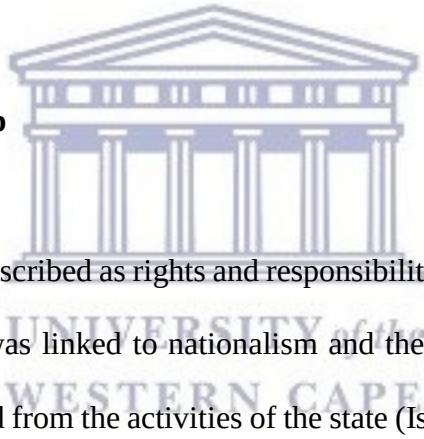
This chapter is about citizenship and its changing meanings specifically in the field of health. In the context of this thesis, citizens are consumers engaged in the consumption of health information and resources for health citizenship.

Health is a concept that has developed over time and that continues to evolve. Van Hooft (1997) says health is when things go well relating to the conative (natural tendency) mode of one's subjectivity. The writer explains that this would suggest that the professional concern for health should be in tune with different modes of subjectivity as health is foundational to the very being of subjectivity (Van Hooft 1997). However, Castro looks at health as a subjective experience by explaining that several sociological studies have demonstrated how the experience of health and illness is a social phenomenon, meaning that different social factors shape the individual's subjectivity. The author details two different approaches to subjectivity and health - one *normative* and the other *interpretive*. Normative approaches focus on the role of social aspects in the construction of the individuals' subjectivity, while interpretive methods emphasise the individual's abilities to attach meaning to different social activities and to act towards those activities.

Health citizenship as one of the offshoots of citizenship has been defined in many ways across multiple contexts and it also represents different meanings for various people. Kickbusch (2004) says health citizenship has become a key characteristic of modernity defined by the expansion of a health territory and the 'do-ability of health'. Both Porter (2011) and Kickbusch (2004) discuss health citizenship, but Porter (2011) focuses on how health citizenship has been constructed over time, while Kickbusch (2004) looks at health governance and how health citizenship is constructed in modernity. However,

Porter (2011) provides great insight into the construction of health citizenship in the affluent societies of Great Britain and the United States by exploring their strategies for creating healthy citizens in the twentieth century. Porter (2011) also looks at the different somatic discourses used by the state to encourage citizens to take control of their health.

Key notions with which to understand this field are 'citizen participation', 'inclusiveness' and 'rights'. The chapter first looks at the changing fortunes of citizenship as a site of struggle, a project and the role of the state and consumerism in health. In conjunction with this, it explores the implications of (different conceptualizations of) citizenship with regard to the governmentality of bodies, consumption, and the idea of health communication for health citizenship.



2.2 The concept of citizenship

Citizenship has largely been described as rights and responsibilities given to the individual by the state (Gaventa 2002). Citizenship was linked to nationalism and the nation-state and referred to whether people were part of or excluded from the activities of the state (Isin and Turner 2002). Rose and Novas (2003) introduce the notion of citizenship projects to refer to the ways that authorities regarded certain individuals as citizens and the manner they acted towards them. This includes the way in which they defined who was entitled to participate in the political affairs of the city, the introduction of a single legal structure across the state, encouraging citizens to converse with one language, establishing universal compulsory education, building, town planning and creating a social insurance system to manage health risks (Rose and Novas 2003). All these citizenship projects were essential for the creation of a nation state and how the states would function.

The idea that citizenship is a concept contained within the boundaries of a nation state has been contested and broadened to consider issues of recognition and equity. Neither is the idea of citizenship simply synonymous with a range of rights that could be exercised at the discretion of the individual or groups, such as the right to vote. Rather it is about liberty and capacity that includes a set of activities and skills, and importantly, come to stand for ways of participating as agents through 'acts of citizenship' (Isin, and Turner 2002) in securing rights in a polity of a social collective. Jennings (2003: 39) describes it as "a kind of social being that one can cultivate and pursue." Thus, scholars are now researching diverse ways of politically participating in a polity, such as: *sexual* citizenship, *multicultural* citizenship, *cosmopolitan* citizenship, or *intimate* citizenship, all of which has had an impact on social and political thought and policy (Isin and Turner 2002). Francis Nyamnjoh (2007: 9) addresses the spirit of these when he says that emphasis should be on the individuals' freedom to belong "with their realities as repertoires, melting pots or straddles of various identity margins." This is a more flexible perspective, which is different to the nation-state view on citizenship (Nyamnjoh 2007).

The new struggles over citizenship because of the global movements and flows of capital, industry and people, have led to new sites of domination, exploitation and resistance (Isin 2008). Struggles over the content and scope of citizenship have embraced gender, sexuality, economic standing, ethnicity and race. Health is one arena that continues to remain one of the most unequal spaces where agentive citizen participation is impacted by access to health resources and material, and where specifically women and marginalised communities have less access to health resources. Therefore, citizenship in health is important for discussions on notions of agency and participation. It has become relevant therefore to look specifically at forms of citizenship that exist in the health setting such as *biological citizenship* and *therapeutic citizenship* specifically and how they relate to health citizenship.

2.2.1 Biological citizenship

In a contemporary health society, there are several so-called 'citizenship projects' simmering simultaneously about relevant contemporary ideas on citizenship particularly in the age of biomedicine, biotechnology and genomics (and personalised medicine) that are taking shape. One such idea worth mentioning is that of biological citizenship. Rose and Novas (2003: 2) use the term to describe "all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as populations and races, and as a species." Biological citizenship also refers to how people use languages to talk about their physiology and how they describe themselves as having high blood pressure, high cholesterol, and sensitive to stress or immuno-compromised (Rose and Novas 2003).

In one sense, biological citizenship seems to be a very different species to the more conventional understanding of citizenship in terms of the nation-state. Yet these two do intersect at certain points to underscore many citizenship projects and to shape conceptions of what it means to be a citizen. Citizenship projects in the nineteenth and twentieth century produced citizens who understood their nationality, allegiances and differences to some degree in biological terms, linking themselves to fellow citizens and distinguishing themselves from others. Clearly biological citizenship is about how people understand how their behaviour can influence their health positively or negatively. The term also indicates that people now have a different relationship with their body where they seek information to understand it. Biological citizenship has become a part of modern health citizenship. Biological images, values and judgements have become entangled with contemporary ideas of the self, as citizens carefully and confidently, shape their life through acts of choice (Rose and Novas 2003: 5).

A good example of this is provided by authors such as Heath, Rapp and Taussig (2002) who have highlighted how citizenship in the time of biomedicine is a site of struggle over individual identities,

community/collectivisation, recognition, access to information and claims to expertise, where new spaces of public dispute around bodily aesthetics and experiences are contested. The challenges are not just those from the powers and responsibilities of the state, but from the spheres of private companies, health care providers and medical schemes, as well as citizens themselves. In addition, new forums for political debate and questions around democracy are debated, each affected by different nationalities, biopolitical histories and modes of government (Rose and Novas 2003).

Petryna (2002), for example, examined the social and political consequence of the Cherynobyl nuclear reactor explosion from the vantage point of radiation monitoring, clinical practices of radiation medicine and compensation tactics. The researcher documented the experiences of workers of the contaminated area and their journey through scientific research centres, public health centres and activist organisations. Together these interest groups constituted an informal economy around illness and compensation, demanding social welfare based on medical and legal grounds around injury and just compensation. In the words of Rose and Novas (2003: 4), "biological citizenship can thus embody a demand for special protections, for the enactment or cessation or particular policies or actions, or, as in this case, access to certain resources – here 'to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it'.

Tied to biological citizenship is another form of citizenship, so-called *therapeutic citizenship*, which widens biological citizenship to notions of health activism and engagement with health institutions and the state, for citizens as individuals and groups, to exercise voice in relation to health issues.

2.2.2 Therapeutic citizenship

Biological citizenship is not the only form of citizenship that has some bearing on health citizenship. Nguyen (2005: 322) for example talks about new kinds of heterogeneous practices and methods that have produced "subjects and forms of life – AIDS activists, resistant viruses, and therapeutic citizens."

Therapeutic citizenship broadens the notion of biological citizenship; whereas biological citizenship refers to the biological construct of, for example, being HIV-positive, therapeutic citizenship refers to a more bio-political approach about the methods and actions followed for the governance of populations and management of individual bodies (Nguyen 2005). Cassidy and Leach (2010) discuss this further by explaining that therapeutic citizenship for example brings together the biological of being HIV-positive with the political that could include the claims to rights for access to HIV treatment and ethical issues, which, for example, in this scenario, could refer to the integration of being HIV-positive into a moral order. Patterson (2015) describes therapeutic citizenship as biopolitical citizenship that encompasses claims and ethical concerns that have emerged from techniques to control and manage bodies.

Mfecane (2011) also uses the notion of therapeutic citizenship to describe the experiences of HIV-positive men at a rural South African health facility who attended support groups for people living with HIV. The article explains that the participants were encouraged to abandon their customary health and gender beliefs to make way for a more biomedical understanding of health by participating in support groups, and actively challenging HIV stigma by talking publicly about their HIV status (Mfecane 2011). The ethnographic study involved fourteen months of fieldwork that was conducted in Bushbuckridge, Mpumalanga, South Africa. In the study, the researchers discovered that most of the men gained the knowledge and skills to adhere to treatment even though they resisted taking on an 'HIV identity' that the support group bestowed on them (Mfecane 2011). However, Nguyen (2005) says that therapeutic citizenship has become a significant force in African resource-constrained settings where claims to illness carry more weight than poverty, social injustice and violence.

According to Nguyen (2005) the rise in HIV/AIDS transnational campaigns for access to lifesaving treatment became more than a social movement, but a complex biopolitical arrangement of global flows of organisms, treatment, discourses and technologies. This arrangement has become widely

known as an AIDS industry. With AIDS posing a threat to the economic and political sustainability of many countries across the globe, the AIDS industry has become part of the development sector, where humanitarian efforts are fast displacing local politics, and in their wake creating new identities and notions of health citizenship. Because these humanitarian issues are largely tied to health issues, that carry threats to lives and the wellbeing of populations (Nguyen 2005), they are highly political. Therapeutic citizenship also points to the transnational confluence of medical knowledge and practices, the word 'therapy' implies some form of exchange between people, but this notion is also about the negotiation of access to therapeutic resources, which also shows the importance of the relationship between the therapies and broader economic and social interactions (Nguyen 2005). The author also introduces the idea of a 'therapeutic economy', which refers to the totality of therapeutic options in a specific place, where therapy deals with what Nguyen (2005) calls 'regimes of value'' – which might encompass financial exchanges - as in the purchase of medicines - or involve 'moral economies' when individuals tap into networks to negotiate for access to therapeutic resources. The idea of a therapeutic economy builds on ethnographic studies that have focused on medical pluralism to show a link between therapies and broader economic and social issues (Nguyen 2005).

As the social and demographic consequences of the AIDS epidemic have become more evident, there has been a push for access to treatment in poor countries by a consortium of AIDS lobby groups, humanitarian structures and health advocacy networks. These groups by making therapeutic claims have created a therapeutic economy that brings together technologies, self-help techniques and new ways to access treatment. These techniques represent an increasingly bio-medicalised form of governmentality, suggesting that the way these groups "produce subjects and citizens cannot be limited to the discursive and the material, but increasingly encompass the biological itself," (2005:127).

In addition, the rise of therapeutic citizenship has been more noticeable in the South because many northern countries provide access to health care through national health insurance schemes. In the

South, however, some individuals had to mobilise their social networks to purchase medicines and gain access to treatment through public health facilities, NGOs and research institutes, where medication would be made available for cheaper or for free. Therapeutic citizenship is therefore about citizen agency and participation, and it is an important aspect of health citizenship.

2.3 Citizen agency and healthy lifestyles

To explain how structure and agency affect citizen participation, Emirbayer and Mische (1998) refer to what they call the double constitution of agency and structure, and how the construction of certain contexts impacts the agency and relationships between different people within that environment. This means all social action is shaped on the one hand by the context, and on the other hand, by agency itself, and that all social action cannot be completely structured (Emirbayer and Mische 1998). In addition, people constantly move across the past, future and present and they regularly reflect on the patterns and repertoires of the past, consider what needs to happen in future, while evaluating the present. This process alters the level and type of response towards structured contexts (Emirbayer and Mische 1998).

William Cockerham (2005) specifically looks at notions of agency and structure in relation to a health lifestyle theory. He mentions that researchers have generally paid little attention to agency and structure while looking at healthy lifestyles, even though these concepts are essential in cultivating an understanding of health and lifestyles (Cockerham 2005).

One notable example of the role of agency in influencing social behaviour in health is in the impact of antismoking campaigns launched since the Second World War (Porter 2011). In the United States the antismoking campaign spanning more than 20 years aimed to reduce cigarette smoking through

educational programmes focused on the hazards of smoking (Cockerham 2005). Although these campaigns encouraged some people to quit smoking, it was only when smoking became outlawed in many public areas that there was a significant decrease. Banning smoking meant smokers were classified as social outcasts and deviants (Cockerham 2005). This strategy for example was followed by both Britain and the United States where campaigns were launched to prevent passive smoking and "[state] action penalised and stigmatised cigarette smokers as social pariahs, failures and moral inferiors, reprobates and inadequates," (Porter 2011:70).

If agency is affected by the range of factors mentioned by Emirbayer and Mische (1998), then any study of health citizenship will need to consider that social action also lives outside the perimeters of individual agency, and that individuals will respond differently to structured health campaigns, which are aimed at encouraging individual agency and transformative health behaviours. Once again health campaigns designed as a call to action among individuals require some level of buy-in and engagement among these consumers. This makes citizen voice a significant part of encouraging agency and participation among citizens about their health issues.

2.4 Citizen voice and participation

Health promotion requires an enabling environment for participation (Ratzan 2001). To participate, the voices of citizens need to be audible and attended to. Peter Elbow (2007) mentions that voice has been used in quite a celebratory manner and could mean several things. Elbow (2007) looks at different categories of voice, one being the literal physical human voice produced by the body, which is metaphorical by nature and is described in a rather honorific and poetic manner, and voice in writing, particularly in texts.

In a further description of voice in texts, Elbow (2007) comments that texts are silent and therefore have no voice, yet hearing text is the norm – as people are accustomed to hearing words. Even then certain texts are easier than others to 'hear', for example a few bureaucratic and legal texts are unidiomatic and difficult to 'hear' because the writers often construct sentences through jargon in a way that is not the norm in speech (Elbow 2007). Voice should be understood from the context of how consumers are engaged through information to feel empowered to navigate and choose health information and to confidently make decisions relating to their health.

To effectively engage individuals in the context of health participation should include the opportunities for them to *express* their voices (Gaventa 2002). Cornwall and Leach (2010: 31) argue that in the South, public involvement in health has been about the participation of social groups such as women to ensure compliance with efforts for creating some level of diversity in historically gender imbalanced contexts. They explain this further when they argue that negotiating health citizenship has become part of a political agenda because:

> In many policy fora, the cases suggest, there is far less substantive debate about issues of health and disease than about the effectiveness of mechanisms to ensure the effective functioning of health systems… Citizens are not being asked, by and large, to play any role in priority-setting or even in defining health problems as they view or experience them. Meanwhile, it is left to the lobbying of disease-focused interest groups to push for their own disease interests whether inside or outside such fora.

Rifkin and Kangere (2002) mention that there is still uncertainty among planners and professionals about the role of (community) participation in improving the lives of people, especially the poor and disadvantaged. They state that community participation has been described differently, from people

mainly being receptive to health and disability programmes, to people actively acting as stakeholders about the policies and programmes relating to their health (Rifkin and Kangere 2002).

Although Rifkin and Kangere (2002) look specifically at community participation, their views on participation in health is relevant to agency. They mention that community participation is beneficial because:

- people know what works for them and professionals can learn from their experiences;
- people can make contributions to health programmes through money, materials and labour;
- people are generally more committed to activities that they have put their efforts into; and
- the knowledge and skills transferred to these people can be used in the future.

Encouraging citizen participation and responsibility for health concerns is entwined with notions of agency. Certain segments of social and political thought have addressed the idea of agency or acts in the form of conduct, practice, routine and habit (Isin 2008). As an action word (a verb) to act refers to being directed and oriented towards something, it also implies to perform an action genuinely or as part of an act, i.e. a simulation (Isin 2008). Medical schemes understand that to direct citizens to use their products or services and to encourage certain types of behaviours through health communication, they should find innovative ways to encourage certain choices.

Generally, medical schemes spend time in research and product development and these products are created for consumption by looking at ways to direct certain types of behaviours among citizens. The notion of *citizens as consumers* – or *citizen-consumers* - is an interesting concept as citizens are seen not just as passive participants but consumers who make decisions on health-related products and services. Still how health information is consumed is determined partly by how information is constructed.

2.5 Citizens as health consumers

According to Canclini (2001) the changes in modes of consumption have reformed the possibilities and forms of citizenship, and how it has come to be understood and expressed. Whereas citizenship focused on public opinion, the new sociocultural scene as described by Canclini (2001) shows that the consumer is more interested in quality of life issues. The author explains that when citizens consume, they also think, select and re-elaborate social meaning and therefore the question should be asked if consumption does not require that consumers do something that nourishes, and to some degree, represents a new mode of being citizens (Canclini 2001).

In the health setting, this new consumer culture was applauded by state policy makers and bureaucrats, as this was a strategy to reduce health costs by using health education to stop people from neglecting their bodies (Feathersone 2001). This strategy based on the procurement of health was meant to influence social behaviour and encourage citizens to follow healthy lifestyles. Eventually it was the bringing together of medicine, social science and public policy that changed the social contract between the state and its citizens and healthy lifestyles were promoted to decrease the rising cost of supporting chronically ill citizens in an aging demographic structure (Porter 2011). Clearly the modern way of looking at health has shifted from the state as the provider of health care for all to health education strategies used to encourage citizen agency and participation in health.

Discovery Health and GEMS also operate within a massive health market place sustained and supported by a vibrant consumer culture. The medical schemes continuously ensure that their consumers are engaged in the programmes they offer. Information plays a critical role as the medical schemes can create their own ideas on what it means to be healthy and what their target audience need to do to reach this goal.

Today, people understand that they are responsible for both the design and health of their own bodies (Cockerham 2005). These messages have been reinforced through large-scale health promotion campaigns targeted at modern day consumers who should become engaged citizen-consumers. This new form of citizenship is also evident in how a healthy body has become the epitome of an elite health status. Consumers are continuously required to be vigilant about maintaining a healthy body as part of their own responsibility (Featherstone 2001).

Kickbusch (2004: 5) describes a citizen-consumer perspective on the health society in the following terms (also depicted in *figure* 1);

- Populations with higher life expectancy and large groups of old people
- A massive health care system that consumes large portions of the budget
- A commercial health market with products and services alongside and within the medical system
- Health as an important topic that is discussed alongside civil rights and responsibilities
- Health as a goal for citizens to work towards and a key to modern health citizenship.

Figure 1- The health society as illustrated by Kickbusch (2004: 3)

Kickbusch (2004) has summarised the new health structure where consumers are agents and consumers, where massive public spending is allocated to health and how health has become a commodity sold on the market place and where health is an integral part of citizenship and civil rights. However, in the new health society, the promotion of healthy lifestyles through health communication has become more about commercial interests than enabling citizen engagement to promote health citizenship. Kickbusch (2004) suggests that the commercial health care market place and the empowerment of the citizen-consumer is what has given rise to the expansion of health as a marker of beauty, sexual attractiveness, social mobility and affluence, rather than medical knowledge. The

market place includes an array of service providers such as Discovery Health and GEMS, these companies are all involved in the crafting of health promotion messages to encourage consumption.

Another aspect of consumerism in a time of modernity has been linked to discourses around choice and change. According to Newman and Vidler (2006), consumers are expecting health services to respond to their needs and they are more desirous of opportunities to make informed choices about their treatment and those who should provide such treatment to them. Greenhalgh and Wessely (2004) also introduce another concept related to health consumerism called "healthism". The notion of healthism is related to consumerism but constitutes a different set of ideologies depending on the context - these include - the different faces of the consumer as a chooser, communicator, explorer, identity seeker, hedonist, artist, victim, activist and citizen. The authors also attach five broad meanings to consumerism as the catalyst to power and happiness, a concept linked to ideologies of conspicuous consumption, economic thinking for global advancement and a social movement to protect the rights of consumers (Greenhalgh and Wessely 2004).

Consumerism has become an integral part of the modern health society where consumers use information to make lifestyle choices relating to their health. Due to the increasing reach of the Internet through computers, mobile devices and other forms of technology, websites have become key repositories of information for consumers seeking health information. Many companies provide information through different modes including the company website, newsletters, SMSs and other artefacts. These tools are important to how health promotion messages are distributed by Discovery Health and GEMS and they will be discussed in detail in the analyses chapters.

Health promotion messages from both the state and the commercial health sector are that beauty, attractiveness and health are part of the citizens' social duty, and there is universal disgust targeted at the unhealthy, broken, abused and self-indulgent or neglected body (Porter 2011). Feathersone (2001:

80) sees body maintenance and appearance according to two categories, the inner body and outer body. The inner body is about keeping the body free from disease and fighting the aging process, while the outer body is about the "movement and control of the body within social space". The latter places emphasis on outer appearances and the management of outside impressions. However, in consumer culture the two are combined. The primary goal of maintaining the inner body becomes the improvement of the outer body.

As seen with New Age ideas of health, the emphasis on the body has shifted to include the whole body, both the inner and outer body. Health management organisations not only focus on the steps consumers should take to fix the outer body, there is also the focus on social and mental wellness. The obsession with the body beautiful can be manifested in various ways. The rise of aesthetic surgery that society views as nonmedical and unnecessary is such a manifestation (Gilman 1999). This type of surgery refers to those procedures that society views as performed because of vanity. Aesthetic surgery is therefore the opposite of reconstructive surgery, which is about restoring bodily function (Gilman 1999). A survey cited in the British Independent newspaper revealed that 90 percent of a group of women who took part in a study in the United States perceived a previous rape conviction in a prospective partner less unattractive than obesity (Porter 2011). Clearly the body has become a vessel and vehicle to index issues of identity, belonging, desires and needs.

Aesthetic surgery is perhaps one of the most contemporary symbols of a postmodern society obsessed with the consumption of health products and services for beauty, achieved through an idolised designer-body. Surgery for beauty has become a global phenomenon and has filtrated into other sectors such as tourism. People from the United Kingdom flock to Marbella in Spain for face-lifts and Germans visit South Africa for breast reductions and penis enlargements while on safari holiday touring the Kruger National Park (Gilman 1999). Also referred to as medical tourism, this phenomenon has become another aspect of health consumerism that is not about preventing chronic illness, but

about allowing people to be architects of their own bodies for vanity and sexual desirability. Kickbusch (2008) also refers to this phenomenon as health tourism in South Australia, where after undergoing medical surgery patients could visit the state's tourism attractions, while enjoying the clean country air, slower pace of life, walks on the beach, fresh produce and access to the best regional health services the country has to offer.

For the postmodern consumer, the designer-desirable body is achieved by reducing fat and constructing a body shape with clearly toned muscles, and by employing a personal nutritionist, a personal trainer, aromatherapy masseurs and taking advantage of elective plastic surgery (Porter 2011). The attainment of the designer-desirable body is an achievement that is purchased with money and maintained by following a healthy lifestyle. These are the constructs of modern health promoted for the consumption of health resources. As these are carefully constructed strategies to encourage the uptake of health-related information and products, the thesis considers these new approaches to health as new forms of civilisation and citizenship.

Citizens are expected to make choices from choosing a health plan, sifting through cost and information about service providers and making sense of complex medical information and services. Consumer health[3] includes the different aspects of the market place such as health products and services. This phenomenon includes the purchase of bottles of vitamins, colds and flu remedies, exercise equipment, dental care, medical aid, and information seeking through websites and other sources of information (Barrett et al 2012). This is also the sort of engagement that is evident in how consumers engage with and navigate the artefacts and modes of information provided for their health subjectivity.

[33] List of Consumer Health Questions (see Appendix D)

The solution for improving the consumer role and interactions with the health care system has been in the form of providing better information, alongside financial incentives to reward their involvement. Discovery Health presents one such programme that marries both the health and lifestyle rewards aspect to encourage consumers to adopt certain lifestyles concerned with knowing their health risks, improving their health and receiving lifestyle rewards based on the widely known frequent flyer points system. However, Barrett et al (2012) caution that there are both positive and negative aspects to consumer health. On the one hand, it is about the facts that allow people to make important health decisions that are medically and financially sound. On the other hand, it entails being able to avoid unnecessary decisions based on deception and misleading information. Arnold (2007) also notes that to encourage the more positive aspects of consumer health such as information seeking and active participation in health issues can be challenging. According to Arnold (2007) these approaches are not effective because information provision alone has not proven to be a motivating factor, since the promotion of new behaviours is against how the consumers were socialised to behave. Arnold (2007) explains that the consumers need to learn new skills, take on new information and they also might have to change their lifestyles. This calls into question how Discovery Health and GEMS promote health through health communication.

This chapter has looked at citizenship and how this concept has been an ongoing project described within the confines of a nation state, to how it has evolved to reflect new civilisations, different citizen voices and actions through biological and therapeutic citizenship. These notions have been discussed in conjunction with that of health citizenship. The chapter also looked at the role of citizen-consumers, as well as agency and participation regarding modern health citizenship. The next chapter will explore how health citizenship is formed when considerations of language come to the fore, also how health

literacy is constructed and the ways in which Discovery Health and GEMS have shaped health and healthy lifestyles in modern times.

Chapter 3: Language and health literacy

Health citizenship requires health literacy and agentive participation from citizen-consumers. In the previous chapter, I discussed notions of citizenship in relation to the idea of health citizenship, emphasising the role of agency and participation for a healthy life, but also pointing out how the genres of engagement are very much determined by contemporary notions of citizens as consumers. In this chapter, I will discuss health literacy, highlighting the role of language in health literacy against the background of South Africa's multilingual context. Language aspects of health literacy is one form of the different semioses, and the structuring of health information through a variety of multi-semiotic means and modalities that is a focus of the thesis.

3.1. Health literacy

Health literacy has historically been regarded as several cultural and communication practices shared by members of a group (National Council of Teachers of English 2008). Kanj and Mitic (2009) refer to health literacy as the extent to which people can access, understand, consider and communicate information to engage with different health contexts in the maintenance and promotion of health.

Health literacy first appeared in literature in 1974 relating to health education and the importance of enhancing the standard of health literacy in the school environment (Kanj and Mitic 2009). However, health literacy was never fully embraced in health education until two decades later, it emerged from the health promotion field with the publication of a paper by Ilona Kickbusch in 1997 titled *Think health: What makes the difference* (Kanj and Mitic 2009: 13).

Improving the levels of health literacy by enabling easier *access* to multimodal and multilingual resources should be a health care priority, but so should the *design* of information and the tools used

to share this information. More than 300 studies done over 30 years to evaluate different health-related materials from consent forms to medication package leaflets show a huge gap between the reading proficiency of materials and the reading abilities of the target audience. In fact, most of the material that was assessed exceeded the reading skills of an average high school graduate (Nielson-Bohlman et al 2004).

Health literacy as a skill required to obtain, review, and understand health information is an essential component of health communication. There have been some tools created to measure health literacy such as the Test of Functional Literacy in Adults (TOFHLA). This is an assessment of functional health literacy including numeracy and reading proficiency that uses relevant health-related material such as prescription bottle labels and doctor appointment slips (Nurss et al 2004). TOFHLA poses questions on medical instructions that consumers could see at a hospital, where the instructions tested comprise sentences with missing words with four possible answers.

Another recognised measurement tool of health literacy is the Rapid Estimate of Adult Literacy in Medicine – which is a seven-item word recognition assessment of patient health literacy. While TOFHLA and REALM are recognised measurement tools of health literacy, Kanj and Mitic (2009: 5) still see these as inadequate to demonstrate the relationship between the definitions of health promotion and health literacy mentioned in their paper. They argue that both assessment tools are only measures of reading comprehension and comment that the Health Activity Literacy Scales (HALS) tool could potentially address some of the shortcomings of TOFHLA and REALM. Still HALS also has its own limits, such as excluding verbal skills, and it also lacks the ability to measure attitudes, values and beliefs (Kanj and Mitic 2009). The point raised here is significant, especially given that language is situated within a social context. As with literacy, none of the tests measure any relevant sociolinguistic aspects that shape how language and literacy as resources are used by different citizen-consumers who access health care.

3.1.1 Health literacy and its impact on health outcomes

Rootman (2009: 5) provides a few effective interventions followed by the Canadian Expert Panel on Health Literacy. These include:

- The National Literacy and Health Program: The Program with twenty-five partner organisations, created a plain language guide for seniors, a health communication training package, plus literacy and health material for the youth.
- The Community Action Program for Children and the Canada Prenatal Nutrition Program – a review done in 2004 showed that both programs encouraged literacy-related projects while helping families to support infant or child development.
- The Healthy Aboriginal Network: The Network provides literacy material such as comic books targeted at Aboriginal youth. A review of one comic book showed that it's an effective communication tool that provides Aboriginal youth and young adults with health information that helps them to think about health, and health issues that are relevant in their communities. This encourages participation or further information-seeking.

Nielson-Bohlman et al (2004: 12) also state that "[socioeconomic] status, education level, and primary language all affect whether consumers will seek out health information, where they will look, what type of information they prefer, and how they will interpret this information." They also point out that older adults, people with little education, and those with limited proficiency in English, have lower literacy levels. Limited health literacy means that health information will probably not be as accessible (Nielson-Bohlman et al 2004). Although health literacy is vital for promoting health by educating

people around their health risks, lack of ability or opportunity to access or take in information on health will obviously hinder effective and positive health outcomes. In the words of Kanj and Mitic (2009):

> If people cannot obtain, process and understand basic health information, they will not be able to look after themselves well or make sound health-related decisions. Improving health literacy is critically important in tackling health inequalities. People with low health literacy have poorer health status and higher rates of hospital admission, are less likely to adhere to prescribed treatments and care plans, experience more drug and treatment errors, and make less use of preventative services.
>
> (Kanj and Mitic 2009: 21)

There is a correlation between health literacy, the use of health care services and health care costs (Nielson-Bohlman et al 2004). Even with limited data, Nielson-Bohlman et al (2004) propose that people accessing public health facilities with lower literacy have more cases of hospitalisation than those with higher health literacy. This increase in hospitalisation means more health care resources are utilised. The Institute for Medicine of the National Academies (2004) agrees with these findings that people with lower health literacy have difficulty understanding health information, that they take less advantage of preventative health care - such as health screenings - which results in expensive health services for emergencies, i.e. they would seek medical care only when the condition has worsened, often requiring more expensive treatment and care.

Nielson-Bohlman et al (2004) further explain that health literacy governs the service provider and consumer exchange of information, but they also offer some colourful incidents demonstrating the failure of this exchange through the following examples:

> I have a very good doctor. He takes the time to explain things and break it down to me. Sometimes, though, I do get stuff that can be hard — like when I first came home from the hospital and I had all these forms and things I had to read. Some words I come across I just can't quite understand.
>
> (Nielson-Bohlman et al 2004: 1)

> A two-year-old is diagnosed with an inner ear infection and pre-scribed an antibiotic. Her mother understands that her daughter should take the prescribed medication twice a day. After carefully studying the label on the bottle and deciding that it doesn't tell how to take the medicine, she fills a teaspoon and pours the antibiotic into her daughter's painful ear.
>
> (Nielson-Bohlman et al 2004: 3)

Cheong (2007) refers to the 'knowledge gap hypothesis', which states that as the flow of information increases, people from higher socio-economic backgrounds are better positioned to use this information in contrast to those with lower socioeconomic status. This results in unequal knowledge and skills to utilise information among different social groups.

Also by looking at the definition of literacy as the ability to read and write a simple sentence in any language, Kanj and Mitic cite a United Nations' report that 80% of the world's population was regarded as literate in 1998. Still literacy rates vary widely from country to country, region to region, and can be linked to the region's wealth (Kanj and Mitic 2009). There is a link between poor health outcomes and lack of health literacy (measured through reading competency) as well as an increase in mortality rates (Kanj and Mitic 2009). Research on health literacy among 2000 adults in the United Kingdom showed that one in five participants had difficulty with the basic skills for understanding simple information to improve their health. Another study found that 60% of adult Canadians (ages 16

and older) have difficulty in obtaining, understanding and acting appropriately on health information and services (Kanj and Mitic 2009).

Health literacy is also necessary for day-to-day and long-term management of chronic conditions. The management of these conditions require people to understand and consider health information to help them with complex medical treatment, and ways to adjust their lifestyle, where necessary. A lack of skill (health literacy) would make it difficult for them to engage with this information effectively (Kanj and Mitic 2009). Nielson-Bohlman et al (2004) citing Kim et al (2001) mention that those with lower levels of health literacy have limited ability to share in the decision-making process on prostate cancer treatment, they show lower adherence to anticoagulation therapy required to discourage the formation of blood clots, they have a higher prevalence of poor glycemic control and a lower self-reported health status.

Lack of literacy also negatively impacts maternal and child health, which is a concern, as the level of literacy among women is linked to child mortality. This is concerning specifically in South Africa which faces a quadruple burden of disease that includes, high maternal and child mortality alongside a high burden of TB, the HIV/Aids epidemic, high levels of violence and injuries and an increasing burden of Non-Communicable Diseases (South African Medical Research Council 2017:14). Kickbusch (2001) also comments that a mother's level of education is closely related to the newborn's risk of dying before the age of two years, and educated women are more likely to postpone marriage and pregnancy, give better health care to their families, send their children to school and contribute to the economy.

Health literacy is important for giving voice to citizen-consumers and for enabling them to participate in health issues. Kanj and Mitic (2009) see health literacy as an empowerment tool for promoting active citizenship. They say health literacy is achieved when individuals understand their rights as

patients, including being able to navigate the health care system, and by actively participating as informed members (Kanj and Mitic 2009). However, Don Nutbeam (2000) comments that health literacy and health education are interdependent, and he describes health literacy as a multifaceted term for the outcomes of health education and communication activities. To distinguish between literacy and health literacy, Kanj and Mitic (2009: 9) refer to Rootman's (2009) definition, which describes literacy as the fundamental skills required for succeeding in society, while health literacy refers to skills required for sourcing, assessing and making sense of health information across different contexts.

Authors distinguish between three distinctive levels of health literacy: functional health literacy, interactive health literacy, and critical health literacy Nutbeam (2000). Kanj and Mitic (2009) also mention three approaches to health literacy: functional health literacy, conceptual health literacy, and health literacy as empowerment.

(i) Functional health literacy is the first level, which refers to traditional health education of disseminating information relating to health risks and how to use the health care system (Nutbeam 2000). However, Nutbeam (2008) argues that functional health literacy is limited for allowing individuals to improve their knowledge of health risks and health services, while some individual benefit is possible, the approach is more aimed at benefiting the broader population, examples include the production of information leaflets and traditional patient education.

(ii) The second level of health literacy is interactive health literacy, which is about giving people the confidence to act independently on knowledge, and this can result in more individual benefit than population benefit, says Nutbeam (2000). There is also conceptual health literacy which is described as an approach that takes cognisance of the cultural world

of people and the body of skills (generic, cultural and technical) that they need to be able to understand their health risks (Kanj and Mitic 2009)

(iii) The more relevant third phase of health literacy for this study is health literacy as empowerment as described by Kanj and Mitic (2009). They explain that health as empowerment requires the strengthening of active citizenship in health by linking health promotion and disease prevention strategies with citizen participation. By ensuring that people: understand their rights as patients and how to find their way through the health system, ensuring they become knowledgeable consumers of health products and services, and that they can individually or in a group influence the decision-making processes by voting, lobbying and social movements.

(Kanj and Mitic 2009)

Kickbusch (2001) explains that the lack of concern over empowerment is a large factor in the failure of large-scale literacy efforts, which is the same for health education efforts, especially those relating to women, sexuality and reproduction. Although information is crucial for health literacy, she argues that this alone cannot address the major issues faced by disenfranchised and marginalised communities. The argument here is that to provide access to excluded communities calls for the design and the processes of sharing this information to be in line with opening areas for the marginalised to exercise voice and participation. Kickbusch (2001) supports this argument by stating that generally people have no option, they cannot compare the risks of various alternatives, and as health care systems become even more complex the health gap is more evident on a global scale. This means that the ability to participate and exercise voice can be constrained by the level of health literacy. Health literacy skills are essential to engage with health information provided by medical schemes and the

citizen-consumers need the skills to appropriate and use this information. In this instance language and health literacy can be the variables that act as a form of exclusion in the health care space.

Literacy is tied down to language, limited literacy skills have a significant impact on the ability of people to seek health-related information and to take an active role as players in different health discussions either through forums or websites. Multilingualism complicates this relationship further. According to Hanafi (2009: 2) monolingualism is almost unheard of as most of the countries are multilingual and a state such as Nigeria has 400 spoken languages while Cameroon has 238 languages. In addition, Edwards (2012) mentions that in about 200 countries there are approximately 4 500 languages, which makes linguistic heterogeneity inevitable, yet only one quarter of those countries recognise more than one language. Clearly such contexts of linguistic heterogeneity make multilingualism a 'fact of life'. Multilingualism is a significant ingredient in communication, particularly for cross-cultural communication.

There are different ways of understanding multilingualism, and not surprisingly, it has been defined differently across several contexts. Lüdi (2006), for example, says the customary belief is that a multilingual person would have learnt all the languages during early childhood and would be competent verbally and in writing in all the languages. However, according to Lüdi (2006) multilingualism also refers to a person who can use more than one language regularly and can switch from the one language to the other when required, "independently from the symmetry of his/her command of the languages, of the modalities of acquisition and of the distance between the varieties," (in cf. Haugen 1953, Oksaar 1980 and Grosjean 1982).

There are also different ways of thinking politically about multilingualism. In South Africa, as elsewhere where the politics of language has engaged multilingualism, language has variously and historically been conceived in terms of language as a *problem*, a *right* or a *resource* (Ruiz, 1984, cf.

also Wright 2002). In the context of language planning and policy, language (multilingualism) was typically seen as a problem in the early, heady, days of postcolonial, independent states. These states often hosted many languages and ethnicities that were thought to be prone to conflict and disruption - at the very least, it was thought, nation-states should comprise of people with a common language and destiny.

3.2. Language and health

Access to information in various languages has been a critical challenge of health provision particularly in South Africa. The question is what role does multilingualism have on access to information, and how does this encourage citizen-consumers to act in a certain way about their health?

Deumert (2010) through a study on language and health care services showed the problems associated with a monoglot service provision in a highly multilingual country. Her study looked at the role of multilingualism in health care through an analysis of data collected in three public health care facilities (hospitals) in the Western Cape, South Africa. The data were collected using three research instruments: a questionnaire, staff and patient interviews, and through ethnographic observation. The focus of the study was on the large group of isiXhosa-speaking patients who had entered the provincial public health system since the 1990s.

According to the data collected by the researcher, the linguistic barriers between English/Afrikaans-speaking health providers and the isiXhosa-speaking patients are a deeply entrenched structural component of the public health system (Deumert 2010). The researcher explains that these linguistic barriers significantly limit the provision of equitable and effective health care even subsequent to the

demise of the apartheid regime (Deumert 2010). The researcher indicated that language can be a hindrance in the uptake of health services.

The findings from Deumert's (2010) study resonate with much other work. Another study that shows how structural conditions create and position the lack of multilingualism in the health service as a problem is DuBard and Gizlice (2008). DuBard and Gizlice (2008) investigated self-reported health status, healthy lifestyles, access to care and the use of preventative health services among 45 076 United States Hispanic adults in 23 states to assess language disparities that prevented the participants in the study from accessing health care.

The study was conducted from 2003 to 2005 where Behavioural Risk Factor Surveillance System (BRFSS) data from the participants, who represent 90% of the United States population, were analysed. The BRFSS has become an important source of national health-related indicators that can influence health policy and the design of health programmes. The system was sponsored by the Centers for Disease Control and Prevention and although the BRFSS also included an optional Spanish language survey instrument, since 1987 only a few states have used it to collect data (DuBard and Gizlice 2008). The data were compared with 25 health indicators between English-speaking Hispanics and Spanish-speaking Hispanics.

DuBard and Gizlice (2008) note the significance of the study as 1 in 10 residents in the United States uses Spanish as a home language and about half of the people report that they cannot speak English 'very well'. Furthermore, preferences relating to language as well as English proficiency have previously been linked to health-related behaviours, vulnerability to disease, and the uptake of health care services among Hispanic populations (DuBard and Gizlice 2008).

The researchers showed that: although the rate of chronic illness, obesity and smoking were significantly lower among Spanish-speaking Hispanics than among English-speaking Hispanics,

Spanish-speaking Hispanics reported a far worse health status and access to health care in comparison with English-speaking Hispanics.

The data collected showed the following:

- 39% vs 17% in fair or poor health
- 55% vs 23% uninsured, and
- 58% vs 29% without a personal doctor.

(DuBard and Gizlice 2008: 2021)

The language challenges faced by Spanish-speaking Hispanics were linked to the poor provision to health care and the likelihood of receiving preventative health services. The researchers showed that the Spanish-speaking Hispanics were less likely than the English-speaking Hispanics to seek pneumonia and influenza immunisation, dental services, breast and prostate cancer test screenings. The authors further explain that Spanish-speaking Hispanics are a particularly vulnerable population with limited access to health care and preventative health services, and that language use and English language competency have been linked to health outcomes, disease prevalence, and access to health care among Hispanics. Anderson et al (2003) support this view by stating that racial and ethnic minorities carry a much higher disease burden, are more vulnerable to disability and death, and they generally receive far worse provision to health care than other populations, even when access to health insurance and income are not a factor.

The advice provided by Anderson et al (2003) is that health systems should become more culturally competent to deal with communication barriers that limit effective diagnosis, treatment and adherence. The author adds that “cultural and linguistic competence is a set of congruent behaviours, attitudes,

and policies that come together in a system, agency, or among professionals and enable effective work in cross-cultural situations," (Anderson et al 2003: 68).

Cultural competence is about the ability to function within a certain context, in the health care setting, which can be realised by:

- ensuring diversity among the staff corps to reflect the communities they serve
- hiring health professionals or translators who speak the community languages
- employing health professionals trained in the culture and languages of the people they serve
- including visible signage and instructions in the clients' languages that are aligned to their cultural norms, and
- creating a culturally specific health care environment.

(Anderson et al 2003)

An important dimension interacting with language in patients obtaining access to health resources is (nation state) citizenship. Ku and Waidmann (2003) state that citizenship status and language impact on equity in health coverage, as well as on access and quality for racial and ethnic minority groups. Asylum seekers or legal immigrants, for example, face far more challenges than citizens on obtaining access to health care, and they also have limited or no opportunities to secure employment that offers health insurance. For that reason, to address health disparities, the appropriate policies to reduce language barriers in the health care sector are essential (Ku and Waidmann 2003).

Luphondo and Stroud (2012) highlight how in multilingual and multidiscursive contexts, meaning and identities are formed and reshaped in different ways and across multiple seams in an environment

characterised by a mix of linguistic and discursive factors. According to the authors, in the African context specifically, diversity in the context of health care is extensive across language, culture, race, religion and socioeconomic differences (Luphondo and Stroud 2012). The authors note the importance of this diversity in efforts to stem the tide of increasing HIV prevalence in South Africa (Luphondo and Stroud 2012). Despite this, diversity is displaced in favour of the uniform and conformist, and that language is a key factor in this process of disguising and undermining diversity.

Clyne (2010) suggests (as does Deumert 2010) that one way forward in resolving the problem of lack of access to health services due to language would be to build the multilingual competency of societies by placing emphasis on language services and by ensuring that access to health care for vulnerable individuals is linguistically enhanced. Hanafi (2009) explains that to promote democratic participation, accountability and transparency among developing economies, the role played by language in this process should be understood. In the words of Hanafi (2009)

> This means taking into account those most marginalised, those at the very grassroots levels of society and building better, regular and more meaningful means of communications and decision making with the bodies that have the power to affect their lives.

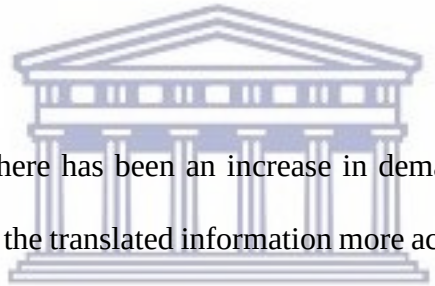
(Hanafi 2009: 9)

There have also been several attempts to address multilingualism as a resource in health (Deumert 2010). For example, multilingual literacy has been the focus of research by Martin-Jones and Jones (2000) and Street and Lefstein (2007). According to Martin-Jones and Jones (2000) the use of the term 'multilingual' in relation to literacy shows the multiplicity of different communicative repertoires by various linguistic groups. Additionally, the term 'multilingual' refers to several ways to acquire the spoken and written languages within the group and people with different language expertise would acquire the languages and literacies differently. This also means that referring to multilingual literacy

talks about multiple ways that people combine codes in their communicative repertoire for speaking and writing (Street and Lefstein 2007).

However, there are undeniable challenges involved in promoting more active participation and equitable access to health services through multilingual services, ranging from inappropriate or under resourced legislation to the lack of sufficiently expert personnel in the required languages. We see an example of some of the problems in the next section with respect to translation. Translation has been identified as one of the strategies for making health information widely accessible, but there are also barriers with translations.

3.3 Translation



According to Kruger (2008) there has been an increase in demand of translated material for public information, including making the translated information more accessible to lay people. Kruger (2008) further explains that translations are one of the most common approaches to making health information available to the broader public. There is further motivation for translating medical information to other languages. Raidt (1997) for example explains that other major languages in South Africa such as Afrikaans have decreased in the relative number of speakers, from 19,4% to 15,4% due to birth control and language shift, however the number of Setswana speakers for example increased by 2%. Also, South Africa mainly has a black majority, many of whom communicate poorly in English.

Fischbach (1961: 462) states that translation takes place when the source language and the target language are different. The source would be the original language in which the material was written, while the target language refers to the language it is translated into. Translating text in health information can be difficult, as demonstrated by Fischbach (1961) who comments that a good

translator should be as competent as the writer who wrote the original text. Kruger (2008) cautions that translators should not rely heavily on English loan words but admits that this can be challenging as some medical terms do not exist in the African lexicon.

Macario and Boyte (2008) note some challenges in translating health information effectively for Latino populations who have lower levels of literacy, limited English proficiency, and health literacy. Macario and Boyte (2008) explain that literal translations between English and Spanish has resulted in errors. One of these inaccuracies is described by Fischbach (1961) relating to an incident by an American toothpaste manufacturer during a big campaign to capture the Latino market. After launching their improved product in ribbon form, the American manufacturers based their marketing on a theme mentioned in (i) and (ii) below:

(i) "X toothpaste now comes in ribbon form"

After the phrase was translated literally in (ii) and aired on radio, it was:

(ii) "La crema dental X viene ahora encinta"/ In English this means "X toothpaste now comes pregnant"

Direct translations are risky and it is important for the translator to establish the context of the information before translating. Fischbach (1961) and Macario and Boyte (2008) have several recommendations to improve the quality of translated text. Some of the suggestions mentioned by Fischbach (1961) include:

- writing clear, straightforward and descriptive English about what is the product, what it does, and how it works

- refraining from using domestic terms or words that the translator cannot understand
- whenever possible giving illustrative guidance through layout dummies, artwork and descriptions to help the translator to visualise, and
- for effective use of gimmicks, a pun or metaphor, these should be discussed with the translator to check if they are translatable.

(Fischbach 1961: 472)

Addressing the problem of clarity of source language, Zeng and Tse (2006) look at how to develop a health language that can be applied to the everyday language of citizen-consumers and to encourage information seeking and health citizenship. There should be a solution towards bridging the knowledge gap between service providers and patients (Seedorff et al 2013). Language specifically medical jargon remains a huge challenge that affects the uptake of health information by citizen-consumers.

Although of great importance, issues of participation, access and agency are not just a question of language or multilingual provision. Also, the modality of communication plays a significant role. There is a strong link between health literacy and health outcomes, the ability of people to seek, understand and act on health information is largely dependent on their level of health literacy and how they are enabled to assess this information. For example, is the information pitched at a level that it is understood by the audience and is the information relevant to the health issues that concern the citizen-consumers receiving this information. Making health-related information more accessible to different audiences is important for encouraging participation in health.

3.4. Summary

Chapter 3 focused on health literacy and language. Noticeably linguistic citizenship is a significant consideration for enabling citizen-consumers to use health information for their health concerns, equally language and the design of information should be important for health literacy and for encouraging health citizenship.

The research mentioned above has been conducted primarily on the public health care sector. However, this current study is solely focused on the private health sector which has a very different citizen-consumer profile – often highly competent in English - and where issues of access to information in different languages can therefore be expected not to be the biggest challenge. In this study the findings, which will be discussed later, did not point to issues with multilingual access to information.

As noted in the introduction, this thesis focuses predominantly on the multimodal structuring of information, and how through different artefacts, citizen-consumers are afforded ways to use information for their health concerns. Understanding how citizen-consumers navigate through multimodal health resources is essential for finding answers on how medical schemes influence citizen agency and participation through health communication.

Chapter 4 will offer further context on the health insurance industry, and on Discovery Health and GEMS. The chapter will also provide a structure of the research process, which included the administration of an electronic questionnaire, interaction with the gatekeepers of the two medical schemes, as well as the methodological challenges.

Chapter 4: Context, research design and methodologies

4.1 Overview

The thesis looks at the different genres of information produced by Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS). The premise of the study is that linguistic citizenship and health literacy are important for health promotion, while participation and voice affect the consumers' ability to obtain, understand and act according to the health information provided.

The starting point of this chapter explains what medical schemes are, how they operate and fit into the private health sector. In addition, to obtain data from citizen-consumers some level of buy-in was requested from the medical schemes. I had to first negotiate with different role players who would determine access to the consumers' contact details, these negotiations are noted under the research methodology section. The research questions and focus areas, as well as the data collection and analysis processes are discussed in detail.

4.2 Shifts in ideologies of health

The struggles of the South African system to find a sustainable and equitable model of health care for all is taking place in a global climate of shifts in ideologies of health generally. As noted by way of introduction to this thesis, there have been significant shifts in how health is viewed by the state and how the responsibility of being healthy has become the responsibility of citizen-consumers. The state no longer carries the sole responsibility as the provider of looking after the health of citizens. This is

a significant shift from the health care for all[4] based model to a more individualistic and commercially motivated notions of health. For over two decades or more 'health care for all' provided an inspirational goal of health equity for the World Health Organization and its member states (World Health Organization 1998). There are significant ideological shifts in global health thinking. Health-related issues such as obesity and chronic illnesses (linked to a poor diet or sedentary lifestyles) for example, are widely discussed as issues that the individual should think about for their own wellbeing. The message here is that citizen-consumers are responsible for their own health and there are ways to avoid health-related diseases and to be healthy. This is a new way of looking at health that is linked to citizen-consumers taking control of their bodies, acting as architects of their own health.

Given the pervasiveness of this consumerist orientation to health, it is quite likely inevitable that sooner or later, the model will also filter into the ideological framing of the general health system. Obviously, the question will be to what extent the commercial model of the new citizen-consumer/health citizen will ever be viable for a broader public health delivery. There is surely little economic feasibility in a wider uptake of commercial models *per se*. However, what may be of interest is the way in which the private health system manages to construct some form of agentive and engaged 'citizen'. One of the problems that beset the public health system (as mentioned throughout the discussions in the previous chapters) is the lack of agentive engagement among patients in their own care for health. Contact to resources for citizen-consumers impacts how they define health and how the notions of health and healthy lifestyles shape their behaviour and how they participate as health citizens. However, where contact to resources for many is limited, which it has been historically and continues to be in South Africa, access to health by underprivileged populations with poor literacy and health literacy presents challenges for constructing health citizenship. Granted that historical social, economic and racial

[4] Health care for all refers to the provision of all citizens of the world a level of health that will enable them to lead socially and economically productive lives (World Health Organization 1998)

disparities, reproduced in contemporary time, are clearly the most fundamental structural conditions that continue to raise barriers in access to health services to all. However, there is undeniably a role to be played in alleviating such inequities through various strategic actions. One such strategic action is that of improving agency and participation through health literacy. And it is here that private health care, and in particular, how commercial health insurance may point one way forward. The focus of the thesis is thus on those who have access to private care and how they are provided affordances in health communication to participate agentively in their own health management.

The thesis focuses on the private health care industry by investigating how Discovery Health and GEMS construct information through various modes, particularly websites, and how the construction of information allows for multiple forms of health literacy.

4.3 Medical schemes

Discovery Health Medical Scheme (Discovery Health) is the largest *open* scheme with over 2.5 million beneficiaries, while the Government Employees Medical Scheme (GEMS) is a *closed/restricted* scheme with more than 1.8 million beneficiaries, covering about 3% of the South African population. Calmeyer (2012) explains that "the market consists of open or commercial medical schemes, as well as restricted or private medical schemes. Both types of medical schemes are administered in the same manner, although, it is the participants that differ." Both Discovery Health and GEMS are key role players that can facilitate agentive participation through health communication.

The private health industry is a powerful entity with about 96 medical schemes that operate in this sector.[5] Clearly this sector is well resourced and consists of a network of specialist doctors, health care

[5] http://www.medicalschemes.com/MedicalSchemes.aspx [Accessed on 06 July 2012]

service providers and health resources that the public sector does not have access to. Keeping this in mind, the thesis focuses on the health insurance industry to find effective models of best practice in how information is designed and offered to citizen-consumers for health citizenship. The thesis attempts to tackle some important questions on how in the private health care sector, citizen-consumers are empowered through information to follow guidelines designed by the medical schemes for health issues.

Discovery Health and GEMS are involved in health promotion through the information they provide to citizen-consumers. How health promotion is shaped in the health insurance industry through health communication presents an opportunity for researchers and scientists to design similar resources for promoting health in the public health sector. Also, the fact that the private health sector is the best resourced across the board and its commercial engagements fosters a 'supposedly' more engaged public/clientele, would suggest how research looking here for solutions to public health problems would be worth conducting. By looking at these different medical schemes, this study provides a unique opportunity to unpack issues of agency, participation and voice in the construction of health citizenship in the private health sector.

4.4 What are medical schemes?

According to McLeod and Ramjee (2007) medical schemes are the most dominant institutions that provide health insurance in the private health sector. Medical schemes are non-profit institutions governed by the Medical Schemes Act (Act 131 of 1998) and managed by boards of trustees. However medical schemes are surrounded by for-profit entities that provide administration, marketing, disease management, consulting and advisory services (McLeod and Ramjee 2007). The Medical Schemes Act determines the framework in which the medical schemes need to operate and it defines their

function as “the business of undertaking liability in return for a contribution to make provision for obtaining any relevant health service” (McLeod and Ramjee 2007: 48). This means that medical schemes can provide financial assistance for health care services, and they can also offer these services directly or through the support of health care service providers. The South African Department of Health (2011) also considers medical schemes to be the most reliable source of health care financing.

Most medical schemes pay accounts for services rendered by health care service providers to the schemes’ members, and some even have payment agreements with health providers, very few provide health care services directly to their members. These medical schemes can either be *restricted/closed* membership schemes if they are linked to a large employer group, union or other institution, but most of them are *open* schemes and must consider anyone who applies for membership (McLeod and Ramjee 2007). Yet the South African Department of Health (2011) cautions that most of the medical schemes cannot be sustained and several have collapsed, or have been placed under curatorship or merged, due mainly to overpricing of health care. The medical schemes in this study have not had to deal with such issues as they are leading companies with a large consumer base and they have shown significant growth in membership over the years.

4.4.1 Context on Discovery Health and GEMS

The parent company, Discovery is a leading financial services provider operating in the health insurance, life insurance and investment markets. Discovery Health, part of Discovery, is based on the fundamentals of engaging consumers through a science-based wellness programme that provides rewards to consumers when they: Get to know their health risks; improve their health; and maintain their health through exercise and a healthy diet. As part of evaluating the multimodal tools and resources offered by Discovery Health, the thesis focused on how it uses its website to communicate

about health and wellbeing and how their wellness programme is designed to lead consumers to behave in a certain way (see chapter 7).

For Discovery Health, their science-based wellness programme underpins all their products and services. The health insurance arm of the company is one of the largest in South Africa. In the United Kingdom, Discovery Health provides health and life insurance products, which are integrated into their wellness programme. There is also a subsidiary of their business in the United States solely based on their wellness programme. As one of the foremost global economic powers in the world, the importance of engaging citizens in the United States cannot be understated in setting international trends, influencing consumer behaviour, the consumption of health information and to influence health markets. In the thesis, I look specifically at how Discovery Health uses its wellness programme to encourage health citizenship, as well as the attitudes and practices of consumers who navigate through this information.

The Government Employees Medical Scheme (GEMS) was created in January 2005 to provide health care benefits to Government employees as mandated by the South African Government. The core organisational model of GEMS is to provide comprehensive and sustainable health care benefits to these employees, while providing access to medical care available to Government employees who previously did not have medical aid. McLeod and Ramjee (2007) view GEMS as an important model that demonstrates how an employer can create medical aid packages that are affordable to all employees. However, they suggest that there are several medical schemes that have a high number of Government employees that could merge with GEMS or those that could be forced to close because their risk pools (member base) have declined in size. Medical aid/health insurance involves risk pooling which refers to the collection and financial management of funds so that unpredictable individual risk becomes predictable and can be distributed among various members of the pool. Risk

pooling can provide financial relief to families who face high health care costs (The World Bank and Gavi Alliance 2010).

In contrast to Discovery Health, the operations of GEMS are administered by another entity, Metropolitan Health, a subsidiary of one of the top financial services provider for lower and middle-income markets. The health division of this financial services provider administers about 26 medical schemes, including GEMS. Metropolitan merged with Momentum, another service provider of insurance and asset management services. The merger led to the establishment of MMI Holdings. Administrators generate revenue through services provided to consumers of the medical scheme. Administering a medical scheme can be a lucrative business as pointed out by Calmeyer (2012) who says that an estimated 6.8 billion rand was paid in 2008 towards medical scheme administration in South Africa.

Medical schemes aim to cater to a diverse group of clients, Discovery Health attracts higher income earners and unlike GEMS, it is open to the public and therefore enjoys a bigger catchment area of consumers. Discovery Health caters to consumers from the high end of the market through their Executive plan and the low-income groups with its Keycare plans. While GEMS offers their Onyx plan as the most comprehensive for Government employees on a higher salary band and their Sapphire option as their cheapest plan, which the employer (Government) subsidises 100% when employees fall into the salary level 1 – 5 range.

The period 1994 to 2006 saw a sharp decline in medical schemes from 170 to 124, however this decrease contrasted with the 20% increase in membership in the same period, from 2 487 to 2 985 million (McLeod and Ramjee 2007), the decline continued with only about 102 medical schemes (Department of Health 2011). The increase in membership can be attributed to individuals who

previously lacked health insurance being brought into GEMS, which has been operating since 2006 (McLeod and Ramjee 2007). Against the backdrop of these highly successful leading medical schemes the thesis followed a research process that involved an electronic questionnaire, consultations with various company representatives, quantitative data collection and a qualitative analysis.

4.5 Research design

This research employed both quantitative and qualitative research methods to explore how information is constructed by two leading medical schemes across multimodal artefacts to encourage health citizenship. The consumers need to navigate several artefacts relating to their health and understanding the problems they face in accessing, understanding and using information is essential. Furthermore, looking at what message about health and healthy lifestyle are contained and promoted in these artefacts was important for this study. And finally, the study wanted to elicit information on what types of agency and participation engaging with the 'ecologies' of (multimodal) health literacies offered by the two insurers.

The research questions asked are repeated here:

RQ1: Who has access to health information and how is this structured?

RQ2: What does the semiotic health habitat look like for the health citizen-consumer?

Thus, what is of interest in this study is to explore how, through which modalities, and to what extent, citizen-consumers can enter and navigate the different artefacts; how the different styles, registers and stances used by the medical schemes encourage or hinder agentive participation; and what the different affordances tell us about how the medical schemes construe their readership and construct their constituencies of citizen-consumers/health citizens.

As the study is concerned with an analysis of information mostly hosted on websites, a virtual/online ethnographic approach was followed for an analysis of the range of artefacts.

4.5.1 Virtual ethnography

Ethnography in new disciplinary approaches such as media, medicine, science and technology, has shifted from studying whole ways of life, to limited aspects, people as patients, television viewers, or as professionals. Although there has been this shift, ethnographers still share a fundamental focus on deep understanding through participation and observation (Hine 2000: 41). Virtual ethnography, which is an approach followed in the thesis, does not involve physical travel, it is experiential rather than physical displacement (Hine 2000: 45) - "you travel by looking, by reading, by imaging, and imagining." This is how the thesis offers an ethnographic approach, as you can through desktop research explore the social spaces of the Internet. The spaces that were observed and analysed in this case included a range of multimodal artefacts and websites of Discovery Health and GEMS, and the experiences of the citizen-consumers who navigate through these artefacts.

The multimodal artefacts include application forms, website images and application guides, these are analysed by looking at aspects of style, register, and stance and how reader positions are crafted. This sets the scene to understand how the semiotic world of the citizen-consumer is constructed and what affordances are made to navigate and use the information provided by the medical schemes. A comic book produced by GEMS for a particular target audience was also analysed through a discourse analysis approach. The comic book offers an important communication tool to discuss issues of racialisation of meaning, how text and image structuring communicates certain notions about race, gender and class.

Virtual ethnography does not mean that the relationship between the ethnographer and reader have collapsed, Internet ethnography is more about how the ethnographer negotiated access, interactions and communicated with participants (Hine 2000). As expressed in the thesis, there was a lot of negotiated access to information and resources to reach the participants, who are members of Discovery Health and GEMS. These participants were not just the people who completed the questionnaires, but also the gatekeepers of these institutions, who the researcher had to go via to reach members of these medical schemes.

Blommaert and Rampton (2011) explain that communication occurs through spaces, social actions, interactional histories, textual trajectories, institutional regimes and cultural contexts. Virtual or Internet ethnography as it has been described above is about how the researcher studies, views and interprets the semiotic world inhabited by the participants. What is seen on the Internet though is a collection of texts and the ethnographer's job is to develop an understanding of the meaning that underlie and are created through various textual practices (Hine 2000: 50).

4.5.1.1 Ethnography of communication

Johnstone and Marcellino (2010) explain that linguistic ethnography is a useful approach with which to analyse language in use. They refer to Hymes's ethnography of communication, which provides a methodology for understanding how language is embedded and used in discourse, and that carefully compiles information along a variety of SPEAKING parameters; Setting and Scene, Participants, Ends, Act Sequences, Key, Instrument. Norms, Genres (cf. Jacobs and Slembrouck 2010). In the thesis these SPEAKING parameters can be observed as follows:

The Setting and Scene is in the private health care sector with two leading South African medical schemes. Discovery Health and GEMS are medical schemes who construct and share health information with millions of people through a variety of tools, such as websites, which are at their

disposal. The Participants include both Discovery Health and GEMS and the millions of South Africans who have access to the information provided to them. Specific to the context of this thesis, these include 80 Participants who completed the online questionnaire and provided data on their perceptions and practices. In this setting the Addressors are the medical schemes and the Hearers are the participants who took part in the study. The Ends for the medical schemes are to offer information and to manage health care risk. The idea is to prevent members/Hearers from becoming sick, but should they become ill, the medical schemes offer the financial assurance that their medical bills would be covered, based on the benefits available on the health plans the Hearers selected.

The Act Sequence includes the messages crafted by Discovery Health and GEMS and packaged across multimodal artefacts for the Hearers. The Key and Instrumentalities can be either in a printed format (application forms, member guides, comic books) or an online format (emails/SMSs, websites). The forms of speech would differ depending on the channel however the institutional voice in how they address the Hearers would be evident across the different Keys and Instrumentalities. Norms of speech are different between Discovery Health and GEMS. Discovery Health tends to use more of an active voice, more marketing and advertising, whereas GEMS is subtler, more of a communication approach. GEMS also uses a different register in how they address their Hearers. Both Discovery and GEMS speak to their audiences to agentively call for a level of participation, Discovery Health through their wellness programme, encourages an engagement in health issues for lifestyle rewards, while GEMS presents a less commercial package. The Genres include the multiplicity of multimodal communication tools at the Addressors disposal, from application forms, where the initial relationship between Addressor and Hearer is initiated to websites that become a ready resource of information and interaction between Discovery Health/GEMS (Addressors) and the Hearers (80 participants). In this study, I have conducted a semiotic analysis of health artefacts, giving selective attention to Hymes SPEAKING parameters.

I have thus used three analytical approaches to health communication that each contributes to the SPEAKING model of Hymes. These are (a) an electronic questionnaire; (b) an inventory of the instrumentalities that make up the scene and setting; (c) an analysis of the act sequences and the events and the goals of managing or negotiating the ecology of artefacts.

4.5.2 The ecology of semiotic affordances

An audit of health literacy artefacts was conducted and the range of artefacts that were part of this process included, among others, application forms, websites, member guides and a comic book. I spent a period of six months collecting and reviewing various artefacts. The range of artefacts included website images, newsletters, annual reports, magazines, a comic book, and application forms; *figure 2* below includes the range of artefacts that formed part of the analysis. The artefacts were selected to offer a range of resources utilised in the medical scheme industry for health communication. As the thesis deals extensively with the construction of information, health notions and lifestyles relating to modern constructs of health, websites offer by far the most comprehensive idea of how the medical schemes construct these health notions and who has access to this information and what cause of action is expected from the citizen-consumers. Application forms were also selected as the first level of interaction with written text that the medical schemes offered to their consumers.

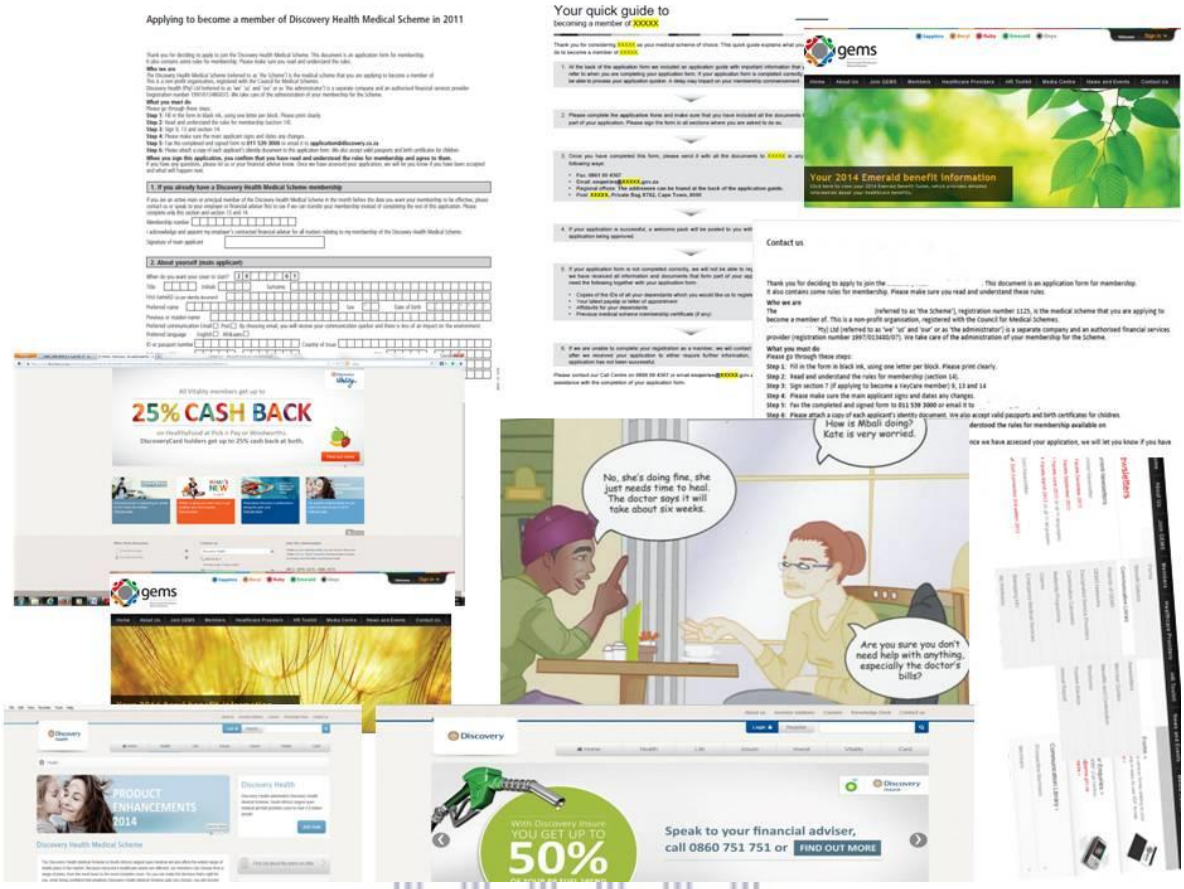


Figure 2: Range of artefacts collected for the analysis

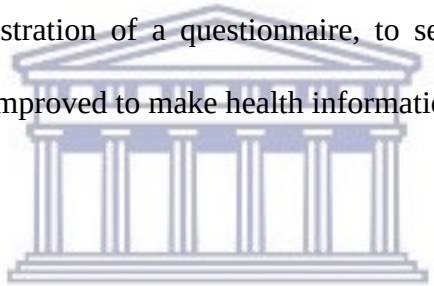
According to Coffman (2004: 1) a communications audit is a structured evaluation, formally or informally, "of an organization's capacity for, or performance of, essential communications practices." The process of compiling the audit involved reading, note taking and writing to highlight aspects of language and text structuring with respect to register appropriateness and style. The stylistic and register characteristics of the information offered across the multimodal artefacts was attended to, as well as the stance, that is, the ways in which communicators create and shape relations with the propositions they utter and with those they interact with (Johnstone 2009), or the ideological positioning carried in the artefacts.

The process of auditing these artefacts was qualitative as it specifically looked at texts and design features. Among the range of artefacts, the most pertinent in terms of multimodality were websites, which allow for the presentation of information via audio, video and multimedia documents (Martin et al 2010).

4.5.2.1 Negotiating websites

In the words of Martin et al (2010) "certain categories of semantically enriched documents as well as multilingual textual resources are still difficult to handle," (ibid 2010). An aspect of this study is to look at how accessible the websites of both medical schemes are, i.e. can the consumers find what they need, and can they navigate these multimodal tools effectively? This feature was observed through data presented by the administration of a questionnaire, to see the challenges citizen-consumers experienced and what can be improved to make health information accessible to these consumers.

4.5.2.2 The questionnaire



To collect the quantitative data an electronic questionnaire was sent to consumers who are members of Discovery Health and GEMS. Questionnaires, and other formal elicitation tasks, are of course not unproblematic. Many authors have noted how elicitation instruments comprise a particular genre of communicative exchange structured by power differentials and following their own rules of engagement. There is nothing 'neutral' about questionnaires, but they are infused with presuppositions and assumptions for how to smoothly partake in the exercise. Electronically administered questionnaires, furthermore, demand a quite significant facility – and access to – technological affordances.

On the other hand, questionnaires – and especially electronic questionnaires – allow the efficient targeting of many participants. As this study focuses on health, the emphasis was on the challenges

faced by the target group in accessing health information across multimodal artefacts, as well as how the information impacted on how they behaved regarding their health. The questions incorporated in the questionnaire reflect this interest of the study.

The questionnaire was designed to ensure that it was accessible on a website where participants landed on the introductory page (informed consent form) requesting their consent to take part in the study (see Appendix A for the request for consent). As the questionnaire was completed by participants in their own time and in different places using computers located in different locations, no hard copy consent forms were signed. The participants gave their consent by clicking on the *Accept* button on the introductory page of the questionnaire. The electronic consent form informed the participants about the research topic, research questions and aims of the study, while informing them about their rights to confidentiality, right to not take part in the study, or even to withdraw from the study during or after data were collected. All completed questionnaires were saved at the backend of the website on which the questionnaire was designed, and all individual completed questionnaires were automatically emailed to the researcher after each questionnaire was submitted.

I have collated the voices of speakers in the form of an electronic questionnaire. I am aware that the questionnaire itself is a specific, pre-structuring event, with tools, rights and obligations. However, all this different information has been triangulated to produce a credible, as much as possible, way in which texts structure participants' interactions with health provisions to produce a specific consumer 'health citizen'.

To administer the electronic questionnaire emails were sent to all participants with a link. An electronic questionnaire is a valid research instrument that is less complex and time-consuming than a paper survey (Bethlehem and Hundepool 2000: 133). The questionnaire was also more efficient in reaching the target groups as it was sent to their emails, instead of the researcher inserting the data in a paper

form. Paper surveys can contain many errors, which will require substantial data editing to obtain acceptable quality data (Bethlehem and Hundepool 2000).

The questionnaire was completed by 80 participants:

- 22 from Discovery Health Medical Scheme
- 29 from the Government Employees Medical Scheme
- 29 from other medical schemes.

Significant data were collected from medical schemes other than Discovery Health and GEMS. The research process did face a couple of challenges regarding interaction with various stakeholders employed by Discovery Health and GEMS.

4.5.3 Research challenges

In my interaction with both medical schemes the way they handled my requests presented its own challenges but also showed two distinct approaches, one of willingness but prudence (Government Employees Medical Scheme) and the other being unresponsive (Discovery Health Medical Scheme).

The initial process began in early 2011 with presenting the research proposal to Metropolitan Health. The proposal was first presented to a senior manager who requested that I set up a meeting with him, the general manager of the business unit and their executive. At this meeting, I was asked to draft a separate proposal for GEMS that they would forward to request the principal officer of GEMS to grant the study permission to use their communication platforms (data and systems) to send the questionnaire to their members. There were no positive results from this meeting as the electronic questionnaire was designed and no progress report or feedback were received.

My experience with Discovery Health was the same and yielded no results. I contacted the health portfolio manager to find out how I could send the questionnaire to their clients like with GEMS. I also wanted to do voice recorded interviews with key representatives involved in the strategies around institutional advancement and development, as well as strategic marketing and communications. From Discovery Health, I requested interviews with the group chief executive officer, chief executive officer for the medical scheme, the chief executive officer for their wellness programme, and their group chief marketing officer. This request was sent to their health portfolio manager in the marketing services department and their media relations officer. However, without any feedback after telephone calls and leaving emails, I was left to conclude that Discovery Health was not interested and that the bargaining process to gain access to data from their clients had failed.

As negotiations with Metropolitan Health had also been unsuccessful, I decided to approach GEMS directly. An email was sent to the principal officer informing him of the study and its objectives. In his interaction with me he was professional and prompt in his responses and the bargaining process started again. The request was then filtered down the chain of command and I received an email that the medical scheme would offer feedback on or before 13 April 2012. After this date passed and there was no correspondence, I followed-up with the relevant person, and I was informed finally that the medical scheme could not participate:

> Due to aspect of concern regarding [Government Employees Medical Scheme] members consent to participate in the exercise.

The process of gaining institutional support from GEMS and bargaining to receive data from their clients had also been unsuccessful. In short, it appeared that there were two different approaches by the medical schemes, even though the results were the same. Discovery Health refused to correspond at all, whereas GEMS was interested but believed getting consent from their clients could be

unattainable. This was a disappointing aspect of the research methodology because without a successful bargaining process and gaining institutional support from the medical schemes, the study could not reach most of the intended consumer base, where much valuable data could have been obtained, and nor could a fully satisfactory ethnographic study of the questions be researched. Given that both medical schemes have many members, the study could have benefited from a larger number of respondents, which could have added to the richness of the data and offered other perspectives that could have added to the analysis on semiotic structuring and the uptake of health information by consumers.

Understanding that to gain access to clients of GEMS without support from the institution, the bargaining process had to shift to negotiating with Government departments, I sent emails to the media liaison officers and ministerial spokespeople at 32 South African Government ministries. There were two types of responses, the one was being referred to other representatives, which frustrated the bargaining process and, in most cases, led to no feedback. The second was willingness and support which the study received from the South African Department of Tourism, as well as the South African Department of Basic Education.

As negotiations with Discovery Health were unsuccessful and the medical scheme is generally an open scheme, I decided to approach a few corporate companies and universities to see whether their staff were willing to take part in the study. Universities per se were not my target audience, but there were participants from universities, and other institutions such as a leading medical research institution, and a pan-African applied research policy research institute that showed interest. I also hoped that a leading South African social science research body would allow their staff to also take part, but the bargaining process with their director of communications at the institution showed that he was equally frustrated

by long internal negotiation processes. Ultimately it can be assumed that none of their staff members completed the questionnaire.

My experience in bargaining with different institutions and individuals perhaps shows the challenges that many researchers face in getting access to participants through institutions and the gatekeepers of these organisations. The Association of Social Anthropologists of the UK and the Commonwealth's (1999) advice about relations between social anthropologists and gatekeepers of institutions is for researchers not to allow the gatekeepers to take responsibility for the research. While respecting the interests of gatekeepers, researchers should aim to obtain informed consent from the participants directly. I requested consent from the participants directly and they participated not as representatives of their employers (institutions) but as individuals relating to their experiences and practices with information received from the medical schemes. The medical schemes were chosen because they are the largest in the industry and they operate according to two different models, one being an open medical scheme (Discovery Health) and the other a restricted medical scheme for Government employees (GEMS).

In the next chapter, I look specifically at various multimodal artefacts and how information is constructed in relation to style, stance, and register.

Chapter 5: Multimodal artefacts in becoming a member

5.1 Overview

This chapter looks at how people become citizen-consumers, and what sort of citizen-consumers they become, through the multimodal artefacts used in health communication by Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS). It addresses the question of how health information is structured and meaning created through multimodal artefacts and across multisemiotic contexts. Communicative practices are multimodal and multisemiotic. Health communication has become multimodal where different styles, stances, registers and modes provide various affordances for meaning making and to share information with citizen-consumers. Such resources provide the affordances on how health information is constructed and how this information is appropriated by citizen-consumers.

Modes can be used to convey different meaning by using various resources, as such "modes have different affordances, potentials and constraints for making meaning," (Bezemer and Kress 2008:171). There is now substantial research that looks specifically at multimodal artefacts (Hiippala 2012; Kress and van Leeuwen 1996, 2001, 2002, 2006, 2009; Lemke 1998; Warschauer 2007). Hiippala (2012), for example, uses a multimodal corpus to investigate how tourist brochures structure and design information through linguistic choices and through imagery for communicative function. Warschauer (2007:43) talks about multimedia literacy, which "refers to the ability to interpret, design, and create content that makes use of images, photographs, video, animation, music, sound, texts and typography."

A discourse analysis that links language use to social behaviour should enable researchers to observe how 'lived textuality' impacts the lived experience of a group (Lancaster, 2013). Social behaviour is about the practices, experiences and norms of people, dimensions that are affected by the

communicative resources and modes, that is, the socially and culturally designed resources for meaning making such as image, writing, design and speech (Bezemer and Kress 2008). An organisation would have had to articulate how they wish to position certain messages, and what they want to influence or receive from interactions with citizen-consumers. The consumers also undergo an identity construction process as part of sense making, which is influenced by what others think and certain cues to find the most plausible meaning to base their sense making (Thurlow 2009). Sense making underscores a growing research area in the field of organisational and communication studies.

The analysis of the artefacts is essentially an analysis of multimodal communication, how messages are conveyed through different modes of communication, how the structure and construction of this information (pre)enables the uptake of the information by citizen-consumers.

The main focus of interest in this chapter, then, is how the information conveyed by and across the multimodal artefacts 'comes across'. How has the sender/addressor (the medical scheme company) designed the information to be received? How is it perceived by the reader/hearer? And what sort of relationship is established between the insurer and the citizen-consumer? These questions relate to the 'mode' of presentation or the 'style of the information; the type of social indexicality enregistered by the message; and the way in which the message is packaged interpersonally (stance).

This chapter then offers a preliminary section to a more extensive analysis of the websites by Discovery Health and GEMS' websites in Chapters 6, below. This chapter is particularly concerned with the transfer of health information to citizen-consumers, in terms of choices made in language, register, stance and style.

5.2 Language, style, stance and register

The analysis in this section can be broken down into three notions, namely style, stance, and register. Style like voice has been described and understood in a rather simplistic way as referencing a way of expression in clothing, hair, and other factors like mannerisms. Stroud and Wee (2013) however offer a deeper and more relevant analysis of style, a sociolinguistics of style, one which is related to identity. Literacy practices in how textual information is constructed are also manifestations of style (Stroud and Wee 2013:65). According to the authors this broadened understanding of style is in line with contemporary developments in mainstream sociolinguistic work. The link between style and identity is one such new development in contemporary approaches to style, where identity construction is explored in terms of style (Stroud and Wee 2013:65). Style can be a form of branding by the medical schemes in how they construct their identities. Stroud and Wee (2013) share the same viewpoint when they explain that individual style allows the individuals to signal their uniqueness, while still being recognised as affiliated with a certain group or groups. This is the essence of branding, the need to differentiate their products and services. Both Discovery Health and GEMS employ an individual style that can be identified as the hallmark of their branding. In the thesis this understanding of style is extended to look at aspects of language and design, as a form of identity, but also a way to encourage a certain readership/clientele. An example on how style and identity are used to construct meaning is in the comic book (*figure* 3 below), an artefact produced by GEMS for salary level 1-5 employees. Here is a short synopsis of the plot.

The comic book has several characters including *Mama Khumalo* the distinctly black character on the left and her white female work colleague *Anne*, the mother of the character *Kate*. *Mbali* and *Kate* are school friends and *Mbali* is *Mama Khumalo's* daughter. *Mbali* had an accident at school where she broke her leg and then the scene is set to show how GEMS provides information and services to *Mama*

Khumalo for *Mbali* to receive medical attention. *Mama Khumula* is a salary level 1 - 5 employee and a member of GEMS. The comic strip is evaluated by following a discourse analysis approach used for the testing of written and verbal communication, body language or other significant semiotic events.

Figure 3: Comic book for salary level 1-5 employees GEMS members

The comic book is aimed at making information more accessible to GEMS members who are on salary levels 1-5; these would be junior level staff on lower salaries. The comic book makes information more accessible to a broader audience through the interaction between picture and language. There is a sequencing in the interaction (following the bubbles), a structure that shows how the conversation should flow, how the reader should read this information, the top most speech bubble is the conversation opener, followed by the response located just above *Mama Khumalo*. The characters portrayed are facing each other to show that they are involved in a conversation, with the white female extending her hand towards the black female again creating a sense of connectedness. From the

perspective of style, the speech bubbles, cartoon style drawings, the publications should be a light read, in contrast to a heavy corporate document like an Annual Report. This is supposed to be accessible and easy to digest information that uses both language and design.

The link between language, style and identity can also be observed in the comic book. The use of the term mama (mother) is used to refer to a mother in the many indigenous languages in South Africa, and calling the character *Mama Khumala* already classifies her as a mother and black woman. The term is also used traditionally as a sign of respect for an older black woman and mother. Even though the character is assigned a name that shows that she is respected, she is portrayed as disadvantaged, possibly in need of financial support and her white female counterpart is sympathetic and willing to help, financial or otherwise. Clearly there are certain assumptions, stereotypes and constructs about *Mama Khumalo* and older black women as a group being made. In the author's own words: "The perspectives of privileged and powerful groups tend to dominate public discourse and policy, these movements have asserted, and continue to exclude and marginalise others even when the law and public rhetoric state a commitment to equality," (Young: 1997: 383). *Mama Khumalo* was a character created for the consumers who are on salary level 1 – 5 and members of GEMS. Essentially, how the comic book categorises her makes certain assumptions about the medical scheme's readership who share similar characteristics, experiences, responsibilities and challenges as *Mama Khumalo*.

An interesting facet about this scene and the character of *Mama Khumalo* is the long history of struggle, oppression and disadvantage of black people, and more so black women, who have been marginalised and have had less access to health resources. There is a long history of oppression, struggle and resistance by women as shown in the women's liberation movement in the sixties and seventies. However, women as a group and even those who *Mama Khumalo* is supposed to emulate are so different in their biographies, experiences, problems and social worlds. Young (1997:387) shares a similar perspective when the author says that attempts to categorise persons belonging to

social groups, "whether imposed by outsiders or constructed by insiders to the group, fall prey to the problem that there always seem to be persons without the required attributes but whom experience tends to include in the group or who identify with the group." The depiction of people and their experiences presents complex challenges for the medical schemes that should apply deliberate and often accidental attributes that could engage or alienate their readership.

5.2.1. Style: Contemporary perspectives

Posner (1995) remarks that style is not just about vocabulary and grammar but includes implicit principles that govern aspects such as the length and complexity of sentences, as well as the arrangement of sentences into paragraphs and the level of formality at which the writing is pitched. This is also related to aspects of *register* where the writer could have used a high or low register. Overall Epstein (2013) sees style as tied to personal attributes and individuality – a way for speakers to distinguish themselves when using language and other semiotic means for identity construction. Posner (1995) sums this properly by stating that these tools, such as a style, are not just for communicating ideas but are used to create a mood and in some cases to provide a sense of the writer's personality.

Jaffe (2000) comments that recent theories on style offer a richer understanding of style as a multimodal and multidimensional group of factors of linguistic and semiotic practices to show identities in communication. These identities are not so much about social classifications such as gender, ethnicity, age or region but more nuanced interactional aspects through which speakers take stances and construct personas (Jaffe 2000). In this instance, Jaffe (2009) returns to the point made by Stroud and Wee (2013) that current theories explain style as a cluster of linguistics for the display of identities in interaction. Jaffe (2009) explains that these current theories rather than linking sociolinguistic meaning to fashion, draw implicitly and explicitly, from how identities are indexed and

how meaning is contexualised, in their understanding of stylistic practice. In indexical theory of style, meaning making is not just about gender, ethnicity, age or region, but a more dynamic flow of interactional moves, through which speakers take a stance, create alignments and establish personas (Jaffe 2009). These contemporary approaches thus demand that sociolinguistics takes into account not only linguistic patterns but also their distribution, and role in the performance of social actions in communication. This is the approach this type of research is aimed at, by looking at the multimodal cascade of information distributed to citizen-consumers by Discovery Health and GEMS.

Related to this, although from a different tradition is work by Miles et al (1990) that looks at style from a buyer and seller perspective. Their study mentions that sellers might change their communication style to best fit the buyers' interpersonal communication style, what is generally known as 'audience design' (cf. Coulthard, 2012). The authors explain this further by presenting Sheth's (1976) normative model of communication styles based on a tripartite style of interpersonal communication. This model they claim has received some degree of conceptual and empirical support. Sheth's (1976) basic assumption is that the outcome of the exchange between the seller and buyer is determined by two communication variables, the first being content and the second the communication style. Communication style, in turn, is viewed as a three-dimensional construct that includes task oriented, interaction oriented and self-oriented styles of communication.

A task-oriented communication style is defined by a high degree of goal directed behavior by the communicator. The example given is of placing an advert that would typically focus more on organisational objectives than self-oriented communicators. The self-oriented communicator is preoccupied with their own welfare and what any activity will mean for them in terms of rewards. Here, there is less focus on relationship building or achieving organisational objectives, while the interaction-oriented style of communication focuses on the social and interpersonal relationships and is less goal driven; coercive strategies are the choice for an interaction-oriented communicator (Miles

et al 1990). These different communication styles are useful for the present purposes of this study – although admittedly do not have the sophistication and detail of more sociolinguistic work on style. The model will be utilised in the upcoming sections to explore how printed and online media are used to craft messages, and how citizen-consumers can navigate this semiotic environment constructed by the medical schemes.

5.2.2. Stance

Stance is an important analytical notion in the context of analyzing information contained in multimodal genres of websites as it captures the way in which the coordination and cooperation between medical schemes and citizen-consumers is accomplished as part of communicative activity.

Ochs (1992) modelled how certain linguistic forms can relate to stances such as - certainty, interpersonal stances that could entail - friendliness or intensity - or even social actions such as apologising. In addition, DuBois evaluated stance-taking by looking at how social actors and an object to which they are both oriented were positioned in relation to the 'stance field' (Johnstone 2009).

Chindamo et al (2012) cite Biber and Finegan who write that *stance* refers to lexical and grammatical expressions of attitudes, feelings, judgements or commitments relating to the propositional aspects of a message. Chindamo et al (2012), mention a few different mechanisms used for personal expression, such as evaluation, evidentiality, hedging and stance. According to Chindamo et al (2012) literature on stance has also classified stance according to an epistemic and affective stance or between evidentiality/commitment. An epistemic stance deals with the degree of certainty or uncertainty about the topic of the conversation, while an affective stance is for example happiness expressed verbally or through body language as a reaction to a statement by an interlocutor. Although Kissane (2007) uses 'intellectual stance' instead of 'epistemic stance', she explains that verbs such as "know", "to think", "to believe", and "to suppose" can be used to express an epistemic stance. These different forms of

stance will be explored further through the practical analysis of multimodal artefacts used to communicate information by Discovery Health and GEMS.

In addition, the psychologist Klaus Scherer characterises stance by referring to interpersonal stances, which are spontaneously or strategically employed in an interaction with a person or group of people by exhibiting qualities such as politeness, coldness, warmth and supportiveness. These interpersonal stances are said to be triggered by events such as meeting a person, but they are less shaped by spontaneous actions than by disposition, interpersonal attitudes and strategic aims. For example, when an irritable person meets a person they dislike there is a higher probability of the irritable person to adopt an interpersonal stance of hostility in the interaction as opposed to an agreeable person (Chindamo et al 2012).

According to Hood (2010: 51) a "stance is the syndrome of resources of evaluation characteristic of a generalised set of texts, and evaluation is the encoding of interpersonal meanings in a given text." Hood (2010) also refers to an evaluative stance in ways that writers position their own work (research) in relation to other knowledge and other knowers. An evaluative style therefore is not regarded as the writer's fixed viewpoint that characterises the whole text, but rather as an ever-changing process of positioning throughout the text. Although the author is looking at evaluative stance in academic research, the analysis of this concept is relevant here as the author explores stance as something that can be constructed within text. The same approach is followed in this study where genres of artefacts are analysed to understand the construction of health information and how among others, stance is positioned in everyday published text by Discovery Health and GEMS.

Chindamo et al (2012) also mention Du Bois who sees a stance act as three dimensional, where a stance taker first evaluates an object, then positions a subject (usually the self) and thirdly aligns with other subjects. This makes a stance a public act by a social actor by evaluating a situation and aligning

the self, according to any salient factors of the sociocultural field. This also means that a stance is dependent on how the other social actors position themselves (Chindamo et al 2012).

A related notion to stance is found in the work of Goffman (1981). This author uses the idea of 'footing' to refer to role alignment between participants linked by spoken utterances, therefore a change in the footing means a change in the alignment. This change can impact the production, management and reception of the utterance. Footing as used by Goffman (1981) also implies a certain ideological positioning or stance in how messages are put together and shared with the intended audience. Agha (2005) also talks about the notion of footing in relation to interpersonal alignment, the author explains that these can be negotiated through technologies and that role alignment extends further than face-to-face conversational interaction. Goffman (1981) suggests that much larger phenomenon such as interpersonal stances, attitudes, forms of irony, parody, respect and formality can be observed in the same way.

These characteristics can also be observed in the comic book (*figure* 3 above), where speech bubbles show the flow of the conversation with the speech bubble positioned at the top as the conversation opener and the interactional relationship between the speakers also following this flow. *Anne* initiates the conversation when she expresses concerns about *Mama Khumalo's* personal situation regarding her daughter *Mbali* and their financial situation. *Anne* is shown to be leading the conversation, showing concern for *Mama Khumalo* and being able to assist if needed. The speech bubbles (language), design, alignment (sequence of speech bubbles) also symbolise/suggest the power dynamics between *Anne* and *Mama Khumalo*. What can be gleaned from the characters as well as race, *Anne* is white and *Mama Khumalo* black. This plays into racial stereotyping and how black people have been depicted as disadvantaged, in one way or another, in media. Agha (2005: 54) talks about role alignment in relation to a process of individuation of difference. According to the author this happens across two tiers: at the *tier of entextualized individuation* where we are engaged in similar semiotic evaluations; but are

socialised to different habits at the *tier of descriptive identification and characterization*. At the tier of *entextualized individuation*, we are concerned with metrical differences among entextualized figures or looking at contrasts, at the *tier of descriptive identification and characterization*, we are looking at ways to group or categorise these differences (Agha 2005). Thus, when we interact with others we are concerned with both tiers, though the latter (descriptive identification and characterization) is easier to perceive and to report on. For example, individuals may observe specific text fractions as conveying agreement or disagreement, sympathy or antagonism, or speak of interpersonal stance or observe that the second figure or voice seems more refined, elegant, prudent or wise than the first figure and classify these differences under psychosocial groups such as character, personality or even observe that the second figure is younger, or lower class or male rather than female and further group these under social-demographic rubrics such as social standing and social identity. The analysis of the genres of artefacts, and the comic book discussed above, in the thesis also occurs across these two tiers, where notable differences are observed in how Discovery Health and GEMS structure information, how semiotic spaces are crafted and how these differences can be characterised in relation to language, register, stance, style.

Johnstone (2009) notes how *stance-taking* moves links to repertoires called 'styles', that in turn is linked to scenarios and social identities. These 'styles' are repeatable but will not necessarily be applied in the same way in each situation. As social actors produce and analyse speech they can draw pre-produced generalisations about the stances that are associated with a particular style. When these styles are linked to particular contextual factors where social actors are confronted with rhetorical demands these are called 'registers'.

5.2.3. Register and enregisterment

According to Agha (2005) registers indicate typical social personalities such as the speaker is male, lower-class, doctor, lawyer and so on. Registers as alluded to in the section of style and identity, are also used in the comic book (*figure* 3 above), where we observe the overt differences between the two characters, one older black female and a middle aged white female. In this instance, the older black female, *Mama Khumalo*, is shown as less privileged than *Anne*, the white female, in need of financial support and perhaps counselling on how to manage her own affairs. Thus, there are really powerful registers that come through in the comic book that highlight the differences, roles, power dynamics and *intersubjectivty* between the two female characters. Register is grounded within a social context in the sense that some language users but not others are socialised in their use, which means every register exists within a social domain. This point is further illustrated by Gimenez (2000) through an analysis of e-mail business communication messages where style and register are juxtaposed, through an analysis of 63 business e-mail messages and contrasted with 40 business letters from the same company. The author demonstrates how electronically managed written text affects written communication, showing a move towards a more flexible register. Also, the fact that registers are inherently used by social persons and that they index social personae, show that registers are so called 'living social formations' and are changed to suit social actors and the context they operate in (Agha 2005).

Talking about a related concept of register, Agha (2005) mentions that register and voice are increasingly linked, for example individuals are said to have a repertoire of cultural registers and voices. However even though register and voice may overlap they are different, Agha (2005) explains that when Bakhtin (1982, 1984) speaks of voices he is referring to the ways in which utterances index

certain speaking personae, whereas registers are about social aspects of the speaker such as gender, class and profession.

5.3 Style in Multimodal artefacts

The first point of contact for potential citizen-consumers are various multimodal artefacts related to the application for membership, such as online application forms, SMSs, telephonic conversations to follow up on information provided and similar. Application forms like websites act as the first written textual interface between medical schemes and citizen-consumers. The construction of information on these forms would also reveal specific ways of communication relating to different styles, stances and registers.

I focus here on the English base text and investigate how medical schemes design their information in terms of register, as well as style and stance-taking. Ideally, versions in other languages would have been desirable. However, constraints of scope made this not feasible. A focus on the English text is motivated by the fact health information is generally translated from English to other languages.

For the scope of the thesis not all the collected material was included in the analysis. Given that the range of artefacts collected was extensive certain artefacts were only selected for the review, but I would contend that the selected material offers the widest range as these would be common texts that consumers are exposed to in this environment. These include texts such as application forms and the websites of Discovery Health and GEMS.

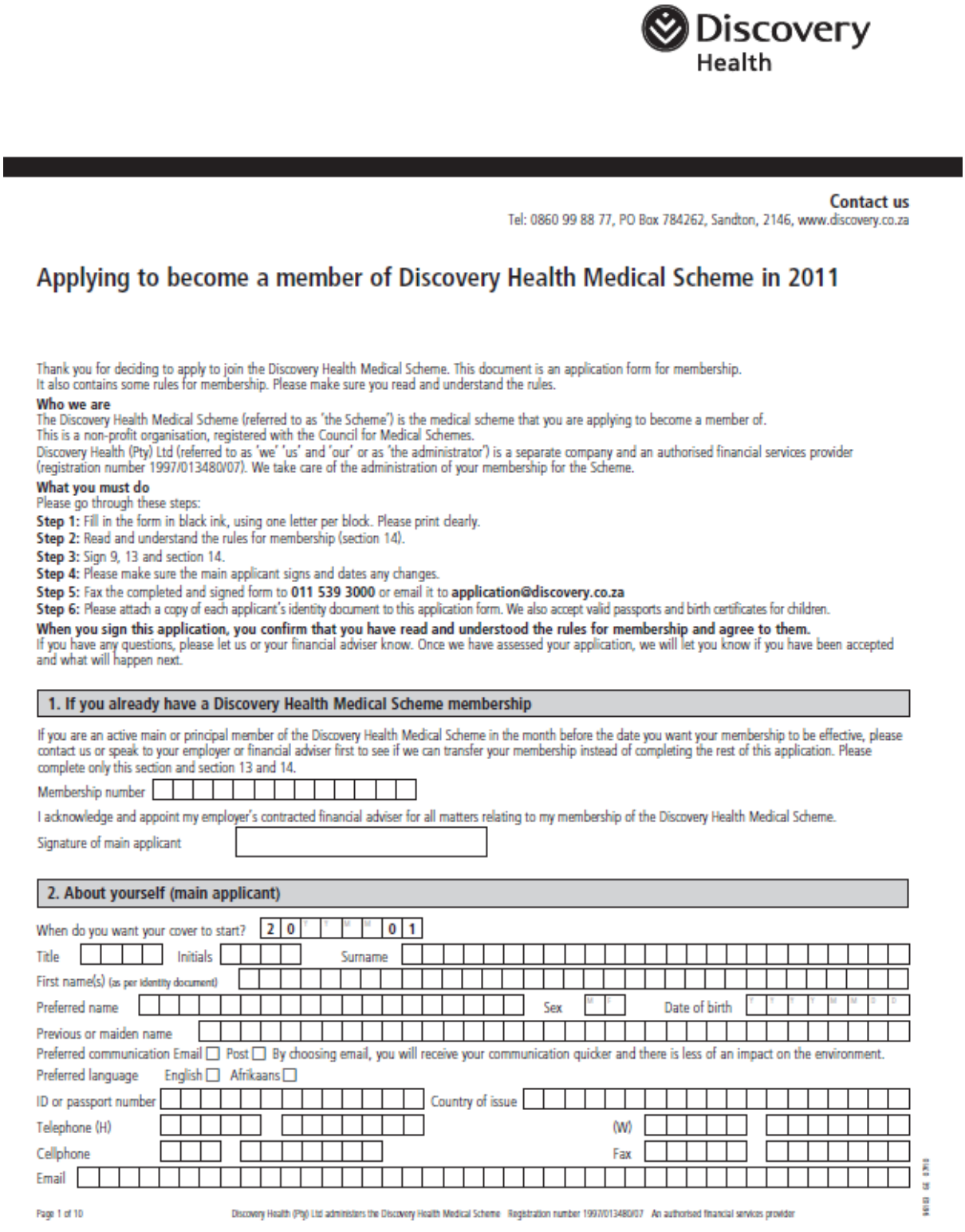
Two multimodal forms have been selected for analysis, namely an online application form and a comic book scene. The next section will provide an analysis of these multimodal artefacts.

5.3.1. Style and positioning

Becoming a member is partaking in a specific community of practice, and of course, of learning to engage in the style of interaction around health that is characterised by a focus on the body and particular ways of talking about this. As discussed in earlier chapters, current notions on health, specifically private health care, focus on personalised health, where people take ownership of their health status. Medical schemes and specifically in the case of Discovery Health, as the focus of the thesis, they are positioning themselves not as the 'fixer' of those with an illness, but as allays in helping people achieve health and wellness through acts of personal choice. The message is that in the case of Discovery Health, they would support the individual on their health journey. Therefore, joining Discovery Health is becoming part of this community of practice, where knowing your health risks, maintaining a healthy lifestyle are recognised, encouraged and incentivised. Although GEMS offers a less commercial package they are also concerned with decreasing and managing their risk pool, not wanting to have a large group of chronically ill members, this would be financially devastating, for any medical scheme. GEMS also has wellness days and promotes these events for their members to attend at Government departments. Then, the application process is not just about joining a medical scheme for the assurance it provides to cover medical costs, but it is also becoming part of a community. It also enables members to have access to health care in a far well-resourced sector. As the first interface between the medical schemes and citizen-consumers, I now focus on the specific linguistic aspects of language, register, style, and stance.

In 2010, I attended a workshop with some of the employees who work for Metropolitan Health. The workshop provided by the Language Centre at Stellenbosch University looked at the Consumer Protection Act (introduced in April 2011) and plain language writing. During this workshop, a range

of documents were examined, among these were application forms, which I have decided to provide a further analysis on.



Discovery Health

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Applying to become a member of Discovery Health Medical Scheme in 2011

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are
The Discovery Health Medical Scheme (referred to as 'the Scheme') is the medical scheme that you are applying to become a member of. This is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as 'we' 'us' and 'our' or as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

What you must do
Please go through these steps:
Step 1: Fill in the form in black ink, using one letter per block. Please print clearly.
Step 2: Read and understand the rules for membership (section 14).
Step 3: Sign 9, 13 and section 14.
Step 4: Please make sure the main applicant signs and dates any changes.
Step 5: Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**
Step 6: Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.
If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know if you have been accepted and what will happen next.

1. If you already have a Discovery Health Medical Scheme membership

If you are an active main or principal member of the Discovery Health Medical Scheme in the month before the date you want your membership to be effective, please contact us or speak to your employer or financial adviser first to see if we can transfer your membership instead of completing the rest of this application. Please complete only this section and section 13 and 14.

Membership number

I acknowledge and appoint my employer's contracted financial adviser for all matters relating to my membership of the Discovery Health Medical Scheme.

Signature of main applicant

2. About yourself (main applicant)

When do you want your cover to start? 2 0 Y Y M M 0 1

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Previous or maiden name

Preferred communication Email ☐ Post ☐ By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

Preferred language English ☐ Afrikaans ☐

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Fax

Email

Figure 4: Application form for membership with Discovery Health Medical Scheme

Although the application forms were available to me in hard copy as presented at the workshop, it was difficult to find the application form for Discovery Health. *Figure 4* above shows the first page of the application form by the medical scheme, with the "how to" section directly under "Applying to become a member" – the different sections then follow to capture all the administrative and health details of prospective members as outlined in the application form (see Appendix E for the full application form).[6] At the time the researcher collected the artefacts, the application form could not be accessed on their website,[7] under the "how to join" navigation button on the website, the following message was generated when I requested more information:

> *How to join Discovery Health Medical Scheme*
>
> *We market our Discovery Health plans through independent and accredited advisers. If you want a financial adviser to help you choose a health plan to suit the needs of your family, please send us your contact details and we will contact you.*

In the text above the message is automated which shows that Discovery Health has the systems in place to provide quick feedback to this type of correspondence. Recently, Discovery Health created a link called "Join Discovery Health Medical Scheme" that is displayed across their website. This then navigates the consumer to a page with all the different offerings by the medical scheme across health, credit card, life insurance, health and their Vitality programme, among others. As shown by *figure 5* below the website asks if the consumer would like a quote for medical aid. A response to this question then navigates the consumer to a page where they can enter their details to request a quote including the number of adults (21 years and older) and children they would like to cover under the medical aid,

[6] Page 3 of 10 was missing from the form downloaded off the Internet.
[7] In this study, the copy of the application was retrieved from an external website www.peterpyburn.co.za (see Appendix E for the application form).

as well as the main applicant's age, gender, their current employment status (working, not working, student, pensioner) and the suburb they live in. There is a sense of a buildup of a relationship in this virtual space, as the questions become more personal and intimate. The next page then allows the applicant to enter their name, surname, ID number, cell phone number and there is a button to get a quote. Capturing this sort of information is also typical of service providers when new clients are on-boarded, where personal information is captured, and often certain checks such as credit and other validations are conducted, to ensure that the new clients' risk profile is acceptable or meets their requirements. I refer to this form of pre-structuring later in this chapter, in how audiences/consumers are selected and how information is used to categorise people. This is also a simplified and task-oriented communication style, in that information is used to capture personal data and to generate a quotation for the client. The process to apply for membership was different when I initially looked through to see how to apply as an individual member in 2011 with Discovery Health.

Figure 5: Three website images that form part of the membership application process

Lancaster (2013) explains that choices in language reflect and are associated with what the participants want the language to do for them. In this example, the style applied is of a company that is well resourced that is ready to process inquiries and ease the application process. Using the three-dimension communication style model, in Miles et al (1990) the message shows an orientation towards being task oriented where consumers should follow a set path to join Discovery Health by filling in a couple of details to generate a quote. On the issue of transfer there are different modes that are used to communicate information. The website as the first interface starts the journey by directing the consumer to fill in information to generate a quote. As this process is purely administrative, telephone calls and emails would be the primary means of communication. The next phase would then open the communication lines between the service centre of Discovery Health and the consumer once their membership has been approved. The different modes of transfer, each with their own potentialities and nuance to communicate information, allow for different ways for sense making among citizen-consumers.

Thurlow and Mills (2007) refer to the concept of critical sense making within an organisational context, of processes where identities are maintained, altered and constrained during change. Critical sense making is a notion that emerged from Weick's (1979) sense making model, which Thurlow and Mills (2007) suggest should be understood in relation to the contextual factors of structure and discourse in which the process of sense making occurs. Thurlow and Yue (2014) also state that theorists have built on Weick's (1979) framework of sense making to develop an understanding that situates communication as the central pillar in structuring organisations. Although the focus areas may vary, the common thrust remains the centrality of language, speech, text and discourse for collective sense making in organisations.

As a result, critical sense making as a "framework for investigating the ways in which individuals construct their identities, sense making provides an opportunity to explore the process by which

changes to identity become plausible or are made meaningful," (Thurlow 2009: 247). Even so, I still maintain that critical sense making as mentioned by the authors is not just a necessary process for organisations during change management processes, but identities that are formed and reformed, when they interact with citizen-consumers.

The application form by Discovery Health has a short summary on what the document is for, how to complete it and where to send the document. Although it is a long form it is easy to navigate and more consistent in how different sections are separated, and in the use of text boxes where consumers fill in their information. The form appears long because of the medical questions, but these questions generally require a yes or no answer. As mentioned, there is a level of pre-screening as the consumer is required to list their pre-existing conditions. The consumer is also expected to be knowledgeable or have an idea of their health status. Generally, the information that is requested requires a whole battery of tests. In this instance Discovery Health shows that they are targeting a specific type of consumer, as a 'normal' consumer would not generally have all this information or be interested in doing several tests to just be considered for membership. There is a type of consumer here that is created, one who knows their health and is concerned with health issues. Although there is an argument to be made that not all the consumers that belong to Discovery Health necessarily obsess over their health, there is a sense that the medical scheme is about following a healthy life and how a healthy lifestyle is a critical part to a rewarding life. For example, 'happiness economists' according to Graham (2008), in her review of the interplay between health and happiness, have produced a substantial body of evidence that health is a consistent determinant of self-reported happiness.

Looking at the three-dimensional communication model referred to earlier (Miles et al 1990), both medical schemes follow a task-oriented communication style towards a desired outcome. We note that there is a specific goal, usually one of an administrative function to process applications quickly.

5.4 Language

If we look at the aspect of language choice, Discovery Health communicates through one universal language - English, while GEMS focuses on making information available in multiple languages. The form is also available in all 11 official languages of South Africa. This is a positive indication of the medical scheme's investment in ensuring multilingual access to information. The approach is different to that followed by Discovery Health. The inclusion of an application form means their prospective members have the document needed to start the process of membership.

Making the application form available in the 11 languages indicates a scheme that, although it targets an employer group, aims to represent the full spectrum of its consumers, specifically relating to their languages. This also indicates a medical scheme that is in touch with the national agenda where linguistic human rights are regarded as an important aspect of transferring information to the public.

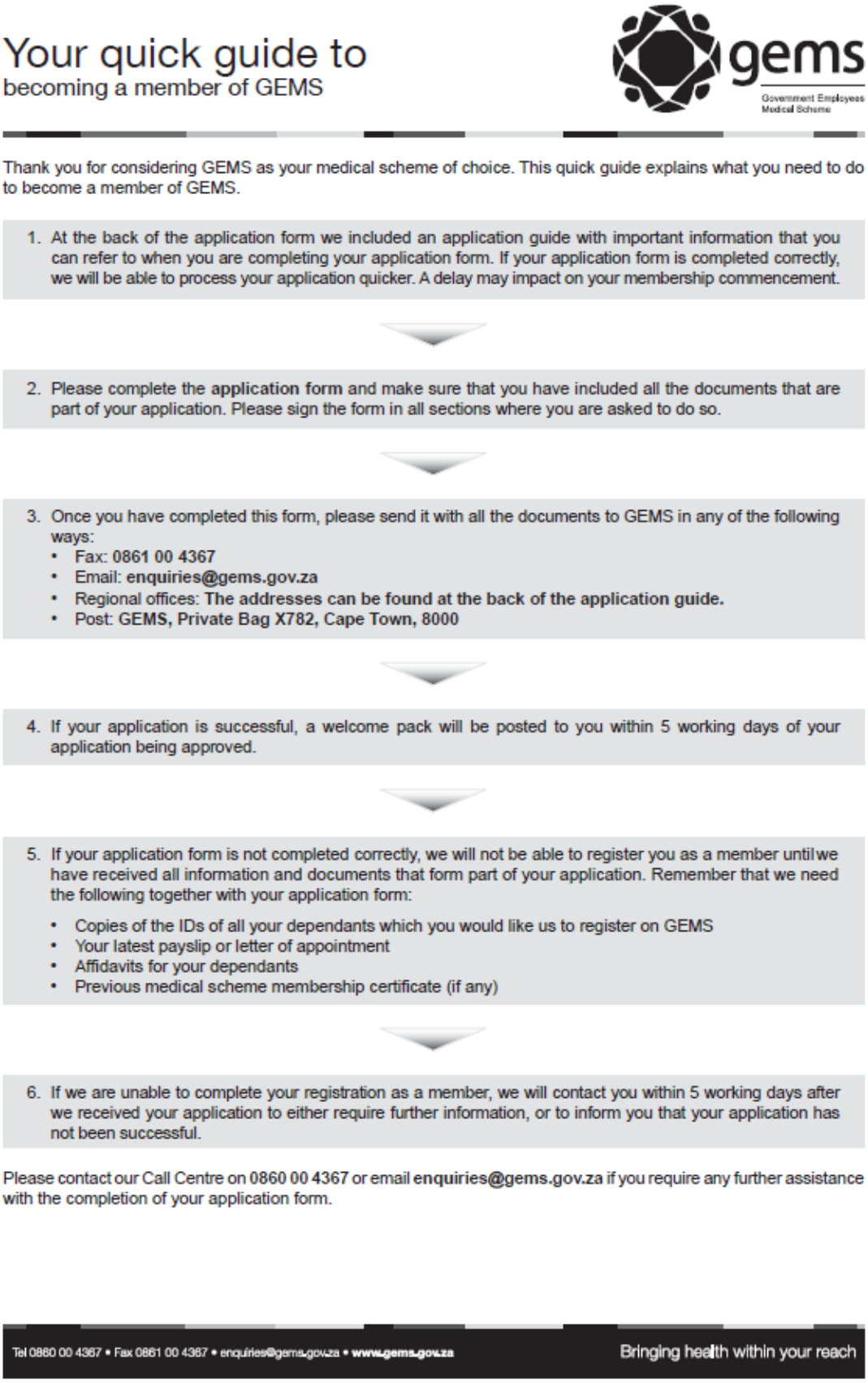
The provision of information in the 11 official languages of the country is a particularly interesting point. As a medical scheme created by the South African Government to provide access to health care cover for employees in the public service, GEMS demonstrates their relationship to the national fervor as a *proudly South African* institution, responding and aligned to the national context. This is further illustrated by the message repeated in their communication material that they cover *about 3% of the South African population*. This shows their approach to portray their scheme as concerned with the national interest, in touch with broader national health issues and a scheme so to speak that is *for the people* (regardless that the people are an employer group).

5.5 Enregistering: how is the citizen-consumer indexicalized

Becoming a member is not just about 'joining' and acquiring a mode of engagement/interaction and being engaged, it is also 'becoming' in a very tangible sense, that is, in allowing oneself to be formed and interpellated/indexed as a specific category or identity.

GEMS and Discovery do 'indexing membership' in slightly different ways. Although both make use of application guidelines, GEMS also enregisters their members through the comic book.

Unlike Discovery Health, GEMS has the application form under the "how to join" section on their web site, which provides prospective consumers with a quick guide to becoming a member. *Figure 6* below is the first page of the guide. The guide tells the consumer to read the application form carefully, complete it and send it through by fax, email, post or by hand at any of their regional offices. The idea of the guide is to ensure that as many forms as possible are filled in correctly to avoid delays and administrative issues. Going back to the three-pronged communication style outlined in the work by Miles et al (1990), GEMS is following both a task oriented and self-oriented communication style. The task-oriented aspect relates to measures to prevent possible backlogs caused by administrative errors, missing and wrong information, to get the process right from the start of the transaction. The process is also self-oriented as the goal is to avoid dealing with administrative errors should prospective members not fill in correct details. This also relates to the issue of how information is transferred and how the medical schemes are prepared to guide the citizen-consumers to navigate through various artefacts.



Your quick guide to
becoming a member of GEMS

gems
Government Employees Medical Scheme

Thank you for considering GEMS as your medical scheme of choice. This quick guide explains what you need to do to become a member of GEMS.

1. At the back of the application form we included an application guide with important information that you can refer to when you are completing your application form. If your application form is completed correctly, we will be able to process your application quicker. A delay may impact on your membership commencement.

2. Please complete the **application form** and make sure that you have included all the documents that are part of your application. Please sign the form in all sections where you are asked to do so.

3. Once you have completed this form, please send it with all the documents to GEMS in any of the following ways:
   - Fax: **0861 00 4367**
   - Email: **enquiries@gems.gov.za**
   - Regional offices: **The addresses can be found at the back of the application guide.**
   - Post: **GEMS, Private Bag X782, Cape Town, 8000**

4. If your application is successful, a welcome pack will be posted to you within 5 working days of your application being approved.

5. If your application form is not completed correctly, we will not be able to register you as a member until we have received all information and documents that form part of your application. Remember that we need the following together with your application form:
   - Copies of the IDs of all your dependants which you would like us to register on GEMS
   - Your latest payslip or letter of appointment
   - Affidavits for your dependants
   - Previous medical scheme membership certificate (if any)

6. If we are unable to complete your registration as a member, we will contact you within 5 working days after we received your application to either require further information, or to inform you that your application has not been successful.

Please contact our Call Centre on **0860 00 4367** or email **enquiries@gems.gov.za** if you require any further assistance with the completion of your application form.

Tel 0860 00 4367 • Fax 0861 00 4367 • enquiries@gems.gov.za • **www.gems.gov.za**

Bringing health within your reach

Figure 6: A quick guide to assist consumers to fill in the application form

According to their quick guide, GEMS will contact the prospective consumer five days upon receipt of the application. The application form requests several details such as the consumer's name, surname and contact details, details of the consumer's dependents if he or she wishes for them to receive access to health care provided by the medical scheme, the health plan they would like to opt for, and the consumer's preferred method of payment. The form also includes consents and declarations as well as terms and conditions that legitimize the transaction between the consumer and GEMS. Along with this application form is another six-page guide to completing the form (*figure 7* below is an extract from the form).

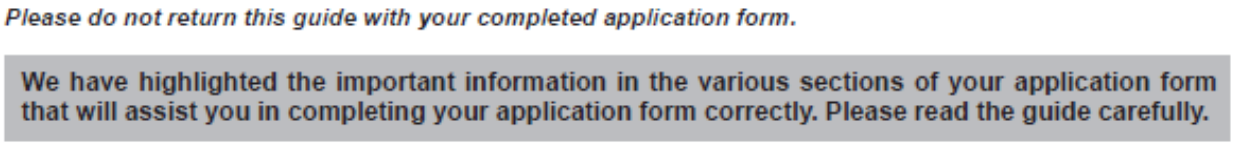


Figure 7 - Extract from the application form guide by GEMS

In contrast, Discovery Health has no separate guide for filling in the application form. The beginning of the form tells the consumer about Discovery Health under the section of "who we are", there is a how-to section that follows called "what you must do" and where to send the completed form, either via fax or email as shown in *figure 8* below. This application further requests the main applicant's details, the details of their spouse, dependents, the health plans they can choose from among a list of options, as well as information relating to the payment of monthly contributions (for membership), financial adviser's banking details, details of a previous medical scheme, and medical questions for the main applicant, their spouse and dependents. There is clearly a high level of detail that is required to apply for membership with Discovery Health. Consumers are prescreened and classified, and health information is constructed for the consumers according to these classifications. There is the chance that consumers might not provide accurate information at the beginning of the transaction however for

the management of chronic ailments the medical scheme will eventually have access to this information.

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Applying to become a member of Discovery Health Medical Scheme in 2011

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Please go through these steps:

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Step 6: Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.
If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know if you have been accepted and what will happen next.

Figure 8 - How to section on the application form by Discovery Health Medical Scheme

From looking at the two approaches, Discovery Health expects a degree of independence in how the consumers handle the form; there is no guide to assist in completing this form, there are no annexures for example, which might provide more information. It contains little detail on how to complete it, with only a short, two-line introductory section offering information about Discovery Health and a section called “what you must do” that provides only six steps to complete a 10-page form that includes five pages on medical questions. About half of the form is meant to profile the applicant with questions that include: The applicant’s height, weight, alcohol intake per week and smoking habits. This also includes medical diagnosis questions that ask if the applicants have any of the diseases, symptoms, conditions or disorders such as cancer, heart and other conditions that relate to circulation, gynecology, mental health, metabolism, brain and nerves, musculoskeletal, blood and other conditions.

The feature displayed by Discovery Health designed to capture all the health-related information to know of any pre-existing conditions can also be a task-oriented approach. However, it also aligns with the notion of pretext and post text structuring, where information is used to already classify individuals and the information provided determines how the individuals are treated and could therefore be a type of interaction orientation. This prescreening of applicants is to assess the risk that the medical scheme is taking on by accepting new members. For example, applicants are not required to disclose their HIV status if they are not comfortable, but they must call a number included on the form to inform Discovery Health within seven working days from the date the medical scheme activates the applicant's membership. There is a 12-month condition specific waiting period that could apply to being HIV-positive, which means that the applicant could become a member but not be able to access the benefits provided by the medical scheme for up to a year, where the medical scheme does not cover any costs for medical treatment for the duration of the waiting period.

Therefore, the application is used as a tool to profile applicants, and construct a particular social identity, the questions serve to enregister consumers. The pretext structuring has to do with the design of the information to gather information about applicants, whereas the post text structuring is about how the answers are dealt with depending on the pre-existing health conditions, where certain waiting periods can apply.

The application form by GEMS does not follow the same pretext structuring process. The form asks for personal details, details of dependents, bank account details, language preferences and permission to access information. The rest of the documents include a quick guide and various affidavits that are meant to assist with the application process. The application form also has a section on what the consumers must do, but this section is succinct. Noteworthy is that although the medical schemes operate in the same environment, they follow different ways in how they construct information and

the structure and transfer of such information shows how they wish this information to be consumed and who will consume it. Also, the style they apply in communication shows how they would construct information and transfer this to consumers. This also means the consumers will have different perceptions and attitudes towards the construction of this information, which is determined by how they experience this information across the different multimodal artefacts.

With Discovery Health, becoming a member means having to jump through several hoops. This process, as well as the pretext structuring, lends itself to attracting a certain type of consumer with the social status, certain degree of education, resources and level of aptitude to navigate this application chain and become part of what has the trappings of an exclusive membership club. This is also related to the notion of citizen construction as in what type of citizens do medical schemes such as Discovery Health construct? When it comes to what these different approaches communicate about their target consumers, Discovery Health clearly assumes that their audience is knowledgeable about health issues and in tune with their current state of health. As a consumer of Discovery Health, you should be concerned with health as more than a medical condition but a lifestyle issue. The consumer is assumed to be health conscious with a reasonable understanding of their current health status. GEMS follows a different approach where the form acts to capture personal information and the space for classification of consumers is limited to the health plans selected by the consumers.

Asking medical questions (in the application form) on illnesses such as cancer, heart conditions, mental health, and blood conditions allows Discovery Health to quantify the risk they are taking based on what conditions the applicant currently suffers from or has been diagnosed with. It also provides the opportunity to know what disease management (managed care) programmes the consumer could be recommended to join. It is noteworthy to see that Discovery Health at the beginning of the transaction is looking at ways to classify their audience and receive the data that can inform what information and

products should be targeted at these consumers. However, Discovery Health does not mention to the applicants why they need this information, it should not be left to the applicants to assume that the information will be used for the purposes mentioned above, the form should state for example in (i) that:

(i) *This section asks about your medical conditions, when you apply for membership you need to inform us of any pre-existing conditions. This information is used to help you manage and improve your health through our range of managed care programmes, and to see what waiting periods apply as part of your membership.*

5.6 Stance and style in written communication

According to DuBois (2007) stance is both a linguistic and a social act, the act of taking a stance encourages an evaluation at one level another, whether as a statement or suggestion, and the very act of taking a stance serves as the benchmark for the next speakers' stance.

Taking a stance is one of the most significant things that can be done with words, stance has the power to attach value to objects of interest, to position social actors in connection with those objects, and to arrange alignment between stance-takers (DuBois 2007). Stance comes from and has implications for social actors whose lives are impacted by the stance taken, thus a stance and stance-taking, connote a level of intersubjectivity, which the author describes as the relation between one social actor's subjectivity and another's.

The author explains that there are two forms of stance taking with evaluation as the most widely recognised and salient as analyzed in conversational analysis (DuBois 2007). Hunston and Thompson (2000) describe evaluation in relation to narratives, as the part of the narrative that reveals the attitude

of the narrator towards the narrative, this is done by emphasizing the relative importance of some narrative units in contrast to others. Munday (2012) mentions Lemke (1992) who discusses evaluation in texts by emphasizing the 'value orientation' of a text, which positions the receiver according to the values of the sender/writer. Lemke (1992), in Munday (2012) further explains that 'value orientation' can be viewed along the following axis: value of goodness (desirability, morality, appropriateness, efficiency), mood and modality (certainty, truth). The information from the medical schemes and what sort of stance is taken could also be viewed according to these parameters. The 'value of goodness' can be applied on what information is packaged and to whom it is targeted, and the mood would be the feelings the information should evoke and/or the actions it should encourage from the citizen-consumers, and the modality would be how this information is shared.

All these different concepts present a solid platform to effectively evaluate stance in the various artefacts that are presented in this study. To also formulate an understanding of who has access to the health information provided and how this information is structured.

Johnstone (2009) explains that the attitude towards certain matters or attributes may index social relations and aspects that show stance-taking as both relating to knowledge and interactional aspects of perspective-taking in discourse. The comic book (*figure* 3 above) is a good example that shows how stance-taking and enregisterment semiotically communicates meaning. By looking first at the use of content, *Mama Khumalo* is illustrated as the actor that has the problem, *Anne* is the actor who is concerned with the wellbeing of *Mbali (Mama Khumalo's daughter)* and *Mama Khumalo*, as well as their financial situation as shown by the third bubble "Are you sure you don't need help with anything, especially the doctor's bills?". Also, *Anne* is positioned as the concerned actor of *Mama Khumalo's* plight, she is confident in her ability to care, provide support and solutions, there is almost a parenting element to their interaction, *Anne* caring for *Mama Khumalo* and her financial wellbeing.

A particularly relevant analysis of this genre of communication is about social stereotyping and difference as a resource in communication. Young (1997) for example is concerned with how difference is used as a mechanism for democratic communication. The comic strip presents a mix of identities, social classifications, cultural and linguistic characteristics. There are intentional and non-intentional attributes assigned to both *Mama Khumalo* and *Anne* that rely on linguistic, racial and cultural arrangements.

Even on websites, the overt differences in how information is packaged stylistically give rise to different stance options. Discovery Health tends to use a personal style of writing, whereas GEMS leans more towards an impersonal style. By looking for example at the application form (see Appendix E) by GEMS on page 4 of 11 under Section I and J, the form states in (i), (ii) and (iii) below:

(i) We are busy updating our database to ensure that we can communicate with you in the language of your choice.

Then there are various language options provided for the applicant to choose from and there are two sentences that follow directly after this that state:

(ii) Please note that if you do not choose any language, your language preference will be registered as English.

(iii) Please note that the choices you have made will come into effect during the course of 2014.

In (i) above GEMS is informing the applicant that they are busy with a process that would make their communication accessible to their members. This is followed by what sounds like disclaimers but this is soft landed with words such as “please note”, which is used twice and at the beginning of the sentence, the message being conveyed is make your choice but if you do not, the default language of communication with you will be in English and whatever choice you have made this will apply from

2014 onwards. The style is official, professional and direct (cf., for example, the phrase “come into effect during the course”) but ‘softened’ by using words such as “please”.

This is also evident in J as follows in (i):

(i) Based on your contact details provided, please indicate your preferred method of receiving written communication for the following communication items. Please choose only one method of delivery for each item based on the contact details you supplied us with in Section A.

The words I have underlined above also resonate with a certain style that is more official than conversational. Collocations such as “details provided” “written communication” and “communication items” all fit within this framework of an official, professional and business-like style and stance of the text in Section J. This is a style and stance that is carried across the entire form, showing how GEMS chooses to position their company when they communicate.

Discovery Health is more conversational in their style of writing as shown in (i) and (ii) below:

(i) Thank you for deciding to apply to join Discovery Health Medical Scheme. This document is an application form for membership. It also contains some rules for membership. Please make sure you read and understand the rules.

(ii) When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.

The sentence in (i) above shows a distinctive style, where Discovery Health explains what the document is about and what it includes. Even in (ii) in what sounds like a disclaimer the tone is still conversational. When someone shifts in speaking or writing into a different style or register it is significant to look beyond the literal meaning of what they are saying.

Also, people can distinguish themselves from others in the way they speak, use language and how they write, all of which can reveal aspects about the self and the personality. This is not different to how the self and personalities impact on organisational communication, as communication would still be between social actors who represent these various organisations. Still organisational voice shapes how these individuals communicate, what they say, how they say it and what means they use to communicate to the external environment. This impacts communicative styles, registers and stance-taking. As language and communication happens in a social context the social actors who operate in this environment, could carry the same mannerisms, behaviours and styles created by their environment. Blommaert and Rampton (2011) explain that a style or code carries associations that are relevant to specific activities and social relations, which can serve the common interest, acting as a powerful instrument of persuasion in every day communicative practice for people who share the same values that have been indexed.

These two different stances and styles also affect how information is transferred. A stance and style that fits with the postmodern take of healthy living is followed by Discovery Health, whereas GEMS follows a more official and impersonal stance that is more traditional, by looking at health and disease, where the medical scheme has to provide access to health care to ill citizen-consumers. Discovery Health is looking beyond that to how to sell health as a way of being, as an everyday activity, something that should stick to the consciousness of citizen-consumers, and that will offer rewards for healthy lifestyles rather than cures for ailments.

5.7 Summary

This chapter has focused on two different artefacts that were collected and how style, stance and register structure access, determine the social category of membership and what these notions convey about the medical schemes. Attention was paid to how information is designed and structured across

the different artefacts. I first focused on the issue of access in how the application forms are made available to consumers through websites. Access is important as it shows what is in place to enable consumers to travel through various artefacts, understand what has been communicated, what is required of them and how to use the information. It also indicates how information is constructed and the type of audience (consumer) who can consume this information. This is linked to the issue of *transfer*, that is, how information is put together and where it is made available, how they put it here and not there, and how those choices enable or prevent certain consumers to use this information.

Dealing with the issue of transference and how information is constructed in the comic book and specifically this scene, the comic book is made available as a printed copy aimed at a specific group of target consumers. The issue of access should be considered here in the age of new technologies and social media platforms, printed material should be complemented with readily available digital content for consumers to access this information via websites and other mobile communication devices.

Different communication styles, be they self-oriented or task oriented, show what the medical schemes have decided to prioritise, whether it is fast tracking an administrative process, saving time, money and resources. The style of communication cannot be taken upon face value. There is more on how an application form and comic books are written, designed and how these modes shift from production to goods that can be consumed. Different ways, in which the text is written, visually put together and the transference processes and modes for access all impact the uptake of information by the citizen-consumers.

The artefacts I discussed here were the application form as the first point of interaction with the consumer and a comic book specifically created to communicate to an audience group by GEMS. The two artefacts showed the different affordances made available by these different communicative modes and styles and how information is constructed and transferred across two different modes of

communication in the health insurance industry. The next chapter will offer a further analysis of the websites by the medical schemes, thereby providing a more comprehensive analysis of further artefacts that were collected during the research phase of the study.

In the following Chapter, I will explore how the construction of information allows for different paths to navigate information, what the different paths encourage in terms of consumption, who has access to this information, where they access it and how they access it. These factors impact on what one can do with it. Most importantly it also indicates what Discovery Health and GEMS wanted to achieve through the communication process, through different artefacts and where this information is made available.

Chapter 6: Semiotic habitats of the health citizen

6.1 Overview

In the previous chapter, I discussed how applicants are constituted differently by the two medical schemes by looking at the style, stance and enregisterment in application forms from Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS), and a comic book strip targeted at government employees on salary levels 1-5, who are members of GEMS. I sought to find out how citizen-consumers are constructed across the different artefacts and how these modes are structured in terms of the stances they create, the general style and register of language, and the implications for the type of access citizen-consumers have to the information provided. In this chapter, I will focus on how information is multimodally structured and the type of citizen-consumer that is able to access this space. I also addressed how the consumers were sluiced to navigate through information, and the nature of the readership that is constructed through textual information design.

In this chapter, I look specifically at the websites by the medical schemes, to show how information is structured here and the design of this virtual semiotic world by Discovery Health and GEMS. Further what the implications may be for consumer agency in how the health artefacts are designed, the nature of their ecologies and use, and the 'reading' trajectories they encourage across their readerships.

According to Androutsopoulos (2013) over the last 20 years, computer-mediated communication (CMC) in linguistics has explored language online from different aspects, particularly in relation to variation, style in digital written language, innovation and change, language and social identities, multilingualism and code switching, and the relation of language, digital media, and globalisation. I explore aspects of style in digital written language across different genres of media specifically website

images and content. However, language focused CMC shows various trends and challenges in online data collection:

- while many linguists are concerned with written language data, CMC is still confronted with the marginal status of written language in sociolinguistics,
- written language online has close relations with other semiotic modes including typography, static and moving images, screen layout that all increases the impact of multimodality on meaning making,
- categories such as ‘message’ and ‘post’ have to be considered in online discourse,
- information on participants and their social relations is limited
- digital language can be exceptionally heterogeneous specifically if researchers do not focus on data from a single mode but sample across a range of digital modes
- digital data is available in large amounts, which makes it difficult to select and focus on a specific data sample or site of discourse.

(Androutsopoulos 2013)

For the purposes of this research and to avoid the methodological issues highlighted above, the thesis has focused on specific artefacts used in CMC by the medical schemes for health communication. Also, the focus on specifically written text and website images streamlines the analysis to better understand how information is constructed, what notions of health are promoted through different designs, text, styles and registers.

In the age of modern technology websites have become one of the primary modes to communicate to a broad audience across multiple frontiers (regions, nationalities, identities and so on) – an analysis of the websites by Discovery Health and GEMS promise to offer a good understanding of how they

design information, how this information is transferred in terms of where it is placed and who has access to it and how the uptake of this information is linked to notions of health citizenship.

This chapter provides a multimodal analysis of the website by Discovery Health and GEMS. Basing the approach on Michael Halliday's (1994) tri-functional conceptualisation of meaning as shown in Kress and van Leeuwen (2006) as a framework, this chapter will demonstrate how information is constructed and transferred across websites and what notions of health and healthy lifestyles are promoted by Discovery Health and GEMS. In what follows, I offer a brief discussion of Halliday's tri-functional metafunctions that will be used along with other models of analysis to explore how and why particular information is designed in a certain way for health promotion and health citizenship by the medical schemes.

6.2 Michael Halliday's metafunctions

According to Kress and van Leeuwen (2006), Halliday (1994) talks about three metafunctions for language, which are *ideational, interpersonal, and textual*. According to Iedema (2003) Halliday's work provided analytical methods for analysing the socially meaningful role of texts. The *ideational metafunction* is about how semiotic modes represent aspects of the world as they are experienced. These semiotic modes provide various ways in which objects and their relation to other objects and processes are represented, for example two objects could be represented as involved in an interaction that could be visually shown through vectors as shown in *figure 9* below with a linear representation showing the relationship between object A and object B:

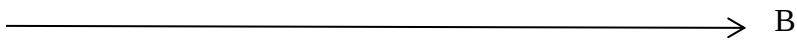


Figure 9 – The relation between vectors

However, objects can also be linked through other means, for example through categorisation. In this instance they would not be represented by a vector but by a 'tree structure' as shown in *figure 10* below.

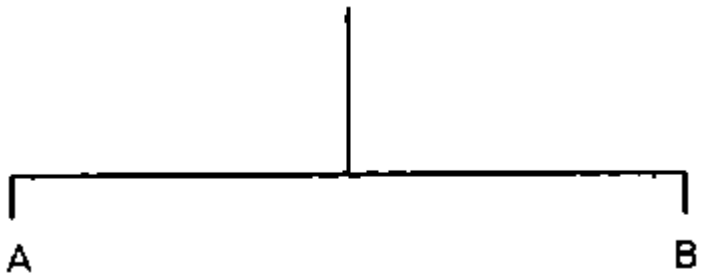


Figure 10 - The relation between vectors in a tree structure

(Kress and van Leeuwen 2006)

There is also the *interpersonal metafunction* that refers to how a semiotic mode should represent the social relation between the producer of the message and the receiver of this message. Kress and van Leeuwen (2006) explain further that any mode should be able to show the social relation between the producer of the message, the receiver and the object that is being represented. The third function is the *textual metafunction*, which explains how semiotic modes should be able to create texts and how the relation of various modes encourages different textual meanings. For example, when the layout of a mode is altered such as in a layout where the text is on the left and the picture on the right - and when this layout changes - the image instead of the written text becomes the 'anchor' of the message.

Vectors are used to show the interaction between two or more objects where the directionality of the vector shows the relationship between the participants. Kress and van Leeuwen (2006) expanded on

this notion of vectors by introducing what they call ‘Actors’. The Actor would be the participant from which the vector emanates, or would be in whole or in part, the vector. For example, when looking at images, the actors would be the most prominent participant through size, place, contrast against the background, the use of colour, sharpness of focus, and through the psychological power that certain participants, for example the human figure or even human face, have for the target audience (Kress and van Leeuwen 2006).

What is important to note here is the impact and interaction between the different aspects that include subtle techniques in the use of language, colour, and styles in visual design to construct meaning. Lemke (2002:299) notes how semiotic products can play both an active role for further meaning making or a more contemplative passive role. O’Halloran (2008) however mentions that studies of visual processing by Ivry and Robertson (1998) have shown that the observation of the image seems to take precedence over perception of the parts. As a result, the aspects of visual design such as image size, the ratio of images in relation to each other, as well as the density of the whole parts should be considered as part of a larger whole (O’Halloran 2008). Kress and van Leeuwen (2006) explain this further that in a situation where the design contains one participant, the participant is usually the Actor; therefore, the action would be a non-transactional process as there is no goal and the process is not aimed at anyone or anything. However, when the design shows two participants, one would be the Actor, the other, the Goal - the Actor would be the participant that instigates the movement – while the Goal is the participant to which the vector is aimed, therefore it is the Goal to whom the action is done or at whom or which the action is directed.

There are other taxonomies drawn by Kress and van Leeuwen (2006) that show the interaction and classification of different Actors. They explain that some participants will play the role of Subordinates in relation to one participant, the Superordinate. The Subordinates would be placed at equal distance to each other, assigned the same size and orientation towards horizontal and vertical axes, while the

Superordinate is placed above or below the Subordinates and although the participants may be realised verbally, visually or even both ways, the process is always visual.

There are other ways relating to the reading of images that would be relevant to this study. This includes what visuals are placed in the background, what the authors call the 'minor process' that is often embedded in the major process. The opposite is where the image is placed in the foreground to make it more salient, through exaggerated size, being well lit (colour saturation), or represented in particularly fine detail or through sharp focus, or through their obvious colour or tone (Kress and van Leeuwen 2006). Lemke (2002), echoing Halliday notes that both text and image make meaning 'presentationally', 'orientationally' and 'organizationally'. *Presentational meanings* are those that show the state of affairs, while *orientational meanings* indicate what is happening at the communicative relationship level and the relation of participants to each other and the presentational situation. While *organisational meanings* are usually instrumental and kept in the background, they give different kinds of meanings the ability to achieve greater degrees of complexity and as a result their role could be more structural by linking textual and visual units. I will now use these main concepts from the tri-functional models to analyze the websites by Discovery Health and GEMS, while also making some reference to other concepts such as "backgrounding", "Superordinates" and "Subordinates". Through this process, I will show how text and images are used on websites to construct and communicate meaning to citizen-consumers, and in instances, to encourage some agentive participation with the communicative messages provided.

6.3 Website pages

The Internet through various websites is an important tool used by Discovery Health and GEMS to communicate with citizen-consumers. I first present commentary from the online questionnaire,

completed by the 80 participants, on how health information is structured on the websites and follow with a deeper analysis of specific website designs by the medical schemes.

6.3.1. Websites as multimodal artefacts in health communication

To evaluate how information is distributed through multimodal artefacts the participants were asked what mode they used to receive health-related information from the medical schemes. The data shows that most of the participants (65%) received information from websites, while others received information from brochures and call centres (28%), which indicates the relevance of websites for informing health communication strategies by the medical schemes, as well as how websites are the most relevant resource for the medical schemes to package information that can be used for health promotion and to encourage consumption of the products they offer.

Participant 6 from GEMS also mentions that "sometimes it is hard to read hardcopies so when you get it from the website it's quicker". Websites are an effective mode to deliver information in real time and the medical schemes would be concerned with keeping the information on their websites current and marketable to their consumers. Participant 46 agrees and says, "I check the information that I need at the time, and it is the latest (relevant)." Also, if one considers that GEMS sends out only quarterly newsletter to the consumers, which are posted, their website offer a far more quicker and ready source of information for the consumers. Regardless participant 8 from one of the other medical schemes argues that:

> "Different resources provide different information. Sometime brochures & newsletters provide info that is useful which one might not really have looked for otherwise. It might be useful to have email & sms alerts like some other schemes provide. Websites & callcentres take a lot of time. One does not always have access to the internet."

According to this participant besides the improvements that medical schemes could make, websites are not always the most appropriate mode to receive information as the participant mentions that they "take a lot of time" and that "one does not always have access to the internet". If this comment is considered from the perspective of the participant in a time of fast internet access and mobile devices with wireless Internet connectivity, it can be taken for granted that consumers from time to time could be in areas where there is limited or no access to the technology that enables access to information through the Internet. In addition, in resource constrained settings where infrastructure to mobile and internet technology is minimal, accessing websites and call centres could be a time consuming and frustrating exercise.

Other participants were satisfied with how information is provided on websites such as participant 12 from Discovery Health who mentions that although the participant is least satisfied "with the jargon/codes used in medical scheme statements" and understanding what Discovery Health pays for and does not pay for, the participant was mostly satisfied with how the medical scheme's website offered "additional general health information linked to the Vitality option." Yet participant 13 also from Discovery Health disagrees that "sometimes information given on the website is contradictory - result of partial updating..." While participant 17 from other medical schemes also believes that websites offer the best option for receiving information as the participant says he or she can find "information on a website in my own time - not being restricted to call centre hours, or waiting for monthly newsletters via post or e-mail." This shows that the transfer of information and how the information and meaning travels and what is understood and how meaning-making occurs is experienced differently by different participants. Some participants believe that websites offer convenience and are a good source of health information, but how they experience the information depends on the design of the information and how they can enter the information as active agents, and health consumers.

Whereas participant 8 does not find accessing information from websites or even call centres efficient and user-friendly, participant 12 and participant 17 find websites to be the easiest and best option for receiving information. Obviously how the medical schemes decide to communicate certain information to the consumers impacts how they will consume this information and when they can consume it. Still how the information is designed through websites and other artefacts creates various forms of health literacy. For example, participant 24 consumes information across different artefacts for different reasons as expressed through the following statement:

> "The call centre is most reliable when i need answers immediately, but for information to familiarise myself about certain issues the website and member guides are more user friendly because they explain in details"

An observation of the content above indicates that participant 24 considers quick feedback as a sign of reliability, but for deeper issues associated with health care, the participant relies more on websites and consumer information guides provided by the medical scheme. There are different forms of health literacy expressed here and different levels of engagement. The participant would seek support from the call centre she/he would speak to a service consultant, where there is an interpersonal interaction with a voice and person, to provide reliable feedback. The second level of interaction with the computer and guide is more a personal search where the participant as an agent seeks detailed answers to questions in what the participant contends is the most user-friendly manner. Ultimately the participant is also saying that although the call centre does offer fast feedback and that the voice and person involved in the exchange is reliable, the call centre for one or more reasons is not user friendly.

Participant 27 mentions that the information that is made available through the different artefacts including websites is general and the participant would have to consider following-up through other means to receive the information that they need as the participants states below:

> "Any website, pamphlet or information documents gives general responses. One may have to go another route for specific information about a specific illness, procedure or treatment."

Participant 61 supports the views of participant 27 and mentions that "sometimes website does not explain fully. But you get what you looking for 24\7" Offering a different view, participant 30 argues that although the information is easily accessible and can be accessed at any time, the disadvantage is that "some websites are dysfunctional and not user friendly." Participant 44 agrees and says that he or she is "[most] satisfied with disease management and healthy alerts from the newsletters. Least satisfied with less of ease in navigating through different menus on the website." Participant 45 also supports this opinion by participant 44 that navigating through the website can be complex as finding the information that you need can be impossible. The participant in fact argues that Discovery Health only designs information in such a way that "makes them look good" as shown below:

> "Disadvantage - when you want to relook the info, you have to remember where you found it in the first place! Far easier to have everything stored in one place. I know if I want info and it's not available on the website, then that is bad news that [Discovery Health Medical Scheme] don't want me to know, like increased fees or exclusions in my cover!! They only post the stuff that makes them look good. Try leaving their Vitality Programme - almost IMPOSSIBLE!!"

Some participants such as participant 65 do not see the medical schemes' newsletters and websites as offering any useful health-related information for their needs. The participant states that the "newsletter is far too busy with all sorts of medical terms and meaningless to the average 'Joe' in the street, even though I work at the company, doesn't make me a Doctor or a nurse!" Participant 65 further continues to mention that he or she often goes to the Health24 website to seek health-related information.

The trend in the data about websites and the other artefacts in general point to the need to make them more accessible and 'user friendly'. Participants have indicated that navigating through information can be difficult, that information is not as detailed as it should be, and they would search elsewhere for more information. Evidently websites, newsletters, call centres and other artefacts offer different levels of engagement with health information as mentioned by the participants, but the transfer, design, style and register contained in the artefacts have an impact on the uptake of information. Still better designed websites and newsletters would make the information they receive more useful. As shown by the data 78% of participants either agree or strongly agree that newsletters and websites should be better designed to make the information they receive through the different multimodal artefacts from Discovery Health or GEMS, and other medical schemes, more user-friendly (see Appendix C question 4 in the summary of the data).

In what follows, I first present an analysis of the home page (also known as the landing page) followed by an analysis of the section of the site that holds health-related information. I conclude with a general assessment of the overall design of the websites. The home page of most web sites would be the first online interface between the consumers and the medical schemes. It also offers the first information about the medical schemes consumed through the Internet. Also looking at the different information housed under the health section was significant to explore how this section is constructed and what notions of health are promoted to influence the consumers' health knowledge and health subjectivity.

6.3.2 Medical schemes' home page

Contemporary website design preferentially uses large imagery called sliders that rotate between two or more images on a web page. These are called website slider images, which are images that are used at the top of a website, they are usually exaggerated in size in relation to the rest of the images and content on the website. The sliders generally rotate to show different images and to communicate

different messages on the website. *Figure 11* (below) is one of the four slider pictures used on the home page of the website by Discovery Health. The slider is much larger than all the launch pads (banners) underneath it, as well as larger than the overall content on this page.

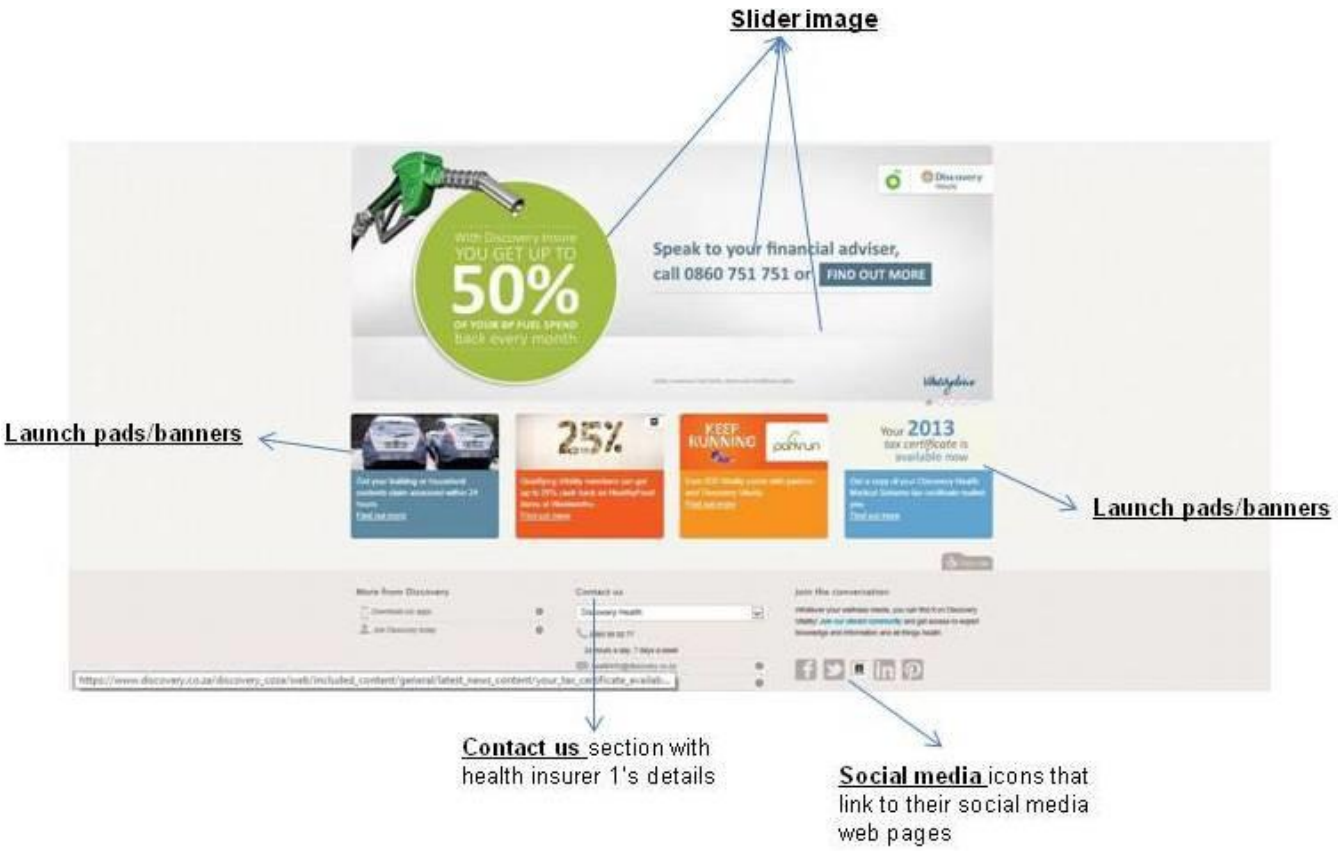


Figure 11 - Home page with slider image and banners

Looking at the model of analysis presented by Kress and van Leeuwen (2006), the *ideational metafunction* is shown through the hierarchy/structure of information where the slider is the most prominent in terms of position and size. The slider is at the top of the page just under the navigation buttons and the launch pads/banners at the bottom are presented as secondary content, while the contact information and various social media icons are contained in the footer of the web page. The content is also much larger on this slider than anywhere else on this page, which makes this the most important

piece of information for the audience to consume at this point. The style followed shows a clear grading of information and the design conveys the message that the content contained on the slider is the most current and important. This is in keeping with current best practice in most website style design where the home (landing) page holds the latest information and users are navigated to other parts of the website for more information. The top structure of the website holds the information that a user would consume first when they visit these websites before they scroll to view the rest of the content.

As mentioned, the *ideational metafunction* refers to how objects can be represented through vectors. There are clear vectors indicating the relationship between the imagery (pictures, illustrations) with the content (product/service descriptions). Throughout the web page the imagery is above the content. For example, on the slider (*figures* 11 above and 12 below) the fuel dispensing pump is above the circular textbox and the relation between the two is created by interloping both objects. Also, the launch pads (banners) use either pictures or illustrations with the textual descriptions underneath and the relationship between the two is created by enclosing the imagery/illustration and the descriptors into colourful boxes. The design style applies multimodal resources and multiple images for meaning making through digital media. There are clearly several layers to how meaning making occurs in *figure 11* and *figure 12*, where the colour, information hierarchy and interloping images is a style utilised to construct a single imagery through these different modes and how messages are backgrounded or elucidated to allow for a particular style of information consumption. This reverts to the point of how the medical schemes construct their readership through the construction of multimodal information in different styles, registers and modes, which allow for audiences with different health literacies to interpret this information and use it for their health concerns.

The website is very structured with information contained in the slider and within the boxes of the four banners at the bottom with the rest of the secondary information, such as contact details and the social

media links, included at the bottom. This is an uncomplicated yet well-structured design, which is followed throughout the entire website with the same template. The design suggests that Discovery Health has spent a great deal of attention in putting things into place, to bring across to the consumer a certain identity, message and alignment with the brand of the organisation and its relationship to its constituency. This would fit with the concept of 'stance', being about positioning, but also comprising an assertion of brand identity and voice.

Another point also relating to stance is that Discovery Health already wants to know what pre-existing conditions the consumer has. They also encourage membership on their Vitality programme focused on health and lifestyle management. The whole approach shows a tendency to want to control the situation, to shift and influence the behaviour of their constituency, and for the medical scheme to play a significant role in managing the health of the consumers. They do this while promoting modern notions about health as something the consumers can manage and control, as architects of their own bodies and health.

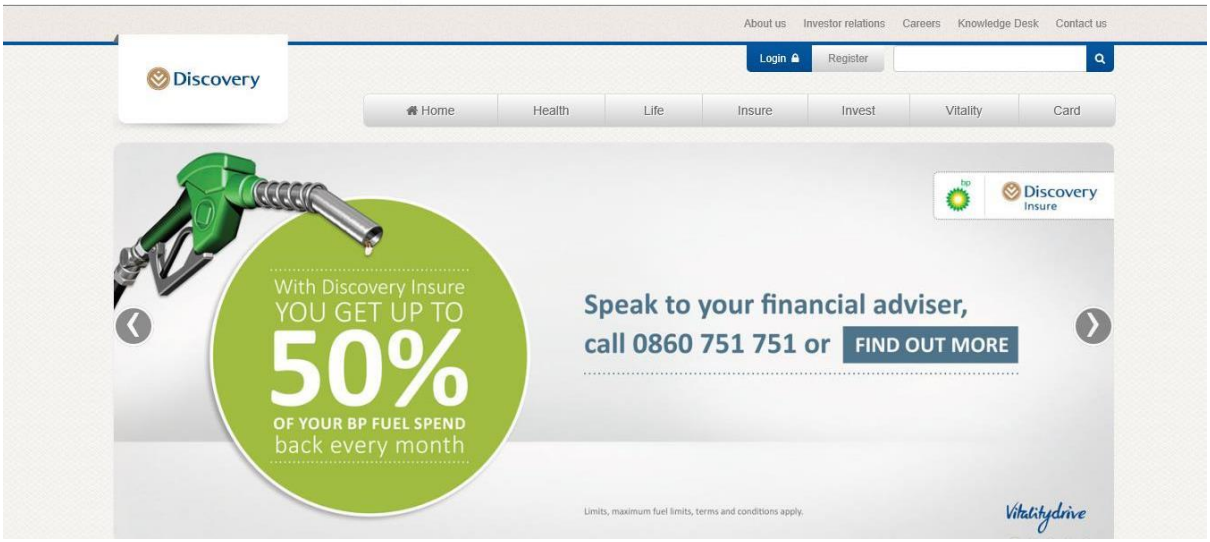


Figure 12 - Slider image on the home page

The use of a petrol dispending pump in *figure 12* above is an interesting means of visual communication and reader positioning. Although in South Africa car ownership is still heavily skewed along racial lines – only 19% of black households owned cars, compared to 91% of white households (Statistics South Africa, 2012), the primary recipients of these images are the consumers who are members of Discovery Health, these members of different races would generally be middle to upper middle class or even high net worth individuals, and there is also a growing black middle and upper class in South Africa. Even though it is interesting given the vast difference in car ownership and what this means to semiotically foreground a petrol pump, and could be a subtle semiotic choice where white middle-class is foregrounded, what is particularly relevant here is class distinction and consumption. A model that fits into the area of class as distinction and consumption patterns is that by Pierre Bourdieu (1979, 1984) who has discussed at length the linkages between prestige, taste and social class.

Bourdieu's (1984) work on taste and social class emerged from his survey looking at the different styles of food among the French social classes. He found a social hierarchy of consumers that was a result of their home background and formal education, and could link taste to consumption, and in turn, to social class. (cf. also Allen and Anderson, 1994: 70). In this instance taste is a social weapon that marks off the high from the low, the sacred from the profane, and the 'legitimate' from the 'illegitimate' in matters ranging from food and drink, cosmetics, and newspapers; on the one hand, to art, music, and literature on the other (Bourdieu 1984)

The Bourdiuean social dynamics that influences what consumers buy into based on the choices they make with respect to their self-image and how they fit into widely accepted notions of self is also supported by how social status is symbolically packaged in society at large. Therefore, images such as

these were a petrol pump is used as a marketing tool classifies its consumers, and subtle notions of middle classness, purchasing power, and even race come into play.

Christiansen (2018) extends on the Bourdiuean social dynamics theory by specifically looking at language and symbolic power. It has been highlighted before that although language, as in the use of different languages, was not identified as problematic per se in the study, the points made by the author are important here for a linguistic study. Christiansen (2018) ascertains that the value of a language variety is dependent on its cultural capital or linguistic capital assigned by the social actors. The author further refers to Bourdieu (1991:18) who concludes that the more linguistic power people have, "the more they are able to exploit the system of difference to their advantage and thereby secure a profit of distinction" (Christiansen 2018: 440). Ideologies of language and language choice are not about language alone but are tied to questions of identity and power (ibid). How the medical schemes brand themselves, the language choices they make, is bound by language ideologies, where certain languages have far greater cultural capital than others.

Back to the framework used for the analysis in this chapter, the *interpersonal metafunction* can be demonstrated by looking at *figure 12* above. The text in the circular textbox says: "With Discovery Insure you get up to 50% of your BP fuel spend every month". Referring to the concepts introduced in Chapter 5, figure *12* is a great example on how style, register and stance are concepts that are linked to the *interpersonal metafunction*. Style is shown using various modes to create messages through images, text, colour, textual information arrangement and so on, while the language shows a particular interpersonal stance, where the consumer is addressed directly with the use of the personal pronoun "you", a personal style can also be used to create a level of interpersonal connection in communication. By speaking directly to a person and explicitly directing a message to those persons. The register would

also be a lower register without the use of technical jargon to not create distance between the sender and receiver of a message.

The *textual metafunction* is then shown in the use of the illustration of a fuel dispensing pump and the text that explains what the dispensing pump is about. There are two modes used here to communicate a message. The text is used to 'anchor' the message about Discovery Health's fuel reward and the dispensing pump offers a visual reference about the product. The textual metafunction here relates to style, where both text and image are used in a design to construct one message.

From a multimodal perspective, the use of colour as a mode in communication is also used in an interesting way here that fits into Halliday's (1994) tri-functional model. Colour can be ideational in that it shows the link between an object and another. For example, *figure 12* above includes an illustration of a green fuel dispensing pump above a green circular textbox. First, the design style helps to clearly indicate what the object should communicate, i.e. a fuel dispenser at a petrol station, however it is the use of the green, and the text also against a green background that makes it clear that the product is presented in conjunction with Beyond Petroleum (BP). The BP logo and corporate colours are the same green as the one used on the dispenser. Additionally, all three metafunctions come through in how the objects are positioned in relation to each other, while the style of design, use of different modes textual alignments/stances through language allow for meaning making.

Colour is one of the modes that is used to create a clear vector between the green dispenser and green textbox (*ideational function*), while showing the relation between the two objects (*interpersonal function*). Colour is also included with the text in a circular textbox and on the dispenser and all these modes interact to communicate one message, where the text acts as the 'anchor' of the design (*textual function*). Obviously the three metafunctions are not used in isolation, in some instances all the metafunctions are used to communicate through different objects and vectors. Lemke (2002) refers to

the term 'hypermodality', that is the combination of multimodality and hypertextuality.[8] Hypermodality shows that there are links between text units across different scales, but there are also linkages among text units, visual features and sound units, which go beyond the principles of traditional multimodal genres. In *figure 12* for instance all the elements come together to provide one coherent visual image and to create various meanings, in a similar way to how style, text, images are applied to create meaning. This shows the multiplicity of modes and styles employed in the transference of information across multimodal artefacts through digital media in computer mediated communication.

Kress and van Leeuwen (2006) provide an adequate summation of the points highlighted above on the role of language in multimodal communication. The authors explain that written text extends further than language, in that:

> it is written on something, on some material… and it is written with something (gold, ink, (en)gravings, dots of paint, etc.); with letters formed as types of font, influenced by aesthetic, psychological, pragmatic and other considerations; and with layout imposed on the material substance, whether on the page, the computer screen or a polished brass plaque.

(Kress and van Leeuwen 2006:41)

The home page by Discovery Health obviously offers a commercial package using informational artefacts. The language choice, wide white spaces, whiteness and designs all express emotions of warmth and cleanliness. The consumers are addressed directly, i.e. "speak to your financial adviser",

[8] Refers to the networks of new media that allow for large quantities of information to move freely within a series of interconnected nodes in the network. http://www.igi-global.com/dictionary/hypertextuality/13557 [Accessed 09 Jan 2014]

but at the same time there is a certain exclusivity, a clear class distinction in terms of the consumers who this commercial package is targeted. What we have here is a space populated by 'informational artefacts' that are highly exclusive, white and full of warm emotion, perfectly tooled for the type of citizen-consumer selected in the application form process.

I now turn to the home page by the Government Employees Medical Scheme (GEMS). Here, there is a clear *ideational metafunction* represented between the image in the background and the textual information in the foreground as shown in *figure 13* (below). The *ideational metafunction* is realised by how the textbox with the information about the Onyx health plan is placed on top of the image in the background. In addition, the textbox uses a (darker) grey colour that is treated to a point where it is almost transparent to make it seem like the image and text are the same object. Using a darker grey colour only brings out the text while ensuring that the content stays in the foreground and the picture then fades into the background. This is another example of style in the design of information where multiple modes, text and image are fused to structure one coherent message. This again demonstrates the intricate, multimodal, multi-integration of linguistic and visual resources for health communication in the private health sector space.

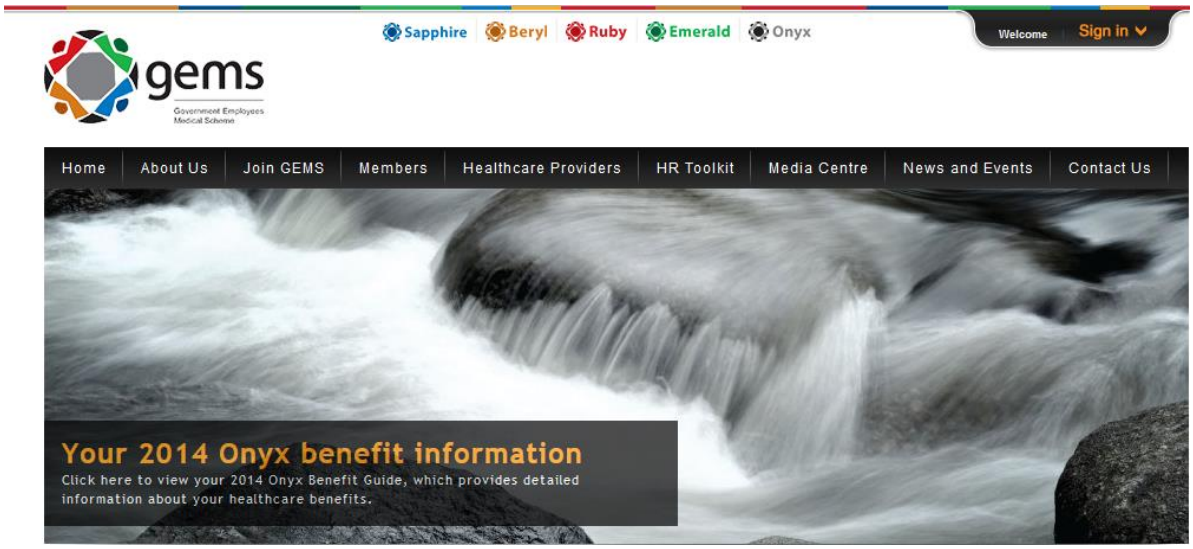


Figure 13 - Back grounding and foregrounding modes to create meaning

The same principles are applied in *figure 14* below where the text appears in the foreground and the image forms the backdrop of the visual spectacle. Still in both *figure 13* and *figure 14,* the *textual metafunction* is used to show the interaction and link between the background image and the foregrounded text, the text is shown using the textual information as the anchor of the message (Kress and van Leeuwen 2006). This interplay of foregrounding and backgrounding elements in communicative message involves style. For example, the style is consistent between *figure* 13 and *figure* 14, there is uniformity in how the information is designed. In terms of transference, consumers would be able to see the clear links between the two separate images (*figure* 13 and *figure* 14). Although they are about different health plans, they can be categorized as speaking about the same topic. Different modes put together bring a multiplicity of ways for meaning making and consumption.

Another interesting set of parameters for the analysis is mentioned by Kress and van Leeuwen (2006) when they refer to how some visual elements form the subordinates and others are the superordinates in visual design. Clearly in both *figure 13* and *figure 14,* although the background image is larger in size, the saturation of colour makes the textbox more obvious. Despite the ability of the larger image to draw attention by its size, the larger image remains as part of the background and an extension of the information contained in the textbox. The text is in a bright yellow colour with a richly saturated black textbox that makes the information more visible and prominent as part of the overall design style. Noticeably the textual information displayed in both *figure 13* and *figure 14* is the Superordinate while the image is the Subordinate as it merely acts as place holder for the information. Additionally, the text acts as the anchor of the message about the health plans offered by GEMS. These aspects of style in how modes can be juxtaposed to communicate messages by putting emphasis on certain modes, "superordinating" and "subordinating" others, reveals how style can be applied to visual elements to structure specific messaging in relation to a certain readership. In this scenario, the different groups who have selected certain health plans are led though different pathways to consume certain

information. For example, *figure 13* is for members on the Onyx health plan, while *figure 14* is targeted at members on Emerald.

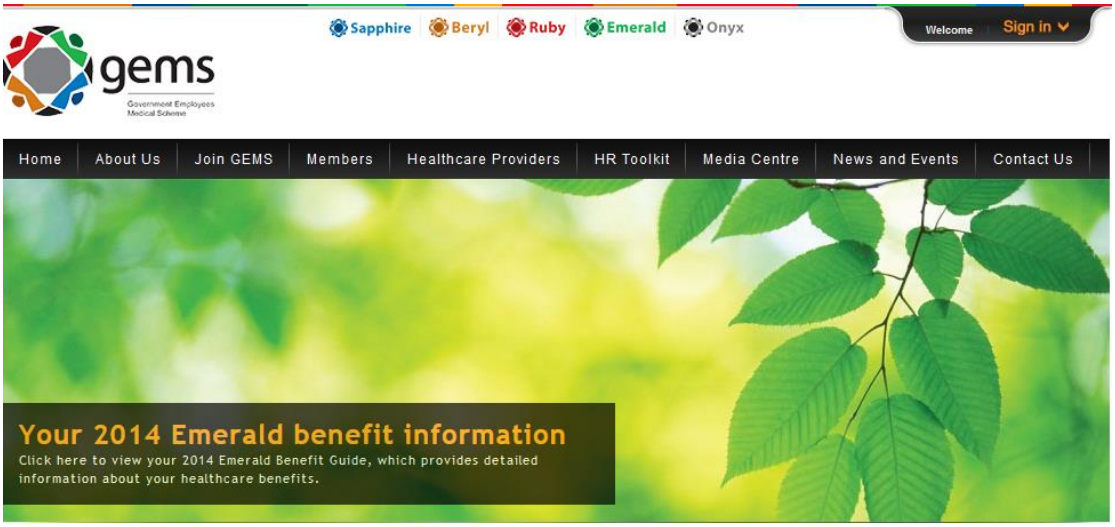


Figure 14 - Meaning making through visual design

In addition, the design style in *figure 13* and *figure 14* is simplistic. There is a background image and text that has been superimposed on the background image. Neither offers much in terms of sophistication of design. The images show that GEMS is providing information on the different health options (products) they offer. However, in terms of an analysis, the basic way the design has been presented fits with how GEMS interacts with consumers and is more a demonstration of stance than style. They are no extras or other incentives to lure the consumer to the product. The image is meant for consumers that are already members and for a specific group of members that have chosen the Onyx option for 2014 for example. Images are a powerful mode in the construction of meaning on websites, however images on their own have very little context. Pictures tend to be shown in generic places and they "lose their origin in time and space"- as they conceptually communicate themes such as vitality and exhilaration, for example, through the raising of limbs to 'heaven' or legs raised on a bicycle (Machin 2004: 325). These types of pictures are generally conceptually linked to a place or time through a range of elements such as a building, other actors, objects or symbols.

According to Machin (2004) most images that are purchased from image banks are decontextualized where the background is out of focus or eliminated altogether. This is also evident in *figure 13* and f*igure 14* (above) where the background Subordinate images are hazy and slightly out of focus with the foreground Superordinate text acting as the anchor of the message. Iedema (2003) explains further that the foregrounding of a specific semiotic is accompanied or results in the backgrounding/automatisation of other semiotics until they seem normal and natural as they appear invisible. Machin (2004) argues that another author, Barthes (1977) says objects, images and patterns of behavior can create meaning. In addition, the author states that globally distributed images like those found on websites have made visual language homogeneous where pictures have come to signify moods rather than actions. General examples include images of someone with a laptop to mean work, freedom which is often demonstrated by someone jumping or ethnicity which is shown through bright and multi-coloured clothing. In fact, Machin (2004: 316) argues that images found in various communication resources such as magazines, news and promotional material "do not represent actual places or events, and they do not document or bear witness, but they represent marketable concepts and moods such as 'contentment' and 'freedom'."

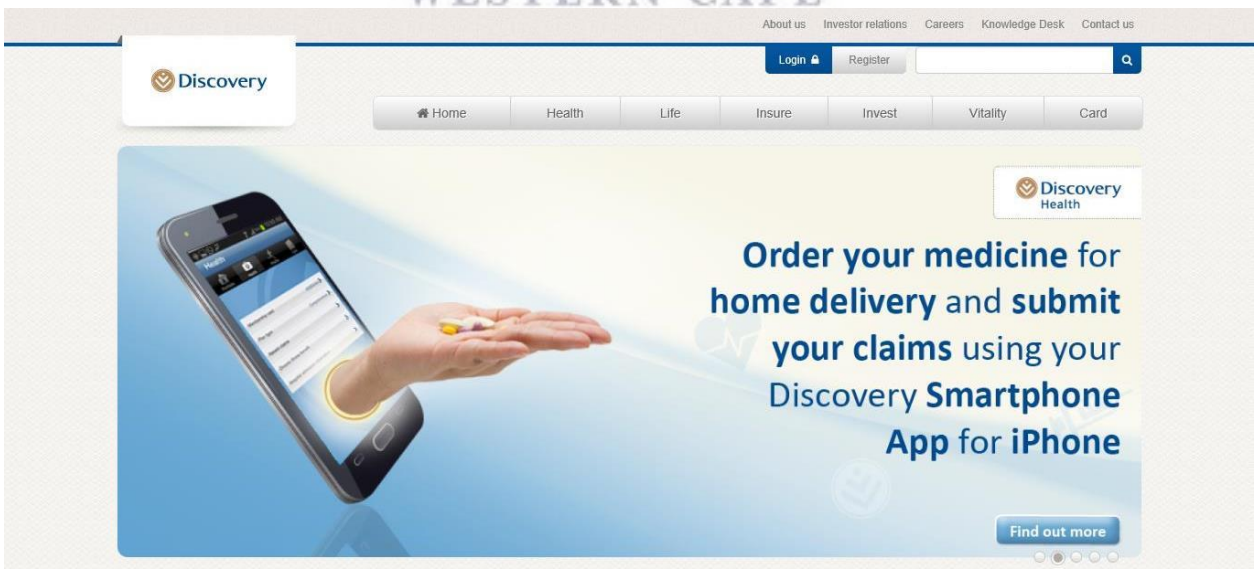


Figure 15 - Slider 2 image on the home web page by Discovery Health Medical Scheme

In *figure 15* (above) both the *ideational* and *interpersonal* metafunctional methods were applied to communicate through two different modes - imagery and text. The *interpersonal metafunction* in this scenario relates to stance and style, the stance taken is of a medical scheme that cares and provides convenience to consumers, while the language style suggests some form of familiarity, addressing the audience directly using the personal pronoun "your" throughout the text, to emphasize that the convenience was specifically for you, not just anyone else, but an individual, almost like they are speaking directly to each individual consumer. There is also the feeling of a special membership an exclusive club to which the consumers belong to which this information is targeted. The slider image (on the website) uses the possessive pronoun "your" three times through the words: "Order your medicine for home delivery and submit your claims using your Discovery Smartphone App for iPhone." The interpersonal interaction between the text and the consumer, as well as the interpersonal link between the text and image is shown through the language used (your) to address the consumer directly, and the proximity of the image and text shows the relation between the two. Discovery Health here expresses a stance that the citizen-consumers are entitled and deserving individuals, and that the website platform has been designed with a view to their comfort and priority in accessing a product such as medication (cf. also Thurlow and Jaworski (2012) who with Sherman (2007) note that customised services show guests that they are unique and deserving people). Again reiterating this feeling of exclusivity, of belonging and identity created in this semiotic world.

Both stance and style were used in this context in *figure 15* (above) for Discovery Health members to use this platform for medicine access. The personal style softens the message; instead of explicitly telling consumers to order their medicine using this new application, the language is more coercive, suggesting that there is a new platform that offers them convenience and they should opt for this new way of ordering medicine. Another aspect of stance here is that Discovery Health is demonstrating that they are innovative; they invest in resources to make the lives of consumers better.

The relation between the text and the picture is clear through the three interconnected objects used in the imagery. The iPhone is the main object out of which the 'hand' emerges; 'the hand' symbolizes the user (consumer) who could order their medicine through the iPhone and the medicine is shown through the open hand holding a bunch of pills. Altogether, the three objects are fused into one main object. There is a clear vector between the three objects as the hand is embedded into the iPhone and the medicine is contained by the hand. The distance from the hand to the text shows a clear vector as the interaction between the hand and the text is shown by pointing the hand directly towards the text. Also, there is a clear interaction to create meaning between the object and the text, the image on the left would be confusing and insignificant without the text to act as the 'anchor' of the message (*textual metafunction*).

Discovery Health is bringing across a message of convenience here by offering the option for consumers to order medicine through their phone. However, this is not just any type of phone; this is a Smartphone application only for iPhone, suggesting the target audience for this information would be people who possess such an expensive phone – reinforcing the message of exclusivity and sophistication. Commodities such as expensive cell phones have become a mark of social status, money and exclusivity. The latest phones in the class of iPhones are highly sought-after commodities in consumer culture. Elliot and Leonard (2002: 348) inform us that: "Consumers do not make consumption choices based solely on products' utilities but also utilise their symbolic meanings; social symbolism and self-identity are provided largely by advertising and are transferred to brands, allowing the consumer to exercise free will to form images of who or what he or she wants to be." As one of the top end cell phones on the market iPhones carry this social symbolism and by having possession of one suggests that one has the means, success and lifestyle that is associated with such a commodity. Applying the same model, Discovery Health is packaging information based on these social classifications of class, prestige and exclusivity. In this instance, like with other images that have

formed the mainstay of discussions in the thesis, the medical scheme is crafting their audience, around notions of class and consumption.

This is also an aspect of stance, where the information is created to align with an audience rather than some other. The application was not created for all types of phones but for a type among the high-end phones on the market currently. Going back to the theme of how medical schemes can create their own target markets, clearly Discovery Health aims for a group that has the material possessions and the finance to follow and lead a certain lifestyle. Their product is obviously aspirational and they constantly show this through their communication that they provide for a niche and well-resourced market.

Kress and van Leeuwen (2006) explain that images used in visual communication are generally publicly known and the target audience would be able to recognise them. However, where images are too abstract and the audience would not understand them, the text is used to ground the image to communicate to the audience. Colour is also a key aspect of the slider image above (*figure 15*), the blue of the background stretches across the blue of the text and the iPhone shows a similar blue on the screen, this blue is also carried across the website to the company logo, the 'login' and search navigation buttons on the web page. This relates to transfer, how brands can communicate with one face (identity) and voice, where modes such as colour are used to index elements of the brand for consumers to identify the link between different messages contained across multimodal artefacts. From a linguistic perspective, this is explained by Johnstone in the following words:

> In certain language ideological contexts, stylistic differentiation can be semiotically linked with speakers, such that individuals claim to recognize other individuals on the strength of their characteristic ways of using language, and some individuals' linguistic styles may come to be named and emulated (2009: 7).

This is particularly relevant when it comes to how health information is transferred on websites and how linguistic styles may be associated with medical schemes.

6.3.3 The health sections of the websites

The health section on the websites also follows a similar design as the home page by both medical schemes. The pages also use image sliders that contain images and text. Discovery Health is obviously marketing their services to prospective members and the message used is about the size of their company as they have more than 2.5 million members[9], which means millions of citizens trust them to oversee to their health needs and issues.

The web page is then rounded off with ten reasons why consumers should choose Discovery Health Medical Scheme. These include among others, that they offer the broadest range of health plans in the market, that the cost of membership on their health plans are the most competitive, they provide full access to the best medical treatment and technology, and that they help their members to stay healthy. These are very attractive promises to consumers as the medical scheme focuses on the freedom (choice) they offer consumers to select the best health plan for their needs, while being able to access the best medicine for treatment and consumers can have peace of mind that their medical scheme is invested in keeping them healthy. The language used here is aspirational, the audience is enticed with competitive pricing to become a member and to have access to health care that is the best on the market, coupled with access to medical treatment and the latest medical technology. Clearly the stance taken by Discovery Health Medical Scheme is that they offer the best options and treatments that money can buy. Again, there is the aspirational aspect that plays into people' sense of vanity of wanting the best,

[9] This was the membership base when the researcher did the analysis of the website.

something better than the rest, which can be achieved by becoming a member of Discovery Health. There is also the factor of how they are focused on helping their members to stay healthy, which they aim to do through their Vitality programme. Discovery Health which offers a commercial package makes for an interesting analysis of how health information is packaged on websites as shown in *figure 16* below.

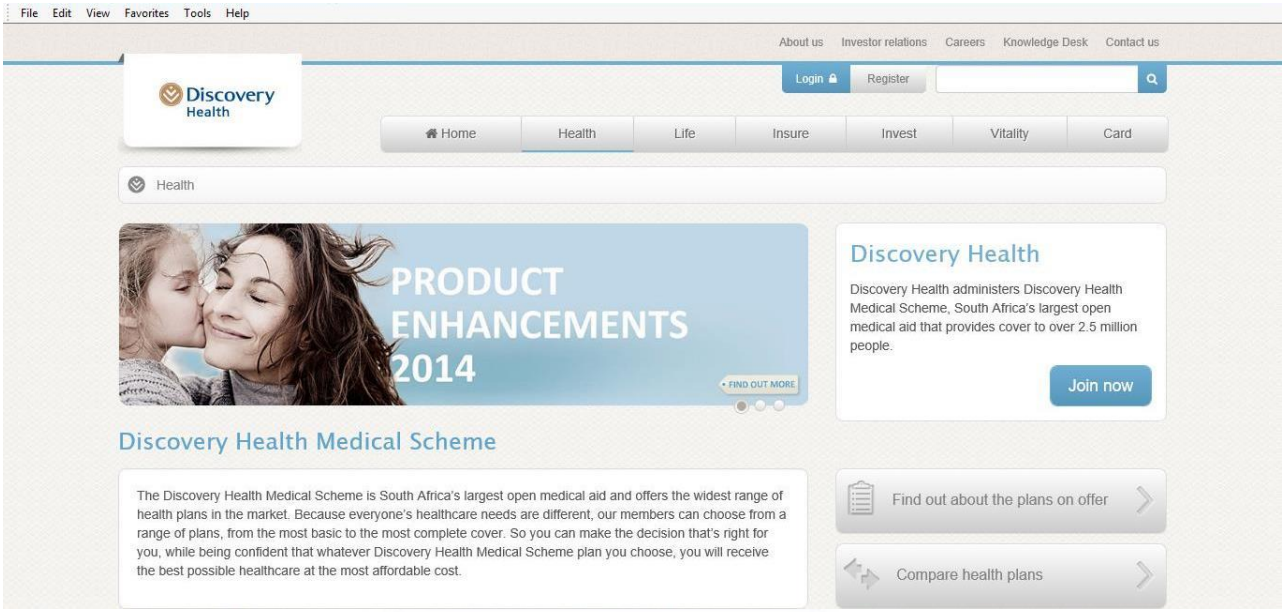


Figure 16 - Slider 1 on the health web page by Discovery Health Medical Scheme

Slider 1 in *figure 16* (above) is an image of a woman receiving a kiss from a young girl. There is clearly a private intimate setting, a sense of individualised bliss, there are two people who are close, there is also the sense of freshness and youthfulness. From the interaction between the two actors you can see that they care for each other. The young woman's head is angled up to receive the kiss, in the same manner two lovers would angle their heads to kiss, but this is pure and innocent a motherly type of kiss. There is a clear vector between this private moment between the two Actors, and the text on "Product enhancements 2014" – the consumer is enticed here to consider the product enhancements to also experience this moment of bliss, to be able to enter the private space of feeling close to another

person. The product enhancements are the entry point into this space and to experience a similar bliss. The *interpersonal metafunction* can also be observed here with the interaction between one Actor and another, where there is a sharing of a special space, a setting of interpersonal exchange and emotional reciprocity.

Kress and van Leeuwen also talk about participants and how participants are connected by a vector, and how "the context usually makes clear what kind of action the vectors represent" (2006:60). In addition, vectors also show how participants are shown as doing something for each other. This comes across in *figure 16* above where the girl kisses the young woman and the receipt of a kiss is met by the woman's closed eyes, her enjoyment and willingness to accept affection from the girl is clear. There are two kinds of 'vectorial representations' that involve participants, conceptual and narrative patterns. On the one hand, conceptual patterns show participants according to class, structure or meaning, on the other hand, narrative patterns represent ongoing actions, events and processes of change (Kress and van Leeuwen 2006). The participants in *figure 16* are depicted through a narrative pattern as shown through the interaction between the girl and young woman. The image is telling a story, not one that is static but ongoing, the vector between the two participants suggests that they are family or well acquainted, they seem happy to be together and close. The other related narrative is that their happiness is linked to the product enhancements introduced through the text. Additionally, from the vectors and the narrative representations the message is that these product enhancements are beneficial for the participants and could be the source of their happiness and closeness.

Although the participants are engaging and their interaction would attract the attention of the consumers who visit the website, the participants are not looking directly at the camera. As is the case with the *ideational metafunction*, different modes provide for ways of representing various interpersonal associations. For example, a depicted person could be portrayed as addressing the

audience directly by looking at the camera. This shows the interaction between the depicted person and the audience. However, where the depicted person is turned away from the audience this indicates the absence of interaction and enables the audience to view the depicted person as though they were specimens in a display case (Kress and van Leeuwen 2006). In this image although the participants are turned away from the audience they are facing each other. The vector between the two participants further reinforces the idea of familiarity and reciprocity.

If one looks back at *figure 15* in relation to the aspect of how information is transferred and what notions are promoted through communication the following can be ascertained. The hand that stretches out of the iPhone is that of a white person judging by the pigment of the hand and the actors shown in *figure 16* are also white. How images are used and the styles that are applied in meaning making are of interest here. Generally, in mainstream media, ideas of freshness, cleanliness and even youth tend to be suggested with white colours, for example adverts about washing detergents focus on the whiteness of soiled and unclean fabrics after they have been washed. White is therefore used to suggest youthfulness, cleanliness and even beauty. If one considers a well-known fact that products such as skin lightening creams in mainstream media have displayed a fairer/whiter pigment as better, there are stereotypical and potentially disparaging notions of health and beauty that are represented here. In *figure 16* white actors are used again to show the target audience for Discovery Health's product enhancements, and they are set against a largely white background on an uncluttered generally white backdrop with clean lines. It should be noted that when these images were analysed the clear majority, if not all, website images included white models, however as shown with figure 5 in Chapter 6, the models were all black. *Figure* 5 is a more recent collage of images than *figure* 16 for example. Figure 5 is used under the section to apply for membership with Discovery Health. This could demonstrate a shift in consumer markets and how they have repositioned their marketing to appeal to a largely black consumer group.

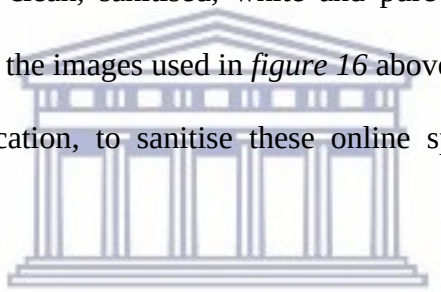
In their ethnographic study of new elite mobilities, Thurlow and Jaworski (2012) also explore the dominant social categories relating to "whiteness". In their view, communication is always ideological as it constructs identities and relationships of power and reproduces dominant belief systems of 'good taste', while maintaining structures of inequality and privilege. They also mention Mike Featherstone (1991), Scott Lash and John Urry (1994) who have argued that post-industrial economies are highly semiotic and increasingly layered with symbolism, imagery and design intensity (Thurlow and Jaworski 2015). This is also true in computer mediated communication (CMC) where messages constructed are deeply layered through modes, stance-taking and register. These factors all impact on the structure and assimilation of such information by citizen-consumers. Therefore, communication is constituted and mediated by space, in what the authors call conceived space, through mental or symbolic images, and perceived space, referring to the material and physical dimension, as well as lived space which is an intersection between the conceived and perceived space (Thurlow and Jaworski 2012).

These lived spaces of luxury and privilege as described by (Thurlow and Jaworski 2012) seem to be empty and desolate where the elite can be left alone in a 'safe bubble', where the choice to occupy vast amounts of space, means there is little conversational exchanges of those who find themselves in this 'safe bubble', and no real interaction but a superficial exchange of human interaction. Also, among the semiotic spaces in their study of luxury travel is Phinga Game Reserve in South Africa, used as a model of imperialist luxury travel. The authors highlight a trend that they have observed in other elite luxury travel spaces where there are:

> [generically] impressive spaces for passing through, but not for lingering or lounging in. Filled instead with plush furniture and freshly plumped cushions, with orderly rows of candles, regiments of single-stemmed vases, and 'hand-carved' basins of scarlet lacquered ostrich eggs. So much for time-space compression. The excessive, expansive spaces of luxury have spaces to spare.

(Thurlow and Jaworski 2015: 498)

In this space and other spaces that form part of their ethnographic study, there is a visible and invisible labour, the effort put in by someone labouring to make the rooms, perfectly marrying culture with nature in, for example, the beach changing room in Burj al Arab, Dubai by perfectly decorating the space with fresh flowers. Yet the labourers are not visible as they merely remove or 'sanitise' these spaces to remove any mark that they have been previously preoccupied. The link between Thurlow and Jaworski's work and the thesis is around the notion of whiteness and clean spaces, as shown with the design of websites, where clean white spaces are used to foreground certain imagery. A look at the website by Discovery Health for example fits into this notion of white spaces and luxury. Clearly how these spaces are observed as clean, sanitised, white and pure relates to the notion of whiteness described in this context about the images used in *figure 16* above, where white clean spaces are used to show luxury and sophistication, to sanitise these online spaces for consumption by citizen-consumers.



Furthermore, the setting in *figure 16* is generic as the two actors could be anywhere and they could signify different meanings. There is a clear vector between the two actors shown by the young woman holding or possibly carrying the young girl (*ideational function*), while the interaction between the two of them is shown through acts that stereotypically illustrate closeness, the proximity of the young woman and young girl as well as the affectionate kiss she is giving (*interpersonal function*). Still the image has little context without the text to act as the 'anchor' of the message. The text which is all in upper case advertises the medical scheme's product improvements for 2014. When the text is considered alongside the image of the young woman and young girl, the people in the picture are one object and as an object they are linked to the text about the product enhancements. In addition, the link between the image and the text (*ideational function*) is shown by the alignment of the text close to and in line with the image.

Contrasting Discovery Health and GEMS by looking at language style, we find a clear distinction between the two. In *figure 16* Discovery Health talks about "product enhancements" meaning that they have improved on what they have offered before, whereas GEMS in *figure 13* and *14* only refers to the benefit option for 2014 not as enhancements but "benefit information". The language style used by Discovery Health also fits with their approach on being the best and providing the finest products. GEMS follows a more modest approach as information that would benefit the consumer. Discovery Health is clearly more aggressive in their marketing and uses more overt marketing speak (language) with the use of the word product, explicitly informing the consumer that they being the best at what they do, have improved/enhanced their product. GEMS follows a more passive form of marketing as it is packaged as "benefit information" for the consumer not a product.

This is where the different approaches and stancetaking becomes more overt, and where Discovery Health is delivering a more commercial package, taking a commercial approach to how they construct information, and positioning themselves in the market. GEMS, on the other hand, tends to downplay the commericial aspects of their business. This is shown through different language styles, where Discovery Health speaks in a commericial voice that is about aspiration, health, vitality and health as a lifestyle, an achievement and a goal to work towards; while GEMS follows a low key approach, where the commercial is downplayed and the focus is more on a language that emphasises health access. *Figure 17* (below) shows a vastly different style and stance followed by GEMS.

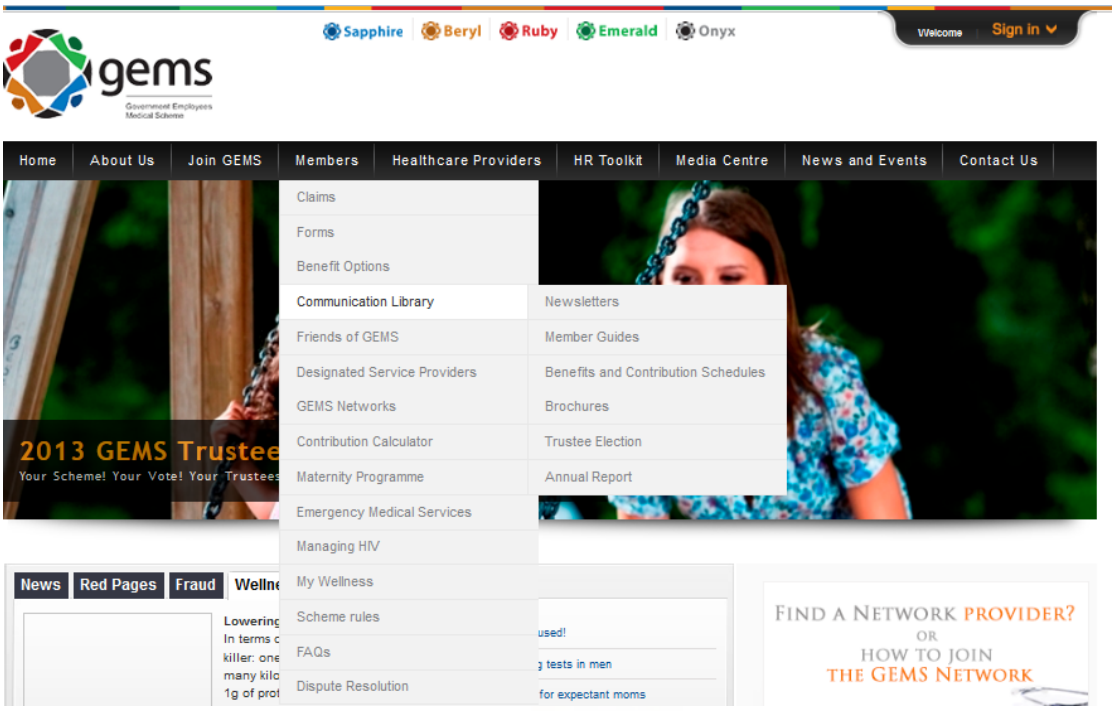


Figure 17 - The range of services offered by the Government Employees Medical Scheme

With GEMS when the consumer clicks through to the health section of the website, the consumer is not directed to a new page as they stay on the home web page, while a list of options are provided by the website as shown in *figure 17* above. The list starts off with claims, followed by forms, benefit options[10]; communication library, as well as the chronic disease management programmes provided by the medical scheme. GEMS, unlike Discovery Health, is not focusing on promotions and cash backs. On this page it is also shown how GEMS markets its services of doctors, which they have a payment agreement with, to pay standard rates, on claims submitted for services rendered to consumers of the medical scheme. The design of information is subtle and does not focus on health consumerism of products but more on access to health care that the medical scheme provides. This contrasts with the rewards consumers are promised if they use the website by Discovery Health.

[10] Refers to the health plans provided by the Government Employees Medical Scheme.

As an alternative approach, GEMS offers citizen-consumers (government employees in this instance) wellness days. Government employees can ask their human resources division to request a wellness event (day) for their department. GEMS hosts wellness days at Government departments where consumers fill in a medical history questionnaire, and there are health care professionals that measure the consumers' blood pressure, blood sugar and cholesterol, weight, height and girth. The results of the tests are shared with the consumers to assist them in taking steps to reduce their health risks. Another health information repository is available on the medical scheme's web site under a section called 'My Wellness', which includes wellness topics such as screening tests for men across different age phases in their lives and nutrition for pregnant women. The idea of 'My Wellness' is to improve the consumers' knowledge through health information and offer advice on health and wellbeing.

6.4. Social class and race

Clearly websites are a critical part of health communication in private health care and in the construction of health citizenship. Cassel, Jackson and Cheuvront (1998: 72) agree when they state that "[if] the Internet can be used for persuasive health communication and its reach continues to expand, then it makes good sense for public health professionals to consider issues in the design and evaluation of Internet-based intervention for health behaviour change." However, they argue that perhaps the greatest constraint in designing Internet-based health communication is the need for expertise in behavioural science theory, research methods, communication technology, advertising and promotions (Cassell et al 1998).

We noted that there are different ways in which Discovery Health designed their information and imagery in comparison to GEMS. The differences are incredibly vast that the only link between the two is their focus on the provision of access to health care for those consumers who access private health care. The website by Discovery Health is more corporate in 'look and feel' through the use of

a homogeneous (blue and gold) colour scheme that displays their brand as clean, sophisticated and exclusive. The website by GEMS is more comic and colourful by using plenty of white space and a rainbow of colours. There are clear distinctions here on the types of audiences that the two medical schemes aim to target through the design of their websites, and through this, they immediately demonstrate how they position themselves in the market. Discovery Health seems to hold the appeal of a product designed for a corporate or professionally skilled market. This is also true of how they approach new markets where they source for members as a group by dealing directly with the companies that employ their target consumers. GEMS works in a completely different space, as a medical scheme created by the South African Government to provide access to care for Government employees their emphasis is on health equity and providing health care to those who previously had none.

Design as expressed throughout this chapter is more than just about branding, language choice, stance, and style. Design perpetuates certain notions or makes commentary about issues of class, identity and race. Language elitism is evident across all multimodal artefacts analysed thus far. The notion of language elitism is on how groups perceive a certain language as economically, politically and intellectually superior and as a tool to dominate/colonise other groups. English elitism is clear across the multimodal artefacts, even though these medical schemes have multilingual consumers. To focus on this issue of multilingual access and English elitism, I refer to the online questionnaire completed by the 80 participants.

6.4.1 Language elitism and access to information

The questionnaire was completed by 80 participants comprising 22 from Discovery Health, 29 from GEMS and another 29 from other medical schemes. Although it was not the point of this study to capture data from participants who are not consumers of Discovery Health and GEMS, the data

received from the other medical schemes were substantial and would support the researcher to respond to the research questions. A summary of the data is available in Appendix C following the electronic questionnaire. 80 participants were asked to specify their home language(s), the languages in which they received information from Discovery Health and GEMS, and the languages in which they would prefer to receive this information. The questions were aimed at responding to the following research question in (i) below:

(i) Who has access to health information and how is it structured?

An analysis of the data showed that there is a preference of the medical schemes to distribute information in English and seldom in other languages. Even though 86% of the participants' preferred to receive the information in English, the information they received from the medical schemes was generally in English (93%).

Although 72% of participants indicated that they found the information from the relevant sources in (question 3b) useful, Participant 9 from GEMS made the following comments relating to the language used by GEMS.

> "Some of the information is not useful as accordance to my needs/questions, and the language used is not easy to understand (medical terms). The use of my language (isiXhosa) would be very confusing as some of the medical terms are not easy to translate (E.G, Biology at school is mostly taught in English, there is no clear descriptive word in isiZulu, isiXhosa, Setswana for DNA)"

Participant 9 is using her/his own frame of reference and experiences in how health information is packaged. Although the participant sees the packaging and distribution of information in English as a problem, the participant contends that the use of the isiXhosa terms for health communication, would be confusing as certain medical terms do not exist in the lexicon of indigenous languages. Blommaert and Rampton (2011: 9) frame an understanding of this, remarking that people communicate in local

and emergent contexts, where their thoughts are readjusted to the eventuality of unfolding events, but they are also infused with information, resources, expectations and experiences that originate in, circulate through, and/or are destined for networks and processes that can be very different in their reach and duration (as well as in their capacity to bestow privilege, power or stigma). The participant is clearly thinking about her local context and how the use of isiXhosa could work, or not, in health communication. Still the participant cannot know for certain if the use of isiXhosa could work in scenarios were the terms are partially or fully, properly or even adequately translated.

Clearly some participants had concerns relating to language and how the technical terms used by the medical schemes made the information less accessible. Participant 46 from GEMS comments that "sometimes the jargon used is not always easy to understand. [the Government Employees Medical Scheme] send statements and SMS's regularly, but, I do not even understand it especially the statements."

Participant 27 from GEMS agrees and mentions that translating information into simpler basic English would allow consumers to understand the information communicated by the medical schemes as follows:

> "Each source is addressing a slightly different population thus a combination of how things are explained gives a comprehensive picture. All specialised topics tend to have a specific vocabulary which is linked to the function - Medical aids also have catch phrases and descriptions which need to be translated into basic english for full understanding."

Participant 27 above sees information as constructed for different populations and that the terminology used to communicate the information talks to the function of the information. This statement can be interpreted to say that participant 27 sees information by the medical schemes as packaged differently for different audiences and this process of how the information is constructed is influenced by what

the medical schemes want to achieve. Irrespective of the 'function' of the information by the medical schemes, participant 27 says that the information should be explained in "basic English for full understanding". Although 'basic English' is a loose term to define, it can be deduced that participant 27 was expressing a need to have the information in a language and register that she/he can understand.

There are different forms of register. Written or verbal communication could have what we call roughly, a high or low register. High registers tend to be more formal, contain elevated lexical choices, suggest sophistication and are pitched at a niche audience, where low registers are more casual and aimed at the lowest base to communicate to a broad audience. Participant 27 is essentially talking about situational registers (Johnstone 2009); the participant sees information packaged in different styles and registers for different populations, using specific vocabulary relating to the function, while using phrases and descriptions that need translation to 'basic English'.

Relating to the issue of multiple forms of health literacy, there was one response to question 9 in the questionnaire (listed as i below) by participant 57 whose response was "yes" to the question:

(i) *Do you find the information about health-related information from the above source, in 3b above helpful?*

> "the question i would ask is this: if you have a company, medical aid scheme, this includes all of them...you have a company that is privately run and is profit driven..the same company ranks its service in terms of least to most monetary wise..the question is are the least paying members getting the "same" treatment as the most paying members??? if the answer is yes then why are there these divisions? the point is that the system is inherently favouring the people with most money to spare!! so will the information on health be given the same to all members? or will all members have the same access to this information? is the health information for a members benefit or is it in line with the profit driven nature of the said company?"

These are particularly relevant questions asked by participant 57. The questions asked speak about issues of class distinction and socio-economic dynamics when it comes to access to resources. The concerns are about barriers to entry, a free market system that fundamentally favours those with the means to production and those who have and those who have not. Both Discovery Health and GEMS have health plans that offer different levels of access to care based on the financial contributions (premiums) paid by the consumers. The more expensive health plans offer the most comprehensive cover for medical costs with the least expensive offering less. The more a consumer can spend the more benefits they would receive, a typical market economy approach that even GEMS buys into, using the same tiered system where higher premiums are linked to better medical benefits.

There are two key questions that the thesis has focused on: *who has access to health information and how is it structured? And what does the semiotic health habitat look like for the health consumer?* The question of access has been addressed in discussions of language choice, style, stance, and register, with the aim to show how citizen-consumers are afforded access and the levels of health literacies required to appropriate this information. Related to the question of access is that of consumer agency and participation, agentive participation will also be largely related to the semiotic landscape that the consumers must navigate. I refer here to the commentary from the online questionnaire to offer perceptions and practices of consumers in the study.

6.4.2 Consumer agency and participation in health

The construction of information and how the information is communicated through various artefacts impacts the consumers' as agents and participants in health. How the consumers interpret and internalise the information is important for health citizenship. It has been argued in the thesis that to allow for agentive participation in issues relating to health, attention should be paid to the multimodal access uptake of information offered to consumers. Taking the above into account, question 4 in the

questionnaire asked the participants what would make the information useful in terms of the modes and multilingual access of this information. 84% of the participants said they found health information from the medical schemes useful. This is a positive response regarding information by the medical schemes in encouraging consumers to be involved in issues concerning their health.

On multilingual access, the participants (34%) were mostly neutral about the usefulness of receiving information in their home language. This is not surprising as 86% of the participants preferred receiving information in English. This is significant and supports the underlying notion that it is not so much about multilingual access to information but rather the affordances through various artefacts provided for the citizen-consumers to engage with health and lifestyle issues.

Participant 9 for example responded that what can be improved in how the medical scheme distributes information is by using "simple language", the participant did not mention that having the information in any language either than English would improve his or her experience with the health information. Participant 9 is far more concerned about the use of technical terms and medical jargon that make it difficult to make use of the information provided. Participant 65 shares the same perspective and adds that "[keeping] things plain and simple. Too much information and medical terminology," would improve the interaction of the participant with information provided. Participant 60 also agrees and explains that the medical schemes should "speak in plain language so that the person on the street could understand" when they explain what medical costs they cover. Noticeably, both Discovery Health and GEMS, through the construction of information, impact how the consumers experience the information provided through these artefacts.

Participant 4 comments that he or she accesses information "to be updated with health information understand what is happening around the world be alert about the break up disease." This could suggest that the participant sees the medical schemes as having a transnational impact as the information

received is said to be helpful for informing him or her about what is happening around the world such as information on the breakup of a disease. This is an out of the ordinary comment as medical schemes play a role in contributing to national and international markets as they broaden their reach and expand their business across national borders.

Participant 9 highlights that lack of information, the complex format of the information and inability to exercise voice are the disadvantages of his or her interaction with GEMS. There are also other participants who feel that the information provided is not detailed enough to empower them to use their medical benefits better, such as participant 12 who said:

> "The health information provided by my medical scheme [referred to as Discovery Health Medical Scheme], does not go into detail about ailments per se, it is just a general healthy lifestyle guide."

Participant 23 mentioned above also expressed the same frustrations by stating that the information glosses over topics and does not empower him or her to access "the benefits by keeping them in the dark."

To encourage active participation among consumers the construction of information across multimodal platforms, used to disseminate the information, are necessary for positive health outcomes. One of the questions in the questionnaire asked if participants were interested in health- information. Most of the participants (82%) said "yes" they are interested, while a smaller number (16%) said they are somewhat interested, no participants selected "no" to indicate that they are not interested in health-related information. Consumers were also asked if they felt, believed, or thought they had control over their own health and the response was "yes" for 62.6% of the participants, while 30.6% of them selected that they "somewhat" had control over their own health, and another 5.3% said "no" in response to this question. Question 9 was one of the most direct questions posed to the participants to understand their perception on the level of consumer investment in health issues, i.e. if the participants

"felt, believed, thought" they had control over their own health, there would be a degree of commitment by the participants in the uptake of information about their health.

To further investigate what actions the participants have taken regarding their health, question 11 asked them to rate their level of involvement in activities such as exercise, following a well-balanced healthy diet and knowing their health risks. 52% of the participants agree that they have a healthy well-balanced diet - while 46% said they know their health risks. Looking at the perceptions relating to diet and exercise are important as a sedentary lifestyle and excess bodyweight have been linked to health issues such as obesity, diabetes and heart diseases.

What can also be extrapolated from the data is a correlation between the participants that said they know their health risks (29%) and the participants that exercised to stay healthy (29%). Generally, there is an overall perception that a well-balanced diet and exercise are key features for maintaining a healthy lifestyle and important tenets for health subjectivity.

In general, a compilation of findings from the questionnaire shows that participants interacted with different artefacts at different points and sometimes a multiplicity of artefacts to respond to different needs. The various artefacts should not be viewed as competing resources but complementary pieces that are used to construct and transfer information to citizen-consumers. The range of artefacts included SMSs, which in the age of mobile applications and smart mobile devices, could be one of the best mediums to reach different target audiences with tailored messages. Other artefacts except websites are far more constrained in terms of reaching out to audiences in the fastest way possible such as newsletters by GEMS that are posted. Still there are participants who struggled with websites, which like SMSs, offer a quicker means for medical schemes to reach out to consumers. Websites were identified as the primary site for information consumption by many participants, while printed material such as newsletters and brochures proved to be useful for some participants to find detailed

information. Other artefacts such as call centres and member guides (which like websites and SMSs), offered different potentialities for access. Websites were regarded as the most accessible, even though some participants preferred to receive information through brochures and newsletters than to search for this on websites, or even to interact with call centers. There is a clear indication from the analysis that information is constructed across multiple artefacts, each with its own affordances for consumption and meaning making and the construction of different readerships.

6.5 Summary

Overall the chapter offered a balanced analysis that showed how different artefacts are used for health communication, how different information through these resources was received, understood and enabled meaning making for various citizen-consumers. By looking at the data qualitatively, I could offer anecdotal evidence from participants for a balanced review of the ecology of artefacts. These showed that in as much as there were positive attributes to the construction and transference of information, on and through specific artefacts, there were equal negatives in how the artefacts were utilised for information seeking and health citizenship.

Although it must be acknowledged that multilingual access to information in indigenous languages in South Africa is a problem, and that Discovery Health and GEMS, would face challenges to provide different genres of information in South Africa's indigenous languages, even though the data did not indicate significant issues with multilingual access to information, where different languages are concerned, Discovery Health and GEMS would find this challenging. How these languages are used, how information and medical concepts are carried across in different languages, for citizen-consumers with different levels of health literacy, would pose problems.

Looking for ways to enhance the citizen-consumers' experience with information is an important step to encourage them to read and understand what is being communicated to them. This is even more

important in the health context as the ability of people to obtain, understand and act on information affects their health outcomes (Kanj and Mitic 2009). With the advent of information and communication technologies in a global world, the use of multimodal artefacts as repositories of information for health promotion and health citizenship has become paramount.

7. The Citizen-Consumer: Cultivating and consolidating notions of health and healthy lifestyles on websites

7.1. Overview

The South African health care sector is polarised into a small group of citizen-consumers who access private health care (less than 20%) and a large population that can only access the public health care system (about 80%). This means that membership of any medical scheme and even access to the Vitality programme is an exclusive product only for the minority of people in South Africa. This minority would be individuals with the income that enables them to become members of the 'club'. Even among those who can afford to be on the Programme and are members of Discovery Health, there is a large number that are not part of Vitality. The implications of this can point to many factors, like this target group has not bought into the product and attaches little or no value to Vitality, and they probably do not see how the Programme fits into their lifestyle or even represents their own notions of health.

7.2 The Vitality programme

Based on the idea that to inspire consumers to act to improve their health, you should incentivise them through rewards, Discovery Health has the Vitality programme that rewards their clients through a *frequent flyer programme point system* where consumers can be categorised into different groups depending on their level of participation, these are: Blue, Bronze, Silver, Gold and Diamond (see *table 1* below).

	Blue status	Bronze status	Silver status	Gold status	Diamond status
Single member		15 000	35 000	45 000	
Main member and spouse	You start at Blue Vitality status	30 000	70 000	90 000	Reach Gold Vitality status for three consecutive years
For each adult dependant add		10 000	20 000	30 000	

Table 1: Demonstrating the different levels on the Vitality Programme

There is a serious level of commitment to progress on this Progamme as to reach what would be the pinnacle, Diamond status, the member must maintain Gold status for three years. The commercial package is very goal oriented and aspirational and there is a clear journey that is carved that includes initiation, participation/socialization, and fully-fledged Vitality health citizen. Vitality is an integral component of all products and services offered by Discovery Health. The idea is that their health products are integrated into Vitality to encourage their consumers to follow a healthy lifestyle. The programme includes lifestyle rewards such as discounts on flights, entertainment and shopping. There is a clear strategy followed by Discovery Health of incentivising consumers to know about their health risks and to work towards changing their behaviour to improve their health. Still the medical scheme's primary objective is not just about simple goodwill - there are benefits associated with having members who are healthier. The benefits of following a healthy diet that incorporates physical activity/exercise is commonly regarded as critical not just for weight management but for general wellness.

What could be said for Discovery Health is that they in turn encourage their members to stay healthy by offering them lifestyle conveniences and they reduce their risk of covering the health care costs

brought on by large numbers of unhealthy members. This means there is a huge financial motivation behind the Programme, the more members they have on the Programme the less likely they would have unhealthy members and the less money would be paid out for health care cover. As there is a huge financial incentive for the medical scheme, there is an underlying strategy for the medical scheme. Consequently, the commercial package resonates with the main thrust of the thesis around modern notions of health. The shift to communities of health practice, where health and its construction, through health promotional messages, and the Vitality programme, puts the consumer in the driver's seat of their own health journey. As shown through the range of artefacts including websites, language choice, style, stance and register are linguistic tools that have been used to construct identities around what it means to be healthy and how to achieve this by Discovery Health. The design of information on their website for example reflects consumerist ideals of health, which are associated with beauty and even other notions such as success, self-worth and happiness.

There is obviously a semiotic world that has been crafted here that promotes what the Vitality citizen would constitute. The Vitality citizen is active, lives a healthy lifestyle, knows his or her health risks and the Vitality citizen strives to improve their health and by default he or she is assumed to live a healthy and full life. Feathersone (2001) for example mentions that the maintenance of one's body has become an important aspect of gratification and self-expression while Porter (2011) explains that attaining a designer body has become part of maintaining social mobility and status. What is interesting about the points made by the authors is the clear links with the statements, deductions and even conclusions about the space citizen consumers must navigate in this programme. There are clear links with personal gratification, contentment, social mobility, identity, class and status. Again, the point is how the maintenance of the outer body has merged with the inner body, around ideas of inner peace, self-love and psychological wellness. The idea of a Vitality citizen is a powerful one in which

Discovery Health advocates for a certain way of being – this is not just about awareness of physical health – but a packaging of human behaviour, actions and lifestyles about health.

The Vitality citizen is depicted through images of active, energetic and happy citizens. *Figure 18* below contains a range of textual and visual elements that are typical of how these citizens are shown on the website by Discovery Health. While the main text is advertising the 25% cash back afforded to Vitality members, there are other images used with participants conveying different kinds of messages.

The first image in *figure 18* with the man carrying a young boy on his shoulders is set against a faded white background with a silver vehicle behind them forming a complete triangle. The image is harmonious, with the vector between the boy and the older man showing a close relationship, one between a father and son. The image invokes ideas of fatherly love with the father carrying the boy on his shoulders, indicating a father who is strong and supportive, and there is also the unstated masculinity and the suggestion of a caring 'father figure'. There are clear messages full of emotions of warmth, closeness and family. What is played on here is on the human need for belonging, for closeness and intimacy, these images promise this, as consumers are invited into this space, and through the purchase of these products, they too can experience these emotions.

The second image shows a person in exercise attire with a range of food in the backdrop with the text "What's New" referring to Vitality and the new developments that Discovery Health has created to give their consumers incentives on ways to become healthier and to gain lifestyle rewards. The person is looking towards the "What new" to show that she is engaged on the Vitality programme looking towards what's new in 2014.

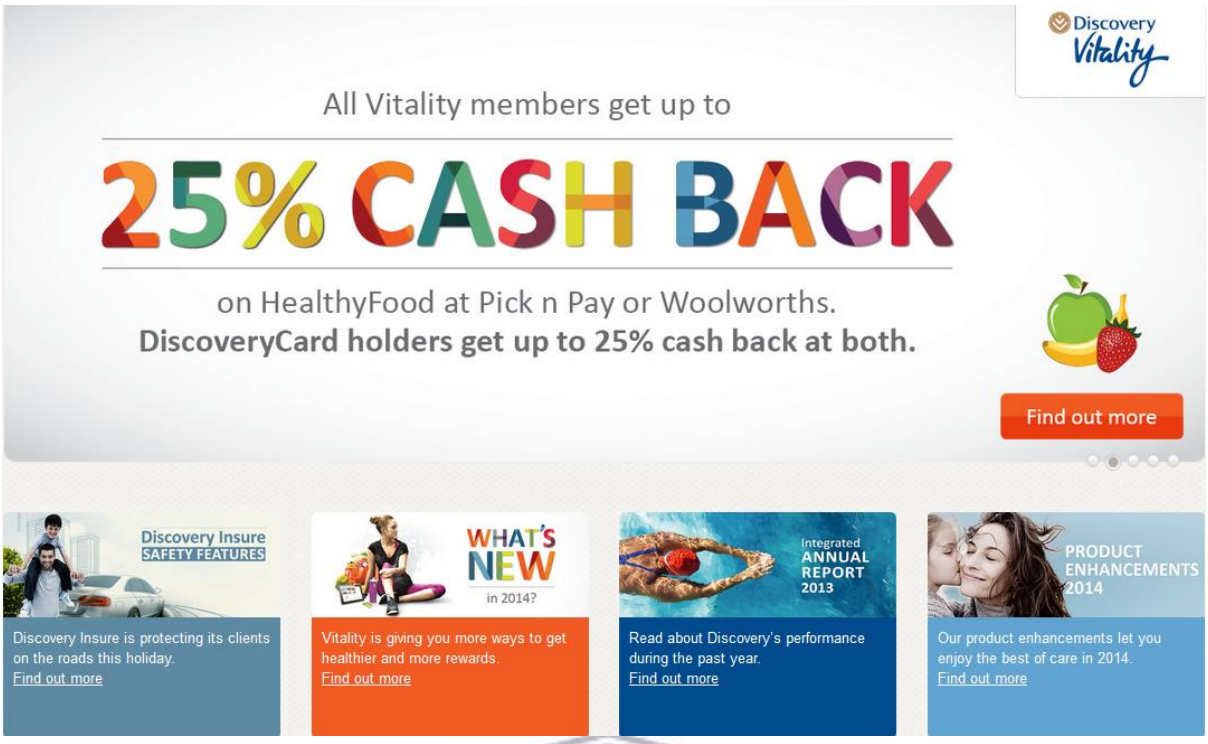


Figure 18 - An idea of the Vitality citizen

The third image shows a person swimming with hands shooting forward. This indicates physical activity with hands arched in the form of an arrow to demonstrate momentum as the person thrusts their body forward in the water. The person is active like a Vitality citizen should be, concerned with being physically active and fit. The fourth image is a smaller version of the slider image in *figure 16* above about the product enhancements for 2014. The image indicates safety, trust and affection. Again, taking the factor of what messages are communicated and what these messages say about Discovery Health and their target audience, the following should be considered.

Across all the images in the banners, the actors are all white, the father and son, woman in gym attire, person in the pool and so forth. The use of only white actors (models) suggests a specific target audience for Discovery Health. The ideas that are promoted here are about the Vitality citizens as people who are possibly white, the citizens have families that they care for and they also care about their own physical wellbeing and that of their families. The Vitality citizen makes smart choices

relating to their health and the wellbeing of their families. According to Kress and van Leeuwen, visual communication is always coded, it appears transparent only when people know the code, "at least implicitly – but without knowing what it is we know, without having the means for talking about what it is we do when we read an image" (2006: 32-34). So what code should we be reading into here, what are the underlying messages in terms of how images are used. Discovery Health does use a range of people of different races if the website is reviewed in its entirety. Yet certain models of specific race groups are used on certain pages, for example figure 5 with the black models focuses on attracting new members. In a transitioning South Africa access to resources for most of the population remains constrained. South Africa is a middle-income country, but low income for most of the population who are black. The country has made significant transformations for racial and socio-economic equality. However economic liberation has not been experienced by most people. The country remains one of the most unequal societies in the world. Yet there is a growing black middle and upper middle class, this class of consumers would be the type of new markets that a company such as Discovery Health would want to attract. This new market made up of 'new money' has become the focus of marketing campaigns in general across popular media. As observed through new media and social platforms such as Instagram these markets center on class, prestige and money. It is about making money and showing that you have it. Even though a typical middle class black person who falls within this new market system might not be the archetype of 'new money'— and about acquiring, spending and flaunting material possessions — this would be more your 'new millionaires'; a middle-class lifestyle suggests that the means exist to purchase certain commodities. Discovery Health as pointed out at various junctures in the thesis would package their content to attract this growing middle class, which would fit in with their default packing, which depict images and lifestyles associated with middle classness.

Through the Vitality programme certain ideals are created on what it means to be a health citizen. This is a membership-based programme and where membership is a factor, notions of exclusivity set criteria

for participation. To explain this further when it comes to belonging to a specific club there are expectations from the owners and management of the club on how the members should do and behave to justify their membership to the club. In the same vein, the very same specifications for membership create barriers to those who do not meet the criteria or behave in a contradictory manner to the rules of the club. Still these rules and ideals of the club cannot be applied to the general population, and their representation of how people should for instance look like and behave is not necessarily valid.

Therefore, even if the Vitality citizen is shown as physically active, smart and happy, there are people who consider living a life of moderation, having a work-life balance, taking an annual vacation and spending some time with family and friends as a way of staying healthy physically and mentally. To such people they are allowing their bodies to rejuvenate while on the occasional holiday, they are working on their interpersonal relationships and doing the things that keep them happy and healthy, making what they consider smart choices to live happy and fulfilled lives. This is their reality; these are authentic representations of who they are and how they choose to design their lives.

There is another theme that comes across relating to the discourses of health that lays further grounds for discussing health notions promoted by the Vitality programme and ultimately those constructed and promoted by Discovery Health. These are discourses concerned with the correlation between health and happiness.

7.3. Health and happiness

In the various communication relating to the Vitality programme, the link between the two concepts is created through the visual design showing people who look content and happy. For example, in *figure 18* above, the man is carrying the young boy on his shoulders while in another image the girl is

shown giving an affectionate kiss to a woman that appears to be her mother. In general, these designs display people who appear cheerful and affectionate. Graham (2008) says there is link between health and happiness and the author talks about "happiness economists" who, she says have long studied the correlation between health and happiness. In the words of Graham (2008: 72) "[by] bringing economic and psychological principles to bear, 'happiness economists' have produced a substantial body of evidence that health is a consistent determinant of self-reported happiness - one that transcends national boundaries, belief systems, and the highly subjective nature of happiness." Graham (2008: 72) further explains that these economists have developed 'happiness equations' in which "health correlates more strongly with happiness than any other variable included - even income - in countries throughout the world."

According to a report by the Harvard Men's Health Watch (2010), in a major survey of 127 545 American adults, the study found that married men are healthier than those men who have never married or whose marriages ended in divorce. In addition, the study reported that men with marital partners lived longer than men without spouses. Therefore, could the secret to a healthy and long life lie with how people stay in healthy and long relationships (i.e. marriages, partnerships)? In the same study mentioned above it is further suggested that several studies conducted over the past 150 years have shown that marriage is good for health and that people living with unmarried partners experienced better health than those who lived alone, yet married men had the best health of all. Richard Easterlin (2003) who has written several papers about happiness (Easterlin 1974, 2004, 2005, 2006) also suggests that life events such as marriage, divorce and serious disability have a lasting impact on happiness. Berg (2007) also mentions that there are several studies that have shown strong correlations between physical health and happiness (Okun & George, 1984; Brief, Butcher, George, & Link, 1993). Still Berg (2007) argues that the effect that health has on happiness is not as strong as expected; there are studies that have shown that people adapt to very serious diseases and disabilities (Brickman,

Coates, & Janoff-Bulman 1978). Clearly the constructs of health of who I call ‘Vitality citizens’ pulls together the different notions of what it means to be healthy, these cannot be applied to the general population. However, these are the constructs and a code to which their audience is expected to live by. The Vitality citizen makes for an exciting analysis of modern constructs of health, beauty and even happiness.

GEMS does not have a health programme that is linked to the design of their products. Just like with the design of their website, they project an official ‘no frills’ approach to how they communicate through their website. Their website uses little imagery and the style they employ in how they choose to speak to their audience is bureaucratic. The design shows a website that was created as an informational rather than a marketing tool. Clearly GEMS does not use the same marketing tactics as Discovery Health. There is far less investment in the design to sell products and services and this could be largely linked to their focus on a specific target audience, Government employees. GEMS operates in a niche market for an employment group, whereas Discovery Health operates in an open market with a strong focus on a prosperous, health engaged and a consumer-focused group.

7.4 Health and illness

I have looked at health and how it has been packaged on the websites of the medical schemes and through the various artefacts, but there is a missing link. What has been observed across these genres of website imagery is the missing experiential images of illness. This is ironic because at the core of what medical schemes are about is the requirement to provide the assurance that members would receive medical cover should they become ill. The shift in new ways of thinking about health as just not the opposite of illness but a way of being, a lifestyle and a product that can be consumed is the point that the thesis has been driving forward. How health citizenship is represented through these

website images promoting health, beauty and consumption, represents a shift in health risk management. These images that resonate with a postmodern popular media construction of health and healthy lifestyles, have made health an aspiration and a marker of success, which makes illness the opposite of this. Therefore, if you are ill you are not only failing at life but should take more responsibility in managing your health risks.

The medical schemes, but more Discovery Health, where health and lifestyle rewards underpin their communication, images of ill patients and people would not fit with how they have positioned their brand. The competition to be both healthy and attractive has intensified says Porter (2011), and control over health matters has shifted from the professional authority of physicians towards greater personal responsibility for citizens in achieving a healthy lifestyle states Cockerham (2005). In the thesis, how messages are semiotically structured should be observed not just on what is presented but what is missing. The choice to put certain images here and not there or to omit certain images like those depicting illness, shows the underlying motive to construct health notions around factors such as health the positive side instead of illness, the opposite. GEMS also in the artefacts that were analysed did not include images depicting illness or people who portray this message of illness. Discovery Health and GEMS through these multimodal genres of imagery direct health-related behaviours and consumption patterns. Even though consumers are regarded as the driver of their own health, it is organisations such as medical schemes who influence what information is consumed, how it should be utilised and what action can be taken to achieve the desired health outcomes. These factors make access to knowledge and information significant in health communication. Clearly there is a clear focus by both medical schemes to provide access to information on health and less on disease, and in turn recruit members to stay committed to a ‘health career’ path.

7.5 Summary

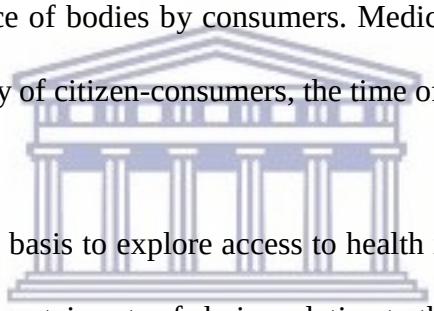
What is a particularly interesting point of stance and style in how both medical schemes communicate pertains to the formation of identities. It is evident that reading positions are constructed, but what does this mean for how individuals construct themselves in a general sense, in relation to social differences. Johnstone (2009) talks about how repeatable linguistic styles come out of stance-taking strategies that prove to be significant for particular speakers for certain interactions and styles can become associated with interactional situations and social identities. Ochs (1993) considers social identity as a cover term for a range of social personae, including social statuses, roles, positions, relationships, institutional and other significant local identities that may be assigned to social life. Wolfram and Schilling (2015) then discuss speech variation and language style and its link with social meaning. The authors explain that speakers may use language based on aspects of their origin, social class, ethnicity and gender, but they argue that to get an understanding of the relationship between linguistic and social identity, one should explore how people capitalise on social identity variations as they speak, convey, shape, re-shape social, interpersonal, personal and sociolinguistic meanings (Wolfram and Schilling 2015).

The notion of capitalising on variants of socio-demographic identities fits well with the thrust of this study, where Discovery Health Medical Scheme and the Government Employees Medical Scheme are seen to apply, to different extents, tactics that benefit on the profiling of citizen-consumers in relation to aspects of social class and identity. They do this through the production of stance and style, where consumers can identify with certain meanings carried across different health communication artefacts. Ochs (1993) supports this perspective as linguistic constructions are critical indicators of social identity for citizens as they interact with each other. Therefore, social identity is a crucial component of social meaning of linguistic constructions.

Discovery Health Medical Scheme and the Government Employees Medical Scheme structure information in ways to construct certain readerships and consumption patterns. Discovery Health and GEMS follow different approaches on how they engage consumers through the information and design of their websites. They clearly take different stances – apply unique styles, tools, information, resources – and strategies all of which indicate different constructs of health and health citizenship.

Chapter 8. Discussion and conclusions

The thesis focused on the design and distribution of health information across genres of multimodal health artefacts and multisemiotic seams by the Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS). The thesis also set to unpack how citizen-consumers are enabled to access this information, the language choice, style, stance, register used in these artefacts, and what sort of semiotic world they must navigate for health citizenship. It has been argued and reiterated through the thesis how ideologies of health have shifted into commercial packages that link health with notions of youth, whiteness, race, identity, and middle classness for example. It has been shown that in the private health care habitat, new ways of being relating to health have to do with the governance of bodies by consumers. Medical schemes promote this new health framework as the responsibility of citizen-consumers, the time of the health for all concept is over.



Two key questions formed the basis to explore access to health information and semiotic structuring to lead consumers into making certain acts of choice relating to their health. The questions asked: *who has access to health information and how is this structured? And what does the semiotic health habitat look like for the health citizen-consumer?* Chapter 2 opened the discussion around the first research question on access to health information as it explored notions of citizenship and how the concept of health has changed. The changing meanings of health are significant as these evolve so would the packaging of information around health.

8.1. The evolution of health and citizenship

Health citizenship was discussed alongside other key modern health concepts that included biological citizenship and therapeutic citizenship. Both concepts fit nicely into the new way of thinking about health. Whereas health citizenship has basically been understood to refer to how citizens construct themselves and behave in connection with their health, biological citizenship is linked to biosciences that involve biomedicine, biotechnology and genomics, and a shift from citizenship as part of a nation-state, to how they think about their individual bodies in a biopolitical sense. Therapeutic citizenship then expanded on this notion of biological citizenship, which is more about linking the biological (the bio-political) with the management of people and individual bodies and entails issues of ethics, claims to rights, the control and management of bodies. Still on the discussion of the commercial nature of modern health, biological citizenship and therapeutic citizenship should also be seen not just from the perspective of empowerment and how citizens are redefining what it means to be a citizen, in relation to rights, but a shift in the health space towards citizen-science. It is also about how these new health constructs and the entities they support, or which drive these citizenship projects, can be hijacked and become a part of largely commercially driven initiatives.

As it should be clear from the above, whatever ‘health’ or ‘health citizenship’ is about today, it is not just about illness and health. The field of health has become a completely re-contextualised space where health is related to attributes such as physical appearances (beauty, youthfulness), sexual attractiveness, along with other aspects such as social status, social mobility and health elitism. This is largely seen in the marketability of health through mainstream advertising, and how medical schemes such as Discovery Health have created programmes based on healthy living and lifestyle rewards, where there are obvious commercial benefits for medical schemes.

With notions of health changing and becoming more commercially oriented, in chapter 3 I expanded on discussions in the previous chapter to discuss what happens when considerations of language come to the fore, and how different health literacies are constructed through language, and how language impacts on access to health information. There are different concepts of health literacy, health literacy measuring tools and translation strategies suggested to enable information access for consumers.

8.1.1 Access and health inequity

Health remains one of the most unequal spaces where agentive citizen participation would be influenced by access to health resources and material. Although an emphasis on the public health service in this respect would have been both relevant and timely, the thesis has argued that important lessons could be learnt from how health citizenship is constituted in the private health setting as particular entities through commercial notions linked to consumerism and taste. Canclini (2001: 15) explains this eloquently in the following words: "Men and women increasingly feel that many of the questions proper to citizenship – where do I belong, what rights accrue to me, how can I get information, who represents my interests? – are being answered in the private realm of commodity consumption and the mass media more than in the abstract rules of democracy or collective participation in public spaces."

The motivation to focus solely on the private health sector despite the urgent and obvious need for different types of research and interventions, in the public sector, was primarily the availability of a rich set of resources that promised a more comprehensive insight into the importance of health literacy for health citizenship and citizen agency. A second motivation is that public health sectors world-wide are slowly being encroached upon by global trends in the marketization of health. The private health

insurance sector which offers a commercial package has like other for profit driven entities working in this space, been active in driving communication to various consumers to increase their reach, inform treatment decisions and health outcomes for many years. Therefore, it made sense that if one must look for answers in an area that focuses on the commodification of information and health, the private health sector would offer the best option. Producing work that would be valuable to the public health sector, focusing on the private health sector and fostering critical discourse relating to the construction of health citizenship and linguistic citizenship and how these are created through health information, a commercial and well-resourced sector, would provide the lessons and codes of best practice that could be useful for the public health care sector.

In addition, looking at the private health sector is a feasible approach as there are lessons to be learnt on how to empower everyday citizens, how empowerment is linked to health citizenship as notions of health in contexts of encroaching commercialism. Additionally, apart from the issue of how the private health sector offers a better platform to consider how health information is used and assimilated by citizen-consumers, when compared against the tax funded public health sector, the private health industry consumes most of the health care budget (more than 60%) and employs over 70% of the health care specialists (Yach and Kistnasamy 2007).

I also discussed what the different communication styles, registers and stance-taking by the medical schemes could tell us about the orientation of the medical scheme towards their constituencies, and, importantly, on how they saw their own role on the health 'market' and globally. The particulars of health care sector in South Africa, and their position in this sector, are reflected in their respective communication styles, in how they structure their communication, and interact and engage with the citizen-consumers for health communication. Firstly, the topic makes it clear that the concern here is

on encouraging health citizenship, which in this context had to be understood first as how citizens navigate health material and artefacts about their health. More specifically, how the construction of this information across a multiplicity of artefacts impact the citizen's perception and practices of health information for their own health subjectivity. Also, how do different notions of health impact on citizen agency and participation for health citizenship. Although when one speaks of promoting or encouraging health citizenship, the question that immediately arises is who is encouraging this and for what purpose?

In the cases studied in this thesis, the encouragement is by two leading South African medical schemes, referred to as Discovery Health Medical Scheme (Discovery Health) and the Government Employees Medical Scheme (GEMS). These two companies are the largest in the health insurance (also medical schemes) private health care environment, with a group of citizens who have membership on their schemes to access, what in an inequitable health space is an enviable commodity - private health care. Therefore, Discovery Health and GEMS that operate in the private health insurance sector were discussed through the lens of the health material and resources they provide for citizens to use relating to their health. The questions of who is encouraging this and for what purpose also poses further questions such as; how are they encouraging this; what resources and material are we talking about; where are these made available, how do health citizens access these resources; in what way can these resources be said to promote what kind of health citizenship?

Chapter 4 set out to respond to these types of questions by defining the concept of virtual ethnography, which involved intensive engagement with a range of multimodal online and print resources. New technologies enable participants to be absent from the researcher, making the relationship fleeting or sustained and to be carried out across spatial and temporal divides (Hine: 2000). The thesis followed

the principles of virtual ethnography to observe, read and analyse the genres of artefacts presented in the study. Virtual ethnography also involves a process of negotiated interactions, which included reaching out to both Discovery Health and GEMS. As the negotiations with the gate-keepers were unsuccessful for the most part, different types of negotiations then followed which allowed the study to reach out to the 80 members of medical schemes, mostly from the two medical schemes. The methodological challenges faced in these negotiations and the outcomes were all detailed in chapter 4. The analyses of various artefacts, negotiations with different stakeholders, and online questionnaire, were part of the research design process to guide the study to explore the semiotic structuring of health information, and how consumers are led through this information by Discovery Health and GEMS.

8.1.2 The semiotics of health citizenship

In a new health structure, the biological exists alongside the therapeutic as well as the commercial and commodification of different aspects of health. This means that different agents, medical schemes, institutions, interest groups and other role players are involved in crafting modern notions of citizenship. In the context of the thesis, I have asked how this is constructed linguistically through health material, and other semiotic resources; and how do parameters such as style, stance and register contribute to the crafting of these notions.

The thesis has shown that there are two vastly different approaches followed by Discovery Health and GEMS. How each medical scheme constructed information across multimodal artefacts particularly on their websites showed the different markets in which they operate. The packaging of information also reflected the different ideologies they promoted and how they planned to grow their business across national and international markets. Discovery Health is about attracting the high end of the market, increasing their customer base in the UK, America and China, whereas GEMS is only reaching

the broadest group of Government employees in South Africa. Discovery Health is concentrating on its international brand as a leader in the health care market place, while GEMS remains rooted to the national context.

The construction of information and design of the websites reflected these different market orientations in their different stances, styles and approaches to engaging with consumers. Whereas Discovery Health focuses on a postmodern take on individual health risk management, GEMS is still focused on the traditional function of encouraging and enabling access to health care for a particular group within society.

Discovery Health offers a far more commercial package, where the structure of health material fits largely with modern notions of health. This is where health risk management is primarily the responsibility of the individual, where people are regarded as architects of their own bodies, where health is linked to consumption and healthy lifestyles, where the goal to stay healthy is in itself about consumption. Through their frequent flyer points programme – Vitality – Discovery Health has created a platform to market and sell a particular health lifestyle based on consumers knowing their health risks/status, changing their behaviour and keeping to a set programme of goals and targets to manage their health. Clearly this has gone beyond providing health access to consumers who access private health care. This is a thoroughly recontextualised view of what it means to be a member of a medical scheme and to live a healthy lifestyle.

8.2 Voice, participation and agency: Linguistic citizenship

To cultivate a sense of health subjectivity agentive participation among citizen-consumers is needed. It was highlighted that communication should enable voice and democratic participation among citizen-consumers. The challenge thus far has been that spaces of participation in health have mainly addressed issues of compliance. The question as to what extent health citizens have been able to make

their voices heard and make an imprint on the delivery of their provisions is still in need of research. The stance in this thesis has been that voice, participation and agency is influenced by how health information is constructed across a wide range of artefacts that allow for negotiation, transaction and engagement on behalf of all participants.

I noted in this context how problems related to (the lack) of multilingual provisions are pervasive in health care contexts. The work by Deumert (2010) for example showed how deeply entrenched linguistic barriers between English/Afrikaans-speaking health providers limited access to equitable and effective health care among isiXhosa-speaking patients. Similarly, Luphondo and Stroud (2012) have emphasized how in the health care context diversity presents a multiplicity of challenges across language, culture, race, religion and socioeconomic differences. Further examples across the international health landscape also give evidence of this dilemma. The work by Dubard and Gizlice (2008) for example showed how a large sample of more than 45 000 Hispanic-speaking adults across 23 states in the United States experienced issues with access to health care due to language disparities (cf. also Collins and Slembrouck, 2015). Collins and Slembrouck (2015) in their analyses call for language focused ethnography to study a dynamic, contemporary and globalised world. The authors assert that the salience of language and language diversity require further exploration and understanding, as language is still regarded as a hindrance for accessing medical diagnostics and treatment (Collins and Slembrouck 2015). Still the point that has been reiterated in this thesis is that beyond the obvious and essential need for multilingual provisions in health contexts, we need to look critically at the nature of other semiotic affordances - modalities, styles, and registers in constructing health citizenship among citizen-consumers. This is tantamount to a wider notion of health literacy.

Improving health literacy levels, it was argued, would make information more accessible, but so should the design of this information and transference of this information. One finding in this study is that the way information has been formulated across interlinked modalities and artefacts impacted the uptake

of this information. The study by Deumert (2010) that considered the role of multilingualism in health care across three public hospitals in South Africa, in fact contradicts the results found in the data. The author's study pointed out how the large number of isiXhosa-speaking patients experienced challenges in health care access due to language barriers between them and English/Afrikaans-speaking health providers. Despite this contrast in the findings between the author's research and this study, it confirms a critical point made in thesis about language and access to health care between the public and private health care sectors. The private sector is not concerned with issues of language and access to health resources through multiple languages. As a better resourced sector, it attracts the type of clientele who can communicate in English, even though it might not be their first language or even language of everyday communication.

This paper considers the role of multilingualism in health care by drawing on the results of an empirical study conducted in three public hospitals in the Western Cape, South Africa. Data were collected through questionnaires, staff and patient interviews as well as ethnographic observation. The focus is on the large number of isiXhosa-speaking patients who have entered the provincial system since the early 1990s. The analysis shows that linguistic barriers between English/Afrikaans-speaking providers and isiXhosa-speaking patients are a deeply entrenched structural feature of the public health system, and significantly impede the provision of equitable and effective health care fifteen years after the end of apartheid.

It has been shown that different consumers view certain artefacts as more suited to their needs than others and some artefacts are used at a certain point and for certain functions and not others. In some cases, various artefacts are used at the same point for different reasons, supporting the view that different artefacts offer their own potentialities to encourage agentive participation among consumers. As a general observation, the consumers utilised a range of artefacts that would offer quick access such as websites, to printed media just as brochures, comic books and magazines. Still, throughout the range

of artefacts there is a component that is missing – namely transactional feedback. Websites do, to some extent, offer transactional feedback where, for example, with Discovery Health a form can be used as a tool to request a quote for membership. However, in terms of real time transactional feedback these artefacts, except for call centres, are limited. As a result, different artefacts offer different potentialities for citizen agency.

Evidently, the crafting of information and transfer thereof through different artefacts creates different readerships and spaces for agentive participation among these readerships (citizen-consumers).

How *language choice* is linked to health and communication shows a definite bias towards making information accessible in English. As shown by the data collected, most of the information is made available in English across the genres of health information artefacts used for health communication by Discovery Health and GEMS. Yet when we look back on the data and the analysis, the participants did not report any challenges in not having access to information in other languages they might master better. In fact, certain participants saw having material in other languages but English as a novelty, expressing the view that although it would be a good strategy to reach out linguistically in such a way, there would be challenges relating to medical terminology and how certain concepts might only be translated with difficulty into indigenous African languages.

Thus, although the promotion of multilingualism and the provision of multilingual resources is an integral part of the social fabric of South Africa and a significant part of furthering linguistic human rights, more is needed. Even though it is recognised that making information accessible in the country's official languages certainly bodes well for increasing access to health for a diversity of linguistic groups, one of the arguments in the thesis is that health citizenship should look beyond the language question in a narrow sense to also include consideration of a range of other semiotics. Fundamentally, this is the issue of linguistic citizenship - a concept that makes room for citizens to decide what

languages are and how they wish to use these languages. In keeping with this idea of linguistic citizenship, the thesis did not emphasise what material was made available in what languages, but what *affordances were made for various groups to exercise voice* through the variety of semiotics. For these groups to express their voice and participate agentively, how health information is structured and meaning created through multimodal artefacts and across multisemiotic contexts is important to understand.

8.3 Constructing the health citizen

The argument that has permeated the different chapters was how Discovery Health offers a far more commercial package than GEMS. This is reflected in how they communicate with their readership. As discussed in the thesis, various ways of constructing information develops and encourages various reader *positions*. Discovery Health has a way of communicating and structuring information that situates the medical scheme in a space that fits with modern constructs of health. From how they communicate about health, to how application forms are used to select consumers and screen them for pre-existing conditions to determine how the information and the applicants will be treated, the whole approach of Discovery Health is of a commercial enterprise that fits with modern notions of what it means to be healthy, successful and happy. This is in stark contrast to GEMS that, as mentioned, still follows a traditional approach to how they construct information and see themselves in relation to their constituency of health citizens.

Still there are interesting patterns of how reader positions are constructed as an effect of how Discovery Health behaves in the market, mediated through how information is packaged in different styles. Where a somewhat impersonal language style is followed by GEMS, Discovery Health generally follows a conversational language style. This makes Discovery Health more engaging to a larger and

different consumer market. GEMS essentially has a captive market as they are a closed scheme only for Government employees and they are well placed in that market as the leading medical scheme operating in this space. Thus, what is significant about these reader positions is how consumers are constructed, where a certain type of consumer is encouraged through the packaging of information by both medical schemes. The ideal Discovery Health consumer would fit with the modern health constructs that place health and leading a certain lifestyle at the center of citizenship.

Strictly speaking citizen-consumers have little influence on health policy and health systems design. In the private health care sector, medical schemes such as Discovery Health and GEMS, determine what health care is provided, how health information is designed, transferred and distributed for consumption. The thesis has argued that to encourage agentive participation among citizen-consumers information is an important tool but the affordances brought on by the construction of this information have given rise to new forms of health literacy and participation, voice and citizenship. Access to health care is an important factor in any health care research, but the thesis discussed health from the perspective of health communication as a form of organisational and social practice.

8.4 Recommendations

The private health insurance industry is a significant player in the overall health care system. As the most resourced sector, it made sense for the thesis to look at how information is packaged and consumed in this sector, how language and literacy affect the consumption of this information and what notions of health are being carved to inspire agency among citizen-consumers. The thesis thus focused on private health care to find codes of best practice in how health information could be effectively designed to inform positive health decisions and outcomes, or to bring critical awareness to the shortcomings of these practices.

In my view, this study has offered a unique opportunity to demonstrate how health communication between medical schemes and citizen-consumers shapes the postmodern perspectives on what it means to be healthy, happy, physically attractive and successful. This was discussed in more detail in chapter 2 and 7, to explain how health is commodified, and how citizen-consumers are affected by mainstream constructs of health, beauty, happiness, prestige and sexual attractiveness.

This study has also presented possible answers on how information could be designed and disseminated for health education and health promotion. Health education refers to carefully constructed opportunities for learning with the aim of improving health literacy including improving knowledge and improving life skills for individual and societal health, while health promotion refers to the process of enabling citizens to enhance their control to better their health (World Health Organization 1998). From this perspective health promotion fits into the idea of health citizenship were empowering citizen-consumers is a means of encouraging them to participate as agentive doers in control of their own health. Participation is an important factor for sustaining health promotion action. The World Health Organization has been instrumental in defining key health concepts and links participation to health promotion, in their view, citizen-consumers should be at the center of health promotion strategies and take part in the decision-making processes for health promotion efforts to be effective.

The hope was that these models of best practice could be replicable and used in the public health context to improve health communication and encourage health citizenship among citizen-consumers. Thus, I had initially planned to work more closely with the medical schemes for them to utilise the thesis as a springboard to critically analyse how they design health information and enable citizen-consumers to engage with this information. Despite the lack of participation from the medical schemes, the data were collected, and presented valuable insight into health communication.

Among these codes of best practice included ensuring that the multimodal artefacts such as websites and newsletters are designed with the consumers in mind by following these guidelines: making information and the artefacts where this information is contained user friendly, explaining information relating to health benefits, what medical costs are covered and how best to respond to consumer needs. There were a significant number of comments from the participants in the electronic questionnaire, who expressed how disappointed they were not so much about the design but with the superficial nature of the information, some of the participants expressed how information is hidden from them if it does not fit with the profit-driven needs of the medical schemes.

Another aspect where there was a common thread in the data collected was a need to centralise information and ensure that the citizen-consumers receive the information they need from that central point. There were several participants who mentioned how often websites contained basic information and they would need to check member guides or even call the customer service centre for more detailed information. In some cases, the customer service centre was regarded as unfriendly and even member guides contained far less information that the consumers would need to follow other channels for more comprehensive information. However, in most cases most of the participants found the websites to be a ready source of information to access health information whenever they wanted. Even so the medical schemes should ensure that their websites are designed in a way that the consumers can: find what they need in the quickest way possible, understand the information they receive, and know what is expected of them to use the information for their health concerns.

In terms of the primary data from the questionnaire, the medical schemes need to consider the distribution of information while considering the different health literacies of their consumers and the challenges of complex medical jargon contained in the artefacts. Across the data it was evident that participants generally perceived medical schemes as enabling them to participate in issues around their

health concerns. However, easy to read newsletters and better designed websites were highlighted as artefacts that could make it easier for the participants to navigate this information.

8.5 Future research

There is limited research into the construction of information in the health context and how this information is utilised by consumers for health citizenship. Additionally, there is much need for linguistic research that looks at the role of language and literacy in health among marginalised populations in South Africa. Local research into the private health care sector has generally focused on health management organisations and not on issues of agency and participation of consumers who receive information and make use of a range of health products and services. Research into the opportunities and challenges of translating health information across multilingual spaces is a possible research problem, the translation of text raises important questions relating to the language, register, tone and voice contained in these texts as they move across different languages, spaces and semiotics, leading to the question of *what is lost in translation*? Could it possibly be the meaning, effect, or even role of this information - and what is translatable - can meaning, metaphors and culture-specific words, phrases and sayings be adapted to ensure multilingual access to information. This type of research would provide interesting data on the challenges that exist in translating medical information, as well as provide a way forward for looking at making health information accessible in South Africa's 11 official languages.

Another exciting research area is an investigation of effective health programmes across sub-Saharan Africa. The objective would be to make a case for the importance of finding cross-cutting health programmes that are replicable and looking at how these programmes can be implemented with attention to the linguistic and cultural world of the different countries across sub-Saharan Africa. Sub-

Saharan Africa faces several health challenges including HIV/AIDS, TB and Malaria. The existence of these challenges has seen local NGOs such as Medicins Sans Frontiers and other institutions introducing innovative interventions to address them. Taking lessons across the sub-Saharan African landscape and exploring the replicable nature of these health programmes and interventions across multilingual and cultural contexts would make for a meaningful research project that can contribute to strengthening health programmes across the continent.

Research into doctor/physician-patient interaction in the medical context has been studied and to some degree well documented. These studies have informed literature relating to health communication, health promotion and even health literacy. Health communication has developed into an exciting applied social science discipline considering human and mediated communication in the health care system. Still health communication in the field of linguistics has not specifically looked at the role of the multiplicity of health information, artefacts, their ecologies and how readerships and citizens are constructed for health citizenship. The thesis has focused on one particular area based on the notion that health is an unequal space where access and the construction of health resources and material allow for different levels of consumption among citizen-consumers. The research carried out has provided valuable data on how health has been constructed over time, modern and commercial notions of health and how these encourage citizen agency and participation among citizen-consumers. As an interdisciplinary topic, promoting health citizenship and multilingualism in the private health insurance industry, cuts across the linguistics, health, and communication disciplines, providing insight into how linguistic citizenship can be shaped and reshaped by the construction of health material and transfer of this information through multimodal artefacts, how health communication is a critical tool for meaning making and the crafting of readerships and how organisational communication with external stakeholders makes visible the internal and often hidden ideologies and agendas of organisations involved in the dissemination of information to consumers.

The thesis has thus attended to how medical schemes use a variety of semiotic/multimodal means to construct information and how this semiotic structuring imbues a sense of agency, among consumers, to use this information to make health decisions. The focus has been specifically on the private health sector, and on how medical schemes and citizen-consumers who utilise their services have crafted modern notions of health and how these ideas are taken over and assimilated into the everyday lives of citizen-consumers.

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APPENDICES

APPENDIX A: CONSENT FORM

Research questionnaire:

Promoting health citizenship and multilingualism in the health insurance industry

CONSENT

Institution: University of the Western Cape - Department of Linguistics

Course: PhD Linguistics (2951)

Study topic: Promoting health citizenship and multilingualism in the health insurance industry

Researcher: Alfred Thutloa

The research will look particularly at how medical schemes communicate in different languages and different modes to provide health information. The specific aims of the research are:

- How are different languages used to foster participation and voice in the health insurance industry?
- How is health information for health promotion constructed across various artefacts?
- How do the consumers of health products and services interpret and internalise this health information?
- How do consumers of health products and services navigate the health landscape, participate and express their voice in the provision of healthcare in multilingual contexts?
- How do medical schemes construct health citizenship and what are their contributions to national and international markets?

Voluntary participation: Your participation in this study is entirely voluntary and you may refuse to answer any questions or choose to stop participating at any time.

Withdrawal from the study: You can stop participating in the study at any time, for any reason, if you so decide. Should you decide to withdraw from the study; all data produced as a consequence of your participation will be destroyed.

Confidentiality: All information you supply during this research will be held in confidence and, unless you specially indicate your consent, your name will not appear in any report or publication of the research. Your data will be safely stored and only the researcher will have access to this information.

Click **Accept** to take part in this study or close this window if you choose not to participate.

Accept

APPENDIX B: QUESTIONNAIRE

Research questionnaire:

Promoting health citizenship and multilingualism in the health insurance industry

Questionnaire

(1) Which medical scheme do you belong to?

- ☐ Government Employees Medical Scheme
- ☐ Discovery Health Medical Scheme
- ☐ Other

If other, please specify

(2a) What is your home language(s), you may choose more than one?

- ☐ Afrikaans
- ☐ English
- ☐ Setswana
- ☐ Sesotho
- ☐ Sepedi
- ☐ isiXhosa
- ☐ isiZulu
- ☐ isiNdebele
- ☐ Siswati
- ☐ Xitsonga
- ☐ Venda

(2b) In which language do you mostly receive information from the medical scheme?

- ☐ Afrikaans
- ☐ English

- ☐ Setswana
- ☐ Sesotho
- ☐ Sepedi
- ☐ isiXhosa
- ☐ isiZulu
- ☐ isiNdebele
- ☐ Siswati
- ☐ Xitsonga
- ☐ Venda

(2c What language(s) would you prefer to receive health information?

- ☐ Afrikaans
- ☐ English
- ☐ Setswana
- ☐ Sesotho
- ☐ Sepedi
- ☐ isiXhosa
- ☐ isiZulu
- ☐ isiNdebele
- ☐ Siswati
- ☐ Xitsonga
- ☐ Venda

(3a) When you need health information, where do you request or find this from, please rank in order of importance from 1 (where you most request information) to 7 (where you least request information).

	1	2	3	4	5	6	7
Website	1	2	3	4	5	6	7
Newsletters	1	2	3	4	5	6	7
Brochures	1	2	3	4	5	6	7
Member guides	1	2	3	4	5	6	7
Call centre	1	2	3	4	5	6	7
Benefit schedule	1	2	3	4	5	6	7
Other	1	2	3	4	5	6	7

(3b) Where do you get most of your information?

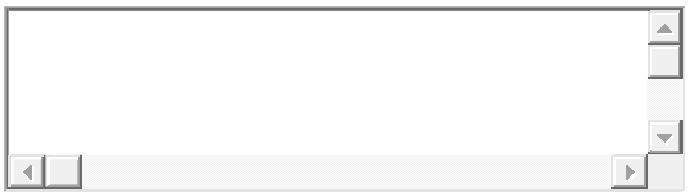
- ☐ Website
- ☐ Newsletters
- ☐ Brochures
- ☐ Member guides
- ☐ Call centre
- ☐ Benefit schedule
- ☐ Other

(3c) Do you find the information about health related information from the above source, in 3b above helpful?

- ○ Yes

- No
- It depends

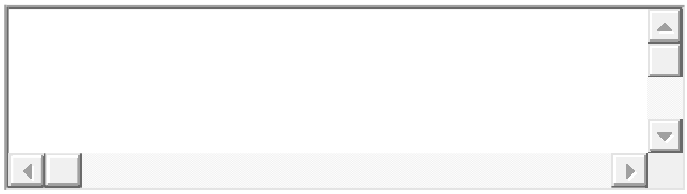
Additional comments



(3d) Was the information easy to understand?

- Yes
- No
- Somewhat/ in part

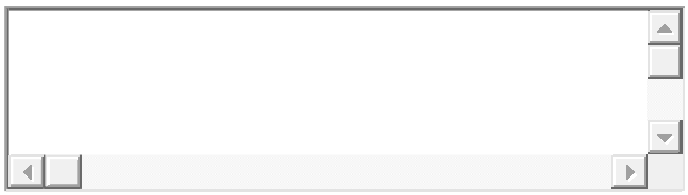
Additional comments



Do you find health-related information from your medical scheme useful?

- Yes
- No

(5) What are the advantages and disadvantages for you of getting information from your medical scheme from different resources (websites/brochures, member guides, benefit schedule etc)?



(6) Please choose an option for each statement below as a response to the following: What would make the information I receive more useful?

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(a) Easy to read newsletters	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(b) Better designed website and newsletters	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(c) Information that is in my home language	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(d) A call centre that offers information in my home language	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

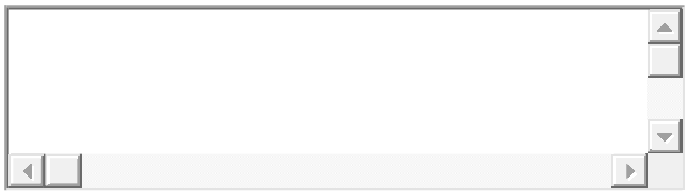
(7) What are you most and least satisfied with about information you receive?

(8) What can be improved in the way your medical scheme gives you information?

(9) Are you interested in information on health?

- Yes
- No
- Somewhat

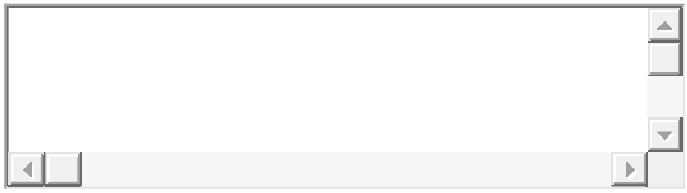
Additional comments



(10) Do you feel/believe/ think you have control over your own health?

- Yes
- No
- Somewhat

Additional comments



(11) Please choose an option for each statement below as a response to the following:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(a) I exercise to stay healthy	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(b) I have a well balanced diet that provides the right nutrients and minerals	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
(c) I know about my health risks	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

APPENDIX C: SUMMARY OF DATA (QUESTIONNAIRE)

Government Employees Medical Scheme	29
Discovery Health Medical Scheme	22
Other	29
Left Blank	32
User entered value	43
Average submission length in words (ex blanks)	1.86
Afrikaans	24
English	36
Setswana	10
Sesotho	6
Sepedi	9
isiXhosa	8
isiZulu	5
isiNdebele	2
Siswati	2
Xitsonga	4
Venda	2

Afrikaans	8
English	70
Setswana	2
Sesotho	2
Sepedi	2
isiXhosa	3
isiZulu	2
isiNdebele	2
Siswati	2
Xitsonga	2
Venda	2
Afrikaans	10
English	65
Setswana	4
Sesotho	3
Sepedi	3
isiXhosa	3
isiZulu	4

isiNdebele	2
Siswati	2
Xitsonga	3
Venda	2

Website	44	5	3	0	2	2	12
Newsletters	12	6	10	7	6	5	15
Brochures	13	8	13	9	8	5	9
Member guides	18	13	9	6	6	6	9
Call centre	21	8	6	8	7	4	13
Benefit schedule	13	13	10	8	6	10	7
Other	4	3	3	1	1	4	19

Website	49
Newsletters	14
Brochures	21
Member guides	11
Call centre	21
Benefit schedule	14
Other	5

Yes	54
No	1
It depends	19
Left Blank	57
User entered value	18
Average submission length in words (ex blanks)	28.11
Yes	52
No	1
Somewhat/ in part	20
Left Blank	65
User entered value	10
Average submission length in words (ex blanks)	12.40
Yes	63
No	10
Left Blank	25
User entered value	50
Average submission length in words (ex blanks)	24.28

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
(a) Easy to read newsletters	3	0	12	28	25
(b) Better designed website and newsletters	3	0	8	29	30
(c) Information that is in my home language	6	6	24	13	19
(d) A call centre that offers information in my home language	4	3	26	13	25

Left Blank	25
User entered value	50
Average submission length in words (ex blanks)	16.26
Left Blank	26
User entered value	49
Average submission length in words (ex blanks)	12.90
Yes	62

Somewhat	12
Left Blank	56
User entered value	19
Average submission length in words (ex blanks)	18.89
Yes	47
No	4
Somewhat	23
Left Blank	56
User entered value	19
Average submission length in words (ex blanks)	24.79

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
(a) I exercise to stay healthy	4	9	21	16	22
(b) I have a well balanced diet that provides the right nutrients and minerals	2	4	17	39	10
(c) I know about my health risks	3	0	12	35	22

APPENDIX D: CONSUMER HEALTH QUESTIONS

- How can the significance of research reports be judged?
- How trustworthy are the media? How can trustworthy information sources be located?
- What are the best ways to keep up-to-date on consumer health issues?
- How can quacks and quackery be spotted?
- What should be done after encountering quackery or health fraud?
- Is it sensible to try just about anything for health problems?
- How should advertisements for health products and services be analyzed?
- How should physicians, dentists, and other health-care specialists be selected?
- What should be done about excessive or unreasonable professional fees?
- When is it appropriate to obtain a second opinion about recommended surgery?
- What periodic health examinations are advisable? How much should they cost?
- Where can competent mental help be obtained?
- What kinds of toothbrushes and dentifrices are best?
- Can mouthwashes and dentifrices control the development of plaque on teeth?
- When are dental implants appropriate?
- Do amalgam fillings pose any health hazard?
- What rights should buyers and sellers have in the health marketplace?
- How trustworthy are chiropractors, naturopaths, and acupuncturists?
- Is it advisable for people with back pain to see a chiropractor?
- What is the best schedule for vaccinations?
- Is vaccination with Gardasil prudent?
- When are self-diagnosis and treatment appropriate?
- How should a hospital, nursing home, or convalescent facility be selected?
- What are the pros and cons of using an ambulatory health-care center?
- What facilities are available for people who need long-term care?
- How can a balanced diet be selected?
- Does vegetarian eating make sense?
- When is it appropriate to use vitamin or mineral supplements?
- Do antioxidant supplements prevent future diseases?
- Should “organic foods” or “health foods” be purchased? Are they worth their extra cost?
- Can taking vitamin C supplements prevent or cure colds?
- Should extra vitamins be taken during pregnancy?
- Will taking calcium supplements help prevent osteoporosis?
- Are any herbal products worth taking?
- How trustworthy is the advice given in health-food stores?
- Are food additives dangerous?
- What is the safe way to lose and control weight? Are diet pills helpful or harmful?
- Are electric vibrators and massage equipment useful for weight control or body shaping?
- Which exercise equipment provides good value for its cost?

- Is it a good idea to join a health club or exercise center?
- What principles should guide the evaluation and management of blood cholesterol levels?
- Can magnetic devices enhance athletic performance?
- Can any food or dietary measures prevent or influence the course of arthritis or cancer?
- Does it make sense to undergo detoxification?
- How do pain relievers compare?
- Should laxatives be used? By whom?
- Is it a good idea to use generic drugs?
- What products are useful for self-care and family care?
- What is the best strategy for protecting against sun exposure?
- Can any product help to grow, restore, or remove hair?
- Can wrinkles be removed with any product or with plastic surgery?
- What forms of birth control are safest and most effective?
- Are over-the-counter pregnancy test kits reliable?
- Are any over-the-counter drug products effective for menstrual cramps?
- What can women do about premenstrual syndrome (PMS)?
- Does the patenting of a health device ensure its safety and effectiveness?
- How do the different types of contact lenses compare?
- Who should determine the need for eyeglasses, contact lenses, or a hearing aid?
- How safe and effective is surgery to improve vision?
- Does it make sense to prepay funeral expenses?
- What services are available for the terminally ill?
- Which health coverage provides the best protection?
- How can consumers reduce their health-care costs?
- How much money should be budgeted for health care?
- What agencies and organizations help protect consumers?
- Which consumer groups are trustworthy?
- How can one register a complaint about a health product or service?

APPENDIX E: APPLICATION FORMS AND AFFIDAVITS

Discovery Health

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

Applying to become a member of Discovery Health Medical Scheme in 2011

Thank you for deciding to apply to join the Discovery Health Medical Scheme. This document is an application form for membership.
It also contains some rules for membership. Please make sure you read and understand the rules.

Who we are
The Discovery Health Medical Scheme (referred to as 'the Scheme') is the medical scheme that you are applying to become a member of.
This is a non-profit organisation, registered with the Council for Medical Schemes.
Discovery Health (Pty) Ltd (referred to as 'we' 'us' and 'our' or as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Scheme.

What you must do
Please go through these steps:
Step 1: Fill in the form in black ink, using one letter per block. Please print clearly.
Step 2: Read and understand the rules for membership (section 14).
Step 3: Sign 9, 13 and section 14.
Step 4: Please make sure the main applicant signs and dates any changes.
Step 5: Fax the completed and signed form to **011 539 3000** or email it to **application@discovery.co.za**
Step 6: Please attach a copy of each applicant's identity document to this application form. We also accept valid passports and birth certificates for children.

When you sign this application, you confirm that you have read and understood the rules for membership and agree to them.
If you have any questions, please let us or your financial adviser know. Once we have assessed your application, we will let you know if you have been accepted and what will happen next.

1. If you already have a Discovery Health Medical Scheme membership

If you are an active main or principal member of the Discovery Health Medical Scheme in the month before the date you want your membership to be effective, please contact us or speak to your employer or financial adviser first to see if we can transfer your membership instead of completing the rest of this application. Please complete only this section and section 13 and 14.

Membership number

I acknowledge and appoint my employer's contracted financial adviser for all matters relating to my membership of the Discovery Health Medical Scheme.

Signature of main applicant

2. About yourself (main applicant)

When do you want your cover to start? 2 0 D D M M 0 1

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth D D M M Y Y Y Y

Previous or maiden name

Preferred communication Email ☐ Post ☐ By choosing email, you will receive your communication quicker and there is less of an impact on the environment.

Preferred language English ☐ Afrikaans ☐

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Fax

Email

Discovery Health (Pty) Ltd administers the Discovery Health Medical Scheme Registration number 1997/013480/07 An authorised financial services provider

2. About yourself (main applicant) *(continued)*

Postal address (Post collected from post box, suite or private bag)

☐ PO Box ☐ Private Bag Box number

☐ Suite ☐ Postnet Suite Number

Suburb Postal code

If your post is delivered to your street address, please complete these details under physical address.

Physical address:

Suite/Unit number Complex name

Street number Street name

Suburb Postal code

Occupation Tax number

3. About your spouse or partner (if applying for cover)

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Previous or maiden name

ID or passport number Country of issue

Telephone (H) (W)

Cellphone Tax number

Email

4. About your dependants (if applying for cover)

Dependant 1

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Relationship to main member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

ID or passport number Country of issue

Is your dependant: married? Yes ☐ No ☐ financially dependent on you? Yes ☐ No ☐ disabled? Yes ☐ No ☐ a full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 2

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Relationship to main member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

ID or passport number Country of issue

Is your dependant: married? Yes ☐ No ☐ financially dependent on you? Yes ☐ No ☐ disabled? Yes ☐ No ☐ a full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

Dependant 3

Title Initials Surname

First name(s) (as per identity document)

Preferred name Sex M F Date of birth Y Y Y Y M M D D

Relationship to main member (for example, mother, child. Where your child is not your biological child, please state relationship, for example adopted child, foster child. Please give legal proof)

ID or passport number Country of issue

Is your dependant: married? Yes ☐ No ☐ financially dependent on you? Yes ☐ No ☐ disabled? Yes ☐ No ☐ a full-time student? Yes ☐ No ☐

Does your dependant earn an income? Yes ☐ No ☐ How much does your dependant earn each month? R

8. Your employment details

8.1 If your employer is paying your full contribution or a part of it and we need to debit their account, please complete 8.1:

Name of employer | Employer or billing number

Employee number (or PERSAL number for government employees. Please attach a clear copy of your salary slip.) | Date of employment (D D M M Y Y Y Y)

Branch name | Branch number

Please ensure your employer completes this warranty if this application form is not submitted with an employer application form:

Employer warranty

1. We warrant that the main applicant detailed in section 2 is an employee of our organisation.
2. The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory

Name

Designation

8.2 Only complete 8.2 if you own your own business and your business will be paying your contribution:

Name of your business

Registration number | VAT number

Telephone | Fax

Physical address | Postal address

Code | Code

9. Your banking details

9.1 Your contributions

If you will be paying your contributions in full, please complete this section:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

Please choose the date you would like us to debit your account

1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

9.2 Your claims refund

Can we use the same account we deduct contributions from to refund your claims? Yes ☐ No ☐

If you do not want to use the same banking details for your contributions and claims refunds, please give us the details you would like to use:

Please note: we cannot accept credit card account details

Bank name

Branch name

Branch code – – –

Account number

Type of account Cheque ☐ Savings ☐

Accountholder

By signing this application, you agree that once claims have been refunded into the bank account you have chosen, the Scheme will not be responsible in any way for the amounts refunded.

Signature of accountholder

10. Previous medical scheme details

Please give us the details of all registered South African medical schemes that you previously belonged to. We will use this information to determine if we need to apply any waiting periods, late-joiner penalty fees, or both.

Main applicant

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		D D M M Y Y Y Y	Yes ☐ No ☐	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes ☐ No ☐	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes ☐ No ☐	D D M M Y Y Y Y	
		D D M M Y Y Y Y	Yes ☐ No ☐	D D M M Y Y Y Y	

10. Previous medical scheme details *(continued)*

If all dependants were on the same medical scheme(s) as completed above, please tick here to confirm this. ☐
If any of your dependants applying for cover belonged to different medical schemes, please complete them below:

Spouse or partner ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

Dependant name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

Dependant name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

Dependant name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Scheme name	Membership number	Start date	Are you still a member?	End date if you have already resigned	Reason for leaving
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	
		Y Y M M D D	Yes ☐ No ☐	Y Y M M D D	

11. Moving from another medical scheme

Please make sure that you have completed section 10.

If you answer no to any question in 11.1, you must complete all the medical questions in section 12.

11.1 I confirm that all people named on this application:

1. are currently or have been members of a South African medical scheme for at least the past 24 months, and — Yes ☐ No ☐
2. have not had a break in membership of more than 90 days since resigning from that South African medical scheme. — Yes ☐ No ☐

If you answered **yes** to the above questions, please answer the questions in **11.2.**

If you answered **no** in **11** you must complete **section 12**.

11.2 For any person named on this application form:

1. Have they been admitted to hospital in the 12 months before this application? — Yes ☐ No ☐
2. Are they currently taking regular medicine or reasonably expecting to need medicine where the treatment costs more than R200 a month? — Yes ☐ No ☐
3. Are they planning to or reasonably expecting to be hospitalised (including for pregnancy) or expecting to receive dental or medical treatment costing more than R2 000 in the next 12 months? — Yes ☐ No ☐

If you answered **no** to **all** questions in **11.2**, we will not apply any waiting periods and you **do not** have to complete section 12.

If you answered **yes** to **any** questions in **11.2**, we will apply a three-month general waiting period to your application and you **do not** have to complete Section 12. During these three months, we will only cover claims relating to Prescribed Minimum Benefits according to the Scheme's rules.

If you feel that a three-month general waiting period should not be applied and you want to give us more information, complete section 12.

12. Your medical questions

A. Only the main applicant, spouse or partner and any adult dependant applying for cover needs to complete section 12.A.

Main applicant

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

12. Your medical questions *(continued)*

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐

Spouse or partner

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐

Adult 1

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐

Adult 2

How tall are you? ☐ . ☐☐ metres

How much do you weigh? ☐☐☐ kilograms

Do you drink alcohol? Yes ☐ No ☐ How many units of alcohol do you drink each week? ☐☐☐☐

1 unit of alcohol = 1 measure of spirits, ½ pint of beer or 1 glass of wine

Do you smoke? Yes ☐ No ☐ Amount each day ☐☐☐

If **no**, have you smoked in the last 24 months? Yes ☐ No ☐ If **yes**, amount each day ☐☐☐

If you stopped smoking, what was your reason for stopping? ☐

B. Have you or **any dependant** in this application ever experienced, been treated for, or are you currently suffering from any of the following symptoms, conditions or disorders?

12.1 Cancer **Yes** ☐ **No** ☐

Example: any form of cancer or pre-cancerous growths.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.2 Heart and circulation conditions **Yes** ☐ **No** ☐

Example: angina, chest pain, heart failure, murmurs, rheumatic fever, high blood pressure, heart attack, raised cholesterol, previous heart surgery or palpitations.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12. Your medical questions *(continued)*

12.3 Gynaecological conditions Yes ☐ No ☐

Example: ovarian cysts, endometriosis, fibroids, cervical disorders, menstrual disorders or pregnancy.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.4 Mental health Yes ☐ No ☐

Example: depression, anxiety, schizophrenia or bipolar disorder.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.5 Metabolic or endocrine conditions Yes ☐ No ☐

Example: diabetes, thyroid disorders, growth disorders, Cushing's disease or Addison's disease.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.6 Liver or pancreatic conditions Yes ☐ No ☐

Example: hepatitis, cirrhosis, liver failure, gallstones or pancreatitis.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.7 Gastrointestinal conditions Yes ☐ No ☐

Example: Crohn's disease, ulcerative colitis or bleeding ulcers.

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12. Your medical questions *(continued)*

12.8 Brain and nerve conditions **Yes** ☐ **No** ☐

Example: stroke, multiple sclerosis, epilepsy, migraine, Parkinson's disease, quadriplegia, paraplegia or cerebral palsy.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.9 Respiratory conditions **Yes** ☐ **No** ☐

Example: asthma, emphysema, chronic bronchitis, shortness of breath, persistent cough, cystic fibrosis, chronic obstructive airways disease, any lung surgery or coughing up blood.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.10 Musculoskeletal conditions **Yes** ☐ **No** ☐

Example: rheumatoid arthritis, osteoarthritis, myasthenia gravis, gout, osteoporosis, loss of limb, back problems and operations, slipped disk, back pain or any other conditions.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.11 Kidney or urinary tract conditions **Yes** ☐ **No** ☐

Example: kidney failure, kidney stones, recurrent infections, nephritis, prostate problems, blood or protein in urine or polycystic kidneys.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.12 Blood conditions **Yes** ☐ **No** ☐

Example: anaemia, leukaemia, bleeding disorders, haemophilia, lymphoma, deep vein thrombosis (blood clots) or pulmonary embolus.

	Name:	**Name:**
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12. Your medical questions *(continued)*

12.13 Are you or any of your dependants expecting surgery or planning hospitalisation or treatment in the next 12 months or have you been admitted to hospital in the last 12 months? Yes ☐ No ☐

	Name:	Name:
Medical diagnosis		
Date first diagnosed	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.14 Any symptoms not yet diagnosed by a medical professional or any condition which is not covered by these questions? Yes ☐ No ☐

	Name:	Name:
Symptom or condition		
Date first diagnosed (if applicable)	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

12.15 Have you or any of your dependants received medical advice or treatment from a medical professional in the 12 months before this application? Yes ☐ No ☐

	Name:	Name:
Symptom or condition		
Date first diagnosed (if applicable)	Y Y Y Y M M D D	Y Y Y Y M M D D
Date of last symptoms, consultation or hospitalisation	Y Y Y Y M M D D	Y Y Y Y M M D D
Medicines used for this condition and dosage		
Date last taken	Y Y Y Y M M D D	Y Y Y Y M M D D
Currently on treatment for this condition?	Yes ☐ No ☐	Yes ☐ No ☐

HIV and AIDS

You do not need to disclose the HIV status of you or your dependant(s) on this form if you do not feel comfortable doing so. However, if you, or one or more of your dependants, are HIV-positive, you or they must call us on **0860 100 417** within seven working days from the date we activate your Discovery Health Medical Scheme membership. We treat this information in the strictest confidence. If you, or one or more of your dependants, are HIV-positive, it is in your interest to register on the HIV*Care* Programme. A 12-month condition specific waiting period may apply to this condition.
When you call in to register on the HIV*Care* Programme, please confirm these details.

13. Permission to process and disclose information and to communicate with you

We and the Scheme will keep your information and the information about those you apply for confidential. You agree to us and the Scheme processing and disclosing your information in the following manner:

1. We will only share your personal and health information or the information of any dependant on your health plan if it is requested by a third party who you have already given your consent to for the disclosure of this information. The party that we and the Scheme share the information with agrees to keep the information confidential. If we want to share your information for any other reason, we will do so only with your permission
2. We and the Scheme may collect, collate, process and store your and all your dependants' personal information, including health information, as provided in this application and any information we get about you and your dependants:
   - for the administration of your health plan,
   - for providing any managed care services that you or any dependant on your health plan may require,
   - for providing relevant information to a contracted third party who requires information to provide a healthcare service to you or any dependant on your health plan; and
   - to profile and analyse any risk to the Scheme.
3. When providing us and the Scheme with personal and health information about a dependant on your health plan, you confirm that you have received appropriate permission to disclose this information to us and the Scheme.
4. We and the Scheme may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including and not limited to information about your credit history, financial history, personal information and judgment or default history.
5. We and the Scheme may communicate with you about any changes in your health plan, including any changes in your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen.
6. We and the Scheme want to keep you updated on information about any offers or new products Discovery may make available at any time. Please indicate whether you agree to receive this information from us and the Scheme. Yes ☐ No ☐

Signature of main applicant

14. Rules for membership

14.1 Rules for membership

Rules for membership are the rights and responsibilities for your membership of the Scheme. They may change from time to time. You may ask us for a copy at any time.

When you sign this application, you confirm that you have read and understood the rules and you agree that you and those you apply for will be bound by them.

Where applicable you also acknowledge and appoint your employer's contracted financial adviser for all matters relating to your membership of the Discovery Health Medical Scheme.

Please speak to your financial adviser or us if there is anything you do not understand.

14.2 Who you are applying for

You may apply to join the Scheme on your own or together with other people – your spouse, your partner and people who are financially dependent on you. To be treated as financially dependent for this application, a dependant must earn an income of less than what is stated in the Scheme rules, or you must have a legal responsibility to provide financially for them. We might ask you to give us proof of financial or legal responsibility.

You will be called the principal member or main member in our future communications to you.

14.3 Acting for others

You confirm you have the right to act for others

By signing this document, you confirm that:

- you have the right to apply for membership and to act for those you apply for in any matter relating to this application.
- you have received permission from your spouse and any dependants over 21 to act for them in any matter relating to this application.

14.4 Giving information

You must give us true, correct and complete information

To consider your application for membership, the Scheme must learn more about you and those you apply for.

Information about you and those you apply for must be true, correct and complete. This includes the details you give in this application form and in future dealings with us. It is important that you tell us about any medical condition, symptom or illness relating to you or those you apply for, even if you do not consider it relevant to your application.

We may ask those you apply for who are 21 and older for information and it will be treated as if we had asked you in your role as main member.

We may get information from other relevant sources

To consider your application for membership, conduct underwriting or risk assessments or to consider a claim for medical expenses, you agree that we and the Scheme can get information about you and those you apply for from other relevant sources. These include any entity that is part of Discovery Holdings Limited, medical practitioners, financial advisers, credit bureaus or industry regulatory bodies. We and the Scheme may (at any time and on an ongoing basis) verify with the parties mentioned in this section that the information you give on this application and in respect of any matter pertaining to or that arose during your membership of the Scheme, is true, correct and complete.

I give my permission that the Scheme may get any information that is relevant to my application from my employer.

Tell us about changes right away

If any of the information you gave to us changes between the day you sign this document and the day your membership starts, you must tell us in writing what the changes are. This includes information about your health and the health of those you apply for.

When the Scheme may cancel my membership/s

The Scheme may cancel any memberships immediately and keep any contributions paid, if you and those you apply for:

- do not give us information that later turns out to be relevant to this application.
- give us any information that is not true, correct and complete.
- do not tell us about any relevant changes (including about your health and the health of those you apply for) between the day you sign this document and the day cover starts.

14.5 About becoming a member

We will consider your application

We will consider your application and any one of the following will happen:

- we will accept you on these terms; or
- we will send a letter with revised terms; or
- we will let you know that we need more information about you and those you apply for before your cover can start.

We might not pay for certain expenses immediately

The Scheme may have waiting periods that apply in certain circumstances. This means there may be a set time period before we start paying for any general or specific medical conditions. Please speak to your financial adviser or us to find out if waiting periods apply to your membership and the memberships of those you apply for.

Resign from current medical schemes when accepted

It is illegal to be a member of more than one medical scheme at the same time. You and those you apply for must resign from your current medical schemes when you receive notice from the Scheme by letter, email or SMS telling you that you and those you apply for have been accepted.

You must ensure contributions are paid on time

As the main member of the Scheme, you are responsible for ensuring that your contributions and the contributions of those you apply for are paid on time every month.

We and the Scheme may record calls

We and the scheme may record telephone conversations with you and with those you apply for.

The recordings and all information we get during the recordings will be processed and kept as required by law.

14.6 Repaying medical savings if you leave

You must repay any medical savings owing if you leave the Scheme

When you become a member, depending on the plan you chose, you may have money available in advance to use for medical expenses during the year. This money is made available in an account called the 'Medical Savings Account'. If you leave the Scheme before the year is up, you must repay the portion of medical savings you have used that is more than you have paid back to the Scheme over the year.

Signature of main applicant

Date 2 0 Y Y M M D D

The main applicant must sign and date any changes

15. What happens next with your application

Once you send us your application, here is what will happen:

- We capture and check your details.
- If any details are missing or if we need more information for underwriting purposes, we will contact you.
- We will send you or your financial adviser a letter, SMS or an email to let you know when we have accepted your application to join the Discovery Health Medical Scheme. This letter may contain certain conditions.
- You sign this letter to confirm your start date or acceptance of any waiting periods or late-joiner penalties (if we apply any) and return it to us.
- When we activate your membership, you will get an SMS from us.
- You will then get a pack in the post. This will contain details about your plan and all you need to get started.

If you do not hear from us seven days after sending us your application, please contact your financial adviser or us on **0860 100 345**.

Discovery Vitality

Contact us
Tel: 0860 99 88 77, PO Box 653574, Benmore, 2010, www.discovery.co.za

Application to join Vitality and KeyFIT

Please make sure that you sign this application

Main applicant's surname

Main applicant's ID number

Please choose one of the following options:

- ☐ Vitality
- ☐ KeyFIT
- ☐ Vitality and KeyFIT
- ☐ KeyClub Starter
- ☐ KeyFIT and KeyClub Starter

Only members with a KeyCare Health Plan can join KeyFIT without joining Vitality as well.
KeyClub Starter is available to main members under age 65 on a KeyCare Plan, who are not in the highest income band.

Banking details

If you are paying your own Vitality contribution, please complete this section.

Bank name

Branch name Branch number – –

Account number Type of account Cheque ☐ Savings ☐

Accountholder

Signature of accountholder Signature of main applicant

Please note: If you are using someone else's bank account, the accountholder must sign above to confirm this.

Please choose the date you would like us to debit your account (if you are not a government employee):
1st ☐ 10th ☐ 15th ☐ 20th ☐ 25th ☐

If your membership is not activated in time for the debit order date you chose above, you will have two separate debit orders in the first month you pay your contribution, because you pay your contribution in advance. The first debit order will be collected on the first day of the month and the second debit order will be collected on the actual date you have chosen in the same month. From then on we will collect your monthly contribution on the date you have chosen.

If you are a government employee on the PERSAL payroll system, please tick the box below to tell us which day of the month you want us to debit your account.
1st ☐ 5th ☐ 8th ☐ 21st ☐ 26th ☐

The Discovery credit card

The DiscoveryCard is a Visa credit card.
Vitality members can get cash back, travel savings and a world of convenience through our DiscoveryCard partners.
Would you like to apply for a Discovery credit card? Yes ☐ No ☐ Gross monthly salary R

Please note: When assessing your DiscoveryCard application, a credit check will be done. An accredited consultant will phone you to complete the application.
A DiscoveryCard will only be issued if you meet credit approval criteria.

Vitality HealthStyle (Pty) Ltd Registration number 1999/007736/07 An authorised financial services provider

Vitality contributions for 2011

	Vitality	KeyFIT	Vitality and KeyFIT
Member	R125	R27	R133
Member + spouse or dependant	R145	R33	R158
Member + 2 or more dependants	R153	R42	R177

Permission to process and disclose information and to communicate with you

We will keep your information and the information about those you apply for confidential. You agree to us processing and disclosing your information in the following manner:

1. We will only share your personal and/or health information or the information of any dependant on your Vitality policy if it is requested by a third party who you have already given your consent to for the disclosure of this information and the party that we share the information with agrees to keep the information confidential. If we want to share your information for any other reason, we will do so only with your permission.
2. We may collect, collate, process and store your personal information, as contained in all sections of this application and any information that is provided to use after the inception of your Vitality policy:
   - For the administration of the Vitality Programme,
   - For the provision of any services that you or any dependant on your Vitality policy may require,
   - For the provision of relevant information to a contracted third party who require such information to render a service to you or any dependant on your Vitality policy and only if such contracted third party agrees to keep the information confidential.
3. When providing us with personal information about a dependant on your Vitality policy, you confirm that they have provided you with appropriate permission to disclose that information to us. This includes consent to the administration their membership to Vitality, the provision of any services to them as required, the provision of relevant information to a contracted third party who require such information to render a service to them.
4. We may obtain relevant health information from Discovery Health (Pty) Ltd and the Scheme to administer the Vitality Programme.
5. We may provide to any credit bureau or credit providers industry association any information relating to your creditworthiness or any consumer credit information including but not limited to credit history, financial history, personal information and judgment or default history.
6. We may communicate to you any changes in your Vitality policy, including any changes in your contributions or any changes/enhancements to the benefits you are entitled to.
7. We would like to keep you updated with information about any offers or new products Discovery may make available from time to time. Please indicate that you agree to receive this information. Yes ☐ No ☐

Signature of main applicant

Rules for membership

Discovery Vitality is separate from the Scheme and administrator

Discovery Vitality is a separate company from Discovery Health (Pty) Ltd ('the administrator') and the Discovery Health Medical Scheme (referred to as 'the Scheme'). It is formally registered under the name Vitality HealthStyle (Pty) Ltd, (registration number 1999/007736/07) and takes care of the administration of the Vitality programme ('Discovery Vitality'), DiscoveryCard and the DiscoveryCard Loyalty Programme.

Rules of the Vitality programme

A full set of rules is available from Discovery Vitality on request. In the event of a conflict between what is set out here, on our website and the rules of Vitality, the rules will always apply.

Your contributions to Discovery Vitality are separate

The contributions you pay to Discovery Vitality are not part of the contributions you pay to the Scheme.

Permission to get information from the Scheme

You specifically give Discovery Vitality permission to get the relevant information from the Scheme to administer the Vitality programme and to increase our product offering to you.

Sharing your information

Discovery Vitality will keep your information and the information about those you apply for confidential. Discovery Vitality may share this information and information about your membership with other relevant parties, including your employer, only if the following two conditions are met:

1. The information is needed only to administer and promote the Vitality programme. This includes asking for and sharing details about your credit standing and the credit standing of those you apply for with any credit bureau in line with the requirements of the National Credit Act.
2. The parties that Discovery Vitality shares the information with will agree to keep the information confidential.

When you sign this application to join Vitality, you confirm that you have read and understood the rules for membership and you agree that you and those you apply for will be bound by them.

Signature of main applicant

Date 2 0 Y Y M M D D

The main applicant must sign and date any changes

5. Your financial adviser's details

Financial adviser's name: Peter Pyburn — Code: 1004647978

Intermediary house: Peter J Pyburn — Code: 1020000277

Financial adviser's telephone number (W): 083 3778893 — Lead number:

Email: peter@peterpyburn.co.za

Bank reference number (if applicable): (Mandatory for all ABSA and FNB financial advisers)

I declare that:

1. I am an accredited financial adviser in terms of the Medical Schemes Act and licensed by the FSB in terms of the FAIS Act at the date of signing this application form.
2. I am appointed by the client to provide advice about this application.
3. I have a valid contract with the Scheme and I have made the client aware of the commission payable by Discovery Health Medical Scheme.
4. I am responsible for providing the applicant with:
   - my name, physical address, postal address and telephone number
   - impartial advice that is in his or her best interest.
5. I am accountable for any advice given to the member about completion of this application form and joining the Scheme.

Financial adviser's signature

6. Please select your health plan

Executive Plan	Comprehensive Plans	Priority Plans	Saver Plans	Core Plans	KeyCare Plans
☐ Executive	☐ Classic	☐ Classic	☐ Classic	☐ Classic	☐ KeyCare Plus
	☐ Classic Delta network option	☐ Essential	☐ Classic Delta network option	☐ Classic Delta network option	☐ KeyCare Core
	☐ Essential		☐ Essential	☐ Essential	
	☐ Essential Delta network option		☐ Essential Delta network option	☐ Essential Delta network option	
			☐ Coastal	☐ Coastal	

How would you like us to refund claims from the Medical Savings Account if your plan has one? Discovery Health Rate ☐ Cost ☐

You have the right to ask for help in selecting a health plan that suits your needs. By signing this application you confirm that you are familiar with the conditions and benefits of the plan you select.

7. If you applied for KeyCare Core or KeyCare Plus

Your KeyCare contributions depend on the higher income of you or your spouse or partner.
Income for this purpose includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment); pension and annuity proceeds; interest earned on active and passive investments, including rental income from leasing properties; and distributions received from a trust.

IMPORTANT NOTICE:

Declaring income lower than your actual income constitutes fraud. This will lead to the immediate termination of your membership. By signing this application form, you give your permission for us to verify your declared income using all relevant internal and external sources, as per 14.4.
If you do not complete the income section, we will assume that you earn more than R100 000 for each year.

	Main member	Spouse or partner
Total earnings over the last 12 months	R	R
Occupation		

I declare that this income declaration is true and accurate.

X Signature of main applicant

If the highest earner received less than R100 000 for each year then please provide the following supporting documentation as proof of income:

- Last 3 months' bank statements; **and**
- If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate
- If student, proof of enrolment at academic institution
- If self-employed, most current financial statements
- If pensioner, proof of annuity and/or employer pension and/or State Older Person's Grant
- If unemployed, UIF certificate

Please complete this if you have selected the KeyCare Plus Plan.

	Name	GP name	Practice number	Second GP name*	Practice number
Main applicant					
Spouse or partner					
Dependant 1**					
Dependant 2**					
Dependant 3**					

* If you live far away from where you work or you often need to work in different towns or provinces, you may need a second GP. Please only choose a second GP if this applies to you.

** Please make sure that the dependant information you give above is the same as the dependant information in section 4 of this form.

Discovery Health

Contact us
Tel: 0860 99 88 77, PO Box 784262, Sandton, 2146, www.discovery.co.za

KeyCare Income Verification

As a member with a KeyCare Plan, you have to give us updated information about your income to ensure that you are in the correct income band for your contribution.

If you do not submit this form, include all the information and sign it, we will change your contribution to that of the highest income band on KeyCare Plans. To verify your income, we may get information from other relevant sources and we may also contact you for more information about the details you provided.

How to complete this application form

- Fill in the form in black ink, using one letter per block. Please print clearly.
- Read, understand and sign section two (2) which is the declaration of your income.
- Please make sure the main applicant signs and dates any changes.
- Fax the completed form and all the required documents to **011 539 2506** or email it to **healthinfo@discovery.co.za.**

1. About yourself (main applicant)

Title | Initials | Surname

First name(s) (as per identity document)

ID or passport number

Membership number

About your spouse or partner

Title | Initials | Surname

First name(s) (as per identity document)

ID or passport number

Membership number

2. Income declaration

Your KeyCare contributions depend on the higher of the income of you or your spouse or partner.
Income includes, but is not limited to, average monthly earnings over the last 12 months from guaranteed earnings, guaranteed allowances, company contributions and variable pay or commissions from employment (including self-employment and informal employment), pension and annuity proceeds, interest earned on active and passive investments, including rental income from leasing properties and distributions received from a trust.

Important notice about declaring your income
Declaring income lower than your actual income is fraud. This will lead to the immediate cancellation of your membership and you will not be able to join the Discovery Health Medical Scheme again. By signing this declaration, you give us permission to verify your declared income using all relevant sources, as shown under 4.4.

	Main member	Spouse or partner
Total earnings over the last 12 months	R	R
Occupation		

I declare that the income and information I provided is true and correct

Main applicant's signature | Spouse or partner's signature

3. Proof of income

We do not require proof of income if the highest earnings declared in section 2 is more than R100 000 for the year.
If the highest earning declared in section 2 is less than R100 000 for the year, please provide your last 3 months' bank statements and the following supporting documents as proof of income for you and your spouse :

- If employed, your last 3 months' payslips and commission schedules, or most recent tax year's IRP5 certificate.
- If student, formal proof of enrolment at academic institution (student cards are not considered as proof).
- If self-employed, most recent audited income statement.
- If pensioner, proof of annuity and employer pension or State Older Person's Grant.
- If unemployed, UIF certificate.

4. Permission to process and disclose information and to communicate with you

1. We and the Scheme will keep your information and the information about your registered dependants confidential. You agree to us and the Scheme processing and disclosing your information in the following manner:
2. We and the Scheme may collect, collate, process and store your and all your dependants' personal information, including health information, as provided while you are members of Discovery Health:
   - for the administration of your health plan; and
   - to profile and analyse any risk to the Scheme.
3. When providing us and the Scheme with personal and health information about a dependant on your health plan, you confirm that you have received appropriate permission to disclose this information to us and the Scheme.
4. We and the Scheme may provide any credit bureau or credit providers industry association with any information about your consumer credit record, including and not limited to information about your credit history, financial history, personal information and judgment or default history.
5. We and the Scheme may communicate with you about any changes in your health plan, including any changes in your contributions or changes and enhancements to the benefits you are entitled to on the health plan you have chosen.
6. We and the Scheme want to keep you updated on information about any offers or new products Discovery may make available at any time.

Please indicate whether you agree to receive this information from us and the Scheme. Yes ☐ No ☐

Member's signature

Date 2 0 Y Y M M D D

Your quick guide to
becoming a member of GEMS

gems
Government Employees Medical Scheme

Thank you for considering GEMS as your medical scheme of choice. This quick guide explains what you need to do to become a member of GEMS.

1. At the back of the application form we included an application guide with important information that you can refer to when you are completing your application form. If your application form is completed correctly, we will be able to process your application quicker. A delay may impact on your membership commencement.

2. Please complete the **application form** and make sure that you have included all the documents that are part of your application. Please sign the form in all sections where you are asked to do so.

3. Once you have completed this form, please send it with all the documents to GEMS in any of the following ways:
   - Fax: **0861 00 4367**
   - Email: **enquiries@gems.gov.za**
   - Regional offices: **The addresses can be found at the back of the application guide.**
   - Post: **GEMS, Private Bag X782, Cape Town, 8000**

4. If your application is successful, a welcome pack will be posted to you within 5 working days of your application being approved.

5. If your application form is not completed correctly, we will not be able to register you as a member until we have received all information and documents that form part of your application. Remember that we need the following together with your application form:
   - Copies of the IDs of all your dependants which you would like us to register on GEMS
   - Your latest payslip or letter of appointment
   - Affidavits for your dependants
   - Previous medical scheme membership certificate (if any)

6. If we are unable to complete your registration as a member, we will contact you within 5 working days after we received your application to either require further information, or to inform you that your application has not been successful.

Please contact our Call Centre on **0860 00 4367** or email **enquiries@gems.gov.za** if you require any further assistance with the completion of your application form.

Applying to
become a member of GEMS

gems
Government Employees Medical Scheme

Who we are
GEMS is a restricted medical scheme, duly registered as such, which provides healthcare funding for its members.

GEMS was specifically created to meet the healthcare needs of Public Service employees. We offer a range of excellent healthcare benefit options: Sapphire, Beryl, Ruby, Emerald and Onyx. Our goal is to help you and your family to get the best possible healthcare at the most affordable rates.

What you have to do to join GEMS
1. Complete all the sections carefully and in full.
2. Read the terms and conditions in **Section L** carefully.
3. Remember to sign the form in all sections where you are asked to do so.
4. Remember to include all the required documents that are part of your application.
5. Send the completed application form with all the documents to GEMS.

Remember: It is important to read the Rules of GEMS, because, by signing this form, you agree to follow them, whether you have read them or not. A free copy of the GEMS Rules is available on **www.gems.gov.za** under 'About Us'. You can also request a copy by calling us on **0860 00 4367**.

Please remember to initial the bottom of each page and sign in all places where your signature is required.

Section A: Member details

Persal/employee no
Employer (on payslip)
Surname
Full first name(s)
Initials Title (Mr, Mrs, Ms or other)
ID no or Passport no
Date of birth D D M M Y Y Y Y Nationality
Gender M F
Marital status Married Single Divorced Widow/er Co-habiting
Income tax no
Postal address
Code
Residential address
Code
Tel no (H) ( ) (W) ( )
Fax no ( ) Cell phone no
Email

In case of an emergency please contact _____ (name and relationship)
on: Tel no (H) ( ) Work no ( )
Cell phone no Email
Postal address
Code
Residential address
Code

FOR OFFICE USE ONLY

Please note that the emergency contact must be above the age of 21 years.

Section B: Details of dependant/s

Please refer to Section B of the application guide to make sure that the people you wish to register as your dependants qualify for membership. Remember to include **certified copies of all IDs**, as we need this information to register your dependants. If you want to register more than 3 dependants, please include the details on a separate sheet and send it with this application form.

Dependant 1

Surname

Full first name(s)

Gender ☐ M ☐ F Date of birth D D M M Y Y Y Y

ID no or Passport no

Relationship Basic income (if applicable)

Language preference (written) Cell phone no

Email address

Postal address Code
(if different from Principal Member)

Residential address
(if different from Principal Member)

Code

Dependant 2

Surname

Full first name(s)

Gender ☐ M ☐ F Date of birth D D M M Y Y Y Y

ID no or Passport no

Relationship Basic income (if applicable)

Language preference (written) Cell phone no

Email address

Postal address Code
(if different from Principal Member)

Residential address
(if different from Principal Member)

Code

Dependant 3

Surname

Full first name(s)

Gender ☐ M ☐ F Date of birth D D M M Y Y Y Y

ID no or Passport no

Relationship Basic income (if applicable)

Language preference (written) Cell phone no

Email address

Postal address Code
(if different from Principal Member)

Residential address
(if different from Principal Member)

Code

Section C: Choose a benefit option

Please select only one benefit option from the list below and mark the applicable block with an X.

☐ Sapphire ☐ Beryl ☐ Ruby ☐ Emerald ☐ Onyx

Section D: When do you want to join GEMS

Please indicate the month from which you want your GEMS medical cover to start 0 1 M M Y Y Y Y

Please indicate the date on which you started with your current employer D D M M Y Y Y Y

Section E: Your basic monthly salary

Employed applicants: Please indicate your basic monthly salary (remuneration on a cost-to-company basis). If you are at middle or senior management level, please indicate your gross monthly package. Remember to include your latest pay slip or letter of appointment if you are a new employee.

Basic monthly salary R _____ . ___

Section F: Previous/current medical scheme details

Are you currently registered on any medical scheme? ☐ Yes ☐ No

If yes, are you the Principal Member or a dependant? ☐ Principal Member ☐ Dependant

If you are a Principal Member of, or a dependant on, another medical scheme, you must ensure that your membership is cancelled before you can be covered by GEMS. We suggest that you give notice of termination of your membership to the other scheme, but ensure that your medical cover is not terminated until such time as you have received written confirmation from GEMS that you have been accepted as a member. **Kindly plan accordingly.** Please include your certificate of membership, which shows the end date of your membership on your current medical scheme, with your application.

Name of current/previous medical scheme _____

Membership number _____

Period of membership From D D M M Y Y Y Y to D D M M Y Y Y Y

Section G: Paying your contributions

Active employees: Monthly contributions are deducted automatically from their salaries, where applicable.

Please choose only one payment method from the list below:

☐ Debit order ☐ Cash

- If you choose to pay in cash, please use the following banking details when depositing your contribution:
  Bank: First National Bank (FNB) **Account Name:** Government Employees Medical Scheme
  Account Number: 62094049593 **Branch Code:** 204109 **Reference:** Your member number

Section H: Your bank account details

You need to complete this section in full, as we cannot register you as a member of GEMS if we do not have your bank account details. We require these details to pay refunds to you, to collect your medical scheme contributions (if applicable) and any money that you owe GEMS.

Name of bank _____

Name of account holder _____

Bank account _____

Branch name _____

Branch code _____

Type of account ☐ Current ☐ Savings ☐ Transmission

Account holder's signature _____ Date of signature D D M M Y Y Y Y

Initial _____

Section I: Your language preferences for written communication

We are busy updating our database to ensure that we can communicate with you in the language of your choice.

Please indicate in which language you prefer to receive your written communication?

☐ Afrikaans ☐ English ☐ isiNdebele ☐ Sepedi ☐ Sesotho ☐ SiSwati
☐ Setswana ☐ Tshivenda ☐ isiXhosa ☐ Xitsonga ☐ isiZulu

Please note that if you do not choose any language, your language preference will be registered as English.
Please note that the choices you have made will only come into effect during the course of 2013.

Section J: Your preferred method of receiving written communication

Based on your contact details provided, please indicate your preferred method of receiving written communication for the following communication items. Please choose only one method of delivery for each item based on the contact details you supplied us with in Section A.

Newsletters*	☐ Email	☐ Post	
Option change communication at the end of the year*	☐ Email	☐ Post	
Personalised letters	☐ Email	☐ Post	
Contribution statement**	☐ Email	☐ Post	☐ Cell phone
Claim statement**	☐ Email	☐ Post	☐ Cell phone

Translated versions are available on **www.gems.gov.za.*
***You need a cell phone that can access the internet to receive your statements in this manner.*

Section K: Permission to access information

Please note: Your application form will not be processed without your signature in Section K.

My dependants and I give permission to healthcare service providers in whose care we are or any other person who has information about me or my dependants' health to share any information:

1. that GEMS and its contracted third parties need to settle my or my dependants' claims;
2. that GEMS and its agents or its case managers need to manage healthcare services rendered to me or my dependants;
3. with the healthcare management department, on an anonymous basis, that is required for administrative and statistical purposes, provided such information shall be treated as confidential at all times.

I agree that my and my dependants' statistical healthcare data may be shared with third parties for trend analysis (eg. employer). ☐ Yes ☐ No

It is important to give GEMS and/or its agents your permission to negotiate with your and your dependants' doctor/s, hospital/s and any other healthcare service providers in order to ensure that you receive optimal care that is cost effective.

I have read and understood the above statements. I have had an opportunity to question and consider these and I agree to the responsibilities entrusted to GEMS. My signature below confirms that I give permission to the above.

Signature of Principal Member _____ **Date** D D M M Y Y Y Y

Section L: Terms and conditions (your responsibilities)

Please note: Your application form will not be processed without your signature in Section L.

Please read the terms and conditions below carefully. These contain acknowledgements of fact that may impact on your rights. These terms and conditions shall be read together with the Rules of GEMS and the Medical Schemes Act (Act 131 of 1998)("the Act"), and all these provisions shall be binding on you and your dependants.

1 The answers that I have given here are full, complete and true. I understand that if my dependants and I are accepted as members of the Government Employees Medical Scheme ("GEMS"), my answers on this form will form the basis of our membership. I furthermore confirm that should I have failed to disclose any material information, my and/or my dependants' membership may be cancelled or suspended.

2 I apply for my dependants and I to join GEMS. I confirm that I am duly authorised to apply on behalf of my dependants. As such, I confirm that my dependants and I shall be duly bound by these terms and conditions, the Rules of GEMS, the Medical Schemes Act (Act 131 of 1998) and any other terms as may be relevant from time to time.

2.1 **I agree that my dependants and I will follow the Rules of GEMS.** I have read the Rules and have been given an opportunity to consider, familiarise myself with and agree to be bound by the Rules, if my application for membership is accepted. I am aware that I can access the Rules of GEMS on their website at **www.gems.gov.za** (About Us) and that I can request the Rules from GEMS on **0860 00 4367**.

2.2 I also understand that, in the event of a dispute, the processes for resolving such a dispute as contained in the Rules of GEMS, will be decisive.

2.3 The Rules of GEMS apply to this application.

2.4 I confirm that my beneficiaries, with the exception of my spouse or life partner, are fully or partially dependent on me and that they do not receive an income that is more than the maximum Government social pension. I also confirm that they are not permanently employed at the date of signing this form.

2.5 I understand that my dependants and I may not belong to two medical schemes at the same time.

3 **I acknowledge that if my dependants and I do not disclose all the information that is relevant to the assessment of this application, it will make any contract which may result from this application void.**

3.1 **I acknowledge and agree that the Board of trustees of GEMS may exclude me and/or any of my dependants from benefits, or suspend (pending investigation) or terminate any of our memberships,** should the Board find any of us guilty of abusing the benefits and privileges of GEMS by presenting false claims or making a material misrepresentation or by the non-disclosure of factual information required in terms of the Act. In such event, any of my dependants and/or I may be required by the Board to refund to GEMS any sum of money which has been paid as a result of such a misrepresentation or non-disclosure.

4 **I will notify GEMS within 30 days of any change in the circumstances on which GEMS based its assessment of my and my dependants' eligibility for GEMS membership. I acknowledge that failure to do so may make any contract which may result from this application void.**

4.1 If any of my dependants and/or I have failed to disclose relevant changes in circumstances and the contract then becomes void, **GEMS will have the right to claim back any amounts** that it may have paid to me or any person on me or my dependants' behalf under such a contract.

4.2 **I again acknowledge and agree that the Board may exclude me and/or any of my dependants from benefits, or suspend (pending investigation) or terminate any of our memberships,** should the Board find any of us guilty of abusing the benefits and privileges of GEMS by presenting false claims or making a material misrepresentation or by the non-disclosure of factual information required in terms of the Act. In such an event, any of my dependants and/or I may be required by the Board to refund to GEMS any sum of money which has been dispersed as a result of such a misrepresentation or non-disclosure.

5 I have been provided with a brochure reflecting the benefits that my dependants and I may become entitled to if this application is accepted by GEMS. **The benefits have also been explained to me and I have had an opportunity to question and consider them.**

5.1 **The estimated monthly contributions that I will be expected to pay if this application is accepted have also been explained to me prior to me making this application.** All subsidies will be confirmed by my employer. **I have had an opportunity to question and consider the monthly contributions and understand that my and my dependants' benefits may be suspended, or our membership cancelled, if I fail to pay the monthly contributions. I give permission to GEMS and/or my employer to start deducting my monthly contributions immediately from my joining date.**

5.2 **It is my responsibility alone (as a member) to make sure that GEMS receives my monthly contribution.**

5.3 I will pay all sums that I owe to GEMS on demand. I acknowledge and agree that failure to pay any debt due to GEMS may result in suspension of membership and/or handover to a third party for debt collection.

Section L: Terms and conditions (your responsibilities) Continued

5.4 **I acknowledge and agree that non-receipt of a single month's contribution will result in suspension of my and/or any of my dependants' medical scheme benefits,** and that this suspension will last until I have paid all arrear contributions.

5.5 **I acknowledge and agree that non-receipt of two months' contributions may result in the cancellation of my membership** of GEMS after due process has been followed in terms of the Rules and the internal processes of GEMS.

6 I understand that if the employer is responsible for paying my medical scheme contributions or any part thereof, I hereby authorise and instruct my employer to:

- Deduct from my remuneration (and any other sums due to me by my employer) any amounts that I may owe to GEMS from time to time; and
- Pay such amounts to GEMS.

6.1 I hereby authorise and instruct any person (such as my employer) who holds funds for my benefit after I cease employment, to pay all amounts owing to GEMS in respect of services rendered to me and/or my dependants by a healthcare service provider.

7 If I am accepted as a member, I must, both now and in future, give GEMS all such information and evidence as it may require from time to time for purposes of my and my dependants' membership of GEMS. For this purpose, **I authorise GEMS and/or its agents to obtain from any person any necessary information that they may require concerning me or any of my dependants in assessing my or my dependants' eligibility or any claim in relation to this application or my medical scheme membership.** I direct that person to provide GEMS and/or its agents with such information on request. I understand that this information will be kept confidential at all times and might be used for research, statistical data and managed care. However, if GEMS wishes to use this information for any other reason, GEMS will obtain my or my dependants' permission to do so.

7.1 I understand that all staff within GEMS and its contracted third parties are bound by confidentiality agreements and that GEMS will ensure that adequate data security measures are in place.

7.2 I understand that if for any reason, there should be a breach in confidentiality, GEMS will take responsibility and manage such a breach according to its internal disciplinary processes.

7.3 I hereby authorise any medical doctor or other healthcare provider who has attended to me in the past or who will attend to me in the future, to provide GEMS and/or its agents with such information as it may require. I understand that this information will be kept confidential at all times.

7.4 **I, on both my behalf and on my dependants' behalf, therefore give up the protection afforded to me under the provisions of any law or regulation that restricts the giving of such information and expressly authorise GEMS the right to access my information as and when it is necessary.**

8 **I consent to the recording of all conversations between myself/any of my dependants and GEMS, its agents or contracted parties,** and acknowledge and agree for all information obtained through these conversations to form part of the records of GEMS. In addition, I consent to all these records remaining the sole property of the GEMS and its agents.

9 I will notify GEMS should I or any of my dependants require hospitalisation for a non-emergency event at least 48 hours before the event. I acknowledge that failure to do so will result in a co-payment that I will have to pay.

10 I acknowledge and agree that GEMS may ask my dependants and I for proof of identification at any stage.

11 I acknowledge and agree that as part of my and my dependents' membership, GEMS may impose certain **general or condition-specific waiting periods.**

12 I undertake to give one **(1) calendar months' written notice should I wish to terminate my membership or deregister any of my dependants.**

13 I understand that if I have selected any of the GEMS Network options (i.e. Sapphire or Beryl), day-to-day and chronic claims will be paid only if I use healthcare service providers chosen by GEMS, unless the healthcare condition is one which requires emergency treatment.

14 I agree to receive member communication from GEMS. If I do not understand the information that I receive, I will ask GEMS to provide this to me in a language that I understand.

15 I understand that GEMS will only pay claims if these are valid and comply with the Rules of GEMS.

I have read and understand the above terms and conditions. I have had an opportunity to question and consider these and I agree to the consequences. My signature below confirms that I agree with the terms and conditions above.

Signature of Principal Member _____ **Date** D D M M Y Y Y Y

Initial _____

Section M: Our responsibilities

GEMS declare that:

1. A member's personal details and medical information will be kept confidential at all times and will not be used for commercial purposes. Adequate data security measures are in place to protect such information from unauthorised access.

2. Access to a member's personal and medical information is granted to employees of GEMS and its contracted service providers.

3. GEMS and its contracted service providers will use member information for the following purposes: processing the application for membership, payment of claims, managed care processes, determining member's access and entitlement to benefits, risk management practice and any other purpose which directly relates to a member's membership of GEMS.

4. All employees of GEMS and its contracted service providers are bound by internal confidentiality agreements.

5. Confidentiality agreements have been entered into with all of GEMS' contracted service providers who have access to member information for the purposes of data transfer and management, GEMS' administration and managed care arrangements.

6. In the event of a breach of confidentiality, GEMS will assume responsibility and will manage such a breach according to the GEMS' internal disciplinary procedures.

Please call us on **0860 00 4367** if you have not received confirmation of your membership on GEMS within 5 working days from the date of submitting your application.

Section N: Affidavits

Please complete the relevant affidavits in full, ensuring that all required signatures are present. All affidavits must be signed by a Commissioner of Oaths before submitting your application to GEMS.

As part of your application, GEMS requires sworn affidavits confirming information about the dependants you would like to include on your membership.

Affidavit A

Sworn affidavit confirming dependency of beneficiaries

gems
Government Employees Medical Scheme

To whom it may concern

Member no _____ Date D D M M Y Y Y Y

Persal/employee/pension no _____

Dear Sir/Madam

I, _____,

(ID no _____) hereby declare the following in respect of my dependant/s:

1. I wish to add the dependant/s listed below as beneficiaries on my membership of GEMS, and
2. The dependant/s are fully (financially and otherwise) dependent on me, and
3. The dependant/s listed are not self-sufficient (financially and otherwise). I also declare that my dependant/s are:
   - ☐ Student/s (please attach proof of registration at a recognised tertiary institution); or
   - ☐ Mentally/physically disabled (please attach a doctor's report).

Please ensure that you complete this section in full.

Details of dependant/s **(please attach a separate sheet if you have more than 2 dependants)**

DETAILS OF DEPENDANT/S					
No	Full first name	Surname	ID no	Relationship	Monthly income
1					
2					

If your dependant/s surnames are different from yours, please provide a reason for this:

_____

Thus declared on this ____ day of ____ 20 ____ in _____.

I know and understand the contents of the declaration. I have no objections to taking the prescribed Oath.

I consider the Oath binding on my conscience. So help me God.

Signed:

Principal Member of GEMS_____ Date D D M M Y Y Y Y

Witness_____ Date D D M M Y Y Y Y

Witness_____ Date D D M M Y Y Y Y

The above statement was made by the deponent and the deponent knows and understands the contents of the statement. The statement was sworn by the deponent and his/her signature placed thereon in my presence in _____ on _____ at _____.

STAMP BY COMMISSIONER OF OATHS

Tel 0860 00 4367 • Fax 0861 00 4367 • enquiries@gems.gov.za • www.gems.gov.za

Affidavit B

Sworn affidavit confirming partner as beneficiary

gems
Government Employees Medical Scheme

To whom it may concern

Member no _____ Date D D M M Y Y Y Y

Persal/employee/pension no _____

Dear Sir/Madam

To be completed by Principal Member of GEMS

I, _____,

ID no _____ hereby declare the following in respect of my partner (details below):

Please ensure that you complete this section in full.

Full first name	Surname	Gender	ID no

That I wish to add my partner as a beneficiary on my membership of GEMS.

To be completed by partner

I, _____,

ID no _____ hereby declare that I am _____

_____ partner.

To be completed by witness

I, _____,

ID no _____ hereby witness that _____

_____ wishes to add

_____

as a beneficiary on his/her membership of GEMS.

Thus declared on this ___ day of ___ 20 ___ in _____.
I know and understand the contents of the declaration. I have no objections to taking the prescribed Oath. I consider the Oath binding on my conscience. So help me God.

Signed:

Principal Member of GEMS _____ Date D D M M Y Y Y Y

Partner _____ Date D D M M Y Y Y Y

Witness _____ Date D D M M Y Y Y Y

The above statement was made by the deponent and the deponent knows and understands the contents of the statement. The statement was sworn by the deponent and his/her signature placed thereon in my presence in _____ on _____ at _____.

STAMP BY COMMISSIONER OF OATHS

Tel 0860 00 4367 • Fax 0861 00 4367 • enquiries@gems.gov.za • www.gems.gov.za

Affidavit C

Sworn affidavit confirming dependency of grandchild/ren

To whom it may concern

Member no _____ Date D D M M Y Y Y Y

Persal/employee/pension no _____

Dear Sir/Madam

Note: Grandchildren include great grandchildren and so forth.

(To be completed by Principal Member of GEMS)

I, _____,

(ID no _____) hereby declare the following in respect of my dependant/s who are my grandchild/ren:

1. That I wish to add the dependant/s listed below as beneficiaries on my membership of GEMS, and
2. That the dependant/s are fully (financially and otherwise) dependent on me and that he/she/they are not self-sufficient (financially and otherwise).

(To be completed by parent, where applicable)

I, _____,

(ID no _____) hereby declare that I am the parent of the child/ren listed below and that Mr/Mrs/Ms _____ is financially and otherwise responsible for my child/ren and wants to add him/her/them as dependant/s on his/her medical scheme.

Please ensure that you complete this section in full.

Details of dependant/s **(please attach a separate sheet if you have more than 2 dependants)**

DETAILS OF DEPENDANT/S				
No	Full first names	Surname	ID no	Relationship
1				
2				

Thus declared on this ___ day of ___ 20 ___ in _____.

I know and understand the contents of the declaration. I have no objections to taking the prescribed Oath. I consider the Oath binding on my conscience. So help me God.

Signed:

Principal Member of GEMS _____ Date D D M M Y Y Y Y

Parent of child/ren _____ Date D D M M Y Y Y Y

Witness _____ Date D D M M Y Y Y Y

Witness _____ Date D D M M Y Y Y Y

The above statement was made by the deponent and the deponent knows and understands the contents of the statement. The statement was sworn by the deponent and his/her signature placed thereon in my presence in _____ on _____ at _____.

STAMP BY COMMISSIONER OF OATHS

Tel 0860 00 4367 • Fax 0861 00 4367 • enquiries@gems.gov.za • www.gems.gov.za

Affidavit D

Sworn affidavit confirming dependency of niece/s and/or nephew/s

gems
Government Employees Medical Scheme

To whom it may concern

Member no _____ Date D D M M Y Y Y Y

Persal/employee/pension no _____

Dear Sir/Madam

(To be completed by Principal Member)

I, _____,

(ID no _____) hereby declare the following in respect of my dependant/s who are my niece/s and/or nephew/s:

1. That I wish to add the dependant/s listed below as beneficiaries on my membership of GEMS, and
2. That the dependant/s are fully (financially and otherwise) dependent on me and that they are not self-sufficient (financially and otherwise).

(To be completed by sibling, where applicable)

I, _____,

(ID no _____) hereby declare that I am the parent of the child/ren listed below, that I am unemployed and that Mr/Mrs/Ms _____ is financially and otherwise responsible for my child/ren and wants to add him/her/them as dependant/s on his/her medical scheme.

Please ensure that you complete this section in full.

Details of dependant/s **(please attach a separate sheet if you have more than 2 dependants)**

DETAILS OF DEPENDANT/S				
No	Full first names	Surname	ID no	Relationship
1				
2				

Thus declared on this ___ day of ___ 20 ___ in _____.

I know and understand the contents of the declaration. I have no objections to taking the prescribed Oath. I consider the Oath binding on my conscience. So help me God.

Signed:

Principal Member of GEMS _____ Date D D M M Y Y Y Y

Sibling _____ Date D D M M Y Y Y Y

Witness _____ Date D D M M Y Y Y Y

Witness _____ Date D D M M Y Y Y Y

The above statement was made by the deponent and the deponent knows and understands the contents of the statement. The statement was sworn by the deponent and his/her signature placed thereon in my presence in _____ on _____ at _____.

STAMP BY COMMISSIONER OF OATHS

Tel 0860 00 4367 • Fax 0861 00 4367 • enquiries@gems.gov.za • www.gems.gov.za

Guide to completing
and submitting your application form

gems
Government Employees Medical Scheme

Please do not return this guide with your completed application form.

We have highlighted the important information in the various sections of your application form that will assist you in completing your application form correctly. Please read the guide carefully.

Please make sure that you also supply the following supplementary documentation for the Principal Member of GEMS:

1. Copy of ID for Principal Member of GEMS.
2. Membership certificate from the previous medical scheme with an end date.
3. Your signature where required (Sections H, K, L and N). Please also remember to initial the bottom of each page.
4. Ensure that applicable affidavits are certified and stamped by a Commissioner of Oaths.

Completing your application form

Section A: Member Details

- It is compulsory to complete all information in Section A, where applicable.
- ***Persal/employee number:*** Your Persal number is available on your salary advice.
- ***Employer:*** Please indicate your current employer's name and organisation code. Your organisation code can be obtained from your salary advice, if you are a civil servant.

Section B: Details of Dependant/s

- Please complete the details of your dependant/s in Section B of the application form.
- It is compulsory to complete the ID details of your dependant/s in this section. We will be unable to process your application if this information is not provided.
- **If your dependant/s earn more than the annual maximum Government social pension or if they are permanently employed, they cannot be registered as your dependants because they are not considered to be financially dependent on you.**
- No dependants, other than those listed in the table below, are eligible for membership. The following documentation is required with an application if the Principal Member wishes to register beneficiaries as dependants on GEMS:

Description of dependant	Documentation required
Spouse	• The completed Section B Details of Dependant/s on application form. • If it is a customary marriage, an affidavit from the member confirming the obligation towards his/her spouse. • A marriage certificate is required if married and the surname of the spouse differs from that of the Principal Member. • A certified copy of the spouse's ID.
Ex-spouse	• The completed Section B Details of Dependant/s on application form. • Evidence (such as the Divorce Order) of a legal obligation to provide medical support per divorce settlement or court. • A certified copy of the ex-spouse's ID.
Partner	• The completed Section B Details of Dependant/s on application form. • A sworn affidavit, confirming that the dependant is the member's life partner (the sworn affidavit is to be completed by the Principal Member, partner and witness). • A certified copy of the partner's ID.
Child (biological, adopted, step, foster or a child to whom a Principal Member is liable for family care and support), with Principal Member's surname, under the age of 21	• The completed Section B Details of Dependant/s on application form. **Note**: If the child's surname differs from the Principal Member's, an affidavit confirming the obligation towards the child and stating the reason for the difference is required (a sworn affidavit is to be completed by the Principal Member of GEMS). • **Note**: The spouse must be registered to add the step child. • A certified copy of ID or birth certificate of the child.

Description of dependant	Documentation required
Child (biological, adopted, step, foster or a child to whom a Principal Member is liable for family care and support) over the age of 21	• The completed Section B Details of Dependant/s on application form. • If the child is a student: - Proof of registration at a recognised tertiary institution; and - An affidavit from the Principal Member confirming financial dependency on the Principal Member. • If the child is totally dependent due to mental or physical disability: - Proof of disability from a medical practitioner (a medical assessment report is to be completed by a Medical Practitioner) and - An affidavit from the Principal Member confirming financial dependency on the Principal Member, and that the child is not in a state institution. • If the child is not a student or disabled: - An affidavit from the Principal Member confirming financial dependency on the Principal Member. • **Note**: The Principal Member's spouse must be registered before a step child may be added as a beneficiary. • A certified copy of the child's ID.
A dependant with a different surname	• If a dependant's surname differs from the Principal Member's, an affidavit confirming the Principal Member's obligation towards the dependant and stating the reason for difference is required (a sworn affidavit to be completed by the Principal Member of GEMS). • A certified copy of the dependant's ID.
Child-in-law	• The completed Section B Details of Dependant/s on application form. • An affidavit from the Principal Member confirming financial dependency of the child-in-law on the Principal Member. • **Note**: The Principal Member, or the Prinicipal Member's spouse, or a child of the Principal Member must be registered to add the child-in-law. • A certified copy of the child-in-law's ID.
Parents, step parents, parents-in-law, step-parents-in-law, grandparents or grandparents-in-law	• The completed Section B Details of Dependant/s on application form. • An affidavit from the Principal Member confirming financial dependency of any such dependants. • **Note**: Parents-in-law, step-parents-in-law and grandparents-in-law may only be registered if the Principal Member's spouse is also registered as a dependant. • A certified copy of the relevant dependant's ID.
Grandchild, great grandchild and so forth	• The completed Section B Details of Dependant/s on application form. • Proof of child support grant received by the Principal Member or the Principal Member's spouse, or a sworn affidavit confirming financial dependency of the relevant grandchild on the Principal Member (sworn affidavits are to be completed by the Principal Member and biological parent, where applicable). • **Note**: If the biological parent of the child is also registered as a dependant of the Principal Member, only an affidavit from the Principal Member, confirming financial dependency of the grandchild or great grandchild, is required. • A certified copy of the relevant grandchild's ID.
Sibling, half sibling, step sibling and in-law sibling	• The completed Section B Details of Dependant/s on application form. • A sworn affidavit confirming financial dependency of the sibling on the Principal Member (the sworn affidavit to be completed by the Principal Member). • **Note**: The sibling of a Principal Member or of a Principal Member's spouse may be registered as a dependant. • **Note**: The Principal Member's spouse must be registered as his/her dependant. • A certified copy of the relevant sibling's ID.
Children of sibling	• The completed Section B Details of Dependant/s on application form. • A sworn affidavit, confirming financial dependency of niece/s and/or nephew/s on the Principal Member (a sworn affidavit must be completed by the Principal Member and sibling, where applicable). • **Note**: The children of a sibling of a Principal Member or the Principal Member's spouse may be registered as a dependant. • **Note**: If the parent of the child (the parent being a sibling of the Principal Member) is also registered as a dependant, only an affidavit from the Principal Member, confirming the financial dependancy of the niece/nephew, is required. • A certified copy of the relevant niece's/nephew's ID.

Adult dependant rates are payable for all dependants over the age of 21, excluding:

- Disabled dependants (child rates are payable);
- Children who are students (child rates are payable until the age of 27).

Please note that your adult dependant/s may be subject to an annual eligibility review. Members must provide annual proof of dependency of all beneficiaries over the age of 21 (excluding disabled dependants).

Your dependants who are students may also be subject to an annual eligibility review. Members may be required to provide annual proof of student registration.

The medical questionnaire for disabled dependants is available on the GEMS website at www.gems.gov.za or can be obtained by calling the Call Centre on 0860 00 4367.

What you need to do if you have to provide GEMS with the following documents:
Medical report: Take the Assessment Report by Medical Practitioner (Disability) Form to the applicable medical practitioner and request him/her to complete the form. The consultation will be covered from the GP consultation benefit for registered members. Unregistered members are required to cover the cost of this consultation out of their own pockets.

Section C: Benefit Option

- Please make your selection carefully, as you are not able to change your option during the course of the year without the approval of the Board of Trustees.
- Your out-of-hospital and other block benefits will be pro-rated if your admission date is not the 1st of January. This means that your benefit limits will be calculated in proportion to the period of membership left for the year from your date of joining.
- You will be able to change your option at the end of each year with effect from the first day of the following year.

Section D: Joining Date

You need to indicate the date on which you wish to join GEMS in Section D of the Application Form.
Please take note of the following:

- Your admission date must be on the first day of a month.
- Where possible, ensure that your admission date at GEMS directly follows the cancellation date of your previous medical scheme, as a break in membership may negatively impact on your employer subsidy and your medical cover.
- If no date is entered, your registration date will be automatically determined for the first day of the month following the month in which your application was received by GEMS so that no arrear contributions (which are debts that you owe to GEMS) are created.
- If your selected joining date causes arrear contributions, such arrears will be deducted from your salary or bank account (where applicable).
- In respect of new employees, your registration date cannot be earlier than your appointment date.

Section E: Your Basic Monthly Salary

Employed applicants: Please indicate your basic monthly salary. If you are at middle or senior management level, please indicate your gross monthly package (include latest payslip or letter of appointment if you are a new employee).

Section F: Previous/Current Medical Scheme Membership

The law states that you and your dependants may not be registered on two medical schemes at the same time. Please note that we do not accept membership cards as proof of cancellation of your membership on another medical scheme.

Please attach a membership certificate with an end date from your previous medical scheme.

What you need to do if you belonged to another medical scheme prior to joining GEMS:

- Please contact your previous medical scheme and request them to provide you with a **membership certificate** with an end date as proof of membership.
- Please note that if your membership certificate does not reflect an end date, we are unable to use it. Remember to complete and forward a termination letter to cancel your membership with the previous medical scheme, if you have not done this yet.
- If you are unable to obtain a membership certificate, we will accept a termination of membership letter on your previous medical scheme's letterhead, as proof of resignation.

Sections G and H

It is compulsory to complete these sections in full, as your application form will not be processed if banking details are not provided.

Section I and J
Use these sections to indicate the preferred language in which you would like to receive your GEMS communication.

Sections K and L
Please ensure that you read these sections carefully before you sign these sections on your application form.

Sections N: Affidavits
- Please complete any affidavits that may be applicable to your situation and have them stamped by a Commissioner of Oaths before submitting your application form.
- Please note: Your application form will not be processed without your signature.

Submitting your completed application form

Once you have completed your application form, you can submit it for registration in any of the following manners:

- **Fax it to 0861 00 4367; or**
- **Email it to enquiries@gems.gov.za; or**
- **Drop it off at any of the following regional offices:**

  FREE STATE
  - Bloemfontein: Bloem Plaza, Shop 124, Maitland Street
  - Welkom: Gold Fields Mall, Shop 51A, c/o Stateway & Buiten Street

  LIMPOPO PROVINCE
  - Polokwane: Shop 1, 52 Market Street
  - Thohoyandou: Unit G3, Metropolitan Centre

  EASTERN CAPE
  - East London: 13A Surrey Road
  - Mthatha: Savoy Complex, Unit 11 & 12A, Nelson Mandela Drive

  NORTHERN CAPE
  - Kimberley: New Park Centre, Shop 14, Bultfontein Way & Lawson Street
  - Upington: 61A Mark Street

  MPUMALANGA
  - Nelspruit: Shop No. 18, Nedbank Centre, 30 Brown Street, Nelspruit CBD
  - eMalahleni (Witbank): Safeways Crescent Centre, Shop S67, c/o President & Swartbos Streets, Die Heuwel

  NORTH WEST
  - Klerksdorp: City Mall, Shop 101, c/o OR Tambo & President Street, Klerksdorp CBD
  - Mafikeng: Mmabatho Megacity Shopping Centre, Shop 39, c/o Sekame & James Moraka Streets, Mmabatho

  KWAZULU-NATAL
  - Durban: The Berea Centre, Shop G18, Entrance 1, 249 Berea Road, Berea
  - Pietermaritzburg: Deloitte House, Suite 3, Block A, 181 Hoosen Haffejee Street (Berg Street)

  GAUTENG
  - Johannesburg: Traduna House, 118 Jorrisen Street, Ground Floor, c/o Jorrisen and Civic Boulevard (opposite Civic Centre)
  - Pretoria: Sancardia Building, Shop 51, First Floor, c/o Beatrix & Church Streets, Arcadia

  WESTERN CAPE
  - Worcester: Mountain Mill Shopping Centre, Shop 125 A & B, Mountain Mill Drive
  - Cape Town: Constitution House, 124 Adderley Street

- **Post it to GEMS at Private Bag X782, Cape Town, 8000**

Upon processing of your application form, you will receive an SMS to confirm receipt of your application. You will be informed accordingly should any additional documents be required to complete the registration of your application.

Upon completion of the registration of your application form, a member pack that includes your membership cards and a comprehensive member guide will be posted to your postal address.